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HIV

Nursing

Southern African HIV Clinicians Society Nursing Magazine



Infant feeding
Midwives perspective
Strengthening Nurses' capacity



Adding value to life.

We are extremely proud to play an ongoing role in the struggle against HIV/AIDS in Southern Africa. We shall not rest until the battle has been won. Life will win.

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**HIV
Nursing**
focuses on
mothers and
babies

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- Infant feeding
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Nelouise Geyer

ed's note

As we approach the end of 2010, we can reflect on a special year for nurses globally and in Southern Africa. This was the International Year of the Nurse during which the highlight for nurses as members of the SA HIV Clinicians Society was to see the birth and first steps of the Society's nursing magazine. We have seen the initiation of NIM-ART in spite of many limitations and barriers to increase access of our people to HIV&AIDS treatment and care as part of the broader HCT Campaign announced by the President one year ago on the previous World AIDS Day (WAD). And as the WAD slogan requests us to do: "Keep the promise". Then there was the excitement of the Soccer World Cup where we as a nation stood together to showcase the best of South Africa and its people.

There were also some negative events to reflect on. The downturn in the economy has left many people without jobs, the protracted public sector strike was particularly violent and saw some nurses harassed and seriously assaulted with at least one nurse dying as a result.

In my mind, the positive events outnumber the negative ones, but it does not mean that we can sit back contentedly. We have to look in the mirror and reflect on whether we are making a contribution - not only in

the workplace, but also in the professional organisations that we are members of - including the Southern African HIV Clinicians Society. Are we only a statistic on the database of the Society or "free riders" that expect to receive the benefits of membership without paying the membership fee? Remember that any organisation is only as strong as its membership - an organisation can only perform at its best if members take responsibility and become active in the structures and business of the organisation. As nurses we have to make our voices heard. Do this by paying your membership fees so that you can participate in the structures!

It also is time for the country to slow down its activities and for many to take a break. For those readers who will be enjoying a well deserved rest, be sure to do so safely. For those of you who will be keeping the nursing services going through the festive season, in an honourable but challenging position at the frontline of healthcare, also do so safely. May 2011 bring us all great opportunities and renewed vigour to face the challenges head on!



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talk
to us

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



Prof Francois Venter

Message from the president

Health
workers
must advocate
for equality in
health care

By the time you read this, World Aids Day will have come and gone. The media will have tried to find an interesting slant, hopefully profiled some people important in the fight against HIV, told the stories of people living with the disease and the endless challenge of taking antiretrovirals, and also analysed the new political context we find ourselves in.

Unfortunately, the constant battle against 'AIDS fatigue' is a hard one. Sexy news stories are hard to tell, especially original ones. Huge scientific leaps forward are becoming less common, with the usual edging forward of research we see with other diseases. The reality, however, is that the disease has not gone away, and is unlikely to for the foreseeable future. Government and donor attention is important to hold, so that appropriate funding flows to HIV programmes. One of the most powerful ways to do this, is through the provision of accurate data on infection rates, illnesses, hospital and clinic utilisation, orphan programmes, and impact on politically sensitive indicators, like maternal and infant mortality.

Hopefully, nobody in the HIV world sees one illness as more important than another – just that resources should be allocated intelligently and appropriately to get as many people treatment and care as possible, whatever their disease. This will always involve rationing, and we need to accept that. However, we should make a noise if that rationing does not make sense, if we see inequality, or, far more certain, we see governments prioritising guns and motorcades and sports events over health.

Communities look up to us, as health workers, as people with their health and broader interests at heart. We have to ensure that health, and especially HIV and TB, are front and centre of the debate, even when everyone has AIDS fatigue..

®

Letters to the editor

Hallo Nelouise

I am working as a HIV/AIDS/STI/TB (HAST) coordinator in the Western Cape, Westcoast district. I received your magazine last week and WOW was I surprised. This is the most amazing magazine. The first time I lay my eyes on a magazine full of articles that are all related to my work.

WELL DONE.

I have a request, and will understand if it is not possible. I am attending a Provincial HAST Bosberaad at Caledon on the 10 – 12 November 2010. There will be ± 150 people, all working with

HIV/AIDS/STI/TB programmes. Will it be possible for you to send me some magazines to put in their goodie bags for the bosberaad? I am just thinking I want each and every one of them to lay hands on this magazine, because I think this is a wonderful magazine with very good articles.

Thank you for my magazine, I will surely subscribe for this one!

Sr Ina Cillié
HAST koördineerder
MATZIKAMA sub-distrik

Dear Sr Ina, thank you for your positive response! We will forward your request for copies of the magazine to the MD.

Ed

Hi Nelouise,

I got my HIVSoc nursing magazine today and have just finished reading it. Thank you. It talks to me. Congrats on a second great achievement for HIV CARE and the Positive people. This magazine can be a BIG voice for us.

Best wishes,
TJ

ICN CONFERENCE AND CNR
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Deadline for abstract submissions
15 September 2010

Visit the conference website
for more information

www.icn2011.ch



news

FPD Launches its NIM-ART Training



The Foundation for Professional Development (FPD) with sponsorship from USAID/PEPFAR proudly introduced its course in Nurse Initiated Management of ART (NIM-ART) at a launch event in Pretoria on 7 October 2010.

The course is offered in response to the National Strategy and will be rolled out to all nine provinces in South Africa with commencement in Limpopo Province. NIM-ART equips nurses with the skills to diagnose, initiate and manage persons

who require antiretrovirals (ARVs). With these skills in hand, nurses will be at the centre of the expansion of treatment and care for HIV/AIDS and TB infected persons in South Africa, epidemics that have adversely affected the nation. This will dramatically increase the number of people who will have access to antiretroviral treatment (ART) consequently allowing the nation to better control the spread of the epidemic.

Foundation of Professional Development
(www.foundation.co.za)
PRETORIA



XDR TB - a glimmer of hope

Khayelitsha's Nolungile Clinic celebrated the first patient to successfully complete the harrowing treatment for Extensively Drug Resistant (XDR) TB, and be cured. Xoliswa Majola *(37) is living proof that XDR TB can be cured and that a patient can be successfully treated on an outpatient basis - Majola remained at home for the largest part of her two year treatment and went to the clinic every day to receive her treatment.

"At first I was told I had TB, later multi-drug

resistant TB and eventually XDR. I took three months of TB treatment then four months of MDR treatment. I later learnt I had to take two years of XDR treatment, but I managed," she said.

Majola said lack of information created fear among many patients and that she would not have survived without the support of her treatment adherence counsellor Busi Beko, herself a survivor of drug-resistant TB. Dr Jenny Hughes, MSF's drug resistant TB co-ordinator in Khayelitsha, presented Majola with a

certificate for successfully completing her treatment.

Hughes said Majola showed that decentralising TB treatment, including XDR, worked and "patients didn't have to spend months in the hospitals away from their families".

*Majola is Xoliswa's clan name her surname is Harmans.

By Lungi Langa
21.10.2010

Health-e News Service



Black blood no risk, after all

As the South African National Blood Service (SANBS) marked its fifth year of implementing its revised risk management model, which includes the use of black donors' blood, the organisation has proudly announced that there have been zero HIV transmissions emanating from its stock, apart from one person who received Hepatitis-infected blood.

Following heavy criticism in 2005 for marginalising black donors, the South African National Blood Service (SANBS) had to regain the public's confidence and it revised its risk management system. What followed was the introduction of what is called the Nucleic Acid Testing or NAT system, a very sensitive tool in detecting infections.

"We started our routine testing in early October 2005. We have now tested over 3.6 million donations over the five year period. We did NAT testing in all the bloods. The significant improvement in blood safety you see with the number of transmissions we prevented is high", says Ravi Reddy, the SANBS's Chief Operations Officer.

Reddy stresses that over the years they have learned that it is critical to eliminate contaminated blood.

"The prevalence in our first time donors was from 4% to 7%. This is really in our blood donor population. By 1996, 1997 and 1998 up to 7% of the females were positive. That means despite all the donor

exclusion questionnaires, 7 out of 100 females that donated at the time, actually tested HIV-positive. Something had to be done".

He adds that black donors were classified as a high risk category, thus their blood was rejected outright. Ironically, though, the blood service now wants to increase the pool of black donors.

"They are the future sustainability of SANBS. We were having an ageing white donor base. Up to 2007 we had got to less than 5% of our donors being black. By 2008, we increased to 11.5%, collecting 65 000 units in total. Now in 2010, 22.3% of our donor base is black donors. That is high. It's has gone up more than four times since we started", says Reddy.

Through the NAT system, SANBS is not only able to detect HIV, but also forms of Hepatitis, also known as HBV and HCV. In the five years that the system has been in place and after 3.6 million donations, only one sample of blood that reached a user was found to be contaminated with Hepatitis.

"It was a donor who had come back and we found him to be Hepatitis-B positive and we had to look back to see who received blood from that donor. The donor details were a 47 year-old white male. We had a negative donation from him in November 2008. His red cells were transfused to the patient in December

2008. And then we got a positive donation in January 2009, upon which our medial team started to do a look-back investigation. Three months later, we were then able to get the recipient's sample in March 2009 and it was strongly HBV-positive", says Marion Vermeulen, manager of the SANBS's NAT system.

By Ayanda Yeni
18.10.2010

Health-e News Service



talk to us

Anything interesting you want to share with us in the next issue. E-mail me at: nelouise@sahivsoc.org

Lack of transport hampering treatment success

Lack of affordable and accessible transport is emerging as a major hindrance towards poorer South Africans accessing state health care, especially for those living in rural areas. The Western Cape is perceived as a well resourced province, but for some HIV-positive patients living in Mooresburg, accessing treatment means relying on the goodwill of strangers for a lift and running the danger of defaulting on their treatment. Several studies have confirmed that lack of transport could be detrimental for access to chronic treatment and adherence, eventually leading to poor treatment outcomes.

Wendy Gwayi (34) a mother of three from Mooresburg was pregnant when she was told she had to collect her HIV treatment every month from Malmesbury Hospital, 35 kilometres away. Gwayi said she did not mind at the time as she was told transport would be made available. As the day for the appointment loomed she booked her place on the 17-seater managed by the province's emergency services division only to be told it was full. She was left to her own devices to arrange last minute transport. Not having the R250 charged by local motorists and not having a friend to take her free of charge she was forced to hitch a lift with a truck passing through Mooresburg.

"The man who offered me a lift asked for me to give him R20. On the way he said he had changed his mind and no longer wanted money. He asked me to agree to have sex with him instead and keep the money for my needs," said Gwayi.

When she refused the infuriated driver drove to a secluded area where he again demanded sex.

"I refused and later told him that I was HIV positive. He asked how I knew. I explained that I found out when I was pregnant and that I was going to collect treatment, but he still insisted on having sex with me. When I asked him if he had a condom he said no and said it did not matter. He then became violent and tried to force himself on me," she said.

Gwayi was saved by a passing truck driver who witnessed the attack. She told her story to the clinic staff at Mooresburg clinic and they transferred her to Tygerberg Hospital.

"After giving birth I was told I would have to go back to collecting my treatment in Malmesbury. I could not go back there and risk being raped," she said.

She stopped her antiretroviral treatment and never returned to Malmesbury.

doctor at Malmesbury Hospital who asked to remain anonymous said there were numerous cases of patients who had stopped treatment because they had been unable to afford the transport to collect their ARV treatment. However, Alvin Pedro, district manager of emergency services in the West Coast district said he had received no complaints about transport problems. He said transporting patients who needed to collect ARV treatment from facilities remained a priority for his office.

"We always treat ARV patients as a priority because once we have started people on treatment we have to make sure that we keep them. But there seems to be a lack of communication between the facilities, the patients and transport. Had we known that there were problems we could have made a plan for ARV patients," he said.

The Treatment Action Campaign (TAC) warned that stopping treatment could place patients' lives at risk. For most patients stopping treatment means reduced immunity against the virus and even death.

By Lungi Langa
19.10.2010

Health-e News Service



MDGs and Mother and Child health

The 2010 report on the South African progress with the achievement of the Millennium Development Goals (MDGs) are available. Set at the heart of the development agenda, the MDGs is a promise for progress on gender equality and women's empowerment. As a result, gender equality and

women's empowerment are critical to achieving the MDGs - in particular Goal 2 on universal primary education, Goal 4 on reducing child mortality, Goal 5 on improving maternal health, and Goal 6 on combating HIV&AIDS, malaria and other diseases.

It is a well known fact that South Africa is a middle income country with both first and third world characteristics. This mixed picture is seen in the progress of the achievement of the MDGs as well. South Africa has achieved some MDG targets 5 years before 2015, while others still have a long way to go. We are privileged to have the data that allows us to measure the MDGs which is not possible in all the African countries. But some of the targets, such as Goal 3 on gender equality, are limited and the stand alone MDGs blurs the multi-sectoral links between the goals, targets and indicators. For example, preoccupation with maternal health and gender disparities in education cannot be addressed without also addressing its relationship to feminised poverty, gender biases in the economy, gendered violence and ideologies which are all factors that could prevent gender equality and the empowerment of women. And therefore the achievement of Goal 3.

What are the MDGs?

The Millennium Development Goals (MDGs) are eight international development goals with 21 measurable targets developed by 192 United Nations member states and at least 23 international organisations to be achieved by the year 2015 as an international commitment to human development. All these goals have an influence on healthcare.

MDGs:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce Child Mortality Rate
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, malaria and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: develop a global partnership for development

Role of nurses and midwives

Nurses and midwives play an important role specifically in the achievement of MDG 4, 5 and 6. Because we work with women and mothers, we also have an influence on goals 1, 2 and 3. The vast

majority of the professions are women who suffer from the same gender inequalities as all other women. Nurses and midwives have low status in many countries in the world and receive little recognition. Consequently there has been insufficient investment in their training, development, support, supervision and often their working conditions and benefits of employment.

It is widely believed that investing in nursing and midwifery training will also contribute to the achievement of the MDGs, in particular to reduce the maternal mortality and morbidity. Midwives in the healthcare system are ideally placed to detect health problems and other challenges amongst the pregnant women and mothers they care for to make early and timely referral possible. They are the first to detect HIV incidence in pregnant and non-pregnant women. They can provide culturally sensitive counselling to help women and their families make healthy choices and to plan their families.

Historical evidence from developed nations like Sweden and many others bear testimony to the effective use of professional midwifery at primary health care level in reducing maternal mortality and morbidity¹. It is reported that some developing countries like Sri Lanka, Malaysia, Thailand, Tunisia, Chile, some states in India like Kerala and Jordan followed the example and achieved remarkable reductions in maternal mortality and morbidity.

Similarly nurses and midwives play a critical role in newborn care, which assists in averting early newborn deaths (MDG 4) and addressing prevention of mother to child transmission of HIV as well as generally preventing² HIV (MDG 6). A study in Botswana indicated that efficient performance with regard to mother and child health was significantly enhanced by trained by midwives at the site of service delivery and through continuous professional development.

Progress with the MDGs in South Africa

The latest country report was designed to be widely consultative as concerns were raised regarding the extent to which previous reports were based on consultation. The latest report emanates

from a Summit on MDGs held in Cape Town on 30 August to 1 September 2010. For the purpose of this edition of HIV Nursing, only MDG 4, 5 and 6 will be mentioned. A full copy of the report is available at <http://www.undp.org.za/remository/func-startdown/277/>.

MDG 4: Reduce Child Mortality Rate³

While infant (deaths under 1) and child (deaths under 5) mortality has been decreasing in most countries, South Africa is the exception to this trend in spite of significant progress in the prevention of malnutrition, mother to child transmission of HIV, immunisation coverage and access to free health care facilities. Child mortality has shown an increase primarily due to the impact of HIV and AIDS. The target set for South Africa of 20 deaths per thousand live births or lower by 2015 compares adversely with the current level of 104.

MDG 5: Improve maternal health⁴

Of the estimated 536 000 maternal deaths worldwide in 2005, developing countries accounted for more than 99 per cent of these. About half the maternal deaths occurred in sub-Saharan Africa alone⁵. To policymakers maternal health can be a very useful barometer for reflecting the health status of the female population, the level of gender equality in health care, and also of socio-economic conditions in general.

The maternal mortality ratio in South Africa has increased from 369 in 2001 to 625 in 2007 which makes it unlikely that the MDG of 38 per 100,00 will be achieved by 2015. This is in spite of a higher reported rate of births attended by skilled health personnel, contraceptive prevalence rate and antenatal care coverage. The 2005 - 2007 Saving Mothers Report indicated that the five major causes of maternal death remained the same during 2002-2004 and 2005-2007. These five causes are:

- Non-pregnancy related infections - mainly resulting from AIDS (43.7%);
- Complications of hypertension (15.7%);
- Obstetric haemorrhage (ante partum and postpartum haemorrhage (12.4%);
- Pregnancy-related sepsis (9.0%); and
- Pre-existing maternal disease (6.0%).

South Africa's reproductive health policies and the laws that underwrite them are among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights. It is therefore concerning that the current level of maternal mortality in South Africa is far higher than the MDG target of 38 per 100 000 live births by 2015. Good maternal health reflects on the quality of and access to maternal (sexual and reproductive) health care, while also offering evidence regarding the health status of women at reproductive age and that of their children. It is evident that maternal mortality is both a multi-dimensional health and broader developmental challenge, and that improved sexual and reproductive health is also dependent on a range of other factors including education, decent work, safety, clean water and sanitation, and adequate transport facilities.

MDG 6: Combat HIV & AIDS, malaria and other diseases⁶

HIV prevalence levels are still high in South Africa as compared to other countries in Northern, Western and Middle Africa. It does appear that the prevalence of HIV has stabilized in the country. The differential infection rates point to predominance in rural provinces which are attributed to gender power relations. Added to this, the emergent relationships that expose young girls to HIV because of gender power inequalities with older male sexual partners, creates concerning trends. On the positive side, a range of coordinated Government and civil society HIV and AIDS initiatives have strengthened national prevention, treatment care and support efforts. The majority of people in South Africa are aware that ARV is a treatment for HIV and that it needs to be taken for life.

Efforts towards the mitigation of malaria should be strengthened. Government has declared TB a top national health priority, and in this context the recent trend in the successful completion of TB treatment in South Africa that has developed over the years should be sustained.





The way forward

In response to this report, the Medium-term Strategic Framework (MTSF) of government identifies twelve outcome areas to focus on for more results-driven performance in the quest to achieve the MDGs. The *TWELVE KEYOUTCOME*⁷ that have been identified and agreed to by cabinet are:

1. Improved quality of basic education;
2. A long and healthy life for all South Africans;
3. All people in South Africa are and feel safe;
4. Decent employment through inclusive economic growth;
5. A skilled and capable workforce to support and inclusive growth path;
6. An efficient, competitive and responsive economic infrastructure network;
7. Vibrant, equitable and sustainable rural communities with food security for all;
8. Sustainable human settlements and improved quality of household life;
9. A responsive, accountable, effective and efficient local government system;
10. Environmental assets and natural resources that are well protected and continually enhanced;
11. Create a better South Africa and contribute to a better and safer Africa and world;
12. An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship.

Concept note : Symposium on Strengthening Midwifery Services, Women Deliver II. 5-6 June 2010, Washington DC retrieved on 25 June 2010 from www.internationalmidwives.org

²Fako, T.T.; Forcheh, N. & Balogi, K.T.O. 2002. Productivity among nurses and midwives in Botswana. *African Sociological Review* 6(1). Also available at https://www.codesria.org/IMG/pdf/09_Research_reports.pdf

³Millennium Development Goals. Country Report 2010:59 - 72. Accessible at <http://www.undp.org.za/remository/func-startdown/277/>

⁴Millennium Development Goals. Country Report 2010:66 - 73.

⁵Udjo, E 2010, UNDP Commissioned study.

⁶Millennium Development Goals. Country Report 2010:74 - 83.

⁷Millennium Development Goals. Country Report 2010:18.





National Consultative Health Forum

The Minister of Health addressed the National Consultative Health Forum (NCHF) at the Birchwood Hotel and Conference centre on 11 November 2010 to share with the invited stakeholders the Negotiated Service Delivery Agreement (NSDA) of the Department of Health.

Dr Aaron Motsoaledi, Minister of Health, presented the keynote address at the National Consultative Health Forum (NCHF) on the revitalisation of Primary Health Care, and improving accountability through strengthening a social compact and mass mobilisation for health service delivery. He presented a synopsis of the Health Sector Negotiated Service Delivery Agreement (NSDA) with delegates. This is a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government.

The commitment of the NSDA

As indicated in the previous article, the Government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 – 2014. Each outcome is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken within the given timeframe to achieve the outcomes associated with a particular output. For the health sector the priority is improving the health status of the entire population and to contribute to Government's vision of goal 2, namely "A long and Healthy Life for All South Africans". This can only be done by broadening and deepening the extent and scope of community involvement and social mobilisation in all aspects of health provision at local level.

Commitment of the Department of Health.

To tangibly contribute towards the realisation of this vision, the national Department of Health's Strategic plan for 2009 – 2014 lists 10 priorities as part of the 10 Point Plan for the overall improvement of the performance of the national health system. More broadly the Government has gone a step further by taking practical measures to ensure that by 2014 the Department of Health would have contributed positively to improving the status of all South Africans. Therefore the following four strategic outputs have been identified for achievement:

- Output 1: Increasing Life Expectancy
- Output 2: Decreasing Maternal and Child mortality
- Output 3: Combining HIV and AIDS and decreasing the burden of disease from TB
- Output 4: Strengthening Health System Effectiveness

Indicators and targets linked to the outputs:

- Life expectancy must increase from the current 53.9 years for males and 57.2 years for females to 58 years for males and 60 years for females by 2014
- South Africa's Maternal Mortality Ratio (MMR) must decrease to 100 or less per 100,000 live births by 2014. The Millennium Development Goals (MDG) country report estimates the current ratio at 625 per 100,000
- The child mortality rate must decrease to 20 deaths or less per 1,000 live births by 2014. The MDG country report estimates child mortality rates at 104 per 100,000
- The TB cure rate must improve from 64% in 2007 to 85% by 2014
- 80% of eligible people living with HIV and AIDS must access ART
- New HIV infections must be reduced by 50% by 2014

Achievement of the outcomes

Re-engineering the health system to one that is based on a primary healthcare approach with more emphasis on promotive and preventative healthcare will underlie all interventions needed to achieve the outputs. Tangible improvements in the effectiveness of the health system must be attained and corroborated by empirical evidence that clearly links to the four output areas.

In terms of strengthening the health system's effectiveness related to key health indicators and overall contribution to population welfare, the Department of Health has identified the need to overhaul key components within the spheres of financing, pooling of resources, purchasing and provision of health services. This will be done through the implementation of the National Health Insurance – a mechanism that will allow us to better harness the human, financial and technical resources within the public and private sectors and use these enhanced resources to improve the impact with which they contribute towards the achievement of the four identified outputs.

Establishing partnerships

Presentations were done on improving quality of care through health system strengthening by Dr Carol Marshall, strengthening human resources for health by Dr Percy Mahlathi and partnering to ensure achievement of

MDGs by Dr Yogan Pillay, all from the national Department of Health.

The delegates divided into 5 groups to discuss improving quality of care, strengthening human resources for health, partnerships for MDGs, improving accountability through strengthening social compact and mass mobilisation for health service delivery. Time was too limited to discuss these issues in depth, but a range of recommendations came from the groups that will be considered by the Minister of Health. All groups recommended that multi-sectoral forums be established with all the relevant stakeholders with the Department of Health fulfilling a coordination role to address the gaps identified and recommendations provided. The group on partnerships has appointed a task team to work on the gaps and needs identified. They will develop a document on how partnerships should be established and how they should work as well as a map to indicate what exists and what should be done. A report will be compiled by the Department of Health to collate all the contributions made.

R

Compassion

in the hearts of
nurses and midwives
makes a difference

AIDS 2010

XVIII International AIDS Conference



By:
Stacie C. Stender, MSN, RN, PGD-Infectious Diseases
Regional Technical Advisor, TB/HIV
Jhpiego, an affiliate of Johns Hopkins University

The XVIII International AIDS Conference, 'AIDS 2010', took place in Vienna from 18-23 July with 19,300 participants from 197 countries. A central theme was the international pledge to provide HIV prevention, treatment, care and support to all those in need by 2010.

Universal access won't be achieved this year, and it was emphasized that access by 2015 will require more effective and efficient use of resources, as well as increased commitment from international donors and national governments. Yet donor nations

aren't keeping their funding promises, and anger was expressed by thousands of activists throughout the course of the conference.

Commitment from the government of South Africa was made evident. South Africans radiated at the conference unlike any AIDS conference since 2000 in Durban: the Deputy President, Honourable Kgalema Motlanthe's speech at the opening ceremony was uplifting, where he stated "we are all working in unison under the theme **I Am Responsible, We Are Responsible, South Africa Is**

Taking Responsibility"; cheers of support came from the audience in Tuesday's plenary at the conclusion of Honourable Aaron Motsoaledi, Minister of Health's speech in which he stated that the government plans to enrol an additional 500,000 patients on the ART program by March 2011, with 4,000 health facilities offering these services; and the biggest buzz in the scientific arena was with regards to the release of the CAPRISA 004 microbicide results, from Kwa-Zulu Natal's own researchers Salim & Quarraisha Abdool Karim.

Prevention

Vaginal microbicide shows promise as a method of HIV prevention:

The 30 month proof of concept, double blinded, randomized placebo control trial, CAPRISA 004, demonstrated that the use of a vaginal gel/microbicide containing the antiretroviral drug tenofovir resulted in a 39% reduction in HIV risk in women over a 30 month period, as well as a 51% percent protection against HSV-2, the virus responsible for genital herpes. The tenofovir gel was tolerated when compared with placebo, and none of the women who seroconverted while using the gel showed the emergence of resistant virus.

This news is indeed promising, as the gel has the potential to give millions of women around the world the power to protect themselves from HIV infection. However there are several things that must be taken into consideration: 1) this was one trial in one population and other studies are required to confirm results; 2) there was a decrease in tenofovir efficacy over time, correlated with decreasing adherence, indicative of how important strategies to address adherence for a life-long prevention method will be; 3) efficacy varied according to adherence levels, from 54% in those with >80% adherence, and only 28% in those with <50% adherence; and 4) in resource limited settings, the strength of health systems will have a huge impact on the ability to deliver any product to the end user.¹

The Vienna Declaration brought to the forefront the need for drug policy to be based on science:

"The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed." The full declaration can be viewed at <http://www.viennadeclaration.com/>

Treatment

When to start ART: WHO formally launched the 2010 antiretroviral treatment guidelines at the conference. In resource limited settings, it is now recommended for adults to start ART at a CD4 count of 350 rather 200 cells/mm³, as this has shown to reduce

the risk of HIV-related illnesses. Another key aspect of the new guidelines is that d4T should be phased out, as safer combinations are made available. Fortunately the 2010 South African adult treatment guidelines are in line with the international recommendations, with the exception that WHO now recommends all HIV positive patients with TB should start ART regardless of CD4 count, whereas our guidelines recommend treatment only in those with CD4 < 350 cells/mm³.

When to start ART in TB patients:

The randomized, open-label trial in Cambodia, CAMELIA, provided further evidence ART should be provided 'sooner rather than later' for co-infected patients. The trial found a survival benefit associated with earlier HAART initiation in HIV-infected patients receiving TB therapy. There was a 52% increased mortality rate in those patients who started ARVs at week 8 compared to those who initiated at week 2 of TB treatment (median CD4 of both groups was 25 cells/mm³). However it must be noted that the incidence of IRIS (immune reconstitution inflammatory syndrome) was higher in those who started HAART early vs. late, indicating the importance of close clinical monitoring in these patients.²

Once daily dosing of NVP: The multicenter, randomized noninferiority study, VERxVE shows promising results with regards to once-daily nevirapine dosing. Once-daily extended release (XR) formulation was found to be noninferior to standard formulation, twice-daily dosing, measured by number of patients with HIV-1 RNA viral load < 50 copies/mL. Adverse events and discontinuation did not differ. Once daily dosing would provide an additional once daily regimen options for country ART programmes.³

There were 248 sessions and 6,238 abstracts in 6 tracks covering a broad range of HIV topics in basic science, clinical sciences, epidemiology & prevention services, social & behavioural sciences, economics, operations, research, care & health systems, as well as policy, law, human rights & political science. For more information on the sessions go to <http://www.aids2010.org/>, <http://globalhealth.kff.org/AIDS2010> and <http://www.aidsmap.com> also offer summaries of presentations.

¹Sokal D, Karim Q, Omar Z, Abdool Karim S. Safety of 1% tenofovir vaginal microbicide gel in South African women: results of the CAPRISA 004 trial. Abstract TUSO504

²Blanc FX, Sok T, Laureillard D, et al. Significant enhancement in survival with early (2 weeks) vs. late (8 weeks) initiation of highly active antiretroviral treatment (HAART) in severely immunosuppressed HIV-infected adults with newly diagnosed tuberculosis. Abstract THLB106

³Gathe J, Bogner J, Santiago S, et al. Comparison of 48 week efficacy and safety of 400 mg QD nevirapine extended release formulation (Viramune XR) versus 200 mg BID nevirapine immediate release formulation (Viramune IR) in combination with Truvada in antiretroviral (ARV) naïve HIV-1 infected patients (VERxVE). Abstract THLB202

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HIV and Sexuality

A new way of thinking

A new shift towards accepting and destructing old ways of teachings and perceptions of sexuality is necessary to survive and prevent the rapid spread of HIV and AIDS

Schenell Rossouw
Medi Shape and Sexational Clinic
Sexual Advisor, HIV Facilitator

2010 has been a landmark year for South Africa becoming the first African country to host the FIFA World Cup. During the month long tournament 64 matches of World Cup football were played in nine cities across the country. This was a truly joyous celebration. Sadly in the same month almost 23 000 South Africans died, many from AIDS.¹

Change in mortality rates

The impact the AIDS pandemic has on our nation is reflected in the dramatic change in South Africa's mortality rates. The annual number of deaths increased sharply from 1997 to 2006 when the number of deaths increased from 316 559 to 607 184. Although these deaths are not solely as a result of HIV and AIDS, there is a close correlation to this source as can be seen in the following statistics:

The biggest increase in deaths amongst South Africans were noted in the young adult age group who are also perceived to be the most sexually active age group according to the latest Durex Sex survey conducted in 2010. Furthermore HIV infections and AIDS related deaths are also quite high in this age group. In 2006 about 41% of recorded deaths were amongst the 25 - 49 year age group which is up from 29% in 1997. There is a strong indicator that AIDS is a major, if not the principal factor in the overall rising number of deaths in this age group.

Change teachings about sexuality

It is seriously alarming to be faced by the fact that regardless of HIV and AIDS education to date, the effects of AIDS are still being felt by thousands of South Africans. The time has come to make a paradigm shift in the way Educators treat and teach aspects of sexuality, HIV and AIDS. It is crucial that Educators become creative in their teachings about sexuality in general but specifically in the way persons behave and deal with their sexuality. When people in general start understanding that sexuality is part and parcel of who they are and will be until death, maybe the tide against HIV and AIDS related deaths can be turned

around. We need to understand that sexuality is a reality and sexual activity will continue whether a person is HIV positive or not or has any other sexual transmitted disease. Although some studies has indicated that the sexual behaviour of HIV positive female can change, it must be remembered that they still have a need to be recognised as a sexual being. Not enough studies have been concluded on this matter.

Being HIV positive and still having a healthy and happy sexual life is often not seen in the same context. This creates major conflict amongst the HIV positive infected population. Outcries about how to be a sexual creature the way they were before being infected are commonly seen in emails and letters, begging for answers and guidance.

The HIV pandemic had a negative impact on sexuality. Teachings are about death and dying and a negative connection is made directly relating to sexuality in general. In the process a negative attitude towards sex is created although the frequency of sexual activity has not changed.

Right to life with dignity and sexual well-being

The right to a life with dignity is the basis of all human rights. An important component of this is the right to sexual well-being - to a healthy and self-affirming sexuality free of violence, coercion, and disease.

A new shift towards accepting and destructing old ways of teachings and perceptions of sexuality is necessary to survive and prevent the rapid spread of HIV and AIDS. Sexuality includes all aspects of sex, lovemaking, intimacy, masturbation, cuddling, kissing, desires communication etc. It is not only the act of intercourse or the act of procreation. The word sexuality is a very complex concept and includes a wide range of acts and feelings individuals have for each other. Sex could be and can also mean different things to different individuals.

Everyone should be brought up with positive thoughts and feelings about sexuality. Your own sexuality as well as the sexuality of others should be seen as a normal part of life. In addition we

should teach individual's sexuality is a normal and healthy aspect of life and one has responsibilities not only towards you but also towards others.

Let's aim to establish a sex positive attitude amongst individuals that need to act responsible.

Reference:

1. Africa Regional Sexuality Resource Centre in collaboration with Health Systems Trust and Women's Health Resource unit of the University of Cape Town (UCT) South Africa



Sexuality

teaching must change to improve understanding of the way we behave and deal with sexuality

Rheumatologic Manifestations of HIV Infection

Patients infected with the Human Immunodeficiency Virus (HIV) may present with a variety of rheumatologic manifestations. These include joint pain or inflammation, disorders of bone or muscle tissue, connective tissue disease, as well as rheumatologic complications due to anti-retroviral treatment. Some of these conditions may also represent the initial manifestation of HIV infection and healthcare workers should maintain a high index of suspicion when confronted with a susceptible host, presenting with any of these conditions.



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Introduction

Since the onset of the human immunodeficiency virus (HIV) epidemic a variety of rheumatologic manifestations and autoimmune phenomena has been reported in HIV infected individuals. These may occur at any stage of HIV infection, although they are more prevalent in the late stages of the disease.¹ The prevalence of rheumatologic manifestations in HIV patients remains to be established, with published figures

varying greatly, ranging from 11% to 72%.² Manifestations with a higher prevalence is usually associated with the variety of inflammatory disorders associated with HIV infection.³

HIV-associated joint disease

HIV-associated arthralgia

Joint pain may be present at any stage of the disease and is a common presenting symptoms in acute HIV infection. Following the incubation

period, of few days to weeks after HIV infection, 40-90% of patients may present with flu-like symptoms, including joint pain in 28-54% of cases.⁶ Non-specific joint pain has been reported in 5 to 45% of patients during the course of HIV infection. It is usually mild and transient, most frequently affecting the knees, shoulders and elbows. Painful articular syndrome is seen in the late stages of HIV infection and presents as a severe intermittent arthralgia. Although attacks only last a few hours, its intensity may necessitate opioid analgesia.

HIV-associated arthritis

This form of joint inflammation occurs in 1-10% of HIV infected patients. It manifests as a non-erosive, oligoarthritis of the lower extremity (without enthesitis), usually lasting less than 6 weeks.

HIV-associated reactive arthritis (Reiter's syndrome)

A spondyloarthropathy resembling Reiter's syndrome may occur in up to 10% of HIV infected patients. The most typical presentation is an asymmetric oligoarthritis (involving 3 or less joints) of the lower extremity, with or without sacroiliitis, usually accompanied by enthesitis (Achilles tendonitis, plantar fasciitis or sausageing of toes or fingers). Other manifestations include mucocutaneous lesions like conjunctivitis, balanitis or urethritis.⁷

Undifferentiated Spondyloarthritis

This clinical syndrome is characterized by enthesitis (inflammation of Achilles tendon, plantar fascia, extensor tendons) accompanied by backpain and stiffness, without radiological evidence of sacroiliitis and/or spondylitis.³

Psoriatic arthritis

The incidence of psoriatic arthritis is approximately 2%. The severity of the psoriasis is generally equal to the severity of the immune impairment. In advanced HIV infection psoriasis may be generalized and extremely resistant to treatment.⁵

Table I. HIV-associated rheumatologic manifestations.^{4,5}

Joint disease
HIV-associated arthralgia (including painful articular syndrome) HIV-associated arthritis HIV-associated reactive arthritis (Reiter's syndrome) Undifferentiated Spondyloarthropathy Psoriatic arthritis Gout
Muscle disease
Myalgia and Fibromyalgia Rhabdomyolysis Polymyositis and dermatomyositis Zidovudine-induced myopathy
Bone disease
Osteopenia/osteoporosis/osteomalacia Avascular necrosis Hypertrophic osteoarthropathy
Connective tissue disease
DILS - Diffuse infiltrative lymphocytosis syndrome Vasculitis
Complications of HIV treatment
Immune reconstitution syndrome Rheumatoid arthritis Systemic lupus erythromatosus Sarcoidosis Zidovudine-induced myopathy Rhabdomyolysis Avascular necrosis Adhesive capsulitis Dupuytren's contractures Tenosynovitis

Gout

Elevated uric acid levels are seen in up to 42% of HIV infected individuals, although clinically apparent gout only appears in about 0.5% of cases. The raised uric acid level is mostly due to increased cell turnover, but it may also result from anti-retroviral treatment.⁵

HIV-associated muscle disease

Myalgia and Fibromyalgia

Muscular pain has been described in up to a third of patients. HIV seroconversion may be associated with transient myoglobinuria and acute muscle pain. CK elevation is commonly encountered in HIV infected patients, and post mortem muscle biopsies have revealed muscle atrophy, inflammation and necrosis.⁴ Fibromyalgia involves pain in muscles, as well as fibrous tissues, tendons and ligaments.

Rhabdomyolysis

The breakdown of muscle tissue has been reported with the use of protease inhibitors (anti-retroviral therapy), especially when combined with lipid lowering agents. In severe cases the resulting myoglobinuria may cause acute renal failure.⁴

A non-inflammatory necrotizing myopathy, due to the primary HIV infection, has also been described. In some cases this entity has been associated with the poorly characterized HIV-related wasting syndrome.⁸

Polymyositis and Dermatomyositis

HIV-associated polymyositis is an inflammatory myopathy that has been reported in up to 7% of patients, and may occur at any stage of the disease. The most common presentation is that of a slow onset, progressive, proximal muscle weakness without prominent myalgia. HIV polymyositis usually responds well to glucocorticoid therapy combined with HAART.⁵

Dermatomyositis, Inclusion-body myositis and Nemaline rod myositis occurs rarely in HIV infected patients.

HIV-associated bone disease

Osteopenia/osteoporosis/osteomalacia

Osteopenia/osteoporosis (decrease in bone quantity) is highly prevalent in HIV infected individuals, as is indicated by a recent finding indicating increased fracture risk. It is thought to be of multifactorial origin, mainly due to HIV-mediated immune activation and cytokine release. Osteomalacia (decrease in bone quality, due to abnormal mineralization) may also result from Tenofovir nephrotoxicity.⁴

Avascular necrosis

HIV infected patients are approximately a 100 times more prone to develop osteonecrosis, when compared to the general population. The most common site involved is the hip joint, followed by the shoulder. MRI investigations have estimated the prevalence of AVN of the hip at 4%. Approximately 10% of these patients will eventually require total hip replacement. The cause of osteonecrosis in HIV patients remains unknown. Hyperlipidemia due to anti-retroviral treatment, glucocorticoid use and antiphospholipid antibodies have all been implicated.⁹

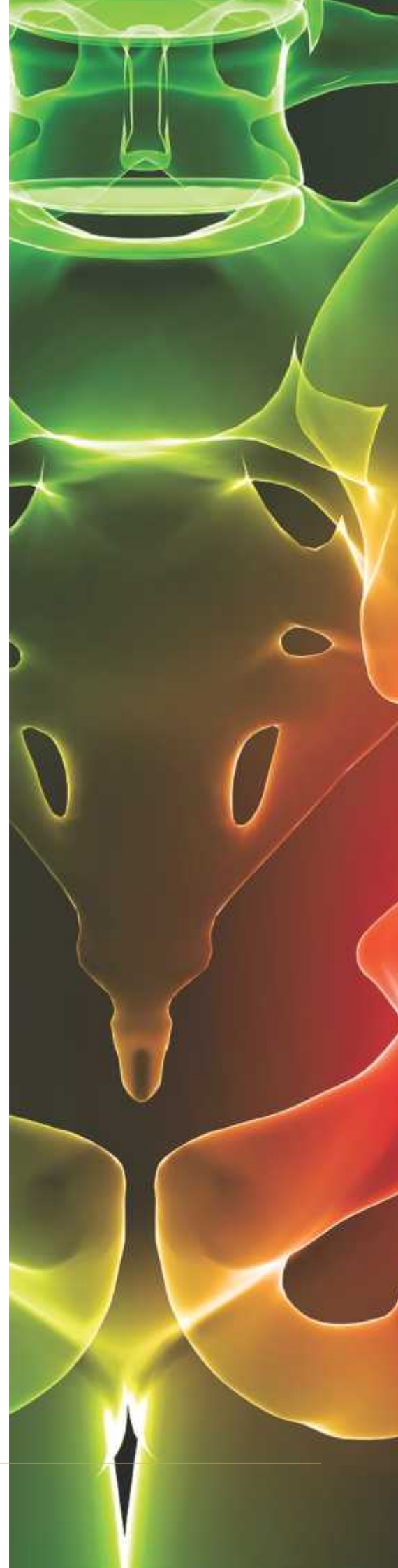
Hypertrophic Osteoarthropathy

This syndrome is characterized by extensive periosteal new bone formation that may extend from the diaphysis to the metaphysis of longbones. Patients typically present with pain, joint effusions or soft tissue swelling, and an association with *Pneumocystis Carinii* pneumonia has been noted.¹⁰

HIV-associated connective tissue disorders

DILS- Diffuse infiltrative lymphocytosis syndrome

Previously known as Sjogren's-like syndrome, DILS is a common problem in HIV infected patients, and usually manifests several years following seroconversion. The syndrome is characterized by bilateral painless parotid and lacrimal gland enlargement associated with dryness of the eyes, mouth and other mucous membranes. The pathogenesis involves an increase in circulating CD8+ lymphocytes as well as CD8+ T cell infiltration of multiple organs. Extraglandular complications



include interstitial pneumonitis, myositis and hepatitis.⁵

Vasculitis

A wide spectrum of HIV associated inflammatory vascular diseases, involving small, medium and large bloodvessels, have been described. Clinical manifestation depends on the specific type of vasculitis that arises. Common manifestations include purpura, peripheral gangrene, neuritis, arthritis, aneurysms and stroke.

Complications of HIV treatment

Immune Reconstitution Syndrome

Traditionally HIV infection was associated with a decrease in the incidence auto-immune disorders like Rheumatoid Arthritis, SLE and Sarcoidosis. This can be attributed to the immunosuppression effect of HIV infection. The introduction of HAART and the return of the patient's immunocompetence may result in the manifestation of Rheumatoid Arthritis, SLE or Sarcoidosis.

Zidovudine-induced myopathy

Muscle weakness due to Zidovudine treatment represents the most common muscular problem in HIV patients.⁵

Other complications

Other complications related to HAART include rhabdomyolysis, avascular necrosis, frozen shoulder, Dupuytren's contractures and tenosynovitis.

Conclusion

The impact of the HIV pandemic continues to grow, and healthcare professionals need to be aware of the wide spectrum of rheumatologic diseases that may manifest in HIV infected patients. Although antiretroviral therapy may have possible musculoskeletal complications, it must be noted that effective antiretroviral treatment results in the improvement of many of the HIV-associated rheumatic diseases and may also dramatically decrease the occurrence of other musculoskeletal complications.

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Effective

ARV treatment improve many HIV-associated rheumatic diseases

Early infant diagnosis in babies in PMTCT programmes

Infant prophylaxis given soon after birth to all HIV-exposed infants can be effective in reducing MTCT.

Polly Clayden, HIV i-Base

The revised South African Prevention of Mother to Child Transmission (PMTCT) guidelines 2010 introduce better strategies for pregnant women both eligible and ineligible for HIV treatment. They include:

- Initiation of lifelong treatment for women with CD4 counts 350 cells/mm³ or less.
- Antiretroviral prophylaxis for women with CD4 greater than 350 cells/mm³ consisting of zidovudine from 14 weeks of pregnancy, plus single dose nevirapine and three hourly zidovudine during labour and single dose tenofovir and emtricitabine after delivery.

HIV-positive pregnant women must be identified and, alongside their infants, receive appropriate treatment and care, in accordance with this guidance. If this is implemented, the number of children infected through mother to child transmission (MTCT) in South Africa should decline considerably.

Infant prophylaxis given soon after birth to all HIV-exposed infants is also effective in reducing MTCT even if the mother does not receive antiretrovirals. A number of infants will still be infected despite PMTCT.

The revised Guidelines for the Management of HIV in Children now recommend universal treatment for all HIV-infected infants less than 12 months of age.

This recommendation followed early results from the Children with HIV Early Antiretroviral Therapy (CHER) trial – conducted in South Africa – which informed children's treatment guidelines internationally.

The CHER trial showed that starting ART before 12 weeks of age reduced early mortality by a highly significant 75% compared to starting at CD4 percentages less than 25%, or guided by clinical symptoms.

The guidelines also recommended that young infants are started on antiretrovirals as soon as possible, and in order to do so HIV-infected children must be identified early.

Standard HIV antibody tests are not

able to distinguish between the mother's and the infant's antibodies. This is because the mother's antibodies are transferred to the baby through the placenta when she is pregnant.

Therefore all infants exposed to HIV in pregnancy will be born with HIV antibodies, and will test positive on HIV antibody tests. These can remain in the baby's blood for as long as 18 months.

Therefore children less than 18 months need to be diagnosed with virological tests that detect the virus not the antibodies.

South African guidelines currently recommend the HIV DNA PCR test for Early Infant Diagnosis (EID). These tests are highly sensitive and specific (about 99%) at six weeks of age. Sensitivity of a diagnostic test means the proportion of true positives that are correctly identified, and specificity is the proportion of true negatives that are correctly identified by the test.

These tests can either be performed on whole blood or dried blood spot (DBS) samples – collected from heel pricks with very young infants.

The guidelines also recommend that infants testing PCR positive have a confirmatory test on a different blood sample as soon as possible. This test will be a baseline viral load test and a viral load above 10,000 copies/mL is considered to confirm HIV infection.

If the DNA PCR test is positive, the viral load must be sent immediately and the family prepared for the infant to begin lifelong ART. If the test is negative and the infant is being breastfed, the baby will require a repeat test 6 weeks after breastfeeding has stopped.

All HIV exposed babies who test HIV negative by DNA PCR should have an antibody test at 18 months.

References:

<http://www.sanac.org.za/documents/2010%20PMTCT%20Guidelines.pdf>
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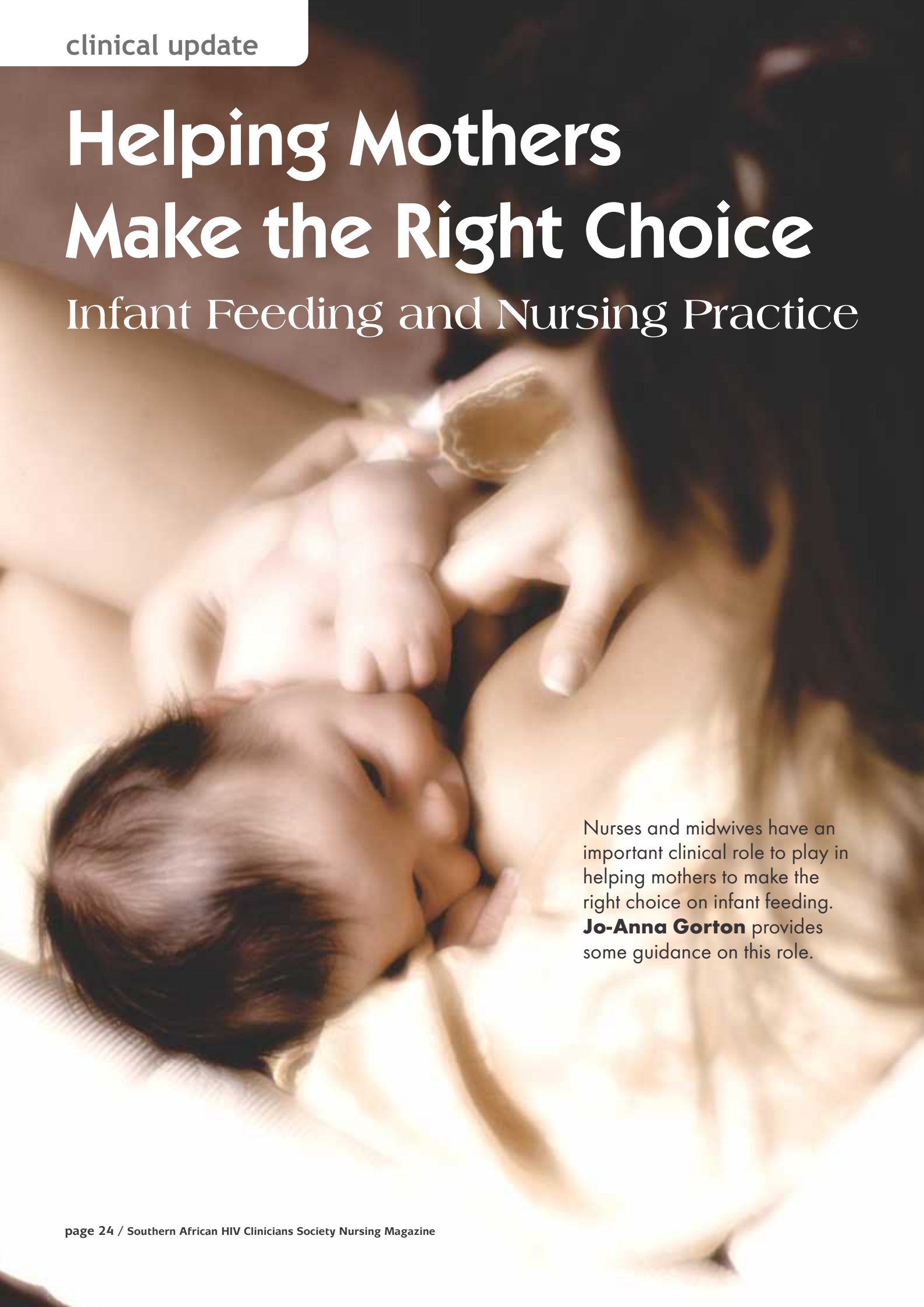


PMTCT

guidelines are
effective in protecting
infants from
contracting HIV

Helping Mothers Make the Right Choice

Infant Feeding and Nursing Practice



Nurses and midwives have an important clinical role to play in helping mothers to make the right choice on infant feeding. **Jo-Anna Gorton** provides some guidance on this role.

For a mother living with HIV, choosing how best to feed her baby is a difficult and complex decision. Breast feeding increases the chance that a mother will transmit HIV to her baby but breast milk protects children from diseases and is more nutritious than commercial infant formula. The best feeding option for an HIV-positive mother depends on her circumstances, her health, the health services she has access to and the counselling and support she is likely to receive. As nurses, we must help mothers make good decisions for themselves and their newborn baby by assessing their needs, giving them accurate and unbiased information, and providing them with the care and resources they need.

The Basics: Breastfeeding and HIV

Mothers can transmit HIV to their children during pregnancy, labour, delivery or breastfeeding. Without antiretroviral therapy (ART), 5-20% of infants that breastfeed from HIV-positive mothers will become infected with the virus. The risk of HIV transmission increases the longer a mother chooses to breastfeed and importantly, if a mother becomes HIV-positive after giving birth and while breast feeding, the risk of transmitting HIV is greater because of her high viral load during the first weeks of infection. Women with low CD4 counts (less than 500mm³) and those with compromised breast health (conditions such as mastitis, nipple bleeding, abscesses or fissures) are at greater risk of transmitting HIV through breast milk. For infants, certain patterns of feeding and any damage to their mucous membranes will put them at higher risk of contracting HIV when they breastfeed.

Infant Feeding Options

Recent evidence shows that when a mother and her infant are given ART for a certain period of time during breastfeeding, the risk of transmitting HIV is greatly reduced. This evidence has shifted international and South African guidelines around infant feeding and has implications for nursing practice. Below is an exploration of the different feeding options mothers have and information nurses need to be able to advise and support HIV mothers as they choose the best feeding option for

themselves and their baby. Counselling on infant feeding should start at a mother's first antenatal visit and be discussed at each subsequent appointment and after delivery.

Breastfeeding

Before ART was available in the public health system, breastfeeding by mothers who were HIV-positive was generally discouraged if infant formula was available and safe to use. South African guidelines have changed though after research showed that the risk of transmitting HIV from mother to child through breastfeeding can be greatly reduced if both the mother and infant are given ART, as discussed above (see below for specific ART guidelines).

Breastfeeding has many advantages. It is more nutritious than formula milk and contains antibodies which protect children against diarrheal infectious and pneumonia. Breast milk contains fats, protein, vitamins, carbohydrates and enough nourishment for a baby up to 6 months old. Breast milk is free and also provides mothers with some protection against pregnancy during the first months after birth.

If a mum chooses to breastfeed, there is important information nurses can provide during antenatal or postnatal visits. The most important thing is to ensure that mum and baby are taking their ART treatment and that mothers know the importance of adherence. Any treatment interruptions can put the baby at risk of contracting HIV. Mothers also need to understand the importance of exclusive breastfeeding during the first six months. Breast milk usually contains enough nutrients and liquid to nourish an infant in its first 6 months of life. Although it is common to complement breastfeeding with tea, water or porridge, this method of mixed feeding is not recommended.

Mothers should breastfeed exclusively for 6 months, introduce complementary foods after this 6 month period and stop breastfeeding altogether at 12 months. If a mother chooses to stop breastfeeding before this time, babies should be weaned off over the course of one month while they continue to receive ART for that month and one week after.

Breastfeeding should be initiated within

the first hour after birth. Milk is usually let down within the first 48 hours after birth and it can take weeks before the baby and mum find a latch that is comfortable and effective for both. Mothers should breastfeed according to the demands of their baby, for example when they are giving feeding cues, which can be as often as every two hours in the first months.

Choosing to Use Formula

Replacement feeding using commercially produced infant formula is the only 100% effective way to prevent transmission of HIV. It is not as nutritious as breastfeeding though and does not give the same immunity protection. Mothers and health workers must weigh these advantages and disadvantages when making a choice about infant feeding. The World Health Organization (WHO) recommends that formula feeding only be encouraged if it is acceptable, feasible, affordable, sustainable and safe (see below for more details).

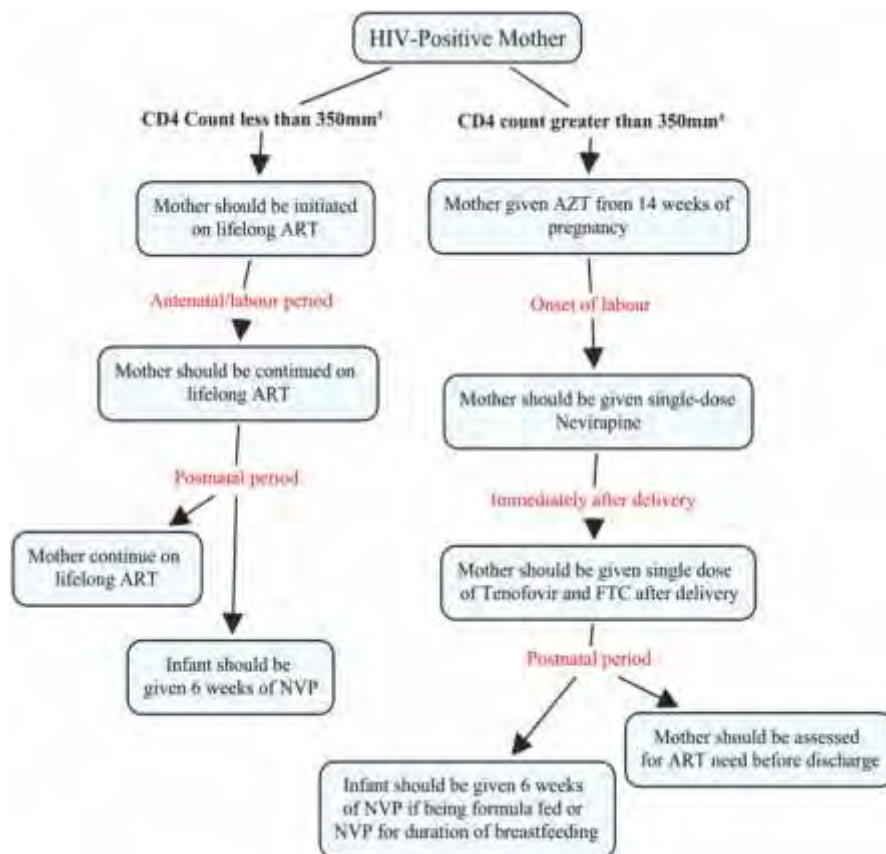
- **Acceptable:** This means that breastfeeding is an acceptable option for mothers and that she will not face (or can cope with) stigma or discrimination from her family or community.
- **Feasible:** A mother must have the time, ability, and resources to follow instructions and prepare formula up to twelve times a day.
- **Affordable:** Besides the formula itself, mothers must also have the money to get clean water, fuel and other equipment needed for feeding. According to South African PMTCT guidelines free commercial infant formula should be provided to infants for at least the first six months.
- **Sustainable:** Mothers need a reliable supply of formula as even brief interruptions in feeding can have serious health consequences. Where commercial formula is provided free of charge at clinics, managers and health workers can ensure a reliable procurement and distribution system is in place so the supply of formula is uninterrupted.
- **Safe:** Formula must be nutritionally sound. Other formula supplies should be germ free and mothers should have the capacity to prepare formula hygienically. Health care workers,

under the South African PMTCT guidelines are obligated to recommend formulas that abide by the provisions of the International Code of Marketing of Breast Milk Substitutes.

It is up to nurses and other health care providers to assess the needs of mothers and provide them with resources they need to ensure formula feeding can be done safely. Families using formula require routine home visits if possible and clear guidance on the volume and frequency of feeds. Nurses and other health workers should emphasize the importance of keeping the feeding equipment clean and mothers should be taught how to prevent breast engorgement and recognize and treat dehydration in their infants. Mothers should also be advised to use cups instead of bottles when giving formula.

Mixed Feeding

Mixed feeding involves breastfeeding and the use of replacement nutrition like water or infant formula. This method of feeding is not recommended by the South African Department of Health or the WHO.



Clinical Guidelines and Nursing Interventions

After a mother has decided how she will feed her child, nurses can be guided in their practice by the new South African PMTCT guidelines. These guidelines were published in early 2010. The most significant shifts in practice include recommendations to commence lifelong ART to all HIV positive pregnant women with a CD4 count of $350/\text{mm}^3$, prophylaxis at 14 weeks pregnancy for HIV-positive mothers non-ART eligible and the provision of ART for infants receiving breast milk.

The diagram, (adopted from the South African PMTCT guidelines) outlines what nursing practices should be followed to most effectively reduce the risk of mother-to-child transmission during pregnancy and infant feeding.

Care during the Antenatal Period and during Labour & Delivery

During antenatal care, all women should be offered HIV testing and counselling if their HIV status is unknown. If a mother is HIV positive, she should enter a PMTCT programme. Mothers living with or without HIV should be counselled on feeding options during each antenatal visit. For HIV-positive women, unbiased and accurate information should be given on the advantages and disadvantages of exclusive formula and exclusive breastfeeding. An HIV-positive mother should be started on ART if her CD4 count is less than $350/\text{mm}^3$. HIV-positive mothers with a CD4 count greater than $350/\text{mm}^3$ should be started on AZT from 14 weeks, given nevirapine at the onset of labour and tenofovir and FTC after delivery.

Care during the Postnatal Period

Immediately after delivery and in the months that follow the birth of a new baby, nurses should provide support to mothers as they breastfeed or formula feed. In the first weeks after birth this may entail teaching, mobilizing resources, doing assessments and providing care for mothers. All infants born to HIV-positive mothers should receive ART after birth. The duration of this treatment depends on the mothers ART regimen, her feeding choices and the infants HIV test result at six weeks old.

At six weeks, both mothers and infants should have a scheduled check-up. Infants of HIV-positive mothers should be tested for HIV using a PCR method of testing if available. The South African PMTCT guidelines also state that children should be started on infant co-trimoxazole at this time until their HIV status is known. Children who are exclusively breastfeeding from HIV-positive mothers who are not on life-long ART treatment should remain on this infant co-trimoxazole until breastfeeding is stopped. If an infant is discovered to be HIV positive in the antenatal period they should be promptly referred for ART treatment. The WHO recommends that HIV positive children be breastfed exclusively for the first six months and then mixed fed with breast milk and other nutritional support until aged two. For more information on nursing interventions for infants feeding from HIV positive mothers please see the South African PMTCT guidelines.

At the six week check-up, mothers on lifelong ART should be assessed and subsequently referred to their closest primary health care facility for on-going ART support. Family planning for the future can be discussed at this time and mothers should be counselled to bring their infants in at 18 months for their next HIV test (if the first PCR test at six weeks is negative). Mothers not receiving lifelong ART should have a TB test and their CD4 count taken. If their CD4 count is less than 200 or they show WHO stage 3 or 4 symptoms they should be urgently referred for ART. If their CD4 count is greater than 200 they should be referred to Wellness Services and counselled to keep in contact with the clinic for future follow-up care.

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Best feeding

options for HIV-positive mothers depend on her circumstances, health, health services available, counselling and support



Challenges of adolescent pregnancy

Helen Gundani, Zimbabwe

Contracting HIV&AIDS is not the only danger related to adolescent pregnancy in Southern Africa. This article presents an extract of a research project amongst pregnant adolescent women attending prenatal care services in Zimbabwe.

Adolescence and the transition to adulthood are laden with risks and challenges, including decisions about sex. These decisions are challenged by social, psychological and biological factors and put the lives of many adolescents at risk of negative health outcomes such as contracting HIV&AIDS. The sexual behaviours and attitudes of adolescents are largely a product of limited and knowledge about biology, sexual development, sex related risks, and limited preparation to cope with feelings and relationships.

Globally every fifth child is born to an adolescent mother and according to UNICEF 80% of adolescent pregnancies occurs in developing countries. Adolescent pregnancies have increased over the years. The highest levels of adolescent pregnancies are in sub-Saharan Africa where women give birth to a child at 19 years (World Health Organization). While adolescent pregnancies are desired by adolescents in sub-Saharan Africa, it exposes young girls to many risks such as HIV&AIDS, premature labour, abortions, post partum haemorrhage, stillbirths, infertility and cancer risks. The increase in pregnancies amongst adolescents is also due to early marriage, social changes, relative social freedom, emancipation of women in society, poverty, and lack of knowledge of adolescent pregnancy complications. The Zimbabwe Demographic Health Survey of 2005-2006 reported a high pregnancy prevalence rate of 21%. Also in Zimbabwe a high HIV&AIDS infection rate of 29% was reported among 13 to 19 year old adolescents.

Knowledge of the complications of adolescent pregnancy

Knowledge of sexual risks among adolescents is generally low and often erroneous. Many adolescents do not consider that they are personally at risk of contracting HIV&AIDS and other STIs, or becoming pregnant; and as a result do not acquire knowledge on pregnancy related complications. This results in adolescents having unwanted pregnancies and pregnancy complications. Despite studies on adolescent pregnancies, little is known about adolescents' knowledge of pregnancy related complications from the perspective of adolescents in Zimbabwe.

Demographic data of participants

In Zimbabwe there is a prevalence of 21% pregnancy among adolescent women. A descriptive survey was conducted in March, 2009 in the Mashonaland area in Zimbabwe amongst pregnant adolescents. The age and marital status of the participants in the survey are indicated in tables 1 and 2.

Table 1. Age of participants (N=66)

Age	Frequency	%
13	5	7.6
14	6	9.1
15	6	9.1
16	8	12.1
17	7	10.6
18	17	25.8
19	17	25.8

Table 2. Marital status of participants (N=66)

Marital status	Frequency	%
Single	18	27.3
Married	38	57.6
Divorced	2	3
Separated	2	3
Co-habiting (eloped)	6	9.1

Knowledge of complications of early pregnancy

Thirty-nine (59.1%) participants had no knowledge of the complications related to pregnancy, while 27(40.1%) knew about the complications related to pregnancy, and only 1(1.5%) knew that HIV&AIDS was related to pregnancy complications. All the participants knew that abortion was a complication of pregnancy. Dropping out of school,

early marriage, social rejection and career disturbance were some of the recognised dangers of falling pregnant early. Fifty (75.8%) participants failed to get contraception because nurses viewed them as too young. In addition in Zimbabwe, society denies adolescents information on pregnancy, sex and sexuality considering them taboo topics.

Table 3. Knowledge on pregnancy-related complications (N=66)

Knowledge on pregnancy-related complications		
Pregnancy related complications	Frequency	%
None	39	59.1
Premature Labour	12	18.2
Obstructed labour	8	12.1
Anaemia	6	9.1
Others	1	1.5

The majority, 21(31.8%), stated that getting pregnant played a part in their dropping out of school. Early pregnancy contributed to career disruption 9(13.6%), social neglect/rejection 10(15.2%), financial constraints 5(7.6%), early marriage 18(27.3%) and 1(1.5%) contracted infections such as HIV&AIDS. Two (3.00%) reported no knowledge of the dangers of falling pregnant at an early age (Table 4).

Importance of knowledge and education

The importance of education and knowledge on the challenges related to early pregnancy is essential to equip young women to make informed choices. Failure to offer appropriate educational messages may be a barrier to meeting the adolescent women's health needs. Properly instituted youth friendly services that are manned by youth friendly nurses could improve adolescents' pregnancy related complications knowledge and also improve better behaviour seeking for adolescent reproductive health.

Table 4 Dangers associated with pregnancy

Dangers associated with early pregnancy	Fre-quency	%
Do not know	2	3
Dropping out of school	21	31.8
Career disturbance	9	13.6
Social neglect/rejection	10	15.2
Financial constraints	5	7.6
Early marriage	18	27.3
Infections (HIV&AIDS)	1	1.5

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2010

International Year of the Nurse

2010

2010 has been declared the International Year of the Nurse (IYNurse), and the centennial year of the death of the founder of modern nursing Florence Nightingale (1820-1910). 2010 IYNurse was founded by Sigma Theta Tau International (STTI), Nightingale Initiative for Global Health (NIGH) and Florence Nightingale Museum (FNM) London.

To celebrate this historic milestone, 2010 IYNurse is a sustained public awareness initiative to actively involve the estimated 15 million nurses globally in a celebration of commitment to bring health to their communities, locally and worldwide. It is a collaborative, grassroots, global initiative honoring nurses' voices, values and wisdom to act as catalysts for achieving a healthy world.

The 2010 International Year of the Nurse seeks to engage nurses in the promotion of world health and to recognize the contributions of nurses globally, including their contributions to the UN Millennium Development Goals. South African nursing organisations have launched the "My Nursing 100 Campaign" to celebrate International Year of the Nurse. Go to www.2010iynurse.net or www.edunurse.co.za to see the contributors that have been made.



Midwives Perspectives

on HIV/AIDS Care in Maternal Health Services

Loveday Penn-Kekana, Busi Kunene

5.30

“Yes we are too busy, but what can we do because we want to save the lives of our communities”



South Africa has committed to achieving the Millennium Development Goal 5 of reducing maternal mortality by 75% between 1990 and 2015. However although the exact maternal mortality ratio (MMR) is contested, the evidence suggests that the MMR has doubled since 1990, mainly due to HIV related maternal mortality (1). If South Africa is to reverse this trend it is clear that there needs to be a major focus on improving the care of HIV positive pregnant women who have, according to the Saving Mother's report, a mortality rate of nearly ten times that of HIV negative women (2). Key policy changes have recently been implemented to try and address this problem, and include the commitment to fast tracking pregnant women, and increasing the CD4 treatment threshold to 350 cells/mm³. Midwives, as the major providers of maternal health care, are central to this effort, yet there has been the suggestion in the past that both midwives and obstetricians have had a 'blind spot' (3) when it comes to HIV & AIDS, with pediatricians running the PMTCT programme to save the baby. There has also been a persistent perception that "if the woman is HIV positive, there is nothing active to do for her" (4). This article briefly summarizes the results of two surveys of midwives' attitudes towards their role in HIV & AIDS prevention, treatment and care carried out by the Midwives Aids Alliance.

The Midwives Aids Alliance (MAA) was launched at the 8th Congress of Midwives of South Africa in Limpopo. MAA was set up under the Khusela project with funds from PEPFAR, and is hosted by PATH. The main aim of the

organization is to mobilize midwives to play a bigger role in HIV & AIDS prevention, treatment and care, and to ensure that midwives' voices are present in the policy making and implementation process. To inform its work the MAA carried out two surveys of midwives attitudes at the 8th and 9th Congress of Midwives in December 2008 and 2009 respectively. The Midwives Congress is an annual event organized by the Society of Midwives of South Africa and attended by a range of midwives working at all levels of the health service.

Methods

At the 2008 Midwives Congress a 2-page anonymous self-administered questionnaire, with closed and open questions, was included in the conference pack, and midwives were asked to return it to the MAA stall. 290 questionnaires were returned, representing about 50% of attendees. Data was entered in epi-info and basic descriptive and multi-variate analysis was carried out in STATA.

At the 2009 Midwives Congress qualitative interviews were carried out to help MAA understand midwives perspectives and ideas about the work of MAA in more depth. A purposeful sample (to ensure representatives of all provinces and all levels of care were represented) of 32 midwives were interviewed, and if they agreed the interviews were taped. Taped interviews were transcribed and coded. Notes were coded for interviews that weren't taped.

The focus of both surveys was on midwives views of their roles, training they had received, views on key policy debates, and suggestions for the work of MAA.

Results

In 2008 midwives from Limpopo, Mpumalanga and Eastern Cape were over represented in the sample reflecting the provinces that sent most midwives to the Congress. In 2009 midwives from Free State were over-represented. In 2008 over 75% of midwives were over 40, and 41 % were advanced midwives. Full results of the 2008 survey have been published by MAA (5) and only a brief summary is provided here.

In both surveys midwives were almost unanimous in feeling that they wanted to play a bigger role in HIV & AIDS prevention, treatment and care, even though they were worried about their workload. In 2009 many commented that the whole attitude to HIV & AIDS had changed in the health service and they were excited to be part of new efforts to improve AIDS care that were taking place. In both 2008 and 2009 many expressed the concern that not enough preventative work was being done among pregnant women and teenagers.

In 2008 97% of midwives felt they ought to be able to initiate ARV's. All of those interviewed in 2009 agreed with this – despite the fact that they felt that they were already overworked. Three main themes emerged from the qualitative interviews about why midwives should be involved in initiating ARVs. Firstly they

Table 1. Number of respondents in 2008 who had received special training and self-assessed adequacy of training.

	% (Range among provinces)
Midwives who had received training on PMTCT	71% (63 - 100)
PMTCT trained midwives who felt that the training was enough	46% (25 - 59%)
Midwives who had received training on ARV's	52% (0 - 79%)
ARV trained midwives who felt their training was sufficient	25% (22 - 37%)

saw women a number of times and developed relationships with them, so would be in a good position to help them through counseling and adherence processes. Secondly, they wanted to provide comprehensive care to pregnant women and therefore felt it was necessary to provide HIV & AIDS care when so many pregnant women were HIV positive. Thirdly they believed that if midwives were able to initiate ARV's this would improve access for women. Midwives commented on how the lack of doctors had impacted on the ability of facilities to provide ARV's and commented on the health costs of delayed treatment, as well as the transport and other challenges that faced pregnant women when they were referred to other facilities.

"The hospital where we refer is 20 km.. its R30 round trip.. it is so difficult for them to go there because they don't have money and they have to go three times for adherence"

Midwife. Eastern Cape.

However, although midwives were currently providing PMTCT, and interested in providing ARV's, many had not had training, or perceived that the training was inadequate. This is not so surprising in ARV services, but is very worrying in terms of PMTCT.

Concerns about training were also raised in the 2009 interviews. Midwives complained of inappropriate nurses who weren't working in maternity services being sent on training, or training being cancelled due to shortages of staff. Some complained that training on other programmes was prioritized by district managers. Midwives also expressed concern about the adequacy of training that they received both off and on site. Some of the midwives complained that they had not had sufficient training, and were still unsure of what to do, and then they were expected to train colleagues.

"We need more (training) on the use of this treatment, the tablets how they are being used because in some institutions it is being said it must be like this and we are doing it differently, and so it becomes confusing, and I am meant to be teaching others"

Midwife. Free State

While midwives agreed on playing a bigger role in HIV & AIDS treatment, and midwifery initiation of ARV's, they were divided on two other policy debates - i.e. whether counselors should be able to do needle pricks, and whether a women's HIV status should be openly written on her records.

In 2008 52 % of midwives felt that counselors should not be allowed to do finger pricks. Midwives from Eastern Cape, Limpopo and Mpumalanga were more likely to disagree, and views were not significantly influenced by whether midwives had received training, or were advanced midwives. One midwife in 2008 wrote that "counselors are not trustworthy and are not professionals".

In 2009 midwives interviewed were still divided on this issue, with views appearing to be strongly influenced by their own experiences of counselors in the services in which they worked. One midwife argued it was only being done because of the "shortage of personnel" and that it was a mistake re-stating that counselors 'were not professionals'. Some agreed because "at times you are busy", and that they felt that it was appropriate as counselors did the pre and post test counseling.

In 2008 54% of midwives felt that a woman's HIV status should be written openly on women's cards and 42% disagreed. Midwives from Mpumalanga were more likely to disagree and midwives from Eastern Cape were more likely to agree. Midwives who had received training on ARV's were more likely to agree, and whether or not they were advanced midwives did not impact on midwives' views.

In 2009 midwives were still divided. Some felt strongly that HIV status should be written on women's cards as part of the process of normalizing HIV.

"In my understanding I don't believe that the HIV status should be a secret area, it should be open for a correct management of a woman at any level of care in the area anywhere"

Midwife. Limpopo

"I think we can strive to a point where if a person is HIV positive, it must be known, she must be supported, they will

get used to that, even the community will get used to that and we can teach them that to be HIV positiveis not a death sentence"

Midwife. Free State.

However others felt strongly that it was not a good idea, and that if the coding system was implemented properly it could work. They were worried that the rights of women if their status was disclosed with relatives looking at ANC cards, and that ANC cards would get lost.

"I think she will tear up the card and say at home they will see this....so I think the coding is doing very well"

Midwife. Mpumalanga.

Discussion and Conclusion

The views of these midwives, half of whom are advanced midwives, may not be representative of all midwives providing maternal health care. However they do show that there are a core of midwives, many of whom are likely to be in a supervisory role, who are committed to playing an important role in HIV & AIDS prevention, treatment and care, and many of them are already doing so.

The fact that there was such overwhelming support for midwife led initiation of ARV's, coupled with international evidence that suggests that task-shifting is key to improving access to treatment and care in Africa (6), suggests that midwife led initiation should be implemented rapidly by the National Department of Health and relevant nursing bodies.

Midwives concern about the capability and quality of counselors reflect real challenges and variability that exist within community health worker programmes which need to be addressed (6). Midwives views on both sides of the debate around whether a pregnant women's status should be openly written on her record suggest the need for further debate on this issue. It is clearly a challenge to move forward in terms of normalizing HIV as a chronic illness, while at the same time respecting women's rights and desire for confidentiality in the face of real or perceived stigma they may encounter.



Midwives' experience of women's real fears needs to be taken seriously.

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The Sister Lilian Centre

The Sister Lilian Centre™ is a unique pregnancy, parenting and health advisory service based in Lynnwood Ridge, Pretoria. It was started by well-known South African pregnancy and parenting advisor, Sister Lilian, who did her original nursing degree through the University of Stellenbosch and trained as a midwife in Johannesburg. She is also a qualified reflexologist and has done a course in Ayurvedic Medicine. Sister Lilian's speciality since 1988 has been in the fields of pregnancy, birth, childcare and parenting although she has always retained an active interest in health generally.

Seven years after qualifying as a nurse and midwife, Sister Lilian started a private nursing practice, teaching antenatal classes and advising mothers after birth on all matters related to their babies and their own adjustment to mothering. She soon started assisting couples with home birth, active birth in special hospital units and water birth. As the need arose amongst her clients, she developed a variety of courses like Home Emergency Care for Families, Nanny & Caregiver Training and Natural Health for the Family.

Sister Lilian's professional activities developed into the Sister Lilian Centre™ which adopts an approach of integrating conventional and complementary health systems throughout all activities. Sister Lilian believes implicitly in empowering parents to become active partners in the health of their families and rely more on instinct and commonsense while raising their children.

Workshops are presented for both the public and healthcare professionals

about a workable, innovative approach to health, pregnancy, birth and parenting. Not surprisingly, Sleep, Nutrition and Behaviour remain three of the most sought after parenting workshop topics all over South Africa.

The Sister Lilian Centre™ also receives international recognition. Sister Lilian was nominated as one of only two South Africans to partake in the annual meeting and conference of the Coalition for Improving Maternal Services in Boston, USA in February 2006. In May 2008 the Sister Lilian Centre™ featured as one of 17 case studies in the Commonwealth Health Ministers Book for their annual meeting in Geneva. Sister Lilian was invited to Argentina in March 2008 as the keynote speaker at a Midwifery conference. Also in 2008, Sister Lilian's pregnancy book was translated into Romanian and Spanish for distribution in Colombia.

The Sister Lilian Centre initiated and organises the Sensitive Midwifery Symposium™, one of the most influential and prestigious midwifery and perinatal conferences. Delegates attend from all nine provinces of South Africa, neighbouring African and other countries abroad. Internationally and locally acclaimed speakers address Sensitive Midwifery Symposium™ delegates each year on the most topical issues in the fields of pregnancy, birth, postnatal care, neonatal intensive care, baby and child development and care.

The first Symposium was held in 1996 in Pretoria and in 2010 celebrated its 15th year. The mission of the Sensitive Midwifery Symposium™ is to support all in perinatal professions to be able to render the most sensitive service possible

to our clients and patients. There is a clear fourfold goal each year:

- To update expertise of, present relevant research and provide new skills to the perinatal nurse/midwife fraternity
- To challenge non-defendable policies that negatively affect mothers, babies and young families
- To encourage complementary and sensitive health and maternity practices relevant to the perinatal field
- To celebrate the professions of midwifery and related fields by making the Symposium an inspiring, delightful and memorable event.

Peri-urban and rural sector midwives are empowered by the Sensitive Midwifery Symposium™ in a way not often available to them, in so assisting the hospitals they come from and ultimately their whole communities. Dialogue between private and public sectors is encouraged and facilitated. Independent midwifery and baby care practitioners as well as allied health professionals also attend the Sensitive Midwifery Symposium™, ensuring that this initiative enables the various players in the field of maternal and baby health to learn from each other.

In 2008 the Sister Lilian Centre™ took a major leap and started the acclaimed **Sensitive Midwifery Magazine™**, to ensure that the goals of the Symposium reach even more professionals throughout the year. We look forward to sustained growth of this successful venture in the future.



Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Strengthening health systems in Sub-Saharan Africa and the Caribbean

The international program of research aims at strengthening health systems in Sub-Saharan Africa and the Caribbean by improving the quality of HIV and AIDS nursing care.

The program of research and capacity-building seeks to address this aim by situating nurses in a leadership role to improve equity, quality and efficiency of health systems for HIV prevention and AIDS care. This is achieved through 4 research projects across four study countries.

Overview of the 4 Projects

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

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

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

Project 4: International comparative case studies.



The international program of research is a 1.5 million CAD funded programme with support from the Global Health Research Initiative (GHRI), a collaborative research funding partnership of the Canadian Institutes of Health Research, the Canadian International Development Agency, the International Development Research Centre, Health Canada, and the Public Health Agency of Canada.

The 4th Annual Executive Committee Meeting hosted by the School of Nursing Science, NWU, Potchefstroom

During October the 4th Annual face to face Executive Committee (EXCO) meeting of the international research and research capacity building program entitled "Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean" was hosted by the School of Nursing Science. The annual face to face EXCO meetings is a wonderful and notable opportunity as it brings together the five partnering countries, the executive members and the research team members from these partnering countries and this year the team was also joined by Nelouise Geyer who is a International Advisory Committee members to the programme of research.

"Strengthening Nurses' Capacity In HIV Policy Development in Sub-Saharan Africa and the Caribbean" is a five-year program of research and capacity-building involving Canada Kenya, Jamaica, Uganda, and South Africa. The goal of this multidisciplinary program 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 programs and practices, and fostering dynamic and sustained

engagement of researchers and research users in the policy development process. It aims to provide a critical platform for developing research and leadership capacity among nurses and midwives.



The EXCO Team Members of the program of research are Prof Nancy Edwards (PI; Canada), Prof Dan Kaseje (Co-PI; Kenya), Dr Eulalia Kahwa (Co-Principal Investigator; Jamaica), Ms Marian Walusimbi (Country Program Director, Uganda) Prof Hester Klopper (Country Program Director, South Africa), Dr June Webber (Co-lead; Canada), Dr Judy Mill (Co-lead; Canada), Dr Jean Harrowing (Co-lead; Canada), and Ms Susan Roetofs (Program manager, Canada).

Research staff that joined the meeting included Uki Atkinson (Jamaica), Nicky Okeyo (Kenya), Eric Seegujja (Uganda) and Francois Watson (South Africa). The South African team furthermore includes Prof Christa van der Walt, Dr Karin Minnie, Ms Rina Muller, Dr Emmerentia du Plessis and Dr Siedine Coetzee.

The overall aim of this year's meeting was on strengthening the research outcomes, strengthening capacity-development and also looking at the sustainability of certain areas within the programme of research. This led to discussions around strengthening the strategies for working with leadership hubs sharing of learning from the different projects and country successes and challenges with the aim of applying these lessons learned to program-wide, project, and country plans for the remaining 1.5 years. There was also looked at how to maximize the use of data collected and the emerging research findings throughout program activities and with the leadership hub initiative and identifying strategies for strengthening country and project teams to support timely implementation balanced with opportunities for capacity-building.

There was a strong focus and a various lengthy discussion and decisions pertaining to project 3, more specifically the Leadership Hubs as they are a central element in the process of critical inquiry, building capacity, taking action and outcomes of health systems strengthening. As this was a big focus the local team organized in conjunction with the EXCO meeting a Leadership hub meeting whereby the international members got the opportunity to meet the South African hub members. This was a great opportunity all around, as all different role players and stakeholders in the project had to opportunity to sit face to face and reflect on the already developed and still developing interactive dialogue and collaboration among health care professionals, researchers and policy makers.

The Leadership Hubs are the cornerstone of this research, bringing together front-line nurses, nurse managers, researchers, decision makers and community members

Leadership hubs are a cornerstone of the research and capacity building program and are contributing to the building of operational capacity for collaborative involvement in the health policy process, creating readiness within the health system for the uptake of local innovations and research findings, and also in the developing of networks with key stakeholders with the aim of communicating the results to outside agencies (e.g. NGOs, ministry partners, international funding agencies).

The 3 Leadership hubs Currently in South Africa are from the Dr. Kenneth Kaunda -, Ngaka Modiri Molema - and the Bojanala district.

Certain outcomes of the EXCO and Leadership Hub meeting highlight the way and road forward for both the local research team and the School of Nursing Science. These outcomes are the development of an action plan for long-term sustainability of the leadership hub intervention and capacity-building initiatives, an action plan for the developing of the next generation of research leaders and also to very short term outcomes which are five manuscripts for publication due in the next 2-10 months and very importantly **The School of Nursing Science will be hosting the 10th Annual International Research Internship for research development in 2011.**

The Purpose of the Leadership Hubs

To to create a sustainable infrastructure for leadership capacity in research and knowledge translation (research-to-action) by building a critical mass of hubs networked within and across study countries.

The hub members in South Africa are from 3 districts in the North West Province and consist of front-line nurses and nurse managers, researchers, decision makers and community representatives.

The hub members were drawn from different levels within the health system and from different disciplines and sectors in order to create horizontal and vertical links among the different stakeholder groups.





**Everyone deserves to live their rights.
Stop AIDS. Keep the promise.**

Access for all to HIV prevention, treatment, care and support is a critical part of human rights.

I am safe

World AIDS Day is celebrated on December 1 each year around the world. It has become one of the most recognised international health days and a key opportunity to raise awareness, commemorate those who have passed on, and celebrate victories such as increased access to treatment and prevention services.

UNAIDS took the lead on World AIDS Day campaigning from its creation until 2004. From 2004 onwards the World AIDS Campaign's Global Steering Committee began selecting a theme for World AIDS Day in consultation with civil society, organisations and government agencies involved in the AIDS response.

Themes run for one or two years and are not just specific to World AIDS Day. Campaigning slogans such as 'Stop AIDS. Keep the Promise' have been used year round to hold governments accountable for their HIV and AIDS related commitments.





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Competition

Winners !

Competition to name the nurses magazine
The name of the HIV Nursing Magazine and the winner of the Nokia cell phone will be announced in the New Year.

Rules:

- The competition was open to paid SA HIV Clinicians Society nurse or midwife members only
- The closing date for the competition was 15 October 2010
- The judges' decision will be final

It appears that no SMS messages were received for the competition. Please let us know if this is correct at nelouise@sahivsoc.org or 011-341 0162

Competition

Competition

Win some more!

Win an a book by participating in the quiz on the content of the magazine for the month of December.

Select the correct answer – there is only one correct answer for every question. SMS your answer to 32759 as follows:

BKK(space) Question number (selected answer)

Provide an answer to all four questions. Standard SMS rates apply.

Entries close on 15 January 2011. Only entries with the correct answers will be entered into the prize draw.

The decision of the judges will be final.

Competition questions:

1. Painful articular syndrome is seen in patients with HIV:

- (a) During the late stages of HIV infection
- (b) During the early stages of HIV infection
- (c) Both
- (d) None of the above

2. Information that midwives should provide HIV positive mothers who choose to breastfeed:

- (a) Ensure mother and baby are taking ART
- (b) Exclusive breastfeeding
- (c) Mother can choose to provide formula feed.
- (d) All of the above
- (e) None of the above

3. At the Vienna conference it was announced that a vaginal microbicide shows promise as a method of HIV prevention. This research was done by:

- (a) Canada
- (b) USA
- (c) South Africa
- (d) None of the above

4. Children's treatment guidelines advise that:

- (a) HIV DNA PCR test for early infant diagnosis (EID)
- (b) Infants testing PCR positive must have a confirmatory test on a different blood sample
- (c) Tests can be done on whole blood or dried blood spot samples
- (d) All of the above

Competition



SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

APPLICATION / RENEWAL FORM – ASSOCIATE MEMBERS
(see reverse side for Doctor Membership form)



MEMBERSHIP FEES FOR 2010

Annual Membership Fees: R120 for Associate Members (i.e. health care 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 kemrysolan@global.co.za, or post to: Suite 233, PostNet Killamey, 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: [grid] Initials: [grid]
Surname: [grid] Title: [grid]

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

Practice address [grid]

Postal address [grid]

City [grid]

State/Province [grid]

Country [grid] Postal Code [grid]

SANC or other Council No. [grid]

Tel No [grid] Cell [grid]

Fax [grid]

Email [grid]

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: [grid] Payment Date: [grid]

SOCIETY SERVICES: Quarterly issues of the Southern African Journal of HIV Medicine 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



Websister – connecting the nursing community of South Africa

www.websister.co.za was launched in December 2008, and is referred to as Websister. It is a niche website which provides ongoing education in the form of topical, credible, researched and referenced articles aimed at nurses working in South Africa. While it was initially aimed at pharmacy clinic sisters, Websister has evolved to include nurses and sisters working within the various healthcare sectors and is no longer exclusive to pharmacy clinic sisters.

The number of loyal registered sisters is a tremendous tribute to the level of knowledge Websister offers them. Emails received from clinic sisters expressing their thanks, "... really in need of all the information – it is just what we need in clinics", bears testament to the value that Websister will offer you.

Websister offers you the following benefits:

- Articles that have been written for the South African market by South African healthcare professionals;
- The content is tailored specifically for nurses;
- Content is available 24/7 365 at the click of your mouse;
- A closed nursing forum whereby you can post enquiries to other registered Websister users, who will respond if they are able to assist you;
- Press releases to keep you informed about the latest products;
- Weekly e-newsletters telling you about the most recently published Websister articles.

To keep abreast with current discussion regarding CPD points, you can enhance your nursing portfolio by acquiring them through Websister.

Information on a variety of topics including babies, children, men, women, seniors, pregnancy, nutrition, wound care, microbial, skin and most importantly HIV among others, is available to registered users. The revamped eye section now offers interesting information.

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 HEALTH CARE WORKER HOTLINE

Are you a doctor, nurse or pharmacist?

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

Contact the Toll-free National HIV Health Care Worker Hotline

0800 212 506 / 021 406 6782

or alternatively send an sms or please call me to 071 840 1572

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 hotline to all health care workers in South Africa for patient treatment related enquiries.

What questions can you ask?

The toll-free national HIV 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

When is the 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 46 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

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



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.

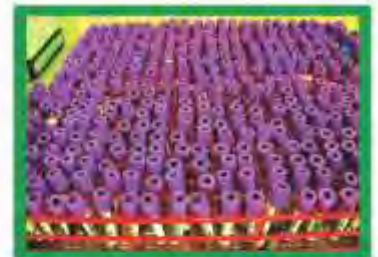
Once you have a Reference number

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.



2010: THE INTERNATIONAL YEAR OF THE NURSE JOIN SA IN THE NATIONAL CAMPAIGN AGAINST HIV/AIDS

BUILDING A BETTER
SOCIETY THROUGH
EDUCATION AND
DEVELOPMENT



FPD

FACULTY OF
HEALTH SCIENCES

ACCREDITATION

Registered with the Department of Education as a private Institution of Higher Education under the Higher Education Act, 1997 (Registration number: 2002/HEC/013).

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.

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

HIV IN THE WORKPLACE

INTRODUCTION

This course offers opportunities for the participants to learn about the management of HIV and AIDS in the workplace. The emphasis of the course is on determining a process whereby primary infection is reduced and those affected and infected with the virus are introduced to a wellness programme whereby HIV and AIDS is accepted and treated as any other chronic condition.

The course is suitable for health care professionals, nurse managers, human resource and other managerial staff responsible for the planning, management, implementation and evaluation of HIV/AIDS (wellness programmes) and occupational health programmes in the workplace.

STRUCTURE

2 day workshop

COURSE FEE

Partially sponsored by FPD, fee to be paid by the delegate is R 250

THIS SPONSORSHIP IS ONLY VALID UNTIL END 2010

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"
- Fulfil their role as health care professionals in community mobilization
- Understand vaccine development and clinical trials

STRUCTURE

3 day workshop

COURSE FEE

R 3 240

REGISTRATION

DANIELLE DANIELS / STACEY DIAS

Tel: 012 816 9000

Fax: 012 807 7165 / 086 567 0279

Email: danielled@foundation.co.za
staceyd@foundation.co.za

Address: PO Box 75324 - Lynnwood Ridge - 0040

Website: www.foundation.co.za

Member of the SASSI group





Midwives Tackling the 'Big 5' Globally



www.midwives2011.org

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19 - 23 June 2011, Durban, South Africa

ICM 29th Triennial Congress
International Confederation of Midwives

