

HIV Nursing matters

A Magazine of the Southern African HIV Clinicians Society



Interview with Minister of Health
Nursing Summit
Accountability in nursing



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All year Registration

ACCREDITATION

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DISTANCE COURSES

DISTANCE COURSE IN DISPENSING

INTRODUCTION

This course is based on the recommended standard for the dispensing course for prescribers in terms of Act 101 of 1965 as amended, which was developed by the South African Pharmacy Council, in consultation with the other statutory health councils. Licensing with the relevant authority as a dispensing health care professional can only take place once a certificate from an accredited provider has been awarded. This course will enable health professionals to dispense and ensure the quality use of medicines prescribed to the patient. The Dispensing Course is presented in association with the Health Science Academy.

STRUCTURE: 6 month distance based course with no contact sessions
COURSE FEE: R 1 539

DISTANCE CLINICAL MANAGEMENT OF TB FOR HEALTHCARE PROFESSIONALS (NURSES)

INTRODUCTION

The World Health Organisation (WHO) declared TB a global emergency in 1993. It is estimated by the WHO (2004) that about 1/3 of the world's population is currently infected with M. Tuberculosis. The WHO also determined that there were about 8.7 million new cases of TB and 1.9 million deaths due to the disease in 2000. According to these statistics it can be deduced that 2 people are infected every second! About 95% of TB cases and 98% of all TB deaths occur in developing countries, mainly among the poor, and mostly in the economically productive age group of 15-20 years of age.

STRUCTURE: 3 month distance based course with no contact sessions
COURSE FEE: R 800

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WORKSHOPS

NURSE INITIATED MANAGEMENT OF ANTI-RETROVIRAL THERAPY (NIMART)

INTRODUCTION

The NIMART course has been developed as a response to the call to action by the South African Government to strengthen the response to HIV and TB epidemics and is specifically developed for and aimed at professional nurses working in the field of HIV and TB. The 5-day course is a stand alone intensive programme that focuses on the management of TB, HIV and STI's as well as strengthening counselling skills, monitoring and evaluation of HIV and TB programmes. Participants should follow the course with a practical mentorship programme that is linked to an experienced HIV and TB clinician.

STRUCTURE: 5 Day workshop
COURSE FEE: R 5 700

CLINICAL MANAGEMENT OF HIV / AIDS FOR NURSES

INTRODUCTION

This course is presented in association with the South African HIV Clinicians Society and will enable participants to acquire or update skills with regard to:

- The diagnosis of HIV / AIDS and STD's
- The management of HIV / AIDS and STD's
- All aspects of counselling (pre- and post-test, therapy compliance)
- Having empathy with people "Living with AIDS"
- Fulfill their role as health care professionals in community mobilization
- Understand vaccine development and clinical trials

STRUCTURE: 3 day workshop
COURSE FEE: R 3 700

REGISTRATION

DANIELLE DANIELS / MELANY MANOHARUM / VUYISILE KHUMALO

Tel: 012 816 9000 / 9101 / 9100 / 9107

Fax: 012 807 7165

Email: enquiries@foundation.co.za

Website: www.foundation.co.za

PLEASE VISIT OUR WEBSITE FOR INFORMATION ON OTHER COURSES

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HIV Nursing Matters
focuses on leadership, accountability & delivery

contents

inside

Editor's note	2	International collaboration	
		Nurse leadership development	28
Presidents message	3		
News	4	Comment	
		What a difference a decade makes	34
Current issue		Competition	
Nursing Summit	8	Naming the magazine - winner	35
Where are the nurses?	12	Win a bursary	36
Clinical Update		Where to go	39
ART knowledge and adherence	16	What to do	42
Ethics & Law			
Ethics of responsibility	20		
Interview			
Minister of Health	24		

on cover

- Interview with Minister of Health**
- Nursing Summit**
- Accountability in nursing**

ed's note



Nelouise Geyer

The theme of this edition of the magazine is *Leadership, Delivery and Accountability* – similar to that of the June 2011 AIDS Conference. Accountability and leadership are important issues for healthcare services and the professionals who deliver them. As individual practitioners we are certainly very involved on a daily basis in the delivery of health and nursing care, including NIM-ART. Very few of us work with the bigger picture of overall leadership and accountability. But there is no doubt that we collectively contribute to the overall accountability and leadership of the professions and the healthcare system in performing our day-to-day tasks.

The leadership role we undertake as healthcare practitioners is multifaceted. It is seen in the one-on-one relationship with patients which entails assessing and helping patients to understand their condition and empowering them with knowledge and support to make healthy decisions for optimal living. It is about the one-on-one relationship with those practitioners we mentor to also become

practitioners of excellence. It is the team leader who leads the team to deliver quality health services to the community; and the managers at various levels that not only has to manage health services, but also has the role to advocate for the clinical practitioners in their units who are responsible for service delivery and empowering these practitioners to deliver those services.

Accountability is the foundation of everything we do irrespective of the level of practice. It is about taking responsibility for what we do or don't do – to do it as best we can even when no-one is watching us. Professor Landman's article clearly points out that accountability rests in both our responsibilities as citizens *and* as professionals. It is an essential part of what we do every day.

We have renamed the magazine to indicate that what you do as practitioners *do matter* - making a difference to the quality of lives of people is what accountable professionals do as leaders to ensure continuous delivery. Therefore we bring 'matters' to you in the magazine to stimulate your thoughts and to support nurse practitioners in the work they do. The new name of the magazine reflects this.

talk to us

Tell us what you think of this issue. E-mail me at: nelouise@sahivsoc.org

The Team

Editor

Nelouise Geyer

Message of the president

Professor Francois Venter

Contributors

Monument Trust

Advertising

Fatima Shaik

SA HIV Clinicians Society

Tel (011) 341 0162

For more information contact

SA HIV Clinicians Society
Suite 233 PostNet Killarney
Private Bag X2600
Houghton
2041

www.sahivsoc.org

Tel: +27 (0) 11 341 0162

Fax: +27 (0) 11 341 0161

e-mail: sahivsoc@sahivsoc.org

Article/letter submissions:

nelouise@sahivsoc.org

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Prof Francois Venter

Message from the president

**PRIMARY
CARE**
revitalisation
is good news
for nurses

The June AIDS conference in Durban has as its theme, leadership. The health system needs it like never before – after over a decade of neglect and political manipulation, we have some of the worst health outcomes per rand spent in the region.

Luckily, we're seeing leadership coming forward – the launch of primary care revitalisation, while it may still be in the planning phase, signals a welcome move to taking primary care beyond the Manto-era rhetoric, where primary care got lip service but no real support. Now, it looks like Treasury is funding pilot sites, and that the Minister of Health and his national Department of Health are throwing their weight behind the programme. Many of us have fond memories of school nurses, home TB and post-natal visits, and of clinics that were trusted and resourced. Now, patients attend hospitals extremely ill, after either

delaying attending primary care, after getting inadequate care at a clinic, or not attending clinics at all. It's a vote of no-confidence in an ostensibly primary-care focused health system, and a devastating indictment on the prior health administration.

This new focus is good news for nurses, and for patients. It allows for preventive therapy to be broadened, interventions to be focused directly on communities, and for us to look hard at referral systems. HIV patients and health care workers should be breathing a sigh of relief – it may mean we get to test, stage and initiate ART faster and more efficiently.

So, pay attention to the forthcoming news on this, and start planning for a better, more appropriate and hopefully happier health system.

®



news

Infant deaths drop after Midwives undergo inexpensive training

A study published in the journal *Paediatrics* and funded by the National Institutes of Health and the Bill and Melinda Gates Foundation indicated that basic training in new born care for midwives can save babies' lives. Giving midwives basic training has already been shown to save new borns' lives, and a new study in Zambia has found that it can be remarkably cost-effective as well. A small pilot project costing only \$20,244 saved the lives of 97 infants, the authors estimated, meaning that it cost just \$208 per life saved. The training was conducted by

American and Zambian university and government doctors. The midwives usually handle births that were expected to be uncomplicated, with women typically going home with their babies after one night in the clinic. Midwives from 18 Zambian clinics were taught a basic course in new born care and encouraged to teach their colleagues as well. The course covers basic interventions like cleaning and warming a new born, resuscitation, breast feeding and diagnosing common illnesses. The researchers compared survival rates

among 20,000 babies born before the teaching and 20,000 afterward. The first-week death rate among babies had dropped by almost half, they found, to 6.8 deaths per 1,000 live births from 11.5 deaths.

By Donald G. McNeil Jr.
9 May 2011

New York Times: Global Update
(http://www.nytimes.com/2011/05/10/health/10global.html?_r=2) For more information go to:
<http://pediatrics.aappublications.org/content/127/5/e1176.abstract>



Study shows gap in HIV prevention messaging for youth (Living with AIDS # 465)

About 40% of high school learners say that they have sex and 19% of these say that they have more than one sexual partner. A significant proportion denies that they are at risk of HIV infection, according to a study by the Foundation for Professional Development (FPD).

About 70 % of the learners surveyed said they knew about HIV and how it infects people. But despite this level of awareness, the sample of almost 900 Grade 8 - Grade 12 learners from seven high schools in Pretoria and the Capricorn region in Limpopo, showed youth apathetic to HIV. Some of the findings are general knowledge and others are shocking, said Jo-Anne Brink, head of the Education Department at the

Foundation for Professional Development (FPD).

"For instance, 40% of the Grade 8 - 12 learners were sexually active. It's kind of in line with the National Survey on Sexual Behaviour. We also found that of those sexually active learners, only 20% of them thought that they were at risk of HIV and only approximately 20% of them had been tested for HIV ever. That



was a little bit of a shock because we were hearing in the focus groups as well as the survey that the factual knowledge is pretty high. The learners were quoting all the different prevention methods... the different transmission methods... They could quote them all to us. But it was done in quite a detached and unemotional kind of way... as if they were just reciting facts. So, when it came to assessing whether they were actually at risk, they didn't think they were at risk, which means that they're not translating that factual knowledge. It's just kind of from text-book knowledge. They're not translating that into behaviour", she said.

Of the 40% of learners who said they were sexually active, almost half - 19% - also reported that they have multiple sexual partners - two or more. Brink said the learners surveyed told researchers that even though they know how to prevent HIV infection, what they know is not always what they do because they find HIV prevention messages boring.

The study also found that learners would prefer it if they could hear about HIV from their own parents.

Brink believes that the HIV Counselling

and Testing campaign that the Health Department is planning to roll out in schools will help re-inforce HIV prevention messages among learners.

She was heartened that the study showed high condom usage at about 70%. With HIV prevalence among school learners estimated to be between 2 - 5%, she believes that schools are the place where HIV prevention messaging should be targeted.

*By Khopotso Bodibe
3 March 2011*

Health-e News Service



Male circumcisions on the rise in GP

Pretoria - Gauteng has seen an increase in demand for male medical circumcision since the launch of the HIV Counselling and Testing campaign last year.

A total of 13 000 were conducted since April last year, 30 percent above the target for the past year. This was revealed at the Provincial Health Council, a meeting between the MEC for Health and Social Development and

members of mayoral committees from Gauteng municipalities.

While circumcision has been shown to reduce HIV transmission to men, it is still important for men to take precautions. Condoms should be used even after circumcision. The Department made available 8 903 000 male and 107 680 female condoms in the month of January 2011 alone, freely available at all public health facilities and other

public centres.

However, it emphasised that knowing your HIV status and that of your partner, abstaining from unprotected sex and faithfulness to one partner remain important methods of stopping the spread of HIV.

*Bua News
01 Mar 2011*



Self-testing for HIV proves highly acceptable in Malawi

Self-testing for HIV under supervision using an oral test proved highly acceptable in Malawi, and could form the basis for wider and more regular testing in countries severely affected by HIV, researchers reported at the Eighteenth Conference on Retroviruses and Opportunistic Infections in Boston. However many of the people who took part in the acceptability study said that they would still like counsellors to be

involved in the testing process, and questioned whether people in one of the worst-affected countries in southern Africa really knew enough about HIV to get their test result without any support from a counsellor.

There is growing interest in offering people the option of carrying out an HIV test for themselves, at home or in private, as a way of increasing the uptake of HIV

testing.

Regular testing - as often as once a year - is being encouraged in many African countries as one means of encouraging and supporting changes in sexual behaviour.

Some countries such as Botswana report high rates of recent testing. But in Malawi just 22% of the population took

an HIV test in 2009, one of the lowest levels in sub-Saharan Africa. Some experts believe that resistance to HIV testing is partly explained by fears about confidentiality in small communities and clinics. However, prevention strategies that place regular testing at the heart of national efforts to limit new infections need to overcome a major hurdle: the lack of healthcare staff and clinic facilities to accommodate everyone who needs to be tested.

Furthermore, relying on a model of testing in which patients must come to the clinic will always fail to reach those who live far away from medical facilities, especially in poor rural areas. Testing and counselling programmes have gone out into the community, and stimulated impressive levels of demand when mobile testing units have arrived in communities.

Door-to-door testing efforts have also

proved successful in identifying new infections. Offering people the opportunity to take and use self-testing kits was the next logical step in expanding the availability of testing.

Keith Alcorn and Michael Carter
28 February 2011

Aidsmap
<http://www.aidsmap.com/Self-testing-for-HIV-proves-highly-acceptable-in-Malawi/page/1680892/>



SOUTH AFRICA:

Activism makes inroads on "corrective rape"



sexual orientation in its constitution, and the first African country to legalize same-sex marriage. However, the country also leads the world in the prevalence of violent crime, and violence against women in particular.

"We're famous as a country with beautiful laws that are not implementable," Yvette Abrahams, the commissioner for gender equality, told IRIN.

"We're sitting in a country where six women a day die at the hands of a husband or intimate partner, so if straight violence is like that, to try and get attention for homophobic violence becomes very difficult."

During the meeting with activists, ministry officials asked for details of specific cases needing immediate attention and promised to present "concrete proposals" to tackle corrective rape by the time they meet again.

"We clearly need an intervention plan," said Praise Tsidi Kambula, the ministry's chief director of the promotion of the rights of vulnerable groups. "It is our responsibility as a department to ensure that victims of corrective rape report these cases. We cannot do this thing alone. We need you guys to define for us what is needed."

IRIN NEWS
15 March 2011

<http://www.irinnews.org/report.aspx?reportID=92198>



Activists rallied outside Parliament in Cape Town calling for action on corrective rape. Photo: Lee Middleton/IRIN

Cape Town - The South African government has agreed to activist demands to address the increasingly common hate crime of "corrective rape", whereby lesbians are raped by men to "cure" them of their sexual orientation.

Although statistics are lacking, gay advocacy groups estimate about 10 new cases of corrective rape occur every week in Cape Town, a city of 2.5 million.

The decision was reached during a meeting on 14 March between senior officials from the Ministry of Justice and Constitutional Development and grassroots activists who brought a

petition signed by 170,000 supporters in 163 countries. More than 100 people gathered outside Parliament in support.

In December 2010, a lesbian activist group, Luleki Sizwe, posted a petition on www.change.org, demanding that the South African government recognize corrective rape as a hate crime. Ndumie Funda, founder of the group, said earlier attempts to gain an audience with the Ministry of Justice had failed, but within weeks of posting the petition, it became the site's most popular, and the Ministry contacted Funda to set up a meeting.

South Africa was the first country in the world to outlaw discrimination based on



Quackdown! website launched

A new website has been launched to expose quackery and keep patients informed. It is called Quackdown! The URL for Quackdown! is: <http://www.quackdown.info> or you can go to <http://quackdown.tac.org.za>

The website is a joint project of members of the Treatment Action Campaign and Community Media Trust. It features a database called the Quackbase, which lists untested, false or implausible health

claims. The first article on the website deals with the Advertising Standards Authority's ruling on Christ Embassy. The first article is at <http://quackdown.info/article/faith-and-choice-health-care/> and is included below.

The website administrators welcome your feedback which you can give via the site's Contact form.

Druginfo mailing list
Druginfo@lists.hst.org.za
<http://lists.hst.org.za/mailman/listinfo/druginfo>



2011 Nursing Summit



The 2011 Nursing Summit brought together more than 2,000 nurses of all categories and all types of workplaces from across the country to debate the revitalisation of the nursing and midwifery profession for the future of a healthy nation.

The Summit was chaired by the Director General of Health, Ms Malebona Precious Matsoso with Deputy Minister Dr Gwen Ramokgopa welcoming the delegates to the Summit. The MEC of Health in Gauteng added her welcome

to delegates to the province. She highlighted the legacy of nurse leaders such as Florence Nightingale, Charlotte Maxeke, and Albertina Sisulu. Nursing should not be a last resort for job seekers but should come from the most

compassionate. The media should not depict nurses as sex symbols. Where are the days that you heard through prayer and song that another dedicated team has come on duty, she asked. Nurses should realise their importance.

Setting the scene

The 2011 Nursing Summit was officially opened by H.E. President Jacob Zuma. The President and the minister of Health set the scene for the Summit. Here is some of the statements they made during the Summit.

Comments by President Zuma

He reminded delegates about the legacy of previous nurse leaders such as Henrietta Stockdale, Florence Nightingale and Cecilia Makiwane. He highlighted how special nurses because even in difficult times they were the ones with their uniforms that will be allowed to pass through. This is a profession that has to be brought back to its old status - the health of our nation is in their hands. This is a moment of renewal for the nursing profession. They have to define the role of the nurse in a free and democratic society. The young ones will learn from the experience of the retired nurses who in turn will shape our future nurses.

The President emphasized that we live in a society in which our people are protected by a bill of rights. We have a constitutional responsibility to ensure that our citizen have good healthcare as it is their right. This should be clear to all of us as nurses deliberate during the Summit - at times public servants may think that they do member of the public a favour when in fact they are delivering service public have a right to. Public Servants become pompous and arrogant. "Citizens should not be treated as if they are a burden or a nuisance by staff that is employed to serve them" said the President. Government wants to do things differently to improve service delivery.

Nurses are the backbone and engine of the health system. However there is a shortage and many are overworked. Government appreciates the contribution nurses are making. Many work long hours attending the sick who are often demanding which become emotionally and physically draining. The recruitment and training of nurses, doctors and other health professionals have to be increased. It has been announced that 106 Colleges of Nursing will be revitalised and we are working to do

that. The training of nurses has been neglected and poorly coordinated.

It is not only about education and training though, there are also other issues that have to be considered, such as the appointment of the right persons in positions. Challenges include that in some hospitals there is a mismatch of skills and that has to be corrected. As part of improving the healthcare system, improving infrastructure, the skills and attitude of staff, and managing the hospital is receiving attention.

Comments by the Minister of Health

The Minister of Health, Dr Aaron Motsoaledi, also highlighted the importance of nurses and midwives in health service delivery. He presented an overview of the burden of disease, particularly HIV&AIDS, in South Africa. Life expectancy has to be increased, deaths of mothers and babies decreased through PMTCT, HIV prevalence must decrease and health systems strengthened. Nurses and midwives play a key role in these areas.

He advised that he was open to the views of the profession and their input was essential to improve the status of healthcare and nursing. He promised to work hard to get the changes that the profession requests.

One could not help but recognise the irony during the opening session, that in spite of this being a Nursing Summit, there were no nurses on the podium during this whole session!

The discussion agenda

Before the break away the Nursing Council was awarded an opportunity to present to delegates - it was unfortunate that the new qualifications and progress with regulations were not addressed as expected. The delegates then divided to consider seven different themes. These included nursing education and training, nursing practice; leadership, governance, legislation and regulation; ethical and value system; planning, infrastructure, financing and resourcing nursing; creating an enabling environment for nursing; and the role of nursing in the improvement of health. The leadership and governance commission discussed the slow progress of

legislation and regulations at Council and the Department of Health, as well as the importance of Council setting standards to ensure the competence of prescribing nurses.

Much debate took place on the reinstatement of white uniforms for nurses. Two nurses dressed in white uniforms and caps from Greys Hospital in Pietermaritzburg attracted wide attention including that of the President and the Minister of Health. While dissenting voices were heard until the closure of the Summit, white uniforms have been included in the Nursing Compact as the preferred dress code for nurses.

Finalising the Nursing Compact

Feedback on the discussions during the break away sessions was given at a plenary session. A Nursing Compact was drafted overnight and agreed to by delegates on the last day. Professor Philda Nzimande, a nurse leader, was invited to read the final Nursing Compact to the delegates. Of particular importance in this Compact is the support for the new nursing education qualifications framework, taking nursing colleges to higher education and the implementation of a nursing cluster with chief nursing officers at all levels of the healthcare system. The Compact provides board guidelines on the issues decided upon. The devil is in the detail though and therefore a statement has been included in the Compact that the detail will be captured in a strategic plan. No timelines were provided for this process to be completed.

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Final Nursing Compact is available on the Department of Health's website www.doh.gov.za

FINAL NURSING COMPACT

We, the nurses of South Africa supported by our stakeholders gathered in the Sandton Convention Centre on the occasion of the 5th-7th of April 2011 for the National Nursing Summit on reconstructing and revitalizing the nursing profession for a long and healthy life for all South Africans.

Guided by the Government's vision as contained in the Negotiated Service Delivery Agreement (NSDA) as well as the four strategic outputs therein; and rights as enshrined in the Constitution of the country;

- Taking note of the President's challenge to nurses in his keynote address;
- Taking note of the agreed ten-point plan;
- Recalling the National Nursing Summit held in 1999;
- Recalling the National Nursing Strategy;
- Recognising the skills and experience brought by retired nurses;
- Deeply concerned about the quadruple burden of disease and the lack of progress that South Africa will not be able to meet the internationally agreed goals including the Millennium Development Goals, in particular to reduce maternal mortality, to reduce child mortality and combating HIV, AIDS and TB if the current state of affairs is maintained;
- Concerned at the declining life expectancy;
- Disturbed about the decline of quality of care;
- Taking note of inadequate health system effectiveness;
- Deeply concerned about, negative image and social position of nurses in the community; and
- Recognizing that nurses, as the engine of an effective health system play a pivotal role in service delivery;

Hereby declare as follows:

We reaffirm that reengineering of the health care system must drive the refocusing of service delivery and developments in the nursing profession within the District Health System (DHS) based on the following three streams of

PHC:

- Multi-disciplinary team of clinically competent professionals in which nurses play a critical role
- Community ward-based multidisciplinary health teams with nurses playing a critical role
- Effective implementation of national school-based PHC system led by nurses

We urge the National Department of Health to establish a task team that will develop and implement a comprehensive national policy on nursing education and training which examines the new nursing qualifications framework, and which addresses among other things: student status, funding models, positioning of public and private nursing education, norms and standards for nursing, and specialised skills

Noting that nursing and midwifery practice must inform nursing education, we urge SANC to finalise and promulgate the scope of practice for nurses (basic and post-basic).

We urge government to declare nursing education a national competency. We call on the Minister of Health to facilitate the declaration of public nursing colleges as Higher Education Institutions.

We call upon SANC in collaboration with National Department of Health, CHE and SAQA to: fast-track the processing and implementation of the new Nursing Qualifications' Framework and appropriate transitional arrangements.

We urge the nursing education institutions to strengthen the implementation of Recognition of Prior Learning in line with national policy and SANC guidelines for access and entry into nursing training programmes Reiterating the commitment to produce clinically competent nurse we:

- Call on SANC, after consultation with relevant nursing stakeholders, to develop core national standards for curricula that respond to national population health and health system needs;

- Urge the National Department of Health with relevant stakeholders to cost and evaluate an appropriate clinical training model and for SANC to regulate for its implementation;
- Call on the National Department of Health to increase investment in nursing education Call on the National Department of Health to develop, implement and allocate adequate resources for a national nursing educator and nurse manager development programme and We urge the National Department of Health to urgently review the occupation specific dispensation (OSD) and other financial incentives for all categories of nurses, and to ensure alignment of remuneration with other health professionals in the health care team. We urge the National Department of Health urgently to establish dedicated structures to deal with nursing issues at the national, provincial and district levels with executive decision making powers.

We urge government to prioritise the creation of a conducive environment for student learning, including:

- Recognising the overwhelming support for a stipend paid through PERSAL, we urge the National Department of Health to standardise and implement financial assistance for nursing students.
- A standardized national model for student funding.
- Appropriate accommodation, transport and learning materials for students.

Recognising the overwhelming support for standardized white uniform, we call on the government and private employers to issue nurses with a complete outfit.

We support the establishment of the office of standards compliance. Noting with concern the shocking state of some of the nursing education institutions and clinical facilities, we urge the National Department of Health to give urgent attention to the revitalisation of these education and training institutions including accommodation for student and nurses, non-infrastructure related requirements in support of training of nurses.

We urge the National Department of Health to develop staffing norms and to fund and fill vacant nursing posts.

We note the negative impact of strikes on the provision of essential services and the health of the community and therefore urge the employer and organised labour to urgently conclude the matter.

We call upon all categories of nurses to commit to the nurses' pledge and the rights provisions of the National Constitution and international treaties.

We call on the Nursing Summit

organizing committee to ensure that the detailed inputs of the commissions, taking into account the national Nursing Strategy, are developed into a strategic plan. We urge the National Department of Health to ensure implementation of the strategic plan, a biennial review and ongoing monitoring and evaluation.

Recognising the need for a positive practice environment for nurses, we urge employers to ensure implementation of ICN guidelines as well as the provision of appropriate ICT support.

We urge government, the private sector, professional associations and labour

unions to ensure the development of nurse leaders able to lead and implement change.

We urge government and the private sector to develop and implement policy for succession planning, career progression and access to continuing learning for all categories of nurses. Recognising the negative health system consequences of moonlighting, we urge the National Department of Health and the private sector to implement measures to manage moonlighting. We urge the National Department of Health to develop regulations for the control of nursing agencies in South Africa.

R

At the Nursing Summit, Sandton Convention Centre



Where Have All The Nurses Gone?

By Saul Kornik, Jeanette Strydom and Kate Theirs (editor)

Delivery is dependent on sufficient resources and in particular, the right skills. This article explores the current shortage of nurses in the South African public healthcare sector and explores the crisis in the retention of these skills.



"Nursing in South Africa continues to be plagued by many challenges such as training; ethos and standards; professionalism; attitude and staffing norms despite it being the backbone of healthcare systems around the world".¹ Yet South Africa's public health care sector is crippled by a shortage of such competent skills. The reasons for this are, quite plainly, issues of workload, pay, lucrative alternatives outside of the public system, as well as it being almost impossible to recruit new resources for the system due to SANC. However, as a country known for achieving the impossible, this is not all without hope.

Quantifying the Skills Shortage

In comparison to the relatively specialized scope of most doctors, nurses' duties include (but are not limited to) provision of care being the team leader of a specific ward or hospital department, responding to medical emergencies, supervising treatment and keeping records. It is therefore not surprising that the role and shortage of nurses is becoming a focal point in the battle to retain and recruit healthcare workers in the public sector and in the country.²

South Africa is currently said to need 35 000 additional nurses to fill the public health sector gaps, whilst only 2 500 to 3 000 registered nurses are produced locally each year from local nursing education institutions.

To add to this scarcity, both the public and private sector draw from the same pool of graduates and, due to the private sector being generally more appealing, the public sector suffers. The private sector³ accounts for 41.4% of South Africa's nurses, while the remaining 58.6% work in the public sector, which services over 80% of the total population.

Furthermore, "it is said that 34 965 of South Africa's 190 449 registered nurses no longer practice their profession and 760 of the 3 800 registered ICU nurses have left the profession."⁴

To put a nail in the coffin, so to speak, it has been repeatedly documented that the continued migration of nurses, driven

by the recruitment efforts of developed countries to poach South African healthcare talent, has significantly intensified the shortages currently experienced by South Africa. For example, in 2006 1 085 nurses immigrated to Australia, 330 to Canada, 423 to New Zealand, 2 923 to the United Kingdom and 2 828 to the United States – amounting to at least 8 921 documented cases of nursing brain drain.⁵

Problems in the Recruitment and Retention of Nurses

Production aside, a few key issues can be identified in the recruitment and retention of nurses in public service. Retention factors can be classified as factors that either push nurses out of the public sector or pull them towards opportunities outside of the sector.

Workload and poor facilities

An average nurse's day is an extremely busy one, which often leaves individual nurses feeling stretched between too many patients and responsibilities⁶. Africa Health Placements (AHP) recently conducted a series of interviews with a number of nurses. These nurses consistently commented that due to inadequate facilities and resources, nurses end up drained, exhausted and struggling to cope with an overwhelming workload. At the same time, while nurses are theoretically able to care for numerous patients at once, many of these patients are extremely ill and require intensive attention. The end result is a mentality where nurses are forced to "treat the numbers, not the patients"⁷ and, ultimately, patient care is compromised. The health, morale and emotional well-being of the nurses themselves also suffer. The combination of these factors acts to push nurses from working in the public sector.

Pay Scales

Despite being faced with stressful and demanding working conditions, many nurses are still very passionate and committed to their profession, as well as to delivering quality patient care. However, significant hindrances remain, not the least of which is the average nurses' salary in public healthcare.

According to the OSD (Occupational Specific Dispensation), a Nursing Assistant (Auxiliary Nurse) earns roughly between R60,000 and R98,000 per annum; a Staff Nurse earns R48,000 to R109,000 per annum; and a Professional Nurse earns between R109,000 and R165,000 per annum. Contrasting this to private sector salaries: a Nursing Assistant can be paid up to R100,000 per annum, a Staff Nurse can earn up to R156,000 per annum with an average salary of R131,000 per annum; and a Professional Nurse can earn up to an estimated R185,000 per annum⁹.

As already mentioned the private sector employs over 40% percent of South Africa's nurses. However, the private sector only services 18% of the population, while only 12% of the population pays for health insurance¹⁰. This leaves 82% of the population (at least half of whom live in rural areas) to be served by just under 60% of the nursing skills in the country. Furthermore, the fact that uninsured people are going to private sector, rather than using the lower cost public sector option, is an indictment on the quality of care they are receiving in public – yet another indication of the skills shortages and working standard problems discussed above.

Given the difference in public sector versus private sector salaries for nurses, it is understandable that they are pushed from the public sector to work for private entities. Additionally, it has been documented that some public sector nurses are taking on part-time or night-shift work in private hospitals to supplement low income. This leads to nurses who are constantly fatigued, have no time to rest and subsequently do not perform at full capacity. The result is a decline in the quality of patient care and in the health of these nurses, feeding back into the work load factor discussed above. Hospital management should regulate nurse overtime hours, but this often not the case.

Recruitment Inhibited by SANC

While the nursing shortage has been called critical, the recruitment of foreign nurses into South Africa has not been pursued as a possible solution.

Since AHP's inception in 2005, the organisation has recruited over 1 000 foreign-qualified doctors for rural hospitals in partnership with the Health Professions Council of South Africa (HPCSA). However, during this same period, AHP has only been able to bring in a handful of foreign nurses from developed nations, and they have taken up to two years to get registered in South Africa. This has not been due to a lack of effort on the part of AHP. The problem falls squarely on the shoulders of the South African Nursing Council (SANC).

The registration process with SANC is long, arduous and complicated. Every nurse wanting to come to South Africa from abroad, is required to sit the SANC exam – which is only written in South Africa no more than 3 times per year.

According to a TimesLive article by Harriet Mclea in *Hurdles for foreign nurses*, Belgian national Lore Claessens was desperate enough to wait two years to register as a midwife in South Africa so that she could work in an understaffed rural hospital in KwaZulu-Natal. "The wait was endless," said the 26-year-old¹¹. Her registration process was frustrating and lengthy. Nurse Claessens had the patience to endure, but it is hard to assume that other foreign and local nurses would do the same.

There are hundreds of foreign nurses currently living in South Africa, who would work if they could, but are not being endorsed to do so because of SANC. Furthermore, AHP has been contacted by hundreds of European, American and Australian nurses who would like to come work in rural South Africa but who are blocked from doing so by SANC. SANC says this is to protect the quality of the country's nursing profession. Yet, in the United States in 1994, 9% of the total registered nurse workforce was foreign and by 2008 that percentage had almost doubled to 16.3% (about 400,000 registered nurses).¹² To broaden this picture, in 2005 15% of all US healthcare workers were found to be foreign born and accounted for a massive 26.3% (803 824) of physicians and surgeons in the country.¹³ A similar situation is also true for the United Kingdom where by September 2008,

32% of UK doctors and 19% of nurses were born outside the European Economic Area (which account for a further 3% of the UK health workforce).¹⁴ If these wealthy nations depend on such resources, why should South Africa not do everything in its power to also take advantage of the globalised economy?

Attractive Alternatives

Aside from the increasing workload, the low pay scales and little hope for additional help (as recruitment is close to impossible), attractive alternatives exist for nurses outside of the South African public sector. Such factor pull nurses to more lucrative positions abroad create the country's notorious brain drain.

Fixing the Problem

These problems are undermining the nursing profession and the ability of nurses to do their jobs well. In turn, this is affecting **everyone dependent on public health**. The lack of structure and support and the demoralising conditions under which nurses work all take their toll. Financial incentives are important, but it is equally critical to motivate nurses with recognition, training and other efforts to boost morale.

Government Policy and Revamp of SANC Processes

Going forward, SANC and the National Department of Health urgently need to address numerous policy issues: the recruitment process (for both local and foreign nurses), nurse compensation and incentives, regulation of overtime, quality training of additional nurses and adhering to the principle of decent working conditions.

More specifically, the recruitment process needs to be streamlined and simplified in order to efficiently hire the new talent that is so vital to the functioning of a strong health care system. This would involve SANC operations becoming a great deal more competent and professional, and certain nurses being exempt from writing the qualifying exam.

Independent Healthcare Initiatives

Civil society and private sector initiatives

that create the capacity to deal with the crippling shortages should be fostered and supported. AHP is an example of such an initiative that is working to alleviate the pressures on public, and specifically rural, healthcare. This is possible through its close working partnerships with the government and HPCSA. AHP has proposed such a partnership to SANC. Time will tell whether this brings some of the improvements discussed above.

Management

A strong support system that begins with inspiring nurses and acknowledging the difficulties that nurses face is crucial in shifting the balance towards nurses who are physically, emotionally and mentally able to do their jobs well. Strong management is able to regulate overtime, reward excellence, as well as recruit and retain the right people for the job, by creating structure and a pleasant working environment. ®

SHORTAGE
of nursing skills
is crippling
health care
delivery

¹Media Alert from the Department of Health by Dr Aaron Motsoaledi's spokesperson - Khomotso Phasha (22 March 2011)

²www.labour.gov.za (2010)

³Health Reform Note 9 – Nurse Supply. Econex (2010)

⁴Health Systems Trust (2008)

⁵“Meeting South Africa's Needs: A Preliminary Report of an Investigation into Specialist Training and Development,” The Colleges of Medicine in South Africa. Strachan, B. (2009)

⁶The South Africa Nursing Crisis by Michelle Robinson.
<http://www.ahp.org.za/news-detail/104/the-south-african-nursing-crisis> (21 January 2011)

⁷Interview with Registered Nurse Emily Melk in The South Africa Nursing Crisis by Michelle Robinson.
<http://www.ahp.org.za/news-detail/104/the-south-african-nursing-crisis> (21 January 2011)

⁸www.info.gov.za OSD (2010)

⁹www.payscale.com (Country = South Africa)

¹⁰StatsSA 2010 – Midyear estimates

¹¹“Hurdles for foreign nurses” TimesLive by Harriet Mclea (2010)

¹²Immigration: More Foreign Nurses Needed. Bloomberg Businessweek. (21 June 2009)

¹³Foreign-Born Health-Care Workers in the United States By Esha Clearfield and Jeanne Batalova. Migration Policy Institute (February 2007)

¹⁴A need for migrant labour? UK-US Comparisons by Philio Martin (August 22, 2009)





ART Knowledge and adherence

Accountability also applies to our patients. Adherence to treatment for chronic diseases is an age old challenge that healthcare practitioners have to deal with. In this article Doreen Mukona and colleagues researched the relationship between the level of knowledge of antiretroviral therapy (ART) and the rate of adherence to ART among HIV positive adults on ART.

Doreen Mukona, A. P. G. Charumbira, Rudo Nyamakura, Dr M Zvinvashe & Ancia Manwere
University of Zimbabwe College of Health Sciences, Harare, Zimbabwe

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) is considered a chronic manageable condition. Adherence to antiretroviral therapy (ART) is closely tied to virologic, immunologic clinical outcomes. The clinical benefits have been dramatic in countries with broad access to ART and far fewer people are progressing to AIDS with the age-adjusted death rate from HIV&AIDS having declined by more than 70%.

Although there is no universally accepted definition, medication adherence may be defined as the extent to which a patient takes a medication in the way intended by a healthcare provider. Non-adherence to medications prescribed over long periods of time is generally common and it is 50% to 75%. Studies from Canada and developing countries in Latin America and Europe demonstrated similar rates of suboptimal adherence with 10% of patients reporting missing at least one dose within the last month. The level of adherence to antiretroviral (ARV) drugs is the second strongest predictor of progression to AIDS and death after CD4 count. Incomplete adherence to ART, however, is common in all groups of treated individuals. Most patients taking ART regardless of their background or life situation will encounter difficulties with adherence. Knowledge of ART may result in a high rate of adherence to ART.

Purpose of the study

The purpose was to examine the relationship between levels of knowledge of ART and rates of adherence to ART in HIV positive adults on ART attending the opportunistic infections clinic at a central hospital in Harare, Zimbabwe. Pender's health promotion model was used as a guiding framework for this study. A sample of 85 HIV positive adults aged between 18 and 35 years were selected using simple random sampling. The study was carried out at a hospital in Harare, Zimbabwe. A descriptive correlational study design was used. The relationship between the level of knowledge of ART (independent variable) and the rate of adherence to ART (dependent variable) was examined. Adherence was measured using self reports from the sample.

Ethical compliance

Permission to carry out the study was sought from the Sister-in-Charge and consultant physician of the Family Care Centre, Chief Executive Officer and Clinical Director of the Parirenyatwa Group of Hospitals, the Joint Research Ethics Committee of Parirenyatwa Group of Hospitals and the College of Health Sciences, Department of Nursing Science, as well as from the Medical Research Council of Zimbabwe (MRCZ). All prospective study participants voluntarily participated in the study. The purpose of the study as well as the risks and benefits of the study were explained to the study participants. They were advised that the results of the study would be used to improve the health education they received about ART. The

interviews were expected to last for about 20 minutes each. Study participants were advised that they were free to withdraw from the study at any stage for any reason without any prejudice or negative effects on their relationships with staff at the Family Care Centre.

Data collection and analysis

The instrument consisted of three questionnaires namely demographic data questionnaire, adherence to ART questionnaire and knowledge of ART questionnaire. Data were gathered using structured face to face interviews. The relationship was analyzed using descriptive statistics, Pearson's correlation coefficient analysis and the simple regression analysis. Data were

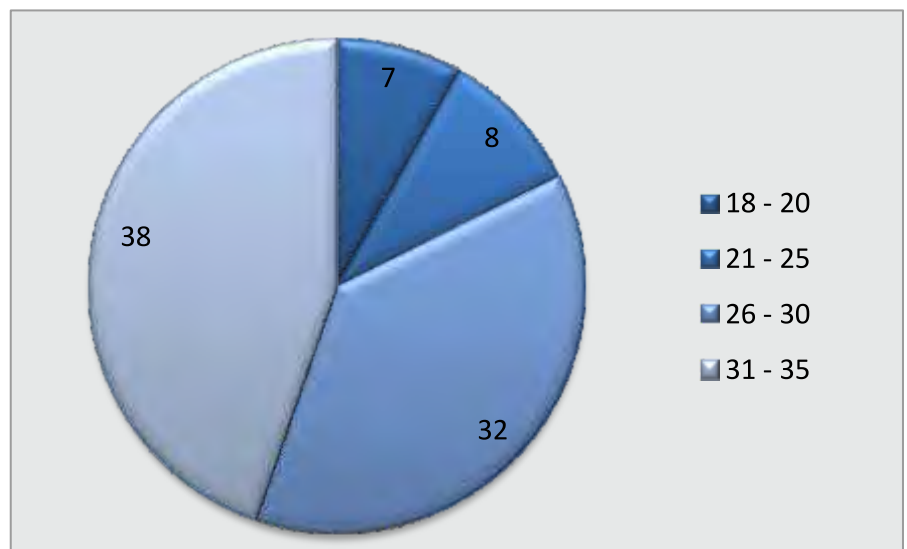


Figure 1 Distribution of age of respondents

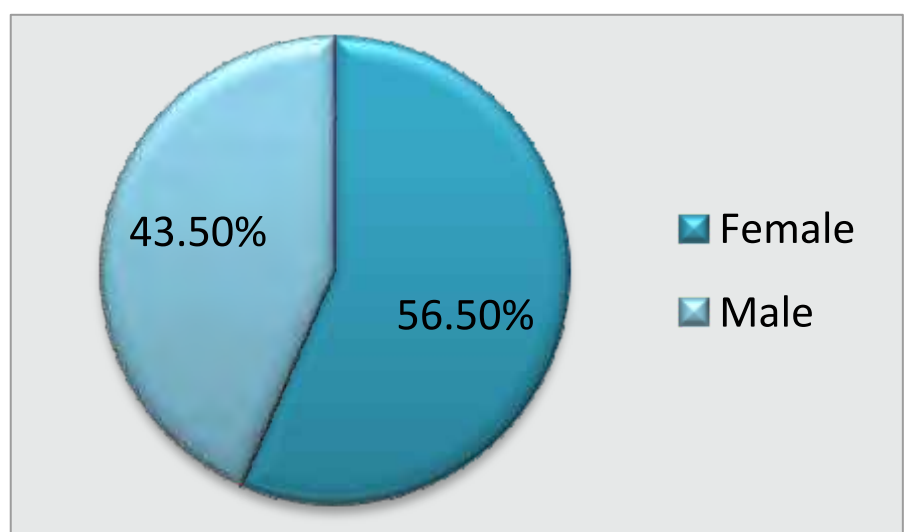


Figure 2 Sex distribution of participants

then entered into a computer and analyzed using the Statistical Package for the Social Sciences (SPSS) System and the Microsoft Excel program.

Results

Age and sex distribution

The sample consisted of 85 HIV positive adults on ART and the ages ranged from 18-35 years (figure 1) of which 37 (43.5%) study participants were males and 48 (56.5%) females (figure 2).

Knowledge of ART

Knowledge of ART was determined on the knowledge of respondents on the indications for ART, how ART works, ARV drugs, their dosages, side effects and special instructions. Understanding of the effects of non-adherence to ART and what to do when one developed side effects was included in the questionnaire. The knowledge of the respondents is indicated in Figure 4 as a percentage.

Relationship between level of knowledge and adherence to ART

Pearson's correlation analysis was used to examine the relationship between the level of knowledge of ART and rate of adherence to ART. The level of knowledge of ART was positively correlated with the rate of adherence to ART ($r = .638, p < .01$) signifying a moderate association between the level of knowledge of ART and the rate of adherence to ART.

Regression analysis was used to examine the strength of the relationship between the level of knowledge of ART and the rate of adherence to ART. The adjusted R^2 was .400. The effect of the level of knowledge of ART accounts for 40% of the variance observed in the dependent variable.

Reliability of the instrument as determined by the computed Chronbach's alpha was .78.

Discussion of the results

Adherence rates were low with the average rate of adherence being 73.62%. Sixteen (18.8%) study participants were 95% adherent or above which is the required level for successful ART. Self-reports were used in this study which tends to overestimate adherence while other studies combined pill counts, MEMS and self-reports. Six (7.1%) study participants had moderate rates of adherence to ART while 63 (74.1%), study participants had low rates of adherence. Adherence rates tended to decrease over time because at 7 days 36 (42.4%) study participants did not miss or take any doses late. The number fell to 31 (36.5%) then 3 (3.5%) at 1 month and since starting ART respectively. The number of people who had missed or taken 3 or more doses late also increased from 3 (3.5%), 13 (15.3%) then to 39 (45.9%) at 7 days, 1 month and since starting ART respectively. This supports the findings of Reid et al (2004) that adherence rates fall over time.

The average level of knowledge of ART was 51.44%. The majority of the study participants, 45 (52.9%), had low knowledge of ART. Nine (10.6%) study participants had a very high level of knowledge, 6 (7.1%) had a high level of knowledge, 25 (29.4%) had a moderate level of knowledge while 45

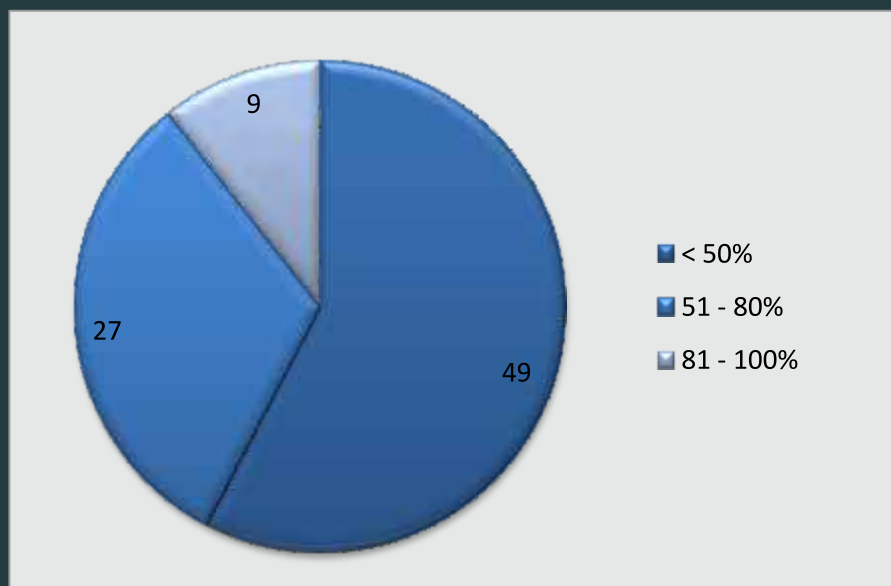


Figure 3 Adherence of respondents to treatment

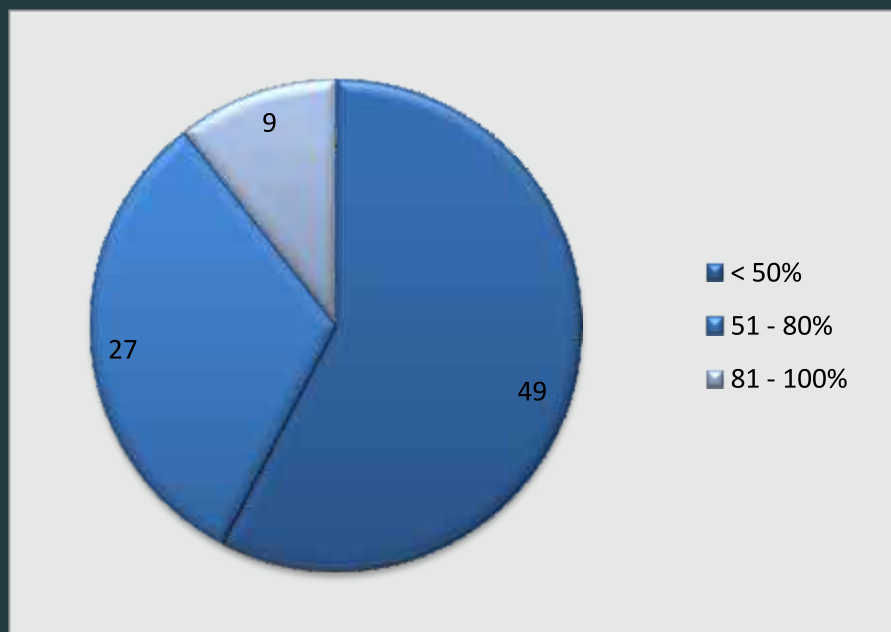


Figure 4 Respondents' knowledge of their treatment

(52.9%) had a low level of knowledge of ART. Eighty-four (98.8%) were aware that ART is supposed to be taken for life. Fifty-nine (69.4%) also knew that three ARV drugs were more effective in managing HIV infection because they interrupt the life cycle of HIV at many different stages of its multiplication in the body. These results could also be a result of the fact that most drugs come with a pamphlet that has all this information so the study participants would have read for themselves in addition to receiving education about ART at the Family Care Centre.

All the study participants (100%) knew at least 2 side effects of ART. The majority, 13 (15.3%), knew 4 side effects of ARV drugs. This is quite low because there were a total of 15 side effects given and this is where most study participants scored low because health education given focuses on the most common side effects only. The majority of the study participants, 64 (75.3%), mentioned an increase in the incidence of opportunistic infections, as one of the effects of failing to adhere to ART. One of the reasons could be that most HIV positive people get tested for HIV because of an increase in the incidence of opportunistic infections such as Tuberculosis and Herpes Zoster¹⁰. However, knowledge of effects of failing to adhere was generally low with the largest group of 28 (32.9%) of the study participants reporting only three effects of failing to adhere out of the seven given.

Pearson's correlation analysis validates the statement by the Ministry of Health and Child Welfare, Zimbabwe (2005) that the importance of counselling and the provision of accurate information to all patients is an important determinant of treatment compliance. Healthcare professionals should strengthen the education given on ART because it is another tool that can improve adherence. The results of simple regression analysis as mentioned earlier further strengthen the importance of education on ART to improve adherence to ART.

Recommendations

Based on the study findings, assessment of adherence should be made routine every time an individual visits the health

centre because adherence is a dynamic and ongoing process that the patient negotiates each time a dose of medication is taken. Objective methods of measuring adherence such as assessment of CD4⁺ counts, viral loads and plasma concentration of drugs should be employed in combination with self reports to minimize bias.

Healthcare workers should encourage literate HIV positive people to read the pamphlets included in medication packages regularly to boost their knowledge of ART and to keep abreast with any new changes regarding ART. This knowledge of ART will empower the HIV positive individual and will be motivated to be part of the collaborative process because initiation of ART is a clinical decision, which should always be made jointly between the informed patient and the healthcare provider.

Healthcare professionals should emphasize education on all the possible side effects of ART because the HIV positive individual on ART needs to be able to distinguish side effects from OIs so that patients are managed effectively. The effects of failing to adhere to ART must also be emphasized because it will motivate the individual on ART to adhere to therapy. Nurses need to be equipped with adequate and current information on ART and adherence to ART.

Nurse administrators need to spearhead collaboration with other departments such as pharmacy and laboratory to ensure holistic and efficient services to the people on ART. These services include the provision of ARV drugs in time and also timeous provision of such results as CD4 counts and viral loads. Nurse administrators should lobby for the provision of more health education material in the OI clinics such as televisions, charts and radios.

The study needs to be expanded to more centres in order to get results on the rate of adherence and level of knowledge of ART that are generalisable to the entire population of HIV positive people on ART.

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Counselling

and provision of accurate information improve treatment compliance

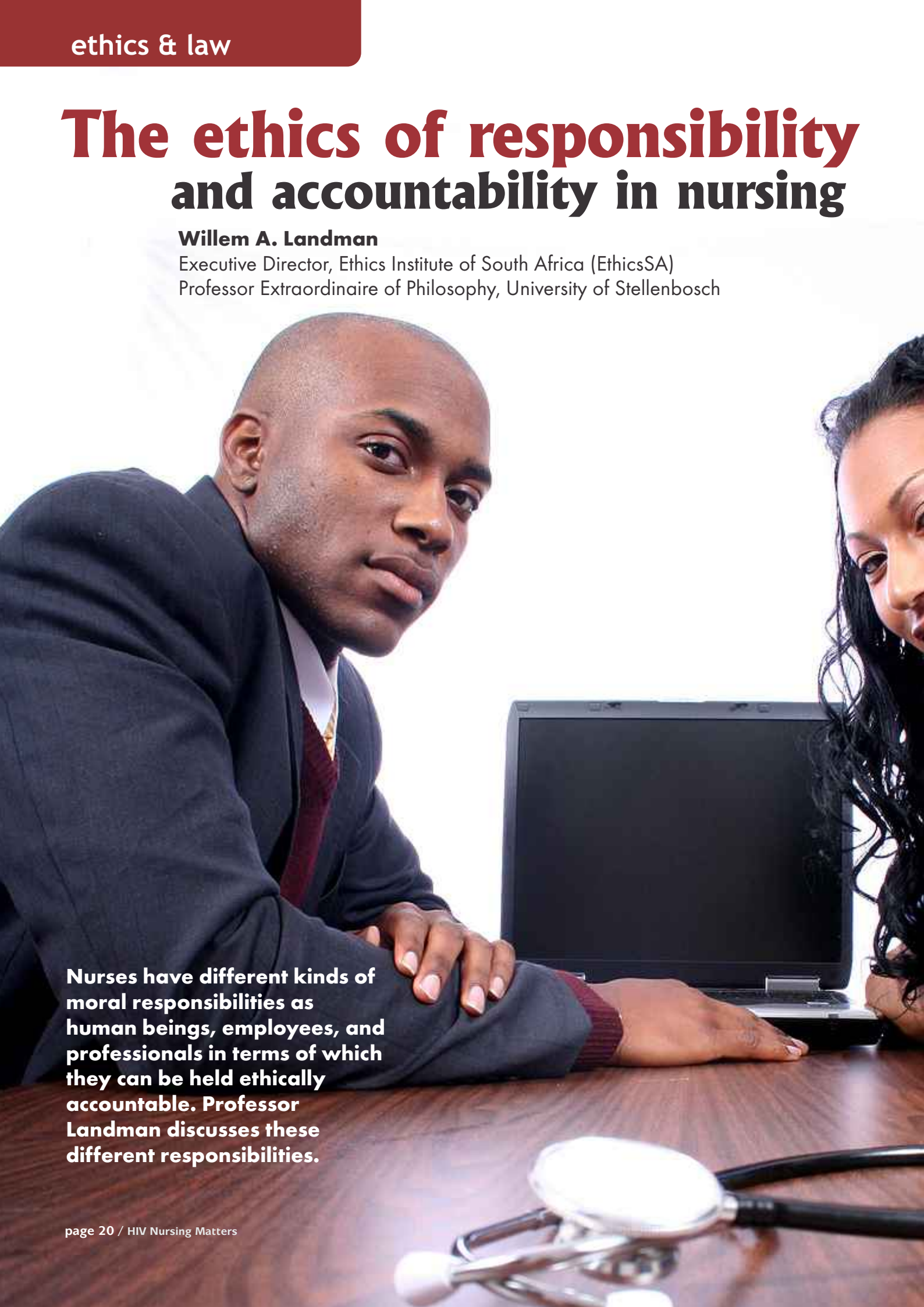


The ethics of responsibility and accountability in nursing

Willem A. Landman

Executive Director, Ethics Institute of South Africa (EthicsSA)

Professor Extraordinaire of Philosophy, University of Stellenbosch

A photograph showing a man in a dark suit and a woman sitting at a wooden desk. The man is leaning forward, looking towards the camera. The woman is partially visible on the right side of the frame. A laptop is open on the desk in front of them. A stethoscope is lying on the desk in the foreground. The background is plain white.

Nurses have different kinds of moral responsibilities as human beings, employees, and professionals in terms of which they can be held ethically accountable. Professor Landman discusses these different responsibilities.

What ethics requires of us can be captured in one word – “responsibility”. We need to take responsibility for our commitments.

Our *commitments* – to others and to ourselves – are defined by the various social roles we play. We may, at the same time, have commitments as a mother, daughter, wife, partner, nurse, and member of a book or tennis club.

The commitments of each social role ground *role-related responsibilities*. Thus, we may have simultaneous responsibilities towards our children, parents, spouses, fellow workers and fellow club members.

Responsibility has a “reverse side”, namely, *accountability*. Precisely because we assume responsibilities, others are entitled – morally and legally – to insist that we “give account of” the way in which we discharged them.

In the nursing profession, responsibility and accountability can be understood on three levels:

1. The nurse as professional person;
2. The health-care institutions in which nurses are employed; and
3. The economic and political order in which institutions are located.

1. The nurse as professional person

One could divide the responsibilities for which nurses as professional persons should give account into three kinds, namely:

- o Natural duty;
- o Institutionalised duties; and
- o Moral obligations.

Natural duty

First, ethics requires that all of us, including nurses, honour our “*natural duty*”.

We all have natural duties by virtue of being *normal, adult human beings, or persons*. Natural duties are general duties that we owe to all persons who cross our path, or to people in general. As such, they are non-voluntary or unacquired. In other words, they are not

self-imposed duties owed to specific identifiable individuals because we do not acquire them by doing something (like concluding a contract) or having a specific relationship with someone else (such as a spouse or a friend).

Examples of natural duties that we *all have as persons*, regardless of our professions, are:

- o The natural duty to *promote human good* which means, for example, that all of us should refrain from causing suffering to others without just cause, or that we should rescue a toddler drowning in shallow water, even though it is a complete stranger.
- o The natural duty of *justice* which means, for example, that we all should treat males and females equally unless there is an overriding reason for not doing so, unrelated to their gender, such as being appropriately qualified to perform a task.

So, nurses can all be legitimately held accountable for discharging their natural duty, but that is because they are human beings, and not because they are nurses.

Institutionalised duties

Second, a nurse, like any other professional, has *institutionalised duties* that are specific to their *employment in an institution* where they fulfil specified functions in terms of specific job descriptions.

These duties, unlike natural duty, are voluntarily acquired by signing on for a job. Nurses have to discharge these duties because they voluntarily assume the role or “office” of a nurse in an institution with its attendant tasks.

The institution that employs nurses sets out nurses' job-related duties. Different nursing specialities may have different but overlapping list of duties. These may relate to specific policies and prescriptions in a hospital or clinic about clearly defined aspects of patient care, such as taking blood pressure, dressing wounds, putting in drips, administering medicine, keeping records, and reporting for duty on time.

In short, as *employees of institutions*, nurses are held accountable for fulfilling their institutional duties. And this accountability is a legal one.

Moral obligations

Third, a nurse has *moral obligations* in virtue of having freely chosen to practise as a *member of the nursing profession*, which is defined in terms of caring for others.

Like natural duty, moral obligations are extra-legal requirements for action (although they may also be or become legal requirements). But they are different from both natural duty and institutionalised duties. Unlike natural duty, they are acquired or voluntarily self-imposed by our exercising a free choice (rather than non-voluntary or unacquired), and they are specific requirements for action (rather than general). Unlike institutionalised duties that we perform like tasks, moral obligations are requirements that we either meet or fail to meet.

The first moral obligation of nurses is to perform their tasks as a nurse as defined by their institutionalised, legal duties to which they have bound themselves contractually. Failure to do so would be morally wrong.

For example, if a nurse on duty neglects a patient by refusing to respond when the patient rings a bell for assistance at night, she not only fails to discharge her institutionalised, legal duty, but she also fails her moral obligation to discharge her duties. In short, neglect of a patient is legally and morally wrong.

The converse, namely appropriately responding to the patient's need, would satisfy both legal and moral requirements.

By freely choosing to become a nurse, one incurs not only institutionalised duties in virtue of being employed by an institution, but one also acquires moral obligations associated with the *nursing profession*. And this creates legitimate expectations in others, not only that the nurse would discharge her institutionalised duties, but also that she would understand caring for patients (or promoting patient well-being) as her moral obligation.

This moral obligation to care for others, as well as the other moral obligations that nurses acquire in the *practice of nursing*, are analogous to parents freely choosing to have a child, thus voluntarily incurring certain moral obligations towards the child that are not exhausted by their legal duties in respect of the child.

Other moral obligations nurses acquire by freely choosing to become a nurse, and that are shaped in the *practice of nursing*, are, for example, respecting patient autonomy (including confidentiality and truth-telling), and respecting patient dignity. As *members of the nursing profession*, nurses can be held accountable for these moral obligations.

Clearly, recognising and living the moral obligations of her profession go to the heart of what it means to be a good nurse. A good nurse would not merely "work to the book" in terms of her time commitments if there is a pressing need that she is uniquely placed to address. By contrast, a bad nurse would not care to address that need, thus failing her moral obligation and indeed her profession.

To summarise: nurses have three kinds of responsibilities, each grounding accompanying accountabilities, namely:

- As human beings, they have natural duties;
- As employees, they have institutionalised duties; and
- As professionals, they have moral obligations.

2. The health-care institutions in which nurses are employed

Nursing is practised in institutions. Thus, a nurse may work in a Netcare, Life Healthcare or Medi-Clinic hospital. These facilities are owned by for-profit companies. Alternatively, a nurse may work in a state-owned hospital or clinic, run by the government and financed through tax revenue.

Now, the way in which institutions in the private and public sectors are governed and managed impact crucially on nurses' abilities to discharge their institutional duties as well as moral





obligations. Institutions may create enabling or constraining environments or cultures in which the practice of nursing may, respectively, flourish or flounder.

A well-run institution in which nursing as a profession can be practised ethically requires leadership that creates an ethical organisational culture. The first principle (1.1) of the *King Report on Governance in South Africa 2009* reads as follows: "The board should provide effective leadership based on an ethical foundation". This is done through an organisational ethics management programme.

Both the private and public sectors have accepted King III as a voluntary standard for good governance. They are therefore committed to instituting such a programme.

An ethics programme is no guarantee against unethical conduct, but it does provide institutional support for nurses to discharge the moral obligations that define their profession. Poor staff relations, theft of linen, bad administration, violent crime on the hospital premises, corrupt admission practices and the like compromise nurses' ability to conduct themselves professionally.

In short, for nursing to flourish as an ethical enterprise, institutions should get their ethical house in order.

3. The economic and political order in which institutions are located

While nurses practise their profession in institutions, institutions, in turn, are located in a wider social and political order that impacts on the ability of those institutions to conduct themselves ethically.

In the private sector, the pursuit of profit by for-profit companies as owners of private hospitals may place limitations on the care that nurses may ideally wish to give to patients, due to, for example, cost-saving measures. And, of course, there is the impact of profit-driven admissions policies on care giving.

Similarly, inefficiencies in the government sector that manages and funds public

hospitals may compromise the professionalism and ethics of staff, including nurses. For example, poor governance practices by government may result in poor staff morale, defective equipment, shortages of medicine, or lack of discipline of improper conduct, all of which may put ethical conduct by nurses under pressure.

The government's denialist HIV/AIDS policy had a huge impact on the ability of nurses to practise their profession ethically. It is therefore crucially important that the planned National Health Insurance (NHI) system makes a fresh beginning by creating the conditions for nurses to live up to the high professional ideals of the caring profession.

Conclusion

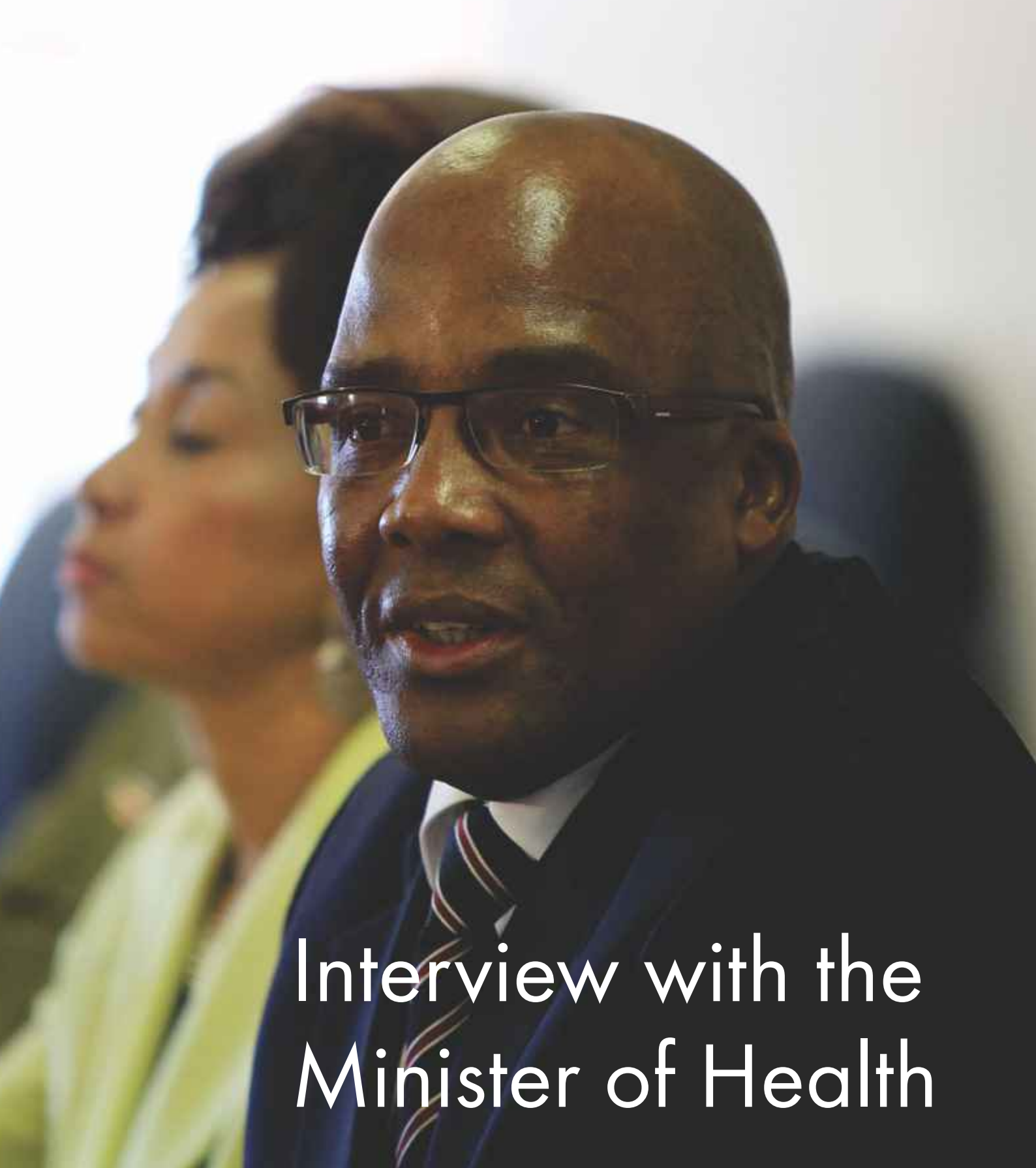
Nurses have different kinds of moral responsibilities, namely, natural duty, institutionalised duties, and moral obligations. They have these, respectively, as human beings, employees, and professionals. In terms of each of these they can be held ethically accountable.

However, nurses work in institutions that impact crucially on their ability to practise their profession ethically. It is therefore incumbent upon the management of institutions in both the private and public sectors to build institutions of excellence by creating a culture in which nurses can assume their responsibilities and truly give account for their conduct.

And, in turn, for-profit companies that own private institutions, as well as the national and provincial departments of health responsible for public institutions, should put in place the background conditions required for institutions to flourish. What they do or fail to do impact crucially on the way nurses understand and perform their daily tasks.

®

Nurses are
ethically accountable
as human beings,
employees and
professionals



Interview with the Minister of Health

The role of nurses and midwives in the healthcare system is at the top of the agenda in the country. Claire Keeton spoke to the Minister of Health, Dr Aaron Motsoaledi, on his views of and vision for the nursing profession in HIV and healthcare service delivery.

Health Minister Dr Aaron Motsoaledi is quick to point out that nurses are as capable as managing antiretroviral (ARV) treatment as doctors and he is determined to accelerate the training of nurses to dispense ARVs.

"Studies have found nurses to be exactly the same and as good as anybody in managing treatment," he told the HIV Nursing Matters Magazine ahead of the 5th SA AIDS Conference, when asked about the role of nurses and HIV/AIDS management.

"We have challenges but we are making progress," he said. "In February 2010 only 50 nurses were allowed to initiate ARV treatment. We have trained large numbers of nurses since that time and now the number is about 2000.

Nurse-initiated management of ARV treatment

"We want to have at least 4000 nurses who are able to dispense ARVs. They are getting training bit by bit and, as soon as we have adopted the training policy, they will be accredited and allowed (to manage treatment)."

Motsoaledi recalled: "We took a decision that by 2011 we needed to cover 80% of the population who needed it with ARVs. Obviously as the minister I would like that to be 100%. "There is no way we can do this if we do not involve nurses, especially in a country with such a shortage of doctors."

The minister said he was happy that clinics around the East Rand with nurses in charge were working well delivering ARVs.

"Patients do not have to go to the hospital anymore, they can go to the clinic to get ARVs."

AIDS management diverting nurses from other critical services

But this minister, who has his feet on the ground, admits that channelling nurses into ARV management does compromise other areas of healthcare.

"Removing a number of nurses from other important functions also (raises) a

challenge," Motsoaledi said. He emphasised a point that was made by a number of political leaders at the country's first ever Nursing Summit held in April - that nurses are the backbone of healthcare systems everywhere in the world.

Nurses the backbone of the healthcare delivery

"They do invaluable work, especially in South Africa where there is a shortage of doctors, and they outnumber any other group of healthcare workers.

"They do the practical work and delivery, in community healthcare structures and complex institutions," said the minister, recognising the range of skills that nurses need to practise.

Besides their professional skills, Motsoaledi told the magazine that nurses had a critical leadership role to play.

Nurses should be leaders

The nursing summit was an opportunity for nurses to define their role, according to the minister.

"This was a chance to talk in clear, unambiguous terms about themselves as leaders, standards in nursing and how nurses wanted to see themselves.

"We need nurses to tell us what they want to do, for example about uniforms. We want to know why there is discord and an answer on whether it is good for them or not."

During the summit two nurses dressed in traditional white uniforms and shoes were invited onto the stage as an example to other delegates.

Motsoaledi said that the way that the state had treated nurses and that they themselves had begun to view their role had "conspired to have a negative impact to destroy the career of nursing and its professionalism".

"We do not even have a nursing directorate at the Department of Health. Some provinces have got one and others do not."

State and nurses have eroded professionalism.

This failure hampered the state in dealing with crucial issues like, for example, the training of nurses.

"We need to decide who is responsible for training nurses, where they are being trained - at hospitals, at training colleges and then hospitals, or at universities.

The shift in the state's policy leading to the closure of nursing colleges in the late '80s - they are now making an effort to revitalise more than 100 nursing colleges - "saw many disruptions to training", Motsoaledi said.

He expressed concern at the emphasis on academic training that took their place when, in his view, "bedside and practical experience should come before university training". The minister himself participated very actively in the commission that was dealing with training.

Prioritise the right type of training, set up task team

"We've been training more professional nurses than enrolled nurses but they do most of the work," he told the HIV Nursing Matters Magazine. "If you take the analogy of an army, what the state has done is (to train) two-thirds to be commanders and only one third to be soldiers."

Some 2000 delegates at the nursing summit urged the Health Department to set up a task team "to develop and implement a comprehensive national policy on nursing education and training that would examine the new nursing qualifications framework".

As well as policy on nursing training, Motsoaledi indicated that the professionalism and effort of nurses needs urgent attention.

Nurses are professionals, need to be accountable

"We need to focus on the attitude of nurses towards the public," said the minister, reflecting on the health workers strike last year when patients were put at risk.

"Nurses and nursing companies should be willing to nurse sick people and not say we will not do nursing today, we do not have enough money. That is not the attitude we want.

"Nurses need to have empathy and humanity for patients, and their relationship with the patient should not be defined by how much money they are getting from government or thinking about what government can do for them."

But Motsoaledi does admit that government needs to be proactive about issues provoking tensions, like the occupational specific dispensations (OSDs) and resources allocated to nursing.

Fixing the OSD inequities

"The OSDs are defined by different levels of training and experience but the various levels are confusing. Nobody is satisfied with what they are getting for the categories in which they are deployed and we need to correct that so that there is concurrence," he said. The controversies around OSDs were raised at the Nursing Summit and nurses urged that the OSDs and other financial incentives be reviewed to be better aligned with those of other health professionals.

Nurses need to be at forefront of health promotion

Motsoaledi said he would like to see teams of five clinically competent health professionals working together proactively in communities to promote health.

"I would like to see a primary healthcare approach unveiled where there are teams in communities headed by a professional nurse.

"They would also consist of community healthcare workers and lay counsellors for HIV/AIDS and TB."

Community healthcare workers could ease the workload on nurses if properly integrated into a health team, despite historical tensions between them.

Motsoaledi said: "None of these two

groups can do without each other. We need to solve this (gap) and then nurses can be the backbone of the system and community health workers the central core.

Primary healthcare only way to win against epidemics

TB, for instance, needs to be managed at a community and at a primary healthcare level to win the war against this invisible threat.

Motsoaledi said: "On World TB Day I went to see a demonstration of a new TB diagnostic (system known as the) GeneXpert.

"It is revolutionary but it is also hospicentric and depends on people presenting themselves as patients.

"We need teams to be visiting families and identifying who has TB and, if somebody is diagnosed at hospital, to be visiting and screening the rest of the family. That's what we need."

Present health system failing patients

Motsoaledi is clear that the present health system operates in a way that falls far short of this ideal. He slammed the current system for being characterised by four negative features, being:

- * very hospicentric in a way that is destructive to patients;
- * very costly;
- * very curative;
- * not promoting health prevention.

Motsoaledi said: "We have a curative healthcare system as opposed to a primary healthcare model incorporating nurses, community healthcare workers and doctors."

Start revolutionary shift with nurse-led programme at schools

The minister asked: "When last did you see a nurse at school? We have 12 million children at school and we should be doing health promotion and prevention there.

"But we are waiting until children are sick and presenting at hospitals."

The outbreak of measles in Pretoria in August 2009 - after the immunisation programme had broken down - was a clear indictment of how the system is failing, he admitted.

"We need to start urgently and immediately with nurses in schools and health prevention," Motsoaledi said.

Nurses summit landmark event

He concluded: "I hope that after the summit (the health system) will become completely different from what it is at the present moment."

At the closing of the groundbreaking meeting, he saluted the "energy, commitment and passion" displayed by the nursing delegates and promised to get the nursing profession "back to its basics", such as restoring pride in delivering a professional and caring service.

Motsoaledi told the HIV Nursing Matters Magazine that he was "happy with the discussions that took place at the summit and the outcome" of the Nursing Compact adopted by all delegates at the end of the historic meeting.

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Nurse Leadership

Development over continents

This article provides an overview of an international project on Nurse Leadership Development through Research and Capacity Building: Strengthening Nurses Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean.

HC Klopper, Professor and SA Country Programme Director, North-West University (Potchefstroom Campus)
FG Watson, SA Country Programme Manager, North-West University (Potchefstroom Campus)
CE Muller, Lecturer and Collaborator, North-West University (Potchefstroom Campus)
N Edwards, Professor and Principal Investigator, University of Ottawa, Canada
D Kasege, Professor and Co-Principal Investigator, Great Lakes University in Kisumu, Kenya
E Kahwa, Lecturer and Co-Principal Investigator, University of Wet-Indies, Jamaica

Nurses are usually not seen at the policy table and often lack the knowledge to influence policy (Mechanic, & Reinhard, 2002:7; Gilson, *et al.*, 2006:13; Zellnick, & O'Donnell, 2005:168). It is however, critical that nurses join in policy development, as health system policy-makers and managers often have to face complex decisions around improving health care and promoting equity (Alliance for Health Policy and Systems Research, 2010:1). In order to capacitate nurse leaders, a South African research team has joined in an international research programme.

DESCRIPTION OF PROGRAM OF RESEARCH

"Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean" is a five-year programme of research and capacity-building involving Canada and four partner countries, i.e. Kenya, Jamaica, Uganda, and South Africa. Health professionals need research and policy capacity to create effective multi-level programmes that address the HIV and AIDS pandemic. In this programme of research, researchers and research users from two regions with the highest prevalence of HIV in the world - Sub-Saharan Africa and the Caribbean - are collaborating with Canadian colleagues to undertake innovative, multi-country comparative studies and capacity-building strategies to improve HIV and AIDS policies and practices. The goal of this multidisciplinary programme is to contribute to health systems strengthening for HIV and AIDS in Sub-Saharan Africa and the Caribbean by improving the quality of HIV and AIDS nursing care, supporting the scaling-up of innovative HIV and AIDS programmes and practices, and fostering dynamic and sustained engagement of researchers and research users in the policy development process (Edwards *et al.*, 2007).

It aims to provide a critical platform for developing research and leadership capacity among nurses and midwives. The programme uses a participatory action research (PAR) approach and involves four research projects with fifteen qualitative and quantitative research instruments. The main research intervention is that of "leadership hubs",

set up in each intervention district. Hubs bring together front-line nurses and managers, researchers, decision makers, and community representatives to promote dynamic engagement and sustained collaboration within and across countries on HIV and AIDS research, health services programmes and policies. They are intended to function as levers for health systems change (Year Four Progress Report, 2011:6).

THE AIM AND OBJECTIVES OF THE PROGRAMME OF RESEARCH

This program of research and capacity-building seeks to address this issue by situating nurses and midwives in a leadership role to improve equity, quality, and efficiency of health systems for HIV prevention and AIDS care. The aim of the research programme is to contribute to health systems strengthening in sub-Saharan Africa and the Caribbean by improving the quality of HIV and AIDS nursing care, supporting the scaling-up of innovative HIV and AIDS programmes and practices, and fostering dynamic and sustained engagement of researchers and research users in the policy development process. The specific objectives of the research programme are:

- To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs), and
- To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

The **capacity-building and knowledge translations objectives** are, to

- promote on-going, long-term, interactive dialogue and collaboration among front-line nurses and managers, researchers, decision makers including physicians, and community representatives on HIV and AIDS research, health services programs and policies
- strengthen the capacity of selected academic institutions and research-user groups to support and participate in nurse-led research that

is highly relevant to health services and policy decision-makers

- integrate best practices for knowledge translation into the work of nurses in senior academic, clinical, government and non-governmental organization (NGO) positions, and
- implement a mentorship program that supports nurses to do and use research in response to key policy issues related to the provision of HIV and AIDS services.

RESEARCH PROJECTS

Four research projects comprise the programmatic focus. All four research projects are being implemented in all four study countries. The goal with supporting research and capacity development objectives of this mixed-method multidisciplinary collaborative programme of research is achieved through three interrelated and one case study based research projects. The first three projects compose of fifteen different quantitative and qualitative data collecting tools. The projects are as follow..

Project 1: Issues affecting the role of nurses in nursing practice in HIV prevention and AIDS care.

Purpose:

Sets out to describe and understand the issues that are affecting the role of registered nurses and registered midwives in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in South Africa and the other participating countries.

Project 2: The interface among health systems priorities, capacity-building, and policy innovation.

Purpose: Focuses on understanding how the HIV and AIDS epidemic affects the nursing workforce and the provision of HIV and AIDS nursing service in South Africa and the other participating countries.

Project 3: Dynamic collaborations to strengthen health care systems through Leadership Hubs.

Purpose: Examines how leadership hubs influence nurses' engagement in policy development and collaborative action to address HIV and AIDS in order to strengthen health care delivery systems in South Africa and the other

international collaboration

participating countries.

Project 4: International comparative case studies.

Purpose: Intends through international comparisons to enhance the learning across the different participating countries. This learning will be generated from the findings of the other three projects by means of comparisons that will answer issues common to all countries.

Each project has two co-Leads: one from Canada and one from a lower- and middle- income country. Co-investigators and collaborators participate on each project team.

PREPARING NURSES FOR THEIR ROLE AS NURSE LEADERS

In achieving the goal of the programme of research a conceptual framework is used as basis for change in the health service. The conceptual framework is embedded within systems change theory and steered by a Participatory Action Research (PAR) as methodology due to its flexibility (Edwards, et al., 2007⁵). The conceptual framework encapsulates critical inquiry, building capacity, and taking action and 'leadership hubs' (LHs) as lever/agents for change (Edwards, et al., 2007⁵) as core concepts in facilitation of the goal. The LHs form the leverage with the intention of being the enabling mechanism that would be able to translate the gained and enhanced capacity into action for the intended policy and practice change. The LHs form the mechanism for collaboration as it brings together frontline nurses, nurse managers, researchers, decision makers and also policy makers within South Africa and the other participating countries. Hubs will promote this collaboration by making new and strengthening current vertical and horizontal relationships among the different individuals and organizations represented by hub members in South Africa. The LHs, their members and the local research team in the collaboration as emphasised above play an important and iterative role in the other elements of the conceptual framework, they are:

- *Critical inquiry*, aims at gaining and bringing forth a context specific understanding by both participants and researchers on the factors that affect individual and institutional capacity, and influence nurses' efforts

to take action on strengthening health systems (Edwards, et al., 2007⁵).

- *Building capacity*, will happen throughout the PAR process if the aim of building both institutional and individual capacity of the participants and the research team continuously over a period of five years. The capacity building focuses on research, leadership and knowledge translation strategies (Edwards, et al., 2007⁵).
- *Taking action*, within the conceptual framework involves a very vital and sustainable building of a facilitative environment that enhances national and international collaboration among the research team the LH's. Taking action will also importantly develop, implement and evaluate evidence-informed innovation (Edwards, et al., 2007⁵).
- *Outcomes of Health Systems strengthening* will throughout the process of research and capacity development manifest in the participating institutions and their members involved (Edwards, et al., 2007⁵). Here are some anticipated process outcomes, evidence on nurses' involvement in a change process on any level, increased research ability and skills along with nurses taking leadership in health care systems and HIV and AIDS policy change. It also anticipated that the nurses and other participating stakeholders will become more and more aware of their role and how they can contribute toward intervention showing greater sensitivity in gender and health equity in their home countries, in this case South Africa.

SOUTH AFRICAN LEADERSHIP HUBS

There are three LHs established in the different countries and in South Africa these hubs are in the North West Province and currently active in the Dr. Kenneth Kaunda -, Ngaka Modiri Molema - and the Bojanala districts. The hubs have ten members on average and consist of nurses, nurse managers, researchers, decision makers, policy makers and community members from over twenty partnering institutions ranging from Non-Governmental Organizations, Department of Health





and private organisations.

Nurse leadership capacity building

Nurse leadership capacity building is kept within the framework of policy and policy development and basic research skills with a strong emphasis on knowledge translation. These continuous development workshops are developed with the local context in mind and are based within the LH's. They are developed around the needs as voiced by the LH's members and not on presumed needs for development and the initiative of influencing policy. Initially the strategy was to develop and deliver these workshops on a per district and LH basis. This strategy proved to be timely and somewhat costly and the members also showed interested in the other LHs. Interestingly the needs as identified from the different districts didn't differ to the extent that it could not be delivered at a single combined event. This brought forth the merging of the LHs at joined meetings. There are still per district meetings as per needs identified the joined one's however are best for the capacity development activities. These combined events are referred to as 'joint LH meetings'. This strategy proved to be exceptionally successful in South Africa as it also provided a great platform for collaboration between districts in the North West Province and also between disciplines and key institutions and organizations, which clearly integrates one of the key objectives. The joint LH meetings are held at the North-West University. All these capacity development activities and/or workshops are done with the aim of letting the LH members take leadership through the knowledge and skills gained at their different institutions. Initially the LHs members were introduced on the different aspects of development within the programme of research and their roles along with the expectation from the local and international team. This was a very informative and successful session and set the stage for development in the following areas:

Research capacity development

LH members were introduced to the research process and basic research methods. This was a great starting point

and LH members didn't hesitate to interact with the local team to get a better understanding of the role of research in health service delivery and specifically the impact that research findings can have on their different institutions.

Knowledge translation strategies

The aim of *influencing practice* is used and incorporated in the capacity development as a practical component. As with the other areas of development the LH members are synthesised and presented with theoretical underpinning to get an understanding and with experts in the field, move forward with the different strategies to influence their current practice environment. The theoretical underpinning used and developed for the specific context is based in the field of evidence based practice and best practice guidelines.

The LHs were also requested to undertake an evaluation project in their different districts. This is seen as one of the successful strategies of how the LHs will influence practice. The LHs are currently in process of obtaining international funding for their evaluations projects. The basis of their evaluation projects focuses on quality improvement with a six month turnaround whereby the LHs would be able to see the direct impact of their projects on practice.

Knowledge translation with the aim of influencing policy

Initial discussions by the LH members around the topic of policy influencing in the South African context focused on the improbability rather than the strategies. The LHs felt that their employment roles did not provide them with the power to influence policy and that policy development in South Africa is a top down approach. The LH member's beliefs and attitudes were incorporated in the approach of developing their capacity. The initial workshops and discussions on policy started at identifying and discussing some broad policies in health service delivery. Through this approach policy awareness was created and the local team built on this awareness by reflecting, and focusing on issues such as who is involved in policy development, where

does the evidence come from that's used in policy development, the policy cycle and what role can nurses play in the process of policy development and specifically the issue of policy voices of nurses.

National, provincial and district multidisciplinary collaboration

As mentioned above, collaboration already became one of the best spin-offs from getting the three different LHs together at one place for their joined LH meetings. Part from this natural and continuous networking among the different LH, members of the LH are continuously synthesised and reminded of the importance of collaboration throughout the course of the research programme.

Context mapping was introduced to the LH members' through a practical workshop whereby their context was captured with their objectives as the structure behind the mapping. This workshop aimed and succeeded at capacitating the LH members' understanding of multi-disciplinary networking and collaboration. The workshop also generated the platform from where the LH members gained great insight on their current working context, how they relate to that context and how they can make use of their networks within that context to strengthen not only their service delivery but also the service delivery of their districts.

NURSE LEADERSHIP CAPACITY INITIATIVE WITHIN THE PROGRAMME OF RESEARCH

Other capacity-building initiatives include:

- focused mentorship activities, whereby LH members and the local research team will have the opportunity to link with decision makers, key policy arena's and researchers
- opportunities for graduate students and junior researchers to be involved in the programme of research through for example pilot funding for new research projects, and
- an annual international research internship which will be held and hosted in 2011 by the School of

Nursing Science, North West University Potchefstroom Campus.

CONCLUSION

The programme of research is currently in its fourth year. Baseline data that has been collected from Project 1 was prepared as research findings and shared/presented to the LHs during 2010 and more sharing of findings is planned on Project 2 during 2011. The findings shared with the LH members form the basis of the knowledge translation that's done. There's still data being collected within projects 2 and 3 and more continuously on project 3 as it has a continuous data collection design. The research team is currently planning and scheduling for follow up data collection. One of the key successes of the programme of research and especially in achieving the goals is the annual face to face team meetings.

The leadership hubs have shown great progress and amazing commitment from the members especially considering that they are participating out of their own free will without any incentives. The local research team and the LH members are starting to look at avenues of establishing continuity of the LH's and their influence on health service delivery in the North West province and also the possibility in other provinces.

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director, Ms M Walusimbi, Mulago Hospital, Uganda and South Africa programme director, Prof HC Klopper, North-West University, South Africa. Co-investigators are Prof J Mill, University of Alberta, Dr J Webber, Canadian Nurses Association, Ms P Juma Atieno, Great Lakes University of Kisumu, Ms C Gwoswar, Great Lakes University of Kisumu, Ms J Raburu, Great Lakes University of Kisumu, Ms C Hepburn-Brown, University of the West Indies, Ms T Rae, University of the West Indies, Ms P Dawkins, University of the West Indies, Ms J Aiken, University of the West Indies, Prof SJC van der Walt, North West University, Dr CE Minnie, North West University, Prof G Cummings, University of Alberta, Dr F Legault, University of Ottawa, Ms S Roelofs, University of Ottawa, Dr J Harrowing, University of Lethbridge, Prof A Tourangeau, University of Toronto, Prof J Etowa, Dalhousie University, Dr C Davison, University of Calgary, Prof M Richter, University of Alberta, and Prof W Kipp, University of Alberta.

Collaborators from Kenya are Perez Akello, Irene Obago, Nicky Okeyo, from Uganda, Joseph Mwizerwa, Edward Kumakech, Rose Nabirye, Scovia Mbalinda, Eric Ssegujja, Godfrey Katende, from South Africa, Mavis Mulaudzi, Rina Muller, Francois Watson, Siedine Coetzee, Emmerentia du Plessis and from Jamaica Jamaica, Uki Atkinson.

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For more information on the Programme of Research and the International partnering individuals and institutions, please contact Francois Watson at Francois.Watson@nwu.ac.za (programme manager) or Prof Hester Klopper at Hester.Klopper@nwu.ac.za (SA country programme director) 

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Participation

of nurses in
policy
development
is critical

What a difference a decade makes!

Looking back to reflect on the progress made, provides food for thought says Dr Tom Boyles HIV clinician at Madwaleni hospital, Elliotdale, Eastern Cape, South Africa

The 17th March 1995 was a Friday. In the UK it was a crisp clear early spring day and the news was dominated by the death of notorious murderer in prison. These facts are etched in my memory because it was the day I stuck an HIV contaminated needle into my finger. I remember almost everything about that day from the feeling of horror at the first sight of blood on my finger to the look on the face of my girlfriend when I told her later that evening. It was a Wednesday three months later when the consultant told me that the HIV test was negative. The details are a blur but I can still remember the sleepless night beforehand and the feeling of utter relief at the news.

It was only a week ago but already I've forgotten the date. Sixty patients had finished collecting a month's supply of anti-retrovirals at the isolated rural clinic when a staff member saw her chance to grab a quiet word. She said she knew deep down that she had HIV and neither of us were surprised when the point of

care test result was positive. It was at that moment that the needle slipped in my hand and stuck into my finger. As I had done more than a decade before I squeezed blood from my finger but my reaction couldn't have been more different. With no occupational health service within 100 miles and a recent negative HIV test under my belt I simply put into action the plan I had rehearsed for this moment. I walked calmly to the pharmacy assistant and asked for a dose of anti-retrovirals. I then just returned to the newly diagnosed woman to offer her post-test counselling. I had no worries for the remainder of the day except the wave of medication-induced nausea that swept over me later that evening.

The important difference between the two events of course is the availability of anti-retrovirals. In 1995 I had yet to enter medical school and to many people, including myself, HIV infection meant an automatic death sentence. The knowledge that the chance of infection

was only around 1 in 300 did nothing to alleviate the terror I felt. The image of Tom Hanks wasting away in the film Philadelphia was only too real to me as I was working as the phlebotomist on a ward where I regularly witnessed people in the last stages of AIDS. I had no idea, I'm not even sure if the experts knew, what was on the horizon.

The figures are debatable but my chances of being infected this time are probably less than my yearly risk of dying in a car crash in South Africa. I also feel comfortable that should the worst happen I could still at least look forward to watching my own grandchildren grow up at the end of a productive life. With the rollout of anti-retrovirals gathering pace, at last many South Africans with HIV can expect the same. The hope is that should I be writing a similar article in a decade's time the big news will be of the huge increase in the numbers accessing treatment rather than the fact that effective treatment exists at all. ®

Win a bursary for the CMART programme in Stellenbosch

The Southern African HIV Clinicians Society and Stellenbosch University's Nursing Division are pleased to offer a ONE bursary to a Society member to attend Stellenbosch University's certificate in the Comprehensive Management of Patients on Antiretroviral and Tuberculosis Treatment (CMART). The course will commence in February 2012; dates are not yet finalised.

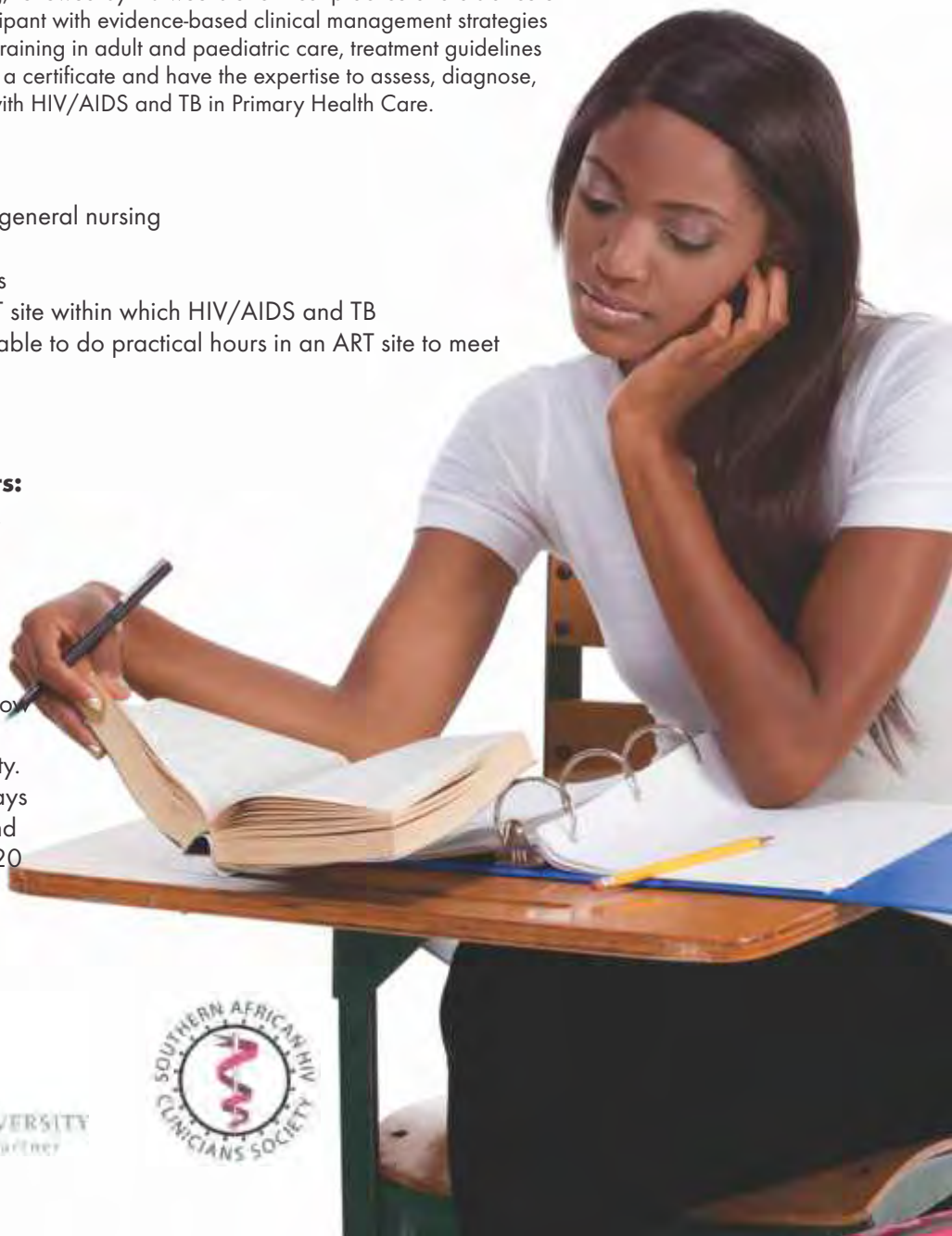
The course consists of a 5 day initial workshop at Stellenbosch University's Tygerberg campus in Cape Town that includes specialized skills training, followed by 20 weeks of clinical practice and distance e-learning. CMART provides the nurse participant with evidence-based clinical management strategies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

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- Two professional references.



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The recommended dose of ATRIPLA[™] is one tablet (containing 600 mg of efavirenz, 200 mg of emtricitabine, and 300 mg of tenofovir DF) once daily, taken orally on an empty stomach.

Dosing at bedtime may improve the tolerability of nervous system symptoms.



ATRIPLA[™] SELECTED SAFETY INFORMATION. COMPOSITION: Each film-coated tablet contains 600 mg of efavirenz, 200 mg of emtricitabine, and 300 mg of tenofovir DF (which is equivalent to 245 mg of tenofovir disoproxil) as active ingredients. **INDICATIONS:** ATRIPLA[™] is indicated for use alone as a complete regimen or in combination with other anti-retroviral agents for the treatment of HIV-1 infection in adults. **DOSAGE AND DIRECTIONS FOR USE: Adults:** The dose of ATRIPLA[™] is one tablet once daily taken orally on an empty stomach. Dosing at bedtime may improve the tolerability of nervous system symptoms. **Renal impairment:** Because ATRIPLA[™] is a fixed-dose combination, it should not be prescribed for patients requiring dosage adjustment such as those with moderate or severe renal impairment (creatinine clearance less than 50 ml/min). **Paediatrics:** ATRIPLA[™] is not recommended for use in patients less than 16 years of age. **CONTRA-INDICATIONS:** Patients with previously demonstrated hypersensitivity to any of the components of the product. ATRIPLA[™] should not be administered concurrently with astemizole, bepridil, disopyrid, midazolam, pimozide, triazolam or ergot derivatives. ATRIPLA[™] should not be administered concurrently with voriconazole because efavirenz significantly decreases voriconazole plasma concentrations. ATRIPLA[™] is contraindicated in patients with moderate to severe renal impairment (creatinine clearance less than 50 ml/min). **WARNINGS:** Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs alone or in combination with other anti-retrovirals. ATRIPLA[™] is not indicated for the treatment of chronic HBV infection and the safety and efficacy of ATRIPLA[™] have not been established in patients co-infected with HBV and HIV. Severe acute exacerbations of hepatitis B have been reported in patients who are co-infected with HBV and HIV and have discontinued emtricitabine or tenofovir DF. Related medicines not for co-administration with ATRIPLA[™] include emtricitabine, tenofovir DF, emtricitabine/tenofovir DF, and efavirenz, which contain the same active components as ATRIPLA[™]. Due to similarities between emtricitabine and lamivudine, ATRIPLA[™] should not be co-administered with medicines containing lamivudine. Serious psychiatric adverse experiences have been reported in patients treated with efavirenz. One percent of efavirenz-treated patients discontinued or interrupted treatment because of one or more of these selected psychiatric symptoms. Fifty-three percent of patients receiving efavirenz in controlled trials reported central nervous system symptoms compared to 25 % of patients receiving control regimens. These symptoms included dizziness (28.1 %), insomnia (16.3 %), impaired concentration (8.3 %), somnolence (7.0 %), abnormal dreams (6.2 %), and hallucinations (1.2 %). Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphataemia), has been reported in association with the use of tenofovir DF. ATRIPLA[™] should not be used in pregnancy. Efavirenz may cause fetal harm when administered during the first trimester to a pregnant woman. Pregnancy should be avoided in women receiving ATRIPLA[™]. **SPECIAL PRECAUTIONS:** In controlled clinical trials, 26 % (206/1008) of patients treated with 600 mg efavirenz experienced new-onset skin rash compared with 17 % (111/635) of patients treated in control groups. In patients with known or suspected history of hepatitis B or C infection and in patients treated with other medications associated with liver toxicity, monitoring of liver enzymes is recommended. In a 144-week study of treatment naïve patients, decreases in bone mineral density (BMD) were seen at the lumbar spine and hip in both arms of the study. Cases of osteomalacia (associated with proximal renal tubulopathy) have been reported in association with the use of tenofovir DF. Convulsions have been observed in patients receiving efavirenz, generally in the presence of known medical history of seizures. Caution must be taken in any patient with a history of seizures. Immune reconstitution syndrome has been reported in patients treated with combination Anti-retroviral therapy, including the components of ATRIPLA[™]. **DRUG INTERACTIONS:** ATRIPLA[™] may decrease the plasma concentrations of the following drugs: Amprenavir, fosamprenavir calcium, atazanavir, indinavir, lopinavir, saquinavir, saquinavir, carbamazepine, phenytoin, phenobarbital, zalcitabine, zalcitabine, zalcitabine, zalcitabine, rifabutin, rifampin, diltiazem, calcium channel blockers, atorvastatin, pravastatin, simvastatin and methadone. ATRIPLA[™] may increase the plasma concentrations of the following drugs: Rilpivirine, didanosine, ethinyl oestradiol. ATRIPLA[™] may increase or decrease plasma concentrations of warfarin and interfere with the cannabinoid test. Medicines which induce CYP3A4 activity (e.g. phenobarbital, rifampin, rifabutin) would be expected to decrease efavirenz plasma concentrations. Co-administration of ATRIPLA[™] with medicines that reduce renal function or compete for active tubular secretion may increase serum concentrations of emtricitabine, tenofovir, and/or other renally eliminated medicines. Some examples include, but are not limited to, acyclovir, abacavir, didanosine, didoxivir, didoxivir, ganciclovir, valganciclovir, and valganciclovir. Atazanavir and lopinavir/ritonavir have been shown to increase tenofovir concentrations. Higher tenofovir concentrations could potentiate tenofovir-associated adverse events, including renal disorders. **PREGNANCY AND LACTATION:** ATRIPLA[™] should not be used in pregnancy. Efavirenz may cause fetal harm when administered during the first trimester to a pregnant woman. Pregnancy should be avoided in women receiving ATRIPLA[™]. Barrier contraception should always be used in combination with other methods of contraception (eg, oral or other hormonal contraceptives). There are no adequate and well-controlled studies of ATRIPLA[™] in pregnant women. Because of both the potential for HIV transmission and the potential for serious adverse reactions in nursing infants, mothers should be instructed not to breast-feed if they are receiving ATRIPLA[™]. **ADVERSE EFFECTS:** Efavirenz: The most significant adverse events observed in patients treated with efavirenz are nervous system symptoms, psychiatric symptoms and rash. Selected clinical adverse experiences of moderate or severe intensity observed in more than or equal to 2 % of efavirenz-treated patients in two controlled clinical trials included pain, impaired concentration, anorexia, dyspepsia, abdominal pain, anxiety, nervousness, and pruritus. Pancreatitis has been reported, although a causal relationship with efavirenz has not been established. **Emtricitabine and tenofovir disoproxil fumarate:** Adverse events that occurred in at least 5 % of patients receiving emtricitabine or tenofovir DF with other anti-retroviral agents in clinical trials include anxiety, arthralgia, increased cough, dyspepsia, fever, myalgia, pain, abdominal pain, back pain, paresthesia, peripheral neuropathy (including peripheral neuritis and neuropathy), pneumonia, rhinitis and rash event (including rash, pruritus, maculopapular rash, urticaria, vesiculobullous rash, pustular rash and allergic reaction). Skin discoloration has been reported with higher frequency among emtricitabine treated patients: Skin discoloration, manifested by hyper-pigmentation on the palms and/or soles was generally mild and asymptomatic. **KNOWN SYMPTOMS OF OVER DOSAGE AND PARTICULARS OF ITS TREATMENTS:** If overdose occurs, the patient should be monitored for evidence of toxicity, including monitoring of vital signs and observation of the patient's clinical status; standard supportive treatment should then be applied as necessary. Administration of activated charcoal may be used to aid removal of unabsorbed efavirenz. Haemodialysis can remove both emtricitabine and tenofovir DF, but is unlikely to significantly remove efavirenz from the blood. **SCHEDULING STATUS:** S4. **REGISTRATION NUMBER:** 42/20.2.8/0729. **CONSULT THE PACKAGE INSERT BEFORE PRESCRIBING PARTICULARLY IN RELATION TO SIDE-EFFECTS, CONTRA-INDICATIONS, WARNINGS AND PRECAUTIONS. DATE OF PREPARATION:** September 2010. Before prescribing, please consult the full package insert.



MSD (Phy) Ltd (Reg. No. 189600379/07), Private Bag 3, Halfway House 1685. Copyright © 2010 Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Whitehouse Station, NJ U.S.A. All rights reserved. ATRIPLA[™] is a trademark of Bristol-Myers Squibb & Glaxo Sciences, LLC. Reference: 1. Kibingyi B, Puzosik A. The First Once-Daily Single Tablet Regimen for the Treatment of HIV-Infected Patients. *Drugs of Today* 2007; 43(7):427-442. ATRIPLA[™]. Each tablet contains efavirenz 600 mg, emtricitabine 200 mg and tenofovir DF 300 mg. Reg. No.: 42/20.2.8/0729. 05-2012-RVNE-2010-2A-05-J. PH shown in "whole" is not actual size.

ATRIPLA[™]
(efavirenz 600 mg/emtricitabine 200 mg/
tenofovir disoproxil fumarate 300 mg) Tablets

One pill. All HAART.



SOUTHERN AFRICAN HIV CLINICIANS SOCIETY
APPLICATION / RENEWAL FORM ASSOCIATE MEMBERS



MEMBERSHIP FEES 2011

Annual Membership Fees: R120 for Associate Members (i.e. healthcare workers other than doctors)

Renewal fees are valid for 12 months from date of receipt of payment. Payments may be made by cheque or electronic transfer payable to: 'Southern African HIV Clinicians Society', Nedbank Campus Square, Branch code: 158-105, Account No: 1581 048 033.

Please fax or email of proof of payment to 086 682 2880 or kerrysolan@global.co.za, or post to:

Suite 233, PostNet Killarney, Private Bag X2600, Houghton, 2041. Tel: 071 868 0789 Website: www.sahivsoc.org

NB! PLEASE PRINT LEGIBLY TO ENSURE WE HAVE THE CORRECT INFORMATION TO PROVIDE YOU WITH OUR SERVICES:

First name:

Initials:

Surname:

Title:

Profession (please tick one): Professional Nurse Enrolled/Staff Nurse Nursing Auxillary Midwife
 Pharmacist Social Worker Community Health Worker Researcher Other.....

Practice address

Postal address

City

State/Province

Country Postal Code

SANC or other Council No.

Tel No Cell

Fax

Email

Please tick relevant box:

- Do you work in rural or urban
- Would you like your quarterly journal, the *Southern African Journal of HIV Medicine*, to be posted to you? Yes No (I will read the journals on-line, on the Society website: <http://www.sahivmed.org.za>)
- Would you like to receive information from the Society via sms email or both
- Names of HIV training courses successfully completed.....

Optional demographic information (for reporting and BEE accreditation purposes):

- Race: Black Coloured Indian White Other.....
- Gender: Male Female
- Date of Birth: Day Month Year

Method of payment: Electronic transfer Direct deposit Post/Cheque Cash

Amount Paid:

Payment Date:

SOCIETY SERVICES:

Quarterly issues of the *Southern African Journal of HIV Medicine*

Quarterly issues of the *HIV & Nursing Magazine* (applicable to nurse members only)

Newsletter Transcript

CPD points for questionnaires and branch meetings

Information on training courses

HIV Advocacy

Conference information and bursaries

Internet discussion groups

Local and international guidelines

NDOH/SANAC Nerve Centre Hotlines

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

Nerve Centre Hotline and, specific emails for each province:

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



AIDS Helpline 0800 012 322

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

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

Services Offered by the AIDS Helpline:

- Information: The Line creates a free

and easy access point for information on HIV and AIDS to any member of the public, in all of the 11 official languages, at any time of the day or night.

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



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
CENTRE**



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

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



**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.

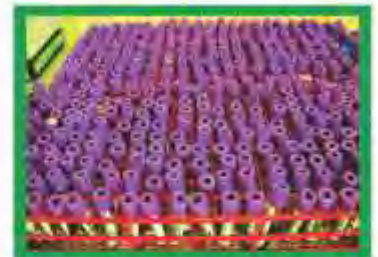
Once you have a Reference number

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.



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2011

THE CONFERENCE FOR

Childbirth Educators & Midwifery Lecturers
 Independent & Labour Ward Midwives
 NICU, Postnatal & Baby Clinic Nurses
 Student Midwives
 Other Obstetric & Babycare Professionals

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2011 PROGRAMMES

**Midrand, Gauteng
 25 February 2011**

Session Time	What's on?
07h00 – 08h00	Registration
08h00 – 08h15	Opening
08h15 – 10h45	Putting Third Stage First Plus other obstetric mythbusters Midwives, Moms & Multiples How to help in pregnancy & beyond Infant Digestive Discomfort Understanding colic and nutritional solutions
10h45 – 11h15	Tea
11h15 – 13h00	Neuroscience to Improve Neonatal Care With Nils & Jill Bergman The Alpha & Omega of Essential Fatty Acids Message from DENOSA
13h00 – 14h00	Lunch
14h00 – 16h45	The Permanent Impact of Gentle Babycare Monitoring Mothers & Unborn Babies Plus Obstetric concerns Q&A with Prof Justus Hofmeyr Breastfeeding, Sexuality & Contraception
16h45 – 17h00	Conclusion & prizes galore!

**Port Elizabeth, Eastern Cape
 20 May 2011
 Rustenburg,
 North West Province
 28 October 2011**

Session Time	What's on?
07h00 – 08h00	Registration
08h00 – 08h15	Opening
08h15 – 10h30	Handling HIV in NICU A sensitive issue Intuitive Perinatal Errors Evidence supports parent power A Mom's Story
10h30 – 11h00	Tea
11h00 – 13h30	Contagious Disease Management in Pregnancy Breastfeeding with Joy, Confidence & Success Help launch mothers onto the journey of lactation Putting Pressure on Postpartum Haemorrhage
13h30 – 14h30	Lunch
14h30 – 16h45	Gastro-Intestinal Health Central to a baby's well-being Understanding Pain in Labour Plus Lesser practiced but proven relief techniques Supplementation Safety in Pregnancy
16h45 – 17h00	Conclusion & prizes galore!

**Nelspruit, Mpumalanga
 29 July 2011
 Somerset West, Western Cape
 9 September 2011**

Session Time	What's on?
07h00 – 08h00	Registration
08h00 – 08h15	Opening
08h15 – 10h30	The Essentials of Aromatherapy Message from DENOSA Respiratory Distress in Neonates Plus a mini-resuscitation course
10h30 – 11h00	Tea
11h00 – 13h30	The Significance of the Partograph Expertise Update Percentiles, Growth Curves & Baby Development Use, don't abuse! Breastfeeding When Everyone Says 'Impossible' Adoption, multiples, breast surgery, HIV infection
13h30 – 14h15	Lunch
14h15 – 16h45	An Inspiring Midwifery Story Making Normal Birth & Postnatal Care Natural Improve patient & professional experience Mental Health in Mothers Essential for a healthier family & nation Understanding how Parents' Brains Work With Nils & Jill Bergman
16h45 – 17h00	Conclusion & prizes galore!

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5th ANNUAL WORKSHOP ON ADVANCED CLINICAL CARE (AWACC) – AIDS DURBAN 2011



P O BOX 37587 OVERPORT 4067 SOUTH AFRICA Tel: +27(0)31 268 5828 Fax: +27(0)31 268 5910 28 McCord Road, Overport, Durban 4001

Annual Workshop on Advanced Clinical Care (AWACC) AIDS DURBAN 2011

PURPOSE OF ADVANCED CARE COURSE FOR CLINICIANS

- Develop experienced clinicians to work independently and serve as consultants in HIV medicine in different district and community health institutions
- Translate the latest evidence based research into good clinical practice specifically for resource constrained areas
 - # Provide an opportunity to share best practice models of care developed by clinicians in various aspects of the care and treatment programme
 - # Create an opportunity for networking between HIV clinicians, academicians, researchers and policy makers.

Programme to follow on website: View previous workshops) **Venue: Elangeni, Southern Sun, Hotel, Durban, Date: 6th and 7th October 2011 (8am -5pm)**

Cost: R1000 for two days

Contact :Karen (karen@mccord.co.za) /Dr H Sunpath (sunpath@mccord.co.za)

Organizing Committee:

H Sunpath: Dept of Medicine, McCord Hospital, Durban

R Gandhi: Infectious Disease Unit, Mass General Hospital, Harvard Medical School

Y Moosa: Infectious Disease Unit, University of KZN

Advisory committee:

S. Reid, UCT (SA); F Venter, WITS (SA) ; D Bangsberg (Uganda)

The workshop is directed to meet the needs of ongoing education in HIV Medicine for professionals from all disciplines of medicine-nurse practitioners, pharmacists, medical practitioners, paramedical professionals and specialists from all fields (internal medicine, maternal and child health, infectious diseases, family medicine, public health and laboratory based faculties)

BURSARY AVAILABILITY

The Society is offering a **limited number** of bursaries to its nurse and midwife members to attend the 5th Annual Workshop on Advanced Clinical Care. The bursary will cover the conference registration fee, and each bursary holder will receive a reimbursement of R1 800 towards their travel and accommodation costs. The reimbursement will be paid after the conference, and bursary holders will be required to sign in each day of the conference in order to be eligible for the reimbursement.

The Society will organize the registration of successful applicants and pay the registration fee directly to the conference organisers. If you have already registered for the conference, please inform us of this in your application. Please note that the Society will not arrange for or pay for travel and/or accommodation – this is the responsibility of the individual.

Minimum requirements:

- Working in a setting where ARVs are available (as ART or PMTCT)
- Personally involved in clinical care of patients at least 3 days per week

Note: only Society nurse members whose annual membership fees have been paid in full will be considered.

Application process:

Please submit the following to fax: 011 341 0161 or e-mail: sahvivsoc@sahvivosoc.org

1. A brief outline of involvement in the field of HIV, including your current job responsibilities. Please include your current job title.
2. A letter of **support for leave** to attend the conference from your manager/supervisor.
3. A letter detailing a commitment and plan to provide information gained at the conference to colleagues.
4. Contact information, including a telephone number, cell number, e-mail address and fax number. Please include your physical address and work address.

Closing date: 31 July 2011

Please note: Bursary recipients who fail to attend the conference after the Society has paid their registration fees will be required to refund the Society for all expenses incurred.

JOIN SA IN THE
NATIONAL CAMPAIGN AGAINST HIV/AIDS & TB

BUILDING A BETTER
SOCIETY THROUGH
EDUCATION AND
DEVELOPMENT



FPD

**FACULTY OF
HEALTH SCIENCES**

All year
Registration

ACCREDITATION

Registered with the Department of Education as a private Institution of Higher Education under the Higher Education Act, 1997 (Registration number: 2002/HEU/D13)

FPD was established in October 1997 by the South African Medical Association and has since then placed a high emphasis on developing the clinical skills and leadership ability of SA's Nurses. Below are a few courses that will be beneficial to Nurses.

DISTANCE COURSES

DISTANCE COURSE IN DISPENSING

INTRODUCTION

This course is based on the recommended standard for the dispensing course for prescribers in terms of Act 101 of 1965 as amended, which was developed by the South African Pharmacy Council, in consultation with the other statutory health councils. Licensing with the relevant authority as a dispensing health care professional can only take place once a certificate from an accredited provider has been awarded. This course will enable health professionals to dispense and ensure the quality use of medicines prescribed to the patient. The Dispensing Course is presented in association with the Health Science Academy.

STRUCTURE: 6 month distance based course with no contact sessions
COURSE FEE: R 1 539

DISTANCE CLINICAL MANAGEMENT OF TB FOR HEALTHCARE PROFESSIONALS (NURSES)

INTRODUCTION

The World Health Organisation (WHO) declared TB a global emergency in 1993. It is estimated by the WHO (2004) that about 1/3 of the world's population is currently infected with M. Tuberculosis. The WHO also determined that there were about 8.7 million new cases of TB and 1.9 million deaths due to the disease in 2000. According to these statistics it can be deduced that 2 people are infected every second! About 95% of TB cases and 98% of all TB deaths occur in developing countries, mainly among the poor, and mostly in the economically productive age group of 15-20 years of age.

STRUCTURE: 3 month distance based course with no contact sessions
COURSE FEE: R 800

COURSE IN THE FUNDAMENTALS OF PROJECT MANAGEMENT AND PMBOK®

NEW!

INTRODUCTION

Introduces students starting their business career, or currently in a supervisory / management position to the fundamental knowledge and skills needed in order to successfully manage diverse projects. Also suitable as preparation for students wishing to study towards the certified project management professional and PMBOK® designation.

STRUCTURE: 6 month distance based course with no contact sessions
COURSE FEE: R 4 950

WORKSHOPS

NURSE INITIATED MANAGEMENT OF ANTI-RETROVIRAL THERAPY (NIMART)

INTRODUCTION

The NIMART course has been developed as a response to the call to action by the South African Government to strengthen the response to HIV and TB epidemics and is specifically developed for and aimed at professional nurses working in the field of HIV and TB. The 5-day course is a stand alone intensive programme that focuses on the management of TB, HIV and STI's as well as strengthening counselling skills, monitoring and evaluation of HIV and TB programmes. Participants should follow the course with a practical mentorship programme that is linked to an experienced HIV and TB clinician.

STRUCTURE: 5 Day workshop
COURSE FEE: R 5 700

CLINICAL MANAGEMENT OF HIV / AIDS FOR NURSES

INTRODUCTION

This course is presented in association with the South African HIV Clinicians Society and will enable participants to acquire or update skills with regard to:

- The diagnosis of HIV / AIDS and STD's
- The management of HIV / AIDS and STD's
- All aspects of counselling (pre- and post-test, therapy compliance)
- Having empathy with people "Living with AIDS"
- Fulfill their role as health care professionals in community mobilization
- Understand vaccine development and clinical trials

STRUCTURE: 3 day workshop
COURSE FEE: R 3 700

REGISTRATION

DANIELLE DANIELS / MELANY MANOHARUM / VUYISILE KHUMALO

Tel: 012 816 9000 / 9101 / 9100 / 9107

Fax: 012 807 7165

Email: enquiries@foundation.co.za

Website: www.foundation.co.za

**PLEASE VISIT OUR WEBSITE FOR INFORMATION ON
OTHER COURSES**

Member of the SAMA group





Midwives Tackling the 'Big 5' Globally



www.midwives2011.org

Congress Secretariat: The Conference Company
Tel: +27 31 303 9852 • Fax: +27 31 303 9529
Nina Freysen-Pretorius - nina@confco.co.za
Claire Cummings - claire@confco.co.za

19 - 23 June 2011, Durban, South Africa

ICM 29th Triennial Congress
International Confederation of Midwives

