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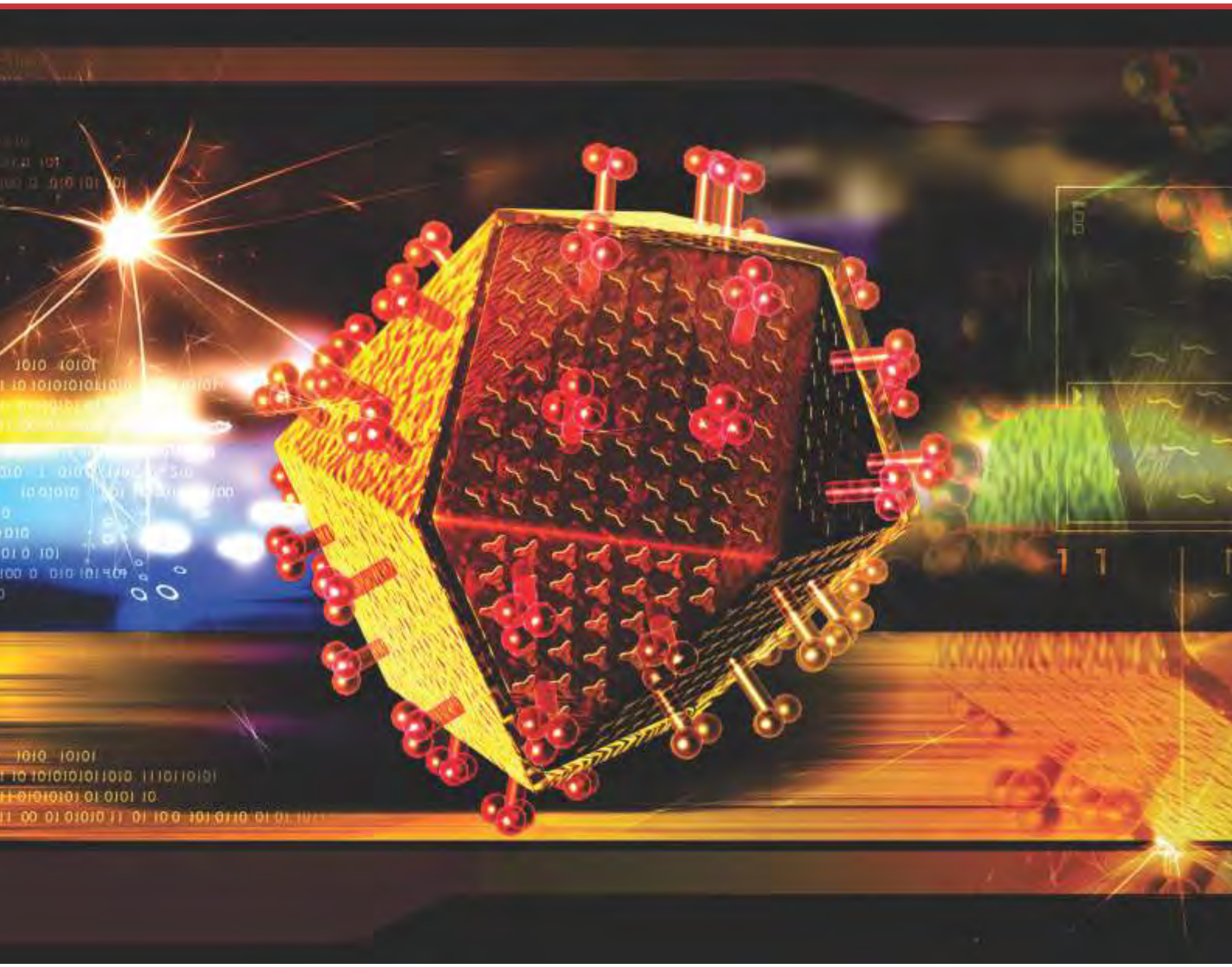
HIV Nursing matters

A Magazine of the Southern African HIV Clinicians Society



Challenges: rural HIV programmes

Cough in patients on ART

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Dr Richard Cooke
Family Physician, RHAP
Guest Editorial

Consider two female patients presenting at their respective primary health care (PHC) clinics. Both are 35 years old, HIVpositive, and unemployed. Each is a single mother with two children. Each had a recent pap smear that showed an abnormality. Coincidentally, the youngest boy in each family fell ill on the day of his mother's appointment at the relevant district hospitals. Caring for the sick boys took precedence, and both appointments were missed.

These two stories appear identical. Even the circumstances affecting follow-up are shared. In reality, their situations are very different. One woman lives in a rural area, and the other lives in an urban setting. This single difference is very significant. In the first place, access to the health system is more difficult for the rural patient; therefore initial pap smear presentations are likely to be more advanced. Similarly, rectifying the problem of missed appointments is more difficult for the same reason. Regarding service provision, good management practice must prevent failures of the health system (e.g. stock-outs, referral problems, equipment malfunction). These are often more expensive to rectify in rural areas. Rural and urban health care are - with respect to demand and delivery thereof - simply not the same. To have *Rural Nursing* as the theme of this edition will create more awareness of the unique issues facing rural health care in South Africa. 2011 was a year full of new government policy proposals, including the release of PHC re-engineering plans, the Human Resources for Health (HRH) Strategy, a new National Strategic Plan on HIV/STIs/TB and the Green Paper on the National Health Insurance. This year will hopefully witness more focused debate around the need for a National Rural Health Strategy. Mainstreaming rural health within the broader policy framework is the current approach, but many (including the Rural Doctors Association of Southern Africa and the Rural Health Advocacy Project[1]) are concerned that the development of tailored, specific rural solutions will be stifled without a specific additional focus.

Rural nurses are crucial participants in this debate. The realities of rural health care are best understood by those working at the coal-face. Without question, the most "grounded" health workers in rural areas are the nurses, particularly with respect to their understanding of the communities. With this knowledge, would the majority of nurses agree that more resources are required to realise similar health outcomes in a rural community compared to a similar urban community? The available evidence would support this. The REACH project found that there are considerably greater access barriers experienced by rural communities compared to urban ones, with respect to distance, time and costs[2]. A study aiming to answer the question "Why patients miss follow-up appointments", found that lack of adequate transport was the main reason for missed appointments, followed by health reasons and finances[3]. Of poor households, 15% live more than an hour from the closest clinic and 20% live more than an hour from the closest hospital[4].
In reality, there is a finite set of national resources for health. In prioritising allocations, funding must reflect health needs, rather than demand. Community-based nurses are perhaps the best placed to understand that rural needs are far greater than the current rural demand. Funding might be easy to calculate around demand, based simply on utilisation of services and existing infrastructure and workforce, but this favours better-resourced, usually urban, facilities. This is referred to as the Infrastructure-Inequity trap; defined as the cycle of greater capacity attracting greater allocations leading to greater capacity[5]. Payments towards improved facilities, as well as more health professionals, equipment and capacity for PHC outreach, must favour rural district health systems.

As the focus of health policy moves to prevention and promotion, the nursing profession should lead other health professions in collective efforts to provide good PHC. Staff shortages will, admittedly, weaken this effort in rural areas; 46% of the population lives in rural areas in South Africa, but only 19% of nurses work there[6]. Many rural facilities operate at or below the critical staff levels required to retain health professionals. Medical officers are also in short supply and overworked; they must, nevertheless find a way to facilitate the growth in the clinical competencies of nurses in the workplace. Work has been done on a South African version of the World Health Organisation's recommendations to attract and retain health professionals in rural and remote areas[7]; both the short-term and long-term recommendations in this document[8] must be actioned promptly.

Documented evidence of good PHC practices in rural settings is scarce. There is an argument that rural health care systems are structurally suited to delivery of good primary health care,

but supporting evidence is required. Experts concur that good PHC needs to be comprehensive, patient-oriented over time, and well integrated with other levels of health care[9]. Another criterion requires a good consumer understanding of first-contact care. Rural PHC systems meet each of these criteria, but under one main proviso: the system must be well-resourced.

The Nursing Compact adopted at the Nursing Summit in June 2011 gave renewed voice to the values of the nursing profession. It is strongly supported by other health professions. Its implementation must not be delayed, and the needs of rural nurses must especially be recognised.Specific needs may warrant some flexibility in rural nursing practice, alongside introduction of new categories of nursing staff. District health systems, however remote, must form part of an integrated academic platform; the research and training will provide rural nurses (and other rural health disciplines in a multidisciplinary team) the professional credibility that they deserve.Rural nurses should play a leading role in driving the re-establishment of nursing schools in rural areas, which in the past so effectively trained rural women and men to serve their communities and beyond.
The National Department of Health (NDoH) is to be commended for including access in remote and rural areas as a strategic priority in the HRH Strategy released in October 2011. Nursing representation on the related Task Team is a necessity. Deterioration in health outcomes for rural communities requires timeframes for improvement to be shorter than is proposed in the HRH strategy. The prioritising of rural health must be evident in the implementation of policy plans.

There are signs that rural health is receiving some, but not enough, attention from stakeholders in health care. Placing the focus squarely on nurses in the rural setting in this edition of *HIV Nursing Matters* is therefore timely. Problems like abnormal pap smears happen to people, not just to organ systems. A more holistic understanding is required, and a greater awareness of the challenges faced by rural communities is a good place to start.

R

Rural Health Advocacy Project

The RHAP is a partnership between the Wits Centre for Rural Health (CRH), the Rural Doctors Association of Southern Africa (RuDASA) and Section27

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2. FINANCING RURAL HEALTH CARE: Rural health care receives the financial resources to provide a quality, equitable service to rural citizens
3. HUMAN RESOURCES FOR RURAL HEALTH (HR4RH): Every rural citizen has adequate access to caring, qualified health care teams
4. IMPLEMENTATION: Policies are implemented in effective and efficient rural health care systems

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[1]The Rural Health Advocacy Project advocates for improved access to high quality, comprehensive health care services in rural areas with the aim of improving the health of the South African population. The RHAP is a partnership between Wits Centre for Rural Health, the Rural Doctors Association of Southern Africa and Section27, For more information and resources, go to www.rhap.org.za

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Message from the president

Dr Francesca Conradie
President Southern African Clinician's Society

I have been working in HIV care and research for over a decade now. Things have changed from the dark days of 2000. We have a very successful antiretroviral programme treating over 1.5 million people. We tested over 15 million South Africans last year for HIV and it is possible that we could eradicate mother to child transmission.

A highlight of my career has been to work on the CIPRA ZA Protocol. In this study, we compared the outcomes of HIV infected patients on antiretroviral therapy when they were treated by doctors as compared to nurses. We wanted to prove that which many of us already knew - nurses do as good a job of treating HIV-infected individuals as doctors. The results showed that whether a patient is treated by a nurse or a doctor, we can expect the same outcome. Most will return to health if they were ill and go on to live long normal lives. So we have the research to back us up, we now need to put nurses in their rightful position in the health care: the backbone of the system. "Words" like NIM-ART are not strange to us anymore.

There is no doubt that if we are to prevent new HIV infections and to treat the infections that have occurred, and then nurses are integral and essential. As the president of the Society, I will commit resources to empowering, encouraging, training and exhorting nurses to take their proud place in the health care system.

HIV Nursing matters

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A day in the life of a rural nurse - Winner!

Babongile Cele (Professional Nurse), Murchison Hospital, Port Shepstone

I think the most challenging and unforgettable changes are more visible in rural areas. As a rural nurse I enjoy my profession almost 24hrs around the clock and even if you can wake me up in the middle of the night and ask me about my work, I will just give you what you want and go an extra mile.

What I like with my job

You know, when I started to work with HIV/AIDS patients as from 1999, while there were no ARV's in the Public Sector patients were dying and families frustrated. But the best of them , what I did was to provide total love on Home Based Care programme with the local NGO South Coast Hospice where I did home visits providing Palliative Care and Memory Boxes for the children as remembrance of their parents. A great pleasure in my work in those days was to see patients dying in a peaceful and dignified manner. Came 2004 - wonderful year!!! but with fear when I started to work on ARV programmes. I knew nothing about ARV's but the counsellors knew a lot. I could hardly pronounce Stavudine or Lamivudine.

What really was interesting was to see patients that were dying in bed waking up with ARV's. Not forgetting another couple who were both stage 4 AIDS whom I counselled and started on ARV's –Guess What ? today they are still alive, happily married with 2 negative children . You know what? They were both admitted in the ward before they got married terminally ill.

My daily challenges in providing of care

Management of paediatric clients, especially where the professional nurses are unable to monitor viral loads, Oh!, is a big challenge but the solution very easy – the visiting doctor in PHC are expected to draw blood from babies to avoid these problems.

NIM-ART training & roving teams

Services need to be integrated - this will need us to talk one language of HAST. Capacity building and mentorship programmes must be integrated into all programmes in HAST & MDR TB. MDR-Roving /injecting teams also need to work hand in hand with all other programmes. The PMTCT-programme requires intensive counselling for mothers and proper history taking to reduce maternal deaths.

Conclusion

In conclusion being a rural nurse has made me a "Mini Doctor" because I have learnt a lot in the management of all programmes and I am very proud to say that "my" ARV Programme has really worked for the people in my district.

The Southern African HIV Clinicians Society is pleased to announce the winner of a bursary to attend Stellenbosch University's CMART programme, Mrs Dina Lebelo. Mrs Lebelois a professional nurse and Society member working at DiphalaneDankop Community Health Centre in Hammanskraal, South Africa. She began the 20 weekcertificate programme in early February. The Society wishes her well in her studies, and will keep readers of *HIV Nursing Matters* posted on her progress.

The Society and Stellenbosch University's Nursing Division would like to thank all of the nurses who applied for the bursary; we received many outstanding applications from highly qualified and motivated nurses. The Society hopes to provide this bursary annually, as funding allows. Keep reading *HIV Nursing Matters* for information on educational and professional development opportunities!

About CMART

Stellenbosch University's Comprehensive Management of Patients on Antiretroviral and Tuberculosis Treatment (CMART) is a certificate programme for nurses with a professional degree or diploma in general nursing. The course consists of a 5 day initial workshop at Stellenbosch University's Tygerberg campus in Cape Town that includes specialized skills training, followed by 20 weeks of clinical practice and distance e-learning. CMART provides the nurse participant with evidence-based clinical management strategies for HIV/AIDS and TB. The course includes training in adult and paediatric care, treatment guidelines and PMTCT. Successful graduates will earn a certificate and have the expertise to assess, diagnose, prescribe medication and manage clients with HIV/AIDS and TB in Primary Health Care.

About the Society

The Southern African HIV Clinicians Society (the Society) is a non-profit, membership organisation of HIV health care workers whose mission is to to promote evidence-based, quality HIV healthcare in Southern Africa. The Society produces two publications, HIV Nursing Matters and the Southern African Journal of HIV Medicine,and develops evidence-based guidelines on the management of HIV for health care providers. The Society fosters interaction among HIV health care professions through meetings across Southern Africa, and advocates for the highest quality HIV care for people living with HIV.

Rural Nurse

Congratulations to Babongile Cele, of Murchison Hospital in Port Shepstone, for submitting the winning entry to the "A Day in the Life of a Rural Nurse" contest. Sister Cele provides a deeply touching, inspirational account of the challenges and triumphs she faces working as an HIV nurse in a rural area. We were moved by her enthusiasm and love for her patients and her job, and her story is a testament to the value and importance of nurses everywhere. Thank you, Sr. Cele for sharing a bit of your life with *HIV Nursing Matters*, and for reminding us all of the vital work nurses do every day.

Ms Cele wins a one year complimentary membership to the SA HIV Clinicians Society and a blackberry. We would also like to congratulate our other two finalists, Joyce Lekalake and Riana Salgado. Ms Lekakake and Ms Salgado both win a one year complimentary membership to the SA HIV Clinicians Society.

The Society and the Rural Health Advocacy Project (RHAP) would like to thank all of the readers who submitted stories about their lives in rural nursing.

Rural Health Advocacy Project

news

Nursing Regulations published for public comment

The long awaited nursing regulations for the new education and training programmes, prescribing by nurses and other important aspects such as the accreditation of nursing education institutions were published for public comment in December 2011. Public comment on these regulations was due by the middle of March 2012.

The regulations relating to the keeping, supply, administering, prescribing or dispensing of medicine by registered nurses relates to section 56 of the Nursing Act, 2005. Interested parties can obtain a copy of these proposed regulation on the SANC website at http://www.sanc.co.za/pdf/34851_rg9646_gon1044KeepingMedicines.pdf. These regulations will prescribe the conditions under which a nurse may obtain authorisation to keep, supply, administer, prescribe or dispense medicine. The regulations also makes provision for transitional arrangements which states that nurses authorised in respect of specific protocols of section 38A of the Nursing Act (Act 50 of 1978) shall continue to be authorised for those protocols for a period of two years after the promulgation of these new regulations.

SOUTH AFRICA: Preventative TB trial disappoints

South Africa's gold-mining industry has the highest TB incidence in the world. After seven years of research, the world's largest study of preventative tuberculosis (TB) therapy has found that untargeted, community-wide distribution of TB prevention drugs did not improve TB control on South African gold mines.

Conducted among 27,000 gold-mine employees in 15 mines, the Thibela TB study tested the theory that treating an entire community with the first-line TB drug isoniazid could result in long-lasting reductions in active TB cases and TB prevalence. Workers in eight mines were offered TB screening. Those with active TB were treated, while those without active TB - about 24,000 - were given a nine-month course of isoniazid preventative TB therapy (IPT). Workers in the remaining seven mines were screened and treated according to national guidelines whereby only high-risk individuals with HIV or silicosis would have been eligible for a six-month IPT course.

But according to results released on 8 March at the annual Conference on Retroviruses and Opportunistic Infections in Seattle, Washington, the community-wide IPT provision did not reduce TB incidence or prevalence within communities. In people who do not have active TB, IPT applies one of the two drugs commonly used in combination to treat active TB as a preventative measure. While many people carry TB, only about 10 percent will ever develop it. However, those with

compromised immune systems, such as people living with HIV or silicosis - a lung-destroying respiratory illness often contracted by miners exposed to silica dust - are much more likely to develop active TB.

Gavin Churchyard, the study's principal investigator and chief executive officer of South Africa's Aurum Institute for Health, said that while Thibela showed poor results at community level, it did underscore IPT's proven effectiveness in preventing active TB among individuals who were on the drug course but this protection waned quickly once patients stopped taking IPT.

He added that the long-running trial also revealed important insights on how to better conduct future large-scale, cluster randomized control studies and that these techniques were helping to shape studies evaluating the effects of newly introduced TB diagnostics such as GeneXpert.

Researchers are now recommending that governments such as South Africa continue targeted IPT provision aimed at high-risk groups. However, Churchyard added that focused rollouts remain difficult when people did not know they were "high-risk", ie HIV-positive or suffering from silicosis.

Poor working and living conditions, coupled with high rates of silicosis, have fuelled TB on the mines for years, aggravated by the advent of HIV. The South African Department of Health, in its TB Strategic Plan for South Africa 2007-2011, has estimated that the country's gold-mining industry has the highest TB incidence in the world.

Thibela investigators will also present their findings at an April 2012 ministerial meeting of the Southern African Development Community. The meeting in Luanda, Angola, is expected to bring together ministries of health, finance and labour and industry representatives, to discuss TB in the mining sector. The meeting is expected to produce a SADC declaration on the issue by August 2012 and a regional plan of action to inform future TB interventions.

PlusNews
9 March 2012
Read the full article at http://www.plusnews.org/Report/95042/SOUTH-AFRICA-Preventative-TB-trial-disappoints

ZAMBIA: Copper-mining downturn sees upturn in sex trade

Huge job losses in Copperbelt Province, Zambia's copper-mining region and economic hub, have triggered an upswing in commercial sex activities, raising fears of a spike in new HIV infections.

Judith Mubanga, 26, started doing sex work in December 2008 after her uncle lost his job at Bwana Mkubwa Mine in Ndola, the provincial capital, and could no longer assist her financially.

"My parents are dead; I was staying with my uncle, [but] when the mine closed, he told me to go to the [home] village in Kasama [northern Zambian]. There is no one to stay with in the village - my grandmother has many orphans - that's why I joined my friends," Mubanga told IRIN/PlusNews.

"We are three and we rent a room in Ndola; we travel to all Copperbelt towns. I think Chingola is where business is good - people pay and they don't complain too much. I am surviving; it is a bad thing, but I have nothing else to do."

Tumbling international copper prices as a result of the global economic slump have forced mining firms to cut their workforce, put expansion projects on hold, and even shut down some operations.In the wake of the mining sector's shrinking fortunes, households are battling to make ends meet and sex work has become a means of survival. "I was very disappointed when my uncle sent me away, but when I look back now, I think it was a good thing. It has taught me to be independent," said Mubanga.

"When business is good, I make over 200,000 kwacha [about US$36] in one night, but when things are not good I can knock off with something like 20,000 kwacha [$3.60]."

More experienced sex workers, like Belinda Zulu, who has been in the trade for six years, say business is at its lowest since mining activities resumed five years ago. "This used to be Copperbelt when we could hook five, six or seven men per night, but now, sometimes you can go back home with nothing except transport money. For me now it only makes sense if I meet a client who wants 'live wire' [unprotected sex], for which I charge double the amount," Zulu told IRIN/PlusNews.

Asked if she wasn't worried about contracting HIV, Zulu said: "Everyone will die, whether of malaria, poverty, road accidents, or HIV - it is the same death. I choose not to think about contracting HIV, but what I will eat today with my four-year-old son and my niece at home."

Poverty, sex work and, inevitably, HIV/AIDS are closely intertwined in the Copperbelt, as elsewhere. The three largest towns in the province, Ndola, Kitwe and Chingola, have the country's highest HIV infection rate - 26.6 percent - compared to the national average of 15 percent. All three towns are also on the main trucking route between Zambia and the Democratic Republic of Congo.

PlusNews, CHINGOLA
26 February 2009
Read the full article at http://www.plusnews.org/report.aspx?reportid=83161

Implementing rural HIV programmes:

CHALLENGES

In 2007 South African government launched an ambitious HIV/AIDS and STI National Strategic Plan 2007-2011. Mr U.K. Sontyale (RN, M Cur, MBA)shares some of the challenges experienced with the implementation of an HIV programme in a rural area.

The aim of this HIV/AIDS and STI National Strategic Plan (NSP) 2007-2011 was to reduce the number of new infections by 50 per cent and expand access to individuals and families to 80 per cent. The NSP was based on four priority areas namely prevention: reduce new infections by 50 per cent by 2011; *treatment, care and support;* provide appropriate packages of treatment, care and support to 80 per cent of HIV positive people and their families by 2011. The third priority was to have a functional monitoring, evaluation and surveillance system. Last but not least, was to uphold human and legal rights of patients.

Implementing such a strategy needed careful planning and involvement of all stakeholders, without such a "buy-in" one anticipated difficulty implementing and realizing attainment of the goals. South Africa is not unique in facing the challenges of scaling up HIV/AIDS programmes, especially in rural areas.

Baseline assessment or situational analysis was useful in understanding the extent of the problem before implementing an HIV/AIDS programme. From the assessment one could depict the needs as well as interventions or approaches to be followed.

Challenges

Eastern Cape is a rural province in South Africa. There are five districts in the Eastern Cape; OR Tambo district is one of the districts. OR Tambo district occupies the eastern portion of the province. Qaukeni health sub-district is one of the sub-districts in this district, the size of the health sub-district is 4868.78 square kilometres with a population of 613 338, meaning there are 126 people per square kilometre. The sub-district is mostly rural with urbanization rate of 0.91 percent.

Human resources are the pillar of health system in South Africa, poor human resources allocation and poor competencies results in inefficiency and poor quality health services. Qaukeni sub-district is one of the sub-district hardest hit when it comes to high vacancy rates and having incompetent staff most probably due to its poor or rural setting.

The HIV prevalence rate was 29 percent in 2003. Initiating and scale up of HIV programme in Qaukeni Sub-district was a daunting task.

Scale up of an HIV/AIDS programme is faced with multiple challenges; some of them need long term strategies to solve them. The following are some of the challenges facing initiation and scale up of ART programmes in rural areas:

- No proper monitoring and evaluation tools;
- Scarce human resources;
- inadequate healthcare infrastructure and
- Few trained HIV/AIDS health personnel; just to mention few.

From the baseline assessment the following are the needs or challenges identified.

- *Health Information system and management*

Health Information System helps to assess the needs of populations and groups and helps with planning and implementation of health interventions. Most importantly it is vital for the evaluation of health programmes from both the perspectives of effectiveness and coverage[1]. On starting the programme in this sub-district one noted the unavailability of proper and reliable Monitoring and Evaluation systems. Pre ART and ART registers were not in place to monitor the number of clients in the programme. The only register available was the Co-trimoxazole adherence register. Clients were entered in this paper base "register" that cannot trace the last visit and does not have a unique patient identifier.

- *Clinicians Knowledge of HIV/AIDS*

HIV/AIDS and HAART was a new concept in this rural district. Majority of Medical Officers and nurses were not trained on HIV in medical and nursing schools hence they had no confidence in managing HIV positive clients.

- *Shortage of Clinical staff*

Due to the rural and resource limited setting few clinicians were attracted to this area. Foreign nationals provided the majority of medical care, accounting for 90% of medical officers employed during the expansion of HIV services.

- *Non-availability of suitable space for counselling and clinical care*

Health facilities were built many years before the era of HIV/AIDS, confidential counselling space needed was not considered previously.

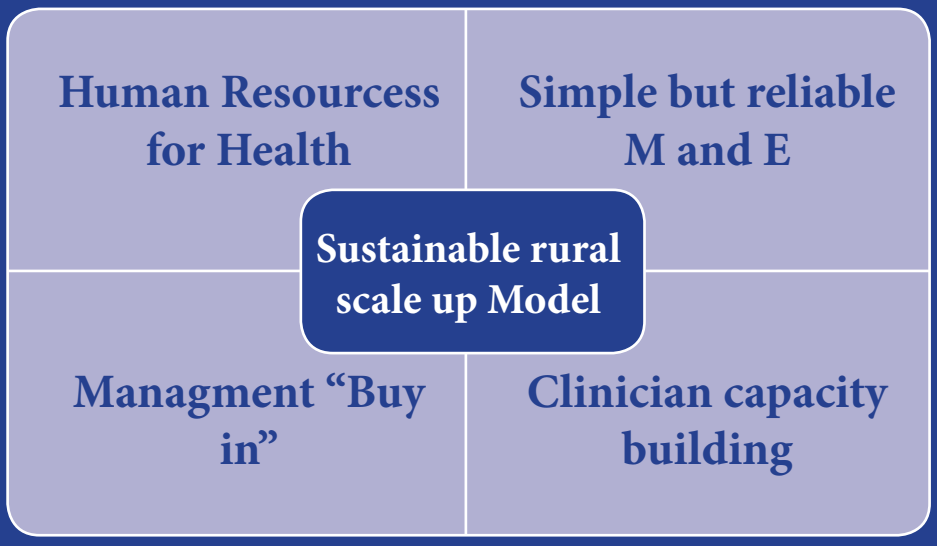
- *Non-availability of clinical equipment*

Basic clinical equipment is necessary for rendering quality patient care, irrespective of HIV status, and non-availability affected the quality of patient care.

Skilled human resources
are essential for successful service delivery

Strategies for sustainable rural HIV/AIDS programme

The following were guiding principles in implementing a sustainable rural HIV/AIDS programme.



- *Implementation of sustainable Monitoring and Evaluation system*

Implementation of Pre-ART and ART registers with the authorization of provincial government seemed to alleviate the problem of unreliable data.

- *Clinician Capacity building (partnership approach)*

The majority of clinicians - Medical Officers, Nurses, midwives and Pharmacists - did not have confidence in managing these clients. Several trainings were done to capacitate these health care professionals. Different specialist came in to support the district for various aspect; physicians, paediatricians, dermatologist, Infectious Disease specialists. Continued mentoring support was available in the form of Clinical Advisors.

- *Employ Clinicians (Partnership Approach)*

Development of partnerships helped in employing more and dedicated clinical staff. The partnership involved local partners as well as partners from other provinces.

- *Training of new cadres and task shifting*

Getting pharmacist to this district was a daunting task. One of the strategies employed to mitigate shortage of staff was task shifting. Task shifting is an effective strategy for addressing shortages of human resources (Callaghan, Ford and Schneider: 2010:2). Task shifting offers high-quality, cost-effective care to more patients than a physician-centred model. The point of departure in implementing this strategy was to develop partnerships with other stakeholders and to train increased numbers of basic and post basic pharmacist assistants who were deployed in needy health facilities on completion of the training. Nurse Initiated and Managed ART (NIM-ART) was not an official concept in public sector, however before this concept was adopted as a policy nurses and midwives were trained on management of ART patients within the hospital and feeder clinics due to necessity. One needs to mention that at this stage nurses were not initiating treatment.

- *Management involvement and Capacity building*

Without the buy in of managers the programme would never be sustainable. Several trainings for managers were organized; operational planning, public financial management, management and leadership skills and project management just to mention few.

Conclusion

In South Africa access to quality healthcare is a fundamental right; despite citizens residing in poorly resourced areas they need to access healthcare. Despite the scarcity of financial, human resources, inadequate infrastructure and lack of support functions quality healthcare need to be delivered. It is vital to adapt models of care to these circumstances for better health outcomes.

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Using social networking to improve patient care

Cellphone technology and Facebook give nurses new tools to help stop the spread of HIV from mothers to babies says Nobanzi Dana, Project Director - Khusela - PMTCT Project PATH

Nurses working in remote areas of South Africa's impoverished Eastern Cape Province have a new tool in the battle against HIV: a Facebook group dedicated to supporting their efforts to preventtransmission from mother to child.The social networking site is a powerful medium from which to encourage professional development and capacity-building amongst nurses& health-care workers. The aim of this novel approach is to provide high-quality, comprehensive PMTCT services in an area where more than one-quarter of pregnant women are living with HIV. .

PATH's Khusela projectsupports the Eastern Cape Department of Health to improve the quality, availability, and uptake of comprehensive PMTCT services. The project is using the widespread availability of cell phone technology and the popularity of Facebook to give nurses quick and easy access to information and advice from colleagues as they care for HIV-infected mothers in their districts.

Group discussions serve as learning tool

The Facebook discussion group created by the Khusela project currently has 142 members, mostly nurses trained in PMTCT from sites supported by the project. Members typically log in through their cell phones two to three times a day, and for many of them, access is free or very inexpensivethrough their cell phone networks.

Nurses regularly post questions raised from their patient encounters, and other members offer potential solutions, comments, and guidance based on their own experiences. The Khuselaproject's PMTCT technical advisers serve as moderators for group discussions, providing a comprehensive response to each question and directing members to specific resources, including national PMTCT/HIV care guidelines.

Fast response time supports nurses when need arises

Response times are usually quick. One recent example illustrates how nurses are using this forum on the job to draw on the collective expertise of their colleagues. At 5:48 p.m. one evening, a nurse who was admitting a woman in active labour to a clinic posted the following on the Facebook group page: *"Help guys. This woman is in active phase of labour–5cm dilated, HCT reactive, CD4 869. What to give coz there's nothing prescribed @ clinic?"* The clinic nurse was not PMTCT trained and did not know what to do for the HIV-positive woman she was admitting.

The first response came just 17 minutes later.Six people then joined in the discussion about appropriate care options for the patient, with 16 responses posted. At 9:10 p.m., the nurse who posted the initial question reported: *"(Mother) has alive female infant, wt 3,670g. I've given 1,5mls nevirapine syrup to the infant.Mother is so excited."* She later added: "Thanks guys 4 yr support. Keep it up." By tapping into the experience of her colleagues and online resources available through the project, the nurse knew to give a critical birth dose of nevirapine, a drug that can block mother-to-child transmission of HIV, to help protect the baby from infection.

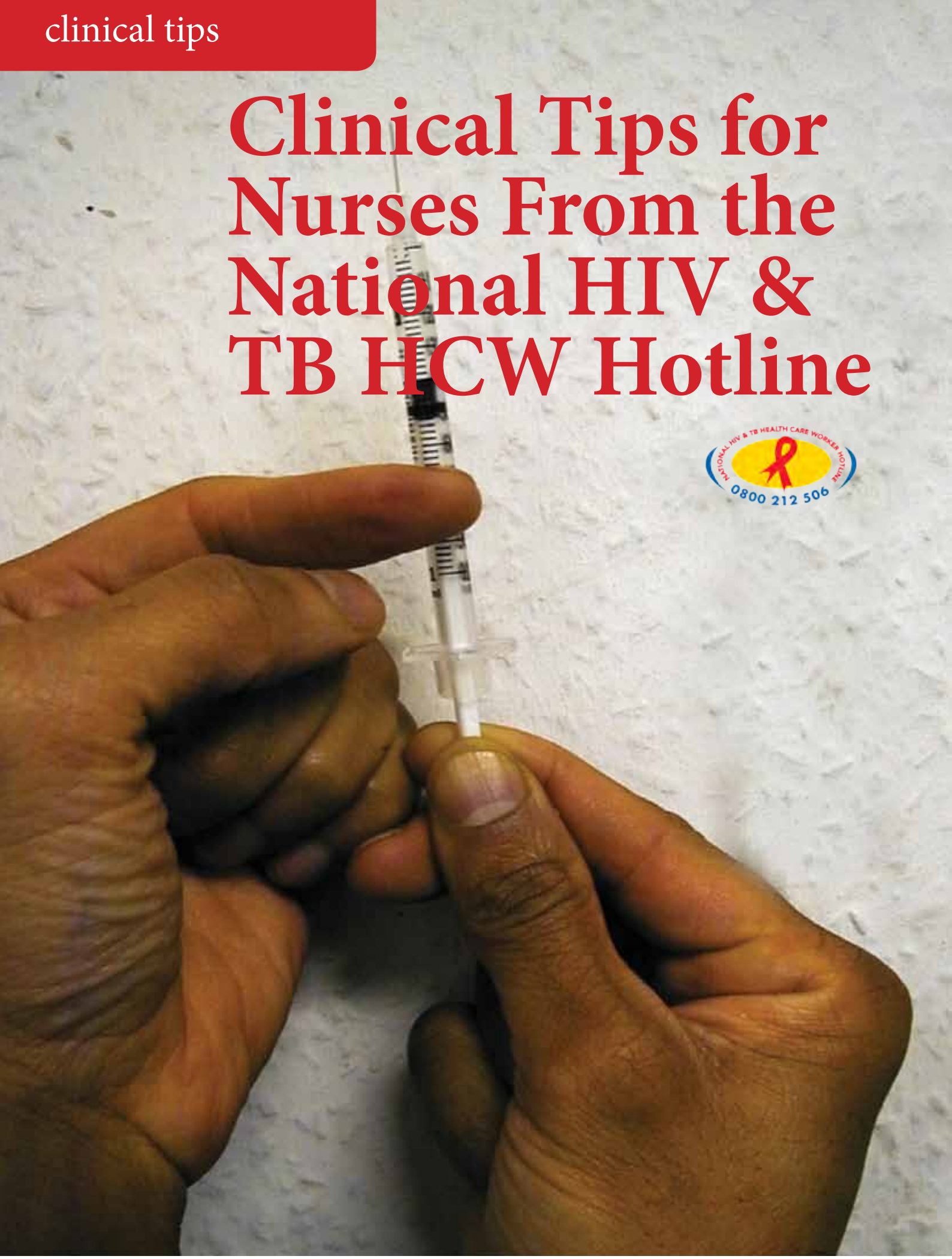
Ground rules keep forum focused

The project technical advisors act as moderators, and have established ground rules to ensure the forum is a useful platform for improving professional practice. Moderators monitor posts to ensure that patient confidentiality is maintained and that no patient-identifying information is displayed. They also moderate the discussion and advice being given by members to ensure that patients receive high-quality care.Member responses must quote the specific PMTCT guidelines that support their advice. Nearly all members are from Khusela project-supported facilities, people that project staff are familiar with through their training and support interactions. Membership is restricted as new members must be invited by existing members.

The Facebook group also provides project staff with insight into the on-the-ground experience and difficulties encountered by nurses managing PMTCT cases. The forum provides an opportunity to support nurses as they implement guidelines and strategies they have learned in training and to guide nurses toward reliable information sources and proper protocols and thus promotes constant referral to guidelines. It also helps focus project training and on-site mentoring to address common issues and concerns drawn from the real-life experiences of nurses working with HIV-positive mothers.

By turning Facebook into an interactive platform for learning and professional growth, the Khusela project is helping nurses and other health care providers improve their practice as they deliver comprehensive PMTCT services, ultimately helping to improve the health of communities.

Clinical Tips for Nurses From the National HIV & TB HCW Hotline



Switching a Single Antiretroviral Drug

Sometimes it is necessary to switch a single antiretroviral drug from a three drug regimen because of toxicity or an adverse event. Ideally we wouldn't want to switch only 1 drug in a failing regimen because this increases the risk of resistance (see below), but if the toxicity is serious we might not have time to check whether the patient is virologically suppressed, or failing their current regimen.

Your approach to this situation depends on how urgently the offending drug needs to be interrupted. Table 1lists the most common adverse reactions to antiretrovirals, but other reactions might also occur. It is important to seek advice if you suspect a drug cause for any adverse event.

When the Drug Switch is URGENT

- With adverse events in the red column of Table 1 you do not have time to check if the patient is fully virologically suppressed before discontinuing treatment.
- Even a short delay may have serious consequences for the patient
- With severe adverse events it is best to discontinue all ARVs.

Severe Adverse reaction Caused by NNRTIs

- NNRTIs (NVP/EFV) have long half lives so it takes many days for NVP/EFV to be completely cleared from the body.
- NRTIs (D4T/3TC/TDF etc) have short half lives so they clear from the body quickly.
- If you stop all three ARVs at once, NVP/EFV is left hanging around in the body long after the NRTIs have been cleared, leaving the patient on NVP/EFV monotherapy.
- NVP/EFV drug resistance develops quickly, especially with monotherapy.
- Resistance to one NNRTI creates resistance to both NNRTIs, compromising first line regimen ef ficacy.
- To avoid NNRTI monotherapy you should "cover the tail" by continuing the 2 NRTIs (3TC & TDF/ AZT/D4T) for one week after stopping the NNRTI. This avoids NNRTI monotherapy by covering the long half life.

	Severe Toxicity Requiring Urgent Switch/Stop	Gradual Toxicity Allowing Time for Viral Load Check
Nevirapine (NVP)	Steven Johnson Syndrome (SJS) Hepatitis/Jaundice	
Efavirenz (EFV)	Acute Psychosis	Persistent dizziness or nightmares Work changing to night shift
Tenofovir (TDF)	Acute renal failure	Gradual worsening of renal function. Discuss these cases with a doctor.
Lamivudine (3TC)	Pancreatitis Pure Red Cell Aplasia (presents with severe anaemia)	
Zidovudine (AZT)	Severe anaemia/rapidly decreasing Haemoglobin	Lipodystrophy Patient distressed by fingernail discolouration
Stavudine (D4T)	Lactic acidosis Symptomatic Hyperlactataemia (SHL) Severe/rapidly progressive painful peripheral neuropathy	Lipodystrophy Abnormal cholesterol/triglycerides Mild painful peripheral neuropathy
Didanosine (DDI)	Pancreatitis Lactic acidosis or SHL	Lipodystrophy
Abacavir (ABC)	Hypersensitivity reaction	
Lopinavir/ritonavir (Aluvia)		Mild gastrointestinal side-effects Abnormal cholesterol/triglycerides

Table 1: Drug toxicity

Severe adverse reaction caused by NRTIs

- If a severe side-effect related to an NRTI occurs and the patient is clinically unstable, then all 3 ARVs should be discontinued immediately e.g. in cases of Lactic Acidosis and the patient referred to hospital/up-referral site.
- In such clinically unstable patients, reintroduce 3 ARVs only once the patient's condition has stabilized. Leave out the offending drug and replace it with another drug - contact thehotline or up-referral site if you are not sure which drug to use as a replacement as this depends on the side-effect which occurred and also drug availability at your clinic.
- If the side-effect is severe but the patient is clinically stable, it is acceptable to immediately switch the offending NRTI for a new one e.g. in mild cases of symptomatic hyperlactataemia or when D4T is causing painful peripheral neuropathy. In such clinically stable patients you can immediately switch from D4T to either TDF or AZT without discontinuing all 3 ARVs.

When you introduce a new drug in this manner, you should still check a Viral Load and the relevant baseline blood for the newly added drug (Creatinine/TDF or Haemoglobin/AZT) at this visit. You should then review the patient within one week to ensure the toxicity reported is not progressing and that the viral load and baseline results are ok.

- IF IN DOUBT, PHONE THE HOTLINE OR CONTACT A DOCTOR AT YOUR UP REFERRAL SITE.

Non-urgent Switch

For toxicities in the green column of Table 1, the situation is less urgent because the toxicity is gradually progressive and not immediately dangerous to the patient. If the patient has been on ART for < 6 months you can make an immediate switch (assuming recent relevant baselines are available). However, if the patient has been on ART for over 6 months you should keep the patient on their current regimen while doing the following:

- Check when the last viral load was done:
- If last viral load within 3 months and undetectable at that point:
  - Check with patient about adherence since last viral load
  - Draw baseline blood needed for intended new drug e.g. Haemoglobin for AZT, Creatinine for TDF
  - Reassure patient & ask them to return in a few days for blood result
  - If patient has been adherent and the blood result is fine, switch offending drug to new replacement drug.
- If last viral load was more than 3 months ago:
  - Repeat viral load today
  - PLUS draw baseline blood indicated for intended new drug
  - Reassure patient & encourage them to continue with adherence
  - Review patient with results as soon as possible

Stavudine	Lamivudine	Efavirenz
Tenofovir	Lamivudine	Efavirenz

  - If viral load undetectable & baseline blood fine you can switch.
- You should not switch a single drug if detectable viral load because the patient may have ARV drug resistance.

- This table shows what happens if you switch one drug in a failing regimen.
  - In the first (failing) regimen, none of the three ARVs (D4T/3TC/EFV) are working because of drug resistance
  - After switching a single drug (D4T to TDF), only the new drug (TDF) works because there is resistance to the two remaining old drugs (3TC/EFV)
  - This means the new drug (TDF) is all alone as monotherapy
  - Resistance to this new drug (TDF) will quickly develop leaving the patient with fewer ARV options.
- If the patient has detectable viral load
  - Counsel the patient and find out about any adherence issues
  - Explain that the side effect they are having only worsens gradu ally so there is time to address the detectable viral load first
  - Emphasise that the patient must adhere to treatment well for 3 months
  - Repeat the viral load after 3 months
  - If viral load > 1000 copies – switch patient to Regimen 2
  - If viral load undetectable – switch patient off offending drug and add in one new ARV
    * If the viral load is detectable but <1000 copies PHONE FOR ADVICE.

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

NATIONAL HIV & TB HEALTH CARE WORKER HOTLINE
0800 212 506

0800 212 506 / 021 406 6782

Alternatively send an SMS or "Please Call Me" to 071 840 1572

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

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clinical update

Top Tips for nurse mentors providing HIV care in rural clinics

Dr Madeleine Muller; MBChB (Pret).MRCGP(Lon)
IYDSA Clinical Advisor, Rural Doctors Organization Representative Eastern Cape.

This article is aimed at nurse mentors in rural areas. TheNational Department of Health (NDOH) has called for nurse mentors to support NIM-ART (Nurse Initiated and Managed Antiretroviral Therapy) in selected clinics in all the districts, following guidelines recommended in the Clinical Mentorship Manual, with additional support provided by implementing partners. Dr Madeleine Muller shares some tips with nurse mentors.

In rural areas nurse mentors have to travel long distances, to reach small remote clinics. Most of these clinics did not provide any ART prior to April 2010 and their HIV programs are at different stages of implementation, depending on when they received NIMART accreditation.

There are few courses available for nurse mentors, which provide the tools and skills needed for effective mentoring. This article is not intended to replace Training on Mentoring programmes conducted by organisations such as ITECH, ICAP or JHPIEGO, but may provide a few tips on how to make the task less daunting.

Top Tips for Top Challenges

The challenging nurse mentee

A frequent concern voiced by nurse mentors is that of an unenthusiastic nurse mentee who may even be hostile. Typically this may be evident in under- staffed and under-resourced clinics and then nurse mentee is already under strain. She may feel that she is expected to take on additional workload without increased support and resources. Managing the ART program is felt to be simply another burden and the nurse mentor is seen as the instigator of this additional pressure. Without a good relationship mentoring is almost impossible. It is through the trust between nurse mentor and nurse mentee that most learning takes place. One of the most important skills in this scenario is that of empathy. Assessments of the mentorshipprogram could help focus on the obstacles and challenges the nurse mentee is facing – "I can see that you do not have enough space to provide adequate confidentiality, that must be frustrating". The more empathy and understanding the Nurse mentor has for the mentee's working conditions, the more able will she /he be in building a relationship of trust over time.

The value of continuity and reliability should not be underestimated. There is evidence of even the most frustrated nurses softening over time as they get to know their nurse mentor and feel the benefit of her support. One regular day per week or every two weeks would be sufficient and all visits should be focused on providing support and encouragement. It can take as much as 3 months before the benefit can be felt and in this time it is important not to lose patience and to stay friendly and empathic.

How to talk so Nurses can listen – the art of praise

One of the best ways to help encourage change is to praise skills which demonstrate good practice. The ART program is a comprehensive package that includes several aspects of care. It is always possible to find gaps in

its implementation and we sometimes forget to praise and encourage the nurse mentee for that which is done well. Praise is an important part of building relationships, cementing good practice and helping prevent burnout. When we speak of providing "support" it often means simply providing positive feedback! The art of praise includes descriptive praise and affirming statements. Being able to be specific and non-judgemental about what is done well shows that you have actually looked at his/her work and helps to confirm good habits. "I noticed that you did WHO staging on all HIV diagnosed patients that enrolled last month" and "I can see that you really connect with your patients". Recognise the difficulties under which she had achieved these results and how it is benefitting patients.

How to talk so Nurses can listen – the art of feedback

One of the greatest challenges for the nurse mentor is how to point out the gaps or the problems that are identified. It may have taken months to build a good relationship and to implement the programme, the nurse mentee may have been thoroughly trained in clinical skills, but errors might be picked up. It is important that feedback is delivered in such a way that it can be heard and that the NurseMentee is motivated to make changes.

A good approach is the well known feedback sandwich. Start with a positive observation; point out the shortcomings and conclude with a second positive observation. For example "I see that your recording of patient information has improved greatly. However, there are still a few patient files where the CD4 count was not recorded. But all files have a follow-up date for the next clinic visit". The discussion needs to be descriptive and objective. State facts, not opinions and be specific. Try to establish if the nurse mentee understands the requirements and ask her to explore obstacles to its implementation. Make a plan and set clear goals. "We will look at this again in 6 weeks".

Time restrictions

One of the greatest obstacles of mentoring is that of time. Usually several clinics are covered by one nurse mentor and the clinics are scattered over a huge area. The nurse mentor may arrive at the clinic and find a situation where the Operational Manager is on leave or an important inspection is under way, or it is end of month and the statistics take priority! There are not always time and space for mentoring. However, this could be avoided. The effective way is to set a schedule or plan a programme, strengthened by effective communication between the mentor and the mentee.

It is important that when a nurse mentor arrives at clinic that the time is used effectively. Every visit needs to leave a positive impact. The only way to achieve this is to be flexible. Make sure to have several mentoring tools available to use on the day. Always include a multi-disciplinary meeting (shorten it if you must) but also have activities you can engage in that do not require the nurse mentee's time. This includes perusing patient files to identify gaps in documenting of care and management (preferably with the help of a good tool), spending time in the dispensary to assess stock management, going through registers and monthly statistics forms and even reviewing infection control policies and practices (use as teaching moment...). Two commonly used strategies of mentoring are side-by-side mentoring or bedside mentoring. Depending on circumstances (see below) and create a slot at the end of the day to discuss gaps and to help find solutions.

Side by side Mentoring: This is when the mentor and the mentee work together side by side. The Nurse Mentor provides assistance during consultation by e.g. filling in the blood forms, helping with taking and making phone calls (e.g. the ambulance) or completing the register. This gives an excellent opportunity to model good practice even in busy clinics, making sure clinical records are completed and that important aspects of clinical care are not missed. With an extra pair of hands the consultation time can be shortened.

Bed-side Mentoring is all teaching and mentoring that occurs in the presence of the patient. It can be in the consulting room, the ward or the clinic. The nurse mentee practices a skill and may present the case to the mentor after she formulated her management plan or they can discuss the patient after the patient has left. This type of mentoring takes additional time and probably lengthens the consultation, in comparison to side- by side mentoring.

In both these strategies, the nurse mentor gives positive feedback on that which was good and help identify gaps as well as strategies to overcome them.

Feeling out of your depth

HIV disease management is a highly specialized field and almost a whole medical discipline in its own right. Its landscape is constantly changing and it is challenging to stay abreast of new developments.

The three day didactic training in mentoring covers the National guidelines and provides nurse mentees with all the information they need to assess, initiate and manage patients on ARTs. It is, however, not a complete training in HIV disease management. All nurse mentors and nurse mentees need to make sure that patients receive good clinical care and the greatest danger is "that which we don't know we don't know". This is why there are stringent selection criteria to mentorship training. It is very important to have good clinical back-up from a doctor or specialist. This can be a challenge in rural areas where primary health care doctors may visit a clinic as little as once a month.

You need to be able to have access to phone support from a clinician that you can contact whenever you encounter any clinical scenario that falls outside your scope of experience. If you do not have a local clinician you can call the HIV hotline on 0800212506.

CONCLUSION

Mentoring and supporting nurses in rural areas can be deeply satisfying and it is possible to have a huge impact on the life of the nurse mentee and the patients. I believe that mentoring can be a powerful strategy to implement and maintain quality programs at grass roots level.

Do not underestimate its importance!

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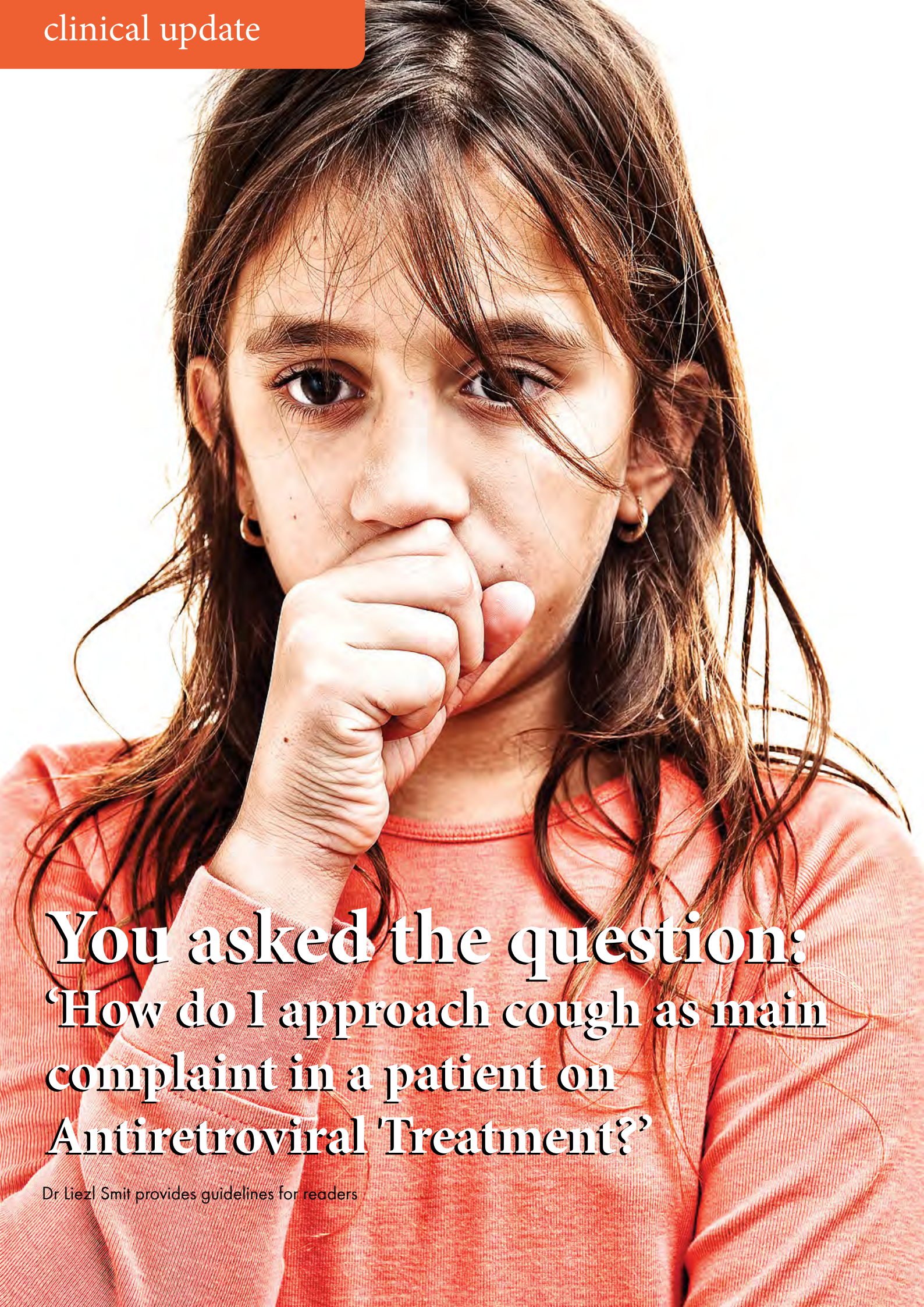

You asked the question:

‘How do I approach cough as main complaint in a patient on Antiretroviral Treatment?’

Dr Liezl Smit provides guidelines for readers

The initial approach to any patient includes a good history and physical examination. The same is true for HIV infected patients on Antiretroviral Treatment (ART).

Remember that cough is a symptom, not a diagnosis; and can be caused by almost any respiratory problem. As the underlying cause may range from mild, self-limiting illnesses, to a severe, life-threatening disease, a systematic approach to cough is important for diagnosis and patient management.

This article aims to highlight some clinical principles to keep in mind when confronted with the above case scenario, and to serve as a guideto the diagnostic evaluation ofcough as main complaint. The specific management of the underlyingcauses of cough is outside the scope of this article; please follow your local guidelines.

HIV related principles

HIV infected patients often complain of cough; and most underlying causes will be the same as in the general population. Most episodes of acute cough are due to the common cold. The commonest severe illness presenting with cough or difficulty breathing is pneumonia. The organisms, signs and symptoms of bacterial pneumonia are generally similar in patients with and without HIV infection

TBis the most common lung manifestation of HIV. A detailed assessment of any possible exposure to active TB is thus an important part of the medical history.Cough for longer than 2 weeks is a red flag for TB.

Even though the use of ART has changed the causes of disease and death in HIV infected patients, in patients who are not taking antiretrovirals or chemoprophylaxis, opportunistic infections and neoplasms continue to occur; with Bacterial pneumonia, Pneumocystis jiroveci pneumonia (PCP), Mycobacterium tuberculosis (TB), lymphoma and Kaposi's sarcoma common.

The initial diagnostic evaluation should therefore be the same in HIV infected patients as for healthy hosts presenting with cough. When these diagnoses have been excluded, orthe patient is immune compromised (CD4 lymphocyte count is < 200 cells/μL.), opportunistic infections and neoplasms should be considered.

When ART is initiated, patients may develop new clinical symptoms as a result of the improving immune system. This is called Immune Reconstitution Syndrome (IRIS) and is especially common in patients with untreated tuberculosis, or patients with TB who have initiated antituberculosis therapy in the past few weeks or months. Other infections may include Mycobacterium avium complex (MAC), Cytomegalovirus (CMV), Cryptococcus, Pneumocystis, Herpes simplex and Hepatitis B. Most patients with IRIS develop symptoms within one week to a few months after the initiation of ART. With later onset, other diagnoses become more likely.

Antiretroviral drug toxicities may infrequently present with cough and associated respiratory complaints like shortness of breath and tachypnea. Lactic acidosis, a long term metabolic complication of the NNRTI class of drugs (especially d4T/Stavudine) may present as cough and tachypnea. Abacavir can produce a hypersensitivity reaction soon after initiation, with fever, rash, muscle pains, shortness of breath, cough and pharyngitis. Cough alone is not enough to make this diagnosis.

Clinical evaluation

The evaluation is aimed at making a specific diagnosis whenever possible and should begin with a thorough medical history and a focused physical examination. Analysing the cough and associated features to distinguish between acute or chronic onset cough will guide you to the diagnosis and management.

It is important however to first recognize who needs immediate attention by assessing the patient for any signs of respiratory distress. Adults in respiratory distress present with cough and/or difficulty in breathing with one or more of the following signs: breathlessness at rest or while talking, tachypnea (respiratory rate > 30 breaths/min), coughing up fresh blood, or general danger signs like agitation, confusion, or hypotension. Signs of respiratory distress in children presenting with cough and or difficulty breathing are chest indrawing or stridor in a calm child; with general danger signs inability to feed, vomiting everything, seizures, lethargy or depressed level of consciousness. These patients need oxygen, the first dose(s) of medicine treating the underlying condition and urgent referral.

For adults (based on PALSA PLUS), give 40% face mask or 4L/min nasal prong oxygen; if patient known with COPD, give only 24-28% face mask oxygen. Give the first dose of antibiotics if the temperature is more than 38'C (chest infection) and refer urgently with continuous oxygen. If associated wheeze, but no leg swelling and 1st episode of wheeze in a patient younger than 50 years, treat as wheeze with salbutamol and prednisone or hydrocortisone as per local guidelines. If difficulty in breathing worse on lying flat with leg swelling or 1st episode of wheeze in patient more than 50 years, heart failure is most likely; treat accordingly.

For children (based on IMCI), start 1-2 L/min nasal prong oxygen; give the first dose of Cetriaxone (50 mg/kg) IM, cotrimoxazole (severe pneumonia), and test for low blood sugar. If stridor, give nebulised adrenaline and prednisolone. If wheeze, give salbutamol and prednisone. Keep the child warm and refer urgently.

If the patient does not need urgent attention, assess for associated symptoms and signs. Added information like productive cough, chest pain and fever (chest infection), leg swelling (heart failure), cough more than 2 weeks, weight loss, night sweats (TB), dry cough, worsening breathlessness on exertion, CD4 < 200 (PCP pneumonia), smoking with weight loss (lung cancer), smoking with productive cough most days for at least 3 months without difficulty breathing or weight loss (chronic bronchitis), or recent upper respiratory tract infection with no difficulty breathing (post-infectious cough) will guide us to the diagnosis and treatment. In children also ask for any TB exposure, poor weight gain (TB), a personal or family history of asthma, history of choking or sudden onset of symptoms (foreign body), paroxysms with whoops or vomiting or central cyanosis (whooping cough).

Although each of the diseases often has characteristic symptoms and signs which can point us to the right diagnosis, (see Table 1), these features often overlap. Occasionally more than one respiratory condition is present.

A chest X-Ray should be done if lung disease is suspected in patients presenting with chronic cough for diagnostic purposes.Additional studies may includesputum cultures; CT scan, lung functions and Barium swallow studies. Management of the patient dependents on the final diagnosis.

In Conclusion

Cough is a common presentation with many underlying causes. Differentiating between mild and life threatening illnesses in the context of HIV and ART is important.

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Cough is a symptom -

a good history and physical examination is essential for diagnosis

Diagnosis (underlying cause)	Features in Favour of the Diagnosis
ACUTE ONSET (lasting less than 3 weeks)	
Upper respiratory tract Infections (URTI)the 'common cold'	• Runny nose • Inflamed throat/tonsils • Low grade fever • May have associated otitis media • Chest clear • Diagnosis clinical
Foreign Body Aspiration	• History of sudden choking • Acute onset of stridor or respiratory distress • May have focal areas of wheeze or reduced breath sounds on one side when listening to the chest • Diagnosis clinical, CXR. Will need a bronchoscopy to remove the foreign body.
Croup (acute laryngo-tracheo bronchitis)	• The paediatric equivalent of adult acute laryngitis (hoarse voice and cough) • Age 4 months to 4 years • Previously well • Immunized against diphtheria • Initial runny nose • Cough and difficulty noisy breathing (inspiratory stridor) and chest retractions developing over a few hours • Diagnosis clinical. X-Ray confirmation only if atypical presentation.
Lower Respiratory Infection (LRTI): Pneumonia • *Viral* (Para Influenza, Adeno, CMV) • *Bacterial* (Streptococcus pneumonia, Haemophylis influenza type B, Staphylococcus aureus) • *Pneumocystis carinii (jirovecii) pneumonia* (PCP)	• Cough or difficulty breathing with fast breathing (tachypnea) • May have pleuritic pain • Lower chest wall in drawing (severe pneumonia) • Fever • Nasal flaring • Crepitations on auscultation • In PCP: increasing air hunger and hypoxia (cyanosis) *CXR indicated if:* • Clinical pneumonia is unresponsive to standard oral treatment • Suspected pulmonary TB • Suspected foreign body (in children) • Severity of pneumonia requiring hospital admission
Bronchiolitis (RSV)	• The most common cause of severe acute viral LRTI in children under 2 years of age • Symptoms follow after 1-2 days of runny nose • Tachypnea • Bilateral airway trapping with wheeze • Diffuse crackles bilateral • Infants may present with apnoea • Diagnosis clinical; CXR not required
Immune Reconstitution Syndrome (IRIS)	• Worsening of known or unknown infection with an improving CD4 • Low pre-treatment CD4 count (often less than 100 cells/microL) , except in TB. • A good virologic and immunological response to ART . • No drug-resistant infection, bacterial infection, drug allergy or other adverse drug reactions, patient noncompliance, or reduced drug levels due to drug-drug interactions or malabsorption. • An association between ART initiation and the onset of clinical features of illness.

Abacavirhypersensitivity	• Fever, rash, muscle pains, shortness of breath, cough and pharyngitis. • Symptoms develop soon after start of drug, and worsen soon after each dose of abacavir.
CHRONIC (persist beyond eight weeks)	
Tuberculosis (TB)	• Chronic cough • Poor growth / weight loss /wasting • Night sweats/fever • Positive contact history with TB patient • Diagnosis with gastric washings/sputum, CXR
Postnasal drip syndrome or allergic rhinitis	• No signs or symptoms specific to condition • Blocked /runny nose • Enlarged tonsils/adenoids • May clear throat often • May have associated lower airway obstruction
Asthma	• Recurrent lower airway obstruction (wheeze), tight chest or cough • Wheeze precipitated by multiple triggers (e.g. cats, grass, colds, exercise etc.) • Wheeze responsive to bronchodilator • may have chest deformity • Diagnosis: the three features mentioned above.
Pertussis (whooping cough)	• Paroxysms of cough followed by whoop, vomiting, cyanosis or apnoea • Well between bouts of cough • No fever • No history of DPT immunisation • Diagnosis is clinical
Bronchiectasis	• History of recurrent chest infections • Productive cough (purulent sputum) and halitosis • May have associated lower airway obstruction • Finger clubbing • Diagnosis is clinical, may need CT scan
Lymphoid Interstitial pneumonitis (LIP)	• Generalised lymphadenopathy • Parotitis • Hepatosplenomegaly • Finger clubbing • Diagnosis clinical and CXR. May need CT scan
Gastroesophageal reflux disease	• Heartburn • Common in smokers • Persistent lower airway obstruction with no other obvious cause • May have regurgitation or vomiting • Cough may be particularly bad at night
Malignancies -Kaposi's sarcoma, -Non-Hodgkin's lymphoma, -Bronchogenic carcinoma	• Unexplained Weight loss • Unexplained shortness of breath/airway obstruction • Chest pain/discomfort • May have haemoptysis
Cystic Fibrosis	• Growth faltering • Persistent lower airway obstruction • Recurrent chest infections • Diagnosis sweat test, CXR

Cardiac Failure	• Raised jugular venous pressure • Apex beat displaced to the left • Gallop rhythm • Heart murmur • Basal fine crackles • Enlarged palpable liver • Cough worse when lying flat (orthopnea) or sudden onset dyspnea (paroxysmal nocturnal dyspnea) at night
Non ART drugs e.g. Angiotensin-converting enzyme inhibitors (ACE-inhibitors)	• Cause a non-productive cough in a small percentage of users. • Cough should subside in a few days to weeks after the ACE inhibitor is stopped
Psychogenic ('habit cough')	• Rare psychosocial disorder • Unnatural 'barking' or 'honking' character • Absent during sleep • Onset may follow mild respiratory tract infection and then persist

Caring for rural communities

"AIDS is becoming a greater threat in rural areas than in cities of the developing world, contrary to conventional wisdom. Growing links between rural and urban areas through trade, migration and improved transportation networks have made HIV prevalence rates rise faster in rural areas."
Topsy Foundation

More than two thirds of the population of the 25 most-affected African countries live in rural areas[1] where information and health services are less available than in cities. Rural people are therefore less likely to know how to protect themselves from HIV and, if they fall ill, less likely to get care. Furthermore the cost of HIV&AIDS is largely borne by rural communities as HIV-infected urban dwellers of rural origin often return to their communities when they fall ill.

Table 1: The Topsy Foundation service offering

Comprehensive HIV & AIDS Care Clinic programme	Community Outreach project	Skills training programme
• Provision of antiretroviral therapy project • Voluntary counselling and testing project • Post-exposure prophylaxis project • Prevention of mother to child transmission project • General care for HIV & AIDS patients project	• Home-based care • Orphaned and Vulnerable children project • Vegetable gardening project	• Shukushukuma Beadwork project • Tinyiko sewing project

The Topsy Foundation

A well established initiative attending to this overwhelming need for care and support is the Topsy Foundation that partners with five rural communities in and around the crossroads of the Mpumalanga, Free State and Gauteng Provinces. The project activities take place from a central project site at Grootvlei which is called the Topsy Sanctuary. The Topsy Foundation, a fully-registered and internationally-respected South African Non Profit Organisation (NPO), provides relief services to these under-resourced rural communities through a multi-faceted approach to the consequences of HIV and AIDS and extreme poverty. Interventions are characterised by the provision of medical and social services (with a strong emphasis on wellness) to people and families who do not otherwise have ready access to such services. The service offering includes three streams, namely comprehensive HIV & AIDS Care Clinic programme, a community outreach programme and a skills training programme (table 1).

Comprehensive HIV & AIDS Care Clinic programme

A comprehensive HIV and AIDS Care Clinic (CHACC) was established at the Topsy Sanctuary in September 2006,

which serves to provide care and treatment, specifically involving antiretroviral therapy to identified and eligible members of the community. A Service Level Agreement has been signed with the Mpumalanga Department of Health which has facilitated the provision of ARV therapy and medicines for opportunistic infections. The clinic team consists of medical and nursing staff and social workers, all of whom have received the appropriate, specialised training. All relevant staff members undergo training, which includes HIV and AIDS Counselling, Laboratory testing, DOTS principle (groups), ARV (General information, Resistance, Side effects, Interaction of medication), Administration of medication, Adherence, Charting (groups), TB, Case studies (groups), Role in the community, Expectations/Fears/Opinions.

On the first visit to the clinic the medical professional will make sure all relevant results are available and stage the client according to WHO staging. The client will be referred to the social worker to start readiness counselling. The social worker then will determine when the client is ready for ART after at least 3 sessions. During this time Topsy provides prophylaxis for opportunistic infections, as well as treatment for any acute infections.

Once a client has been selected, a clinical examination, including height and weight, HIV ELISA, PCR (if ELISA undetermined), CD4 count, Viral Load, and Full blood count are done as part of the screening. The client is seen by a health professional and social worker every two weeks (or monthly thereafter) for the first 3 months. Adherence checks are undertaken, e.g. pill count and the checking of medical charts. The social worker does adherence counselling. All of which is documented. If the client is adherent and the viral load has dropped to below 400 copies per ml blood, the client will receive treatment for 3 months. Children are required to come to the Comprehensive HIV and AIDS Care Clinic every month to receive their medication due to dosage changes according to weight.

Follow up blood tests are done every three months (CD4; Viral Load; FBC and Liver Function Tests). Rapid tests for urine dipstick, glucose, cholesterol and lactate with finger prick are also done in three-monthly intervals. Additional tests are done if the clinical picture raises the suspicion of side-effects developing. In doing this, the efficacy of the drugs is monitored as well as the possible development of side effects and / or resistance.

The families caring for children are visited daily for at least one month upon commencing treatment during which the trained field-workers ensure that the care-giver administers the medication correctly. Each dosage given must be charted. After that they are visited regularly to follow up. This enables the Topsy Foundation to deal with all social and medical problems as soon as they arise.

Since the start of the Comprehensive HIV and AIDS Care Clinic, mothers who are pregnant have been supported. The Prevention of Mother To Child Transmission (PMTCT) project was finalised in 2007. Since this project started, not one HIV-positive baby has been born to an HIV-positive mother who completed the PMTCT Project.

PEP and post-exposure prophylaxis is offered to staff and community members exposed to HIV due to needlestick injury or other exposure. This service includes pre- and post-test counselling, the provision of medication and after-care.

A final word

The communities surrounding the Topsy Sanctuary struggle with poverty. Compounded by the fact work is scarce, the disease prevents people from gaining access to employment. Furthermore when an infected person has progressed to the final phase of the disease, looking after the immediate families in terms of food and basic health care becomes an overwhelming challenge unless assistance is forthcoming. The programmes offered by Topsy not only provides access to healthcare, but also provide for the other needs of the comunities they serve. Read more about the work done at the Topsy Sanctuary at http://www.topsy.org.za/.

Reference:
1. Focus. Food and agriculture organisation of the United Nations. Fact sheet: AIDS - a threat to rural Africa. Accessed at http://www.fao.org/FOCUS/E/aids/aids6-e.htm

Community outreach projects provide for essential HIV services to rural communities

3rd SA TB Conference

TB/HIV Integration Conference

12-15 June 2012
ICC Durban

TB Conference | 12-15 June 2012 | ICC Durban

CONFERENCE PROGRAMME

TUESDAY, 12 JUNE 2012
16h00 - 17h30 Conference Opening

WEDNESDAY, 13 JUNE 2012
09h00 - 10h30 Plenary
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Parallel Sessions
12h30 - 14h00 Lunch
14h00 - 15h30 Parallel Sessions
15h30 - 16h00 Afternoon Refreshments
16h00 - 17h30 Parallel Sessions

THURSDAY, 14 JUNE 2012
09h00 - 10h30 Plenary
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Parallel Sessions
12h30 - 14h00 Lunch
14h00 - 15h30 Parallel Sessions
15h30 - 16h00 Afternoon Refreshments
16h00 - 17h30 Parallel Sessions

FRIDAY, 15 JUNE 2012
09h00 - 10h30 Late Breaker Sessions
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Conference Close

www.tbconference.co.za

Reaching the Target

IMPORTANT DATES

1 Sept 2011 - Early registration, scholarship application and abstract submission opens
14 Dec 2011 - Regular registration opens
20 Jan 2012 - Close of abstract submission and scholarship application
9 Mar 2012 - Notifications of abstracts
18 May 2012 - Regular registration closes
12 June 2012 - On-site registration opens

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How structured patient clinical records can assist nurses in the management and monitoring of patients within the South African HIV/ART programme

Claudine Hennessey BScN, Meg Osler MPH
University of Cape Town - Centre for Infectious Disease Epidemiology and Research

Throughout time, documenting events and experiences has provided us with an idea of what happened at the time of the event, and that information influences future decision making. Without documenting events how do we know our history, how can we improve on past mistakes?

This is the very question that nurses should consider when documenting patient information. How can we truly know our patients status if we do not have the complete clinical history documented in our patients' folders? Similarly how can we expect other clinicians to provide continuity of care if we have not accurately documented information during previous visits?

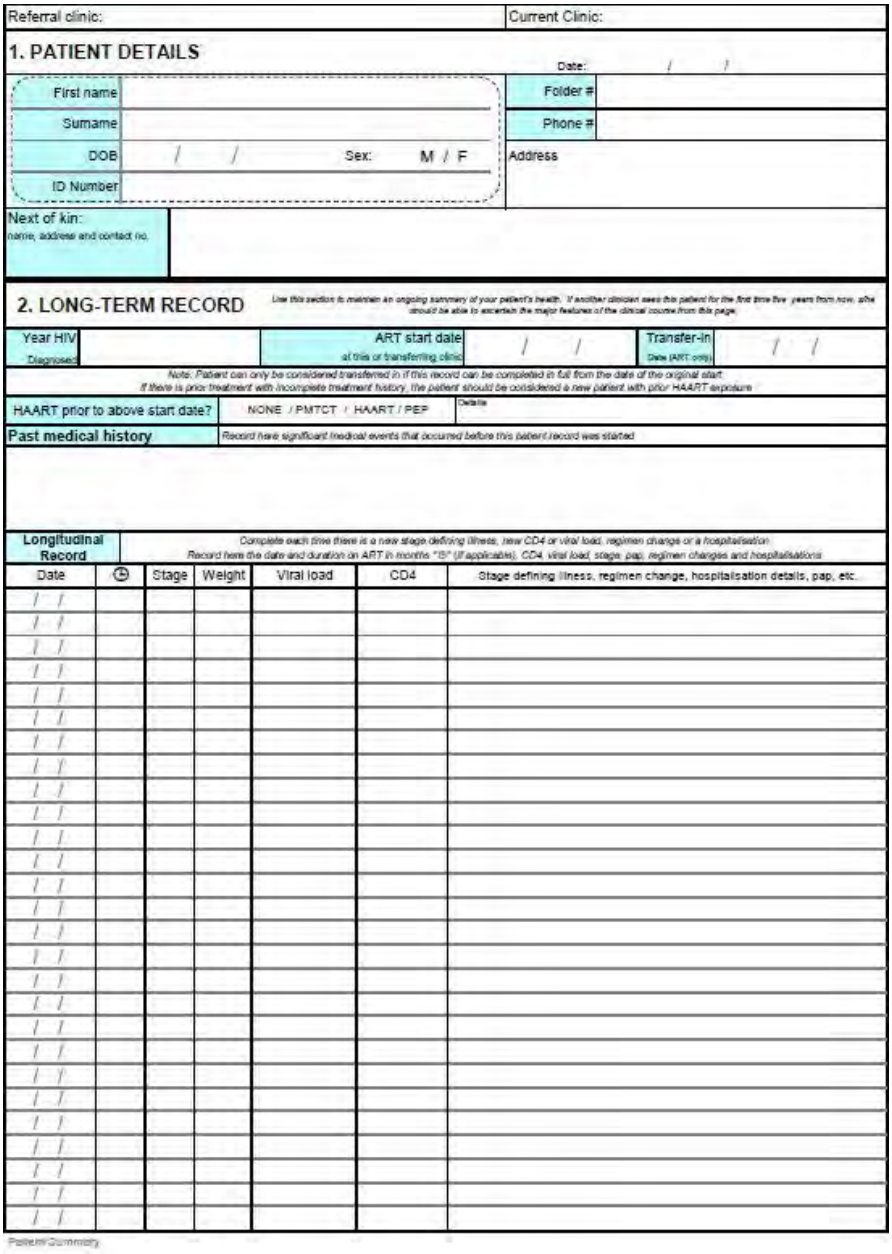
Fortunately for clinicians working in the Anti Retroviral Therapy (ART) programme, stationery has been adopted by the South African Department of Health to assist nurses and doctors with the clinical documentation of patient treatment information. This stationery can be used by clinicians working in the smallest rural clinic to a large urban facility.

This HIV/ART stationery was developed several years ago in the Western Cape by a team of experts working in the HIV/ART field and was a collaborative effort between the University of Cape Town (UCT) Centre for Infectious Disease Epidemiology and Research (CIDER), Medecins Sans Frontieres (MSF) and the Provincial Government of the Western Cape (PGWC) who recognized the need for a standard and simplified method of documenting patient information. This clinical stationery incorporates the international standard of clinical care in chronic disease management and is in keeping with the recommendations put forth by the WHO (WHO, 2006)

In October 2011 the National Department of Health introduced the standardised clinical stationery for the HIV & ART programme within the Primary Health Care sector and recommends that it be the only stationery used within the ART programme (National Department of Health, 2011a). The implementation of the National HIV/ART Clinical Stationery supports the call for the establishment of one monitoring system and supports the 3 Tiered ART Monitoring and Evaluation program (National Department of Health, 2011b)
The stationery consists of 4 documents that constitute a simple user friendly tool for doctors and nurses to easily and accurately record reference a patient's treatment history over time. Accurate use of the stationery provides a pathway for improved communication between patients, doctors and nurses, data capturers, and the management team from facility to national level within the ART program. The stationery plays an integral role in ensuring correct data collection that tracks and directly influences the clinical management of a patient from the time a patient first test's positive and continues throughout their treatment years in the ART program. Furthermore, with the limited time allocation that doctors and nurses have for patient consultations the stationery allows for quick referencing and easily recognisable changes in temporal trends so that more time can be spent with the patient, rather than time spent looking laboriously through hand written notes in the patient folder.

The stationery includes four forms – the Patient Summary Form (figure 1), the Patient Continuation Sheet (figure 2), the Patient Held Card (figure 3), and the Lab Results Form– all of which contain the required information to manage a patient in the HIV/ART programme. The Patient Summary form or the patient's 'passport into care' is implemented the day the patient tests positive in a facility.

Figure 1a Patient Summary Form Page 1



Referral clinic: | Current Clinic:

1. PATIENT DETAILS

Date: / /

First name | Folder #
Surname | Phone #
DOB / / Sex: M / F | Address
ID Number

Next of kin:
name, address and contact no.

2. LONG-TERM RECORD

Use this section to maintain an ongoing summary of your patient's health. If another clinician sees this patient for the first time five years from now, s/he should be able to ascertain the major features of the clinical course from this page.

Year HIV Diagnosed | ART start date at this or transferring clinic / / | Transfer-in Date (ART only) / /

Note: Patient can only be considered transferred in if this record can be completed in full from the date of the original start.
If there is prior treatment with incomplete treatment history, the patient should be considered a new patient with prior HAART exposure

HAART prior to above start date? NONE / PMTCT / HAART / PEP | Details

Past medical history | Record here significant medical events that occurred before this patient record was started

Longitudinal Record

Complete each time there is a new stage defining illness, new CD4 or viral load, regimen change or a hospitalisation
Record here the date and duration on ART in months "0" (if applicable), CD4, viral load, stage, pap, regimen changes and hospitalisations

Date	◷	Stage	Weight	Viral load	CD4	Stage defining illness, regimen change, hospitalisation details, pap, etc.
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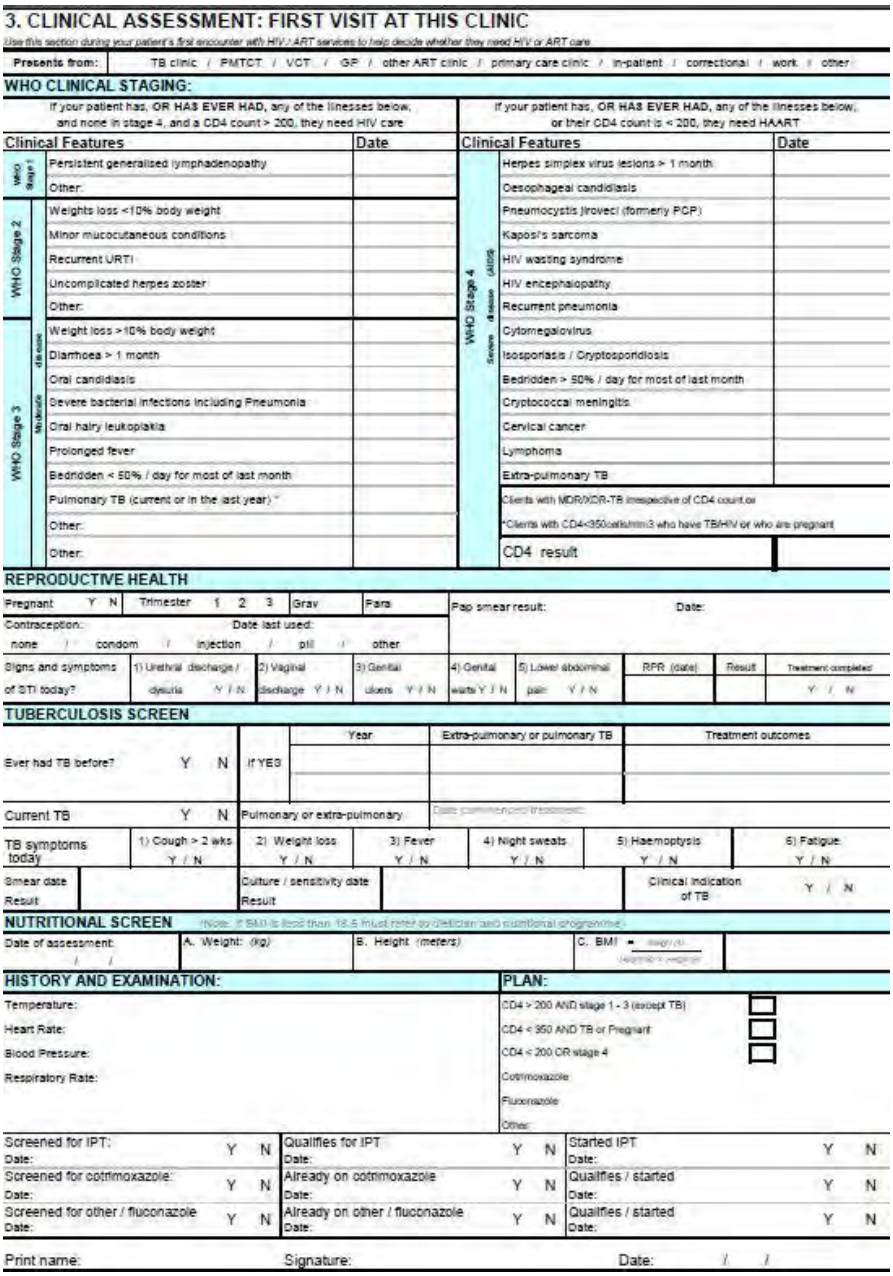
Patient Summary

Figure 1b – Patient Summary Form Page 2



3. CLINICAL ASSESSMENT: FIRST VISIT AT THIS CLINIC

Use this section during your patient's first encounter with HIV / ART services to help decide whether they need HIV or ART care

Presents from: TB clinic / PMTCT / VCT / GP / other ART clinic / primary care clinic / in-patient / correctional / work / other

WHO CLINICAL STAGING:

If your patient has, OR HAS EVER HAD, any of the illnesses below, and none in stage 4, and a CD4 count > 200, they need HIV care

Clinical Features	Date
WHO Stage 1: Persistent generalised lymphadenopathy	
WHO Stage 1: Other:	
WHO Stage 2: Weights loss <10% body weight	
WHO Stage 2: Minor mucocutaneous conditions	
WHO Stage 2: Recurrent URTI	
WHO Stage 2: Uncomplicated herpes zoster	
WHO Stage 2: Other:	
WHO Stage 3 Moderate disease: Weight loss >10% body weight	
WHO Stage 3 Moderate disease: Diarrhoea > 1 month	
WHO Stage 3 Moderate disease: Oral candidiasis	
WHO Stage 3 Moderate disease: Severe bacterial infections including Pneumonia	
WHO Stage 3 Moderate disease: Oral hairy leukoplakia	
WHO Stage 3 Moderate disease: Prolonged fever	
WHO Stage 3 Moderate disease: Bedridden < 50% / day for most of last month	
WHO Stage 3 Moderate disease: Pulmonary TB (current or in the last year) *	
WHO Stage 3 Moderate disease: Other:	
WHO Stage 3 Moderate disease: Other:	

If your patient has, OR HAS EVER HAD, any of the illnesses below, or their CD4 count is < 200, they need HAART

Clinical Features	Date
WHO Stage 4 Severe disease (AIDS): Herpes simplex virus lesions > 1 month	
WHO Stage 4 Severe disease (AIDS): Oesophageal candidiasis	
WHO Stage 4 Severe disease (AIDS): Pneumocystis jiroveci (formerly PCP)	
WHO Stage 4 Severe disease (AIDS): Kaposi's sarcoma	
WHO Stage 4 Severe disease (AIDS): HIV wasting syndrome	
WHO Stage 4 Severe disease (AIDS): HIV encephalopathy	
WHO Stage 4 Severe disease (AIDS): Recurrent pneumonia	
WHO Stage 4 Severe disease (AIDS): Cytomegalovirus	
WHO Stage 4 Severe disease (AIDS): Isosporiasis / Cryptosporidiosis	
WHO Stage 4 Severe disease (AIDS): Bedridden > 50% / day for most of last month	
WHO Stage 4 Severe disease (AIDS): Cryptococcal meningitis	
WHO Stage 4 Severe disease (AIDS): Cervical cancer	
WHO Stage 4 Severe disease (AIDS): Lymphoma	
WHO Stage 4 Severe disease (AIDS): Extra-pulmonary TB	
*Clients with MDR/XDR-TB irrespective of CD4 count or	
*Clients with CD4<350cells/mm3 who have TB/HIV or who are pregnant	
CD4 result	

REPRODUCTIVE HEALTH

Pregnant Y N | Trimester 1 2 3 | Grav | Para | Pap smear result: | Date:

Contraception: | Date last used:

none / condom / injection / pill / other

Signs and symptoms of STI today?	1) Urethral discharge / dysuria	2) Vaginal discharge	3) Genital ulcers	4) Genital warts	5) Lower abdominal pain	RPR (date)	Result	Treatment completed
	Y / N	Y / N	Y / N	Y / N	Y / N			Y / N

TUBERCULOSIS SCREEN

Ever had TB before? Y N	If YES	Year	Extra-pulmonary or pulmonary TB	Treatment outcomes

Current TB Y N | Pulmonary or extra-pulmonary | Date commenced treatment:

TB symptoms today	1) Cough > 2 wks Y / N	2) Weight loss Y / N	3) Fever Y / N	4) Night sweats Y / N	5) Haemoptysis Y / N	6) Fatigue Y / N

Smear date | Result | Culture / sensitivity date | Result | Clinical indication of TB Y / N

NUTRITIONAL SCREEN (Note: If BMI is less than 18.5 must refer to clinician and nutritional programme)

Date of assessment: | A. Weight: (kg) | B. Height (meters) | C. BMI = weight (kg) / (height x height)

HISTORY AND EXAMINATION:

Temperature:

Heart Rate:

Blood Pressure:

Respiratory Rate:

PLAN:

CD4 > 200 AND stage 1 - 3 (except TB) ☐

CD4 < 350 AND TB or Pregnant ☐

CD4 < 200 OR stage 4 ☐

Cotrimoxazole

Fluconazole

Other:

Screened for IPT: Date:	Y N	Qualifies for IPT Date:	Y N	Started IPT Date:	Y N
Screened for cotrimoxazole: Date:	Y N	Already on cotrimoxazole Date:	Y N	Qualifies / started Date:	Y N
Screened for other / fluconazole Date:	Y N	Already on other / fluconazole Date:	Y N	Qualifies / started Date:	Y N

Print name: Signature: Date: / /

The patient summary form (figure 1) is printed front and back and folded as a cover (or folder) for the patients' HIV and ART history and prospective visit information. The patient summary contains a living record and demographics (figure 1a), the first HIV positive visit (figure 1b) the workup for ART drugs (figure 1c) and family and counselling information (figure 1d). There is important information contained on the form such as the medical history of the patient, details about tuberculosis (TB) and opportunistic infections status, nutritional and WHO clinical staging, readiness to start ART and counselling sessions, the clinical plan for the patient, baseline bloods and Isoniazid (INH) and Cotrimoxizole Preventative Therapy (CPT) history.

The second part of the stationery is the Patient Continuation Sheet (figure 2) – which contains multiple columns, with one column completed per clinic visit. Information such as TB and Sexually Transmitted Infection (STI) screening, reproductive health, adverse events, stage changes, opportunistic infections, blood requests/results, drug regimens, number of months of medication prescribed and next clinic appointment dates are included. Both the Patient Summary Form and the Clinic Visit Summary forms have been structured to offer prompts for new doctors, nurses and locums in the ART service, ensuring that patients receive a comprehensive assessment at each clinical visit.

The Patient- held card (figure 3) contains information such as demographic information, next clinic appointment (figure 3a) the current treatment regimen and latest CD4 results (figure 3b) information. This card is carried by the patient and brought to the clinic each visit.

The final part of the stationery suite is the NHLS Lab Results Form which contains results from various lab tests requested by the clinician. The results are written onto the Visit Summary and then filed in the patient folder.

Although the stationery is available to each health facility, it is not enough to simply place it in the patient's folder. Clinical record training will ensure that the health team understands how to use the stationery, knows how and what must be documented, and which data is collected for reporting purposes. Clinicians should also understand that these tools are considered legal records for patients within the ART program. During a recent audit of several ART sites that looked at transfer of data from the patient folder into the Tier 2 electronic ART monitoring system (TIER.net), it was noted that clinicians' documentation of patient data was scored consistently lower than that of the data clerks' transfer of data into the system. Data clerks were proportionately more accurately capturing recorded data in comparison to clinicians completing the patients' clinical record. The information recorded in the standardized clinical stationery is used not only to clinically manage our patients, but it is also the foundation for the monitoring of the HIV/ART programme. If patient information is not documented, then our data clerks cannot capture the key programme information that is used to guide and inform policy for the HIV/ART programme. In addition missing data will result in either an under or over-inflation of burden for the health

facility, district and province, affecting resource allocation, projections and business plans

As previously stated, the clinical stationery is easy to use, and comes complete with detailed instructions on how and what needs to be documented and by whom. Since the NDoH has adopted the clinical stationery for the entire country this means that a nurse working in one province who moves to another province can transition quite easily as 'learning' a clinical documentation system will not be necessary. This will allow nurses and doctors to spend more time with their patients.

Completion of the clinical records informs the province of possible clinical governance issues as well as the quality of service individual facilities may be offering.

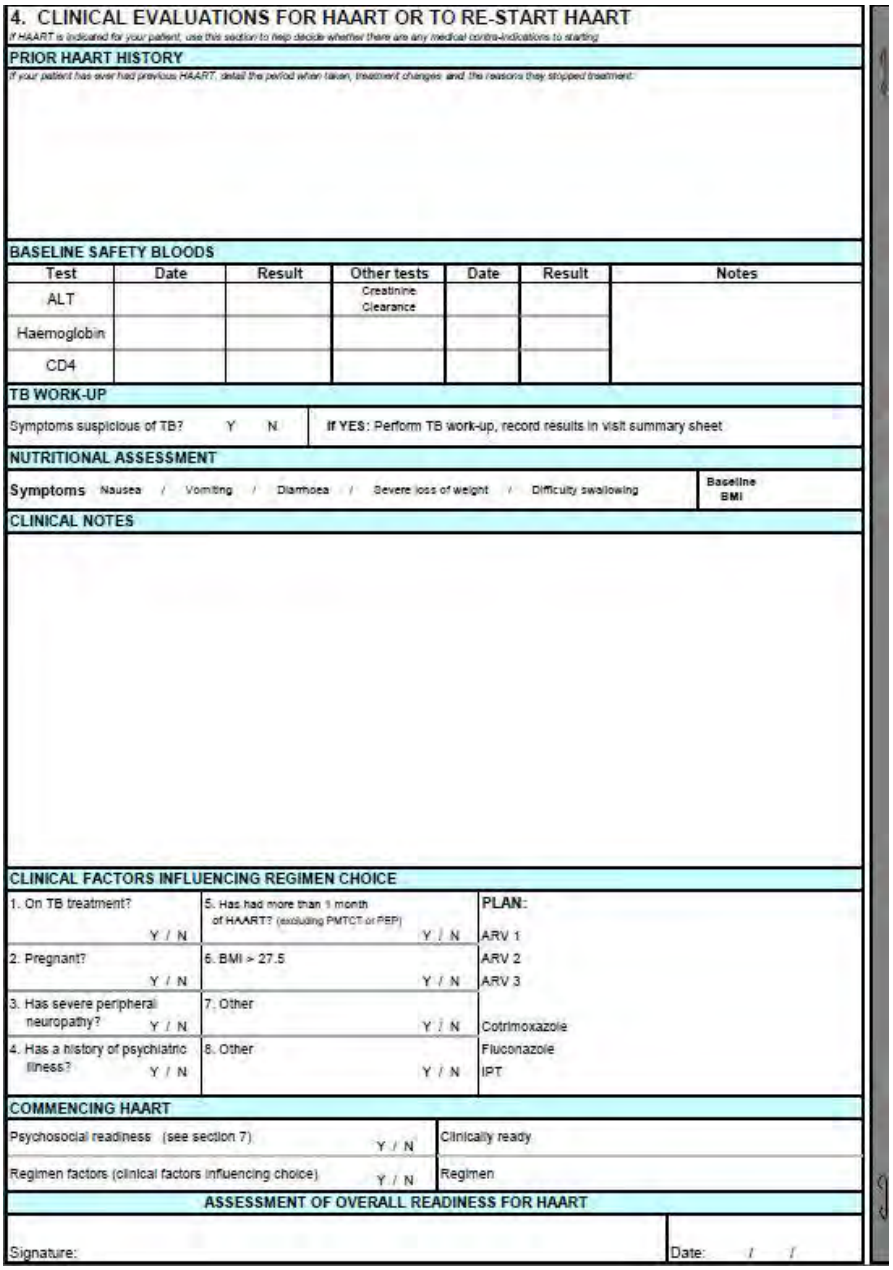
Low recorded and reported CD4 and viral load proportions among all patients who should have these safety bloods recorded and reported can alert central programme managers of a facility which may not be performing to clinical standards, affecting the quality of services offered to the patients.

If the facility was taking safety bloods according to protocol (National Department of Health, 2010), the under-recording of the bloods may affect future resource allocation.

Audit data such as the number of patients in a cohort reported as having been screened for TB plus the number reported to be on TB treatment at baseline of ART can provide another alert in regards to clinical governance.

If a facility has really made a concerted effort to screen all patients for TB, but that information is not documented by the nurse, the hard work of the facility will not be recognized, and the facility may be penalized despite fulfilling their clinical obligations.

Figure 1c Patient Summary Form Page 3



4. CLINICAL EVALUATIONS FOR HAART OR TO RE-START HAART

If HAART is indicated for your patient, use this section to help decide whether there are any medical contra-indications to starting

PRIOR HAART HISTORY

If your patient has ever had previous HAART, detail the period when taken, treatment changes and the reasons they stopped treatment:

BASELINE SAFETY BLOODS

Test	Date	Result	Other tests	Date	Result	Notes
ALT			Creatinine Clearance			
Haemoglobin						
CD4						

TB WORK-UP

Symptoms suspicious of TB? Y N | **If YES:** Perform TB work-up, record results in visit summary sheet

NUTRITIONAL ASSESSMENT

Symptoms Nausea / Vomiting / Diarrhoea / Severe loss of weight / Difficulty swallowing | Baseline BMI

CLINICAL NOTES

CLINICAL FACTORS INFLUENCING REGIMEN CHOICE

1. On TB treatment? Y / N	5. Has had more than 1 month of HAART? (excluding PMTCT or PEP) Y / N	**PLAN:** ARV 1
2. Pregnant? Y / N	6. BMI > 27.5 Y / N	ARV 2
3. Has severe peripheral neuropathy? Y / N	7. Other Y / N	ARV 3
4. Has a history of psychiatric illness? Y / N	8. Other Y / N	Cotrimoxazole
		Fluconazole
		IPT

COMMENCING HAART

Psychosocial readiness (see section 7) Y / N	Clinically ready
Regimen factors (clinical factors influencing choice) Y / N	Regimen

ASSESSMENT OF OVERALL READINESS FOR HAART

Signature: | Date: / /

With ever - increasing pressure being placed on the health care system (Parsons et al., 2010) and the shortage of nurses across the country (Medecins Sans Frontieres, 2011) we must look for ways that nurses can decrease the amount of time spent on administrative tasks and increase the amount of time spent in direct consultation with their patients. By implementing and completing carefully structured stationery, a nurse or doctor can quickly glimpse all vital changes in a patient's history, understand via the prompts which assessments are critical in a comprehensive service, and accurately provide all relevant information needed by the monitoring and evaluation team. The health facility team's effort to accurately use clinical records at a facility can have a critical influence on future interventions, policy and resource allocation provided within the ART services.

Figure 1d Patient Summary Form Page 4

5. SOCIAL ASSISTANCE

Use this section to assess the need for social assistance (record the date this social assessment was made) / /

Lives in what sort of dwelling? (please circle) informal dwelling / formal house / hostel / other (specify) | Number of rooms | Refrigerator: Y N

Number of adults in household | Current partner in household Y N | Is current partner husband/wife? Y N | Is current partner aware of HIV status Y N

Age and HIV status of children

Own children	Age								Other children in household								
HIV status	- / +								Age								
In household	Y / N								HIV status - / +								

Has patient disclosed HIV status Y N | To Whom:

Source of income? (circle) employed / grant / pension / friends or family

Qualifies for grant Y N | DG Child Other: | Receiving grant Y N | Application Submitted Y N

Current drug use	Current alcohol use	CAGE questionnaire					Cage Score
Y N	Y N		Have you ever felt you should cut down on your drinking Y N	Have people annoyed you by criticising your drinking Y N			
			Have you ever felt guilty or bad about your drinking Y N	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover Y N			

Referral Clinic: | Appointment Date:

6. PRE-ART COUNSELLING

Use this section to record your patients counselling history

Session	Date/s	Counsellor / group	Tx buddy attended?	Comments (e.g. motivation, level of understanding)
General HIV Education and Healthy Living				
Antiretroviral Therapy				
Adherence Planning				
Other				

Name and contact details for treatment buddy:

Patient agreed to home visit Y N | Name of community health worker: | Attends a support group Y N

What is clients understanding (in their own words) for wanting HAART?

7. PSYCHO-SOCIAL READINESS Date: / /

If it has been decided HAART can safely be started (section 4) use this section to help decide if your patient is psychologically and socially prepared for HAART.

Review and update section 5 (above) if it was completed some time before this section

IMPORTANT NOTE: The checks below are ONLY a prompt for the health care worker to check that the patient is:
a) self motivated, b) has received HIV / ART education and c) has a degree of social support

	Y	N		Y	N
Have they attended all the required counselling sessions? (see above)			Do they have a treatment buddy		
Have they disclosed to anyone?			Have they been attending the clinic regularly?		

If the answer to all of the above questions is YES then the patient is ready to commence HAART

References:

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NATIONAL DEPARTMENT OF HEALTH 2011b. TIER T1 and T2 ART monitoring and evaluation implementation plan. In: NATIONAL DEPARTMENT OF HEALTH (ed.) 4 ed.

PARSONS, A. N., MATHOLE, T. & SANDERS, D. 2010. The Impact of Global Health Initiatives on Access to Antiretroviral Therapy in South Africa. In: HEALTH SYSTEMS TRUST (ed.) South African Health Review 2010. School of Public Health, University of the Western Cape.

WHO. 2006. Patient montioring guidelines for HIV care and antiretroviral therapy (ART) [Online]. Geneva: WHO. Available: http://www.who.int/3by5/capacity/ptmonguidelinesfinalv1.pdf [Accessed January 14 2012].

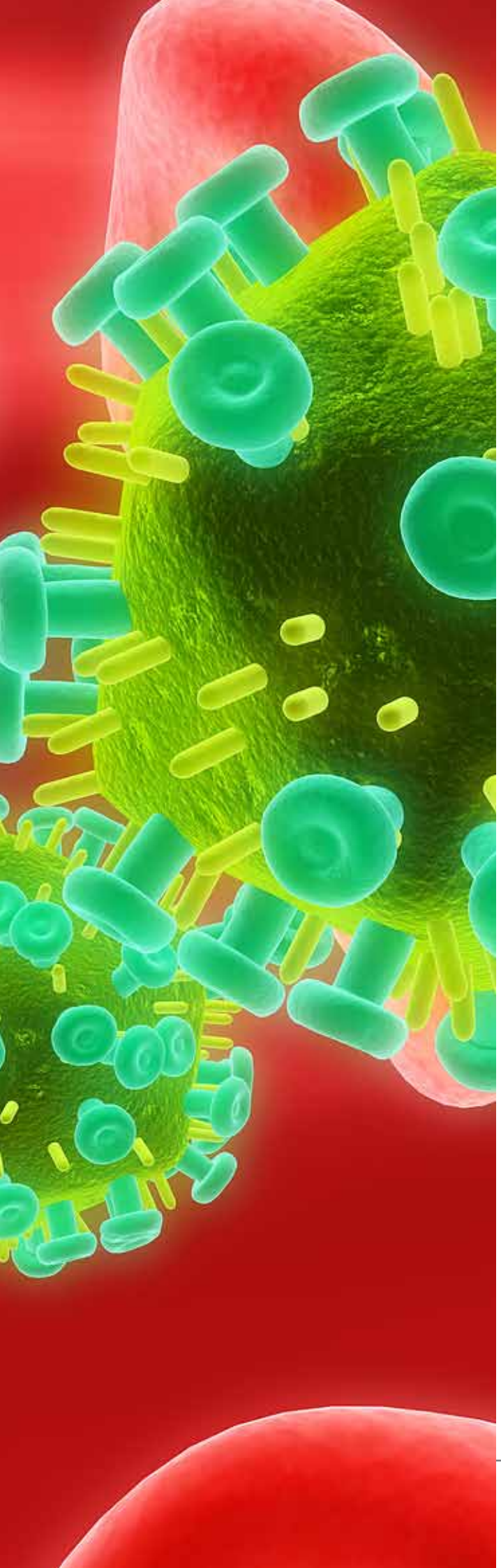


Figure 2 Patient Continuation Sheet

Figure 3a Patient Held Card

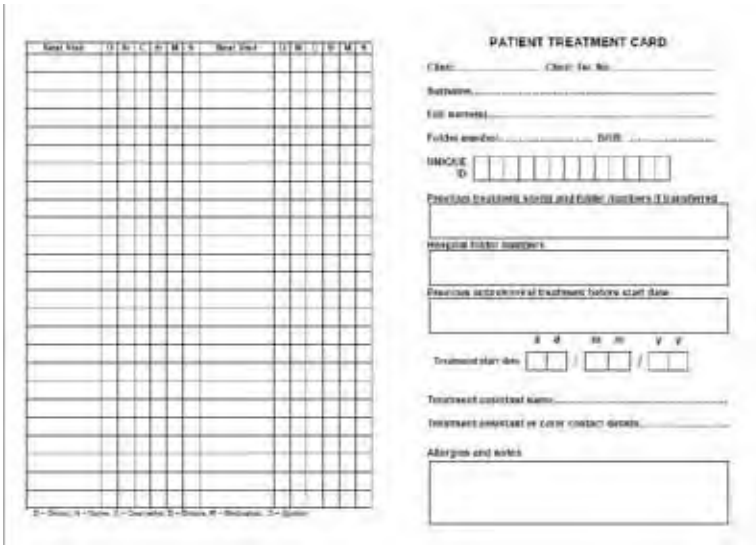
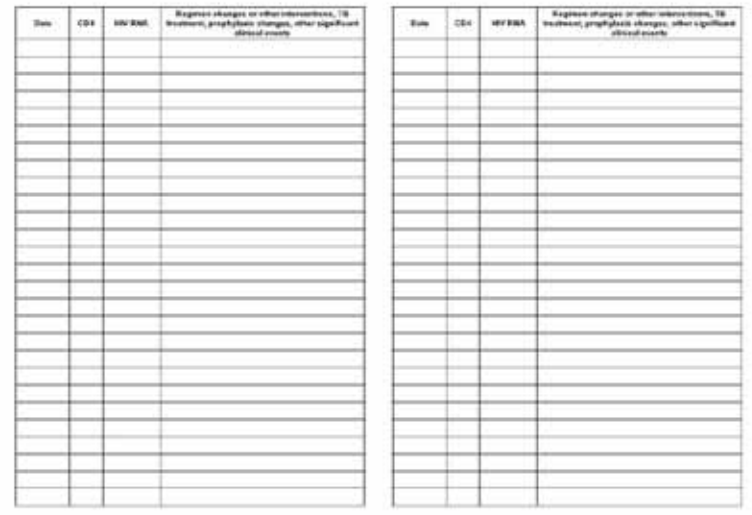


Figure 3b Patient Held Card (inside)



The Joint WHO-ILO-UNAIDS policy guidelines:

improving health workers' access to HIV and TB prevention, treatment, care and support services

Health workers often lack adequate access to preventive measures such as personal protective supplies or equipment as well as treatment access. The Joint WHO-ILO-UNAIDS 14-point policy guidelines have been developed to respond to this need and contribute to the promotion of universal access to HIV and TB prevention, treatment, care and support. A summary of the policy guidelines are provided for readers.

A	**NATIONAL POLICIES**
A.1	Introduce new national policies or refine existing ones that ensure priority access for health workers and their families to services for the prevention, treatment, care and support for HIV and TB.
A.2	Introduce new policies or reinforce existing ones that prevent discrimination against health workers with HIV or TB, and adopt interventions aimed at stigma reduction among colleagues and supervisors.
A.3	Establish schemes for reasonable accommodation and compensation, including, as appropriate, paid leave, early retirement benefits and death benefits in the event of occupationally-acquired disease.
B	**WORKPLACE ACTIONS**
B.1	Develop, strengthen or expand existing occupational health services for the entire health workforce so that access to HIV and TB prevention, treatment, care and support can be attained.
B.2	Develop or strengthen existing infection control programmes, especially with respect to TB and HIV infection control, and collaborate with workplace health and safety programmes to ensure a safer work environment.
B.3	Develop, implement and extend programmes for regular, free, voluntary, and confidential HIV counselling and testing, and TB screening, including addressing reproductive health issues, as well as intensified TB case finding in the families of health workers with TB.
B.4	Identify, adapt and implement good practices in occupational health and the management of HIV and TB in the workplace in both public and private health care sectors, as well as other sectors.
B.5	Provide information on benefits and risks of post-exposure prophylaxis (PEP) to all staff and provide free and timely PEP for all exposed health workers, ensuring appropriate training of PEP providers.
B.6	Provide free HIV and TB treatment for health workers in need, facilitating the delivery of these services in a non-stigmatizing, gender-sensitive, confidential, and convenient setting when there is no staff clinic and/ or their own facility does not offer ART, or where health workers prefer services off-site.
B.7	In the context of preventing co-morbidity, provide universal availability of a comprehensive package of prevention and care for all HIV positive health workers, including isoniazid preventive therapy and co-trimoxazole prophylaxis, with appropriate information on benefits and risks.
B.8	Develop and implement training programmes for all health workers that include: pre-service, in-service and continuing education on TB and HIV prevention, treatment, care and support; workers' rights and stigma reduction, integrating these into existing training programmes and including managers and worker representatives.
C	**BUDGET, MONITORING AND EVALUATION**
C.1	Establish and provide adequate financial resources for prevention, treatment, care and support programmes to prevent both occupational or non-occupational transmission of HIV and TB among health workers.
C.2	Disseminate the policies related to these guidelines in the form of codes of practices and other accessible formats for application at the level of health facilities, and ensure provision of budgets for the training and material inputs to make them operational.
C.3	Develop and implement mechanisms for monitoring the availability of the guidelines at the national level, as well as the dissemination of these policies and their application in the healthcare setting.

The health sector is responsible for the prevention, diagnosis, treatment and care of illness and can contribute to reducing stigma and discrimination in the context of health services. Countries must protect the health and rights of their health workers by optimising their working conditions. By protecting health workers, countries would ensure that those providing health services are themselves healthy. This will in turn facilitate people's rights of access to quality health services.

Health workers take care of people with illnesses and counsel people to protect their health and prevent HIV and tuberculosis (TB). However, health workers are at particular risk of occupational exposure to HIV and TB by nature of their work environment. Unfortunately, they often lack adequate access to preventive measures such as personal protective supplies or equipment as well as treatment access.

The Joint WHO-ILO-UNAIDS 14-point policy guidelines have been developed to respond to this need and contribute to the promotion of universal access to HIV and TB prevention, treatment, care and support. These Guidelines were developed by health workers and health service employers, in collaboration with the ministries of health and ministries of labour through the collaboration of the International Labour Organization, the World Health Organization and UNAIDS.

The new policy guidelines cover guidance on:

1) National Policies, including rights, legislation and social protection schemes;
2) Workplace actions, including workplace policies, programmes and training;
3) Budget allocation, monitoring and evaluation, which involve both national and workplace coordination.

The Guiding principles for the Guidelines are based on respect for:

- Workers' rights and human rights
- Gender equity
- Primary prevention
- Effectiveness and efficiency
- Involvement of people living with HIV, TB, or both
- Active participation of health workers, their representatives and their employers

A copy of the publication "The Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services: a guidance note" can be downloaded from http://www.ilo.org/aids/Publications/WCMS_149714/lang–en/index.htm

Joint WHO-ILO-UNAIDS policy guidelines have been developed to improve access of healthcare workers' to HIV and TB prevention, treatment, care and support services

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY
2012 MEMBERSHIP APPLICATION FORM

PROFESSIONAL INFORMATION

Title: Prof ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ **Initials**: _____ **First Name(s)**: _____
Surname: _____ **Institution/Organisation**: _____

Profession (check one):
☐ Doctor Generalist ☐ Doctor Specialist ☐ Pharmacist ☐ Professional Nurse ☐ Other _____

If Doctor Specialist, select specialty:
☐ Cardiology ☐ Clinical Pharmacology ☐ Dermatology ☐ Family Physician ☐ Infectious Diseases ☐ OB GYN ☐ Paediatrics
☐ Physician/Internal Medicine ☐ Psychiatry ☐ Other _____

Council number (e.g. HPCSA, SANC): _____ **Practice number (if applicable):** _____

Primary Employment affiliation (please choose one):
☐ Clinic ☐ Government(non-clinical) ☐ Hospital ☐ Industry ☐ Non-governmental Organisation (NGO) ☐ Private practice
☐ Student ☐ University ☐ Other _____

Professional Activities (write "1" for primary and "2" for secondary):
☐ Administration ☐ Advocacy ☐ Patient care ☐ Programme Management ☐ Research ☐ Sales/Marketing ☐ Teaching /Education
☐ Other _____

Please indicate if you have passed a postgraduate diploma on the **clinical management of HIV** from one of the following institutions (**doctors only**):
☐ Colleges of Medicine of South Africa ☐ University of KwaZulu-Natal ☐ Other _____
Year Completed _____ Year Completed _____ Year Completed _____

CONTACT INFORMATION

Postal address: _____
_____ **Suburb/Town**: _____ **Postal Code**: _____
Province: _____ **Country**: _____
Telephone: _____ **Mobile**: _____
Fax: _____ **Email**: _____

DEMOGRAPHIC INFORMATION

Race/ethnicity: ☐ Black ☐ Colored ☐ Indian ☐ White ☐ Other _____
Gender: ☐ Female ☐ Male ☐ Intersex/Transgender **Date of birth**: ☐☐/☐☐/☐☐☐☐

MEMBERSHIP PREFERENCES

How would you prefer to receive your *Southern African Journal of HIV Medicine*?
☐ Post ☐ Electronic version - www.sajhivmed.org.za
Would you like to receive a posted copy of the Society's magazine for nurses, *HIV Nursing Matters*? (Copies are available for free on the Society's website: www.sahivsoc.org) ☐ Yes ☐ No
Would you like to participate in the Society's online membership directory? (Your contact information will be available only to other Society members through the members portal on the Society's website) ☐ Yes ☐ No
How would you like to receive communications from the Society (check all that apply): ☐ SMS ☐ Email

ENROLMENT IN PROVIDER DIRECTORY

If you are a practicing health professional who sees HIV patients in the private sector and would like to be listed in our provider directory, which is accessible to the public via our website, please indicate below and we will follow up with an enrolment form.
☐ Yes ☐ No Where should we send form (e.g. email/fax): _____

PAYMENT INFORMATION - Annual Membership Fees: R300

Renewal fees are valid for 12 months from receipt of payment. Payments may be made by cheque or electronic transfer payable to: Southern African HIV Clinicians Society, Nedbank Campus Square, Branch Code 158-105, Account No: 1581 048 033. Please reference your surname and/or membership number on the payment. Please fax or email proof of payment to 011 341 0161 or admin@sahivsoc.org, or post to: Suite 233, Post Net Killarney, Private Bag x2600, Houghton 2041.
Method of payment: ☐ Electronic transfer ☐ Direct deposit ☐ Post/Cheque ☐ Cash Payment date: ☐☐/☐☐/☐☐☐☐

HAVE QUESTIONS? Please contact us at: 011 341 0162 / admin@sahivsoc.org / www.sahivsoc.org

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 AIDS Helpline (0800-012-322) provides a confidential, anonymous 24-hour toll-free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

The helpline was initiated in 1991 and is a partnership of the Department of Health and LifeLine Southern Africa. The Helpline, manned by trained lay-counsellors, receives an average of 3,000 calls per day, and is seen as a leading telephone counselling service within the SADC region.

Services Offered by the AIDS Helpline:

- Information: The Line creates a free and easy access point for information on HIV and AIDS to any member of the public, in all of the 11 official languages, at any time of the day or night.
- Telephone Counselling: Trained lay-counsellors offer more than mere facts to the caller. They are able to provide counselling to those battling to cope with all the emotional consequences of the pandemic.
- Referral Services: Both the South African Government and its NGO sector have created a large network of service points to provide a large range of services (including Voluntary Counselling and Testing, medical and social services) to the public. The AIDS Helpline will assist the caller to contact and use these facilities.The National AIDS Helpline works closely with the Southern African HIV Clinician's Society to update and maintain the Karabo Referral Database. www.sahivsoc.org
- Treatment Line: A specialised service of the AIDS Helpline, the Treatment Line, is manned by Professional Nurses. They provide quality, accurate and anonymous telephone information and/or education on antiretroviral, TB and STI treatment. They also provide relevant specialised medical referrals to individuals affected and infected by HIV and AIDS in South Africa.

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 assit 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.

Hospice Palliative Care Association of SA

Short Course in Palliative Nursing for Professional and Enrolled Nurses run in conjunction with the Hospice Palliative Care Association of SA and the Foundation of Professional Development.

INTRODUCTION
The WHO defines palliative care as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psycho-social and spiritual."

Palliative care is an integral part of every nurse's role. This course equips the nurse with the particular skills and knowledge required to care for patients with non-curable and terminal illness and to support the patient's family members. This short course is run as a collaborative venture between HPCA and FPD.

WHO SHOULD ENROL?
All professional and enrolled nurses registered with the SANC who care for patients with life-threatening illness.

ASSESSMENT / CERTIFICATION
Formative and summative assessment methods are used to evaluate learning at both theoretical and practical levels. To qualify for the certificate of completion for this short course, participants should fully attend the workshops, successfully complete the assessment process and complete the clinical work.

COURSE DESIGN
The course consists of 3 parts:
1. Day release learning based on methods suitable for adult learners.

2. Assessment component (examination, communication skills and portfolio).

3. 128 hours clinical work – done in a HPCA approved Hospice.

COURSE STRUCTURE
1. Describe the development of palliative care and its role within the health care system and apply legal, ethical and professional principles in the care of patients and families, with particular reference to death and dying.

2. Describe the management principles of pain and symptom control in advanced illness with particular reference to malignant disease, HIV and AIDS, progressive neurological disorders and end stage organ disease.

3. Be competent in the interpersonal communication skills required to establish rapport and facilitate the grieving process with patients, families and colleagues.

4. Demonstrate the ability to understand the developmental stages as applied to social, cultural and spiritual dimensions in the provision of palliative care based on respect for the uniqueness of the individual.

Starting date:
February - 2012
Day Release: 9 February 2012
Distance Learning: 6 February 2012

REGISTRATION
Educational Grant
This course is partially sponsored through an educational grant from HPCA
All interested nurses can apply for this grant from:

LeshokoKomane
Tel: 012 664 8538
Fax to email: 086 513 9814
Email: lesoko@hpca.co.za

COURSE FEE
R 6 740

A member of the SAMA group

Registered with the Department of Education as a private Institution of Higher Education under the higher education act, 1997 (Registration number: 2002/HE07/013)

Foundation for Professional Development (Pty) Ltd Registration number 2000/002641/07

Joint conference of the Public Health Association of South Africa (PHASA) and the Rural Doctors Association of South Africa (RuDASA)

PRESIDENT HOTEL, BLOEMFONTEIN, SOUTH AFRICA
5 – 7 September 2012

"Bridging the Health Divide: from Policy to Practice"

The conference will be held as follows:

- 5 September 2012 Workshops
- 6-7 September 2012 Main Conference

ABSTRACT

PHASA and RUDASA are now calling for abstracts for the **2012 joint Conference.** Authors should submit abstracts online by no later than **28 May 2012.**

Please note, this year PHASA and RUDASA will offer a mentorship for new researchers and students that will assist them in developing their abstracts and powerpoints/ posters for the conference. If you are interested in being mentored by a seasoned researcher, please let us know and we will put you in touch with someone willing to support you. Please contact Deon Salomo by 5 April 2012 at Deon.Salomo@mrc.ac.za

The Conference tracks will be:

Track 1: Improving clinical practice and primary care
Track 2: Improving the performance of the health system
Track 3: Policy, Advocacy and Community action for public and rural health
Track 4: Burden of disease and disability, and the social determinants of health
Track 5: Public and Rural Health Leadership and Education

Special Conference Features

- Launch of Rural Rehab South Africa (RuReSA)
- Climate change focus
- Student Assembly

CONTACT DETAILS:

MRC EVENT MANAGEMENT OFFICE
TEL: +27 21 938 0237
E-MAIL: deon.salomo@mrc.ac.za

www.phasaconference.org.za

SA HIV Clinicians Society Conference 2012

International Convention Centre • Cape Town • South Africa

Striving for Clinical Excellence

25 – 28 November 2012

www.sahivsoc.org

For further information contact:

SAHIV Conference 2012 • Cape Town • South Africa

T: +27 (0) 11 447 3876 • F: +27 (0) 11 442 8094 • E: clauds.suemc@tiscali.co.za