

HIV Nursing matters

A publication of the Southern African HIV Clinicians Society



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New vaccine effective against Ebola

Migration, HIV & access to public health in Southern Africa

SAfAIDS Young Women Leadership Programme

September 2015 Volume 6 No. 3





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• T H E • M O N U M E N T • T R U S T •

Guest editorial



Glenn de Swardt

Senior Technical Advisor, Anova Health Institute, Johannesburg

Within the context of the HIV pandemic, several groups within society have emerged as being particularly vulnerable to HIV infection. "Key populations" (sometimes referred to as most-at-risk populations) have been identified as: gay men and other men who have sex with men (MSM), sex workers, people who inject drugs, transgender persons, and refugees and displaced people.^[1]

Members of key populations share two common realities: they are disproportionately infected by HIV compared to the general population, and they experience high levels of institutionalised prejudice and discrimination from society at large – and from the public health sector, in particular. Thus, key populations are often at the highest risk of HIV infection and have very low levels of health care access. They are generally ignored in mainstream HIV-related messaging and are often denied access to basic health services through harmful stereotypes and negative attitudes emanating from many health workers.^[2-5]

Discrimination against members of key populations by health workers has a

direct effect on the burden of HIV-related disease – both within the sometimes hidden epidemics affecting each key population and within the broader, general HIV epidemic affecting all of South Africa (SA). In this regard, sex workers have clients who engage sexually with others; people who use drugs have sex with non-users; and most MSM also have sex with women, in addition to having sex with men.

Importantly, health workers in SA are ethically obliged to render equally competent services to all members of society without prejudice or discrimination. Such obligations are enshrined in the National Health Plan for South Africa (1994), The Patients' Rights Charter, the White Paper on Transforming Public Service Delivery (Batho Pele White Paper, 1997) and the Policy on Quality Health Care for South Africa (2007). These documents are intended to ensure equal access to health services for everyone, with all patients being treated with consistent levels of respect and dignity. The South African National Strategic Plan on HIV, STIs and TB: 2012 - 2016 also specifies the need for health interventions targeted at key populations.^[6]

In this issue of *HIV Nursing Matters*, we are proud to present a series of writings on the novel ways in which the needs of specific key populations and vulnerable groups are being addressed by non-governmental organisations (NGOs) in SA. Two of the articles focus on MSM: developments regarding the incorporation of pre-exposure prophylaxis (PrEP) in combination prevention for MSM (p. 28); and insights into innovative MSM-focused services undertaken by the Health4Men Initiative (p. 30). An article on human rights challenges encountered at the Lindela Detention Centre highlights the reality of the institutionalised stereotypes experienced by refugees and displaced

people (p. 16). The final article highlights how SAfAIDS challenges traditional patriarchal values when working with young women. Although not regarded as a key population, in that they do not experience high levels of prejudice and discrimination, young women are a group that remain highly vulnerable to HIV.

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Message from the president



Dr Francesca Conradie

President, Southern African HIV Clinicians Society

Health care workers have responded effectively to HIV by, in the first instance, working hard to access treatment for people who are HIV-positive. They have gone on to identify people needing treatment, and to find novel ways to ensure access and care. However, often these patients were relatively easy to find. The challenge now is to find and deliver treatment and care to those who are harder to reach, due to stigma and related difficulties. These key population groups include: truck drivers, sex workers, men who have sex with men (MSM), drug users who inject drugs, young women and prison inmates. Truck drivers are on the move by the nature of their work. Sex work is stigmatised and is not legalised. The people involved in such work may not want to come forward for medical services. Men who have sex with men may fear a homophobic response at a health care facility. Inmates in the correctional system seem easy to reach until you understand that the primary concern of the correctional services is security. Young women may have had negative clinic experiences and often do not perceive themselves as belonging to an at-risk group. Health care needs to be delivered within these confines. As health care workers, we need to be careful not to convey any judgement and discrimination. We have managed challenges in HIV before and we need to do so again. So please read on and enjoy the second part of our focus on working with key populations.

To explore these and other clinical best practice issues, please join us from the 13th to the 16th of April 2016 in Johannesburg for our third biennial conference: *Our drugs, our patients, our issues*. We have an exciting group of speakers and sessions lined up. The draft programme can be accessed online: www.sahivsoc2016.co.za



Rural reflections: There is a problem

By **Guest Author** on July 27, 2015 in *HIV - Antiretrovirals (ARVs), Rural Health, Rural Reflections*

As public debate rages about whether or not there are antiretroviral (ARV) stockouts in the county, our rural doctor and blogger reminds us what three letters and ARV stockouts really mean

This week I met a 19-year-old boy in my outpatients cubicle ... He was tall and lanky, sporting skinny jeans, Converse All Stars and a flat cap – and his English was better than my isiZulu. He came into the doctor's room with a host of sexually transmitted infections and no HIV.

He was worried about his genital ulcers and his urethral discharge.

I was worried about the fact that his worry list didn't contain those three letters: H-I-V. He'd tested for HIV and

the results in front of me were negative – but so was the blatant evidence that he wasn't protecting himself from chlamydia and gonorrhoea: HIV's partners in crime.

This week I had three children between the ages of one and three years old who were recently diagnosed with HIV and started ARVs in the ward. One of them was too small to speak, she just looked at me with milky brown eyes as her gogo tried unsuccessfully to console her malnourished cry. Her mom

had passed away and they didn't know that the mother had HIV, her gogo explained. They also don't have a child support grant or an income.

When mothers are children and viruses are inheritances

Last week, a 13-year-old girl tested positive for HIV five days before delivering her baby. She lied to the nursing staff and said that she was 15. She was only started on ARVs as part of the prevention of mother-to-child

transmission programme a few days before delivery.

Starting late on ARVs meant that the amount of HIV in her blood was high through her pregnancy and delivery – increasing the risk that her unborn baby would contract the virus.

I met her when her newborn son was admitted to the neonatal nursery with neonatal sepsis, or an infection in the bloodstream. The baby was started on the ARVs nevirapine and zidovudine to prevent mother-to-child transmission of the virus while I tested him for HIV. These ARVs work to help protect him from any HIV to which he was exposed before or during birth, but also from any that may be in his mother's breastmilk.

I found out five days later when the blood results came back that the baby boy had contracted HIV before or during birth. This wriggling, pink, tiny human now had a chronic medical condition for which he'd have to receive lifelong medication.

So start the baby on ARVs ... and what? Send the teenager home to her parents who know nothing of her HIV status with three 500 ml bottles of ARVs to give to a baby twice a day? She would go back to school, and then who would bring the baby to all the follow-up visits and blood tests to check that the ARVs weren't damaging his liver or blood?

She said she didn't know that her 23-year-old boyfriend was HIV-positive. Then she said that he had told her that he was born with HIV, and she didn't know if he was taking medication. Then she said her stepfather would chase her away if he knew her status. Then she said her mother was an alcoholic.

“This wriggling, pink, tiny human now had a chronic medical condition for which he'd have to receive lifelong medication.”

Finally, we phoned her mother and the young new gogo came in to the hospital, two weeks after her daughter had given birth to this beautiful baby boy. She smelled of the local brew.

The gogo would help take care of the new baby. The only income in the house was this new mother's own child support grant that the gogo was receiving for her 13-year-old daughter, now mother of one.

Can you default when there are no drugs?

An 82-year-old woman was brought in by her family. She complained of two weeks of vomiting and diarrhoea. She was also coughing, and becoming confused. Her skin was dry and floppy, lacking subcutaneous tissue. Her eyes were sunken deep into their sockets and I got the feeling that she was tired of seeing her surroundings, or maybe seeing her surroundings when she was in the hospital ... again.

I asked a few questions from her family while feeling her weak pulse and inserting a drip into her dehydrated veins, taking some of the dark purple blood for baseline tests.

She'd been in and out of hospital many times in the last few years, I realised as I paged through her dog-eared patient-held clinic card that all our patients carry with them containing all their medical records. It said, “RVD+, known defaulter. Previous TB x3.”

It was clear that she had HIV, and had stopped and started her ARVs many times, putting her at risk of ARV resistance. She had also had tuberculosis (TB) three times before.

The family said that she didn't take her medication because she didn't like swallowing her pills ... they stuck to her throat, they made her feel nauseas – she'd been taking them for too long. I tried discreetly to take a couple of

steps back and reach for a TB mask to secure around my mouth and nose before listening to her chest rattle. I hoped strep pneumonia was the culprit and not TB once more, or worse, multidrug-resistant TB.

Earlier this year there was a shortage of abacavir, one of the second-line ARVs that we use to treat patients. Some unfortunate patients effectively defaulted on one of their three daily ARVs for no fault of their own.

The clinics ran out of abacavir and then the province ran out of abacavir. We waited for the new financial year, the new tender ... and bent the protocols and treatment guidelines until it happened – to make sure that patients are at least receiving something that will prevent drug resistance or treatment failure.

Abacavir returned, the crisis was over. Then there was no aluvia, another ARV also used as part of second-line HIV treatment. There is a supply problem; there is no time scale in terms of a solution, we are told.

“I am sorry to the pregnant woman who I saw today who is on abacavir and aluvia, with a virus unsuppressed in her blood and a growing foetus in her womb.”

I am sorry to the pregnant woman who I saw today who is on abacavir and aluvia, with a virus unsuppressed in her blood and a growing foetus in her womb.

I don't think it would be forgivable if our lack of medication were to result in her inability to access drugs to prevent her baby from being born with this preventable, incurable condition.

I write out another prescription, in the hope that this week things might change ... and I can't help but feel helpless.



Nurse combines passion for mums with business know-how

By **Itumeleng Tau** on August 19, 2015 in *OurHealth, Women's Health*

Nurse Precious Mashupi has gone from consulting at her local clinic to running her own business in a bid that she hopes will help increase access to women's health services in Klerksdorp

Precious Mashupi started her own women's health clinic in 2009. This year, she bought another practice and expanded her Klerksdorp clinic - one of only a few catering to women in the district, she says.

After graduating from Klerksdorp's Excelsius Nursing College, Mashupi worked for three years at the city's Orkney Clinic, before moving to an office close to the Klerksdorp Taxi Rank.

In 2009, Mashupi opened the Preshco Mother and Child Clinic. This year, Mashupi bought the Matlosana Women's Clinic and with the new addition, moved into a bigger office space. According to Mashupi, Preshco is now one of the few private practices catering to women in the Dr Kenneth Kaunda District.

Mashupi's inspiration to become her own boss, and help mothers and babies in the process, came from one influential report: the government's 2012 report on maternal mortality.

The product of maternal health audits initiated by former Health Minister Dr Manto Tshabalala, the report found that almost 5 000 mothers died between 2008 and 2010 - more deaths than in any previous years.

The deaths were attributed to causes including infections, HIV and tuberculosis, and hypertension.

Mashupi's clinic not only offers safe termination of pregnancies, but also contraception, Pap smears, ultrasounds, HIV counselling and testing, infertility counselling and vaccinations.

The clinic also offers services that are very rare in a small city like Klerksdorp, such as exercises for pregnant women, although deliveries are not done at the clinic.

Mashupi tells *OurHealth* she hopes her clinic will ease pressure on the public health sector.

During a 2014 protest against illegal abortions, North West MEC for Health, Magome Masike, said that illegal abortions were placing further strain on the public sector.

"The main problem faced by the department is that women using back-street abortion services often flock back to the public health facilities with serious complications and they die in our hands," he said.

Six steps to take if you have been raped

By **Emily Whiteside** and **Kathleen Dey** on August 27, 2015 in *Sexual violence, Violence, Women's Health*

As Women's Month winds to an end, Rape Crisis gives advice for rape survivors.

'Claire' (*identity withheld upon request*) joined a study group in her second year at university. One afternoon, a guy from the group offered to walk her home and she invited him in for a cup of coffee. As they chatted, he moved a little too close to her but she thought it would be rude to say anything. Then suddenly he took her coffee cup out of her hand and dragged her from her kitchen into the lounge, where he raped her on the floor. She struggled and shouted at him to stop but he ignored her. He later told her that she had invited him in, which meant she wanted sex and so what was she complaining about? After he left, Claire felt stunned, dazed and numb. She had no idea what to do next.

Like Claire, many rape survivors are too shocked to act in the moments immediately following a rape. But there are practical steps you can take immediately after someone rapes you to keep yourself safe and minimise both short- and long-term health risks, and to strengthen your chances of bringing the rapist to justice.

1. Get to a safe place

The first thing you should do if you are in any immediate danger is to get yourself to a safe place.

2. Tell someone what happened

Once you are out of danger, tell the first person you see what has happened or contact someone you know and trust, and tell them the whole story while it is fresh in your

mind. Although this can be difficult, it is very important because this person can help with the police investigation and later support your story in court. They are known as the first contact witness.

3. Preserve evidence of the rape

The one thing you may want to do is wash. If you do, you run the risk of washing away all physical evidence of the rape so do not bath, shower or wash your clothes. Doing this would get rid of blood, semen, saliva or hair that could be used as evidence of the rape. If you are injured, go straight to your nearest hospital, community health centre or doctor.

4. Decide whether you want to report the rape

You do not have to decide immediately whether to report the rape to the police, but the sooner a doctor examines you, the more likely they are to find physical evidence that they can link to the rapist. If you decide to report the rape to the police, then you should go to your nearest police station where the officers must take your statement. The police will take you to a health centre where you will receive medical attention and undergo a forensic examination. If you do not report the rape, you can go directly to a health centre to get these services.

5. Get medicine to prevent unwanted pregnancies, HIV and STIs

After the forensic examination, the doctor will give you the morning-after pill to prevent pregnancy and

antibiotics to prevent possible sexually transmitted infections (STIs)). You will also be given an HIV test, and if the result is negative, you will be given antiretroviral treatment for 28 days to prevent contracting HIV. This is called post-exposure prophylaxis (PEP).

6. Get support to help you recover

You can get the support you need further down the line by asking for pamphlets or booklets on rape, and the number of a local counselling service that can give you support and advice on the police report, an eventual court case, and your own physical and emotional wellbeing. If you do fall pregnant or contract an STI, then it is important to seek follow-up medical care and counselling.

Claire called the Rape Crisis helpline later the same afternoon that she was raped and got advice about what to do. As a consequence, she decided to report the rape to the police. A friend who knew what had happened went with her. You have the right to access all of these services that will protect you from the health risks associated with rape and to complain if the services do not meet your needs.

Rape Crisis offers free services including face-to-face counselling, a 24-hour helpline and support through court cases and the criminal justice system. You can visit their website or call their 24-hour crisis line on 021 447 9762.

This story was developed in partnership with Health-e News by Rape Crisis Cape Town Trust intern Emily Whiteside and director Kathleen Dey.

Teen's suicide highlights risk for LGBTI youth

By **Bontle Motsoeneng** on August 14, 2015 in *Children's Health, LGBTI, News, OurHealth, Sexuality*

While locals are still reeling about the suicide of 14-year-old Klara Göttert, who took her life at Northgate Mall this week, another mother in the Free State's rural town of Bethlehem is also mourning the death by suicide of her 18-year-old daughter

The Free State teen's family believes that their reaction to the girl's sexuality may have prompted the death of the teen, who the family asked not be identified.

Trouble at home started when the mother began suspecting that the young woman was smoking. "My son came to me and said not only was my daughter smoking at the tuck shop, but that she was a lesbian," said the mother who stays about 250 km east of Bloemfontein.

"I was so angry," the woman told *OurHealth*. "I waited for her and when she got in I couldn't hold myself back. I slapped her so hard and took a belt to her and beat her."

"That day I went straight to my bedroom and left her to cry by herself," she added. "I didn't go after her when she went to the outside back room."

A 2004 study conducted among 360 LGBTI youths found that about 20% had considered suicide. Globally, LGBTI youth are at a higher risk of suicide, homelessness.

"The next morning when I went to look for her, I found her," said the mother, who later found a heart-breaking letter her daughter had written to her.

"I was cleaning the back room and I found a letter between the sheets where she wrote, 'I just wanted you to accept me for who I want to be, mom. I am a lesbian,'" she explained. "That's when I knew why she took her life and it was too late for me to bring her back."

Her mother now lives with unshakable guilt over the loss of her only daughter. "If only we had been able to talk in a calm manner, but I reacted badly," she said. "I blame myself for my child's death."

LGBTI youth more likely to report contemplating suicide

In South Africa, about 8% of all deaths may be due to suicide and suicide deaths have more than doubled in the last 15 years, according to the South African Depression and Anxiety Group (SADAG).

Globally, research has shown that LGBTI youth may be at a higher risk for suicide. About 20 percent of the 360 LGBTI youth surveyed in a 2003 study

by the non-profit organisation OUT, reported having considered suicide.

Local psychologists have attributed this increased risk among LGBTI youth to feelings of rejection and isolation that may stem from stigma around same-sex sexuality.

SADAG project manager, Naazia Ismail, said it was vitally important for parents to keep communication open. "It is difficult for parents," she told *OurHealth*. "It is essential to try and keep open and clear communication and to try and have at least 30 minutes face-to-face with children. I suggest have at least one meal together daily so you can monitor changes. Often communication only happens when one is angry when in fact it should happen when both are comfortable," she added.

SADAG has urged parents teens and parents to reach out for help if they are having thoughts of suicide. The non-profit operates a specialised hotline for people thinking of suicide on 0800 567 567. People can also phone its 24-hour help line on 0800 12 13 14 or SMS 31393 to have a SADAG operator call you back.



**NATIONAL HEALTH
LABORATORY SERVICE**

RESULTS HOTLINE

0860

RESULT 737858

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

Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

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

Follow the voice prompts and select option 1 to register to use the hotline
A hotline registration form will be sent to you by fax or e-mail.

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

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

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

Select option 2 to access laboratory results.

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

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

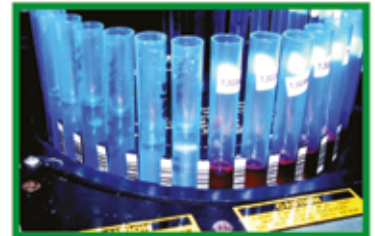
Once you have a Reference number

Select option 3 to follow up on a reference number

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

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

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



Migration, HIV and access to public health care in Southern Africa

Jo Vearey, PhD

Associate Professor, African Centre for Migration & Society (ACMS), University of the Witwatersrand

The SA government has a range of bilateral agreements with neighbouring countries that relate to the specific, arranged use of the SA public health care system for their citizens

KEY CONCEPTS

- Globally, people move within their countries of birth and across borders for a variety of reasons, the most common of which is the search for improved livelihood opportunities such as work and education.
- South Africa (SA) reflects global norms: cross-border migrants account for 3 - 4% of the SA population.
- Evidence does not support prevailing assumptions that cross-border migrants travel to SA in order to access public health care.
- All pregnant and breastfeeding women, and all children under 6 years of age, have the right to free services at all levels of health care regardless of nationality/documentation status
- Responses to migration and health should be mainstreamed into public health care programming and form an integral part of a health-for-all approach in SA.

Background

Globally, people move within their countries of birth and across borders for a variety of reasons, the most common of which is the search for improved livelihood opportunities such as work and education. An important, but much smaller number of people are forced to move in order to escape political persecution and civil unrest. It is estimated that 3 - 4% of the world's population lives and works in a different country to that of their place of birth - i.e. are cross-border migrants. It is important to acknowledge that approximately three times as many people have moved within the countries that they were born in, making internal migration the greater global development challenge for regional, national and local governance structures. Migration can - and should - be good for social and economic development, but in order for these benefits to be realised, this requires ensuring that those who move are able to maintain their health and wellbeing, an ideal of "healthy migration".^[1-3]

Drawing on data from the South African (SA) government census, and from independent research, the country has a population of non-nationals (cross-border

migrants) that reflects global norms, accounting for 3 - 4% of the total SA population. This includes migrants from other countries with visitor visas, work and study permits, permanent residence, asylum seeker and refugee permits, and those who are currently without the documents required to be in the country legally - undocumented migrants.

However, popular assumptions, including those made by the media, often grossly over-estimate the number of cross-border migrants in SA. In addition, those who move internally in SA are not considered migrants. This has far-reaching implications for how migration is perceived and responded to in SA, including when thinking about public health responses. It is also important to recognise that - as in other countries globally - the cross-border (and internal migrant) population is not evenly distributed across SA; higher densities of non-nationals (and SA migrants) are found in major urban centres, in border areas and in smaller, growing urban areas.

In SA, cross-border migrants are often - unfairly and without evidence - positioned as spreading communicable diseases and as placing a burden on the

SA public welfare system, including the public health care (PHC) system.^[3-5] It is of concern that policy and programmatic decisions relating to health and migration are often made in light of assumptions, rather than being based on evidence. The result is that some non-nationals struggle to access the PHC services to which they are legally entitled and may, from time to time, require while in SA.

All pregnant and breastfeeding women, and all children under 6 years of age, have the right to free services at all levels of health care, regardless of nationality and documentation status

The healthy migrant effect

Evidence suggests that there is, globally, a phenomenon known as the 'healthy migrant effect'.^[6] This effect shows that there is a positive selection of those who move: to migrate, you need to be healthy. The majority who move are not moving in search of health care and are likely to be healthier than the population into which they move. They may – once in a new country or place – need health care from time to time, including maternal and child health care.

However, despite available data that suggest otherwise, it is often assumed that people move to SA in order to access PHC services. This assumption can lead to a misunderstanding of the reasons why non-nationals may occasionally need to make use of the SA PHC system and, as a result, cross-border migrants are often unfairly blamed for placing a burden on an already struggling PHC system.





The SA government has a range of bilateral agreements with the governments of neighbouring countries that relate to specific, arranged use of the SA PHC system for their citizens. These are limited to times when countries do not have specialist facilities/services available, and a formal request for medical travel to SA will be made.

These arrangements involve granting a specific visa issued for medical travel to SA. The costs incurred by the SA PHC system in treating the patient are then repaid by the patient's country of origin.^[7]

The South African policy context

At a global level, the World Health Assembly (WHA) – of which SA is a member – passed a Resolution in 2008 that calls for improved health systems responses for migrants.^[8] In addition to a global consultation in which SA participated in 2010, two national consultations on the WHA Resolution have been held in the country (2010, 2013). Within the SADC, two key processes exist that relate to addressing migration and health. The first is the 2009 Framework on Population Mobility and Communicable Diseases that remains

in draft form.^[9] In 2015, the SADC Secretariat produced a framework for its implementation, including a much-needed costing model (unpublished). At the time of writing, member states are being asked to review and ratify the drafted framework and financing model. The second key process relates to the SADC Declaration on Tuberculosis in the Mining Sector that was ratified in 2012.^[10] This calls on member states to improve responses to TB (with a focus on multi- and extremely drug-resistant TB) within the mining industry, and holds mining companies accountable for associated health care costs.

At a national level, SA has a progressive policy framework that upholds the right to health care for all in SA, and different categories of non-nationals are afforded different rights to health care. Everyone in SA has the right to free emergency health care at the point of use – no fees can be charged before care is provided.

All pregnant and breastfeeding women, and all children under age 6 years, have the right to free services, at all levels of health care, regardless of nationality and documentation status. This includes all antenatal care, childbirth and vacci-

nation services. In SA, a means-tested co-payment system exists for all when accessing higher levels of care, i.e. hospitals; users are means-tested on the basis of income and are charged accordingly, with individuals receiving social welfare grants or those who have no income being exempt from paying. This means test should be applied to SA citizens, permanent and temporary residents, refugees and asylum seekers, as well as undocumented SADC nationals. Non-nationals in SA who hold visit or permits – e.g. tourists – should be charged full fees.

Additionally, the South African National Strategic Plan (NSP) for HIV, STIs and Tuberculosis recognises that there is a need to improve responses for migrants and mobile populations, refugees and asylum seekers. However, despite the advances made in upholding the rights of non-nationals to access PHC in SA, recent years have witnessed an increase in access challenges being reported.

These challenges relate to a range of concerns, including:

- A demand for the up-front payment of fees by non-nationals in need of maternal health care, including at time of delivery, with reports suggesting that the babies of non-national mothers are not released to the mother until full fees are paid.
- A demand for up-front payment of fees before emergency treatment will be provided.
- The misclassification of non-nationals when calculating co-payments, including documented refugees and asylum seekers being incorrectly categorised as full-fee-paying patients.

What is needed?

There is a need to think about what is needed at two levels: (i) nationally within SA and (ii) regionally within the SADC region. In SA, despite the protective

legislative framework that exists, evidence indicates that some non-nationals face challenges when accessing PHC services.^[3] It is essential to recognise that denying or delaying access to treatment or the services needed for non-nationals (including maternal health care) has an impact on the wider SA public.

There are two key considerations here. Firstly, a progressive and efficient public health response needs to consider the health of the whole population and recognise that delayed or interrupted access to treatment for communicable diseases – such as HIV or TB and to vaccinations for children – will negatively impact all who reside in SA, including citizens. Secondly, delaying access to health care can result in higher costs when treatment and care are eventually provided; e.g. when someone is so sick that they now require emergency health care treatment. Based on existing evidence, the following needs have been identified.^[3]

- Training on migration, mobility, health and development for all levels of staff in the Department of Health, including frontline staff, health care providers, facility managers, district and provincial health co-ordinators, and within the national department.
- Recognition of the importance of internal mobility within SA and other countries in the SADC region, and the development of migration-aware health systems.
- The development of a co-ordinated regional response to migration, mobility and health.
- Effective implementation of current protective and progressive legislation relating to the right to health for non-nationals in SA.
- Correct classification of non-nationals when being means-tested for co-payment for health care.
- Implementation of national monitoring of the correct implementation of exist-

ing legislation within health facilities.

- Health passports or regionally recognised 'road-to-health' cards for all (a form of patient-held records).
- Referral letters for internal AND cross-border migrants.
- The establishment of local migrant health forums.

Generating evidence to inform (improved) responses

Various research projects are currently underway at the African Centre for Migration and Society (ACMS) that involve a range of partnerships with other academic institutions, civil society and government actors, and – importantly – students from Wits University and beyond. It is anticipated that this research will contribute to the body of evidence needed to inform effective policy and programmatic responses to migration and health in SA and the SADC region.

This research includes (but is not limited to): investigation into policy processes associated with migration and health planning at regional, national and local levels; examination of access to maternal and child health care services for non-nationals, including vaccination programmes; exploration of HIV-related stigma among Mozambican migrants in Johannesburg; and an assessment of the ways in which migration – both from within the country and across borders – is impacting the SA PHC system.

Conclusion

Migration and health are both important social concerns that remain associated with a range of public and political misunderstandings that negatively – and unfairly – associate the movement of people with (i) poor health and the spread of disease, and (ii) placing a burden upon the PHC system. It is imperative that responses to migration and health are mainstreamed into PHC programming

and form an integral part of a health-for-all approach in SA. This would better allow for the ideal of 'healthy migration' to be realised for all who move within and into SA – citizens and non-nationals alike.

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Understanding immigration detention and deportation in South Africa:

A summary of law, practice and human rights violations at the Lindela Detention Centre

Roni Amit

African Centre for Migration & Society

With respect to healthcare specifically, the National Strategic Plan on HIV, STIs and TB, 2012 - 2016 (NSP) sets out the country's comprehensive strategy in relation to HIV and TB

This ACMS issue brief explores the state of immigration detention in South Africa. It lays out the legal framework for detention and the procedures for detaining someone at the Lindela Detention Centre, where individuals arrested as illegal foreigners are detained pending deportation.

It also highlights the key detention-related human rights violations identified in previous research.

What is Lindela?

Lindela is a detention facility that holds individuals arrested as illegal foreigners while they await deportation. It was established by the Department of Home Affairs (DHA) under Section 34 of the Immigration Act (No. 13, 2002). Section 34 authorises the Department to detain illegal foreigners "in a manner and at a place determined by the Director-General" provided that a range of procedural guarantees are followed. Lindela is the only designated facility for the detention of illegal foreigners in South Africa (SA).

The facility is located about 40 km outside of Johannesburg, and can hold up to 4 000 detainees. There are male and female sections. Minors are not detained at Lindela. The DHA

has contracted daily operations at the facility to Bosasa, a private company.

What procedures must be followed at Lindela?

Detentions at Lindela are administrative in nature, which means that individuals are not entitled to a trial. There are, however, certain administrative procedures that must be followed in order for the detentions to be legal. Detainees are also protected by the Constitution. We detail these procedures and legal protections below.

Just administrative action

Both police officers and immigration officers are empowered to arrest individuals suspected of being illegal foreigners. Before an individual can

be sent to Lindela, however, an immigration officer must confirm within 48 hours that the individual is an illegal foreigner, or release them. Police and immigration officers must take all reasonable steps to help an individual confirm his/her immigration status (Section 41), including accessing nearby documents and departmental records (Regulation 34). After 48 hours, any detention may only be for the purpose of deportation. If the DHA is unable to confirm that an individual is legally residing in the country, s/he will be deemed an illegal foreigner. In practice, the burden is generally on the individual to provide adequate documentation showing legal status.

Section 41 of the Immigration Act sets out several conditions for being detained as an illegal foreigner at a designated facility such as Lindela. These conditions include that the individual:

- a. must be notified in writing of the deportation decision and of the right to appeal this decision.
- b. may request at any time that the detention for purposes of deportation be confirmed by a court. If a court does not issue a warrant confirming the detention within 48 hours of the request, the individual must be released immediately.
- c. shall be informed of the above rights and in a language that s/he understands where practicable and possible.

Before an individual can be sent to Lindela, an immigration officer must confirm within 48 hours that the individual is an illegal foreigner, or release them.

An individual must be notified of his/her rights of review and appeal, may request at any time that a court review the detention, and cannot be held for more than 120 days.

- d. may not be held for more than 30 days without a warrant of the court extending the detention for a maximum of 90 days.
- e. shall be held in detention in accordance with the minimum prescribed standards protecting individual dignity and human rights.

In short, an individual must be notified of his/her rights of review and appeal, may request at any time that a court review the detention, and cannot be held for more than 120 days.

Health care and other basic rights

At a general level, the Constitution upholds the inherent right to human dignity for all individuals (Section 10), as well as the right to access to health care and sufficient food and water (Section 27). These protections apply to all individuals, including those in detention. The Constitution also guarantees rights specific to detention, including the right “to conditions of detention consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment” (Section 35). Both the Constitution and the National Health Act (No. 61, 2003) ensure that everyone has access to emergency health care, regardless of nationality.

The Immigration Act requires that an individual be detained “in compliance with minimum prescribed standards protecting his/her dignity and relevant human rights” (Section 34). Annexure B of the Regulations to the Immigration Act sets out the Minimum Standards of Detention. These include:

- Every detainee:
 - o shall have access to basic health facilities (Section 1(a)).
 - o shall be provided with a bed, mattress, and at least one blanket (Section 1(b)).

- o shall be provided with an adequate and balanced diet (Section 2(a)).

- The diet shall make special provisions for detainees who require a special diet because of their physical condition (Section 2(b)).
- Food should be served at intervals not less than four and a half hours apart and not more than 14 hours should elapse between the evening meal and breakfast during a 24-hour period (Section 2(d)).
- The Department shall provide the means for every detainee to keep his/her person, clothing, bedding and room clean and tidy (Section 3).

With respect to health care specifically, the National Strategic Plan on HIV, STIs and TB, 2012 - 2016 (NSP) sets out the country’s comprehensive strategy in relation to HIV and TB. It identifies migrant populations as a “key [target] population for the HIV and TB response” urgently in need of a “comprehensive package of services.” With respect to detention, the NSP states that detention facilities must target specific efforts to screen, diagnose and provide treatment services to detainees (Intervention 3.1.2). Screening and treatment measures that target TB and HIV are particularly important, given the close quarters of detention.

The Constitution upholds the inherent right to human dignity for all individuals, as well as the right to access to health care and sufficient food and water. The Constitution also guarantees rights specific to detention, including the right “to conditions of detention that are consistent with human dignity, including exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment”. Both the Constitution and the National Health Act ensure that everyone has access to emergency health care, regardless of nationality.

Who can be detained at Lindela?

The DHA is authorised to detain individuals at Lindela for the purposes of deportation only. This means that only individuals who have been confirmed to be illegal foreigners can be detained at Lindela. Individuals with valid immigration documentation may not be detained there, even if they were not carrying these documents at the time of arrest. Individuals whose immigration status has not been verified by the DHA cannot be sent to Lindela, as no verification of status takes place at the facility.

Asylum seekers – both documented and those individuals who have stated an intention to apply – may also not be detained there if a final decision has not been made on their asylum claim. An individual may apply for asylum from detention. Various court rulings have determined that if an individual has applied for asylum while at Lindela, the individual is no longer an illegal foreigner and must be released from detention.

The deportation of asylum seekers violates the international principle of non-refoulement, which prohibits sending an individual back to a country where s/he may face harm. South Africa's Refugees Act (No. 130, 1998) has incorporated this principle. Accordingly, refugees may not be detained at Lindela unless there has been a determination that they are no

Individuals with valid immigration documentation may not be detained at Lindela, even if they were not carrying these documents at the time of arrest. Individuals whose immigration status has not been verified by the Department of Home Affairs cannot be sent to Lindela, as no verification of status takes place at the facility.

longer in need of protection and their refugee status has been withdrawn.

Who has oversight over Lindela?

Lindela is under the authority of the DHA. The DHA has contracted daily operations of the facility to a private company: Bosasa Operations (Pty) Ltd. Bosasa is responsible for the provision of food, accommodation, and security at the facility. However, the DHA is ultimately responsible for conditions and procedures at Lindela.

The Department of Health (DoH) is responsible for ensuring that the legislated requirements relating to the provision of health care within detention facilities are upheld.

To date, monitoring and oversight of Lindela has been severely constrained. The South African Human Rights Commission (SAHRC) is the only institution that has unfettered access to Lindela. The Constitution empowers the Commission: "to investigate and report on the observance of human rights" (Section 184(2) (a)). The Commission's statute also gives it monitoring and investigatory powers. Following a 1999 legal challenge around unlawful detentions, the DHA agreed to provide the Commission with access to Lindela and to produce regular detainee lists for monitoring purposes. The Commission has not conducted regular visits to Lindela since this agreement. The Commission delegated its authority over monitoring of the detainee lists to Lawyers for Human Rights (LHR). The DHA stopped providing these lists to LHR in April 2009.

Civil society and research organisations have had limited access to Lindela. The DHA has denied formal requests for access from both groups. As a result, there is no monitoring of conditions at Lindela. Outside of individual detention cases, there is also no information

Asylum seekers may not be detained at Lindela if a final decision has not been made on their asylum claim. An individual may apply for asylum from detention, and if they have done so, the individual is no longer an illegal foreigner and must be released from detention.

Because of the international non-refoulement principle, which South Africa has incorporated into the Refugees Act, refugees and asylum seekers may not be deported; hence, they may not be detained at Lindela.

To date, monitoring and oversight of Lindela has been severely constrained. The South African Human Rights Commission is the only institution that has unfettered access to Lindela.

regarding who is being detained or for how long.

Embassy representatives consult with their nationals in special embassy consulting rooms. Lawyers have limited access to consult with their clients, but these visits must often be cleared two days in advance. Lawyers do not have access to the inside of the facility and must consult in an area that does not accord privacy and where they are separated from their clients by a glass partition.

What are the issues of concern at Lindela?

Despite the restraints on regular oversight and monitoring, a series of reports, investigatory visits, and legal challenges have identified a range of concerns around legal procedures and health care at Lindela.

These reports and legal cases have tracked a pattern of violations of legal rights and standards of care. The main

areas of concern identified from these sources are summarised below.

Violations of administrative justice

- **Failure to verify immigration status**

Individuals are often sent to Lindela before their immigration status has been verified. The result is that individuals with documentation, including asylum seekers and refugees, are detained for purposes of deportation at Lindela. In his response to the SAHRC's investigation (2014), the manager of Lindela, Job Jackson, acknowledged that individuals are sometimes admitted to Lindela without their immigration status being checked (para. 7.4.8.1). This practice contravenes the law.

- **Detention of asylum seekers and refugees**

The SAHRC survey encountered 16 asylum seekers (out of 109 respondents) in detention. An ACMS survey in 2009 encountered 257 asylum seekers and refugees (out of 734 respondents) in detention. A number of legal cases have also challenged the detention of individual asylum seekers and refugees. These detentions violate the international and domestic legal principle of non-refoulement, as well as the legal procedures around the detention of asylum seekers and refugees found in the Refugees Act. The Department has maintained that it is entitled to detain asylum seekers until a final decision has been made on their asylum claim, a practice that contravenes the Refugees Act and has been ruled unlawful by the courts. Moreover, there is no mechanism within Lindela to prevent the deportation of these individuals while they await a final decision.

- **Failure to notify individuals of their rights**

A large number of detainees at Lindela report not receiving the required notifications advising them of their legal rights upon being detained, being classified as illegal foreigners, and being slated for deportation. Many are unaware of their rights of review and appeal/are unable to exercise these rights.

- **Extra-legal detentions**

Immigration officials have routinely failed to obtain required warrants

to extend detentions beyond a 30-day period. This renders these detentions extra-legal in nature, as they have no basis in law.

- **Excessive and indefinite detentions**

The DHA often detains individuals beyond the maximum 120 days allowed by law. It has defended this as being necessary, despite multiple legal pronouncements declaring the practice unlawful.

Reports published about Lindela:

- South African Human Rights Commission: Lindela at the Crossroads for Detention and Repatriation (2000)
- Lawyers for Human Rights: Monitoring Immigration Detention in South Africa (2008)
- Forced Migration Studies Programme (now ACMS): Lost in the Vortex: Irregularities in the Detention and Deportation of Non-Nationals in South Africa (2010)
- Lawyers for Human Rights: Monitoring Immigration Detention in South Africa (2010)
- ACMS: Deportation and Public Health - Concerns around the ending of the Zimbabwean Documentation Process, Issue Brief (2011)
- Lawyers for Human Rights: Monitoring Immigration Detention in South Africa (2012)
- ACMS: Breaking the Law, Breaking the Bank: the Cost of Home Affairs' Illegal Detention Practices (2012)
- Solidarity Peace Trust: Perils and Pitfalls: Migrants and Deportation in South Africa (2012)
- Justice Edwin Cameron: Visit to Lindela Repatriation Centre, Krugersdorp (2012)
- South African Human Rights Commission: Investigative Report on Access to Health at Lindela (2014)

There have been numerous judicial decisions finding individual detentions and broader detention practices unlawful. A selection of these cases is listed below:

- Arse v Minister of Home Affairs and Others, SCA (12 March 2010)
- Abdi and Another v Minister of Home Affairs and Others, SCA (15 February 2011)
- Bula and Others v Minister of Home Affairs and Others, SCA (29 November 2011)
- Ersumo v Minister of Home Affairs and Others, SCA (28 March 2012)
- South African Human Rights Commission and Others v Pandor and Others, South Gauteng High Court (28 August 2014)

Violations of conditions of detention

• Excessive periods between meals

Lindela serves a morning and an afternoon meal; there is no evening meal. This violates the minimum required standards of detention, laid out in the regulations, that there be no more than 14 hours between the evening meal and breakfast.

• Personal hygiene

Individuals are provided with some basic items for personal hygiene, but they must purchase some items, or purchase additional supplies of items that run out. Many arrive at Lindela with only the clothes they were wearing at the time of arrest and are not provided with a change of clothes.

• Health care

This is problematic at Lindela, and it is unclear who is currently in charge of health care at the facility – Bosasa, DHA, or the DoH. The SAHRC report identified a range of problems:

- o Detainees have no access to psychological services.
- o Lindela does not provide extensive counselling and testing services for HIV.
- o The clinic isolation unit lacks ventilation and natural light.
- o There is no tetanus vaccine in the clinic fridge.

- o There are not sufficient measures to ensure continuity of treatment for detainees on chronic medication, particularly treatment for TB and HIV.
- o Detainees do not receive any buffer stock of medication upon deportation.

What rights violations have been identified?

Both the courts and the Human Rights Commission have identified a range of violations of South Africa's Bill of Rights based on the above practices. The constitutional rights that are being violated at Lindela include the following:

- the right to human dignity (Section 10)
- the right to freedom and security of the person (Section 12)
- the right to health care (Section 27)
- the right to access to information (Section 32)
- the right to just administrative access (Section 33)
- the rights of arrested, detained, and accused persons (Section 35).

African Centre for Migration & Society (ACMS)

The ACMS is an independent, interdisciplinary and internationally engaged Africa-based centre of excellence for research and teaching

that shapes global discourse on human mobility, development and social transformation. The ACMS is one of the continent's leading institutions for research, teaching and outreach on migration.

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- South African Human Rights Commission Act, Act No. 40 of 2013.

STOP STOCKOUTS

What is the Stop Stock Outs Project?

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

How do you report a stock out to the SSP?



**Our hotline number is
084 855 7867**

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

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



**You can also email us at
report@stockouts.co.za**



What information do you need to report to the SSP?



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



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

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





New vaccine is effective against Ebola in a large trial in Guinea

Article from **Doctors Without Borders (Médecins Sans Frontières) Southern Africa**

Despite the ongoing prevalence of Ebola in West Africa, July brought fresh hope of ending the epidemic: a preliminary review in Guinea, one of the three West African countries stricken by Ebola, has found an Ebola trial vaccine to be 100% effective. We spoke to Doctors Without Borders (MSF) Southern Africa about the organisation's involvement in the vaccination trials.

Although MSF began responding to the largest Ebola outbreak in history in March 2014 and progress has been made in the fight against the virus, Ebola stubbornly lives on in Guinea, Sierra Leone and Liberia with more than 27 678 people infected and 11 276 lives lost.

In May 2015, Liberia was declared Ebola-free after 42 days with no new recorded cases of the disease. But in July, new cases emerged in the country. With cases of Ebola also recorded in neighbouring Guinea and Sierra Leone, MSF teams are still fighting the disease. In July 2015, the number

of cases in Guinea, Sierra Leone and Liberia stagnated at around 30 new infections per week, a number that would be considered a disaster in normal circumstances.

In Sierra Leone, the number of Ebola cases continues to fluctuate as hotspots

persist in Western Area (Freetown), Port Loko and Kambia districts. In Guinea, active chains of transmission persist in Conakry, Boké and Forecariah.

In Liberia, MSF is not directly involved in the patient care or investigation of the new cases, but remains ready to support the Ministry of Health should they require it. For now, MSF is running a 69-bed paediatric hospital in Monrovia to help restore the secondary health system, which like those in Guinea and Sierra Leone has been paralysed following the deaths of hundreds of health workers. In the grounds of the hospital, MSF also runs a clinic specifically for Ebola survivors who suffer from a number of health complications following their recovery from the virus.

Results of tests of the new VSV-ZEBOV vaccine to protect against Ebola indicate a high level of efficacy in a trial involving more than 4 000 people in close contact with the deadly virus. British medical journal *The Lancet* published the results of the trials on 31 July.

In March 2015 the clinical trial started in Guinea to test the safety, efficacy and capacity of the substance to provoke an immune response of the vaccine. The trials were run by the World Health Organization (WHO) in collaboration with MSF and a broad consortium of organisations and countries, including Norway, Canada, Guinea, MSF, the Universities of Florida, Maryland and Bern, and the London School of Hygiene and Tropical Medicine.

The trial focused on vaccinating 'rings' of people around infected patients – who are most at risk – as well as frontline workers at risk of contracting the disease. In the ring vaccination, the direct contacts in a 'ring' around an Ebola patient are vaccinated to stop the virus from spreading further. MSF was heavily involved in the trial and administered the vaccine to 1 200



frontline workers in Guinea including doctors, nurses, paramedics, laboratory staff, cleaning staff, and burial teams. The volunteers who received the vaccine came from areas in Guinea that had Ebola outbreaks. These volunteers were directly in contact with those who had contracted the virus or were contacts-of-contacts, such as neighbours, classmates or extended family. In some cases, the clusters were whole villages. In others, the clusters were smaller sections of towns and cities. The trial monitored immune response and side-effects.

According to WHO, the vaccine combines a gene encoding a key pro-

tein of the Zaire strain of the Ebola virus, which ravaged West Africa, and VSV, another unrelated virus. The combination of these components results in a weakened vaccine virus that cannot cause disease, but that does stimulate the body to generate an immune response. In this way, the vaccine triggers the production of antibodies to fight off the disease, without having the disease present.

Using the ring approach, vaccinators and the trial team were able to move with trials when the Ebola epidemic in Guinea had dispersed into smaller local outbreaks. This allowed the trial to continue and at the same time



seamlessly contribute to the control of the Ebola outbreak.

MSF Medical Director Dr Bertrand Draguez, who has been spearheading the MSF platform on experimental tools for Ebola, said the results are encouraging. "More data are needed to tell us how efficacious this preventive tool actually is, but this is a unique breakthrough. The mere possibility of finally possessing a tool to put an end to this epidemic is very exciting," said Draguez.

MSF is now calling for the vaccine to be expanded for use in Liberia and Sierra Leone. MSF urges the manufacturer (Merck) and financing mechanisms to ensure the availability of enough doses as soon as possible.

While the epidemic persists, a vaccine could help end it. At the moment, according to MSF, the epidemic is quite localised in a few hotspots

across the affected region. It would be more effective to focus energy and resources on vaccinating people most at risk of contracting the disease. All the components of the fight against the disease need to be continued. "This includes Ebola case management, isolation, community outreach, safe burials, health promotion, psychosocial support and contact tracing," said Draguez. "Now that we know that the vaccine works, people who need it most should imperatively get it as soon as possible to break the existing chains of transmission," he said.

"Adding a preventive tool in the mix will accelerate the break-up of transmission chains by targeting people who have been in contact with infected patients as well as frontline workers," said Draguez.

MSF is urging governments in affected countries to start using this vaccine as soon as they can within the framework of the existing trial. MSF International

President Dr Joanne Liu declared in July, "going from hundreds of cases to 30 per week took considerable time and massive resources, yet getting from 30 to 0 requires the most meticulous, difficult work of all." Liu also stated that no one was prepared for the scale of this epidemic, the largest in human history, nor that it would last so long. "But we cannot lose focus now and must push on until the entire region is declared Ebola free," said Liu.

Liu emphasised the need to remain vigilant in the fight against Ebola. "We have seen so many reports calling for change, with everyone focused on how to improve future responses to outbreaks and meanwhile, with new Ebola cases each week in the region, we still don't have the current epidemic under control. On Ebola, we went from global indifference, to global fear, to global response and now to global fatigue. We must finish the job."

Sexual and reproductive health for adolescent girls: SAfAIDS Young Women Leadership (YWL) Programme

Looking to the future: Unleashing the power of young women leaders to amplify the voices of young people on sexual and reproductive health and gender equality at continental level

Virginia Maserame Mojapele, BNSC (Hons), MCur
SAfAIDS

Unleashing the power of young women leaders is important in amplifying the voices of young people to champion issues of sexual and reproductive health and gender equality at continental level. It is hoped that this will give them personal skills to make choices and decisions that positively impact at an individual and community level.

Background

Sexual and reproductive health and rights (SRHR) are usually understood as the rights of all people, regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition that these decisions do not infringe on the rights of others. This includes the right to access education and information, services and health care on SRHR.

Through the ratification of various prolific international, regional and national instruments, sexual reproductive health is understood to be of vital importance to the overall well-being of all individuals.^[1]

Adolescence is a decisive age for girls around the world. What transpires during a girl's teenage years shapes the direction of her life and that of her family. For many girls in developing countries, the mere onset of puberty that occurs during adolescence marks a time of heightened vulnerability - to leaving school, child marriage, early pregnancy, HIV, sexual exploitation, coercion and violence. Adolescent girls are less likely than older women to access sexual and reproductive health care, including modern contraception and skilled assistance during pregnancy and childbirth.^[2] Many girls who become pregnant drop out of school, drastically limiting health and the health of their children. Thus, adolescent pregnancy fuels the intergenerational cycle of poverty and poor health. It is

estimated that girls under the age of 15 are at greater risk of dying in childbirth than women in their 20s.^[3]

Educated young women offer a powerful boost to their families' well-being, contributing to increased household income and savings, better family health and improved opportunities for future generations. Taken together, their actions can help lift communities and countries out of poverty. The delaying of marriage until later in life increases the space between generations, lowering the desired family size as more educationally accomplished girls are less reliant on multiple children for security, and decreases the power differential between partners, thus positively affecting a woman's ability to meet her fertility goals.^[4]

Young people have the right to decide whether or not, and when, to have children

SAfAIDS experience

As a way of addressing these gaps, SAfAIDS designed a young women leadership-training programme with a three-tier approach to enhancing the leadership capacity of young women. Launched in 2011, the SAfAIDS Young Women Leadership (YWL) Programme focused on building the leadership skills and capacity of young women aged 18 - 24 years from Botswana, Namibia and Zimbabwe, to become leaders and champions in SRHR, HIV and gender-based violence (GBV) prevention, gender equality and sexual rights in Africa.

The programme seeks to mobilise young women; empower them to serve as advocates; provide them with information and skills to develop their leadership capacity and to implement gender equality programmes; and provides a platform to raise awareness of SRHR and HIV issues and speak on behalf of young women and girls at country, regional and continental level.

The aim is to:

- inspire change in the lives of young women and girls
- empower them to take charge of their sexual and reproductive health
- reduce the risk and vulnerability related to HIV and GBV.

The selected candidates underwent training based on three modules: (i) theoretical skills, (ii) competencies in SRHR and (iii) leadership development. Modules 1 and 2 focused on enhancing the theoretical skills and competencies of the candidates; providing them with a platform to



YWL graduates (Photo courtesy of SAfAIDS).

explore and assess their individual personalities in order to identify their strengths and areas for improvement through comprehensive guidance. In module 3, the candidates underwent a 10-month rotational placement: they were placed at a recognisable SRHR, gender and women's organisation to put their gained knowledge and skills (from the training in modules 1 and 2) into practice.

The programme has a strong mentoring approach: each day the young women were attached to elder and prominent women who inspired them and linked them to educational and economic opportunities.

The YWL candidates were able to unpack their innate capacities and build their vision, gaining technical skills such as negotiation, interrogating policy, advocacy and organisational management. To date, the nine young women are employed by different organisations at African Union and local level. SAfAIDS expanded this programme to other southern Africa countries to reach out to more young women.

Lessons learned

Unleashing the power of young women leaders is important in amplifying the voices of young people to champion issues of sexual and reproductive health and gender equality at continental level. It is hoped that this will give them personal skills to make choices and decisions that positively impact at an individual and community level. It is also important to give young women an opportunity to design and implement personal projects that relate to SRHR in their communities, so that they create change at a community level.

Recommendation for clinical service providers

Young people are diverse; programme approaches are multifaceted and should therefore be tailored for young people's individual characteristics and contextual factors (age, sex, sexual activity, sexual orientation, gender identity, marital status, school enrolment, residence, employment status, and family bonds).

Young people face unique challenges and have distinct needs compared with

adults; these should be recognised and programme approaches should be prioritised to accommodate age-related needs, challenges and access barriers.

Young people have the right to decide whether or not, and when, to have children. Information and education materials can assist young people in understanding their readiness to have children. As example, the diagram below (derived from the *SAFAIDS toolkit on Integrating SRHR into HIV Programming*) probes information on the use and type of contraception, and whether the partner was involved in decision-making. Such resources should be implemented more widely and young people should be encouraged to access and make full use of them.



“Your right to decide whether or not, and when to have children”

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Preparing for PrEP: From theory to practice in key populations

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The WHO estimates that the use of pre-exposure prophylaxis (PrEP) could prevent 1 million new HIV infections in MSM over the next 10 years

With 7 400 new HIV infections daily, South Africa (SA) is in need of sound strategies for HIV prevention. This is particularly true among vulnerable and key populations, which are those groups of people in SA who are the most likely to be exposed to, or transmit HIV.^[1-3] These key populations include men who have sex with men (MSM), people who inject drugs, commercial sex workers and transgender persons, as well as vulnerable populations such as prisoners, migrants and young women aged between 15 and 24 years old, among others.^[4]

A look at MSM in particular

Local research conducted by the Anova Health Institute in Johannesburg and Cape Town has confirmed that MSM are at a very high risk of HIV transmission and acquisition.^[3,5] In fact, during their research, more than one in three MSM tested HIV-positive.^[3] In virtually every country that reports reliable surveillance data, it is shown that MSM have a disproportionately higher HIV prevalence.^[6] In the Marang study,

the largest MSM surveillance study to have been conducted in SA, MSM were found to have sub-optimal HIV knowledge and to engage in ongoing risky behaviours such as alcohol abuse and low condom use. They also report experiencing stigma from some health care providers.^[7]

PrEP for MSM – what does the research say?

The WHO estimates that the use of pre-exposure prophylaxis (PrEP) could prevent 1 million new infections in MSM over the next ten years.^[4] Currently, PrEP consists of a combination regimen of antiretroviral (ARV) medication (tenofovir and emtricitabine) taken as an oral pill. When used daily on a long-term basis, such as in the iPrEX study, it decreased the HIV transmission rates by 44% in MSM.^[8] Although this does not look like a good protective result, it represents an average protection level for men in the study, independent of whether they took medication or not. If only men who actually adhered to the study guidelines and took PrEP correctly

were considered, the protection rate was approximately 90%.^[8] Additionally, in the PROUD study in the UK, PrEP was so effective at preventing HIV in MSM that the study was stopped early; the intervention provided an 86% reduction in the risk of acquiring HIV.^[9] PrEP was well tolerated, with nausea and other gastrointestinal symptoms being the most common minor adverse effects that occurred in a minority of subjects, and these were self-limiting.^[9] When adherence was measured by looking at the levels of ARVs in the blood of study participants, it was shown that when adherence was high, HIV protection was consistent and high.^[9] Another French study, known as the Ipergay study, examined the use of sex-based dosing of PrEP in MSM, as opposed to daily dosing. This is known as intermittent, coitally based PrEP. The study yielded similar results to the PROUD study and showed an 86% reduction in the risk of contracting HIV.^[10]

An interesting point is that in the studies, unprotected sex and STIs were less common over time – suggesting that

ongoing risk-reduction counselling along with PrEP was decreasing the amount of risky behaviour in which the MSM were engaging.^[8-10] This is important as it answers a concern that many people have about MSM increasing their sexual risk-taking because they feel they are protected by PrEP.

The conclusion drawn from these and numerous other trials is that PrEP can be delivered safely as part of an effective HIV-reduction package. PrEP trial subgroup analyses have also shown that PrEP is effective for those at greatest risk of contracting HIV.^[8,11]

Prescribing PrEP

Guidelines for the safe use of PrEP in MSM have been published by the Southern African HIV Clinicians Society and should be used when prescribing PrEP in SA.^[12] Candidates for PrEP are those at high risk of contracting HIV. The candidate should be HIV-negative, have adequate renal function and should be tested for hepatitis B virus (HBV), although recent data have shown that PrEP use could be safe for people infected with HBV.^[13] PrEP is prescribed for daily use, with regular HIV tests conducted every three months. Risk-reduction counselling is essential as is creating and supporting an adherence plan. PrEP is not meant to be lifelong and should only be taken during periods of highest risk, i.e. periods when the likelihood of HIV exposure is highest. For example, if an HIV-negative MSM has a longstanding sexual relationship with an HIV-positive person, he may choose to take PrEP

while that sexual relationship endures, but may choose to stop PrEP if the relationship ends and he is no longer being exposed to the virus.

Implementing PrEP in SA

There are logistical challenges in implementing PrEP in the public sector, such as cost, creating demand (MSM must know about the option to take PrEP and be willing to do so), how to minimise the number of health care visits needed and adherence support. Additionally, health care workers need to be trained on administering PrEP, and how to monitor for possible side-effects and poor adherence.

Ultimately, PrEP has a significant role to play as one of the range of HIV-prevention options MSM and other high-risk groups can use to prevent becoming infected with HIV. This has been reinforced by a recent announcement by WHO that PrEP will be included in their revised recommended HIV guidelines due for publication in December 2015. It is now important that PrEP demonstration projects in key populations such as MSM are conducted in SA as this will pave the way for scaling up this intervention for MSM, but also for all South Africans who may benefit from it.

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Currently, PrEP consists of a combination regimen of antiretroviral medication (tenofovir and emtricitabine) taken as an oral pill

The Health4Men Initiative: HIV and sexually transmitted infections

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Many of the MSM who attend Health4Men clinics also have sex with women and do not identify as gay

Background

Men who have sex with men (MSM) are at increased risk of HIV infection compared with their heterosexual peers.^[1-4] (See textbox for an explanation of the term 'MSM'.) MSM are often reluctant to seek health care because of real or perceived stigma from health providers because of their sexual behaviours.^[5]

MSM frequently report that the state health system is not responsive to their medical needs. The combination of higher HIV prevalence and incidence in the MSM population, together with homophobia and discrimination in the state health care system means that without a focus on providing MSM-specific HIV treatment, care and prevention, these individuals' right to adequate and competent health care will not be met.^[6,7]

Furthermore, researchers have demonstrated that countries that have both generalised heterosexual epidemics and key population epidemics, will see benefits in their general heterosexual

HIV rates if they provide targeted key population services.^[8] This holds true for South Africa (SA) where we have a generalised heterosexual HIV epidemic and concentrated epidemics in key populations including MSM and sex workers. MSM-targeted services are likely to provide positive overall country benefits in the response against HIV; a reason for this being that MSM may form a bridging population. Up to 50% of surveyed Soweto MSM reported they also had female partners.^[4]

The Health4Men Initiative was developed and implemented in 2008 by the Anova Health Institute to address these concerns.^[6,9] Funding and support was initially received from PEPFAR/USAID to implement a broad-ranging package of services aimed at improving the health of MSM in SA. The initiative has been successful and, in partnership with the National Department of Health (DoH), MSM-competent services have expanded from Cape Town and Johannesburg to over 200 trained and mentored public clinics across the country. Key components of the Health4Men Initiative include:

1. Direct HIV and STI service provision at two Centers of Excellence and related support sites.
2. Training and mentoring of state sector health care workers in MSM sensitivity and skills competency.
3. Community engagement, outreach and peer education activities to stimulate community awareness of

Men who have sex with men (MSM) refers to sexual behaviour and not sexual identity. The term 'MSM' simply describes the fact that such men have same-sex sexual partners. The term does not refer to identity, culture or belonging to any specific group. For example, some MSM identify as homosexual (gay) and some MSM identify as heterosexual (straight) despite having same sex partners. Using the term 'MSM' is more inclusive, especially in Africa where many MSM do not consider themselves as 'gay' and have no notion of a 'gay identity'.

relevant sexual health issues and the initiative.

4. A dynamic national sexual health campaign targeting MSM, initially focusing on Gauteng Province.
5. The provision of support to MSM-focused, community-based organisations to render direct services to MSM, with an emphasis on conducting HIV counselling and testing (HCT).
6. Deployment of diverse media platforms to link MSM into care, including a dedicated cellular phone site for MSM (H4M.mobi) that directs them to their nearest, competent public clinic.
7. Research relevant to informing SA's response to HIV among MSM.

Prior to approximately 2010, very little was known about the epidemics of HIV and other sexually transmitted infections (STIs) among MSM in SA. Since then, a large volume of research has confirmed that this key population has HIV rates of 10 - 39%, significantly higher than the general male population, and that STIs are also common.^[10,11]

Since the launch of the Ivan Toms Clinic, sexual health and wellness services have been provided to almost 8 000 MSM. This clinic is regarded as a flagship of the Health4Men Initiative and has become a site where best practice guidelines for the care of MSM have been developed, implemented and monitored. A second flagship clinic is now operating in Yeoville, Gauteng. Lessons learned from these clinics serve as a template for medical service delivery and training of health providers in MSM health skills across SA.

The Ivan Toms and Yeoville clinics are positioned as primary-health-care level, sexual health clinics, rather than HIV clinics. They are also positioned as enabling health spaces for MSM to attend, irrespective of their identity, cultures and traditions, rather than as

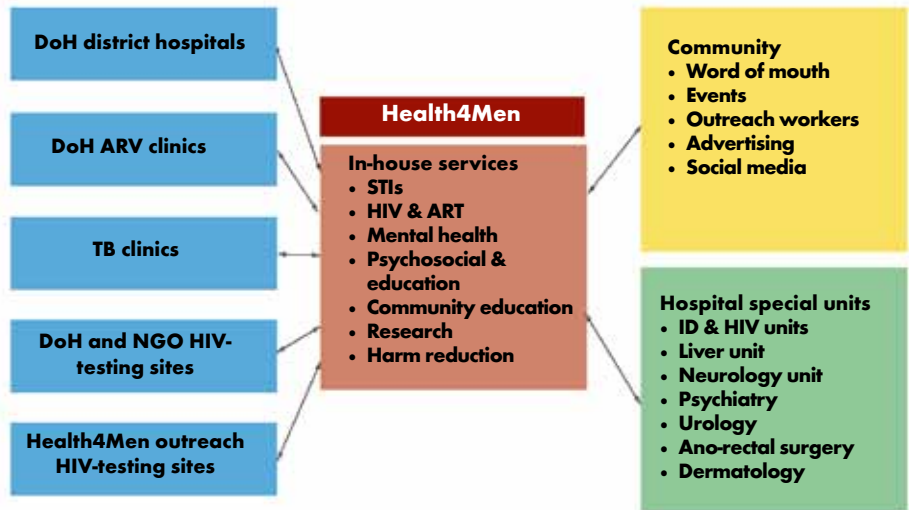


Figure 1. Referral pathways for Health4Men clinics.

spaces only for 'gay' men. Many of the MSM who attend Health4Men clinics also have sex with women and do not identify as gay.

The clinics receive referrals from a variety of sources and are networked with other primary, secondary and tertiary health services (see Figure 1 above).

Scope of services

1. HIV. The clinic offers a range of HIV services from testing, to monitoring and antiretroviral therapy (ART) where indicated. Testing is performed according to the DoH's ACTS model, but with appropriate counselling which is not heteronormative and is accepting of MSM sexual behaviours.^[12] Counselling

Table 1. HIV testing at the Ivan Toms Clinic in Cape Town.

HIV screening (includes only in-clinic screening and excludes off-site activities) (February 2009 – July 2015)	
Total clients who received HCT	3 062
Tested HIV-positive	410 (13.3%)
Tested HIV-negative	2 652 (86.7%)

Table 2. Current HIV treatment in Cape Town.

MSM receiving HIV treatment (antiretrovirals) via Health4Men* (February 2009 – July 2015)	
Total HIV-positive ever in care	1 887
Total HIV-positive remaining in care	957
Total HIV-positive pre-ART (HIV wellness)	391
Receiving DoH-sponsored ART	920
First-line DoH regimen (2 NRTIs + 1 NNRTI)	87%
Second-line DoH regimen (2NRTIs + 1 PI)	13%
* Excludes MSM who receive care at the clinic but obtained ART privately or from an alternate source.	

also includes sexual risk-reduction advice including discussions about anal sex. ARV initiation and selection are as for any adult in SA.^[13] When prescribing ART, consideration needs to be given to side-effects, which if experienced, could decrease adherence. Examples include avoiding nucleoside reverse transcriptase inhibitors (NRTIs) which cause lipodystrophy in body-conscious MSM and being aware of protease inhibitor (PI)-induced diarrhoea in MSM who practice receptive anal sex. Also, additional care needs to be given to adherence support, as MSM may not have the support they require from their families or their communities. Conditions such as depression and alcohol and substance abuse need to be addressed to support adherence.^[14] See Tables 1 and 2 for indicators of HIV care.

ARVs can also be used for HIV prevention in the form of post- (PEP) or pre-exposure prophylaxis (PrEP). PrEP does not currently form part of the DoH's HIV response plan despite mention in the National and various Provincial Strategic Health Plans. The Ivan Toms and Yeoville clinics will be offering PrEP as part of a demonstration project funded by the Elton John Aids Foundation during 2015 (Cape Town) and 2016 (Johannesburg). PrEP can also be obtained in the private sector.

2. STIs. Providing HIV and other STI services together at a single site has served the Health4Men clinics well. It assists in creating an enabling clinical space as approximately half of clinic

visits revolve around STIs other than HIV. Patients attending our clinic are not identifiable as HIV-positive because they are attending an 'AIDS clinic'. STIs thus serve as a hook to attract MSM into HIV care.^[9]

A wide range of STIs is seen at the clinics. The most common conditions are non-specific urethritis and syphilis. Genital warts are also extremely prevalent. More than half of clinic visits are for STI symptoms rather than for HIV care. STI numbers from the Ivan Toms Clinic in Cape Town are shown in Table 3 below.

STIs are managed according to the DoH's syndromic guidelines document and are similar to management in heterosexual men.^[15] Although it is not possible to discuss all STIs as they pertain to MSM in this article, there are some important factors to consider and some specific examples are discussed below.

Syphilis: Syphilis rates are high among MSM globally and have risen in many countries despite good risk-reduction health messaging. MSM need to be screened frequently (6 - 12-monthly) if there is risk of exposure.^[16] Clinical presentation may be atypical in that syphilitic chancres can occur intrarectally and may not be visible to the patient or health provider. Treatment is with intramuscular penicillin.

Gonorrhoea and chlamydia: The usual symptoms include non-specific urethral

discharge, which is managed as per DoH guidelines with ceftriaxone and azithromycin. MSM are, however, more likely to be asymptomatic in the face of an STI and the rates of gonococcal resistance to cephalosprins is increasing.^[17,18] *Neisseria gonorrhoea* is becoming increasingly resistant to cephalosporins and this could lead to treatment failure in MSM. To date, four cases of resistant infections have been detected among SA MSM and this is likely to increase.^[18] Treatment failure should be referred for assessment and retreatment with alternative antibiotics.

Human papilloma virus: This causes sexual warts that are often difficult to treat at primary health care level. Acids such as podophyllin are difficult to use safely for anal warts, and cryotherapy is often unavailable. The Health4Men clinics have arranged for cryotherapy services to be available and are able to refer MSM with extensive or non-responsive warts for surgical excision. Gardasil® vaccination should be advised to all young MSM (9 - 26 years of age), but cost is currently prohibitive and this vaccine is not available to men in the state health sector. Vaccination would prevent warts and future penile or anal cancers.^[19]

Viral hepatitis: Hepatitis A, B and C can all be spread sexually by MSM. MSM who are at risk (e.g. multiple sexual exposures, substance abuse or abnormal liver function tests) should be screened for viral hepatitis and referred for management if positive.^[16]

Asymptomatic STIs: Many STIs produce no or minor symptoms that are unrecognised by MSM. Examples include viral infections such as viral hepatitis and even HIV. Bacterial examples include gonorrhoea and chlamydial infection, among others. A recent study at the Ivan Toms Clinic found that one in four MSM screened was positive for asymptomatic gonorrhoea or chlamydial infection despite a lack of symptoms.^[20] The World Health

Table 3. STIs at the Ivan Toms Clinic in Cape Town.

STIs 2010 - 2015	
Number of STI consultation visits	15 103
Number of patients with an STI	7 780
Asymptomatic STI diagnosis	3 808
New ano-genital fungal infection *	300
* Approximately 10% of clients with STIs present with anal symptoms	

Organization recommends empirical STI treatment for MSM who are at high risk of asymptomatic gonorrhoea or chlamydial infection.^[21]

In summary, HIV and STI treatment for MSM at Health4Men clinics is similar to that for heterosexual men, with the addition of the factors discussed above. All services are offered in an enabling environment by staff who have received extensive training to meet the needs of MSM patients in a sensitive and non-judgemental fashion.

Lessons learned from the Health4Men clinics show that state-sector MSM-targeted health services are feasible and implementable in South Africa. Such services are well received by gay and other MSM who have attended in numbers for a large variety of prevention and treatment interventions. Word-of-mouth promotion of MSM-friendly clinics, together with community-based work by peer educators and ambassadors allied with nuanced health promotion material distributed in places where MSM congregate, has resulted in increased service utilisation by MSM who perceive the programme as valuable to themselves individually and to the MSM community.

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Yes, I am a sex worker; but first and foremost, I am also a human being

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“Sex workers are mothers. They are fathers. They are sisters and brothers and sons and daughters. They work hard to put food on the table and to care and provide for their families.” ‘Maria’ (not her real name) is a member of Sisonke, a human rights movement which is run by sex workers for sex workers. Established by the Sex Workers Education and Advocacy Taskforce (SWEAT) in 2003, Sisonke aims to unite and organise sex workers across South Africa (SA) in order to advocate for better living and working conditions. In SA, there are an estimated 130 000 - 180 000 sex workers, 90% of whom are female and 10% male or transgender.

One of the issues Sisonke is focused on, explains Maria, is that of access to

health care. Sex workers are incredibly vulnerable to abuse and stigma, which threatens their health in numerous ways. HIV prevalence rates among female sex workers is estimated at 59.6%, compared to 13.3% in the general population, and the associated risk of contracting TB and sexually transmitted infections (STIs) is much higher among sex workers.

Police harassment is a big issue for sex workers, with very negative consequences for those who are HIV-positive. Sex work is criminalised under the Sexual Offences Act, and if women are found with more than four condoms on them at once, police are able to arrest them as potential sex workers. Once they are locked up, there is no access to their ARV medication, resulting in them

defaulting on treatment and running the risk of becoming ill or developing drug resistance. Maria emphasises, “And then, once they are released, they go on to infect their clients, who infect their wives and partners.” SWEAT and Sisonke have embarked on a sustained campaign for the decriminalisation of sex work. This would make it more difficult to exploit and abuse sex workers and would bring about legislation to give sex workers occupational health and safety protection. Maria is firm on this: “Sex work is work. It is a profession like any other.”

Another important issue facing sex workers with HIV, STIs and other health issues is that of marginalisation when attempting access health care. Maria describes how sex workers



and in addition, increases their risk of transmitting infections to their clients. Maria also points out that reproductive health services are also denied to sex workers. Some are forced to give birth at home as the result of being turned away from hospitals, others choose to have illegal terminations after failing to obtain one in time from clinics who refuse to see them. Maria is quick to add that "It is not all doctors, not all health care workers who treat sex workers this way. However, there are problems with people who disapprove of what we do and thus, judge us or treat us with less respect than other patients." She adds, "It is very hurtful to experience this. We are human beings who have chosen to make a living this way. Perhaps we cannot make enough money for our children's education another way. Perhaps our own lack of education limits our options in terms of work. Some of us are educated, but just cannot find another job." Maria suggests that sensitisation training be conducted to assist health care workers to feel more comfortable working with

sex workers, as well as being better equipped to understand their health needs. Ultimately, though, Maria, SWEAT and Sisonke all wish to bring awareness to the fact that sex workers deserve to be treated with dignity and respect when being treated by a health care professional. Maria says, with determination, "We won't stop fighting, until sex work is decriminalised. We won't stop until we have the same rights as everybody else."

are insulted or shouted at when at the clinic to collect ARV drugs or test for STIs. Some sex workers are too afraid to seek health care, as they are afraid of how they will be treated. This results in them becoming very ill,

Sisonke is a national sex worker movement formed in 2003. It works alongside SWEAT to advocate for equal rights for sex workers, to inform sex workers about their rights through peer education, provide legal assistance to sex workers and give them support in the form of activities such as Creative Space workshops and work skills training courses. For more information call +27 (0) 21 448-7875 or email info@sweat.org.za. The Sex Worker Hotline number is 0800 60 60 60.



LEADING • PIONEERING



'OUR ISSUES, OUR DRUGS, OUR PATIENTS'
SA HIV CONFERENCE • 13 – 16 APRIL 2016
SANDTON CONVENTION CENTRE

Call for Abstracts

The Scientific Committee of the 2016 Southern African HIV Clinicians Society Conference hereby invites you to submit papers of high quality in HIV research. Work that introduces new research, ideas and understanding to the field is encouraged.

Abstract Guidelines:

- Abstracts must be submitted online
- Submissions are peer reviewed for scientific content, logical presentation, and current interest of the topic to the scientific community
- Submission deadline is 30 October 2015
- Information pertaining to format requirements, conference tracks as well as awards can be viewed at <http://www.sahivsoc2016.co.za/index.php/abstracts>





For further information contact: Scatterlings Conference & Events
 Tel: +27 (0) 11 463 5085 Email: stephanie@soafrica.com or jeanne@soafrica.com

www.sahivsoc2016.co.za

Experiences of a professional nurse working in Ebola-infested areas in Africa

Q&A with Anna Cilliers (professional nurse)



When faced with an unprecedented outbreak, MSF rallied against the disease with a swift reaction and creative strategies. MSF Southern Africa sent more than 34 highly experienced people (professionals) to join the massive Ebola response.

Intensive care nurse Anna Cilliers was one such fieldworker who chose to travel to Sierra Leone to work at Bandajuma in Bo, one of MSF's Ebola Treatment Centres (CTCs) for five weeks in 2014. Anna currently works as a Medical Focal Point for MSF Pakistan. She also worked with MSF in South Sudan in 2013.

Why did you decide to offer your services as a fieldworker in the Ebola response?

I was initially hesitant to work in an Ebola project. When the outbreak happened I was on an emergency assignment in South Sudan, working in the midst of a cholera outbreak. I

was actually relieved that at the time I couldn't even consider joining one of the Ebola teams. I expressed this notion to the MSF recruitment department. I suffer from claustrophobia and wearing the yellow Hazmat suit seemed like something I wouldn't be able to bear. Secondly, these are malaria areas where it is essential to use anti-malarial medication. I have always suffered from severe side-effects from using anti-malarials, so that alone put me off going to an Ebola project.

What made you change your mind?

In September 2014, I was home for a month and started to reconsider my decision. MSF urgently needed more staff for their Ebola projects in order to try and bring the epidemic under control, and I decided to take up the challenge.

Of all the countries where MSF is treating Ebola, why did you go to Sierra Leone?

I had a choice between going to Liberia and Sierra Leone. I chose to go to Sierra Leone. I had previously worked in Liberia and was afraid I would not be able to cope with the emotional trauma of possibly seeing former colleagues suffering from Ebola.

Did you require any special training to work as a nurse in an Ebola context?

As a nurse, one needs to be vigilant with infection control in any health care setting. This basic nursing skill is very important when it comes to Ebola

care. In my training as a nurse, I had also learnt to counsel patients – which became an essential tool in working in an Ebola project. One skill I had to learn, however, was getting dressed in the protective suit. I also had four days of training on working with Ebola – on what to expect, how the CTCs work, infection control, psychosocial support and health staff.

What were your initial impressions of the situation when you arrived?

When I arrived in Sierra Leone, I was struck by the fact that most other health services in the country had either been discontinued, or had been severely hampered by Ebola-related restrictions. Transmission so often happened at rural and under-developed health centres, where infection control measures with elaborate protective gear were not always implemented. For that reason, many health centres were forced to close down in the country as they were unable to take the necessary precautions to prevent other patients from contracting Ebola. Where they stayed open, only non-invasive services were provided. Many pregnant women who would previously have been helped by these centres were turned away because health care staff did not want to be exposed to the body fluids related to the delivery process.

What was your role as a fieldworker in the Ebola Treatment Centre?

As a nurse, I provided regular nursing care to patients. Once in full protective



the high-risk zone is also limited. That was also challenging!

What did you find particularly difficult in your day-to-day life on the project?

A no-touch policy is implemented throughout our Ebola assignments. But sometimes, a patient or a colleague would simply need a hug to comfort them. I wasn't able to hug anyone unless I was fully protected by the Hazmat suit. That meant not even being able to hug fellow colleagues who might have had a challenging day. But the precaution was necessary, as one could not be sure who might be infected with the virus and who might not.

Were there any moments in particular that left a deep impression on you?

It was a challenge dealing with the sadness that comes from patients dying inside the Ebola CTC. Staff in the CTCs were not able to be around patients at all times, so an even greater sadness came from knowing patients might sometimes die while alone. Early in the mornings, at 6:30am, I would visit and talk to patients in the visitor's area through the chicken wire separating patients from their families. On my visits the patients and I would count the days to help determine if they had finally entered the stage that meant their chances of survival were high. My happiest moments came in informing patients that their blood results showed they were free of the Ebola virus.

What have you learnt from this experience?

This experience confirmed to me that choosing to follow my heart first and brain second is the right choice. I do of course still contemplate things to make sure my decisions are made based on a good balance of emotion and rationale – but I believe one should take up the opportunities presented to us in life.

gear, a nurse can touch patients and provide, with challenges, the basic care they need. This included cleaning soiled patients and beds when patients were too weak to clean themselves, administering the necessary oral and IV medication, inserting IV-lines, and drawing blood. I also ensured that dying patients were as comfortable as possible, and helped feed weak patients. We asked healthier patients to assist with cleaning and feeding when the medical staff were not present in the high-risk area. As the Medical Focal Point at the MSF Ebola Treatment Centre where I worked, I was responsible for the daily medical activities in the centre and staff health care.

What stands out for you from your work in West Africa?

I was very humbled by my Sierra Leonean colleagues. As fieldworkers with MSF in Ebola assignments, we only stay for a few weeks at a time. But the staff who come from, live and work in West Africa worked in these projects for months on end, risking their lives for the men, women and children in their communities.

Was it a difficult decision to undertake work in an Ebola context?

Before going to West Africa, I asked myself if I was prepared to risk death should I contract the disease. I had to get my head around the idea of what might happen before I left on my assignment. It's getting easier for health workers to make the decision to go now, though, because there is the possibility of receiving the vaccine to prevent the infection.

How did you feel working in the areas of the Ebola CTCs where the risk of contracting Ebola was so high?

We were very careful to make sure the full protective equipment was properly fitted at all times – which means covering up from head to toe with protective disposable material. I didn't find it too difficult to work in the what was termed as 'high-risk zones' once I made a head shift about all the layers of personal protective equipment. The Hazmat suits hinder real eye contact with patients – so that is something to get used to. The time one can spend in

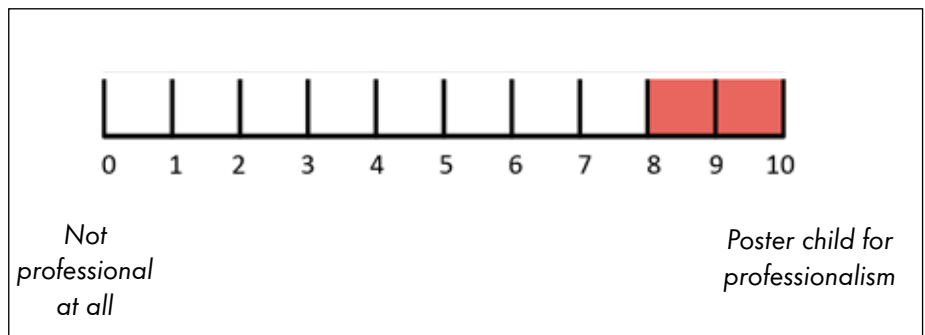
IT'S MY LEGACY

L de Kock, BSc (Hons), MA

Quality Improvement and Training Department, The Aurum Institute

Improvement will only happen when it is planned for and when professionals like you and I see it as being central, rather than peripheral, to our professional roles

Have you ever had that moment when you stand back and think: what will people remember me for? What difference have I made with my time as a professional? I'm sure we all have, and continue to contemplate similar questions. As health care workers, we have an awesome opportunity and responsibility to truly make our legacy felt and count. I despair at times when I hear questions/statements like, "Why should I do Quality Improvement (QI)?" "QI adds too much work to my current load"; and "It's not my job". Today I hope to address such naysayers by answering the question, "Why QI?".



of people rank themselves between an 8 and a 10 (see above). When I ask for qualities of a professional, I am flooded with a range of responses:

Honest **Courteous** **Organised**
Respectful **Punctual** **Ambitious** **Good subject matter knowledge**

Why QI?

I could very easily answer this question by providing a list of indicators whose targets are currently not being met, and we could quite simply close the debate. But today I wish to present a more impassioned opinion as to why QI is not actually a choice, but rather a mandate. I will do this by addressing two important concepts: Professionalism and Humanity.

1. Professionalism

While conducting a number of QI meetings and conferences recently, I had the opportunity of asking colleagues whether they considered themselves as professionals. Without fail, 100% of those in attendance declared themselves as such. When asked to rank themselves on a scale of 1 to 10 in terms of professional behaviour, the vast majority

Not once, however, to my dismay, has anyone mentioned that a professional is someone who meets targets!

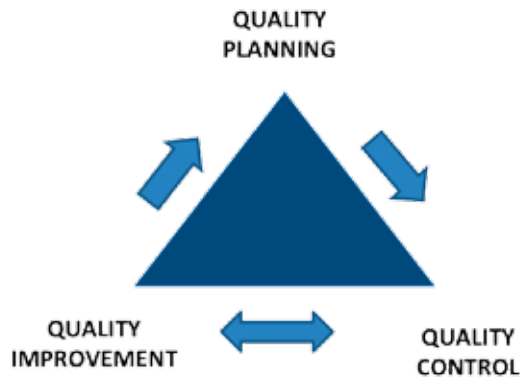
The Webster's Ninth New Collegiate Dictionary provides a definition for a professional which includes "Conduct, aims or qualities that characterise or mark a profession or a professional person". Surely one of these rules of conduct, aims or qualities that mark us as health care professionals, should be that of being target-driven and improvement-focused?

We are not dealing with figures, but human lives. Our failure to meet targets and improve is not simply a loss of turnover or profit – it literally can mean a loss of life.

By default, are we saying that simply ignoring targets and not doing much to improve performance month after month is ok, acceptable, the norm and a mark of our profession? I truly hope not!

Not planning for improvement and not responding appropriately to indicators that are not meeting monthly targets is not a mark of a professional!

Dr Joseph Juran, provided us with a very insightful health management trilogy known as the Juran Trilogy®. He stated that if we are to be successful in managing health, then the following three aspects must be in place and applied:



Far too often we create yearly or monthly plans and design all sorts of quality control measures to ensure that what we have planned for actually happens; but unfortunately, the improvement part of Jurans trilogy is lacking and often non-existent. The result is evidenced when we continue to miss targets month after month. Simply controlling and monitoring each month will not bring about improvement. Improvement will only happen when it is planned for and when professionals like you and I see it as central, rather than peripheral, to our professional roles.

2. Humanity

The second point to my argument of why QI is simply not an option, centres on the principle of humanity; the quality of being humane. Synonyms include compassion, brotherly love, fellow feeling, humaneness, kindness, kind-heartedness, consideration, understanding, sympathy, tolerance, goodness, good-heartedness, gentleness, mercy, charity, generosity. Surely these have to be qualities synonymous with health care professionals? Many of us have taken oaths to care for those who cannot care for themselves. In fact, the very first line of the Nurses Pledge of Service reads: "I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity".

Unfortunately, some of us have started taking the 'care' out of 'health care'. Our jobs exist to serve our patients and to ensure that they receive the best quality service and health we can possibly provide. In order for

us to do this, we must begin to see the patient as central to what we do and not an inconvenient interruption.

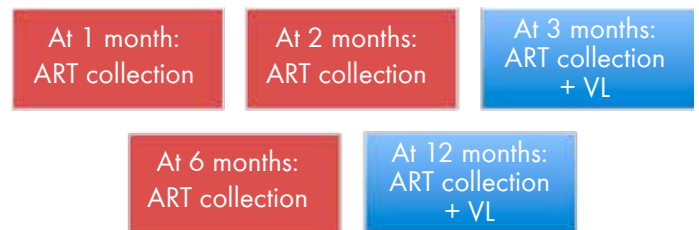
Patient-centeredness should be our aim, our purpose and our outcome. If this truly is our purpose, then what would this patient-centred care really look like? Here are a few practical examples to illustrate the point:

a. Viral load (VL) completion rate

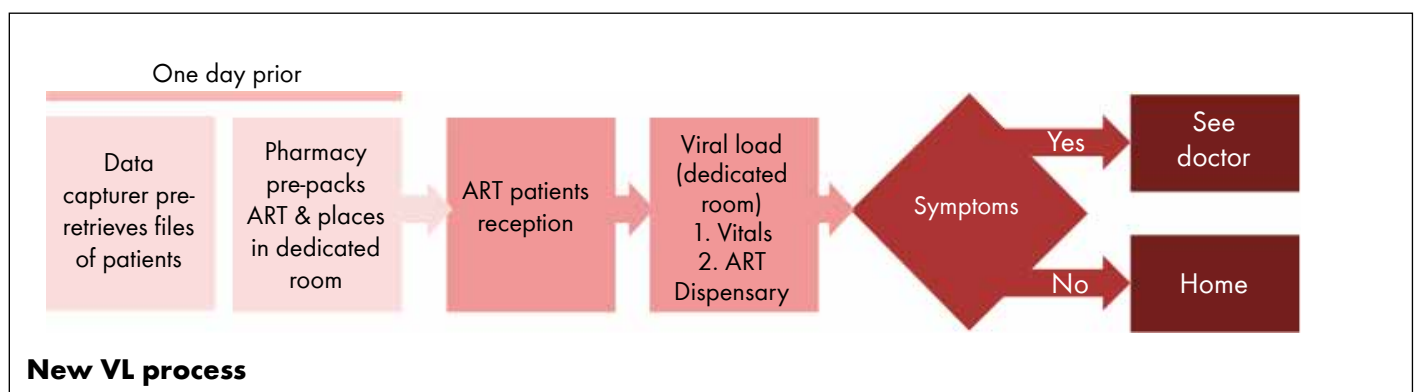
In order for us to meet the third '90' of the current USAID 90-90-90 goals, which prescribe that all those receiving ART should have a durable viral suppression, we need to ensure that we are actually taking bloods for the VL to be measured. A low VL completion rate is a rather widespread problem in many provinces in South Africa. Some very practical ideas have been generated from a primary health care facility in Ekurhuleni, which demonstrates how easy it can actually be to put the patient in the centre of health care, and by so doing, improve health indicators.

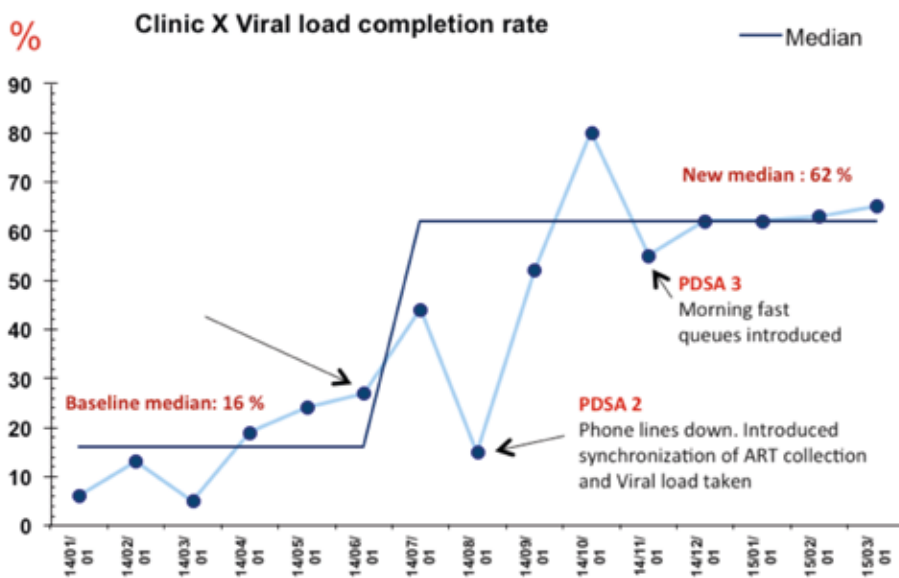
Through a Root Cause Analysis (RCA) process, this QI team identified four change ideas that have dramatically affected their VL completion rate:

- On a monthly basis, generate a list of eligible patients using tier.net
- Call patients to remind them of their appointments
- Implement a Fast Queue for VL
- Synchronise ART and VL visits – this can be achieved by implementing the following schedule:



The new VL process is shown in the flowchart below.





The impact of these changes to the VL completion rate can be seen in the line graph to the left (top).

b. TB screening

Many patients have to wait hours in waiting rooms until they are seen for a consultation. During the consultation, a nurse or doctor will screen them for TB and then obtain the required sputum. Unfortunately, many courier companies who collect the daily specimens, do so in the mornings. Patients who have been waiting all morning to see a clinician and who are required to produce a sputum are too late for that day's courier and are therefore asked to return the next day so that their sputum can be collected and transported on the same day to the laboratory. A patient-centred approach can quite easily be achieved by screening patients while they wait, before a consultation. If there is a need for the client to produce sputum, they can do so while waiting to be consulted and the courier can take that sputum to the laboratory on the same day. Refer to the flowchart to the left (middle).

Old process



New process



A clinic in Bojanala district is currently testing this idea and their initial results are very encouraging (bottom left diagram).

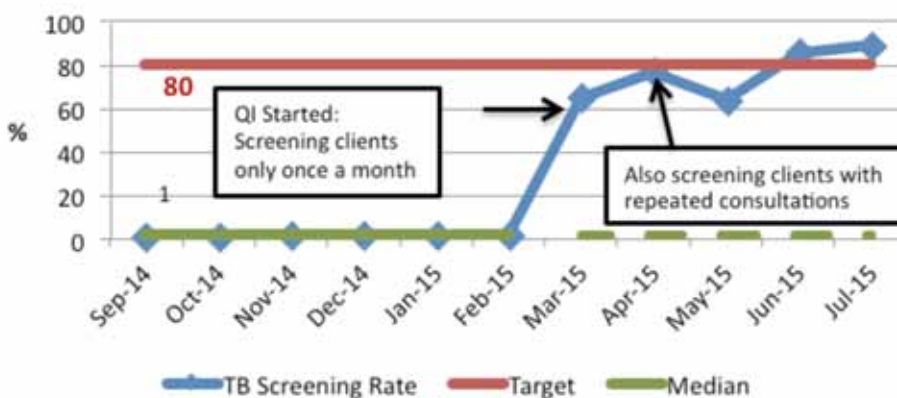
Conclusion

QI cannot, and should not, be seen as an option, or something to be done only when there is time or a mandate in place. As professionals, constant striving to meet targets and improvement should be our 'mark' - a mark so compelling and consuming that it drives us on a daily basis. Our patients are not unmet targets, but human beings who deserve our best, and deserve services designed with their best interests at heart.

References

1. <http://www.juran.com>
2. <http://www.sanc.co.za/aboutpledge.htm>

Clinic Y: Headcount >5years TB Screening Rate



AWACC

9TH ANNUAL WORKSHOP ON ADVANCED CLINICAL CARE - AIDS

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Elangeni Hotel, Durban



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Enquires to: info@awacc.org
Twitter: [@awacc_aids](https://twitter.com/awacc_aids)



Answer the quiz on page 44 and
you could win one of two free
entries to this conference



Competition

HIV/TB nursing

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

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

Submit your typed piece, not exceeding 1 000 words, by 1 November 2015 and stand a chance to win a free, one-year membership to the Southern African HIV Clinicians Society; and have your piece published in *HIV Nursing Matters*!

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

Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

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

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



**0800 212 506 /
021 406 6782**

Alternatively send an SMS or
"Please Call Me" to 071 840 1572
www.hivhotline.uct.ac.za



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

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

What questions can you ask?

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

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

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

When is this free service available?

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

Who answers the questions?

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

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



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

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

Quiz questions for September 2015

1. What is the maximum number of days that an individual be detained at Lindela Detention Centre?

Answer.....

2. Who can be detained at Lindela Detention Centre?

Answer.....

3. True or False: The Southern African HIV Clinicians Society's guidelines can be used when prescribing pre-exposure prophylaxis (PrEP) in South Africa?

Answer.....

4. Currently, which combination of ART can be used when prescribing PrEP?

Answer.....

5. True or False: ART can be used for HIV prevention in the form of PrEP or post-exposure prophylaxis (PEP)?

Answer.....

6. Which vaccine can be used to prevent warts?

Answer.....

7. In which year was the resolution to improve health systems responses for migrants passed?

Answer.....

8. Which age group of girls does the SAfAIDS Young Women Leadership (YWL) Programme train?

Answer.....

9. Where in Africa does the SAfAIDS YWL Programme take place?

Answer.....

10. How many people were infected with Ebola in Guinea, Sierra Leone and Liberia?

Answer.....

Quiz answers from 2015 the June Issue

1. 56%

2. Sex workers and communities with limited or no access to medical services

3. True

4. False (19.4%)

5. A high-tech digital x-ray

6. 259%

7. Emotional and practical needs

8. 9 - 70%

9. Sex Worker Education and Advocacy Task Force

10. 59.8%

NDoH/SANAC Nerve Centre Hotlines

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

Nerve Centre Hotline and specific emails for each province:

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



AIDS Helpline 0800 012 322

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

In 1992, LifeLine was requested by NDoH, to take over the management of the Line by rotating it between the 32 existing community-based LifeLine Centres, and manning it with volunteer counsellors. In 2000, in response to an increasing call rate, a centralised Counselling Centre was established in Braamfontein, Johannesburg, to house the AIDS Helpline.

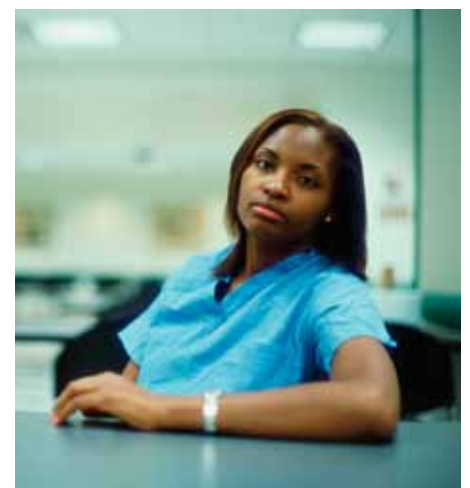
The AIDS Helpline a national toll-free service, operates on a 24/7 basis and is utilised by people from all walks of life in urban and rural areas, in all 11 languages at no cost from a landline telephone.

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

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

Cases presented range from testing, treatment, transmission, TB, medical male circumcision, etc.

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





If you have any HIV/TB clinical questions, send them to "Ask the clinician" via nonhlanhla@sahivsoc.org and you will get an answer in the next issue of *HIV Nursing Matters*. If your question is urgent, then please state so on your email and the answer will be emailed back to you and still be published in the magazine.

Dear clinician

For how long do we give co-trimoxazole to a patient who is HIV-positive?

Dear nurse clinician

Patients receiving co-trimoxazole should continue taking it until their CD4 count rises above 350 cells/ μ l. For more info see: <http://bit.ly/1JbixME>



HIV NURSING MATTERS ADVERTISING RATES 2016 Effective 1 November 2015



HIV Nursing matters

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HIV Nursing Matters features clinical, programmatic and policy articles and updates relevant to nurses managing HIV and antiretroviral therapy (ART). The magazine supports and strengthens the capacity of nurses to deliver high quality, evidence-based HIV prevention, care and treatment services.

By advertising in HIV Nursing Matters, you reach many partners in the health industry - Nurse Managers, NIMART nurses and doctors.

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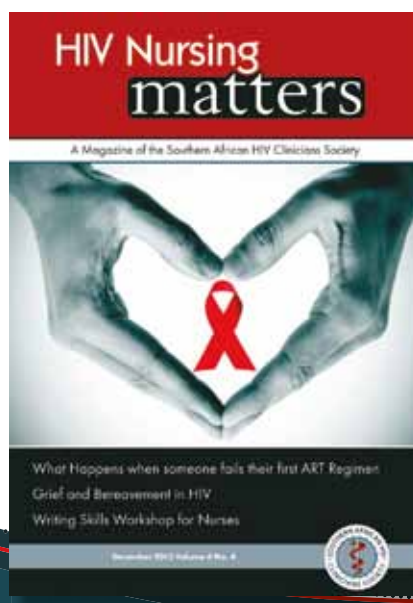
Our magazine is posted directly to 1 600 nurses throughout South Africa, doctors, libraries, NGOs and academic institutions in South Africa. It is also distributed to primary health care clinics across the country and available as a free PDF download on our website: www.sahivsoc.org

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

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

2 CONNECTING • CONVENING • ENGAGING

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

3 ADVOCATING • INFLUENCING • SHAPING

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

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

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

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