UNIT 12 HIV/AIDS AND PALLIATIVE CARE

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12.1 INTRODUCTION

You have learnt about the implications of HIV/AIDS on the individual, family and community and about the care of the terminally ill from previous units. This section deals with the palliative care for people living with AIDS.

There are people living with AIDS in every part of India and from every walk of life. They are living as best as they can, faced not only by illness but also by emotional stress, economic crisis and most of all social stigmas and discrimination. The general fatigue, fevers and diarroha, the wasting away of their bodies; the sudden onslaught of many different illnesses can leave a once healthy person feeling weak, unable to walk or breathe or do anything that they did usually. These people are often shunned and hunted out of their own homes and neighbourhood by family, in-laws, neighbours and friends. They are often denied basic health care. Even in death, they are not spared. Their bodies are at times discarded and families are denied the privilege of performing the last rites, leaving families and friends devastated.

Our society seems unable to cope with a situation that apparently challenges them to be non-judgemental. One wonders where all the warmth and hospitality have gone when society deals with people living with HIV/AIDS (PLWHA), who more than anyone else, need an empathic, caring community around them. We perceive ourselves as sympathetic, gentle and tolerant yet, we fail to reach out to and hold hands of those in need. We need a society, which will act together to bring about a change in the lives of PLWHA and their families so as to allow them to live a better quality of life.

In major cities and towns, such services may be purchased at a small cost but in smaller towns and villages, professional care is scarce. Hence, PLWHA migrate to larger towns or cities. However, newer surroundings offer limited access to their usual recreational activities and significantly curtail interaction with supportive groups of persons; friends or family, however, small it may have been.

12.2 OBJECTIVES

The purpose of this unit is to provide you with an understanding about the concept of palliative care for a patient with AIDS and how this care caters to the physical
and mental concerns of a person with HIV/AIDS as well as his deterioration over a period of time till the time of his death. By the end of this unit you should be able to:

- describe the term ‘palliative care’;
- understand the differences between AIDS palliative care and traditional palliative care;
- have knowledge of pain management in AIDS palliative care; and
- have knowledge of simple treatment measures to make the patient comfortable.

12.3 AIDS AND PALLIATIVE CARE

Addressing the psycho-social needs of persons living with AIDS requires that care givers adhere to the principles of palliative care which include:

- providing open communication;
- respecting the individual;
- nurturing unconditional positive regard;
- involving significant others; and
- developing the support network.

The goal of palliative care is relief from pain and suffering in advanced disease, spiritual and psychological or emotional support to the patient. In the context of AIDS, good palliative care often includes active and supportive/prophylactic treatment the palliative care team may work along with a primary care physician. Palliative care begins from the time the diagnosis of AIDS.

Initially, the domain palliative care in India was restricted by a narrow perspective developed in patients dying of cancer- a model based on withholding disease specific treatment and providing simple hospice-based terminal care. Of late, palliative care has been extended to taking up a key role in the management of patients with advanced AIDS. It works with supportive treatment and has increasing importance as symptoms increase. Palliative care is provided in a very few centres across the country. YRG CARE at Chennai, and Snehadan in Bangalore are two such centres, which provide palliation to the patients. The concept of palliative care is presently also being introduced in several teaching institutes, hospitals, clinics as well as in homes. Designated palliative care services must be provided flexibly to meet the needs of the patient rather than according to one specific mode of service delivery. They are frequently provided on a consultative basis to assist the basic primary care team, General Practitioner (GP), community nurse or hospital staff in providing continuum of care for the patients. At first, palliative care had little to offer to patients with advanced AIDS. The incidences of infections rise over time making palliative care for AIDS different from other terminal illness. Palliative care includes disease-specific antimicrobial/antiviral and other non-AIDS treatment when appropriate, largely because this is often the best way to relieve symptoms. For a major number of PLWHA, costs of Antiretroviral Therapy (ART) are costly and thus, GPs and HIV related organizations recognize the need for palliative care. It is important to remember the unit on care of the dying after this section as the aftermath of death on the family is also an important component of palliative care in AIDS.
Table 12.1: Differences Between AIDS Palliative Care and Traditional Palliative Care.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Traditional palliative care</th>
<th>AIDS palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Care only for cancer patients</td>
<td>Care for AIDS patients</td>
</tr>
<tr>
<td>2</td>
<td>Mainly older age group</td>
<td>Mainly younger age group</td>
</tr>
<tr>
<td>3</td>
<td>Not much variation in disease patterns</td>
<td>Wide variation of disease patterns</td>
</tr>
<tr>
<td>4</td>
<td>Predictable terminal phase</td>
<td>Unpredictable terminal phase</td>
</tr>
<tr>
<td>5</td>
<td>Less drugs required</td>
<td>Several drugs required at same time</td>
</tr>
<tr>
<td>6</td>
<td>Less incidence of psychological symptoms</td>
<td>More psychological symptoms and dementia</td>
</tr>
<tr>
<td>7</td>
<td>Less substance abuse</td>
<td>More substance abuse</td>
</tr>
<tr>
<td>8</td>
<td>Pain management most important</td>
<td>Control of many symptoms including pain</td>
</tr>
</tbody>
</table>

The philosophy of contemporary palliative care is to shift the focus of care away from the disease and prolong survival. It is also towards meeting patients' needs and improving their quality of life. Palliative care doctors can assist GPs and AIDS specialists in:

- making an assessment of the patho-physiology of symptoms;
- managing palliative therapeutics;
- clinical decision making in advanced disease;
- identifying the psychological, social and spiritual components of suffering;
- breaking bad news to patients and families;
- liaisoning between hospital and home care; and
- managing the terminal phase.

Check list for regular examination

As part of palliative care, it is important to know what and where the problem could be if the patient complains of particular symptoms and how best to ease this problem. Table 12.2 briefly describes this.

The information given in table 12.2 will be useful for health care providers, particularly, doctors and nurses.

It helps to perceive a person with AIDS as living with the disease, rather than dying of it. Many people living with AIDS are challenging society's perception that AIDS is a death sentence. They are coming out in the public announcing their HIV status openly without any shame, guilt or hostility. Self help groups and support groups are emerging all over the country to make society acknowledge their existence and to support those in need. It is no longer US and THEM but US only is the positive replacement.
Table 12.2: Check List for Regular Examination.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Symptoms</th>
<th>Important conditions to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Localized weakness</td>
<td>Cerebral space-occupying lesion, cytomegalovirus, polyradiculopathy</td>
</tr>
<tr>
<td>2</td>
<td>Numbness</td>
<td>Periphereal neuropathy, drug toxicity</td>
</tr>
<tr>
<td>3</td>
<td>Abdominal pain</td>
<td>Gastritis/Oesophagitis, acalculous cholecystitis, colitis, intraabdominal malignancy, enteric pathogens</td>
</tr>
<tr>
<td>4</td>
<td>Skin rash</td>
<td>Folliculitis, Norwegian scabies, molluscum contagiosum, Kaposis Sarcoma</td>
</tr>
<tr>
<td>5</td>
<td>Difficulty swallowing</td>
<td>Oral/esophageal candidiasis or ulceration</td>
</tr>
<tr>
<td>6</td>
<td>Cough</td>
<td>Pneumocystis carinii Pneumonial, bacterial infection, tuberculosis, pulmonary Kaposis Sarcoma</td>
</tr>
<tr>
<td>7</td>
<td>Change in mental state</td>
<td>Toxoplasmosis, cryptococcus, progressive multifocal leukoencephalopathy, dementia, cerebral lymphoma</td>
</tr>
<tr>
<td>8</td>
<td>Change in vision</td>
<td>Cytomegalovirus retinitis, papilloedema, (cryptococcus, lymphoma)</td>
</tr>
<tr>
<td>9</td>
<td>Diarrhoea</td>
<td>Enteric pathogens, cytomegalovirus, cryptosporidium</td>
</tr>
</tbody>
</table>

(For identifying some of these infections, special laboratory techniques are required)

Check Your Progress

Notes: a) Use the space provided for your answer.

b) Check your answer with those provided at the end of this unit.

1. What are the differences between HIV palliative care and traditional palliative care?

12.4 DEFINITION OF PALLIATIVE CARE

Palliative care as a philosophy of care is the combination of supportive and compassionate therapies intended to comfort and support individuals and families who are living with life threatening illness. During both illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices. Palliative care may be combined with therapies aimed at reducing the illness or it may be the total focus of care.

Palliative care is planned and delivered through the collaborative efforts of an inter disciplinary team including the patient, family and care givers. It should be
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available to the patient and his/her family at any time through the illness phases and bereavement.

While many caregivers may be able to deliver some of the therapies that provide comfort and support, the services of a specialized palliative care programme may be required as the degree of distress, discomfort, and dysfunction increases.

AIDS has challenged palliative care. The complex dynamics of the disease process, the treatments, the social circumstances, including stigmatization, have all brought new dimensions to the provision of palliative care. Most care programmes/services did not respond quickly to meet the needs of persons living with AIDS. Over the last few years, a few specialized programmes have been developed. Snehadaan, Bangalore, YRG CARE, Chennai and Missionaries of Charity centres are a few that attend to the patient and his/her family without any hesitation. There are, however, still large gaps in the palliative care resources available to persons living with AIDS in India.

While symptom control and support may be needed prior to knowing the diagnosis, disease-specific therapies are likely to play an important role soon afterwards. As the degree of disease, distress, discomfort and dysfunction waxes and wanes over time, there is a varying need for:

Disease-specific therapy (anti-retrovirals, anti-microbials)

Therapy focused on providing comfort, including symptom control, and psycho-social support. During the last days of a person’s life, therapies that provide comfort and support are usually more important, though, disease-specific therapies may continue until death, for e.g., anti-retrovirals, anti-microbials for cytomegalovirus (CMV) etc.

Three essential components of palliative care are:

- Teamwork and partnership
- Psycho-social support
- Symptom relief

Teamwork and partnership

Palliative care is best administered by a group of people working as a team. In practice, some of the following will be involved:

- Doctors and nurses
- Physiotherapist, occupational therapists and others
- Social worker, counsellors etc.
- Chaplain, priests, spiritual comforters etc.
- Volunteers

Because, there is an overlap of roles, co-ordination is an important component of teamwork. The essence of palliative care is partnership between the caring team, the patient and the family. Partnership requires mutual respect and this is manifested as follows:
- Courtesy in behaviour
- Politeness in speech
- Being honest
- Listening and explaining
- Agreeing on priorities and goals
- Discussing treatment options
- Accepting treatment refusal

**Psycho-social support**

In order to provide excellent palliative care, the care giver must have underlying respect and understanding for the person living with AIDS (PLWHA). Needs and interventions should be discussed with the PLWHA along with the care givers and must include issues of concern to the PLWHA and his/her family and friends as well.

Psycho-social aspects of care should include:
- Communication-breaking bad news
- Strategies for coping with uncertainty
- Psychological aspects of terminal illness
- Care of the relatives, spiritual care, religious needs etc.
- Helping the family cope with bereavement

The aims of communication are to reduce uncertainty, enhance relationships, and give the patient and family a direction in which to move. It includes active listening, asking questions and avoiding distance.

In breaking bad news, it is important to remember, never to lie to a patient, and avoid thoughtless candor. The caregiver-patient relationship strategies for coping with uncertainties really depend on how long the caregiver thinks the patient has to live.

Coping strategies:
- A rolling horizon
- Hope for the best but plan for the worst
- Reaching anniversaries
- Living one day at a time

Remember that if a patient is deteriorating month by month, he/she is likely to live for months, if s/he is deteriorating week by week, he/she is likely to live for weeks and if she is deteriorating day by day, he/she is likely to live for days.

Regarding the other aspects of psycho-social care, kindly refer to the units on "care of the dying' and ‘implications of HIV/AIDS on individual, family and community’

**Symptom relief**

Pain is common in AIDS. It is progressive, occurring in patients at different stages of infection especially, in hospitalized patients and ambulatory AIDS patients. The
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disease or a side effect of treatment or debility or an unrelated condition may cause pain. In relieving pain, it is essential to identify the cause and treat it specifically, if possible, as the best form of palliation is direct treatment.

Some common examples include peripheral neuropathy, headache, abdominal pain due to enteric pathogens, malignancies and perianal pain due to herpes simplex, and ulcers in the mouth. Pain in patients with advanced diseases is not simply a sensory event but a multi-dimensional phenomenon with cognitive, psychological and socio-cultural components, each of which has to be addressed for optimal pain control.

Often, pain is an under-rated and under-treated problem in patients with advanced AIDS disease.

Management of pain

The goal of palliative care is to relieve the patient from acute and chronic pain even if it means dosing the patient with round-the-clock analgesics.

Aggressive treatment of pain is required in the later stages or terminal phase of the disease. It is important to reassure the patient and family at all times. The underlying pathology must be diagnosed and treated as soon as possible. Oral medications are recommended before initiating parenteral drugs, if possible. Treat associated conditions like nausea, constipation, depression and insomnia. Make use of complementary treatment e.g., warm compresses, radiotherapy, and regional/local anesthesia.

There is also a three-step model for pain treatment of AIDS disease.

Step I: Mild pain

Use nonopioid analgesic medications as recommended (dosage and frequency) by the doctor like. Paracetamol, Ibuprofen, Acetaminophen etc.

Step II: Moderate pain

If the above, drugs fail to relieve, a weak opioid can be used in addition to the Nonopioid like. Codeine, Propoxyphene.

Step III: Severe pain

When the above combination is no longer effective, a strong opioid may be used e.g., Morphone, Methadone, Pethidine. All types of medication should be carried out under the direction of a qualified physician.

Check Your Progress

Notes: a) Use the space provided for your answer.

b) Check your answer with those provided at the end of this unit.

2. Illustrate with the help of diagram the three essential components of palliative Care.

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12.5 COMMON SYMPTOMS AND THEIR RELIEF MEASURES

Wasting

PLWHA usually lose up to 20 percent of their body weight, leading to repeated infection and progressive deterioration. The patient may show a general lack of interest in food and loss of appetite as he/she deals with fatigue and depression.

Managing wasting of ambulant patient:
- Give foods enriched with extra energy.
- Give foods of the patient’s choice, and on demand.
- Give small and frequent meals, attractively presented.

Fever

In AIDS, the patient’s metabolic rate is increased to fight infections, thus, raising the body’s temperature. Prolonged fever exhausts the body, requiring food and drink to replenish the depleted energy.

Managing fever:
- Keep the room well ventilated.
- Record the temperature at regular intervals, if very high, sponge out the patient’s body with tepid water.
- Fevers may last a few hours to a few days. If the patient is shivering, cover with extra blankets, which can be removed when the fever goes down.
- When fever breaks, the patient may sweat profusely. Change the wet clothes and bed linen so that the patient’s skin is dry.
- Ask the doctor to prescribe an antipyretic to bring down the fever.

Nausea and vomiting

Nausea may be caused by a blocked intestine, constipation, anxiety, etc.

Managing nausea and/or vomiting:
- A washcloth soaked in cool water on the forehead and slow deep breathing exercises may help to alleviate nausea.
- Avoid keeping stomach empty for long intervals, offer frequent small meals
- Give at room temperature.
- Avoid liquids with the meals, give them an hour before/after the meals.
- Avoid sweet, spicy, greasy or strong smelling foods.
- Make the patient sit up at least for half an hour after eating/drinking.
- Anti-emetics may need to be given orally at least 30 minutes before feeding. If that does not work, then medication may need to be given either by injection or rectally.
- Keep a clean kidney tray or a bowl handy at all times.

Keep the patient on his/her side to prevent choking on his/her own vomitus.
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- Wipe the patient's face clean during and after each episode of vomiting.

- Make the patient rinse out the mouth with water to which a teaspoon of salt has been added. This will not only remove the taste of vomitus but will also cleanse the mouth of acids and enzymes of the stomach, which would otherwise irritate it.

- Make sure that the patient does not become dehydrated or malnourished because of frequent vomiting. Give frequent small portions of clear liquids such as water, juices, coconut water, soups, rice or barley water etc., through a straw so that the patient can drink it sip by sip.

- Avoid giving alcohol, coffee, tea, chocolates and sugar.

Diarrhoea

Watery stools may stem from intestinal infections, stress or ingestion of strong drugs. They compromise the body's ability to absorb nutrients and also lead to dehydration.

Managing Diarrhoea:

- Keep a clean bedpan/commode handy at all times.

- After each bowel movement, clean the patient thoroughly with warm water, dry well and apply Vaseline to prevent skin breakdown.

- Sometimes, the diarrhoea may be foul smelling. Be sensitive to the patient's embarrassment; do not make a big issue out of it. Just use room fresheners.

- Give the patient lots of fluids. To compensate for the loss of electrolytes, give a quarter glassful of oral rehydration liquid with/without lemon juice several times a day.

- Do not give alcohol, coffee, tea, colas, chocolates, sugar and milk.

- Do not give spicy or greasy foods.

- Give foods which are low in roughage and easily digestible. Do not give raw fruits and vegetables.

- Since potassium is lost in diarrhoea, supplementing the food with banana, potato (without skin), broccoli, avocado, etc., may be a good idea.

- For medicines, always consult the doctor.

Constipation

Tuberculosis of the intestinal tract, long-term use of narcotics, lack of activity, weakness, poor diet, low fluid intake or stress may cause blockage of bowel movement. Constipation can be very painful and embarrassing and may cause nausea and a decreased appetite. The best way to deal with constipation is to prevent it.

Preventing constipation of the ambulant patient:

- Encourage the patient to exercise, even if only in bed.

- Gradually increase the roughage in the diet by adding whole grain cereals (wheat, legumes, vegetables, fruits and their juices (esp., prunes) to the diet)

- Add more liquids to the diet, especially, a hot drink such as tea, coffee or milk in the morning to start the bowel movement.
If all this fails, the doctor can prescribe a laxative in the form of a pill, syrup or suppository. Sometimes, the patient may be too weak and may not respond to any of these. In that case, the doctor might prescribe an enema. A simple soap-water may induce bowel movement.

**Acidity and heartburn**

There can be a side effect of medicines.

**Managing Acidity**

- Encourage the patient to chew food well.
- Encourage the patient to avoid smoking.
- Make the patient sit up at least half an hour after eating or drinking.
- Avoid alcohol, coffee, tea, chocolates and sugar.
- Avoid spicy and greasy foods.
- Ask the doctor to prescribe some antacid etc.

**Shortness of breath**

Breathlessness can occur with illness like pneumocystis carinii pneumonia (PCP), other pneumonias, lung tumors, excess secretion (fluid) in the lungs, asthma, weakness and anxiety.

Managing moderate to severe breathlessness.

Let the patient rest in a well-ventilated room, in his/her most comfortable position, supported by pillows if required. Ask the patient to raise arms for maximum lung expansion and to breathe deeply inhaling through the nose exhaling through the mouth, before and after every activity including eating.

If the problem persists, ask the doctor for medication.

**Insomnia**

Because of physical, psychological and spiritual problems, the patient may have difficulty in sleeping. Sometimes, the patient may sleep throughout the day and stay awake all night thus causing stress to the care giver.

Managing insomnia:

- Do not force the patient to sleep as per your wishes.
- Let him/her relax, read, listen to music or watch television if he/she so desires.
- Make a proper time schedule for sleep.
- Closer to the evening, relieve patient of all physical discomforts and keep the physical activity low and relaxed.
- You could listen/talk about all concerns.
- Give the patient a hot sponge/bath/body massage to relax.
- Avoid caffeinated drinks.
- Warm milk works as a good sedative.

As the last option, the doctor could advise certain medication to reduce restlessness, confusion and agitation, which are causing the insomnia.
Skin care

The skin is the first line of defense against injury and infection. When it is weakened, irritated or broken, bedsores can develop. Patients, who are bedridden and not able to control their bladder or bowel movement, are prone to bedsores. Bedsores are caused by a part of the body pressing continuously against a hard surface. The blood circulation in the bony parts of a skinny body constantly pressed against hard bed or chair, is cut off thereby killing the cells in that area of the skin. This dead skin then peels off exposing the tissue underneath. The commonest sites for bedsores are back, hips and shoulders. The first sign of a bedsore is redness of the skin.

Prevention and management of bedsores:

- Relieve the pressure by changing the position of the patient, providing water bed or water pillow.
- Massage around the red portion with light cream, lotion or moisturizer to stimulate blood circulation.
- If the redness persists, keep the pressure off the side and apply a simple protective dressing (white petroleum jelly, ghee, malai or any other soothing cream with gauze) which should be changed twice/thrice a day.
- In extreme cases, the skin can break down exposing muscle and bone. These sores are very painful and require complex wound dressing with acriflavin and glycerol.
- The dressing should always be kept clean and dry and done once a day, after a thorough wash with potassium permanganate or hydrogen peroxide.
- Prevention is the key to managing bedsores.

Mouth and throat sores:

Thrush (a side effect of medication or dehydration) makes eating painful and may make the patient nauseous. Oral hygiene may increase the patient’s ability and desire to eat/drink.

Oral hygiene:

- Encourage the ambulant patient to brush the teeth at least twice a day.
- If brushing is too painful, then rinsing the mouth several times a day will suffice.

Bedside care:

If the patient is too sick to take care of oral hygiene then the caregiver will have to do it for him/her.

- Use a soft brush. Be gentle but thorough.
- Take care not to wet the patient’s clothes by keeping a towel under the chin. Use a kidney tray for the spittle.
- Try and make the patient sit up or lie on his/her side to swish the water in the mouth and spill it out.
- If the patient is unconscious, clean his/her mouth with a cotton swab dipped in rinsing solution or glycerin. If he/she bites down on the swab, do not pull it out. Wait for the mouth to relax and then remove the swab.
• Read the instructions carefully, especially, on the rinsing solution - whether it is for swallowing or spitting out (home made-rinsing solution - 1 cup of water mixed with 1 tablespoon of baking soda or salt).

Eating in presence of mouth or throat sores:
• To prevent discomfort during eating, apply a topical solution before feeding.
• Drinking liquids through a thick straw or sucking at room temperature.
• Give soft foods, which can be swallowed easily.
• Avoid alcohol, salty, spicy, rough and acidic foods.
• Give more water, coconut water and juices (non acidic ones like carrot, avocado).
• Give more liquid food like very fresh yogurt, fruity milk shakes, ice cream etc.

Personal hygiene
Understand that the patient has managed to take care of his/her personal hygiene all his/her life; be sensitive to their need for privacy, in order to help him/her retain his/her dignity.
• A full bath may not be required everyday, but it is necessary to keep the eyes, mouth and genital areas clean.
• If the patient is mobile and strong enough he/she should be encouraged to go to bathroom and clean up thoroughly.
• Keep a stool for them to sit on, so that they don’t get tired.
• Keep soap, oil, towel, fresh clothes etc., handy so that you don’t need to leave the patient alone in the bathroom.
• If the patient has any wound, wrap it well with plastic to keep it from getting wet during bathing; if the dress does get wet, change it.
• Select a family member with whom the patient is most comfortable, for giving assistance in personal hygiene.
• If you are giving the patient a bath, be careful not to rub against fragile skin or lesions.
• When giving sponge bath in bed, keep the room warm and free from draft and clean small areas of the body at a time while keeping the rest of the body covered so that the patient does not get chilled. Change the water as and when necessary, especially after cleaning genital areas. Dry well. Apply moisturizer; give a back rub for better blood circulation.
• Wash patient’s eyes with water only. If there is a dried discharge from the eyes, soften it with a soft cloth soaked in warm water or moisturizer or oil, only then pry it off.

If at the end of it all, there is a problem ask your doctor for advice.

To date, there is no cure for AIDS in Ayurveda, Homeotherapy or any other line of medication. However, antiretroviral (ARV) treatment is available in allopathy. These medicines have side effects and have to be taken lifelong. They require regular monitoring and increase life expectancy by an average of four years. The medicines cost about $350 (Rs. 15,750) per person per year. Most people may not have enough
money to take (ARV). For such people one should try to assuage the symptoms with alternate therapies such as antimicrobials for opportunistic infections, good nutrition, distraction, massage, relaxation, acupuncture, skin stimulation, yoga etc.

**Nutrition**

A well balanced diet of clean, germ-free food can be one of the healthiest ways of preventing several infections, thereby maintaining good body weight and consequent strength. But this is easier said than done. There is one major problem in the care of a patient; he/she may not feel like eating/drinking; the quality/quantity of food/drinks that you think are nutritionally correct.

**Maintaining nutrition:**
- Provide the patient with wholesome, nutritious and hygienically prepared food.
- Consider the likes/dislikes of the patient and work the menu around him/her.
- Give the food in small quantities at frequent intervals.
- Present the food attractively to make it appetizing.
- Remember a pleasant atmosphere is conducive to a healthy appetite.
- When feeding a patient don’t shovel food down his/her throat; give small spoonfuls.
- Try to maintain the patient’s body weight according to the standard weight chart.

**Recommendations for safe eating**

When a person is infected with HIV, his immunity is weakened, leading to easy infections from air, food and water. Therefore, it is important for the patient to:
- wash hands frequently with soap and water;
- drink boiled water only;
- wash all vegetables and fruits before use;
- avoid alcohol, tobacco and cigarettes;
- reduce oil, salt and spice;
- avoid eating outside food;
- eat freshly prepared foods; and
- avoid uncooked foods.

**Check Your Progress**

**Notes:**
1. Use the space provided for your answer.
2. Check your answer with those provided at the end of this unit.

**3. What are the recommendations for safe eating?**

<table>
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</tbody>
</table>
12.6 LET US SUM UP

In this unit, you studied about the concept of palliative care, it’s essential components, and the management of pain and relief of simple symptoms in terminal AIDS disease. Remember that this unit cannot be studied in isolation. It is better understood when studied along with the Basic Course on HIV/AIDS, Block-2, Units 1 and 2.

12.7 UNIT-END EXERCISE

1. What are the common symptoms of AIDS? What advice would you give to the family members of a HIV patient to provide him relief?

12.8 SUGGESTED READINGS

Grame Stewart (1997): Managing HIV.

Palliative Care - A Comprehensive Guide for the Care of Persons with HIV Disease (1995), Mount Sinai Hospital, Casey House Hospice: Toronto, Canada.

Robert Twycross, Introducing Palliative Care.

12.9 ANSWERS TO CHECK YOUR PROGRESS

1. | Sl. No. | Traditional palliative care | AIDS palliative care |
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<thead>
<tr>
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<tr>
<td>1</td>
<td>Care only for cancer patients</td>
<td>Care for AIDS Patients</td>
</tr>
<tr>
<td>2</td>
<td>Mainly older age group</td>
<td>Mainly younger age group</td>
</tr>
<tr>
<td>3</td>
<td>Not much variation in disease patterns</td>
<td>Wide variation of disease patterns</td>
</tr>
<tr>
<td>4</td>
<td>Predictable Terminal Phase</td>
<td>Unpredictable terminal phase</td>
</tr>
<tr>
<td>5</td>
<td>Less drugs require</td>
<td>Several drugs required at same time</td>
</tr>
<tr>
<td>6</td>
<td>Less incidence of psychological symptom</td>
<td>More psychological symptom and dementia</td>
</tr>
<tr>
<td>7</td>
<td>Less substance abuse</td>
<td>More substance abuse</td>
</tr>
<tr>
<td>8</td>
<td>Pain management most important</td>
<td>Control of many symptoms including pain</td>
</tr>
</tbody>
</table>

2. The three essential components of palliative care are:
   - Teamwork and partnership
   - Psycho-social support
   - Symptom relief
3. When a person is infected with HIV, his immunity is weakened, leading to easy infections from air, food and water. Therefore, it is important for the patient to:

- wash hands frequently with soap and water;
- drink boiled water only;
- wash all vegetables and fruits before use;
- avoid alcohol, tobacco and cigarettes;
- reduce oil, salt and spice;
- avoid eating outside food;
- eat freshly prepared foods; and
- avoid uncooked foods.