

HIV Nursing matters

A publication of the Southern African HIV Clinicians Society



The role of a clinician in health systems strengthening
Health systems strengthening: What about mental health?
The Sustainable Development Goals
Clinical HIV/AIDS Services Strengthening (CHASS)
Project in Mozambique
HIV re-testing and viral load monitoring during
pregnancy and breastfeeding

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Guest editorial



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As South Africa (SA) grapples with a quadruple burden of diseases, with HIV/TB leading the pack, it relies heavily on a functional health system that is able to cater for the needs of patients who access it to prevent, promote and sustain health. We are all too aware of the challenges our health systems face – a health system that is too over-burdened, with too few resources to meet ever-increasing demands.

In SA, healthcare workers form part of the backbone of the healthcare system and consequently should be an integral part of the solution in strengthening such systems. But this can seem too overwhelming. The question is, where does one begin? What is my contribution and how do I, as a clinician, make a difference in my own small world that will impact the greater system? Is it a silver bullet from someone who has figured this whole problem out, or is it a simple, brick-by-brick, step-by-step solution by you and me?

In this issue of *HIV Nursing Matters* we have lined up articles that provide us with the insight or tools to navigate this problem. We cover topics that deal with broader health systems strengthening (HSS), down to the fundamental basics of health systems, including communication between key role players within the system: the clinician and the patient. We

also delve into specialised topics such as mental well-being and prevention of mother-to-child transmission (PMTCT) of HIV; so join me in a journey of exciting, useful and thought-provoking reading!

We begin with an article on page 6 that deals with the role of clinicians in HSS. The author gives a brief description of HSS, as defined by the World Health Organization, and addresses the most apparent question: what is our role as clinicians, wherever we may be stationed, in strengthening broader health systems? The author provides us with useful quality improvement tools to tackle day-to-day systems challenges that have the potential to impact greater systems.

The article on page 21 perfectly dovetails into the aforementioned one by asking the thought-provoking question: **if not us, then who?** More often than not I have heard corridor talk of 'unsustainable quality improvement projects (QIPs)'. QIPs that last as long as partners are present in facilities – yes, those people who visit our facilities to nag us about root-cause analysis, plan-do-study-act (PDSA), etc. This article deals with fundamental weaknesses of QIPs, your **intrinsic** role as a clinician, and even more importantly, the role of data in diagnosing health systems challenges. The author illustrates this with successful QIPs that address challenges we are faced with daily in our facilities. After all, borrowing from the author, we should avoid being **'mindless implementers'** if we are to impact change.

Sometimes it doesn't take changing the entire world to effect change. It takes simple communication skills such as listening and empathy to save lives and improve well-being ... and therefore improve outputs ... and therefore improve performance against targets ... and therefore improve health systems ... see how all the dots connect? The article on page 16, a must read, demonstrates how communicating openly and holistically with a patient can lead to desirable outcomes for both patient and clinician.

This article brings hope into a faceless, nameless health system. We are, after all, a service industry and deal with people, along with their fears, hopes and dreams. Paying attention to this, I found to be very rewarding, even in an overcrowded, impossible clinic situation.

Mental health is the cornerstone of well-being. Can you imagine the sheer psychological stress faced by the most vulnerable of all in our communities: HIV-positive adolescents? It is our role as clinicians to detect the warning signs before it is too late. We cannot afford to look away and hope that someone else – such as a counsellor in a room along the corridor – will deal with this. Remember, **mentally distressed patients do not adhere to treatment**, so avoiding this issue is futile for all, and impacts negatively on health systems. The article on page 8 deals with this topic and not only gives us perspective on the pervasiveness of the problem, but also provides tools to screen for mental health disorders, and **at the very least**, refer patients who require intervention to more specialised care. Also a must read.

Lastly, although SA has been successful in reducing mother-to-child transmission of HIV, we are still faced with transmission in women who seroconvert after the initial negative HIV test result, either during pregnancy or during breastfeeding. A high viral load during pregnancy or breastfeeding poses a great risk of HIV transmission from mother to child. In this article, the author takes us on a journey of the history of PMTCT in SA and addresses the challenges mentioned above. There is also a useful case study to test applicability.

I am certain that you will enjoy this issue, as I have, and emerge more confident of your ability as a healthcare practitioner to go out there and make a difference in our healthcare system. At the risk of sounding clichéd, my answer to this, after reading these great articles, is yes, we can!

Happy reading ...

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Message from the president



Prof. Yunus Moosa

President: Southern African
HIV Clinicians Society

HIV has effectively been converted from a disease with certain death to a chronic disease that can easily be managed, making a near-normal life expectancy a reality. This complete reversal of outcome has been a long and tortuous journey. Guidelines have been changing at such a pace that healthcare workers have to relearn constantly how to manage their patients. This task is made easier by educational platforms, such as this journal, which helps one keep pace with the rapidly evolving clinical science.

The progress in HIV therapeutics has been nothing short of miraculous. We have moved from relatively toxic regimens with high pill burdens to once-daily fixed-drug combinations with minor side-effects. This has gone hand-in-hand with a shift from initiating treatment at CD4 cell counts of less than of <200 cells/ μ l per microliter to a test-and-treat strategy. This new treatment initiation paradigm has seamlessly merged with the fact that one of the most effective tools to prevent transmission is fully suppressive antiretroviral treatment (ART). In essence, evidence suggests that if **all** infected subjects are placed on a fully suppressive regimen, the epidemic could potentially be halted in its tracks.

The current challenge is to identify at least 90% of all infected subjects, start 90% of them on effective treatment and ensure that at least 90% on treatment remain virologically suppressed (90/90/90). South Africa has already initiated over 3.5 million on ART. In addition to managing this large burden, the healthcare system is under tremendous pressure to continuously identify infected subjects, get them firmly linked to care, initiate ART as soon as possible, and keep at least 90% of those on treatment motivated to sustain an adherence of 90%. This is a very high expectation for a healthcare system that is overburdened, resource-constrained, with limited human capacity at all levels, with weak supply chain management systems and chronically failing infrastructure.

Despite all the obstacles, striving to meet the above expectations is a non-negotiable. As Winston Churchill said, 'Success is not final, failure is not fatal: it is the courage to continue that counts'. This issue of the journal specifically calls to attention issues around health system strengthening and quality improvement strategies. This gives us some insight into how to work smart and make optimal use of limited resources. We need to keep our shoulder to the grind and remember that despite what we have achieved, the journey has just begun.



News

Working with the Clinical HIV/AIDS Services Strengthening (CHASS) Project in Mozambique

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The goal of the Clinical HIV/AIDS Services Strengthening (CHASS) Project is to improve the quality, coverage and effectiveness of high-impact, evidence-based HIV/AIDS interventions, towards improving the health status of target populations and meeting country-specific goals. The purpose is to achieve epidemic control – the point at which new HIV infections fall below the number of AIDS-related deaths, as defined by the United States Agency for International Development (USAID).

Accordingly, the CHASS project is pursuing five specific objectives:

- Increased coverage of antiretroviral therapy (ART) to 90%
- Increased retention on ART to 80% at 12 months and 70% at 36 months
- Increased average CD4 count at initiation of ART
- Complete tuberculosis (TB) treatment for 90% of HIV-positive people diagnosed with TB
- Operationalise viral load (VL) testing.

To achieve the above objectives, CHASS combines capacity strengthening of local institutions, direct support for service delivery, and health systems strengthening (HSS) at provincial and district levels. Implementation is done jointly with local organisations, district and provincial health teams, and the Ministry of Health (MOH). In line with the President's Emergency Plan for AIDS Relief (PEPFAR) and USAID's Forward principles, CHASS puts more emphasis on technical assistance to host government and local organisations. In addition, CHASS is supporting expansion of HIV prevention and treatment services in high-prevalence areas and high-risk population groups in scale-up districts. This approach aims to close existing coverage gaps and increase access by saturating services in districts and communities where HIV prevalence and unmet needs are high.

The Society commenced work with the CHASS team in the Manica Province, Mozambique, in May 2016, with the first site visit taking place in August, under an FHI360 grant. A team of four

South African doctors were employed as technical advisors.

Specific tasks performed by the Society

The Southern African HIV Clinicians Society (SAHIVSoc) supported health-care worker (HCW) skills-building through training and mentoring, by conducting baseline assessments with the CHASS and MOH staff to identify capacity-development needs.

Action plans were developed for eight high-burden facilities identified by the CHASS team, namely: Vanduzi Healthcare Centre, Gondola District Hospital, Sassundenga Healthcare Centre, Manica District Hospital, Nhamaonha Healthcare Centre, 1 de Maio Healthcare Centre, 7 de Abril Healthcare Centre and Eduardo Mondlane Healthcare Centre. The overall objective of the baseline assessment, using an adapted Site Improvement Monitoring Systems (SIMS) tool, was to assess the availability, functionality and quality of HIV/AIDS, prevention of mother-to-child

transmission (PMTCT), family planning and TB healthcare delivery systems in these facilities. This resulted in Quality Improvement (QI) action plans that the facilities have owned and started implementing, in order to improve the quality of care to the communities served. The ultimate objective of the assessment, training and mentoring process is to strengthen the health system and capacitate local facility staff, as well as local CHASS technical support, to continue to improve the system. Each of the Society technical advisor doctors was allocated two clinics, and the relevant zonal leaders, who are doctors working for CHASS, were the primary contacts for the facilities.

Assessment and fieldwork strategy

The facilities varied in terms of need, quality and available systems. Each facility identified two priority focus areas and a continuous medical education (CME) programme was developed to address these. The whole system was assessed: HCT; TB/HIV collaboration; family planning; HIV management in adults, paediatrics and pregnant women; laboratory services and point-of-care testing; commodities management; TB infection control; waste management; injection safety; and QI and assurance.

CME and mentoring sessions

The Wits Reproductive Health and HIV Institute (Wits RHI) 10-day Advanced HIV Management training was adapted and conducted with the CHASS team in Beira in August 2016. Thereafter, sessions for CME were conducted to update and reinforce specific knowledge areas, tailored to the various categories of HCWs and topics linked to CHASS objectives. The first was held in Maputo on 26 November 2016 on *Viral Load and Creatinine Clearance Monitoring in HIV Management*; and five more were held over 24 - 26 May 2017 on *Clinical Monitoring in Adults on ART; TB Diagnosis and Management; TB/HIV Collaborative Activities; Laboratory Monitoring in HIV; and Care of HIV-Exposed Newborns*.

Mozambique guidelines were dis-

cussed extensively and all sessions were well attended by HCWs from most of the facilities in Chimoio. The Society enrolled new members after each CME session, and disseminated *HIV Nursing Matters* and the *Southern African Journal of HIV Medicine*.

Over and above this, the Society scheduled and facilitated out-of-country mentoring sessions. The first, focused on TB, was performed via Skype call on 27 January 2017. As zonal leaders are not necessarily office-based and use cellphones to communicate while in the field in various areas around Mozambique, there are often challenges of connectivity; so the team had to be innovative and minimise costs for all concerned. This session went extremely well with 18 participants in attendance. Participants used both writing and audio to obtain clarity from the facilitator and to discuss among themselves in Portuguese; thereafter someone would provide translation to English. The second Skype mentoring session on *HIV-Exposed Paediatrics* was scheduled for 3 April 2017 but unfortunately cancelled due to poor weather, and as not all participants could connect on time. It was decided that those interested in further information would have their questions addressed via email.

Development of materials, tools and resources

The Society developed resources and adapted materials as needed, basing them on Mozambique national guidelines. A webpage was created to share the Portuguese resources, including the Adherence Flipchart Tool, Thermometer Poster for Quality Improvement Monitoring, the mentoring session summaries, CME presentations, and so forth. The Society home page has been translated into Portuguese and the MOH guidelines made available in Portuguese on the site. The remainder of the Society's tools and resources are also readily accessible, although in English.

The Society is currently working to identify CHASS and MOH staff to serve as certified trainers on tailored materials developed for QI. Trainers will be identified through mentoring, HSS on-the-job training and from the

formal training sessions conducted from May 2016 to August 2017. The Society and CHASS project staff work well with the MOH at central, provincial and district levels in Chimoio, to implement training targeted to address site-specific weaknesses, and to coach clinicians/HCWs as needed on the most up-to-date, national clinical guidelines on adult ART, paediatrics, TB and PMTCT (Option B+).

Challenges

Language is a barrier; consequently, translators who understand the content are required to minimise impact. The first few site visits proved frustrating for both the Society doctors and facility HCWs. Road and facility infrastructures are generally dilapidated or non-functional. Despite this, the HCWs do their best to serve their communities. The Society doctors must be escorted to facilities for safety purposes, and have been exposed to life-threatening situations such as a robbery and associated gun violence.

Conclusion

Our observation is that limited resources and poor infrastructure, owing to lack of political will and corruption, do not stop ordinary HCWs from pouring all their energy into serving their communities to the best of their abilities and making the most of what they have. Working with the CHASS project, the MOH HCWs appreciate the feedback they receive from the Society technical advisors in terms of how to improve systems within their facilities. Examples include: implementing innovative filing methods that can be understood by any staff member coming into such role; placing attendance registers for patients that have collected their blood results in key areas; and assigning a person responsible to facilitate easier patient tracking in future. One of the facilities has hired a psychologist to strengthen counselling services; this means the partnership between the Society and FHI360 is being valued and the health system is becoming strengthened. Optimistically, such acts in time will result in realisation of the CHASS objectives and successful replication of the model in other areas of Mozambique.

The role of a clinician in health systems strengthening



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Strong health systems prevent, detect and respond to deadly diseases, thereby preventing outbreaks from becoming epidemics, promote the well-being of people and save lives.^[1] Strong health systems are essential in achieving the Joint United Nations Programme on HIV/AIDS (UNAIDS) and South African 90-90-90 targets to reduce morbidity and mortality from HIV and TB. As a clinician, one can appreciate how improving the health system can have a greater impact and improve the outcomes for people not only on an individual basis but for the greater

population accessing these services, thus making a greater difference. That is what health system strengthening (HSS) is all about – improving the overall healthcare system of a unit, for example a facility or a ward in which we work, to improve the effectiveness and efficiency of a larger health system for the greater benefit of the whole province and ultimately the country.

HSS is defined by the World Health Organization (WHO) as:

- the process of identifying and implementing the changes in policy

and practice in a country's health system, so that the country can respond better to its health and health system challenges

- any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality or efficiency.^[2]

For this purpose, the WHO has provided guidance by describing a framework for HSS, with six building blocks (Table 1).

Table 1. The six building blocks of a health system

1	Good health services are those that deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.	4	A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
2	A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).	5	A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
3	A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.	6	Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

WHO'S Framework for Action 2007^[3]

But where do you even start? If a health system needs to be strengthened, you need to identify what the problem is, where, when and why the intervention is needed, what the expected outcome will be and how it will be monitored and evaluated.^[3] That seems overwhelming when considering a massive system, such as the South African health

system that is complex and too often overburdened. It is, however, feasible for you as a clinician to make an impact within the system in which you currently work – the ward, clinic, private practice, hospital, etc. – then make small incremental changes that will result in improvements and start having an impact on larger systems.

Even with this guidance, it can seem overwhelming to try to improve or 'fix'

an entire system within your workplace. Therefore, one practical and feasible method to start making improvements and seeing sustainable results is to implement quality improvement projects (QIPs).

There are multiple resources available for implementation of QIPs, but the list in Table 2 suggests a practical and summarised way to go about conducting quality improvement (QI) work:^[4]

Table 2. Practical approach to conducting QI work*

1	Work as a team	Identify a team of people who will work together. It is very important for a team to take ownership of implementing change.
2	Identify and prioritise the problem(s)	Work out what the problems are that you are facing, and prioritise which ones should be dealt with first, even if this means which ones will be 'quick wins' or have the fastest/easiest impact.
3	Have an aim, and decide on the objectives	Identify the ultimate goal of the project – quantify what you want to achieve by when.
4	Analyse what is causing the problem	Look at all the factors that contribute to the problem so that you can determine where you need to intervene and make changes.
5	Collect baseline data	You have to be able to quantify if there has indeed been any change at the end of your project, so collect the data you have so that you are able to measure the change.
6	Implement the change	Try out your change idea for a specific time period.
7	Collect data and analyse the impact the change has had	Compare your baseline data with the data since the change idea was implemented to see if there had indeed been any improvement.
8	Decide to continue with the new process, or make any changes and review progress again	Did your change idea work? Does it need to be implemented permanently, or be adjusted and tried again? Did it not work at all and you need to come up with a new idea?
9	Identify any challenges experienced	This is useful as you can learn from experiences so that future QIPs become easier and you avoid challenges you have faced in the past.

* Adapted from the NAS toolkit.

Many small changes to improve the system in which we work will ultimately have a larger impact on the health system as a whole. You and I as clinicians play a critical role in improving effective and sustainable health systems. The use of QIPs is one of the tools at our disposal in the work place that can ultimately achieve the goal of broader HSS, resulting in improved patient outcomes,

as well as a conducive and rewarding working environment for you and your colleagues.

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Health systems strengthening: What about mental health?

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The National Mental Health Policy Framework and Strategic Plan (2013 - 2020)^[1] asserts that mental health should be integrated into all aspects of healthcare. It should target certain vulnerable groups including children and adolescents. Likewise, the *Child and Adolescent Mental Health Policy Guidelines (2013)*^[2] state that all front-line providers must be able to recognise and manage mental health issues in these populations.

The age band of 10 - 19 years, defined by the World Health Organization (WHO) as adolescence, is a developmentally challenging period involving significant social, emotional, cognitive and physiological change. It is recognised that adolescents are particularly vulnerable to psychiatric disorders at this stage of their

development. Nearly half of all mental disorders start by age 14 with far-reaching implications for adolescent health and development.^[3]

A significant number of adolescents and children suffer from anxiety, depression, post-traumatic stress disorder and attention deficit hyperactivity disorder. HIV-positive adolescents are especially vulnerable to mental health problems.^[4] Studies suggest that when compared to the general population and other high-risk groups, perinatally infected adolescents present with more emotional, behavioural and psychiatric problems than their non-positive counterparts.^[5-7] This has implications for the course and outcome of HIV infection, most notably in terms of the negative impact on adherence to antiretroviral treatment (ART).^[8]

The multitude of external challenges that often confront HIV-positive adolescents increases the risk of poor mental health outcomes. A study which looked at the life circumstances of HIV-positive adolescents in Harare, Zimbabwe, found psychological health to be strongly linked to social problems.^[9] Factors such as sexual violence and abuse, chronic illness, economic instability, stressful life events, poverty and unemployment can all have a detrimental impact on mental health.

Poverty is strongly linked to poor mental health, which is in turn related to feelings of isolation, helplessness and hopelessness, which all affect well-being.^[10] Although poverty has declined in South Africa, it remains a significant challenge with 10.2 million South



Figure 1: Course of action for screening for mental health disorders.

Africans living below the poverty line in 2011.^[11] Parental loss is a significant contributor to poor psychological well-being, with AIDs orphans experiencing more mental health difficulties than children orphaned by other causes.

The identification of mental health disorders in adolescents with HIV represents a key aspect of care. Early detection of mental health problems, effective intervention, and appropriate referral for those who need more specialised care can do much to improve health outcomes. It is essential that screening is conducted to ascertain common mental disorders, that young people with difficulties are adequately supported, and that appropriate referrals are made.^[12]

Screening refers to a process of gaining a broad range of information about the mental state of a patient to determine whether they need referral or care. Comprehensive psychometric assessment of mental health disorders can be conducted by a psychologist, if available. If not, healthcare workers (HCWs) can undertake routine screening to identify mental health difficulties and refer as and when necessary.

Five key points should be considered when determining the best course of action (Fig. 1):^[12]

- Conducting a mental state exam
- Collecting a thorough history and collateral information
- Pre-screening
- Screening to identify and refer

suspected cases

- Following up with those who screen positive and/or are referred.

The mental state examination is an assessment of the client based on their presentation when they access healthcare. For example, the HCW might consider aspects such as physical appearance, and behaviour, as well as concentration, attention and memory – all of which help to build a picture of the young person, but cannot be used as proof of a mental health problem.

Taking a person's history requires the HCW to gather information about a patient's life, in a systematic and sensitive manner. It is generally agreed that questions should be asked in sequence starting with the present complaint and past medical history, and continuing with mental health, medication history, family, and social and sexual history. Collateral information refers to obtaining information from sources other than the patient, e.g. a teacher or close family member. This should always be done with the patient's consent.^[13]

Mental health screenings are informal symptom checks that may take the form of a checklist, a rating scale, questionnaire or other screening tool. In busy clinics where there is not always time to conduct a full mental health screening, a brief screening tool can provide important information in a short period of time. Questions can be asked at every visit to ensure that mental health is tracked and monitored over time. This form of screening does not diagnose a mental disorder, but it is

useful for deciding on a treatment plan. Based on the results of pre-screening, a full screening can be undertaken to determine the appropriate referral pathway, e.g. a counsellor, social worker, psychologist, or psychiatrist. There are a variety of screening tools available electronically and at no cost, e.g. for anxiety, depression and post-traumatic stress disorder. While the choice of screening tool lies with the facility manager or HCW, any tool that is used should be well-researched and validated.^[12]

It is important that support for patients diagnosed with a mental health problem does not end with referral to a mental health professional. A return date should always be given and a full screening conducted in the areas of concern noted before the referral.

'Early detection of mental health problems, effective intervention, and appropriate referral for those who need more specialised care, can do much to improve health outcomes ... Healthcare workers can undertake routine screening to identify mental health difficulties and refer as and when necessary.'



Progress should be monitored until recovery is noted. Pre-screening should then be carried out at each subsequent visit. Adherence support should be ongoing with every effort made to build skills that will assist them to manage the challenges of everyday life.

Mental health prevention and promotion remain the cornerstones of any mental health programme. Essentially, prevention initiatives aim to strengthen the protective factors that increase the likelihood of positive outcomes. Achieving this requires an emphasis on building important protective competencies. A mental health enhancement model therefore suggests that recipients of an intervention become more competent and capable, their psychological well-being improves and they are better able to deal with factors that can lead to poor adjustment. Even when a disorder has developed, its severity, course and duration can be reduced through preventive measures.^[2]

The *Child and Adolescent Mental Health Policy Guidelines (2013)*^[2] propose various strategies that aim to address a person's psychological needs, including their emotional, social, cognitive, spiritual and social needs, which include their relationships with others, the environment and society.

Generally known as psychosocial interventions, approaches include psycho-education, among others. Psycho-education is an evidence-based practice that has proved highly effective in both clinical and community settings as a form of support that responds effectively to the psychological stress associated with illness. The approach has shown largely positive results including retention in care and improvements in treatment adherence. As an important means of helping patients to understand their condition, it is based on the principle that when people are informed and knowledgeable they experience more control over their situation. In addition,

psycho-education has considerable value in building important life skills such as coping and problem-solving.^[14] Various tools are available to support this process.^[12]

The delivery format can be individual or group-based. A group-based intervention affords patients the opportunity to come together in a supportive environment where experiences can be shared and discussed with others confronting similar challenges. It provides an ideal platform for the dissemination of information to numbers of individuals at the same time within a time-period that will not feel rushed.^[15] Reviews of the efficacy of groups show largely positive results with important benefits including retention in care and improvements in treatment adherence.^[16]

However not all patients want to join a group. They may feel concerned or anxious about being with others, or may worry about confidentiality.

'Psycho-education ... has proved highly effective in both clinical and community settings as a form of support that responds effectively to the psychological stress associated with illness.'

HCWs who interact with patients in the healthcare system are expected to provide counselling across a range of conditions. Counselling for mental health problems with psychotropic medication prescribed where appropriate, can be extremely effective. In this regard, there is growing interest in cognitive behavioural therapy (CBT) as a model that addresses both adherence and mental health problems such as anxiety, depression and conduct difficulties. CBT is variously defined but is perhaps best described as a form of therapy that challenges negative thought patterns. HIV-positive adolescents have four-times the risk of developing depression than their non-positive counterparts, with consequences for treatment adherence and behavioural choices.^[17,18] As an intervention that can be delivered by nurses as well as non-health specialists, CBT is showing promising results in this area.^[19]

As many as one in six South Africans suffer from anxiety, depression, or substance abuse problems and over 40% of people living with HIV have a mental health problem.^[10] The risks that exist across the psychological, biological and social domains, underscore the importance of recognising and strengthening protective factors to reduce the possibility of negative outcomes.^[2] This requires implementation of a basket of interventions, which includes routine screening for mental health problems. The detection of mental health issues, especially those that do not necessarily warrant hospital referral, is not always optimal. Less serious problems are often

overlooked and never treated. Research has shown that intervening early, as soon as mental health problems are identified, significantly increases the likelihood of a good outcome.^[20]

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The Sustainable Development Goals

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The United Nations (UN) announced the 2030 Agenda for Sustainable Development in September 2015 and endorsed 17 Sustainable Development Goals (SDGs) with 169 targets and indicators. The goals follow on the achievements of the Millennium Development Goals (MDGs), developed in 2000 (Table 1), which were to reach their term by 2015. Unlike the MDGs, the SDGs are not aimed specifically at improving the lives of the world's poorest people or under-developed countries, but include all the countries globally, adding new elements such as economic inequality, climate change, peace and justice, among other goals. The 169 targets set out of the 17 goals are interconnected, aimed at ending poverty, protecting the planet and ensuring prosperity.^[1] They further provide guidelines for countries to apply them in accordance with each country's challenges, needs and priorities as determined by its policies for sustainable development. Except for a number of goals in each, the MDGs were developed using a top-down

approach, whereas the SDGs were developed through an extensive multi-year international consultation process, which involved input from citizens, civil society, and various stakeholders globally.^[2]

SDGs

According to the Brundtland report, sustainable development refers to development aimed at meeting the needs of the present without compromising

future generations' ability to meet their own needs.^[3] The SDGs (Table 2) cover the social, economic and environmental dimensions of sustainable development around five themes, namely people, planet, prosperity, peace and partnership, generally referred to as the 5Ps (Fig. 1).

Certain principles apply to the SDGs:^[1]

- *Universality* - the goals apply to every nation and are relevant to all countries globally.

Table 1. The Millennium Development Goals (MDGs)

Goal 1	Eradicate extreme poverty and hunger
Goal 2	Achieve universal primary education
Goal 3	Promote gender equality and empower women
Goal 4	Reduce child mortality
Goal 5	Improve maternal health
Goal 6	Combat HIV/AIDs, malaria and other diseases
Goal 7	Ensure environmental sustainability
Goal 8	Develop a global partnership for development

- *Integration* - the goals are all interconnected and interlinked in a system. Countries cannot aim to achieve just one goal, but must achieve all.
- *Transformation* - Achieving these goals will require countries to make fundamental changes in various aspects and areas, ranging from governance to health systems.

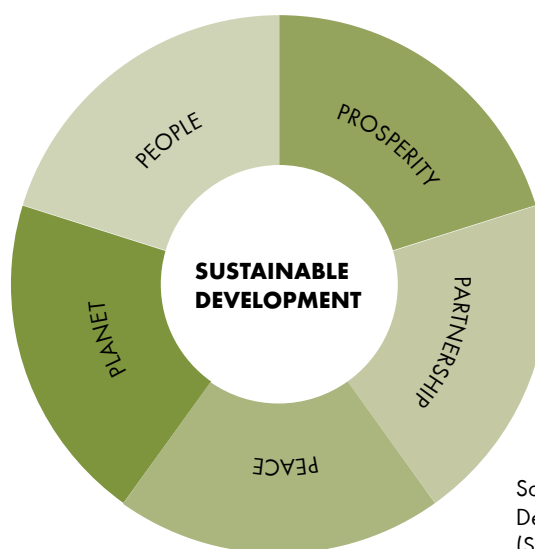
SDGs and HIV

The MDGs had a specific goal for HIV/AIDS (MDG Goal 6: To combat HIV/AIDS, malaria and other diseases). In the SDGs, HIV/AIDS is included in Goal 3; however, due to the interrelated and interlinked nature of the SDGs, this goal cannot be achieved in isolation, but would need actions in a number of other goals and targets that are related to health and HIV (Table 3). Some example of the interrelated goals and targets are as follows:^[2]

Nurses' role in the achievement of SDGs

While nurses are mainly tasked with healthcare delivery, there are areas where they can play a significant role towards the achievement of SDGs as individuals, as a profession and as part of the multidisciplinary team. For its campaign, the International Council of Nurses (ICN)'s selected theme for International Nurses Day in 2017 was *Nurses: A Voice to Lead, Achieving the Sustainable Development Goals*. The campaign's aim was to increase nurses' understanding of the SDGs, their importance and to encourage nurses to lead, inspire colleagues to share and celebrate the work in which they are involved, which contributes towards the achievement of the SDGs.^[4] While the MDGs led nursing to be one of the main contributors to the achievement of goals 4, 5 and 6, the SDGs force nurses to look wider into areas such as education, the economy, poverty, sanitation and the environment, which are familiar to them, albeit indirectly.

The 5 P's of Sustainable Development



Source: UN Sustainable Development Goals (SDGs) 2015

Figure 1: SDG themes.^[3]

Table 2. Sustainable Development Goals (SDGs)

Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, halt and reverse land degradation, and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalise the global partnership for sustainable development

Table 3: SDGs and targets related to HIV

	Goal	Target
Goal 1	End poverty in all its forms everywhere	<ul style="list-style-type: none"> 1.3 Implement nationally appropriate social protection systems and measures for all and achieve substantial coverage of the poor and the vulnerable
Goal 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	<ul style="list-style-type: none"> 2.2 End all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
Goal 3	Ensure healthy lives and promote well-being for all at all ages	<ul style="list-style-type: none"> 3.1 Reduce the global maternal mortality 3.2 End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	<ul style="list-style-type: none"> 4.2 Ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education 4.a Build and upgrade education facilities that are child-, disability- and gender-sensitive and provide safe, non-violent, inclusive and effective learning environments for all
Goal 5	Achieve gender equality and empower all women and girls	<ul style="list-style-type: none"> 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation 5.6 Ensure universal access to sexual and reproductive health and reproductive rights
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation	<ul style="list-style-type: none"> 9.5 Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, encouraging innovation and substantially increasing the number of research and development, public and private research and development spending
Goal 17	Strengthen the means of implementation and revitalise the global partnership for sustainable development	<ul style="list-style-type: none"> 17.16 Enhance the Global Partnership for Sustainable Development, complemented by multi-stakeholder partnerships that mobilise and share knowledge, expertise, technology to support the achievement of the Sustainable Development Goals in all countries, in particular developing countries 17.18 Enhance capacity-building support to developing countries, including for least-developed countries to increase significantly the availability of high-quality, timely and reliable data

Conclusion





The response to HIV/AIDS informs and intersects with the SDGs and health is central to all human development and therefore linked to all the SDGs. What is important is to realise that no one goal can be achieved on its own. Successful implementation will require integration and a multisectoral and inclusive approach at global, national and local levels, built through mobilising human and material resources, collaboration and partnerships.

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NATIONAL HIV & TB HEALTH CARE WORKER HOTLINE



	<p>0800 212 506 or 021 406 6782</p>		<p>pha-mic@uct.ac.za E-MAIL</p>
	<p>071 840 1572 SMS/PLEASE CALL ME</p>		<p>www.mic.uct.ac.za WEBSITE</p>

What questions can you ask?

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

- Pre-exposure prophylaxis (PrEP)
- Post exposure prophylaxis (PEP)
- HIV testing
- Management of HIV in pregnancy & PMTCT
- Drug interactions
- Treatment/prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of tuberculosis
- Antiretroviral Therapy (ART)
 - ~ When to initiate
 - ~ Treatment selection
 - ~ Recommendations for laboratory and clinical monitoring
 - ~ How to interpret and respond to laboratory results
 - ~ Management of adverse events

Who answers the questions?

The centre is staffed by specially-trained pharmacists who share 50 years of drug information experience between them. They have direct access to the latest information databases, reference sources and a team of clinical consultants.

When is this free service available?

The hotline operates from Mondays to Fridays 8:30am - 4:40pm.



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A clinical approach to a pregnant mother who refuses to test for HIV

Dr Trevor Majoro, MBChB (UKZN), DipHIVMan (CMSA), CIME (ABIME)
DOH (Wits)

Refilwe Anderson, a 22-year-old woman, presented with lower abdominal pain (LAP). An ultrasound showed that she was pregnant at 12 weeks' gestation. She was so excited to discover this, because she and her boyfriend of two years had agreed to have a child together.

She then stated that she did not want to do an HIV test.

Upon explaining the benefits of knowing whether or not she was living with HIV, she displayed a thorough understanding and knowledge about HIV and antiretroviral therapy (ART), from which some healthcare workers (HCWs) would learn a lot!

So, why would a visibly excited, newly pregnant mother, with a deep understanding of HIV and the benefits of ART for herself and her unborn child refuse to test for HIV? Possibilities could include that:

- She already knew her status
- She did not know whether or not

she was HIV-positive, but had fears or concerns about stigma and discrimination.

A detailed history-taking was conducted while her decision not to test was respected. A great atmosphere of commitment to serve and not to judge was mutually established with her. An agreement of honesty in conversation was also declared bilaterally.

The onset of LAP was of 3 days' duration, with the pain consistently mild from the first day and localised behind the pubic symphysis with no radiation. It was a 'dull' pain lasting a few seconds and experienced once to twice per day. There was no identifiable aggravating nor relieving factors, nor associated phenomena.

Systemic enquiry revealed no complaint with no urinary symptoms and no vaginal discharge. Her activities of daily living were not limited by the pain.

She was not on any medication, had no

previous history of pregnancy, and no known allergies. Added to this, there was no known present chronic condition. She stated that her last HIV test was one month after breaking up with her ex-boyfriend and she repeated it three months later, which was one month before she met her current boyfriend. She said all the rapid test results were negative. No history of trauma to her pelvis, abdomen nor body existed and there was no family history of hereditary diseases. She also had no known family member who had disclosed being HIV-positive.

Refilwe was unemployed having passed Grade 12 four years ago; however, she had a sponsored beautiful lifestyle of luxury. She spoke confidently about how she was adequately and holistically taken care of, and deservedly so. She said she did not smoke, drink alcohol nor abuse any substances. Her diet revealed a health-conscious person who enjoyed an impressive variety of nutritional food. She trained four times a week (without fail) with the guide of a personal trainer and had 12-weekly biokinetic assessments.

She admitted to having unprotected penetrative vaginal sex exclusively with her boyfriend for the past two years. It was at this point that I really wanted to understand why she did not want to test for HIV as it looked like she had a desirable life. She further informed me that her parents were supportive despite her having dropped out of three tertiary institutions over three consecutive years after she had passed Grade 12. Then, her face dropped and she said, "I can't" to which I asked, "Can't what?"

Tearfully she said she did not want to 'spoil' her relationship with her boyfriend – a popular, respected community leader who was married with three children (all older than her), and who was so good to her. It then became clear why she would not test: 'to preserve her relationship with her dream boyfriend married man'.

Now that the reason was clear, it became easier to persuade her to test. In brief, she bought into the reality of the need to know whether she was HIV-positive or not, so that she could automatically disclose to herself first. Bringing awareness of her self-neglect in the name of a 'sterile or perfect' intimate relationship made her choose herself first. She proactively agreed to test for HIV and the results confirmed that she was HIV-positive. She even admitted to noting that her entire life was about her boyfriend, not her. A basic clinical tool of detailed history-taking made available to her a life-changing realisation beyond just testing for HIV. Instead of being bitter she cherished the opportunity to consciously improve her life.

She agreed to be referred to a clinical psychologist as part of self-care and holistic support.

Take-home message

Using basic detailed clinical history-taking as a tool affords HCWs an opportunity to navigate towards finding the main reason(s) why a person would not only refuse to test for HIV (other than the assumption of fear about stigma), but also to get to know their holistic life state which impacts on any intervention with which we may need to mutually assist them. In short, the reasons for refusing to test for HIV or any other disease, are not only about stigma, discrimination and misconceptions, etc. Systematically ask clinical questions of relevance, listen attentively and realise the opportunities that will guide specifically needed interventions.



The journey towards the elimination of mother-to-child transmission of HIV

HIV re-testing and viral load monitoring during pregnancy and breastfeeding

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The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission (MTCT). In the absence of any intervention, transmission rates range from 15% to 45%. This rate can be reduced to below 2% with effective antiretroviral treatment (ART).^[1] These interventions primarily involve ART for the mother and a short course of antiretroviral drugs for the baby. Prevention of mother-to-child transmission of HIV (PMTCT) also includes measures to prevent HIV acquisition in the HIV-negative pregnant woman and appropriate breastfeeding practices.^[1]

History

It has been just over a decade since the launch of the ART programme at public health facilities in South Africa (SA), and great progress has been made in terms of saving lives, extending life expectancy and PMTCT.^[2] In 2013, new interventions included the introduction of a fixed-dose combination (FDC) pill which included three antiretroviral

drugs namely tenofovir, emtricitabine and efavirinz (TDF/FTC/EFV) to be taken once daily as part of first-line ART.^[3] This intervention reduced the pill burden. With the launch of Option B+ in 2015, all HIV-positive pregnant and breastfeeding women started lifelong ART regardless of staging and CD4 T-cell counts.^[1] These interventions are in line with the 90-90-90 targets and World Health Organization (WHO) guidelines.

To improve both mother and child survival and reduce mortality and morbidity from HIV, all HIV-positive women should be on sustainable ART and be virally suppressed by the time they deliver and during breastfeeding. This is not achieved in many instances as we have challenges with late booking, ART interruptions, non-disclosure resulting in non-adherence to ART regimens and inconsistent use of condoms. This is evidenced in the high rate of maternal deaths due to non-pregnancy-related infections in 2011 - 2013. Of these patients, 90% were HIV-positive women.

How do we prevent HIV acquisition in HIV-negative pregnant and breastfeeding women?

One of the key PMTCT interventions is prevention of HIV acquisition in women of child-bearing age:^[1] 'HIV testing services (HTS) are offered at all service points during the antenatal and post-natal period. Women should receive information regarding HIV, the risks of MTCT and information regarding risk reduction and prevention of re-infection with consistent condom use. Providing HTS early in pregnancy enables HIV-positive pregnant women to benefit from all the relevant prevention interventions. This includes early ART, treatment and care services which will reduce the risk of MTCT'.^[4]

These women need to be educated about all the future HIV tests during pregnancy, labour and breastfeeding. HIV education, formerly known as pre-test counselling, does not have to be repeated with every test. Women need to be reminded about these tests. Record-

keeping of these repeated test results has to be done on the patient-held maternity case record in the public sector and in the facility records. To gain co-operation, women should be informed that HIV information will be written on the patient-held record for continuity of care and shared confidentiality between healthcare workers/practitioners. Women need to be informed about their test results and informed when the next test is due during the post-test counselling sessions.^[1]

Women should also be encouraged to bring their partners in for HIV testing. Discordant couples at high risk of HIV acquisition or transmission can benefit from pre-exposure prophylaxis (PrEP).^[4]

What about the HIV-positive pregnant and breastfeeding women?

All pregnant or breastfeeding women are initiated onto ART at HIV diagnosis regardless of staging or CD4 T cell counts. Women are screened for co-morbidities such as hypertension, renal disease or Diabetes and Psychiatric disorders especially psychosis and co-infections especially Tuberculosis (TB). Due to the risk of MTCT all pregnant women are initiated on ART on the day of diagnosis. Screening bloods to check renal function and CD4 cell counts are done and women are to return for results within a week as recommended.

When is viral load monitoring done?

For the elimination of MTCT to occur, women need to be virally suppressed. Viral load (VL) monitoring is effective in monitoring adherence to treatment regimens. When VLs are lower, the risk of HIV transmission is reduced. Viral suppression is expected 16 - 24 weeks after ART initiation with appropriate treatment. Other factors that can affect viral suppression include the general health of the woman, CD4 T-cell count and drug resistance.

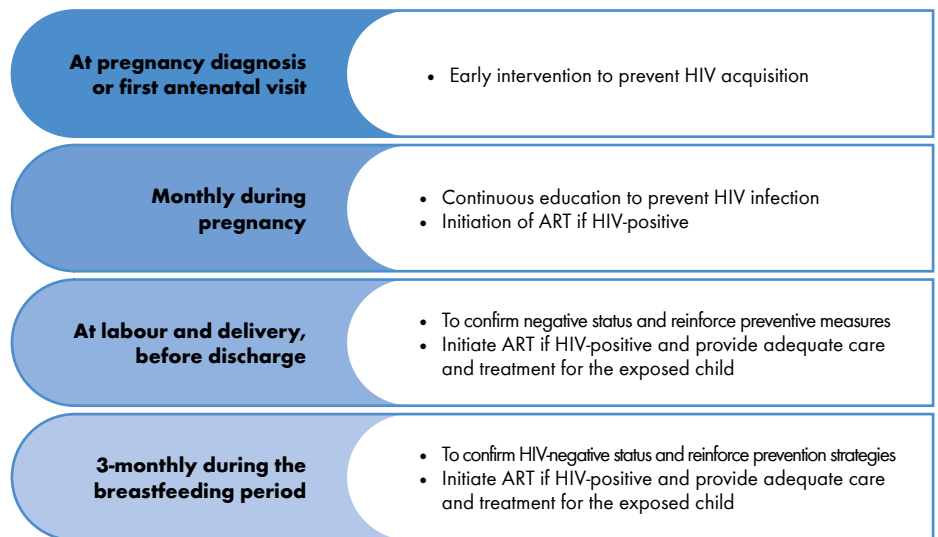


Figure 1: Frequency of HIV testing and the appropriate interventions.^[1]

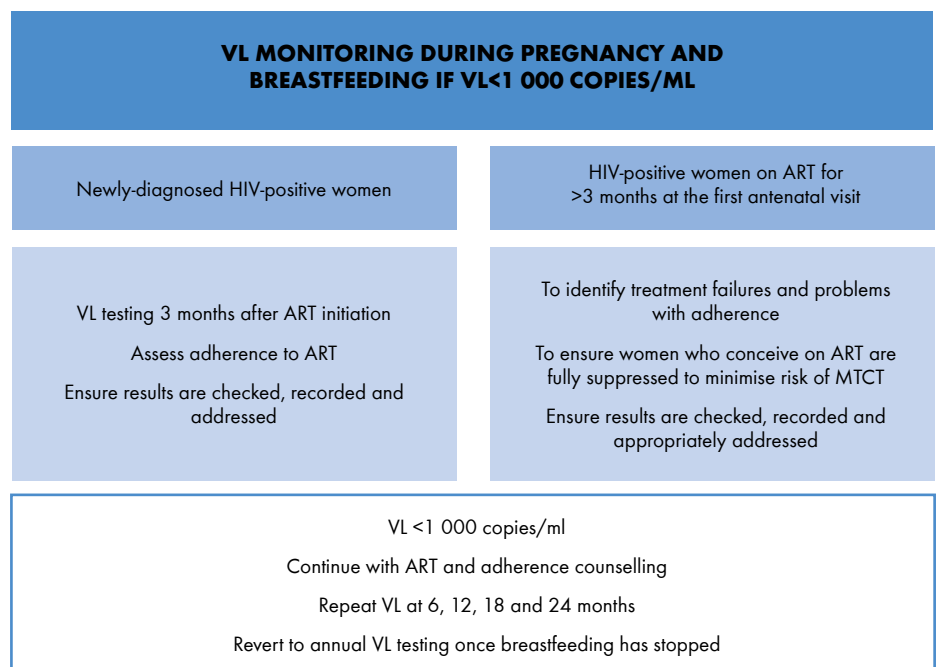


Figure 2: Viral load monitoring during pregnancy and breastfeeding.

The PMTCT programme allows for VL monitoring at any time outside the routine testing schedule if there are concerns about adherence to ART.^[3]

For viral suppression to occur, adherence to ART and consistent condom use to prevent re-infection with a positive partner must be adhered to. Figs 2 and 3 explain the recommended VL monitoring for the PMTCT programme in the public sector in South Africa.

‘For viral suppression to occur, adherence to ART and consistent condom use to prevent re-infection with a positive partner must be adhered to.’

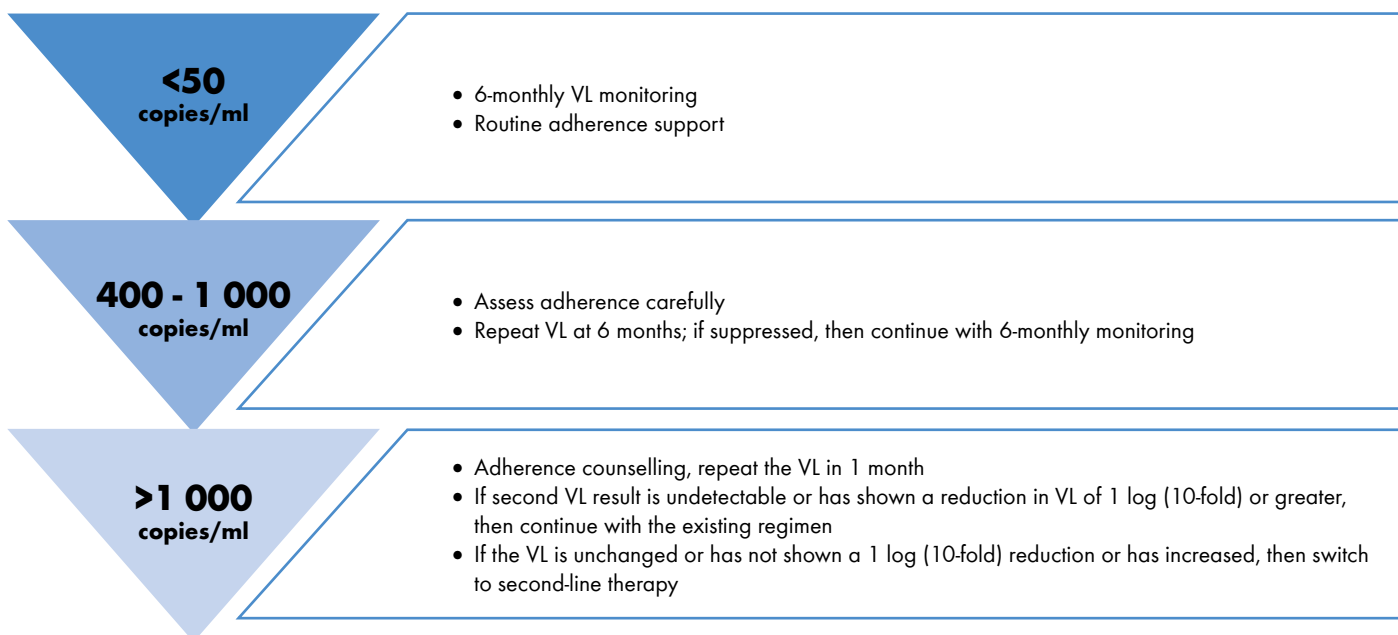


Figure 3: Response to viral loads.

Other interventions

What other interventions should be implemented for mother and child? Refer to Table 1.

Conclusion

Implementation and integration of the guidelines remains challenging at facility level, which has a negative impact on PMTCT. The re-testing of HIV-negative women during pregnancy and breastfeeding needs to be implemented at all levels of care at all service points, including the expanded programme on immunisation (EPI) and Family Planning services.^[3] VL monitoring during pregnancy and breastfeeding needs to be implemented and recording of these results must consistently be acted upon. To keep women alive and prevent new HIV infections, ART adherence during pregnancy, labour, breastfeeding and lifelong, must be ensured, with consistent viral suppression being the goal.

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Table 1. The six building blocks of a health system

Mother	Child
Always check for hepatitis B before stopping TDF. Patients with chronic hepatitis B may have a fatal hepatitis flare. Positive result, TDF to be included in 2nd line therapy as a fourth drug.	Will require additional immunisation at birth: hepatitis B vaccine – hepatitis B immunoglobulin immunisation to prevent hepatitis infection.
Recording of VL results accurately and acting appropriately in response to results is imperative to management of the patient.	To receive the correct infant ART prophylaxis in response to the VL results of the mother.

ART – antiretroviral therapy; TDF – tenofovir; VL – viral load.

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A fundamental shift: Weaknesses in QI implementation

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In this opinion piece, I discuss two critical weaknesses I have observed in quality improvement (QI) implementation, and reasons why I think our current QI initiatives are not being sustained. I will briefly indicate how I perceive that these challenges could be rectified in order to strengthen our health system. Furthermore, I will share examples from primary healthcare (PHC) facilities that have been able to address these challenges and celebrate the results they now enjoy.

Weakness 1: It's not my job

QI is understood, defined and practised very differently within the same health system. This article will not be commenting on the various improvement methodologies, their strengths and weaknesses; rather, I wish to provide a

generalised definition of QI to ensure common understanding. I personally love this definition of QI by Batalden *et al.*: 'We propose defining it (QI) as the combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). This definition arises from our conviction that healthcare will not realise its full potential unless **change-making becomes an intrinsic part of everyone's job, every day, in all parts of the system.** Defined in this way, improvement involves a **substantial shift in our idea of the work of healthcare ...**'⁽¹⁾

From this definition, I wish to highlight the first weakness, which is the fact that 'change-making' is not an 'intrinsic part of everyone's job'. **This 'intrinsic change-making' is precisely what QI is; it is the will, desire, tools and ability to be able to critically look at how you do your work and then ask yourself the question, 'can I do it differently to get a better outcome?'** We cannot simply do what we have done and keep doing what we have always done in a world and health system that is continuously changing and then think that we will meet current standards, expectations and targets.

Change-making (QI) must be intrinsic in all of us. It is therefore not an add-on or a special project in which only some people get involved. It is neither

a conference nor a once-off symposia; it is, however, a **lens we must use every day to evaluate what we have done and the impact of how we have done it**. We cannot simply choose to say that change-making should be done by someone else; who is that someone else? As John E Lewis so eloquently stated, 'If not us, then who? If not now, then when?'. QI is the 'unceasing efforts of everyone ... every day, in all parts of the system' - **it is therefore your job!**

Improving viral load (VL) completion and suppression rates is something many of us are grappling with at the moment. A number of healthcare professionals have questioned how they can get different results and have come to realise that they can do things differently in order to get better outcomes. In a PHC clinic, the staff realised that they were filing patient files before the results were actually recorded in TIER.net. Through their collective reflection and analysis, they have now identified a new way of working (Fig. 1) which involves:

- Upon delivery and receipt of results, the data capturer records all results in the blood book register
- Thereafter, the results are captured in TIER.net
- Lastly, the results are filed in the patient folders.

Albert Einstein years ago stated: 'The significant problems we have cannot be

solved at the same level of thinking with which we created them'. Why are many of our QI efforts not sustained? Because healthcare providers have not made that 'substantial' and I would like to say, **fundamental** shift, in how we do and think about our work. We have to be prepared to experience a new level of thinking.

Healthcare providers need to be reflective! All too often I hear the words, 'QI is not my job' or 'I don't have time to do QI'. Unfortunately, ladies and gentlemen, we have to make a fundamental shift in how we do our work. Improving how you do your work, is your work. If your efforts are not yielding the results your manager, sub-district or district require, then you must consider that you may be part of the problem, and therefore, you must be part of the solution. **Each of us has two important components to our work: (1) doing it; and (2) improving how we do it.**

Weakness 2: Data, what data?

Every day, healthcare providers are putting in huge amounts of effort to care for the hundreds and thousands of patients presenting at health facilities. The queues often seem endless and must feel so overwhelming at times. There are literally hundreds of data indicators that are collected on a monthly basis to reflect all of this effort. The problem is,

most often these data are not fed back to the workers at facility level who are rendering the services. Data reviews happen at a sub-district level and therefore staff are very reliant upon their management to feed data back to them. **If we truly are to be reflective as I suggested earlier, staff need to have access to data sets and need simple skills to analyse them.** Facility-level data reviews and daily informed data decision-making are essential if change-making is our mandate. There are many enlightening reports that can be drawn from the various data systems and made available to staff to enable them to make the fundamental shift. All too often, facility-level staff are told about an indicator that is already 'red', already a crisis; what they need is access and encouragement to evaluate data on a daily, weekly and monthly basis, in order to improve on what they do proactively and not retrospectively. This is especially vital when you consider that we are talking about patients' lives and not some product in a factory.

A PHC facility in a rural district in South Africa had a high TB defaulter rate. A root cause analysis showed that there was poor communication between the facility and home-based caregivers (HBCs) around tracing of tuberculosis (TB) early missed appointment clients. Tracing of clients and feedback to the facility was slow because the HBC supervisors were not providing the early missed appointments list to HBCs on time for tracing. Weeks and months would pass before these lists were received and before any action could be taken.

The facility staff realised that they could generate simple data on a daily basis to help them address this issue and determine their impact. The nurse compiled and provided a list of TB early missed appointments to the supervisor and HBCs for tracing on a daily basis, and the HBCs were expected to provide feedback to the nurse within 24 hours of any missed appointments. This simple change was tracked and documented

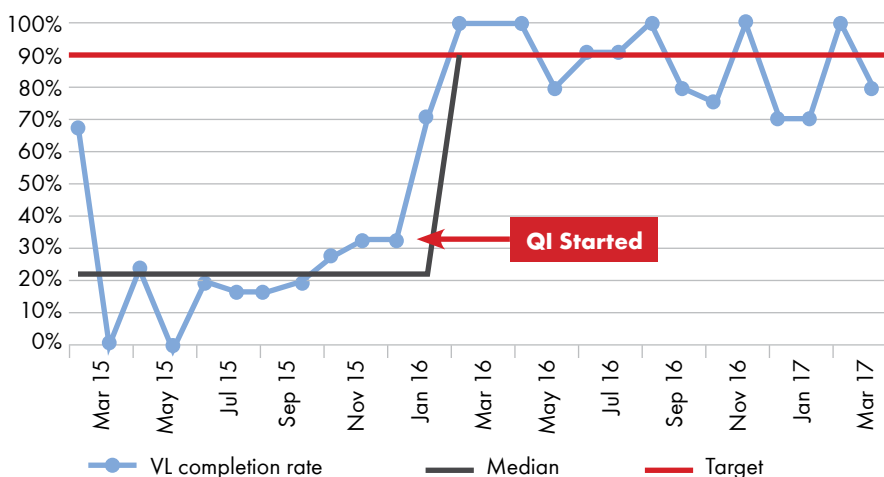


Figure 1: Facility X Viral Load Completion rate at 12 months

on a daily basis using the following process measures:

- # of clients booked/expected for follow-up visit
- # of clients who missed their appointments
- # of clients on the list given to HBCs/supervisor for tracing
- # of clients who came back to the facility within 24 hours
- # of clients who came back to the facility after 24 hours.

Through consistent daily monitoring of process data and a willingness to be reflective about what they did, this facility has achieved great improvements in their TB defaulter rate (Fig. 2).

With these hundreds of indicators that are routinely collected, assessments that take place and standards that have to be met, we need to ensure that we are **not just creating a reporting culture, but that we are creating a culture of reflective practitioners that use the data** that come as a result of all of these activities **to make continuous implementation adjustments.**

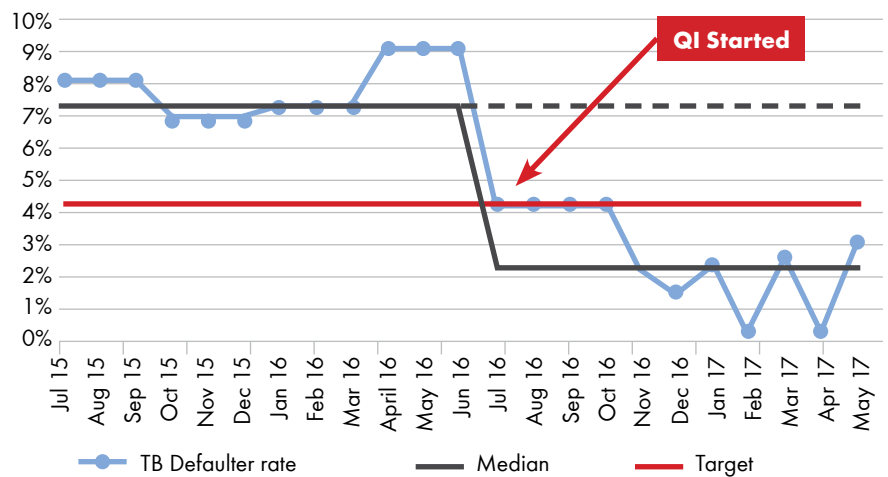


Fig. 2: QI to effect change in TB defaulter rate.

Conclusion

If we are to strengthen our health system through our continuous improvement efforts, then two essential weaknesses in our current QI implementation must be addressed. Firstly, everyone needs to realise that ‘change-making’ is indeed their job. This requires a fundamental shift in how we perceive and practise our work. Secondly, we are not just simply required to mindlessly implement. We

must work in an informed, data-driven way that allows for constant incremental adjustments in order to meet the changing needs of patients, government and funders.

References

1. Batalden PB, Davidoff F. What Is ‘quality improvement’ and how can it transform healthcare? *Quality & Safety in Health Care* 2007;16(1):2-3.

The festive season is just around the corner. Make sure your patients stay healthy and have peace of mind by ensuring that you have enough essential medicines in stock. If you haven't already done so, check the stock levels at your clinic and order the extra medicines you may need.

You can also help your patients by reminding them how critical it is not to miss doses of their ARVs and to adhere to their regimens over the holidays. It's tempting to let your hair down and party, but;

- Drug and alcohol use can lead to risky behaviours like unprotected sex, and this can increase your chances of getting or transmitting HIV
- Drugs and alcohol weaken your immune system and damage your liver, which helps your body process ARVs
- Alcohol can also make the side-effects of ARVs worse

So yes, it is the season to be jolly, but make sure to make your health and that of your patients' top priority.

Happy holidays

Source: <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/25/84/hiv-and-drug-and-alcohol-users>

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.org



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.



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. Many patients with TB are also co-infected with HIV/AIDS, so the TB nurse has to be extremely knowledgeable about both infections. A TB nurse has to work with a high volume of patients and 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 to exceed 1 000 words, by 1 February 2018 and stand a chance to win a free one-year membership to the Southern African HIV Clinicians Society (the Society); and have your piece published in *HIV Nursing Matters*! One winner will be chosen by 1 March 2018. The winner agrees to the publication of their story in the next 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
sahivsoc@sahivsoc.org



**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.

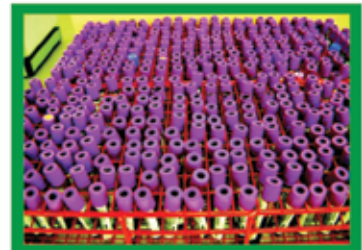
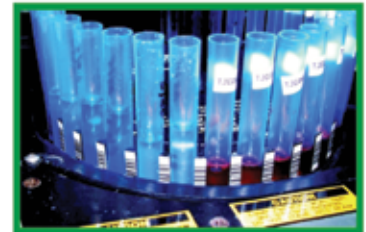
Once you have a Reference number

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.



Quiz questions for December 2017

1. Which statement regarding quality improvement (QI) is FALSE?
 - A. Change-making should be an intrinsic part of everyone's job.
 - B. QI is understood by everyone to mean the same thing, and is practised in a similar way in every health facility.
 - C. A culture of reflective practitioners should be created to make continuous implementation adjustments.
 - D. Continued and repeated access to data is needed to make improvements.
2. Which of the following is NOT an objective of the Clinical HIV/AIDS Services Strengthening (CHASS) Project?
 - A. Increased coverage of ART to 90%
 - B. Improve HIV counselling methods
 - C. Complete TB treatment for 90% of people living with HIV diagnosed with TB
 - D. Increased average CD4 count at initiation of antiretroviral therapy (ART).
3. Which statement is TRUE?
 - A. The Millennium Development Goals (MDGs) include all the countries globally, adding new elements such as economic inequality, climate change, peace and justice, among other goals.
 - B. The five themes that the Sustainable Development Goals are based on are: people, planet, prosperity, power and partnership.
 - C. The principle of 'Universality' means that the countries cannot achieve just one goal, but must achieve them all.
 - D. Sustainable development refers to development aimed at meeting the needs of the present without compromising future generations' ability to meet their own needs.
4. Which of the following is NOT an MDG?
 - A. Promote gender equality and empower men
 - B. Reduce child mortality
 - C. Combat HIV/AIDS, malaria and other diseases
 - D. Achieve universal primary education.
5. Which statement is TRUE regarding mental disorders?
 - A. Nearly half of all mental disorders start by age 10.
 - B. HIV-positive adolescents have eight times the risk of developing depression than their non-positive counterparts
 - C. Following identification of a mental health problem, early intervention significantly increases the likelihood of a good outcome
 - D. Over 60% of people living with HIV have a mental health problem.
6. Which statement is FALSE?
 - A. Mental health prevention and promotion remain the cornerstones of any mental health programme.
 - B. Adherence support should be an on-going process.
 - C. Psycho-education is an evidence-based practice that is highly effective as a form of support that responds effectively to psychological stress associated with illness.
 - D. Psycho-education is based on the principle that the more informed and knowledgeable people are, the less control they have over their situation.
7. Part of taking a detailed clinical history is exploring reasons as to why patients may or may not want a specific investigation or intervention. Is this statement TRUE or FALSE?
 - A. True
 - B. False
8. Which statement regarding mother-to-child transmission (MTCT) of HIV is TRUE?
 - A. Patients with hepatitis B who are on a tenofovir-based ART regimen should stop tenofovir when switching to a second-line ART regimen.
 - B. The five C's of HIV counselling and testing are: consent, confidentiality, contact tracing, counselling, and correct test results.
 - C. The purpose of doing a viral load test at confirmation of pregnancy in those already on ART for more than 3 months is to identify treatment failures and problems with adherence.
 - D. In the absence of any intervention, HIV transmission rates from mother to child range from 30% to 65%.
9. Health systems strengthening (HSS) is defined as the process of identifying and implementing changes in policy and practice in a country's health system in order for the country to respond better to challenges in the health system. Is this TRUE or FALSE?
 - A. True
 - B. False
10. Which is considered by the World Health Organization to be a building block as part of the framework for HSS?
 - A. Good health services
 - B. Leadership and governance
 - C. A good health financing system
 - D. All of the above.

Quiz answers from the May 2017 issue

1. True

2. C

3. C

4. D

5. A

6. True

7. False

8. B

9. True

10. B

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.





2018 MEMBERSHIP APPLICATION FORM

PROFESSIONAL INFORMATION

Title: Prof Dr Mr Mrs Ms Initials: _____ First Name(s): _____

Surname: _____ Institution/Organisation: _____

Profession (check one):

Doctor Generalist Doctor Specialist Pharmacist Professional Nurse Other: _____

If Doctor Specialist, select speciality:

Cardiology Clinical Pharmacology Dermatology Family Physician Infectious Diseases OB GYN Paediatrics

Physician / Internal Medicine Psychiatry Other: _____

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

Primary Employment affiliation (please chose one):

Clinic Government (non-clinical) Hospital Industry Non-governmental Organisation (NGO) Private Practice

Student University Other

Professional Activities (write '1' for primary and '2' for secondary):

Administration Advocacy Patient care Programme Management Research Sales/Marketing

Teaching/Education Other

Please enter the year you began treating HIV patients: _____

Please indicate if you have passed a postgraduate diploma on the clinical management of HIV from one of the following institutions:

Colleges of Medicine of South Africa University of KwaZulu Natal Other: _____

Year completed: _____ Year completed: _____ Year completed: _____

Professional Associations: SAMA IAS FIDSSA Other: _____

CONTACT INFORMATION

Postal Address: _____

Suburb/Town: _____ Postal Code: _____

Province: _____ Country: _____

Telephone: _____ Mobile: _____

Fax: _____ Email: _____

DEMOGRAPHIC INFORMATION

Race/ethnicity: Black Coloured Indian White Other: _____

Gender: Female Male Intersex/Transgender Date of Birth: //

MEMBERSHIP PREFERENCES

Would you like to receive a posted copy of the Society's magazine for nurses, *HIV Nursing Matters*? (Copies are available free on the Society's website: www.sahivsoc.org) Yes No

Would you like to participate in the Society's online membership directory? (Your contact information will be available only to other Society members through the members portal on the Society's website) Yes No

How would you like to receive communications from the Society (check all that apply): SMS Email

- **Doctors** **R400 per annum**
- **Nurses & Allied Health Professionals** **R300 per annum**
- **Pharma Package** **R14000 per annum**
includes 10 pharma rep memberships, 2 mailers and 1 social media event / article
- **Organisation (NGO) Package** **R3500 per annum**
for 10 staff memberships or R6000 per annum for 20 staff memberships

Signed: _____

Date: _____

I hereby agree to support the values and mission of the Society; and agree to the membership code of conduct

Method of payment: Electronic Transfer Direct Deposit Post/Cheque Cash Payment Date: //

Fees are now charged for a calendar year or pro rata according to the date of application. Payments may be made by cheque or electronic transfer payable to: Southern African HIV Clinicians Society, Nedbank Campus Square, Branch Code 158-105, Account No: 1581 048 033. For alternative online payment please go to <http://sahivsoc.org/about/membership-application> and click the "Pay Now" button. Please reference your surname and/or membership number on the payment. Please fax or email proof of payment to 011 728 1251 or admin@sahivsoc.org or post to: Suite 233, Post Net Killarney, Private Bag x2600, Houghton 2041.

HAVE QUESTIONS? Please contact us: 011 728 7365 / admin@sahivsoc.org / www.sahivsoc.org



UNITING NURSES IN HIV CLINICAL EXCELLENCE, BECOME A MEMBER.



Who are we?

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

1 LEADING • PIONEERING

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

2 CONNECTING • CONVENING • ENGAGING

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

3 ADVOCATING • INFLUENCING • SHAPING

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

Member Benefits

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

- Free online subscription to the *Southern African Journal of HIV Medicine*
- Free quarterly subscription to the Society's e-newsletter, *Transcript*
- E-learning through CPD-accredited clinical case studies and online discussion group forums
- Free tri-annual 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

SOCIETY CONTACT DETAILS:

Tel: +27 11 728 7365 • **Fax:** +27 11 728 1251

Email: sahivsoc@sahivsoc.org

Post: Suite 233, Private Bag X2600, PostNet, Killarney, Houghton, 2041

www.sahivsoc.org

