

# HIV Nursing matters

A publication of the Southern African HIV Clinicians Society



TB in South African prisons

Intimate partner violence against women & HIV

The importance of gender assessment in TB

June 2015 Volume 6 No. 2





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# guest editorial



*Dr Fareed Abdullah, CEO, SANAC*

South Africa has made very good progress with the provision of antiretroviral treatment and in the prevention of other to child transmission of HIV. There are now 3.1 million people on treatment and the MTCT transmission rate is between 2 and 3 percent in most provinces. The Minister of Health attributes these achievements to a decision of the Department of Health to allow nurse-initiated and management of anti-retroviral therapy or NIMART. In other words, the success of the government's ART rollout depended wholly on the thousands of nurses who now prescribe ART in almost 4000 public health facilities throughout the land.

Even though there are so many people on ART, this edition of *Nursing Matters* points out that there are some groups of patients in some settings that deserved more specialised care and indeed, more caring than, the general population. These population groups or key populations are truck drivers, sex workers, men who have sex with men, injecting drug users and prison inmates.

The article by Lalla-Edward et al, points out that South Africa's 70 000 truck drivers have higher rates of HIV than the general population and require care

at the roadside or at truck stops where NGO run programmes provide for their special needs including ARVs and medication for other chronic diseases, STI treatment, HIV testing and conditions relating to their sitting behind the wheel for long periods of time. Nurses working at these roadside services should be skilled in all truck driver related conditions and all other nurses should be able make truck drivers aware of the availability of these roadside services.

Nurses also need to be aware of the special needs of sex workers. These include contraception regular health checks for STIs, HIV testing and antiretroviral treatment if the CD count is less than 500 cells/ul and a generous supply of condoms and lubrication. The use of female condoms should be promoted. Work commissioned by SANAC estimates that there are 153 000 sex workers in South Africa in almost every municipality. Nurses should therefore familiarise themselves with the special needs of sex workers. As Stacy points out in her compelling article on the scale of the national sex worker programme, sex work is illegal in South Africa; this puts sex workers in a very vulnerable position when it comes to the acquiring of STIs and HIV in particular; but especially to abuse, violence, unlawful arrest and exploitation. Sex workers have it hard in this country. They are exposed to the worst forms of brutality. The role of the nurse towards sex workers is to be especially caring and supportive of their needs, and should avoid judging them.

The same applies to men who have sex with men and injecting drug users. Men who have sex with men have higher rates of HIV than the general population and are the most stigmatised in our communities. They have special needs and nurses in clinics should not add to their stigmatisation but learn the skills needed to address their health needs. The article by Williams et al highlights

the special needs of injecting drug users or People WHO Inject Drugs (PWID). In the past this group has been completely neglected even though we've always known the risk of HIV transmission where needles and syringes are shared is the highest of all forms of HIV transmission.

The article by Unathi Mahlati on TB in prisons reminds us of how high the risk is of contracting TB in prison. It also reminds us that prison inmates have a much higher HIV prevalence rate than the general population.

One of the aims of this issue of 'Nursing Matters' is to bring to your attention that we have now entered a stage in our battle against TB, HIV and STIs where we will all be required to give special attention to key populations; populations that are at a higher risk of contracting these diseases than the general population. The main reason that these populations have a higher risk of HIV and TB is because they are marginalised, generally poor, highly stigmatised and excluded socially and they do not receive the protection they need from the law or from society. Health professionals need to be cognisant of their position and rise to their calling or care for these groups.

At the South African National AIDS Council, we have prioritised these groups for special attention. We are making the public aware of the negative effects of stigmatisation of these population groups and we are making more resources available for services for key populations. We are also talking to government about the need to change laws which are barriers to reach these key populations. This work is led at the highest level by the Deputy President and numerous Ministers and Deputy Ministers. If the leaders of the HIV response in this country are changing their attitudes, so can we! ®

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# Message from the president



*Dr Francesca Conradie  
President, Southern African HIV  
Clinicians Society*

As a group of health care workers, HIV clinicians and nurses have done a great job in diagnosing and treating the HIV-infected population of South Africa. We have worked very hard in making sure that all HIV-infected women are started on treatment. When we see TB in a patient, we immediately test them for HIV. In this way, we are making a huge impact already.

However, the truth is that these were the easy patients to reach, the ones already in the system. Now we have to work hard to reach another group. They are termed the key population groups: truck drivers, sex workers, men who have sex with men, injecting drug users and prison inmates. These groups are difficult to reach. For example, truck drivers are on the move due to the nature of their work. Sex work is stigmatised and is not decriminalised, which means that many sex workers may not want to come forward for medical services. Thus, we have to be very careful in our attitudes in order to avoid being judgemental and to give people the care that they need. Similarly, men who have sex with men may fear a homophobic response at a health care facility. Finally, inmates in the correctional system seem easy to reach until you understand that the primary concern of the correctional services is security. Health care needs to be delivered within these confines. Considering the challenges to providing high quality health care for these at-risk groups, we have put together a number of articles which we hope will help to clarify the issues and provide information on how to manage and treat these patients. So please read on and enjoy the articles.

Finally, I hope you are all preparing for our conference next year. We are holding it in April 2016, from the 13th to the 16th at the Sandton Convention Centre in Johannesburg. Already we have lined up an exciting group of speakers and sessions, including skills-building sessions, and it promises to be even better than the last one. We hope to see you all there! 



# NEWS

## GUIDELINES: PRIMARY CARE 101

By Health-e News on May 7, 2015 in Diseases and Disorders, Non-Communicable Diseases (NCDs), Reports

The National Department of Health guidelines outline care for adults living with conditions like HIV, diabetes and mental health within primary health care.

Primary Care 101 is a symptom-based integrated clinical management guideline for the management of common symptoms and chronic conditions in adults. The guidelines are intended for use by all health care practitioners working at the primary care level in South Africa, according to the document's forward.

The 108-page guidelines begin with an introduction into effective communication between health care

workers and patients. The guide then provides indexes of typical conditions – both chronic and not. Each condition is then discussed quickly, including treatment algorithms. ®

The resource also covers relevant legislation such as the [Mental Health Care Act](#).

Download the guidelines: [Primary Care 101](#)





# PNEUMOCOCCAL VACCINE

## cuts hospitalisations by 70 percent

By Laura Lopez Gonzalez on May 7, 2015 in Children's Health, Vaccines



New data shows that South Africa's expensive pneumococcal vaccine roll out has cut childhood hospitalisations due to meningitis, pneumonia and rotavirus by about 70 percent in just five years, according to Minister of Health Dr Aaron Motsoaledi.

In 2009, South Africa became the first African country to introduce the expensive conjugate pneumococcal vaccine.

Motsoaledi announced the new figures yesterday while speaking at the opening of the African regional consultation on the United Nations' new Global Strategy for Women's, Children's and Adolescents' Health. Still in draft form, the strategy is set to guide global strategies to reduce

maternal, child and adolescent deaths.

New data from the National Institute for Communicable Diseases has also shown that the vaccine led to declines in drug-resistant infections.

In 2009, South Africa became the first African country to introduce the expensive pneumococcal conjugate vaccine. At the time of the vaccine's introduction, Deputy Director of the Pneumococcal Diseases Research Unit at Witwatersrand University Dr Shabir Madhi estimated the vaccine would add R700 million to the R100 million spent annually on vaccination. However, Charlotte

Maxeke Hospital Head of Critical Care Division Professor Guy Richards said he believes the roll out should be expanded beyond young children to include adults with compromised immune systems such as those older than 60 years old and people living with HIV.

"The use of vaccines all in all reduces costs, hospital admission and the use of antibiotics, so this should be viewed

as a full package," he told Health-e News while speaking at the Africa Health conference yesterday.

Richards also stressed that more South Africans should be vaccinated against flu each year. Currently, only about 20 percent of people receive annual flu jabs.

"We need to create awareness in our communities of the importance of this vaccine," he added. "Influenza doesn't give you a warning sign - it hits you straight and hard." ®



# Strategy: Draft National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers

By Health-e News on January 16, 2015 in Alcohol & Drugs, HIV/AIDS, Men's Health, Policy and Legislation, Reports, Tuberculosis (TB), Women's Health

Released by the South African National AIDS Council (SANAC) on 12 January, this 49-page preliminary document outlines plans to, for instance, increase HIV and tuberculosis (TB) prevention, care and treatment among sex workers and families.

The strategic plan outlines three main aims, mainly:

- Increase coverage and access to comprehensive HIV, sexually transmitted infections (STI) and TB prevention, treatment, care, support and related services for sex worker and their sexual partners, families and clients;
- Reduce violence and human rights abuses experienced by sex workers; and
- Foster enabling health and related systems to enable sex workers to realise good health and their Constitutional Rights.

This draft plan also proposes rolling out new HIV prevention science such as pre-exposure prophylaxis and antiretroviral invitation irregardless of CD4 counts, or 'test and treat.'

SANAC is currently collecting inputs regarding challenges and success regarding sex workers and national programmes to reduce HIV, TB and STIs. These inputs will feed into the finalization of the plan prior to its official launch in a few months. <sup>®</sup>





# 'I sleep with older men so that we can eat'

By Bontle Motsoeneng on June 23, 2015 in Children's Health, News, OurHealth

Poverty-stricken children in the Free State are being forced into prostitution, often by their families, in order to be able to eat.

Under-age girls are being forced into prostitution to help feed families, says SWEAT (File Photo)

Dire financial situations, with families languishing in poverty in the Free State, has seen an escalation in mothers who sell their young daughters to feed their families, said Sex Workers Education and Advocacy Task Group's (SWEAT) provincial manager in the Free State and North West, Sogomotso Ntlhaile.

In Bethlehem in the Free State, OurHealth spoke to a 16-year-old schoolgirl\* who spends her afternoons doing sexual favours for her mother's male friends instead of doing school work because "if I don't, we won't eat". She has been doing this since she was 14 and gets about R100 for having sex, she said.

This was not the life she had dreamed of for herself, but "my mom told me that I have to use my body so that we don't starve. So every time her male friends come to our house, they sit around and drink and when I get home from school my mom will come to me in my room and tell me: 'You should prepare yourself' for a man".

"I started doing this two years ago, I would sleep with these older men and they will give me money, which my mom and I will use to buy food. At first it felt so weird but I got used to it."

## Child prostitution a problem since 2013

The soft-spoken teen's case is not an unusual one, with underage prostitution in Free State long been seen as a problem. As early as 2013 government was called to intervene. But, said Ntlhaile, it has had little or no affect.

My mom will come to me in my room and tell me: 'You should prepare yourself' for a man"

"There was more of an approach of arrest instead of rescue by some police and that has not worked. Many families see sex work as a way out – as a quick fix to fend for their families."

While SWEAT advocates for the decriminalisation of adult, consensual sex work, as a best possible way to combat HIV and protect sex workers' rights, it seeks to prevent underage men and women from being forced into the field.

"It is so sad that these young girls engage in underage sex and who are forced into sexual activities at such early ages. It exposes them to illnesses such as STIs, HIV and even cervical cancer," Ntlhaile told OurHealth.

"Socially, their bright futures are stamped out, as many end up dropping out of school or failing because of underperformance. It is so imperative that they avoid this. And in the Free State, with many standing to wait for clients in the darkest roads, they are being killed brutally. Ultimately they are paying with their lives. These young girls' lives are in

danger.

"Women don't see any other option of finding a way to provide for their families. They think the best way is to use kids. Ignorance also plays a part."

The teen OurHealth spoke to said that she always used protection. "I fear for my life, I don't want to get sick and am also preventing pregnancy at the clinic. I wish I could stop, but I can't – I eat because of that money."


When OurHealth approached the mother, she was angry and defensive.

"There is nothing I can do, I didn't go to school so where will I work? There is nothing we can do – I am doing this for her. I know it's not right, but what can I do?"

A neighbour in the area said: "The mother offered her daughter to me. I was so shocked as to what mothers were capable of doing to their children. It is prostitution."

OurHealth was unable to get comment from the Department of Social Welfare in Bethlehem, but a social worker who works in the area commented on the case.

"It's not fair what the mother is doing to the child. She is the one who's supposed to take care of the child not the other way round. We work with issues like this and we normally take the children to a place of safety to give them better life in our centres."

\*Names of teenager and mother withheld to protect the child 

# GUIDELINES:

## Study estimates 153,000 sex workers active in South Africa

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By Laura Lopez Gonzalez on January 13, 2015 in HIV – Antiretrovirals (ARVs), HIV/AIDS, Men’s Health, News, Reproductive Health, Sexuality, Statistics, Tuberculosis (TB), Women’s Health

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First of its kind research released yesterday shows that South Africa is home to about 153,000 sex workers as a new plan aims to decriminalise one of the world’s oldest professions.

To protest abuses at the hands of police, sex worker organisations will picket the offices of police oversight body, the Independent Police Investigative Directorate (IPID), on 3 March, which marks International Sex Worker Rights Day.

Commissioned by the South African National AIDS Council (SANAC), the research used data gathered from sex worker interviews in 12 sites nationwide to estimate the country’s sex worker population.

Of the 153,000 estimated sex workers active in the country, about 8,000 are men and about another 6,000 are transgender, according to the research led by the Sex Workers Education and Advocacy Taskforce (SWEAT).

The study found that sex was for sale in a wide range of places including brothels, at least one adult store and via local Internet sex sites.

### **New HIV prevention science to be piloted among sex workers**

The research is aimed at helping SANAC roll out the country’s first national HIV care and treatment plan for sex workers. Unveiled yesterday, the plan aims to provide better prevention and care services for not only HIV, but also sexually transmitted infections tuberculosis among sex workers and their families.

At the 2014 Southern Africa HIV Clinicians Conference, SANAC CEO Fareed Abdullah quoted unpublished research indicating that HIV prevalence rates among some South African sex workers could be more than 70 percent.

A July 2014 study published in the international medical journal The Lancet estimated that at least six percent of all new HIV infections in the country are linked to sex work.





South Africa is just one of many countries in the region looking to use money from the international financing mechanism the Global Fund to Fight AIDS, TB and Malaria to address vulnerable populations where HIV prevalence rates remain high.

"If HIV is about sex, where else should we start looking (to address it) but in sex work?" said Fareed, adding that the US Centres for Disease Control is currently funding a large study to gauge HIV prevalence rates among sex workers in major South African cities.

To address high rates of infections, SANAC's new plan aims to pilot the latest HIV prevention science among sex workers. As part of a pilot study, some HIV-negative sex workers will be offered pre-exposure prophylaxis, or antiretrovirals (ARVs) to prevent HIV infection. Those living with HIV will be offered ARVs as soon as they are diagnosed as part of the pilot in an approach commonly known as 'test and treat.'

- *Read more: 6 ways to fix South Africa's HIV response*

### Renewed push for decriminalisation of sex work

Like the country's past two national

strategic plans, SANAC's National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers also pushes for the decriminalisation of the "world's oldest profession."

"If decriminalisation is to go through, it's important that it has the majority of support from the people of South Africa"

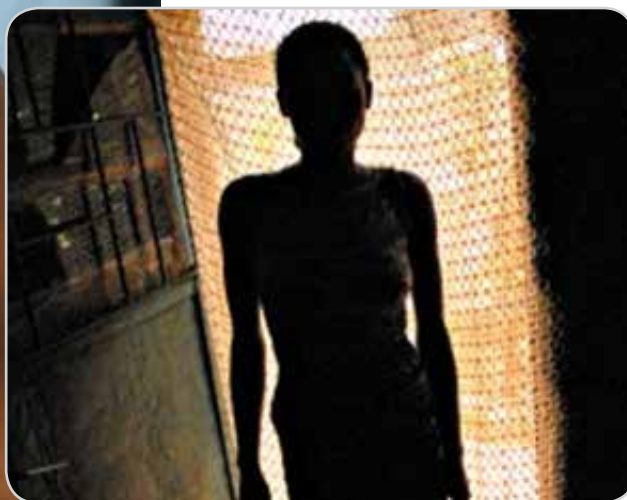
"Sex work is criminalised and that has made us more vulnerable," Buthelezi told Health-e News. "Police rape us and, if we are arrested, they will need sexual favours in order for us to be released." If South Africa moved to decriminalise sex work, it could look at regulating the profession and create a safer working environment, argue advocates like Buthelezi.

But the fight for decriminalisation is likely to be a long one for sex workers.

Deputy Minister of Justice and Constitutional Development John Jeffery said the Law Reform Commission is currently nearing the end of its long-running review of legislation criminalising sex work. The commission may then submit written recommendations to amend the law to the Minister of Justice and Constitutional Development. The minister then could move to table these before Cabinet and then Parliament.

Changing the law will need strong public support, Jeffery cautioned.

"We are on the one hand a very conservative country," he said. "If decriminalisation is to go through, it's important that it has the majority of support from the people of South Africa." - Health-e News.®







# INTIMATE PARTNER VIOLENCE AGAINST WOMEN AND HIV

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**Kate Joyner**, D Phil (SSM), MSocSci, BSocSci (Hons), BSocSci, Post basic Diploma in Psychiatric Nursing Science, Diploma in Nursing (General, Community and Psychiatric) and Midwifery  
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Intimate partner violence has profound mental and physical health consequences<sup>[2]</sup> that impact the entire family systems over generations

## KEY CONCEPTS

**Gender:** roles and norms society allocates to males and females.

**Gender discrimination:** Any distinction, exclusion or restriction made on the basis of society's gender roles and norms, which prevents a person from enjoying human rights.

**Gender-based violence:** any violence, or threat thereof on the basis of gender, that causes psychological, sexual, physical or spiritual harm.

**Intimate partner violence victims and survivors:** Survivors are still living, whereas victims are dead.

**Intimate femicide:** 'The killing of a female person by an intimate partner (i.e. her current or ex-husband or boyfriend, same-sex partner or a rejected would-be lover)'.<sup>[1]</sup>

**Vicarious traumatising:** The sustained impact on service providers of listening to horrifying stories of physical and emotional cruelty.

**Secondary victimisation:** The inappropriately unsympathetic and disbelieving responses that gender-based violence survivors experience from society in general, including health and criminal justice systems. In reference specifically to sexual violence, it refers to how a poorly performed forensic examination can re-traumatise the survivor by reminding her of the sexual assault.

## INTRODUCTION

Intimate partner violence has profound mental and physical health consequences<sup>[2]</sup> that impact the entire family systems over generations. This burden of disease especially affects women. The use of violence to maintain dominance in relationships characterises masculinity throughout Southern Africa, where coercive and even violent sex is often normative. In South Africa, interpersonal violence is the second highest contributor to years of life lost, after HIV<sup>[3]</sup> In sub-Saharan Africa, 59% of those living with HIV are women.<sup>[4]</sup> Here prevalence among women aged 15-24 is on average six times higher than in men of same age, and women aged 15 - 24 comprise 90% of new infections.<sup>[5]</sup>

Such discrepancies result from social, cultural, economic and biological circumstances that cause females greater risk for acquiring HIV. For example, gender norms affect expectations, behaviours and life possibilities. In turn women have diminished access to resources that limit prevention and spread of the disease.<sup>[6]</sup> Conversely, males are impacted by gender expectations that encourage polygamy and risk-taking sexual behaviour and which discourage accessing health services. Furthermore, their roles as partners and fathers are narrowly and inadequately defined.

Strengthening the capacity of health systems and healthcare providers to address violence against women is a priority for the WHO.<sup>[7]</sup> This article exposes links between intimate partner violence and HIV, and provides guidelines for appropriate clinical care.

## LINKS BETWEEN INTIMATE PARTNER VIOLENCE AND HIV

Intimate partner violence has been associated with HIV infection in numerous studies.<sup>[8]</sup> Intimate partner violence against women is a massive but relatively hidden social problem which secretly drives the HIV epidemic.

It increases psychosocial distress, risky sexual behaviour and sexually transmitted infections. Durevall and Lindskog's report<sup>[9]</sup> in *The Lancet Global Health* (2015) provides key evidence about the positive association between intimate partner violence and HIV across sub-Saharan Africa.

'Men who are physically violent are more likely to have HIV'.<sup>[10]</sup> This is explained by an underlying construction of masculinity founded on violent and controlling behaviour, and the finding that 'men who disclosed violence were very much more likely to have engaged in a range of risky sexual behaviour, as well as to have raped and been raped.'<sup>[10]</sup> Previously, violent controlling behaviour from male partners has been reported as strongly associated with risk of HIV infection among women.<sup>[11]</sup> Durevall and Lindskog have recently confirmed this finding, reporting that intimate partner violence is most consistently related to women's HIV-positive status when combined with male controlling behaviours. This result highlights the role of the context of intimate partner violence, particularly if the violence is part of a syndrome of perpetrator-related behaviours, in establishing the effect of intimate partner violence on health outcomes.<sup>[12]</sup>

Experiencing intimate partner violence can be associated with HIV in other ways such as delayed diagnosis, less frequent disclosure of HIV status, or poor access to HIV care.<sup>[8]</sup> Furthermore, women living with intimate partner violence may have relative immune dysfunction/suppression as a result of the associated stress.<sup>[8]</sup>

The HIV epidemic also disproportionately affects females in their gendered role as caregivers within families and communities. Females bear the largest burden of caring for those with AIDS-related illnesses<sup>[13]</sup> This reduces time available for income-generating activities or education, potentially exacerbating their poverty and increasing their economic dependence on men.

## THE PROBLEM OF INTIMATE PARTNER VIOLENCE

Prevalence figures that only measure physical violence are misleading. Emotional abuse is wide-spread and concurrent with sexual and physical abuse.<sup>[14]</sup> Internationally the prevalence of emotional abuse within intimate partnerships ranges from 9% to 70%.<sup>[15,16,17]</sup> Emotional abuse diminishes social support, lowers self-esteem, and exacerbates anxiety states. It has been found to be a primary contributor to postnatal depression.<sup>[18]</sup>

Michael Johnson's typology of domestic violence delineates four contrasting forms: intimate terrorism, violent resistance, mutual violent control and situational couple violence.<sup>[19]</sup> *Intimate terrorism or coercive control* describes use of violence by one partner to control the other; *violent resistance* describes the resister's response to the effort of their partner to gain control; *mutual violent control* refers to use of violence by each partner to control the other; while in *situational couple violence* either partner can be violent due to escalating conflict, but not to exert control.

The issue of female on male IPV is controversial. Although some men suffer abuse at the hands of their partners, most IPV survivors/victims are women. Furthermore, women experience more sexual violence, severe physical violence, more abuse after separation, and more coercive control by their male partner.<sup>[20]</sup>

## ESSENTIAL CLINICAL CARE FOR INTIMATE PARTNER VIOLENCE

The silence surrounding IPV is reflected in healthcare providers' denial and patients' shame. IPV survivors are hesitant to disclose, often because they have been treated badly when doing so in their past. As a provider, you should identify IPV and offer appropriate clinical care.

Thoroughly documented records are an essential service that healthcare providers should offer abused women. Asking about violence is a responsibility that forms part of best clinical practice. Being supportive and affirming, rather than judgemental, is very important.

**Assess:** Build rapport by listening sensitively to understand the patient's story of abuse from her perspective. Pay attention to all aspects of abuse and document key points to confirm a history of intimate partner violence. Ask about symptoms of other sexually transmitted infections (STIs), possibility of pregnancy and use of family planning. Offer the appropriate examination or test.

**Assist:** Treat STIs. Offer family planning, sterilisation or termination of pregnancy. Manage acute injuries appropriately. Take notes with legal issues in mind in terms of:

- Evidence that can support an application for a Protection Order
- Evidence that can be used to complete the J88 and be presented in court

Emotional abuse is wide spread and concurrent with sexual and physical abuse.

Therefore briefly describe the following:

1. Events leading to the injuries
2. Use of weapons, whether injuries resulted from their use or threatened use
3. Name of abuser and relationship to client
4. Make quotations verbatim where appropriate
5. Type of injuries, eg bruise, abrasion, laceration
6. Location of old and new injuries
7. Size of injuries
8. Express an opinion as to whether the injuries are consistent with the history of abuse
9. Note if there appears to be inconsistency between the injuries and explanation (there may be reluctance to confirm abuse)
10. Sign every page of the form, and write your name in block letters
11. Ensure that date of entry is recorded too.

*Note! The more complete and legible it is, the less likely it is that you will be called to court.*

### ARRANGE

Refer the client for psychosocial and forensic care to:

## WHY IS VIOLENCE AGAINST WOMEN DIFFERENT?

A woman who has experienced violence has particular needs. Note the following:

- Support, not diagnosis, is your most important role.
- She needs help to feel more in control and able to make decisions.
- She may or may not need physical care.
- She may have various emotional needs that require attention.
- Her safety may be an ongoing concern.
- She may need referrals or other resources for needs that the health system cannot meet.<sup>[21]</sup>





## FIRST-LINE SUPPORT CARES FOR EMOTIONAL NEEDS

First-line support is valuable care that you can provide, and may be all that she needs.

First-line support is care for emotional and practical needs:

- Identify her needs and concerns
- Listen to and validate her concerns and experiences
- Help her to feel connected to others, calm and hopeful
- Empower her to feel able to help herself and to ask for help by affirming her resilience and strengths
- Explore what her options are
- Respect her wishes
- Help her to find social, physical and emotional support
- Enhance her safety

Remember when you help her deal with practical issues, it helps her emotional needs. When you attend to her emotional needs, you strengthen her ability to deal with practical needs.<sup>[21]</sup>

- Community mental health nurse (at her local CHC)
- Non-profit organisations such as MOSAIC, Western Cape - at some Family Courts, to assist with applications for Protection Orders
- Psychologist
- Victim Empowerment Units at Police Stations
- Family Units, Magistrates Courts

## CONCLUSION

Over time, intimate partner violence against women decreases their capacity for sustainable livelihoods and markedly increases their risk for developing new HIV infection. Further, as mothers of the nation, it also profoundly impacts the mental health of family systems and communities nationwide. Hitherto healthcare providers have neglected

responsibilities to be supportive to HIV-infected patients who are struggling in such circumstances. To achieve progress towards improving women's, children's and adolescents' health and achieving the Sustainable Development Goals, knowledge needs to be transformed into effective practice. <sup>®</sup>

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*LESSONS LEARNT FROM SCALE UP OF THE*

## **NATIONAL SEX WORKER PROGRAMME**



Maria Stacey trained as a Professional Nurse at Carinus Nursing College in Cape Town, and later qualified as a Clinical Psychologist. She has worked in the fields of human rights; psychological trauma; substance abuse; HIV; reproductive health and sexuality. Her current work with sex workers brings all these areas together. She has worked at SWEAT since 2009. She is currently Deputy-Director and also is the Programme Manager for the national Red Umbrella Programme.

Decriminalisation is recommended by the World Health Organisation and South Africa's National Sex Work Programme Plan.

A few months ago, I was in Port Elizabeth, presenting on the national sex worker programme, the Red Umbrella Programme, at the Nelson Mandela Municipality Summit on TB/HIV. While I was listening to the presentations preceding mine, I noted that participants gasped and tut-tutted with shock and disapproval when speakers spoke about "girls selling their bodies at the back of shebeens", and of "prostitutes having sex with 25 or more men per week". I looked forward



to my presentation with relish, thinking "Great, a virgin audience!"

I started by asking the audience to call out words they associated with the word "sex worker". The words that came up were, "money", "young girls", "police", "HIV and STIs", "poverty" and "low morals". This is always a useful informal barometer of attitudes in the room. I focused my presentation on a simple message: "Sex workers are human beings, and enjoy the same Constitutional Rights as any other citizen". I advocated for sex work to be recognised as work, and argued why decriminalisation of adult, consensual sex work was the legal model with the best possible outcome to combat HIV and protect sex workers' rights. As an aside, I noted that sex workers say, "We are not selling *our bodies*. Our bodies belong to us. We are selling sex".

As usual, questions after the presentation were lively. People asked about types of sex work; transactional sex; promiscuity and morality; culture; child sexual exploitation; pimps; population size estimation data and care for HIV+ sex workers. I knew that there had been some shifts in attitude when a later speaker again spoke about sex workers "selling their bodies", and the group corrected him: "not selling *bodies*, selling sex!"

But the fact that I was at that meeting at all, and that sex work was on the agenda at all, is the confluence of a cascade of factors, and a vindication of a long, often unpopular struggle in the margins of HIV.

In 2010 it was reported that, while almost one in five new HIV infections could be attributed to the sex work industry, less than 5% of sex workers were reached with HIV prevention services (aids2031; 2010). Thankfully, four years later, we can say that this is no longer the case. Things have moved very rapidly in the sex work sector. In the past year, the Global Fund-supported national sex worker

programme, now branded the Red Umbrella Programme, has scaled up rapidly and dramatically.

We have gone from 8 sites around South Africa, to 70 sites, in all 9 provinces; and from 50 peer educators to 560. Before last year there were 8 implementing partners; now there are 19.

These 70 sites, in all 9 provinces, were selected to take services to sex workers where they were most needed, and to avoid duplication with other sex worker projects, most notably those funded by PEPFAR.

At these 70 sites, sex worker peer educators, led by a site coordinator (most of whom are also sex workers), implement combination prevention programmes for sex workers. They engage with sex workers wherever they work: streets, brothels, truck stops, shebeens and sex workers' homes. They distribute condoms and lubricant, provide health and human rights support, and refer for HIV testing and other health, social and legal services. Local service providers are also offered sensitisation training to increase their "sex work(er?) friendliness".

Peer educators and site coordinators have been trained, with some receiving additional training as human rights defenders and HIV Counselling and Testing (HCT) counsellors.

My organisation, the Sex Worker Education and Advocacy Taskforce (SWEAT) is responsible for coordinating the programme with Principal Recipient National AIDS Coordinating Organisation of South Africa (NACOSA). SWEAT provincial managers have taken the work into provinces and districts, engaging with Provincial Strategic Plans, and working towards strengthening sex worker inclusion in provincial, district and local AIDS Councils. They also provide support and capacity-building for the 19 implementing partners to ensure programme quality and consistency.

South African female sex workers have an estimated HIV prevalence rate of 59.8% (Baral et al, 2012). This is a shocking legacy of decades of criminalisation, marginalisation, stigma, discrimination and human rights violations. Whilst most sex workers are knowledgeable about safe sex and support the idea of 100% condom use, the environment in which sex workers operate often creates obstacles to condom use. These obstacles include: sex workers are subject to high rates of violence, including rape, from police and clients; police are known to confiscate condoms, or use condoms as evidence of sex work, which makes carrying condoms risky; police harassment and threat of arrest means that sex workers are often not able to negotiate properly with prospective clients; sex work is conducted in unsafe spaces; brothels often do not support sex workers' occupational health; in some areas, condoms are scarce, and sex workers avoid going to clinics to ask for condoms out of fear of stigma, exposure and ridicule; and clients offer financial incentives for non-condom use.

If these and other structural impediments to HIV prevention are not addressed, the programme will have limited success. Whilst the foundation of the Red Umbrella programme is bio-behavioural interventions - HIV Counselling and Testing; distribution of condoms and lubricants; referrals to services, and safe sex education - the game-changer is its attempt to tackle structural interventions. The concept of structural interventions is one that the South African HIV community has struggled with in the past, but

**South African female sex workers have an estimated HIV prevalence rate of 59.8% (Baral et al, 2012).**



fortunately there is a growing evidence base for the impact of structural interventions on HIV infection in sex workers. These interventions include policy reform, addressing gender based violence, addressing workplace safety; collective mobilisation; skills development; gender empowerment; and interventions to address stigma and discrimination.

The idea that sex work should be recognised as work, in order to protect sex workers' human rights and labour rights, and in order to reduce sex workers' HIV risk, is no longer as controversial as it was even five years ago. Decriminalisation is recommended by the World Health Organisation and South Africa's National Sex Work Programme Plan. Recently, in a special edition on HIV and Sex work, an article by Shannon et al in the Lancet concluded that, "decriminalisation of sex work could have the largest effect on the course of the HIV epidemic, averting 33-46% of incident infections over the next decade through combined effects on violence, police harassment, safer work environments, and HIV transmission pathways" This means that decriminalisation is the single, simplest thing that governments can do to reduce HIV amongst this population.

Unfortunately, our campaign for this evidence-based intervention is still held hostage by the infamous US Government "Anti-Prostitution Pledge". Despite the fact that the Pledge - which requires recipients of US funds to acknowledge that they are "opposed to the practices of prostitution and sex trafficking, because of the psychological and physical risks they pose for women, men and children" - has been overturned in the US, it still applies to international recipients of US funding, and is in fact being applied with greater vigour, as now not only recipients, but also sub-recipients are required to sign the pledge. This puts many of our partner organisations, who receive funds both from Global Fund (which follows the WHO recommendations on

decriminalisation) and from PEPFAR, in a very difficult position, and places the Red Umbrella Programme at risk of not being able to fulfil its mandate.

We have to push back against recommendations which are based on morality and political opportunism, as opposed to those which are based on evidence and a respect for human rights. As Victor Hugo said, "Nothing can stop an idea whose time has come". Decriminalisation of adult consensual sex work is an idea whose time has come. ®

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Maria Stacey  
September 2014

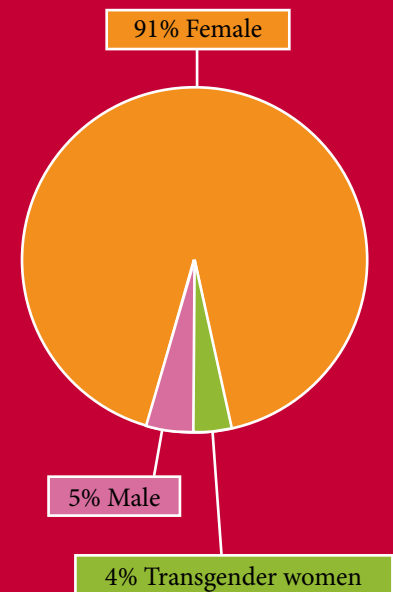
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## SOME QUICK FIGURES

Estimated 153 000 sex workers in South Africa



95% report having used a condom with their last client, but 81% report having used a condom last time they had sex with an intimate partner  
92% of sex workers surveyed know their HIV status  
57% Report having been a victim of violence in the past year. The most common perpetrators of violence were clients and police.

The Red Umbrella Programme has reached 34425 sex workers on outreach in the past quarter (January - March 2015)

15223 workers tested for HIV (Between October 2013 and March 2015)

Female sex workers support a median of 4 dependants with their earnings.



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# TRUCK DRIVER POPULATION...

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The objectives of this programme are to produce and harmonise policies, frameworks, and guidelines in order to improve collaborative HIV responses; to strengthen HIV and AIDS mainstreaming across sectors and HIV/AIDS monitoring and evaluation systems for key target populations; and to coordinate and enable sustainable HIV interventions.



Long distance truck drivers, due to the nature of their occupation can face important challenges accessing healthcare and are vulnerable to poor health outcomes. In high income countries, obesity levels tend to be very high among truckers, often severe enough to affect seatbelt use,<sup>(11)</sup> with a quarter experiencing associated sleep apnoea with resultant consequences for road safety. Smoking prevalence is several-fold higher in this population than the general population, while there are predictable problems associated with long haul trucking, such as backache due to posture, cargo loading, and prolonged sitting.<sup>(2)</sup> Research recently published by the Centers for Disease Control and Prevention in the USA shows that truck drivers face a disproportionately high risk for fatal crash-related injuries (11 times that of the general worker population) and other serious health disorders.<sup>(3)</sup> Further, research has shown consistently that in high, middle and low income countries mobile populations are more susceptible to both acquiring and transmitting HIV, thus contributing significantly to the HIV/AIDS pandemic.<sup>(4-10)</sup>

In South Africa, the national trucking industry plays a major role in the overall economy, as it facilitates the movement of products nationally and internationally and contributes to social development.<sup>(11)</sup> With an approximate population size of 70,000 truck drivers health initiatives for this group have been part of the South African National Department of Health programmes since 2007. Furthermore, there has been renewed recognition of the importance of truckers in our country's response to HIV with the National Strategic Plan on HIV, TB and STIs 2012-2016 (NSP)<sup>(12)</sup> distinguishing the trucking population as a specific key population requiring prioritization in HIV care and prevention responses to achieve the strategic objectives set.<sup>(12)</sup>

### Truck drivers and the HIV epidemic

There is limited published literature on the trucking population of South Africa; however the burden of HIV is estimated to be high. The first South African truck driver study published in 2001 reported a 56% HIV prevalence. This however was only among truck drivers who were clients of female sex workers<sup>(13)</sup>. In the absence of general truck driver population HIV prevalence information, a second South African survey conducted a few years later estimated HIV prevalence rates in the general truck driver population to be 26%.<sup>(14)</sup> Moreover, few studies have investigated both the role of mobility and migration in ensuring the success of public health initiatives as well as the importance of adapting any response to mobility patterns of the population prioritised.<sup>(8,9)</sup> In this context, such information is vital to the field of HIV prevention in truck drivers in that it contributes to understanding the burden of disease, the outcome of response efforts, and the needs for improved response to the pandemic in this population.

### Prioritisation of interventions

The design of prioritised initiatives for any at-risk population have been based on the premise that a subgroup of individuals with high numbers of partners<sup>(15)</sup> may sustain the transmission of any STI (including HIV) within a population.<sup>(16)</sup> Therefore prioritising these subgroups may have the potential to reduce HIV transmission; the extent of this impact may vary greatly depending on the local context.<sup>(17)</sup>

Recent evidence from India has shown that prioritised prevention programmes at scale can have an important population impact and that the investment is at least cost effective, and likely to be cost saving if a commitment is made to ensure access to clinical

services, e.g. antiretroviral therapy.<sup>(18)</sup> Indeed, key to success for priority interventions is whether the interventions are implemented in a way that the population of interest can access and use them. The service delivery package and the healthcare worker are two key elements linked to the success of prioritised interventions.

In particular, although there is limited information to date around the effect of HIV prevention interventions prioritised for truck drivers in Southern and, more specifically, South Africa,<sup>(19)</sup> studies from other countries have shown the importance of certain service delivery aspects in facilitating both client uptake and retention in care, i.e. a user-friendly approach including flexible operating times, accessible locations, and tailored service packages.

### Partnering to improve truck driver health in South Africa

Drawing on all the global evidence and in response to the NSP's strategic objectives of prioritising truck drivers, several donor-funded implementers have established roadside wellness clinics (RWCs) for service provision with the overall goal of improving truck drivers' health outcomes. The African trucking corridors, and in particular the South African network of trucking corridors, have initiatives such as North Star Alliance and Trucking Wellness. Since 2007, North Star Alliance has worked with 70 partners from the private, public and humanitarian sector to grow from one clinic with 5,000 visitors, to a network reaching over 280,000 people in 13 countries every year.<sup>(20)</sup> Trucking Wellness has partnered with agencies including the Swedish International Development Cooperation Agency (SIDA), the transport industry, unions and the National Bargaining Council

of the Road Freight Industry (NBCRFI) to provide services including HIV counseling and testing, condom distribution, chronic disease care, and malaria and TB screening through mobile clinics.<sup>(21)</sup> Trucking Wellness and Engen embarked on the annual Driver Wellness Campaign to improve truck driver health by providing screening, treatment and referral services at Engen garages. This campaign has succeeded in providing services to 400 drivers in 2011 and 841 drivers in 2012.<sup>(22)</sup>

In late 2012, the Wits Reproductive Health and HIV Institute (RHI) was awarded a five-year PEPFAR innovation grant to support the South African Government to develop, implement, and evaluate a national sex worker, male client, and truck driver programme

as a means of providing health care to these mobile, hard-to-reach, at-risk populations and mitigate the impacts of HIV/AIDS on mobile populations and affected communities. The objectives of this programme are to produce and harmonise policies, frameworks, and guidelines in order to improve collaborative HIV responses; to strengthen HIV and AIDS mainstreaming across sectors and HIV/AIDS monitoring and evaluation systems for key target populations; and to coordinate and enable sustainable HIV interventions.

Since 2013, RHI and North Star Alliance have partnered to implement clinical services for truck drivers, sex workers, and local communities through the establishment of RWCs

in Bloemfontein, Bloemhof, Cato Ridge, Johannesburg (now moved to Ekurhuleni), Mussina, Ngodwana, Pongolo, and Upington. There are plans to increase services to other areas of the country.

North Star Alliance brings health to hard-to-reach people across Africa in a "Blue Box". Converted shipping containers (painted blue) serve as clinics that deliver public health programmes for people with increased health risks, like truck drivers and sex workers, and primary health care to communities with limited or no access to medical services (Figure 1). Each drop-in clinic is run by well-trained clinical and outreach teams and supported by North Star Alliance's electronic health passport system, COMETS,

Figure 1: North Star Alliance's service delivery model



North Star Alliance brings health to hard-to-reach people across Africa in a “Blue Box”.

which allows patients to access their health records at every clinic within the network. A daily data feed also helps to maintain quality standards and monitor shifting disease patterns across entire regions.<sup>(20)</sup>

A process evaluation of the North Star Alliance model of care (as a proxy of South African Roadside Wellness Service delivery) is underway to explore how RWCs respond to the health care needs of truck drivers travelling along the South African trucking corridor. This programme evaluation has been funded by the Regional Office of the Dutch Ministry of Foreign Affairs. Watch out for the publication of these results. 

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# Pioneering HIV Prevention Services with People Who Inject Drugs in South Africa



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## The lack of harm reduction services is a significant gap in addressing HIV in South Africa.

### Introduction

The South African National Strategic Plan (NSP) on HIV, STIs and TB (2012 – 2016) identifies people who inject drugs (PWID) as a key population with a higher risk of exposure to or transmission of HIV<sup>[1]</sup>. In order to meet the NSP target to reduce HIV prevalence in key populations by 50% there is a need for interventions targeting the PWID population. Although data on injecting drug use in South Africa are limited, the use of contaminated injecting equipment, ineffective needle and syringe

cleaning practices, unprotected sex, low levels of HIV-related knowledge, and sex work have been identified among PWID in South Africa<sup>[2-5]</sup>. HIV prevalence among the approximate 67 000 PWID in South Africa is estimated at 19.4%<sup>[6]</sup>. Uptake of HIV counselling and testing (HCT) among PWID is limited and data on PWID on antiretroviral treatment (ART) is unavailable<sup>[6-8]</sup>. Research in low-income and middle income countries has shown that only 25% of PWID who are HIV positive are receiving ART<sup>[9]</sup>. The NSP and other national drug related policies, notably

the Central Drug Authority's (CDA) National Drug Master Plan and the National Department of Health's (NDOH) Mini Drug Master Plan, highlight the need for interventions for PWID<sup>[10;11]</sup>. However, PWID targeted interventions for HIV have been largely ignored in South Africa. This article briefly discusses the need for services which address the harms of injecting drugs (see Table 1) and describes a pioneering project designed to deliver evidence-based HIV prevention services to PWID in South Africa.

Table 1: Common health issues for PWID

<b>Infection-related injuries</b>	Bruising/scarring Swelling, inflammation and urticaria Venous/arterial injury Ulcers
<b>Infection-related injuries</b>	Cellulitis and abscess Thrombophlebitis
<b>Complications of injection-related infections</b>	Bacteraemia and septicaemia Muskuloskeletal infections Endovascular complications Tetanus
<b>Infectious diseases</b>	Sexually transmitted infections Viral hepatitis (hepatitis B and C) Respiratory tract infections Tuberculosis (TB) HIV/AIDS
<b>Non-infectious disorders</b>	Psychiatric disorders Substance dependence and substance use-related disorders
<b>Other common health problems</b>	Pain Constipation Poor dental condition/hygiene

transmission among PWID and their sexual and drug using partners, and the broader population<sup>[15,16]</sup>.

### PWID harm reduction

HIV prevention, treatment and care services for PWID have been available since the 1980s. Over time, extensive research has provided a set of evidence-based interventions that are recommended by a number of international agencies (Table 3). These interventions are based on the principles of harm reduction. According to the International Harm Reduction Association, harm reduction 'refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.' The approach is based on a 'strong commitment to public health and human rights.'<sup>[17]</sup>

Two examples of effective harm reduction interventions are needle and syringe programs and medically assisted treatment (MAT) for opioid use disorders. Needle and syringe programs significantly reduce HIV incidence amongst PWID<sup>[16,18]</sup> are easily initiated, cost effective and have shown significant return on investment<sup>[19,20]</sup>. Contrary to some criticism of needle and syringe programs, there is no evidence that they encourage injecting drug use. MAT, using opioid agonists and partial agonists such as Methadone, has significant benefits such as reduction in illicit drug use, reduction in mortality, and increased access to medical services. MAT has been shown to have a direct effect on incidence and treatment of HIV amongst PWID<sup>[21-26]</sup>. It is clear that similar harm reduction initiatives are required in South Africa if HIV prevalence and incidence targets amongst PWID are to be met.

### PWID and HIV

PWID are at disproportionately higher risk for HIV exposure and transmission compared to the general population.<sup>[12]</sup> There are both direct and indirect risk factors that contribute to this additional burden (Table 2). Indirect risks include systemic, structural and social factors such as poverty, stigma, discrimination, lack of appropriate services, violence and high risk sexual practices. Direct

risks relate to individual risk taking behaviours.

Stigma and discrimination towards PWID contributes to delayed health seeking behaviour and barriers accessing health care<sup>[13,14]</sup>. A lack of appropriate HIV prevention, treatment, care and support services to meet the unique needs of PWID contributes to the HIV burden and onward HIV

Table 2: Direct and indirect drivers of HIV risk in PWID

<b>Direct Risk of HIV</b>
<ul style="list-style-type: none"> <li>• Needle &amp; Syringe reuse</li> <li>• Ineffective cleaning of used needles</li> <li>• Sharing of needles</li> </ul>
<b>Indirect Risk of HIV</b>
<ul style="list-style-type: none"> <li>• High risk sexual practices</li> <li>• Low levels of knowledge</li> <li>• Limited access to appropriate services</li> <li>• Violence</li> <li>• Stigma, discrimination &amp; exclusion</li> </ul>

Table 3: Evidence- based comprehensive package of services for HIV prevention for PWID

**Recommended package of services for PWID:**

1. HIV counselling and testing (HCT)
2. Antiretroviral therapy (ART)
3. Vaccination, diagnosis and treatment of viral hepatitis
4. Condom and lubricant dissemination, and skills education for PWID and their sexual partners
5. Needle and Syringe programs (NSPs)
6. Medically assisted treatment (MAT), including OST, and other evidence-based drug dependence treatment
7. Prevention and treatment of sexually transmitted infections (STIs)
8. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
9. Prevention, diagnosis and treatment of tuberculosis (TB).
10. Peer education

Endorsed by: WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, United Nations Joint Programme on HIV and AIDS (UNAIDS), the Global Fund and PEPFAR.

**Harm Reduction Services in South Africa**

Substance use disorder and HIV-related services for PWID are limited, and primarily provided by civil society organisations (CSOs). Access to services is often inequitable<sup>[27,28]</sup>. Few drug dependency treatment services are provided free, making cost a major barrier to accessing treatment<sup>[8]</sup>. Publicly funded drug dependency treatment services are almost exclusively abstinence-based and therefore not suitable for those unable or unwilling to stop their drug use.

The recommended harm reduction services (Table3) for the prevention and treatment of HIV in PWID are not consistently available in South Africa. For example, one needle and syringe programme targeting men who have sex with men (MSM) who inject methamphetamine, provided services for 18 months in central Cape Town<sup>[29]</sup>, but is no longer operating. MAT is not generally available in the public sector. In the Western Cape a single small pilot study (n=80) made MAT available in a high-threshold service at a community treatment program, but

to date no data has been published or reported on. The lack of harm reduction services is a significant gap in addressing HIV in South Africa. In order to redress these gaps in services for PWID, TB/HIV Care Association (THCA) has drawn on previous experience with key populations to inform the delivery of services to PWID. This is the first stage in the endeavour to reduce HIV prevalence amongst PWID by 50%.

**TB/HIV Care Association’s experience in working with key populations**

TB/HIV Care Association is a registered non-profit established in 1929 to support people with TB and their families. Since 2011, THCA, in collaboration with a variety of partners (CDC/PEPFAR, Global Fund and Departments of Health) has been implementing a large national peer-linked mobile HIV prevention project for sex workers (SW). THCA’s peer-linked, clinical staff supported mobile health, wellness and human rights project has been recognized as a best practice model to work with sex workers and other hard to reach mobile populations.

During the implementation of the SW programme, THCA developed links with people who use drugs through service delivery in the sex work community. THCA was also a lead implementing partner of the recent Rapid Assessment of HIV and Related Risk Practices of PWID in Five South African Cities<sup>[30]</sup>. Based on this experience, and having recognised the gap in services, THCA with support from international donors, are rolling out together with OUT-Well-being in Pretoria, South Africa’s first PWID HIV prevention harm reduction programme in South Africa, called the Step Up Project.

**The Step Up Project**

The Step Up Project is a demonstration project working in Cape Town, Durban and Pretoria to implement the full

Stigma and discrimination towards PWID contributes to delayed health seeking behaviour and barriers accessing health care



recommended package of services for PWID.

The Step Up Project aims to improve the health and health seeking behaviours of PWID and to ultimately reduce HIV infections among PWID, and their using and sexual partners. For more than 12 months PWID have been consulted through monthly community advisory groups (CAGs). Information provided has informed various aspects of service delivery from service operating hours and

HIV prevention commodities, to the prioritisation of common health and psychosocial needs. PWID in all three cities have participated in health education meetings, human rights conferences and engagement with local government structures. A key program principle is the empowerment of service beneficiaries to find solutions to their health challenges, with professional support. Service beneficiaries are reached where they live or congregate with primary health care, behaviour change interventions

and targeted health education, using the THCA mobile outreach model (Figure. 1). Service users are then linked to mobile health and wellness services and provided peer navigation and health professional support to further link them into treatment and care.

Health teams include professional nurses, lay counsellors, key population peer educators, and drivers. Team are also trained as para-legals in order to document human rights violations for advocacy purposes, and referral. Clinicians provide primary nursing care, which includes comprehensive health screenings, HTC, wellness services, sexual and reproductive health (SRH) care, wound care, health education (e.g. overdose prevention), and risk reduction counselling for high risk drug and sexual practices (Figure 2). Women's needs are prioritised. An integrated approach to screening, testing and linkage to care for HIV, TB, Hep C and STIs is used. Point of care CD4 is available to expedite referrals and the initiation of ART to eligible PWID.

Linking individuals successfully to care through accompaniment, information and support is crucial because of the importance of HIV/TB care, substance abuse counselling, survivors of gender-based violence and assistance with human rights violations. THCA has developed a novel peer navigation system that provides direct PWID peer to client support in navigating the public health environment. THCA's robust data collection system efficiently tracks successful linkages into existing public health structures. The monitoring and evaluation system is structured to track PWID and other key population success against the UNAIDS' 90-90-90 target of 90% tested, linked to care and virally suppressed. A comprehensive monitoring and evaluation protocol will ensure that project aims and objectives are met and that improvement can be made to facilitate scale-up into other

Figure. 1 THCA Mobile Outreach Model:

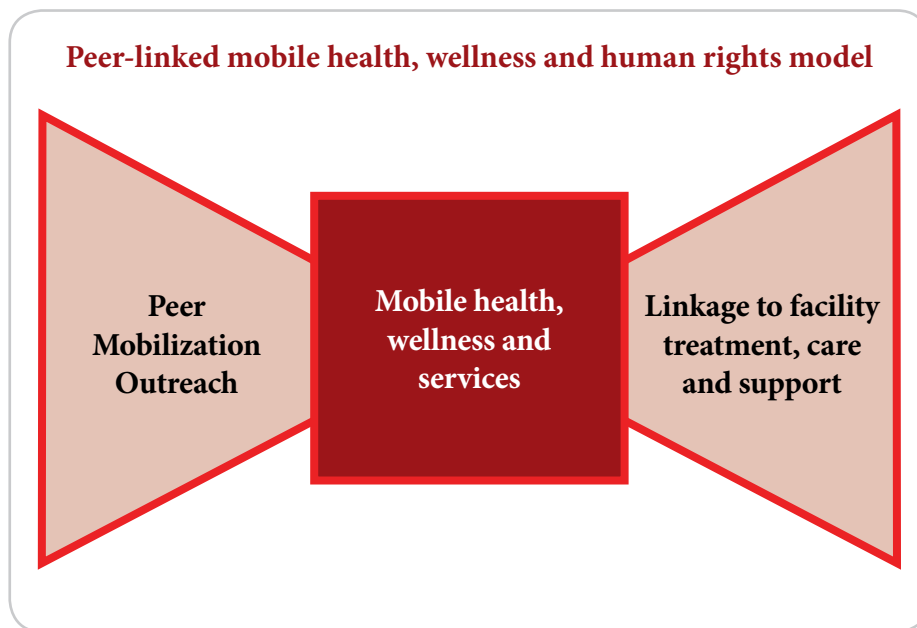
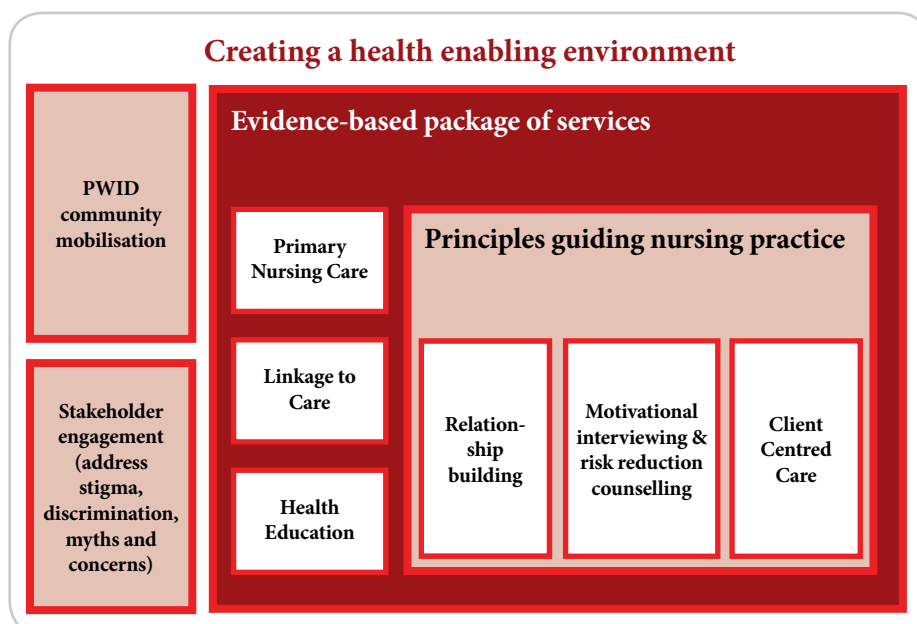


Figure 2. The Step Up Project Nursing Care Model



areas of South Africa and beyond.

### The challenges ahead

Working with PWID is uniquely challenging. The legacy of stigma and discrimination is an understandable reluctance on the part of the PWID community to engage with formal services. Building trust with the PWID community and reaching this mainly hidden population with essential HIV and basic health and human rights services will take time. Despite significant global evidence that shows that specific and tailored programmes for PWID improves health outcomes, countries like South Africa, that are new to harm reduction principles, may be sceptical. Ongoing government support, stakeholder advocacy, community engagement and increased services will be required. Despite the challenges that lie ahead lifesaving interventions, and important research that addresses the complexity and diversity of PWID in the South African context, are beginning to be implemented. Nurses should be able to apply the principles of harm reduction across their clinical, coordinating, research, education and advocacy roles. Risk reduction counselling, motivational interviewing and relationship building skills should be developed and prioritised within nursing practice. Nurses are ideally positioned to write and implement inclusive policies and procedures, advocate for resources, appropriate care and sensitivity to PWID with students, health professionals and community structures. Counteracting myths and misinformation about drug use, or people who use drugs, is vital. Nurses can ensure that evidence-based services are available in their facility, provide targeted health promotion and strategically link clients to appropriate, sensitive care on macro and micro levels. An equitable and effective health care system must cater skilfully to the full spectrum of human experience and difficulty, and the role of the nurse in realising this is a vital one. <sup>®</sup>

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# TUBERCULOSIS (TB) in South African prisons

Unathi Mahlati, BSc., *The Wits Justice Project*

Dudley Lee spent four and a half years as an awaiting trial detainee at Pollsmoor maximum security prison from November 1999 until September 2004 on charges of fraud and money laundering. After over 70 court appearances, he was acquitted of all charges and released in September 2004.<sup>[1]</sup> However, during those years of incarceration, he was subjected to prison conditions that have been dubbed as 'inhumane'<sup>[2]</sup> and led to his contracting tuberculosis (TB). After a drawn-out court battle that ended in the Constitutional Court, Lee was awarded R270, 000 in damages which he received in November 2013, just a few months before he died in May 2014.<sup>[3]</sup>

With Lee's court victory, South African civil society expected a legal precedent in liability for TB transmission to be set. But the State is now backtracking on its promise to settle cases of Zaid Seedat (Lee's co-accused who was also hospitalised in Pollsmoor with him) and Glen Spencer, inmates who contracted TB in similar circumstances as Lee. Jonathan Cohen, lawyer of Lee and the two inmates, explains:

*The State attorney's office requested that the cases of Seedat and Spencer be held in abeyance ...as it was agreed that we would first await the outcome of the Dudley Lee matter, and on receipt of that*

Prisons are a breeding ground for the spread of communicable diseases. Just for the quarter October – December 2014, the Judicial Inspectorate for Correctional Services (JICS) received 11 reports of natural deaths caused by TB,<sup>[4]</sup> a preventable and treatable disease.

*outcome, the Seedat and Spencer matters may well settle. Despite that agreement, the State has persisted with its defence of both the Seedat and Spencer matters.*

According to Cohen, the State's refusal to accept accountability for causing harm to its citizens, despite the fact that such harm can be prevented through reasonable measures, is a challenge. Cohen is currently in the process of 'taking steps to bring these two matters to trial' and since his success with Lee's case; he has been approached by other inmates with similar cases, illustrating the critically high rate of TB in South African prisons.

## Relationship between the Human Immunodeficiency Virus (HIV) and TB

Prisons are a breeding ground for the spread of communicable diseases. Just for the quarter October – December 2014, the Judicial Inspectorate for Correctional Services (JICS) received 11 reports of natural deaths caused by TB,<sup>[4]</sup> a preventable and treatable disease. Worldwide, the prevalence of TB is alarmingly high in prisons compared to the general population.<sup>[5]</sup> The link between HIV and TB further exacerbates the spread of TB in South Africa prisons, where the burden of HIV is already high. According to Emily Keehn from Sonke Gender Justice, as of March 2014, 27 980 inmates were on record as being HIV positive in South African prisons. Globally, TB is the number one cause of illness and death in people living with HIV, including those on antiretroviral treatment (ART).<sup>[6]</sup>

It should be noted that the prevalence and spread of communicable diseases in prisons is not only a concern for inmates and correctional services staff, but has implications for society at large because those detained will eventually be released back into their communities.<sup>[7-8]</sup> During the 2012/13 financial year, a total of 65 931 inmates were released back into the community.<sup>[9]</sup>

### Overcrowding

Overcrowding, poor ventilation, late case detection, debilitated prison infrastructure, limited access to health care, weak preventative interventions for HIV, inadequate funding and constant movement of inmates to and from the community have been cited among the factors propelling the spread of TB in prisons.<sup>[7, 8, 10]</sup> Lee was diagnosed with TB three years after his incarceration. When he arrived at the prison in 1999, he was reasonably healthy and did not have TB: 'Apart from some trouble with his heart and prostate he was healthy and he had never been ill with TB prior to his incarceration.'<sup>[11]</sup> However, the Supreme Court of Appeal (SCA) ruled that Lee could not prove that he would not have contracted TB had conditions at Pollsmoor been different. Lee

appealed to the Constitutional Court and finally won in December 2012. The Constitutional Court's decision to overturn the decision by the SCA reiterates the point that negligence by the department to improve poor conditions at Pollsmoor caused Lee to become infected with TB. After his diagnosis in June 2003, Lee was returned back into his cell, where he was confined for up to 23 hours per day, with at least one other inmate, with limited sunlight and poor ventilation,<sup>[11]</sup> creating an optimum environment for TB-causing bacteria to thrive. TB-causing bacterium stays airborne for a long time in dark, confined, and poorly ventilated spaces.<sup>[12]</sup>

In addition to perpetuating the spread of TB, high levels of overcrowding infringe on the rights of inmates enshrined in the Constitution. Section 35(2) (e) states that:

everyone who is detained including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.<sup>[13]</sup>

*(See information boxes for responsibilities of health care workers (HCWs) working with inmates and basic human rights of inmates).*

### Awaiting Trial Detainees

Awaiting trial detainees<sup>1</sup> are by law "presumed innocent" and more than half will be released back into society on acquittal or their case being struck off the roll.<sup>[14]</sup> What are they doing in detention for extended periods of time where they are exposed to inhumane conditions? In *Lee v Minister of Correctional Services*, conditions in awaiting trial centres were put in the spotlight. The judge stated that:

Pollsmoor is notoriously congested and inmates are confined to close contact for as much as 23 hours every day – thus providing ideal conditions for transmission; on occasion, the lock-up total was as much as 3052 inmates

### WHY FOCUS ON PRISONERS?

1. Upon imprisonment, inmates still retain all their other basic human rights, including access to health care
2. When the state deprives a person of his/her liberty, it assumes responsibility to provide appropriate care.
3. Ineffective TB/HIV prevention inside prisons contributes to the TB and HIV burden in the general community because most inmates will be released into their respective communities.

### RESPONSIBILITIES OF A HEALTH CARE WORKER (HCW) WORKING WITH INMATES

HCWs have a role of acting, within the legal framework, as advocates for access to health care, & not to restrict or ration care. This may mean that HCWs may be faced with conflicting loyalties to the authorities and to their patients. In that case, HCWs may need to seek support from their representative associations.

Furthermore, HCWs should advocate for adequate medical and support staffing to meet the health needs of inmates.

No motive, whether personal, collective or political, shall prevail against HCWs' obligation to alleviate distress to their patients.

and single cells regularly housed three inmates; communal cells were filled with double and sometimes triple bunks ... [para 8]<sup>[11]</sup>

According to JICS 2013/2014 annual report, the inmate population in South Africa is one of the highest per capita in the world, with sometimes inmates doubling or tripling the cell capacity.<sup>[15]</sup>

Professor Robin Wood, Director of the Desmond Tutu HIV Centre at the University of Cape Town, and colleagues used data from court evidence and judicial reports to mathematically calculate the likelihood that an inmate held in the awaiting trial section at Pollsmoor would contract TB. They found that a person incarcerated in Pollsmoor for one year had a 90% chance of contracting TB. Furthermore, if Pollsmoor implemented the cell occupancy standards required by South African prison regulations, transmission probability would be reduced by 30%. They concluded that "current conditions of detention for awaiting trial prisoners are highly conducive for spread of drug-sensitive and drug-resistant TB".<sup>[10]</sup>

Although the legal framework (see Chapter 3 of the Correctional Services Act 11 of 1998)<sup>[16]</sup> stipulates that conditions where inmates are accommodated must be consistent with human dignity, current conditions in many South African prisons are indicative of the gap between theory and practice.

### Current situation and moving forward

On March 24 2015- World TB Day - a fixed high-tech digital X-ray machine was installed at Pollsmoor prison. The machine, according to Professor Harry Hausler, CEO of the TB/HIV Care Association, will reduce the time between diagnosis and initiation of treatment. Inmates whose x-rays show abnormalities will be separated and their sputum collected for GeneXpert testing, thus reducing the likelihood of transmission. The fixed machine came a few months after TB/HIV Care started providing mobile x-ray services on December 18 2014 and two years after the launch of a GeneXpert machine, on

March 24 2013, at Pollsmoor. Over a period of just three months (December 2014 - February 2015), the mobile x-ray service diagnosed 31 new TB cases that were started on treatment. Since the launch of the GeneXpert machine, the time from sputum collection to initiation of treatment has decreased from almost a week (6.5 days) to less than two days (1.9 days).

Moving forward, one short term solution cited by Prof Hausler to address the issue of TB transmission in prisons would be to rapidly train and mentor Department of Correctional Services (DCS) nurses in TB diagnosis and treatment. In the long-term, he stated the necessity to: (1) continue partnership between civil society and government; (2) increase the number of facilities with decentralised HIV services which enable DCS nurses to prescribe and dispense ART; and (3) focus on systemic change that can positively affect the criminal justice system as a whole - for instance, look into restorative justice for minor offences. According to Professor Hausler, decriminalizing of petty offences and release of offenders into community care will reduce overcrowding, which he cited as one of the leading challenges in the fight against the scourge of TB in South African prisons.

Globally, overcrowding in prisons is exacerbated by excessive use of remand detention.<sup>[2]</sup> Correct application of bail laws could help alleviate overcrowding: awaiting trial detainees are in remand detention because they have either not been granted bail or granted a bail amount they cannot afford.<sup>[17]</sup> The poor, even if accused of petty offences, will likely be in remand for prolonged periods, susceptible to the spread of communicable diseases,

In addition to perpetuating the spread of TB, high levels of overcrowding infringe on the rights of inmates enshrined in the Constitution

where 'conditions are even worse than those for convicted prisoners'.<sup>[18]</sup> According to DCS statistics, as of April 20 2015, occupancy of Pollsmoor remand detention facility (RDF) was at 295%. In contrast, occupancy at medium B and C (both housing sentenced offenders) was at 236.8%, and 144.8%, respectively.<sup>2</sup> Justice is often delayed and freedom denied for the poor who are unable to pay even the smallest amounts of bail.

In conclusion, improving prison conditions, effective early detection, and adherence to rigorous treatment regimens - in both RDFs and facilities housing sentenced offenders - are of utmost importance in the struggle to combat the spread of TB in South African prisons. Despite high levels of overcrowding at RDFs, provision of health services is scanty. Chapter 6 of the White Paper on Remand Detention states that 'the provision of programmes to RDs [remand detainees] has been somewhat haphazard. Many difficulties exist in providing programmes to such a fluid population.'<sup>[19]</sup> This sentiment was echoed by then Minister Correctional Services, Nosiviwe Mapisa-Nqakula: 'Remand detention has for a long time been the stepchild of the DCS. There was no clear policy in government as to where matters of remand should be situated and this has resulted in a situation where the needs of remand detainees were not on the forefront of developments within the DCS.'<sup>[18]</sup> Robust medical screening and provision of treatment should be enforced at RDFs to ensure that those presumed 'innocent until proven guilty' are afforded the right to health care and human dignity as enshrined in the Constitution. The state, as mandated by domestic and international legal framework, should take responsibility for inmates - a group amongst the most vulnerable to HIV/TB co-infections. <sup>®</sup>

<sup>1</sup> As of March 31 2014, 44 236 - or 29% - of South African inmates were awaiting trial (JICS 2013/2014 Annual Report, p.39).

<sup>2</sup> Email communication with Clare Ballard, attorney at *Lawyers for Human Rights*



## WHAT ARE THE BASIC HUMAN RIGHTS OF INMATES?

**Right to health care and to be treated with dignity:** Inmates retain all their rights, including the right to health care, after incarceration and should be treated with human dignity.

Upon admission, all inmates, irrespective of HIV status, should have immediate health briefing and TB symptom screening. This will help establish medical treatment status.

**Right to refuse treatment:** However, HCWs should be aware of the lack of information in prisons and ensure that refusal of treatment is based on an informed consent.

**Confidentiality** of private medical information should be maintained, as is done for all patients. In cases where other inmates are assisting provide health care services, they should be trained on handling sensitive & confidential medical information. Inmates should be educated regarding enclosure so that necessary steps are taken by HCWs to provide appropriate medical care.

**Nutrition:** Inmates have a right to balanced nutritious meals, three times a day.

**Source:** Guidelines for the Prevention and Treatment of HIV in Arrested, Detained and Sentenced Persons, 2008.

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# SEEK FIRST TO UNDERSTAND

L de Kock, N Masike, B Pitse, C Jack, S Radingoana, W Jassat  
Quality Improvement and Training Department, The Aurum Institute

Sometimes we are like the lady in the picture, we are simply working too hard, doing something that is not expected of us, or doing it in a way that is not required, simply because we didn't understand the instruction correctly or we interpreted it differently. This is why it is so important we understand exactly what our data elements ask of us!

Many of us are very familiar with the phrase, 'If it's not recorded, it's not done!' The harsh reality of this little powerful phrase is that it is very true. Our daily work is translated into a series of numbers that are reported on a daily, weekly and monthly basis, which supposedly indicates exactly what we have done. Therefore, if it is not recorded, it is not done! In this article however, we will explore and explain the importance of first seeking to understand precisely **what needs to be done** according to our District Health Information System (DHIS), so that when we do record what we have done, it is (1) **an accurate reflection of our work and (2) we haven't wasted unnecessary time and resources doing something that may not be expected of us.**

## Data Indicators And Elements – What Are They?

Most of the clinical procedures we perform in our facilities are defined by a data element. To help us understand this and other data terms, we will quote directly from Module 4 of the Aurum Institute Quality Improvement HOW To Guide – HOW TO Select Measures to Know

your Change is an Improvement . "The simplest way to measure is to **count how many**. For example, you could count how many women you tested for HIV during their first ANC visit. In the South African healthcare system, this is known as a **data element**. Imagine on Wednesday you tested 8 women and on Friday only 4. Has your performance gone down? The answer is "I don't know". Until we know **how many women attended** for a first ANC appointment on both days and **needed** an HIV test we can't answer this question. Imagine on Wednesday 16 women should have received a test and on Friday only 6. Is our performance going up or down? The answer is UP because: On Wednesday we tested 8 out of the 16 women who should have been tested; therefore our testing rate was 50%. On Friday we tested 4 out of the 6 women who had a first ANC visit, so our testing rate was 66%."

When we make a **calculation** like the above that **compares** who **should** have received the service with who **got** the service, we call the value an **indicator**. It is usually **presented as a percentage**. An easy way to remember this is to think

of the following calculation:

$$\frac{\text{Number of people receiving the service}}{\text{Number of people who should have received the service}} = \text{Indicator (x 100 for \%)}$$

## Why Do They Matter?

Recently a picture went viral on Facebook and Twitter that gave us all a good chuckle. We do not have the original source, so please email us and tell us if you do.

The picture depicts a lady taking a dog for a walk. However, this walk was not how we had imagined it; instead of the dog pulling the lady along as it tried desperately to break free from his collar that held him captive, it was rather a picture of a dog being carried on a ladies back as he sat back blissfully enjoying the walk that required no energy from him at all.

Sometimes we are like the lady in the picture, we are simply working too hard, doing something that is not expected of us, or doing it in a way that is not required, simply



because we didn't understand the instruction correctly or we interpreted it differently. This is why it is so important we understand exactly what our data elements ask of us!

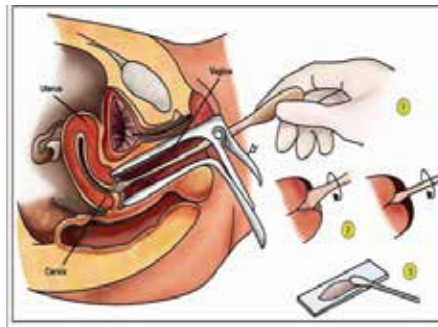
In our Quality Improvement (QI) work, we have found a number of elements from the HIV and TB programme that are often misinterpreted or not understood correctly. Examples of these included: Sputum turnaround time (TAT) within 48 hours: This data element mainly measures the efficiency of the laboratory; however some facility staff members calculate the TAT from the time when the client coughs (and not from when the courier collects the specimen), and include weekends when the facility is actually closed. This often leads to a TAT being more than 48 hours.

The data element 'antenatal clients HIV first test positive' is also often incorrectly recorded to include antenatal clients with known HIV positive status at first visit in the data element. This incorrectly inflates the incidence of HIV among antenatal clients.

We will now indicate the impact of not understanding the cervical screening data element by drawing from examples from Primary Health Care facilities in

3 districts around South Africa. Each of the facilities we worked with had a similar problem, low Cervical Screening Coverage. All were disheartened as they could not understand why they kept missing their target each month.

## Why is Cervical Screening so important?



<sup>2</sup>Cervical cancer is one of the most common cancers in South African women but it is also preventable through regular screening tests and follow-ups. Currently the South African cervical cancer screening programme recommends the Papanicolaou (or Pap smear) screening test to help prevent cervical cancer or find it early. The Pap test (or Pap smear) looks for pre-cancer cell changes on the cervix that might become cervical cancer if they are not treated appropriately.

The Pap test is recommended to be performed every ten years for all women between the ages of 30 and 60 years old, and can be done in a doctor's office or clinic. Because HIV is associated with cervical cancer, women who are HIV positive should be screened more regularly, starting from a younger age. Pap smears will be offered to HIV positive women from the age of 20 years and repeated every three years. During the Pap test, the doctor/nurse will use a plastic or metal instrument, called a speculum, to widen the vagina. This helps the clinician examine the

vagina and the cervix, and collect a few cells and mucus from the cervix and the area around it. The cells are then placed on a slide or in a bottle of liquid and sent to a laboratory. The laboratory will check to be sure that the cells are normal.<sup>3</sup>

## How Was Cervical Screening Being Done Before The QI Intervention?

In order to understand what was actually happening, the QI team decided that it was imperative to map out the exact steps being followed in order to determine possible root causes for the low cervical screening rates. A very similar pattern emerged; see an example of a process map on the next page.

This process map identified the following gaps:

- The reporting of the indicator was not done as per DHIS requirements. Only women over 30 years of age who received the service are supposed to be reported. However, women <30 were also been included in report tallies. This showed the lack of understanding of the indicator definition
- The recording of the service was not carried out in a consistent way. A tick register is supposed to be used to record the pap smears done for the over 30 year old females. However, in many instances, registered nurses were including pap smears done for the under 30 year old women, which significantly inflates their statistics.
- The cervical screening service was not marketed as part of the facility service package to female patients.



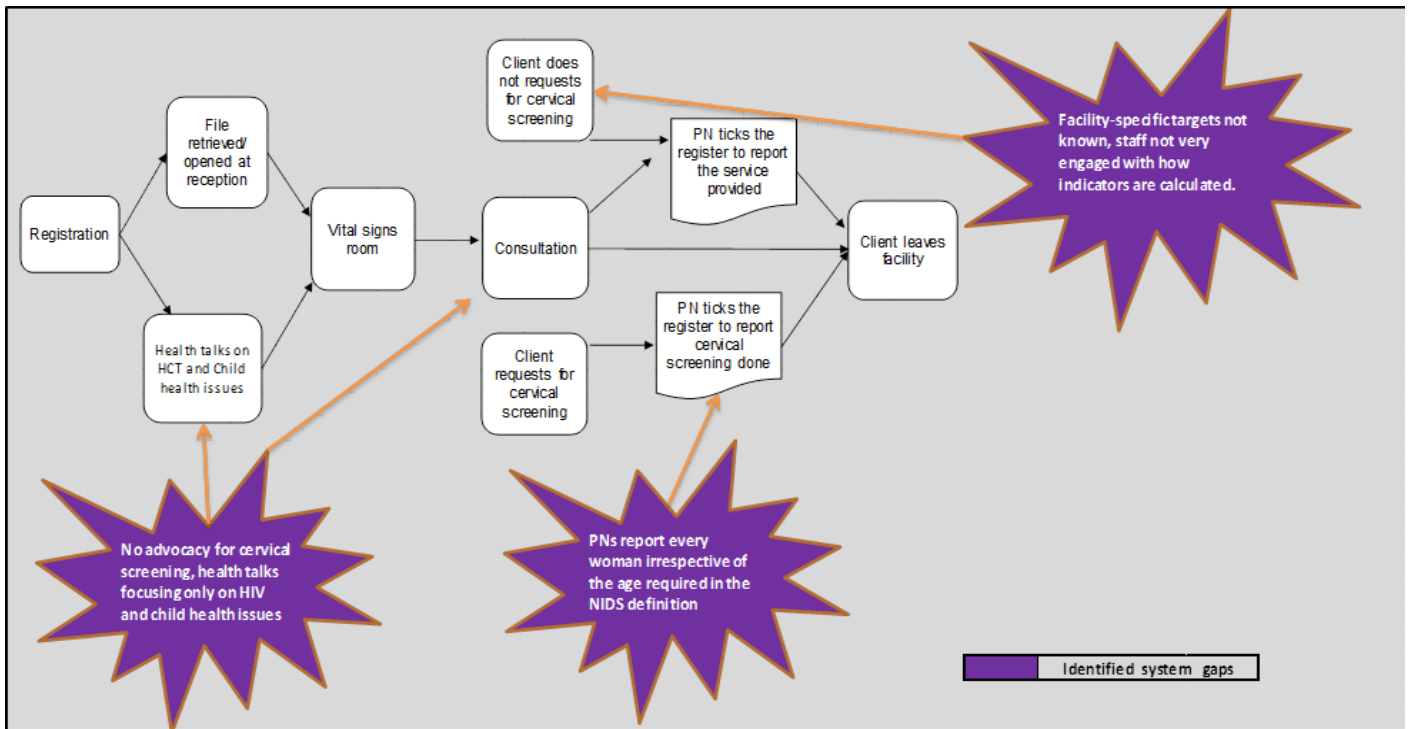


Table 1: Process map

- Registered nurses were not aware of the targets they were expected to meet
- Staff were not aware of how to calculate their facility specific target

### Seek First To Understand My Indicator

Each month we observed that many nurses were working hard at providing the service to as many women as possible. Cervical screening is however a long procedure, taking approximately 35-40 min. So when emergencies happen and staff shortages occur, time consuming procedures such as these are often not prioritised. After doing a screening, the Pap smear is recorded in the tick register, knowing it would be counted toward the facility's monthly target. The problem was however, when this target is calculated on a monthly basis, the indicator does not cover all women, but only those 30 years and above. Additionally, their target is not simply a percentage of all women attending the clinic, as was thought, but a

population based target, specific to each facility. In this case the target calculation is based on 10% of the facility's female population 30 years and above.

It became very apparent to the QI team that no incentive, reward, target or new innovative way of promoting cervical screening would ever have an impact on this indicator until staff knew exactly:

- What cervical screening coverage actually meant
- How the indicator was calculated (numerator and denominator)
- How to determine their facility specific target

### What Does Cervical Screening Coverage Actually Mean?

Women who are defined as high risk

$$\frac{\text{Cervical screening done on women >30 years}}{10\% \text{ of the population of women >30 years}} = \text{Cervical Screening Coverage Rate (Indicator)}$$

for developing cervical cancer are those who are 30 years and above. Coverage therefore means the number of screening Pap smears done in a particular month on women 30 years and above and recorded in DHIS. This indicator does not include diagnostic and repeat smears.

### How Is The Indicator Calculated?

Data elements used to calculate this indicator are: 1) Cervical screening done on women 30 years and above as a numerator, and 2) Population of women 30 years and above divided by 10 or simply 10% of the population of women 30 years and above, as a denominator.

Many of us are very familiar with the phrase, 'If it's not recorded, it's not done!' The harsh reality of this little powerful phrase is that it is very true

## An example of how to determine a facility specific target

In the DHIS, the population of women >30 years is calculated by adding women 30-34 years, 35-39 years, 40-44 years, and 45 years and above. See example below for a step by step

guide of how to calculate your facility target.

## Results of Seeking First to Understand

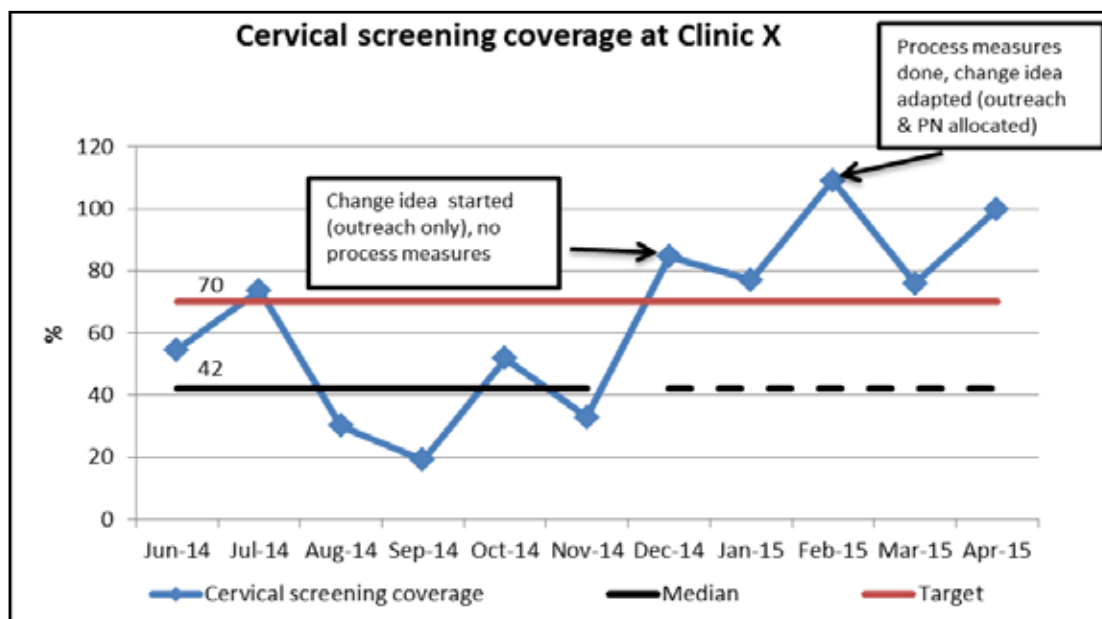
The line graph below is an example of a cervical screening project in one of the primary health care facilities supported by Aurum Institute. This facility experienced the same challenges identified previously of incorrect data element interpretation as well as incorrect recording and reporting. Through utilising QI Plan-Do-Study-Act methodology however, the facility was able to reach their monthly target of 70% of women who

had cervical screening done and are well on their way to maintaining this change as staff now understand what needs to be achieved and how.

## Conclusion

Seeking to understand our data elements is an essential part in understanding exactly what we as healthcare providers should be doing, how we should be doing it and therefore how it is recorded and reported. Often the best place to start in the process of improvement is to seek first to understand data indicators and elements.

Step 1	<b>Calculate your population by adding:</b>	• Female 30-34 years	959
		• Female 35-39 years	813
		• Female 40-44 years	780
		• Female 45 years and older	1 958
Step 2	<b>Calculate your population Total by adding all the categories above</b>	• Total	4 510
Step 3	<b>Calculate 10% of your target</b>	• 10 % of total to get annual target	451
Step 4	<b>Then divide number above by 12 to get monthly target/denominator•</b>	451/12=37.5	37.5 ≈ 38



# The Importance of Gender Assessment in TB

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Stacie C. Stender, MSN, MSc Inf Dis, *Jhpiego*

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Tuberculosis remains a global health problem with an estimated 9.0 million people who developed the disease in 2013. One quarter of the 1.5 million who died were HIV-positive.<sup>1</sup> In most low and middle-income countries, two-thirds of reported TB cases are among men and one-third are among women. It is not clear whether this is due to a higher risk among males or under-notification of TB among females. While TB disease and deaths occur more frequently among men globally, some studies have shown that females experience longer delays in care seeking, diagnosis and treatment of TB.<sup>2</sup>

A systematic analysis of global, regional and national incidence and mortality for tuberculosis by the Global Burden of Disease Study 2013 provides evidence that sex bias in HIV-negative individuals does not arise until puberty. In other words, boys and girls from birth to 10 years of age have the same rates of TB.<sup>3</sup> The study also showed that girls 10-19 years of age had higher rates of TB than boys the same age; however from 20 years of age and above, men had higher rates: between the ages of 40 and 75, the incidence of TB among men was **double** that of women. In South Africa, in a study by McLaren et al., it was shown that women were tested for TB more frequently than men between 2009 and 2011, yet there were still more men diagnosed with TB in the same time period.<sup>4</sup>

The importance of understanding what populations are most at risk for TB is essential to END this curable disease. People living with HIV are up to 30 times more likely to develop TB than HIV-negative individuals. Malnutrition, diabetes, alcoholism, silicosis, overcrowding, poverty, and smoking are additional risk factors. Is being male a risk factor in and of itself? To what extent does behavior

and physiology contribute to infection and progression to disease?

In 2013, a HIV Gender Assessment tool was developed by UNAIDS, as there was recognition of a need for more systematic data collection on gender equality and HIV after the mid-term review of the UNAIDS *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014*.<sup>5</sup> In 2014, the Stop TB Partnership acknowledged the need for a similar tool to inform the TB response, and a partnership with the UNAIDS Secretariat was established. The HIV Gender Assessment tool has subsequently been revised to address TB as well.

According to UNAIDS, **key populations** for HIV are those most likely to be exposed to or transmit HIV, including people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, migrant workers, people in prison, women and girls, and seronegative partners in sero-discordant couples are at higher risk of exposure to HIV than other people.

Key populations for TB (or **key affected populations**) are not the same as for HIV. Key affected populations for TB include:

1. People who have increased exposure to TB bacilli. This includes individuals who may be in settings of overcrowding or poor ventilation, i.e. healthcare workers, household contacts of TB patients, institutionalized individuals (prisoners, hospitalized patients)
2. People who have limited access to health services. This may be due to gender, geographical, financial, social (stigma), or legal factors.
3. People at increased risk of TB because of biological and behavioural factors that compromise

immune function. This includes those factors that increase an individual's risk of developing TB disease after infection, most notably people living with HIV.

In order to **End TB in our lifetime**, we must change the way we conceptualize the care of individuals and communities. Adequately addressing TB, an airborne disease, requires 'thinking differently' at every level, from global strategies to facility-specific workplans. As a nurse working in a facility serving a specific population, it is important to understand who gets TB and why – determine what their risk factors are in order to 'do differently'. Assessing the sex differences of TB cases reported at your facility over the last few years might be a good first step to knowing your TB epidemic. <sup>®</sup>

<sup>1</sup> World Health Organization. Global Tuberculosis Report 2014. World Health Organization.

<sup>2</sup> Fazlul Karim et al. : Gender differences in delays in diagnosis and treatment of TB, <http://heapol.oxfordjournals.org/content/22/5/329.full> ; accessed on 21, October 2014

<sup>3</sup> Murray CJL on behalf of Global Burden of Disease Study 2013. Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2014 September 13; 384(9947): 1005–1070

<sup>4</sup> McLaren ZM, Brouwer E, Ederer D., Fischer K, Branson N. Gender patterns of tuberculosis testing and disease in South Africa. *Int J Tuberc Lung Dis* 2015; 19(1):104–110

<sup>5</sup> [http://www.who.int/tb/publications/global\\_report/gtbr13\\_executive\\_summary.pdf?ua=1](http://www.who.int/tb/publications/global_report/gtbr13_executive_summary.pdf?ua=1) accessed from the WHO Global TB report 2013



# competition

## HIV/TB Nursing

Working in the TB room as a nurse is a very challenging task because you are faced with more than TB. Most patients with TB are also co infected with HIV/AIDS, so the TB nurse has to be extremely knowledgeable about both infections. A TB nurse has to work with a high volume of patients and she/he risks becoming infected with TB her/himself.

We want to hear about your experiences working as an HIV/TB nurse. What strategies do you use to support patients through treatment for both diseases? How do you keep them motivated, ensure they come for their appointments, make sure people living in the household are investigated, etc.? We would love to publish your strategies for success in *HIV Nursing Matters*.

Submit your typed piece, not to exceed 1000 words, by 1 August 2015 and stand a chance to win a free one-year membership to the Southern African HIV Clinicians Society (the Society); and have your piece published in *HIV Nursing Matters*!

One winner will be chosen by 15 August 2015. The winner agrees to the publication of the story in the September 2015 issue of *HIV Nursing Matters* and to submit a picture to accompany the article. The judges' decision is final and no correspondence will be entered into. Please note that only typed stories will be considered.

Please submit via email to [Nonhlanhla@sahivsoc.org](mailto:Nonhlanhla@sahivsoc.org).



# Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

Do you need clinical assistance with the treatment of your HIV or TB patients?

Contact the TOLL-FREE National HIV & TB Health Care Worker Hotline



**0800 212 506 /  
021 406 6782**

Alternatively send an SMS or  
"Please Call Me" to 071 840 1572  
[www.hivhotline.uct.ac.za](http://www.hivhotline.uct.ac.za)



The Medicines Information Centre (MIC) situated within the Division of Clinical Pharmacology, Department of Medicine at the University of Cape Town is the largest and only clinically-based medicine information centre in South Africa.

In collaboration with the Foundation for Professional Development and USAID/PEPFAR, the MIC provides a toll-free national HIV & TB hotline to all health care workers in South Africa for patient treatment related enquiries.

## What questions can you ask?

The toll-free national HIV & TB health care worker hotline provides information on queries relating to:

- HIV testing
- Post exposure prophylaxis: health care workers and sexual assault victims
- Management of HIV in pregnancy, and prevention of mother-to-child transmission
- Antiretroviral Therapy
  - When to initiate
  - Treatment selection
  - Recommendations for laboratory and clinical monitoring
  - How to interpret and respond to laboratory results
  - Management of adverse events
- Drug Interactions
- Treatment and prophylaxis of opportunistic infections

- Drug availability
- Adherence support
- Management of tuberculosis and its problems

## When is this free service available?

The hotline operates from Mondays to Fridays 8.30am – 4.30pm.

## Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 50 years of drug information experience between them. They have direct access to:

- The latest information databases and reference sources
- The clinical expertise of consultants at the University of Cape Town's Faculty of Health Sciences, Groote Schuur Hospital and the Red Cross War Memorial Children's Hospital



**MEDICINES  
INFORMATION  
CENTRE**



**Call us - we will gladly assist you! This service is free.**

This service is brought to you as a result of the generous support of the American people through USAID/PEPFAR



# STOP STOCKOUTS

# What is the Stop Stock Outs Project?

The Stop Stock Outs Project (SSP) is an organisation that monitors availability of essential medicines in government clinics and hospitals across South Africa. The SSP aims to assist healthcare workers in resolving stock outs and shortages of essential medicines at their facilities, enabling them to provide patients with the treatment they need.

## How do you report a stock out to the SSP?



**Our hotline number is  
084 855 7867**

- Send us a Please Call Me
- Send us an SMS
- Phone us or missed call us

We will then phone you back to get some more information.



**You can also email us at  
[report@stockouts.co.za](mailto:report@stockouts.co.za)**

## What information do you need to report to the SSP?



**The name of the medicine  
that is out of stock**



**The name of the clinic or  
hospital where you work**

Reporting is an anonymous process and your name, if provided, will not be disclosed to anyone outside of the SSP.



## ANSWERS FROM THE MARCH 2015 ISSUE

1. From 176-153 per 100 000 live births
2. 36 months
3. True
4. True
5. About 94 000 diagnosed cases
6. 20% of 94 000
7. Because instead of 3 separate guidelines, one consolidated guidelines was produced
8. Yes
9. Patients with active TB
  - Patients who have a history of MDR/XDR TB
  - Patients with acute or chronic active liver disease
  - Those who use alcohol excessively (more than 28 units/week in males; more than 21 units/week in females)
  - Pre-ART TST-negative patients
  - Patients with peripheral neuropathy
  - Those with a history of a severe adverse reaction to isoniazid.
10. 5mg/kg/day, maximum dose is 300mg.

## QUESTIONS AND ANSWERS

# QUESTIONS

1. According to the study published in 2001, what is the HIV prevalence amongst truck drivers in South Africa?  
Answer.....
2. Which other at-risk population does the North Star alliance brings its services to?  
Answer.....
3. True or False: Peer education and antiretroviral therapy are part of the recommended package for services offered to people who inject drugs?  
Answer.....
4. True or False: HIV prevalence among the approximate 67 000 people who inject drugs in South Africa is estimated at 56,5%?  
Answer.....
5. What equipment was installed in Pollsmoor prison on the 24th of March 2015?  
Answer.....
6. What is the occupancy rate for prisoners who are sentenced in Pollsmore prison?  
Answer.....
7. Name both needs that the first-line support cater for, when dealing with intimate partner violence?  
Answer.....
8. What is the prevalence internationally for emotional abuse within intimate partnership ranges from?  
Answer.....
9. What does SWEAT stands for?  
Answer.....
10. What is the estimated HIV prevalence amongst female sex workers in South Africa?  
Answer.....

Answers can be e mailed, faxed or sms to:  
 E mail: [Nonhlanhla@sahivsoc.org](mailto:Nonhlanhla@sahivsoc.org)  
 Fax: 011 728 1251  
 Sms/WhatsApp: 082 756 1510



**NATIONAL HEALTH  
LABORATORY SERVICE**

# RESULTS HOTLINE

# 0860

# RESULT 737858

*This line is dedicated to providing results nationally for HIV Viral Load, HIV DNA PCR and CD4 to Doctors and Medical Practitioners, improving efficiency in implementing ARV Treatment to HIV infected people. This service is currently available to members of Health Professionals Council of the South Africa and the South African Nursing Council. The hotline is available during office hours from 8am to 5pm Monday to Friday.*

### **Register to use the RESULT HOTLINE**

Follow this simple Step-by-step registration process

Dial the **HOTLINE** number **0860 RESULT (737858)**

Follow the voice prompts and select option 1 to register to use the hotline

A hotline registration form will be sent to you by fax or e-mail.

Complete the form and return it by fax or e-mail to the hotline to complete your registration process.

Once you are registered, you will be contacted with your unique number. This number is a security measure to ensure that the results are provided to an authorized user.

To use the hotline dial **0860 RESULT (737858)**

Select option 2 to access laboratory results.

- You will be asked for your HPCSA or SANC number by the operator.
- You will be asked for your Unique Number.
- Please quote the CCMT ARV request form tracking number (bar coded) and confirm that the result requested is for the correct patient.

Should the results not be available when you call, you will be provided with a query reference number which must be used when you follow up at a later date to obtain the result.

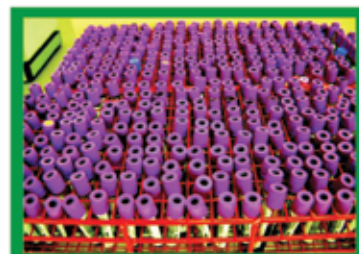
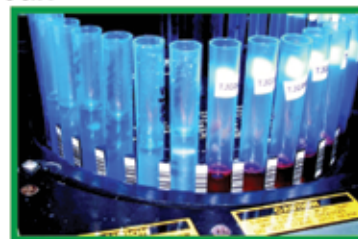
Once you have a Reference number

Select option 3 to follow up on a reference number

Should the requested results not be available, a query reference number will be provided to you.

A hotline operator will call you within 48 hours of receiving the laboratory results.

*Registering for this service from the NHLS, will assist in improving efficiency, providing improved patient care and streamlining clinic processes. Call now and register to access results for HIV Viral Load, HIV DNA PCR and CD4.*





## NDOH/SANAC Nerve Centre Hotlines

• Any HCT concerns from facility and district managers should be reported to the NDOH/SANAC

### Nerve Centre Hotline and, specific emails for each province:

- **Western Cape:** 012-395 9081  
sanacwesterncape@gmail.com
- **Northern Cape:** 012-395 9090  
sanacnortherncape@gmail.com
- **Eastern Cape:** 012-395 9079  
sanaceasterncape@gmail.com
- **KZN:** 012-395 9089  
sanackzn@gmail.com
- **Free State:** 012-395 9079  
sanacfreestate@gmail.com
- **Mpumalanga:** 012-395 9087  
sanacmpumalanga@gmail.com
- **Gauteng:** 012-395 9078  
sanacgauteng@gmail.com
- **Limpopo:** 012-395 9090  
sanaclimpopo@gmail.com
- **North West:** 012-395 9088  
sanacnorthwest@gmail.com



## AIDS Helpline 0800 012 322

The National Toll free AIDS Helpline was initiated in 1991 by the then National Department of Health's (NDoH) "HIV/AIDS, STD's and TB Directorate". The objective of the Line is to provide a national, anonymous, confidential and accessible information, counselling and referral telephone service for those infected and affected by HIV and AIDS, in South Africa.

In 1992, Lifeline was requested by NDOH, to take over the management of the Line by rotating it between the thirty-two existing community-based LifeLine Centres, and manning it with volunteer counsellors. In 2000, in response to an increasing call rate, a centralised Counselling Centre was established in Braamfontein, Johannesburg, to house the AIDS Helpline.

The AIDS Helpline a national toll-free, operates on a 24/7 basis and is utilized by people from all walks of life in urban and rural areas, in all eleven languages at no cost from a landline telephone.

Annually, the Line provides anonymous, confidential and accessible telephonic information, counselling and referrals to over 300 000 callers.

The AIDS Helpline plays a central role in providing a deeper preventative and more supportive service to those infected and affected by the disease, but also serving as an entry point in terms of accessing services from government, private sector and other NGOs/ CBOs

Cases presented to the range from testing, treatment, transmission, TB, Medical Male circumcision, etc.

The AIDS Helpline incorporates the Treatment line. The treatment support services were included to complement the services provided by lay counsellors on the line. The Treatment Line is manned by nurses who provide quality, accurate, and anonymous telephone information and/or education on antiretroviral, TB and STI treatment





If you have any HIV/TB clinical questions, Send your questions to “Ask the clinician” via [Nonhlanhla@sahivsoc.org](mailto:Nonhlanhla@sahivsoc.org) & you will get an answer in the next issue of HIV Nursing matters. If your question is urgent, please state it on your e mail & the answer will be e mailed back to you and still be published in the magazine.

Dear clinician,

What HIV treatment do we give to HIV exposed infants if the mother has a high viral load?

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Dear Nurse Clinician

Mothers who have the latest viral load of more than 1000 copies/ml, you give the infant NVP & AZT for 6 weeks. Perform HIV PCR at birth, if -ve repeat it at 6 weeks.



# Southern African HIV Clinicians Society 3rd Biennial Conference

13 - 16 April 2016

Sandton Convention Centre Johannesburg

*"To rub shoulders with the best minds in the field, in the region, the SA HIV Clinicians Society Conference is the place to be."*

**Professor Yunus Moosa (2016 Conference Chair)**

*"This conference really is the place to be for any self-confessed HIV clinician – the field moves so fast, and so differently in different parts of the world...this is the most efficient and entertaining way to find out what and who is important in our region."*

**Professor Francois Venter (2014 Conference Chair)**



## OUR ISSUES, OUR DRUGS, OUR PATIENTS

- ☑ **Leading International & Local Speakers**
- ☑ **Current & Thought-provoking Presentations**
- ☑ **Skills Building Sessions**
- ☑ **Lively Debates**
- ☑ **Challenging Case Studies**

### Conference programme focus areas include:

Antiretroviral Therapy

Basic Science

Primary Health Care and Nursing

HIV Resistance

Women's Health

Monitoring and Evaluation

TB

Prevention

Paediatric and Adolescents

Operations Research

Opportunistic Infections

Clinical Skills Building

Whether you are an infectious diseases physician, NIM-ART trained (or interested) nurse, general practitioner, HIV specialist, academic or other health care professional there will be something for you at this conference.

Visit [www.sahivsoc2016.co.za](http://www.sahivsoc2016.co.za) for further information and to register to attend

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# UNITING NURSES IN HIV CLINICAL EXCELLENCE, BECOME A MEMBER.



## *Who are we?*

We are a member-based Society that promotes quality, comprehensive, evidence-based HIV health care, by:

### **1 LEADING • PIONEERING**

We are a powerful, independent voice within Southern Africa with key representation from the most experienced and respected professionals working in the fight against HIV.

### **2 CONNECTING • CONVENING • ENGAGING**

Through our network of HIV practitioners, we provide a platform for engagement and facilitate learning, camaraderie and clinical consensus.

### **3 ADVOCATING • INFLUENCING • SHAPING**

With our wealth and depth of clinical expertise, we can help health care workers take their practice to a new level. We are constantly improving and expanding our knowledge, and advocating for clinical and scientific best practice.

## *Member Benefits*

Join today and gain instant support from a credible organisation. The Society helps connect you with the best minds in HIV health care. Build your knowledge, advance your profession and make a difference by getting involved now!

- Free quarterly subscriptions to the *Southern African Journal of HIV Medicine*
- Free monthly subscription to the Society's e-newsletter, *Transcript*
- E-learning through CPD-accredited clinical case studies and on-line discussion group forums
- Free quarterly subscriptions to *HIV Nursing Matters*
- Weekly SMS clinical tips for nurse members
- Free CPD-accredited continuing education sessions
- Listing in the Society's online HIV provider referral network

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