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Nursing

Southern African HIV Clinicians Society Nursing Magazine



Task Shifting
Prescribing and dispensing
IPT and HIV/AIDS



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contents

WIN
a cellphone
and a
boardgame

inside

Editor's note	2	Profile	
		SANC'S Tendani Mabuda	32
President's message	3	Policy	
		Palliative care in HIV	34
News	4	International collaboration	
		Occupational Health of health workers & HIV	38
Launch of magazine	10	Competition	
		Name the magazine	42
Current issue		Win HIV Board Game	43
Task Shifting	12	Where to go	46
HCT Campaign	18	What to do	50
Clinical update			
TB Preventative Therapy	20		
Osteo-articular tumours & infection	24		
Ethics & Law			
Prescribing & dispensing by nurses	28		



on cover

Task Shifting

Prescribing and dispensing

IPT and HIV/AIDS



Nelouise Geyer

ed's note

We find ourselves on the brink of Summer after some weeks to reflect on the impact of the World Cup on all of us. It has been five weeks of Gees, excitement, passion, vibrancy, waving flags and an atmosphere that none of us will ever forget with the infamous vuvu tooting our pride in having made a huge success of this massive event. In spite of many saying that we will not make it!

Have you reflected on the World Cup and what it means for all of us? For me the most important lesson learnt is that as a nation we can do anything if we put our minds to it and focus our energies on achieving our common goal. The second important aspect is the togetherness this event created amongst all of us and this certainly was the main ingredient for the successful hosting of the World Cup.

Surely if we allow some of this to spill over into the work we do every day, it can make us achieve great things, particularly so in HIV/AIDS care. Each of us must make an honest effort to ensure that we remain updated and competent practitioners so that as a collective, working together with all the other role players in HIV/AIDS care, we can turn the tide around. So let's not focus only on the problem, but

let us see how we together can find solutions to the challenges we face in the prevention, treatment and care of those living with HIV and AIDS. The newly appointed Registrar of the Council makes a good point when he calls on nurses to take pride in what they do and remember that we have to balance our scientifically based competence with our humanity when caring for our patients. This is what we need to do to improve the image of our profession and to start tooting our own vuvuzela from an informed position.

Nelouise Geyer



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Professor Francois Venter

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talk
to us

Tell us what you think of
this issue. E-mail me at:
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Prof Francois Venter

Message from the president

Nurses
are the
foundation of
our healthcare
system

The huge Vienna AIDS conference has come and gone, with a renewed focus on the issue of 'donor fatigue' and decreased funding in a recessionary environment. This despite the fact that we have many people who still need HIV care. There was justifiable anger at broken promises by certain political leaders, as well as a call for the world to acknowledge that AIDS remains a huge problem, particularly in sub-Saharan Africa.

Bill Clinton has however made a good point, in his plenary: we need to do better with the money we have. We could work smarter, faster and more effectively with the human resources that exist in our health system. We could use our current antiretrovirals and TB drugs better, decreasing the need for migration to expensive regimens for resistant organisms. We can start looking at where wastage and duplication occur, and stop it.

Nurses will need to be in the forefront of this - they usually control the health system delivery processes, and understand systems of care better than anyone else. If efficiencies are to be extracted, they are the ones to do it. They also understand concepts such as 'task shifting', often casually thrown out by policy wonks as a cure-all for African health systems.

We cannot let donors or governments off the hook. But in a recessionary environment, we have to ensure that every rand, pula and kwacha is stretched as far as possible, so that we can help as many patients as we can.

®

Letters to the editor

Dear Nelouse,

On behalf of SASOHN Eastern Cape I would like to congratulate you on a stunning HIV Nursing magazine.

Your articles are easy to read & understand & I know that you will keep us informed about all the latest developments in the field.

Well done!!

Maggie
Chairlady SASOHN EC
Vice President SASOHN

Good day,
Compliments on your magazine. At last I can read and understand and be up to date in the HIV field.
Blessings,

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

Dear Editor,
What a great initiative of the Clinicians Society to publish this magazine! The information is relevant and useful and for those of us in isolated service delivery areas this is really a helpful tool. Keep up the good work!

Margaret, Northern Cape

I bring you greetings in the name of the Almighty God from here in Ghana. I must say this, that the HIV Nursing magazine is masterpiece and one of a kind on the African continent at the moment. Reading through the magazine, I came to the realization that there is alot to be done in terms of

combating the menace that has plagued our continent and the world over. I want to congratulate the entire body of the Southern African HIV Clinicians Society as well as the editorial body for bringing out such a masterpiece. I am a specialist E.N.T Nurse but has a particular interest in the care of HIV/AIDS patient. What I need now is a specialist course or training in the area to equip me with the necessary skills and knowledge to enable me to deliver. What i want to know is whether your outfit can organise such workshops or training programs in Ghana to equip people like me and others who have similar interest in that area. May God grant you all the strength and resources you need to continue with the good works you are doing. And for the magazine it shall grow from strength to strength in Jesus Name, Amen.

My name is Michael Tetteh Donkor.

Dear Michael,
We will follow up your request to see how you can be assisted.
ED

Hallo Nelouse,
WOW!!! is the only expression that comes to mind. I have long been waiting for this moment, which is definitely the moment of truth. It had been such a pleasure to recieve the Journals, but now it is even more than a pleasure to recieve a Journal that adresses the common challenges as seen and experienced by nurses. I have at some stage stopped paying, not because I am not challenged by the other journals, but sometimes would find it difficult to understand some of the microbiology language. Now I have no reason not to update my subscription, I am also very grateful that Doctors have

kept the ball rolling all these years, it has been such a pleasure to know that as nurses we have been kept in mind. You could not have chosen a better period to introduce this Journal to celebrate 2010 THE YEAR OF A NURSE. This fight will be won if we attack from all the angles and we arm one another with important information to treat our patients.

I hope the venture grows from strength to strength. GOOD LUCK

Yours faithfully,
Patience Ntamane

GDoH (Professional Nurse)
SUBJECT: SOUTH AFRICAN HIV
CLINICIAN NURSING MAGAZINE

Dear Nelouse
I am excited with the first issue of this Nursing magazine. I was looking forward for this because we Nurses most of the time, are not recognised. For you Nelouse to realise us is greatly appreciated and we will be able to add in the magazine our challenges as PHC Nurses regarding our clients as you know we are the first contact with the patient especially in the Primary Health setting.

The first issue has made me think of the next letter I will be writing and I am anticipating the next edition of the magazine.

Much appreciated

Regards

Mrs. R.M. Masombuka
Primary Health Care Nurse (B Cur in Nursing)

Dear readers,
Write to us, we welcome your thoughts, discussions, comments and other contributions to the nursing magazine. Direct your correspondence to the editor at nelouse@sahivsoc.org

news

Nurses just as good as doctors in ARV care

The Lancet published the results of a randomised trial run between 2005 and 2007 involving more than 800 patients at two primary healthcare clinics. The assignment of patients was 408 patients to doctor-monitored treatment and 404 to nurse-monitored care. The findings support earlier evidence that "task shifting" to nurses could accelerate the rollout of access to ARV treatment.

After two years "deaths (10 vs 11), virological failures (44 vs 39), toxicity

failures (68 vs 66), and programme losses (70 vs 63) were similar in nurse and doctor groups, respectively", supporting the shift to nurses.

The study, supported by the South African Department of Health and the National Institute for Health (US), was run at Masiphumelele in Cape Town, and Soweto, Johannesburg.

"To tackle this shortage, South Africa is planning large-scale task shifting, where it

plans to increasingly use nurses for HIV care and the monitoring of anti-retroviral therapy. However, prior to this study, there was not much research undertaken to investigate if this approach is safe and effective" says Professor Ian Sanne, director of the Clinical HIV Research Unit at Wits University. ®

By Claire Keeton
18 July 2010
Sunday Times

Resources on the CAPRISA Microbicide Trial Results



When the story about the CAPRISA 004 trial results broke on 19 July, there was a flurry of public statements and news stories that reflected the promising nature of the results and the impact they could eventually have on HIV prevention scale up.

The trial tested the safety and effectiveness of 1% tenofovir gel, an antiretroviral-based vaginal microbicide among nearly 900 women at two sites in South Africa. Trial results were presented at AIDS 2010 on 20 July. ®

Posted By Conference Secretariat
20 July 2010
AIDS 2010 Blog
<http://blog.aids2010.org/post/2010/07/20/Understanding-the-CAPRISA-Microbicide-Trial-Results.aspx>

New Director-General Health appointed



Malebona Precious Matsoso

The SA HIV Clinicians Society congratulates Malebona Precious Matsoso on her appointment in the position as the Director-General, Health on 8 June 2010. Prior to returning to South Africa, she was a Director In Public Health Innovation and Intellectual Property (PHI) in the office of the Director-General, at the WHO. Prior to her employment with the WHO she was the Registrar of Medicines for the Medicines Control Council (MCC) of South Africa. She began her career following completion of a degree in

pharmacy and a post-graduate diploma in health management in South Africa and worked at the management level as a pharmacist in both the public and private sector. She has various certificates and is currently pursuing an LLM in Law and Ethics. ®

Voluntary Male Medical Circumcision is Safe and Effective. But beware of unsafe devices

The Southern African HIV Clinicians Society and the Treatment Action Campaign support the implementation of a country-wide voluntary male medical circumcision (VMMC) programme. Male medical circumcision reduces the risk of heterosexual men contracting HIV and the Human Papilloma Virus (HPV). Despite the effectiveness of VMMC, it is essential that circumcised men are encouraged to continue using condoms during sexual intercourse.

The South African government is taking to implement VMMC is welcomed. Kwazulu-Natal has run several events encouraging youth to have medical circumcisions and the Department of Health together with the South African National AIDS Council is developing circumcision guidelines. The continuous disturbing reports of traditional circumcisions that have resulted in deaths and penile mutilations show how important it is to implement a medical circumcision programme that is safe and in which adverse events are kept to an absolute minimum. The success of VMMC is dependent on public confidence in the programme's safety.

TAC and the Clinicians Society are

therefore deeply concerned that a Malaysian company, Taramedic Corporation, and its South African partner, Carpe Diem Enterprises, are aggressively marketing a circumcision device called the Tara K Lamp (TK) to several sub-Saharan African countries, including South Africa, Lesotho, Kenya, Botswana and Zimbabwe. A randomised controlled trial in adolescents and adults found a very high rate of adverse events and much greater pain associated with this device compared to the standard forceps-guided circumcision technique.

The TK must be withdrawn from sale and distribution for adolescent and adult circumcision throughout sub-Saharan Africa until the device's safety concerns are addressed. ®

Joint statement by the Treatment Action Campaign (TAC), SECTION27 and the Southern African HIV Clinicians Society

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



Conditions in mines contribute to TB-epidemic

Poor and dangerous working and living conditions of mine workers, particularly in gold mines in South Africa, contributes significantly to the TB-epidemic in Southern Africa and should receive urgent attention according to the research report "Mining and Risk of Tuberculosis (TB) in Sub-Saharan Africa" published in the American Journal of Public Health.

Researchers indicate that up to 760 000 new cases of TB are reported annually in this region. The poor, crowded living conditions in hostels and dust leading to silicosis in gold mines create the ideal conditions for transfer of TB. In addition the majority of mine workers are migrant workers who take their disease to their homes in Lesotho and Swaziland where they infect their wives and families.

Sex workers forms an integral part of the gold mine industry. The report indicate that in a small mining community near Johannesburg 52% of the women are sex workers and at least two thirds are HIV positive. Statistics indicate that mine workers are four times more likely to contract HIV than workers in any other industry. HIV positive workers are also more susceptible to TB.

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*By Elise Tempelhoff
3 June 2010
Beeld*

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

Survey of children accessing HIV services in high prevalence settings: time for adolescents to count?

Infection with HIV is the leading cause of death in Southern Africa which has the highest prevalence of HIV infection in the world. The healthcare needs of children are poorly served in most low income countries and adults have been the main targets of HIV-care programmes. The number of adolescents is increasing as more and more children living with HIV get access to ARV treatment.

A study by Dr Rashida Ferrand (London School of Hygiene and Tropical Medicine) et. al. investigated the number of children receiving HIV care in Zimbabwe. The purpose of the study was to establish the proportion of adolescents (10 - 19 year of age), and to ascertain the perceptions of clinic staff of the main problems faced by HIV-infected children.

The results of the study showed that 24 958 (13%) of all patients seen at the clinics surveyed, were children under the

age of 19 years. This group could be further broken down to 8370 (33%) 0-4 years, 6130 (25%) 5-9 years, 6334 (25%) 10-14 years and 4124 (17%) 15-19 years.

The report states that "The major problems reported for younger children reflect the dependence of younger children on caregivers. The main issues reported for adolescents, however, reflect the physiological and psychological changes that occur during the transition to adulthood. These issues are likely to affect successful management and are in line with the experience in industrialized countries, where psychosocial concerns (e.g. mental health problems, low self-esteem, lack of social support and poor drug adherence) pose substantial challenges to the successful clinical management of adolescent chronic illness. Poor adherence risk developing drug resistance and subsequent treatment

failure. This has adverse health consequences for the individual (particularly in settings with limited access to second-line ART); it also carries a risk of HIV transmission. Failure to address emerging sexuality may further increase the risk of unsafe sexual behaviour. Delayed disclosure of HIV diagnosis to children, commonly reported by respondents in this survey, is likely to have an additional impact on both drug adherence and secondary HIV prevention".

®

Rashida Ferrand et al WHO: Bulletin of the World Health Organization Volume 88, Number 6 June 2010. For a copy of the full research report go to <http://www.who.int/bulletin/volumes/88/6/09-066126.pdf>

Retired nurses to mentor young nurses

Pretoria - In an effort to retain skills within the health system, the Gauteng Health Department has launched the retired nurses forum, which will be responsible for guiding and mentoring young nurses.

The forum, which was launched recently by Gauteng Health and Social Development MEC Qedani Mahlangu, began returning retired nurses to the department in early 2008, where they assisted in maternity wards and clinics. Approximately 480 retired nurses were working in the province's primary health care clinics and hospitals.

Operation Kuyasheshwa-la was launched by the department to deal with the challenges faced at health facilities in order to deliver the best accessible health care to residents.

®

*By Gabi Khumalo
May 2010
BuaNews*



ART prevents MTCT (mother-to-child-transmission)

A clinical study in Botswana published in the *New England Journal of Medicine* has indicated that treatment with ARVs prevents 99% of breastfed babies from contracting the HI virus from their HIV positive mothers. Breastfeeding provides antibodies from the mother which protects babies from infections. Without ARV treatment, there is a 25% chance for the mother to transfer the virus to her child through breastfeeding. The biggest risk

remains combining breastfeeding and bottle feeding as this increases the chances of transferring the virus.

The study involved 730 HIV positive mothers who started with ARVs early in the third trimester of their pregnancy and the HI virus was well suppressed at the time of labour and delivery of the baby. During breastfeeding the viral count remain undetectable due to the ARV treatment.

Only 1,1% of the babies breastfed exclusively until six months of age contracted HIV.

The researcher concluded that the best option is to treat mothers with ARV and to promote breastfeeding.

R

By Antoinette Pienaar
June 2010
Beeld



Launch of HIV Nursing

The HIV Nursing magazine was launched at the TB Conference in Durban on the 3rd of June 2010. The KZN Health MEC, Dr Sibongiseni Dhlomo, graced the event as the keynote speaker and here is a summary of what he had said.



From left to right – Fatima Shaik; Natalie Martyn; Kerry Solan; Francois Venter (President of SAHIVS) and Nelouise Geyer; Dr Dhlomo (MEC of Health, KZN)

The KZN MEC, Dr Sibongiseni Dhlomo, congratulated the Southern African HIV Clinicians Society for its insight in developing a Nursing Journal, a much needed tool for the development and advancement of our nurses who are the backbone of the country's health system.

"This journal will go a long way in giving significance to our core function as the Department which is to provide and dispense quality health care services which encompass effectiveness, efficiency, safety, timeliness, patient-centeredness, continuity of care and satisfaction" he said.

In the words of our late Deputy Minister of Health, Dr Molefi Sefularo:

'Our staff and all health workers need to have the knowledge and the tools to be able to improve how they do things - and this is what will ensure we can provide quality health care.'

Dr Dhlomo highlighted that nurses in particular, are expected to shoulder the mammoth task bequeathed to the Department of Health by the National Cabinet in January 2010 when it resolved to specify four broad categories in which they must focus on, namely:

- Increasing life expectancy
- Combating HIV and AIDS
- Decreasing the burden of disease from Tuberculosis, and
- Improving health systems effectiveness,

by strengthening Primary Health Care and reducing the costs of health care.

The Cabinet went further and specified 20 national outcomes that ought to be realized out of the four categories outlined. Dr Dhlomo indicated that out of the 20 he had selected 10 that have a direct bearing to the competencies of Nurses and Midwives, these being:

- Increased life expectancy at birth.
- Reduced child mortality.
- Decreased maternal mortality.
- Managing HIV prevalence and improving the quality of life of people living with HIV and AIDS.
- Reduction of new HIV infections.

launch of mag

- Expanding access to the Prevention of Mother to Child Transmission programme.
- Improved TB case finding.
- Improved TB treatment outcomes.
- Improved access to antiretroviral treatment for HIV-TB co-infected patients.
- Decreased prevalence of drug-resistant TB.

In the pursuance of the above objectives, it is clear that nurses require continuing education in the form of research, practice and treatment for the prevention and care of diseases like HIV and TB.

As healthcare practitioners our main focus in this regard is to decrease the burden of TB and HIV in co-infected patients. As a country we are very much perturbed about the statistics which say that the co-morbidity of HIV and TB is estimated at 70%. Our leadership at all levels expect us to do something about this as elucidated in the KZN Provincial Premier's 2010 State of the Province Address when he said: "The focus will be placed on the treatment of TB in order to reduce the spread, the emergence of the resistant strains, reducing the defaulter rate and improving the cure rate." Indeed the nurses are the key to the attainment of the Premier's vision. As a Department, in as far as TB is concerned; they rely solely on nurses for the whole package, vis:

- Case finding and diagnosis of the TB
- Patient Education pertaining to the disease itself as well as treatment adherence
- Monitoring of response of patients, as well as,
- Reporting and discharge.

The KZN Department thus welcomes every effort and input that might be presented by the availability of this Journal as we see it as means that will empower our nurses to adopt and practice the principle of:

- One patient
- Two conditions [or more]
- One consulting room.

"With the advent of this Nursing Journal we foresee a situation whereby our nurses will be guaranteed to have

adequate, accurate and up-to-date information necessary to update their knowledge, skills and practices" says Dr Dhlomo.

He indicated that they envisage a beginning of a new era where the Journal will serve as an instrument that will empower nurses and midwives in particular to be educators. The general public including youth, pregnant women, school children, parent groups, sex workers, and drug users, all need information about HIV and AIDS.

We know for example that much of the misinformation, myths and folklore surrounding HIV and AIDS has and continues to generate fear, stigma, isolation, and denial of care for people living with HIV.

He stated that, as we speak, the KwaZulu-Natal College of Nursing has a captive audience of 5 200 student nurses at various levels of training who will benefit from this Journal. The 38 653 clinical staff in KZN will also immensely benefit.

As a Department, they commit to contribute to this Magazine as they want to see their nurses:

- leading education and information campaigns;
- ensuring that health messages are clear and consistent;
- influencing policies related to access to healthy living;
- providing access to health services such as nutrition advice or blood pressure screening;
- encouraging the creation of healthy environments; and
- creating an environment in which the healthy choices are the easy choices.

All the above fits in well with the well thought 2010 Nurses Day theme that says:

Delivering Quality Nursing Services,
Serving Communities: Nurses
Leading Chronic Health Care
Management.



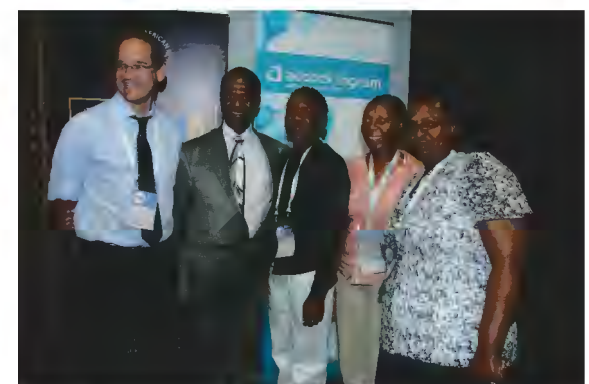
Adcock Ingram representatives Luella Naidoo and Sean Parker



Left to Right Natalie Martyn; Nelouise Geyer & Ms Jabu Makhanya (SA Nursing Council Chairperson)



Guest at the launch



Guest at the launch

TASK SHIFTING

a professional issue

The term "task shifting" has become a household word within the health professions. The word is tossed around boardrooms and in the field, often in relation to solving the human resource shortages that have been exacerbated by the HIV epidemic. A great deal of work has been done related to using task shifting as a solution to staffing problems caused by HIV and AIDS but it needs to be seen in a wider context. Whatever decisions are made will affect the nursing profession as a whole so it is important to decide how the profession should respond to the inevitability of this policy and practice.

*Dr Sue Armstrong
Director Quality Assurance,
Gauteng
Department of Health and
Honorary Researcher Health
Policy Unit, School of Public
Health University of the
Witwatersrand.*



THE CONCEPT OF "TASK SHIFTING"

The World Health Organization defines the term as "a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications."¹

Lehmann² et al point out that the delegation of tasks from one cadre to another is not a new phenomenon and that it has been done in response to emergency needs or to provide adequate care in understaffed facilities.

Task shifting during the war time

Perhaps the widest use of the strategy of task shifting has been in war time. The literature on the Red Cross Society of both America and Britain during the First and Second World Wars indicate that it was used in several ways.³⁻⁵ Red Cross nurses undertook extended responsibilities at home due to the shortage of physicians and nursing staff caused by the exodus of trained doctors and nurses to war service. The need was further exacerbated by "outbreaks of communicable diseases fostered by the close quarters of military camps and congested metropolitan areas."³

Volunteers were given short courses before being used as nurses in hospitals. The United States Army's course for this purpose lasted 144 hours. This translates into the equivalent of about one month's training after which they worked in hospitals where there was supervision by the few remaining trained nurses. In the field, however, it would seem that supervision was erratic depending on their situation. In the British Hospitals during the war a matron directed the work of the nursing staff and may or may not have had other nurses assisting her to supervise the "short course" nurses.⁵

Mid-level health workers

The debate about the wisdom of using mid-level workers in health care, and in what circumstances they should be used is inextricably linked with the debate about task shifting. At the launch of the medical assistant programme in 2004, the late Dr Tshabalala Msimang⁶ stated that "midlevel cadres should be

developed by various health professional groups to facilitate the implementation of the primary health package within the country". She pointed out that while medical assistants were initially intended to work in the PHC field, this had expanded to other medical specialties. She stated that medical assistants do not work "independently" but always work "in association" with physicians (even if not physically present) who take responsibility for the work of the medical assistant.

The important distinction to make between task-shifting and mid-level workers is that the former refers to moving specific, named tasks to another health worker with a shorter training and fewer qualifications. Mid-level workers, on the other hand, have a scope of practice within which they work and a formal training to prepare them for this work. The scope usually indicates broadly not only what they may do but also the context in which they may work. Enrolled nursing auxiliaries will, it is envisaged, in their new scope of practice, practice independently and will take accountability for what they do for patients.

Non-regulated groups

Task shifting can also take place to a non-regulated group such as community health workers whereas, thus far, mid-level workers all have to be registered with a statutory body. Clearly there is some overlap with the concepts, as the whole reason why medical assistants, for example, were created was to relieve the shortage of doctors in rural areas and this meant they will take on tasks and groups of tasks such as diagnosing and treating patients.

An Essential Health Package

The distinction becomes even fuzzier when we look at the work by the World Health Organization on Essential Health packages⁷ where the intention is to develop a limited, but guaranteed, list of public health and clinical services which will be provided at primary and/or secondary care level, particularly in poorly resourced countries. Some of these packages are what the WHO refers to as "priority" EHPs for particular

demographic or disease groups such as HIV/AIDS prevention, treatment and care, mental health; and for maternal, newborn and child health interventions. Clearly the intention is to use available health workers to provide these packages which will inevitably involve the need to task-shift to lower categories where there are insufficient trained, or professional health workers. Here, an entire service or package may be provided by a lower category than is normally done in a more advantaged location.

All the above discussion refers to people who are paid to do work. For time immemorial lay people have carried out tasks that are done by professionals. Nursing of patients at home has always been practised by family members and some carry out quite sophisticated treatments once taught to do so such as feeding a relative with a gastrostomy tube. This, however, is not usually seen as task shifting as although the person is not trained to do these specific tasks, they do so for relatives and only in the context of their home. If this person wanted to continue caring for others, he/she would normally be trained as a care worker before being allowed to do this although there is as yet no regulatory body to control practice.

THE CONTEXT OF TASK SHIFTING

It is clear that task shifting is considered when a country is faced with shortages of skilled workers in a specific field. What makes the difference to the longer term implications is the context.

A short term problem

In a war situation, the war is assumed to be a short term problem. Shortages occur in the health field because doctors and nurses and other health professionals go to the war zone to care for military casualties leaving shortages at home. Added to this the number of patients tend to increase not only because of injury but due to social problems that inevitably accompany war such as food shortages and overcrowding. The response to the situation has to be quick and cost effective, but the intention is that the problem will only last months or a few

years. Certainly there are concerns that lesser qualified people will not render as good a service but it is seen to be the best solution in a difficult situation. Such a process is inevitably and probably reasonably, accompanied by an outcry from health professionals who feel threatened as their jobs may become vulnerable. However, if the problem is a short term one, these are not major issues as the expectation is that the situation will normalize after the end of the war or other crisis. The biggest problem after a short term problem such as a war is to integrate these workers once the war is over. The assumption is that, once it is, things will go back to normal and health professionals will resume the level of work they did prior to the outbreak of the war.

A long term problem

In a situation that we are currently faced with where there is a shortage of trained professional nurses to carry out their traditional roles as a result of a long term training deficit and lack of adequate retention strategies, we are not looking at a short term problem. The same applies for the HIV epidemic. It has resulted in far more sick people and fewer health professionals, but it will sadly not be resolved within a few months or a couple of years. This means that all the plans for task shifting will be long term. This, in turn, means that expectations will be raised amongst health workers with shorter training that they will continue to work in the field doing what they have been allocated to do for the rest of their working lives. Once a community health worker, for example, has been executing and interpreting rapid HIV tests for a few years, she is not happily going to stop once our staffing situation improves or the HIV epidemic is controlled as this, and other tasks, enable her not only to earn a living, but doing them improves self esteem and gives her a sense of identity as an important member of the community.

The literature produced by the World Health Organization (WHO)⁸ is careful to state that, while task shifting is one of several strategies the organization supports to address the severe human resource constraints, it should be done along with:

- Pre-service education: (which provides clinical content within a public health approach
- Interventions to help retain health workers: attention to their safety (universal precautions, 24/7 availability of post exposure prophylaxis), personal support and on-going learning through clinical mentoring, and attention to burn out
- The expansion of clinical teams providing HIV services with people living with HIV.

The WHO¹ further states in its Task Shifting Global Recommendations and guidelines document in recommendation 15 that "countries and donors should ensure that task shifting plans are appropriately costed and adequately financed so that the services are sustainable" further indicating that these are long term plans.

Task shifting in the South African health context is therefore a long term strategy, mainly, but not exclusively, related to improvement of health care provision in the HIV/AIDS epidemic context and inclusive of all health workers, not just health professionals.

IMPLICATIONS OF TASK SHIFTING

Task shifting has only been discussed openly in recent years in response to the HIV/AIDS epidemic. Certainly mid-level workers have existed for some time and certainly task shifting has been practised for years. However, it is as a result of what the WHO refers to¹ as the "global health workforce crisis" precipitated by the HIV epidemic on top of existing shortages that widespread discussion is occurring.

This implies that task shifting is seen as a response to a crisis and we need to recognize that it is not a strategy that we would have employed were there not a crisis. This in itself implies that task shifting is not an ideal measure.

(i) Implications for patients

Most people can be taught to undertake tasks providing they have enough training. Most of the time they will carry

out that task without any negative effects, but if they do not understand the context or systems in which they are working problems can arise.

For example, a person can be trained to commence an intravenous infusion. It is not a difficult skill, and one does not even need to understand a lot of anatomy if one is taught how to find a suitable vein and how to insert the cannula. The person may miss the vein, or may cause discomfort until he is proficient but it is a skill that most people can be trained to perform. When that person starts administering intravenous fluids, however, we are in different territory. Here you do need knowledge of physiology and pharmacology to choose the right fluid in the right quantity. If this is not done correctly it is quite possible to cause serious harm or death to the patient.

There are, however, hundreds of tasks relating to nursing that can be done by people with little or no training that can be carried out without harming the patient. Some, such as a bed bath, can be done by anyone but the way it is done will make the difference between being a pleasant therapeutic experience during which time the patient is assessed and communicated with, and an uncomfortable experience where the patient merely gets "cleaned." What cannot be done without adequate training is the total management of the patient. Someone with adequate training needs to oversee the total care of the patient.

In deciding which tasks can safely be "shifted" the Department of Health's work on core standards becomes an unexpected but useful source⁹. They have established a "risk matrix" whereby standards are classified as extreme risk, high risk, medium risk and low risk depending on the likelihood of something happening and the severity of the impact. The severity of a situation is assessed by establishing the impact of the measure on the patient, processes, finances and the reputation of the establishment. The likelihood is examined in terms of its expected frequency of occurrence.

If there was a formal process of determining risk of tasks considered for

task shifting, it would bring with it an element of credibility and trust. For example, if one was considering whether a nursing auxiliary could, or should, be allowed to take blood for testing in the laboratory, one need to think how often is it likely that a problem would occur during the procedure, and how serious would that problem be in terms of patient harm (e.g. developing a haematoma or become septic), and harm to processes (e.g. putting the blood in the wrong tube so it clots and cannot be used), financial cost (e.g. having to retake the blood and redo the tests) and harm to the reputation of the establishment (e.g. the patient might tell everyone she knows not to go to that laboratory as they cannot do the job properly). One would then need to decide how often these problems would arise. If a nursing auxiliary might have this problem once out of every hundred patients, one may consider that it is "worth" the risk but if it is likely to happen with every fifth patient, one probably would not. The other issue is to decide how often that procedure needs to be done as, in terms of human resources, if it is needed very often, it might be more cost-effective to train a lower category person to do the job as it would otherwise take a great deal of time of a higher category health worker.

With regard to implications for patients, then, the two big issues are whether the person has had enough training and whether the task that has been "shifted" has been assessed in terms of risk before allocating it to a lower category worker.

(ii) Implications for nurses

The implications of task shifting for nurses are inextricably linked with those for the patients as they also involve training and risk management. No health worker, whatever the category, should accept the delegation of a task unless he or she has been trained and is competent to carry it out. The difficulty for lower category health workers is that they often do not have the insight to realize there is a risk involved.

It is helpful, when considering the implications of task shifting for nurses, to consider the different ways we already allocate work, or care delivery models^{1a}

- Total patient care refers to a nurse caring for all the needs of several patients for an entire shift. This ensured consistency of care and gave the nurse and patient the opportunity to develop a relationship. It is an expensive model of care because the nurse needs to cope with all aspects of care, the "highest denominator" nurse has to be allocated i.e. the one who could manage the patient in the group of patients allocated with the most complex problems.
- Functional Nursing is closely related to task shifting as, in this model, the nursing work is divided into functional units and each care provider is responsible for specific duties or tasks. This means that care can be delivered to a large number of patients and nurses from different categories can be used if there is a shortage of professional nurses. There is a distinct possibility that there will be a lack of continuity of care using this model.
- Team Nursing attempts to resolve the problem of lack of continuity. "Staff are assigned to teams that are then responsible for a group of patients. Each team is usually led by a professional nurse. The team leader supervises and coordinates all of the care provided by those on the team. Care is divided into the simplest components and then assigned to the care provider with the appropriate level of skills."⁽¹⁰⁾ This model maximizes the role of the professional nurse but often still leaves the patients feeling "fragmented" and communication among the team is complex. There is also a concern that shared responsibility and accountability can cause a lack of accountability.
- Clinical Pathways outline the expected clinical course and

outcomes for a specific patient type. It is similar to developing a standardized nursing care plan for a patient with a health problem such as for a patient booked for an inguinal hernia repair or one admitted with a respiratory infection. The pathways outline the normal or expected course of care for the patient and nursing care can be allocated appropriately. The advantage of this model is that the care pathway indicates what has to be done for the patient at a certain time during his stay and who should do it which is informative, saves time and maximizes the utilization of the nurses from different categories. The disadvantage is that not all patients are "standard" The plan needs to be modified according to individual patient needs. Lower category nurses may not have the insight to recognize the need to make changes.

When looking at these various models of nursing care, one can see that task allocation, if not shifting, is a factor in all, but the implications will vary from model to model. Lower categories of nurse can work within a total patient care set up if the level of care required by all patients is at a functional level only e.g. in an retirement home where patients may only need assistance with activities of daily living. The functional nursing model depends on task allocation in that lower categories of nurse are allocated the tasks that require a lower level of training or where those lower categories have been taught to do more complex procedures. In both these models the assumption is that a professional nurse, or possibly an enrolled nurse is available to supervise care in the unit.

In both team nursing and the clinical pathways models, lower categories of nurse can work within a team and in the latter system, he/she has the added benefit of working according to a protocol so that they know what to do and when, and there is always a more qualified person within reach who can supervise and is available to teach and also to answer questions. They allow for individualized management of the lower

current issue

category nurse in that the local supervisor can decide which tasks the particular nursing auxiliary can manage.

In a hospital there are always professional nurses somewhere in the hospital to supervise and coordinate care, either directly or indirectly. In a clinic this is not the case, and task shifting takes on another dimension in terms of implications for nurses. Supervision is not always available and the irony is that it is in clinics where task shifting is needed most to cope with the HIV/AIDS epidemic as this is where the vast majority of patients receive care. Here we need to acknowledge that the tasks can be taught, but that the crucial overview of the total patient and the coordination of care may be missing thus increasing the risk.

(iii) Implications for the Profession

While task-shifting is inevitably a long term strategy to cope with the human resource shortage due, in part to the HIV epidemic, the question needs to be asked when is the task still being shifted and when does it become the normal and expected function of a category of worker? Task shifting itself needs to be done rationally according to risk but once the decision has been made that, for example, a care worker can take on that task it will become part and parcel of his/her work, unless the task is being shifted to an individual for a defined period of time in which case it must be done explicitly.

For this reason it makes more sense rather than to refer to task-shifting forever, to look at the scopes of the various health workers and to include tasks that can be done by them in these scopes. That also means they will know what is expected, training programmes can be developed accordingly and we can have a rational way of using health workers in the long term.

It is one thing for nursing auxiliaries (ENA) to take on tasks and functions formerly done by professional (PN) or enrolled nurses (EN), but another thing entirely when it is a care worker or a community health worker that takes on the role. The reason is that the ENA and the EN are both registered with the



South African Nursing Council who will regulate their practice. This is not the case with a care worker or a community health worker. Accountability then falls on the manager that offers the service. In revising the scopes of practice for the various categories of nurse, it is understood that the South African Nursing Council is ensuring that each category of nurse is held accountable for her own actions which is a very positive move and it becomes incumbent upon the nurse not to take on a task or function unless he/she is competent to do so. This will assist task shifting to be done safely. Care workers and

community health workers are currently not required to take accountability in this manner which raises concern.

SOLUTIONS FOR NURSING

Task shifting has always involved shifting tasks downwards, never back up again. The nursing profession has been dealing with the issue for a long time. The most notable "task-shift" that took place was when there were insufficient doctors to diagnose and treat patients in primary health care and nurses then took over sets of tasks which had always been the domain of the doctor. The nursing

profession responded appropriately by creating a course for primary health care nurses and recognizing that they were working outside their original field. Changes were made to the Act, the regulations and policies and primary health care nurses have been able to function as such. It was recognized at the time that this was going to be a long term, or rather a permanent solution and the profession responded accordingly.

The response to the problems of HIV/AIDS can be dealt with in the same way. It needs to be decided what tasks and groups of tasks can be carried out by lower categories of nurse and written into their scopes of practice so that they will be adequately trained to fulfil the responsibilities. It is essential that the WHO Global Recommendations and Guidelines on Task Shifting¹ distinguish between different categories of nurse. At present the suggested allocation of tasks is merely done between Medical Doctor, non-physician clinician, nurse and community health worker. Whereas this categorization differentiates the primary health care nurse from other nurses, it is important to distinguish between what professional nurses, staff nurses and nursing auxiliaries can do. This probably needs to be done at country level rather than at global level but is a responsibility the profession needs to take on quickly, before the scopes of practice of the various categories are redrafted. If this is done, task shifting as a concept can disappear from the nursing literature as the profession will have provided for a long term solution to the problem.

This leaves the issue of the community health worker who is not regulated and traditionally is expected to be supervised by a nurse which in itself is a problem. There is an expectation that community health workers will be regulated in the not too distant future and when this is done their scope of practice will need to include all the "tasks" that they are required to carry out.

There is little doubt that the nurses' solution to other problems i.e. working in teams and according to clinical pathways will assist the whole issue of managing HIV/AIDS. Teams can include community health workers but the

reporting and accountability lines need to be carefully defined. While clinical pathways are not one hundred percent applicable to all patients, they do cover the majority of patients and provide useful guides to ensure the safety and complete management of patients. Parcelling tasks into essential packages that teams can manage rather than separating out individual tasks will further enhance the management of the very difficult problem of not having sufficient health professionals to manage the epidemic.

CONCLUSION

In March 2008, DENOSA¹¹ led discussions on the challenges of task shifting during their Strategic Consultation named "Task Shifting - considering legal and regulatory barriers". All the issues were carefully considered and there was consensus, even two years ago, that task shifting is not going to go away. The health professions need to respond appropriately and this means incorporating the "tasks" into scopes of practice and training adequately for their safe delivery.

Nursing as a profession has done this in the past and needs to rise to do this appropriately once again.

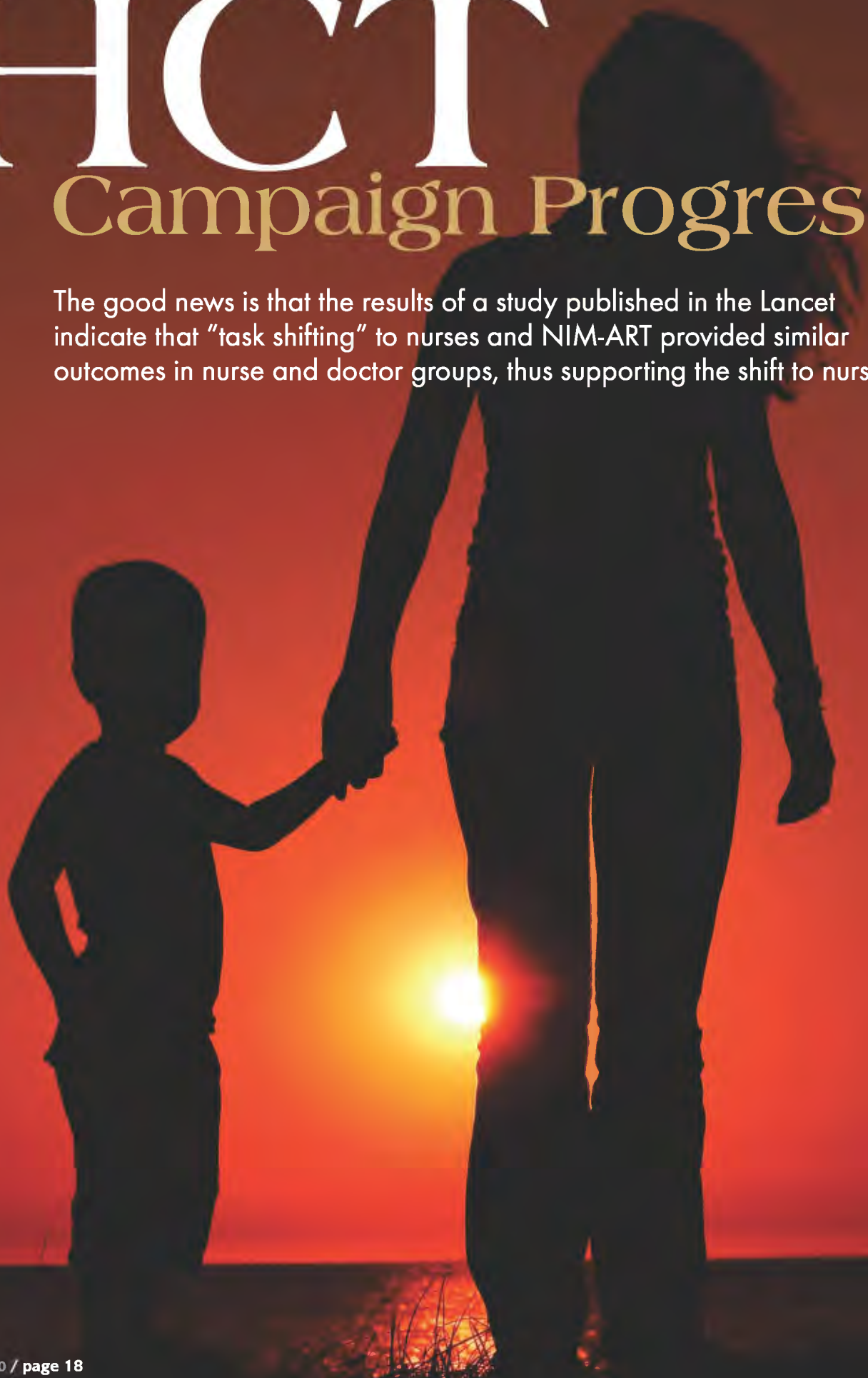
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HCT

Campaign Progress

The good news is that the results of a study published in the Lancet indicate that "task shifting" to nurses and NIM-ART provided similar outcomes in nurse and doctor groups, thus supporting the shift to nurses.



Campaign progress

The Department of Health reports in its June 2010 newsletter that the Department is on its way to meeting the campaign goals, and everyone who has changed their approach to providing HIV (and other screening) testing should be congratulated.

The progress reported includes:

- 163 nurses have been trained in nurse initiated management of ART (NIM-ART).
- Between the launch of the campaign and end of May 2010 more than 348,319 people were tested as part of this campaign but there is still a long way go to reach the target of 15 million people tested.
- Over 513 additional public health facilities were prepared to initiate patients on ARV treatment since 1 April 2010 and 919 new patients have been initiated on ART at these new sites since April 1st
- Most ARVs are available at provincial depots, with some provinces still facing challenges procuring sufficient quantities of ARVs, including Abacavir solution and Nevirapine suspension. Emergency stock of these products may be purchased from alternative suppliers.
- Current supplies of Abacavir solution can accommodate existing patients, but not all new patients. Healthcare practitioners are urged to ensure that sufficient supplies are available before initiating new patients on Abacavir. If sufficient stocks are not available, new patients should be treated as per the previous

guidelines.

- The NDOH is collecting stock data from each medical depot on a bimonthly basis. This data has been used to monitor the stock situation in each province.

HIV counselling and testing (HCT) is an umbrella category for all forms of HIV counselling and testing, including VCT as well as provider initiated counselling and treatment (PICT). The old green PICT registers and the new HCT registers can be used to record and report the same information. Provincial and district managers must ensure that PICT is implemented in all facilities. District managers must constantly evaluate progress against district targets and report problems to their respective Nerve Centres and HODs.

Decisions taken at the National Health Council meeting (NHC)

To be able to report on the campaign's progress it was decided that all provinces will provide the NDOH with reports every two weeks. The conditional grant allocations will be reviewed to ensure that the HCT campaign can be more adequately funded. The period during the FIFA World Cup was used to review the programme and strengthen it with a view of reinvigorating the campaign soon after the end of the World Cup.

Challenges experienced at operational level

In the challenges highlighted by field workers and funding partners, pharmaceutical services and the access to drugs remains the biggest obstacle to the roll out of access to ARVs. In some instances nurses have been trained and are competent in NIM-ART, but the process to designate sites as ARV sites is awaited which means that nurses cannot proceed with NIM-ART.

It has also been highlighted that achieving competence and confidence amongst nurses takes considerable time – one example highlighted stated that it took 2 – 3 weeks and approximately 64 cases with direct supervision before nurses felt competent to proceed on their own. PHC trained nurses became confident much sooner than those without such a qualification. Mentoring is still not sufficient for all areas and the need for ongoing support and 'soundboarding' for NIM-ART practitioners remain a reality. Paediatric initiation on ARVs remains a big gap in the roll out and it is reported that there are doctors who also do not feel competent to initiate infants and children on ARVs.

Keeton, C. 2010. Nurses just as good as doctors in ARV care. *Sunday Times*, 18 July 2010.

<http://www.the-press.co.za/johannesburg/article510850.ece/Nurses-just-as-good-as-doctors-in-ARV-care>

[#] EXPANSION OF HIV TESTING & TREATMENT, Friday June 18 2010 Provincial & District Update.

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TB Preventative Therapy SA National Guideline in a nutshell

More than 5 million people in South Africa are HIV infected. Antiretroviral therapy (ART) has resulted in a marked improvement in morbidity and mortality of HIV infected people worldwide. Although we can also see this trend is also observed in South Africa, co-infection with tuberculosis (TB) remains a major obstacle in reaching the desired outcomes.

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It is estimated that around 70% of all new TB cases in South Africa have HIV infection. TB is currently the most important cause of morbidity and mortality in HIV infected persons in South Africa. The risk for TB increases very soon after becoming HIV infected and increases steadily with progression of HIV disease. Although ART significantly decreases the risk for developing TB, the HIV infected individual will always have a higher risk for developing TB compared to an HIV negative person. The highest risk for developing TB while on ART is during the first 6 months of therapy. This is often associated with unmasking immune reconstitution inflammatory disease (IRIS) and can be prevented by properly screening patients for TB disease before commencing ART or by preventing the development of TB disease in patients with latent TB infection before starting ART by providing TB preventative therapy.

Isoniazid preventative therapy

TB preventative therapy, also known as isoniazid preventative therapy (IPT) or TB prophylaxis has been part of the National HIV/AIDS Comprehensive Management Plan since 2004/5. Per definition, it is the administration of isoniazid to individuals with latent *M. tuberculosis* infection in order to prevent progression to active TB disease. Although there are still some unanswered questions regarding this intervention, trials done all over the world including South Africa, have shown that the maximum benefit is achieved from TB preventive therapy in HIV-infected persons with evidence of tuberculosis infection, i.e. a positive tuberculin skin test (TST). In these patients, the risk of developing TB disease can be reduced up to 60%. Some trials also showed benefit among HIV-infected persons in general, regardless of their tuberculin test result. The benefit in TST negative patients, is however still a matter of debate between the experts. New research data on this matter is eagerly awaited.

TB preventive therapy should be part of the package of care for all people living with HIV/AIDS, but should only be offered if patients can be adequately screened for active TB disease and followed up monthly to encourage adherence, address side-effects and to continue TB screening.

It is also essential to have strong collaboration (preferably integration) of HIV/AIDS and TB programmes and to monitor the IPT programme by collecting data on the numbers of people started, completed and failed.

How to effectively exclude active TB disease

The main risk of giving a single TB drug to a patient who has active TB disease is the rapid development of resistance to that drug. Single drug resistance, specifically INH mono resistance is usually the first step in the development of MDR TB. The exclusion of active TB disease is therefore essential before initiating IPT and if there is any doubt that a patient has active TB, one should not start IPT.

Evidence shows that a simple symptom and sign screening procedure is very effective in excluding active disease. The additional use of a chest X-ray in patients who has a negative screening test, does not increase the yield significantly and is therefore not recommended in the routine workup prior to starting IPT.

Suggested symptom and sign screen:

- **Current cough for > 24 hrs**
- **Fever**
- **Drenching night sweats**
- **Significant loss of weight**
- **Lymphadenopathy > 1 cm**

Any patient with 1 or more positive symptom (listed in the box) is considered a TB suspect and is not eligible for IPT until active TB disease has been excluded with sputum smear and mycobacterial culture. Where clinically indicated extrapulmonary TB must be excluded with appropriate investigation eg. fine needle aspiration of significant lymphadenopathy. If the smear and culture are negative and the patient has become asymptomatic, IPT may be reconsidered in three (3) months.

If the smears are negative and the patient is still symptomatic, smear negative TB must be considered. Doing a chest X-ray in this situation is often helpful to accelerate the clinical

diagnosis of TB disease and commencement of therapy while awaiting culture results.

The golden rule remains: If there is any doubt that active TB disease is present, IPT should not be given.

Tuberculin skin test

Due to the strong evidence of the benefit in TST positive HIV patients, the current national IPT guideline recommends that, in places where tuberculin tests are feasible and can be performed, IPT should only be offered to those who are TST positive (>5mm).

However, the practicalities and logistics of doing a tuberculin skin test may be an obstacle for the provision of TB preventive therapy in some situations. Where it is not possible to do the TST or it is deemed by the provider to be an obstacle to IPT, the guideline suggests that IPT can be prescribed without a TST if the risk of developing TB disease is very high.

The following populations are at particularly high risk of developing TB and would benefit most from IPT: mine workers, prisoners, close TB contacts, health care workers and children.

IPT and Pregnancy

TB is a major factor in HIV related maternal deaths in Africa. Active TB during pregnancy is also associated with spontaneous abortions, and adverse perinatal outcomes.

Pregnant HIV infected women will benefit from IPT and it can be started at any time during pregnancy and should be completed if a woman falls pregnant while taking IPT.

IPT and ART

Patients who are receiving IPT and who are eligible for ART according to the latest National Guidelines should commence ART without unnecessary delays. IPT can be completed while taking ART and should not be stopped after initiating ART.

There is currently no good data supporting the initiation of IPT in patients already on ART. Some experts will

clinical update

recommend it on the basis of some retrospective studies and it may be an option in very high risk groups with low CD4 counts.

Although INH is generally well tolerated during ART, shared side effects of INH with commonly prescribed ARV's include peripheral neuropathy (stavudine and didanosine) and hepatotoxicity (nevirapine). Patients on IPT and ART should be monitored clinically, and INH stopped immediately if there is evidence of severe peripheral neuropathy or hepatotoxicity.

Contra-indications for IPT

The contra-indications for IPT include the following:

- Suspected or confirmed active TB disease;
- Active liver disease;
- Active alcohol abuse.

Recommended Regimen

The standard regimen for TB preventative therapy is:

- Adults: Isoniazid (INH) 5 mg/kg/day (maximum **300 mg per day**).

- Children: Isoniazid (INH) 10 mg/kg/day (maximum **300 mg per day**).

Vitamin B6 (pyridoxine) 25 mg per day should be given concomitantly with isoniazid to prevent the occurrence of peripheral neuropathy.

The recommended duration is 6 months of continuous treatment, which can be completed over 9 months. This allows for interruptions of less than 3 months, as long as the patient remains asymptomatic for TB disease. The protective effect is expected to last 18 months. IPT should be given once only.

Conclusion

IPT undoubtedly is effective in preventing TB disease and subsequent mortality in HIV individuals with a positive TST. The latest South African National Guideline gives improved and simplified guidance on the exclusion of active TB disease and has succeeded in removing some of the perceived obstacles to the effective implementation of the programme. However, the lack of integrated HIV and TB services and the absence of

dedicated chronic care primary health services in many regions remain important obstacles to the improvement of HIV/TB related mortalities in South Africa. [®]

Reference:

Guideline for TB preventative therapy among HIV infected individuals in South Africa 2010. South African National Department of Health.

IPT
must be
considered in
all HIV infected
patients





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.



Osteo-articular Tumours and Infections in HIV/AIDS



Patients living with Human Immunodeficiency Virus (HIV) infection may present with a variety of opportunistic infections or tumors involving bones and joints. Common manifestations include osteoarticular tuberculosis, septic arthritis, osteomyelitis, lymphoma, myeloma and sarcoma. A high index of suspicion needs to be maintained by all healthcare workers as a delay in diagnosis may add significant risk of morbidity or mortality in affected individuals.

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HIV infection is associated with progressive immunosuppression and development of multiple systemic opportunistic infections. Deregulation in the production of certain cytokines may play an important role in the increased susceptibility of HIV patients to infection with intracellular micro-organisms, especially *Mycobacterium tuberculosis*. T-cell deficiency is almost always accompanied by some abnormality of antibody response; this may partially explain the increased prevalence of bacterial infection in these patients.¹ The exact mechanisms by which malignancies are induced in HIV infected individuals are not exactly known. It is likely to vary with different types of cancers, but a common underlying mechanism is a depletion of cell mediated immunity. In addition several types of cancers have been linked with other viral etiological agents, for example CMV, EBV and HPV.^{2,3}

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

Musculoskeletal infections

- Osteoarticular TB
- Osteomyelitis
- Septic arthritis
- Pyomyositis
- Discitis
- Bursitis
- Soft tissue infections

Musculoskeletal tumours

- Lymphoma
- Myeloma
- Sarcoma

HIV-associated musculoskeletal infections

Osteoarticular Tuberculosis

Osteoarticular tuberculosis remains one of the most common HIV-associated musculoskeletal infections. According to a previous study in Zambia the spine (especially the thoracic and lumbar region) is most commonly affected (66%), followed by the hip (18%), the knee (10%), other joints (5%) and other bones in 1% of patients.⁴ In contrast to bacterial infections of the spine, that usually involve the intervertebral discs,

tuberculosis of the spine usually starts in the vertebral body, progressing under the anterior longitudinal ligament. In other bones, tuberculosis usually originates in the metaphysis, sometimes leading to sepsis of the adjacent joint. The treatment consists of chemotherapy, combined with surgical debridement and stabilization in certain cases. The duration of antibiotic treatment for osteoarticular tuberculosis in HIV infected patients is longer than in pulmonary tuberculosis, with a minimum treatment duration of 12 months recommended.



Figure 1: Tuberculosis involving proximal femur and hip joint.

Osteomyelitis

Several patterns of osteomyelitis occur in HIV infected individuals. Re-activation of quiescent chronic osteomyelitis (usually the end result of childhood haematogenous osteomyelitis) occurs commonly and may occur at earlier stages of the disease. Patient may present with pain, inability to bear weight or a draining sinus. Systemic signs of sepsis is usually absent in this subset of patients.

Acute haematogenous osteomyelitis, is associated with markedly low CD4 cell counts, usually below 100/mm³. *S. aureus* and mycobacteria are the most common organisms involved. This form of osteomyelitis carries a poor prognosis with a high mortality rate, often exceeding 20%.⁷

The incidence of late onset peri-prosthetic infection, following arthroplasty or fracture fixation, is also increased in HIV patients. On the other hand, the effect of HIV infection on the prevalence of early post-operative sepsis or early peri-prosthetic infections remains controversial. The post operative risk of infection is definitely increased in cases with pre-operative contamination, as is indicated by the increased infection rate in HIV patients with grade III open fractures.



Figure 2: Reactivation of chronic osteomyelitis of the femur.



Figure 2: Reactivation of chronic osteomyelitis of the femur.

Septic arthritis

The severity of the clinical characteristics of septic arthritis in HIV infected individuals may be less pronounced than those in non-immunocompromised patients. Although some studies suggest that HIV-infected patients with CD4 counts over 250/mm³ seldom become affected, many cases of septic arthritis, especially those caused by pyogenic microorganisms, are seen in the early stages of HIV infection and may occasionally be the presenting clinical manifestation. The clinical picture observed is predominantly mono-articular (involving only one joint), but poly-articular cases (involving multiple joints) do occur, almost exclusively in patients with CD4 count <200/mm. The large weightbearing joints of the lower limb (predominantly the knee, but also the hip joint) are most commonly affected. Other joints that may be affected include the wrist, shoulder, sternoclavicular joint, ankle, sacro-iliac and intervertebral joints. A wide variety of causative microorganisms have been implicated, *Staphylococcus aureus* being the most common. Others include *Streptococcus*, *Mycobacterium tuberculosis*, *Candida*, *Salmonella* or *Neisseria* species.

Pyomyositis

Pyomyositis is a rare, but serious, infection associated with HIV infection. Typically caused by *Staphylococcus aureus*, it usually presents as a painful swelling in muscle tissue. The thigh muscle are most commonly involved and multiple lesions may be seen in up to 30% of cases.⁸

Soft tissue infections

Various other soft tissue infections have been described in HIV infected patients, including cellulitis, tenosynovitis and bursitis.

HIV-associated musculoskeletal malignancies

Lymphoma

HIV positive patients have a 200-fold increased risk of non-Hodgkin's lymphoma (NHL) and a 8-fold increased risk for Hodgkin's lymphoma when

compared with the general population. HIV associated lymphomas have heterogeneous histological characteristics, but are generally aggressive, and often occur among patients in good clinical condition (75% of patients have CD4 counts >50/mm³). Primary and secondary bone involvement is reported in 20 to 30% of cases and predominantly involves the lower extremities. Patients may present with pain, fever or a pathological fracture. The typical X-ray appearance is that of a poorly defined, permeative, osteolytic lesion. Treatment includes internal fixation of pathological fractures, radiation and chemotherapy.⁹



Figure 3: Pathological fracture of tibia due to non-Hodgkin's lymphoma.



Figure 3: Pathological fracture of tibia due to non-Hodgkin's lymphoma.

Myeloma

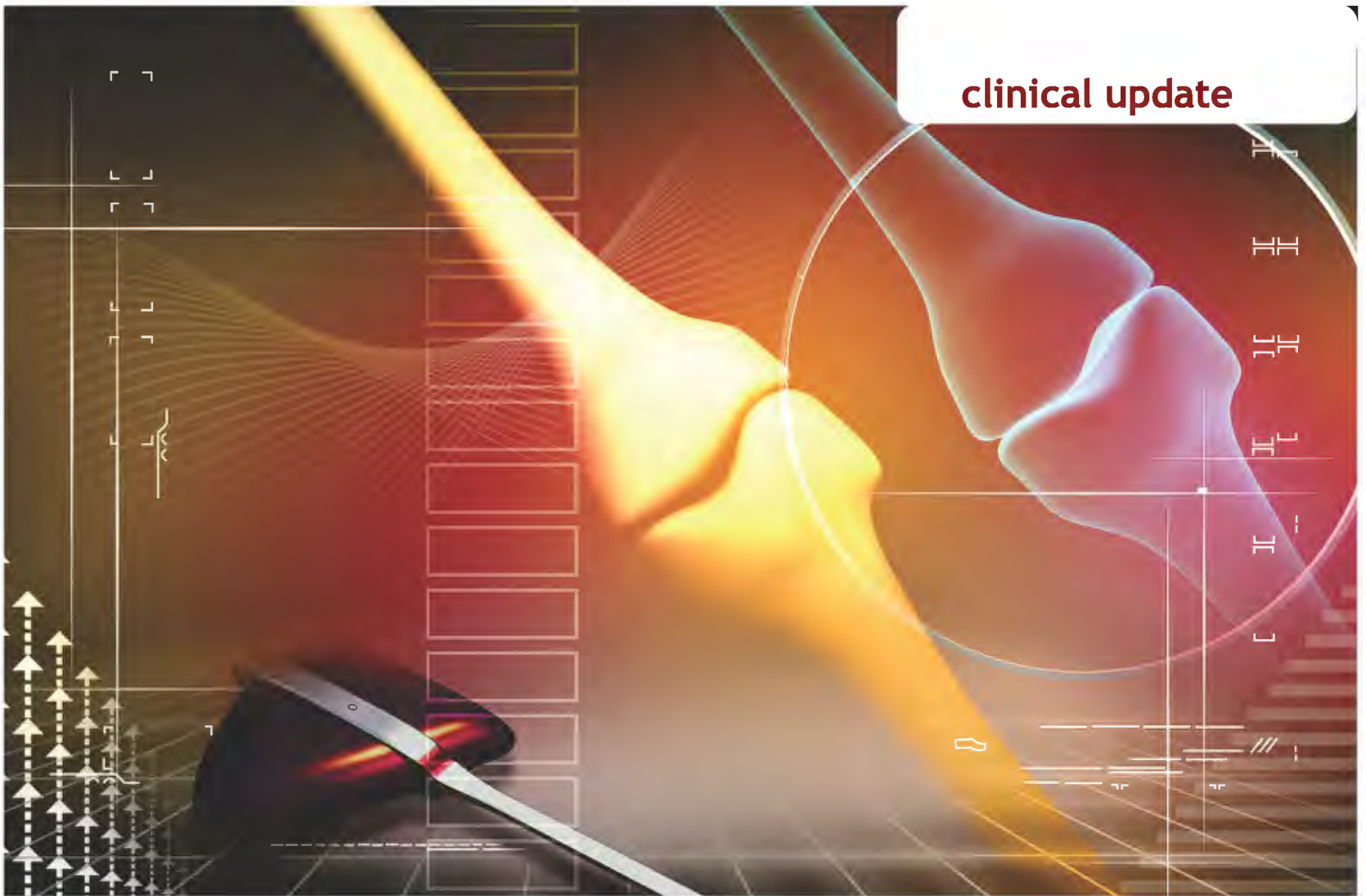
Myeloma is reported to occur 4 times more commonly in HIV infected patients and tends to occur at a much younger age than in the general population. Anemia, renal failure and current bacterial infections are the most common early manifestations of multiple myeloma, but these conditions are also common in HIV/AIDS infection in general. The diagnoses of myeloma is thus often delayed and skeletal osteolytic lesions or pathological fractures are the most common presenting manifestation.¹⁰



Figure 4: Pathological fracture of humerus due to myeloma.

Sarcoma

Kaposi's Sarcoma is the most common malignancy in HIV infected patients, eventually occurring in approximately 20% of AIDS patients. Osseous lesions are rare, except in the endemic African type, and usually occur late in the



disease. The radiological picture may involve cortical destruction from soft tissue lesion, distinct osteolytic lesions or diffuse osteopenia.⁹

Conclusion

Healthcare workers should maintain a high index of suspicion when confronted with a susceptible host, presenting with septic or malignant musculoskeletal disorders. A delay in diagnosis may add significant morbidity and mortality in the affected individuals, and judicious early referral for further special investigation is advocated. Effective antiretroviral treatment may dramatically decrease the occurrence of many of these serious musculoskeletal complications. [®]

EARLY
diagnosis is key
in preventing
morbidity
and mortality

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Prescribing and dispensing by nurses neglected steps in the legislative process

While there is wide acceptance of nurse-initiation and management of antiretroviral therapy (NIM-ART), the legal means to enable nurses to be recognised as authorised prescribers remain elusive. Section 56(6) of the Nursing Act (Act 33 of 2005) enables nurses to be issued with a permit to keep, prescribe and supply medicines in the absence of a medical practitioner or pharmacist. However, this should be seen as a temporary or transitional mechanism,

and not as a long term solution. Sections 56(1) to (5) need to be brought into effect so that nurses can be recognised as authorised prescribers and so that patients can have access to the full set of services, including a full pharmaceutical service. Only by basing access to prescribing (and dispensing) on demonstrated competence can a safe and effective system of task-shifting be put into effect.

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The publication in the 15 June 2010 issue of *Lancet* of the results of the CIPRA-SA study has again focused attention on the issue of nurse-initiation and management of antiretroviral therapy (NIM-ART)¹. In this randomised non-inferiority trial, HIV-positive patients at two South African primary-care clinics with a CD4 cell count of less than 350 cells per μL or WHO stage 3 or 4 disease were randomly assigned to nurse-monitored or doctor-monitored ART care. Based on a composite endpoint (including all-cause mortality, loss to follow-up, virological failure, toxicity failure, withdrawn consent, defaulting clinic schedule, and HIV-disease progression), nurse-monitored ART was shown to be non-inferior to doctor-monitored ART. Participants allocated to the nurse-monitored arm were initiated on ART by medical practitioners. Their care was then continued by experienced primary health-care nurses, described as drawn from "a nationally registered cadre of nurses who have undergone 1 additional year of clinical training in primary health care". Both the medical and nursing staff involved were provided with "similar structured didactic and clinical training in HIV and the use of ART". Both groups "were supported by a clinic nurse who ensured that the participant saw the correct clinician, did routine clinic procedures, and scheduled further patient visits; and by a team of lay community counsellors who were trained in treatment adherence counselling". Lastly, the study team reported that "[a] pharmacist oversaw ordering and dispensing of antiretroviral drugs at each site". The authors noted that they were not able to assess "nurse-initiated ART", as "the prescription of licensed drugs in South Africa is restricted to doctors". They further noted that the "[i]mplementation of nurse-initiated therapy would therefore need additional changes to the existing legislation", but that "wide-scale task shifting to nurses for ongoing patient management" was a feature of the South African National Department of Health HIV and AIDS and STI strategic plan for South Africa, 2007–2011.

At first glance, this programme would seem to embody exactly the sort of task shifting that was recommended by the World Health Organization².

Recommendation 5 of that document states that "Countries should assess and then consider using existing regulatory approaches (laws and proclamations, rules and regulations, policies and guidelines) where possible, or undertake revisions as necessary, to enable cadres of health workers to practise according to an extended scope of practice and to allow the creation of new cadres within the health workforce". It would also seem to be in line with the National Drug Policy for South Africa, which states that "[a]t primary level prescribing will be competency, not occupation, based"³. It goes on to state that "prescribing by nurses will only be in accordance with the provisions of Act 101 of 1965" and that "nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available" and "such persons will be in possession of a dispensing licence issued by the Medicine Control Council".

The legal situation, though, remains fraught with difficulties and hostage to a process that seems to have stalled.

The enabling provisions

Medicines and Related Substances Act (Act 101 of 1965)

The General Regulations issued in terms of the Medicines and Related Substances Act (Act 101 of 1965) define 'authorised prescriber' as "any person authorised by the Act to prescribe any medicines"⁴. The Act itself [in section 22A(5)] limits the prescribing of any Schedule 2 to Schedule 6 substance to medical practitioner, dentist, veterinarian and to "a practitioner, a nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist".

However, this last category "may prescribe only the Scheduled substances identified in the Schedule for that purpose" and may "compound and dispense ... only if he or she is the holder of a licence contemplated in section 22C(1)(a)"⁵. Further, s22A(14) of the Act states that "no nurse ... may prescribe a medicine or Scheduled substance unless he or she has been authorised to do so by his or her professional Council concerned".

Read in isolation, this set of legal provisions is clear and unambiguous. A nurse wishing to prescribe medicines will need to be deemed competent and authorised to prescribe by the South African Nursing Council and the medicines which s/he can prescribe will need to be listed in the Schedules to the Act for this purpose.

The Nursing Act (Act 33 of 2005)

This construct is echoed in section 56 of the Nursing Act (Act 33 of 2005), which enables the Nursing Council to register a professional nurse, midwife or staff nurse to "assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions", but only on "proof of completion of prescribed qualification and training"⁶. The Act also specifies that such a nurse may only "acquire, use, possess or supply medicine" and "dispense medicines" subject to the provisions of the Medicines and Related Substances Act (Act 101 of 1965).

Had the Nursing Act ended with section 56 at this point, the transition from the previous section 38A permit system to one based only on demonstrated competency (completion of a prescribed qualification and registration in this special category) would have been very difficult. The legislators therefore saw fit to include a similar permit system in section 56(6) of the Nursing Act. This enables the national Director-General, the head of a provincial Department of Health, the medical officer of health of a municipality or the medical practitioner in charge of an organisation authorised for this purpose to issue a permit to a nurse employed in such settings to engage in "the physical examination of any person", "the diagnosing of any physical defect, illness or deficiency in any person" and "the keeping of prescribed medicines and their supply, administering or prescribing on the prescribed conditions".

However, such acts are to be performed only "if the services of a medical practitioner or pharmacist, as the circumstances may require, are not available".

The entire new Nursing Act has been brought into effect by 3 promulgation notices (Government Notice R.4,



Government Gazette No. 29634, 16 February 2007; Government Notice R.18, Government Gazette No. 30159, 8 August 2007; and Government Notice R.6, Government Gazette No.3086, 13 March 2008), but is still lacking many of the Regulations necessary to allow its effective operation. No new Regulations have been issued to provide the details listed as to be "prescribed" in section 56, for instance. Section 61 of the Act

provides for transitional arrangements: "Any proclamation, notice, regulation, authorisation or order issued, made or granted, any registration or enrolment, any removal from a register or roll or any appointment or any other thing done in terms of a provision of any law repealed by section 60(1) is, unless inconsistent with any provision of this Act, deemed to have been issued, made, granted or done under the

corresponding provision of this Act". Section 60(1) repealed the whole of the 1978 Nursing Act. Therefore, any nurse issued with a section 38A permit in terms of that Act can continue to practise as enabled by that permit. In addition, the Regulation that covered such permits is still being used in relation to section 56(6) permits⁷. This is, however, by no means a satisfactory solution for the long term.

The missing pieces – consequences

If it is accepted that the intention of the State is still to implement the National Drug Policy of 1996 and to ensure that all prescribing and dispensing of medicines is performed in terms of the Medicines Act, then a number of key steps need to be completed. The Nursing Council needs to formalise the qualifications and training that will enable nurses to gain access to the specialist registers contemplated in section 56. Once this is settled, the Nursing Council needs to propose which medicines should be listed in the Schedules for each specialist category. These proposals will be considered by the Medicines Control Council and those recommended will be included in new Schedules made by the Minister of Health. Only then will such nurses be recognised as “authorised prescribers” in terms of the Medicines Act.

The consequences of continued delay in this process are serious. The South African Pharmacy Council has confirmed that, in its interpretation, antiretroviral medicines (which are Schedule 4 substances) “may only be dispensed by a pharmacist on a valid prescription by a medical practitioner or an authorized prescriber”⁸. The Pharmacy Council has made it clear that “nurses who are registered in terms of Section 38A (old Nursing Act) / Section 56 (new Nursing Act) are permitted to dispense medicines they have prescribed, i.e. nurse initiated treatment in terms of prescribed regulations”. However, they have stated most categorically that “pharmacists cannot dispense nurse initiated treatments unless such prescription has been authorized by a medical practitioner”.

Conclusions

The safe provision of medicines is premised on a set of overlapping responsibilities and double checks. Central to this construct is the belief that, wherever possible, prescribing and dispensing should be separated. In accordance with this approach, section 56(6) of the Nursing Act should be seen an exceptional mechanism, not the norm. The ultimate goal should be to use sections 56(1) to (5) and the Medicines

Act, and to allow for nurse-initiated prescriptions to be dispensed by pharmacists and pharmacist's assistants. However, to achieve that end, the stalled process of bringing the Nursing Act into effect must be addressed urgently. Colvin *et al.* wrote that “the combination of decisive leadership, political will and an expanded delivery platform has the potential to accelerate ART access in our country like never before. But the complexity and risks this may present to the backbone of our public health sector, nurse-led primary care, must be recognised and addressed and all tested strategies employed to ensure that the system is strengthened and not undermined”⁹.

Failing to develop the necessary qualification and Regulations and further delaying the process of amending the Schedules to the Medicines Act will continue to leave nurses exposed and deprive patients of access to a full pharmaceutical service, even where such a service is available.

Nurses & pharmacists
are being issued with conflicting instructions by DoH and their Councils - there is a way forward

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SANC's Tendani Mabuda

It is with great excitement that we inform readers that Mr Tendani Bernard Mabuda has been appointed as the Registrar of the South African Nursing Council (SANC) on 1 July 2010. This position has been unfilled for more than a year which has placed serious constraints on the ability of the Council to deliver during this period.

Nelouise Geyer



Professional experience

Tendani completed his 4-year Diploma and basic training in nursing at Venda Nursing College in 1991. He furthered his education to obtain a BA Cur Degree in 1998 and a Masters Degree in Health Studies in 2006, both at UNISA. He attended a variety of other courses to improve his skills in management and leadership.

His work experience includes clinical work, education and management. He started his career as a professional nurse in Siloam Hospital and moved on to become a nurse educator in 1998 at the Limpopo College of Nursing where he stayed until 2000. He moved to the George Masebe Hospital as the Deputy Manager Nursing until 2002 and then became the Manager Nursing Service at the Tshilidzini Hospital until 2006. The last four years Tendani was employed in the Western Cape as the Director of

Nursing Services in the provincial office where his main responsibility was to provide strategic leadership within the Directorate Nursing Services.

What are the challenges and opportunities in the new position?

Tendani was asked about the challenges and opportunities as he sees it in his new position.

Alignment of nursing qualifications

His biggest challenge and opportunity to influence the nursing profession, is to fast track the alignment of the nursing qualifications with the NQF. "This matter has been on the table for a long time and people on the outside are anxious to start working on the new qualifications" says the big man with the captivating smile.

Improve efficiency and turnaround time

The second opportunity is to address the efficiency of the Nursing Council and to improve the turnaround time of Council business. The turnaround time is not good on all fronts and systems have to be put in place to improve it. He highlights some examples of how Council responses can be linked to the information system of the Council. "Why can we not send bulk SMSs to remind nurses of their certification fees that are due, or to advise that their payments have been received?" he says. Matriculants receive their examination results by SMS; why can the Council not also do it? Implementing a system like this requires an update of the data of registered and enrolled nurses. In terms of improving turnaround time for printing and issuing of certificates for those who successfully completed their learning programmes, processes should be adapted to streamline the process.

When completion of training documents are received, they should be quality controlled and processed immediately and staff should not wait until the money has been received to start the process. Certificates will still only be sent out when payment has been received, but if the process is started immediately when completion records are received, certificates can be posted when reconciliation indicates that fees are paid. In addition to this, certificates

should, instead of going to the individual, rather go to the nursing education institution where the learners can get their certificates and sign on receipt thereof. The certificates can be dispatched with a return form on which all learners have to sign when they receive their certificates. "One of my first calls in this office was from a nurse who was crying because she has been sitting at home for 6 months because she has not received her certificate yet. I was informed that it bounced back to the Council" he says. This is just not fair to someone who has successfully completed a programme and wants to go to work and earn a living.

Professional conduct hearings

The service delivery in terms of dealing with disciplinary cases should be improved. It is not fair for a nurse or midwife to be subjected to a hearing 6 years after the incident and strategies have to be put in place to prevent such long waiting times.

Increased visibility

Tendani's vision is to increase the visibility of the Nursing Council to interact and share information through road shows or other events with the public and with the profession. The case studies of disciplinary hearings at the Council offers a rich source of training materials to equip members of the profession on the things that can go wrong and where the most mistakes are made. It will also offer the profession the opportunity to speak to the Council and for the Council to listen and then reflect on the needs of profession. This provide an opportunity to show the profession that the Council is not only there to discipline them!

Accreditation

Still in line with improving efficiency, accreditation capacity must be increased. Accreditation guidelines must be made more accessible and knowledge on how to get institutions accredited must be reinforced. One of the options that will be explored is to decentralise accreditation by dividing the country into geographic areas and appointing accreditation teams to do the accreditation visits and make recommendations. These teams can consist of educators in the area. Such teams will work much more efficiently than one team having to visit all nine

provinces. Developing a detailed database to indicate which accredited programmes are offered at the different institutions that are accredited will be of great value.

Annual payments

It is also essential to start looking at ways to make it easier for nurses to pay their annual certification fees without having to stand in a queue for a day or two at the Council so that their names are not removed from the register. While electronic payments will also be promoted, it is recognised that not everyone has access to the internet and therefore other options such as payments at the post office or other pay points should be explored.

Message to the profession

His message for the profession says Tendani is "Have pride in what you are doing. The healthcare services are only sustainable with the service of nurses. Knowing well what skills nurses have, I have no doubt that nurses and midwives will have a big impact in the field with the management of HIV/AIDS and other health problems. Nurses and midwives must do their work in a pragmatic and professional manner. Together we have the responsibility to improve the image of the profession at a time where the community seems to be losing trust in us and we have to cultivate a caring ethos and re-establish our former pride".

This can only be achieved by all our nurses going back to basics – it is not only about the sophisticated aspects of care, it is above all also about the patient. We have to listen to the patients and their needs, to assist them in whatever way they need and to refer them to another practitioner if necessary. "Nurses are persons who have skills and scientific knowledge that they can use to care for a patient, but above all it requires nurses to be human – nothing can supersede this and this is why we do not have machines that provide nursing care" says Tendani. The challenges remains that nurses have to continually update our skills and knowledge, but this has to be balanced with our humanity and caring ethos – this is ultimately how we will improve the image of the nursing profession; by creating competent and caring practitioners.

Palliative Care In HIV



There are a number of key concepts to understand when considering the importance of palliative care in the continuum of HIV care. Patient-centeredness, respect for patient autonomy and restoring a sense of control for the patient are important principles in palliative care with a focus on quality of life and holistic care.

*Dr Liz Gwyther
CEO, Hospice Palliative Care
Association of South Africa*

Quality of life

Palliative care focuses on quality of life and the WHO definition of palliative care emphasises enhancing 'quality of life', that palliative care 'affirms life', supports the patient 'to live as actively as possible', and 'is applicable early in the course of the illness, in conjunction with other therapies that are implemented to prolong life'. These other therapies include chemotherapy and radiotherapy for cancer patients and HAART for HIV patients.

The discipline of palliative care was developed in the 1960's in the UK as a response to cancer patients dying in pain without appropriate care. Palliative care has been adapted to different illnesses and different settings and the current WHO definition of palliative care reflects this development (see box 1). Palliative care initially provided care towards the end-of-life the role of palliative care has expanded to include restoring health in patients who are HIV positive.

Definition of Palliative Care

WHO Definition of Palliative Care

Palliative Care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative Care:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;

- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- Will enhance the quality of life, and will also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are implemented to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical

In South Africa, communities and hospice organisations responded effectively to assist people who are HIV positive to live as actively as possible – for living positively and improving quality of life.

Patient-centred care

Communication skills are important in eliciting patient concerns, understanding the person's experience of his/her illness and addressing these concerns. It is important to treat the HIV infection and any complications such as opportunistic infections or cancers but it is equally important to understand the impact of the HIV infection on the person as an individual and on his/her family.

Holistic care

The WHO definition describes palliative care as the 'impeccable assessment and treatment of pain and other problems,

physical, psychosocial and spiritual'. We have discussed the foundation of impeccable assessment as good communication with the person who is HIV positive. A comprehensive discussion guides the clinical and psychosocial assessment and physical examination and appropriate investigation of clinical problems. Ideally, an interdisciplinary team approach is most helpful for the patient who is ill with HIV and the professional nurse is the co-ordinator of care. Co-ordination of care is important to optimise antiretroviral treatment from the clinic, home-based care or admission to hospital or hospice in-patient unit for control of opportunistic infections or distressing symptoms.

Clinical aspects of palliative care in HIV

(i) The control of opportunistic infections

HIV-infected patients who develop opportunistic infections should undergo appropriate investigations to establish an accurate diagnosis, and early anti-infective treatment should be initiated. Tuberculosis (TB) is the commonest opportunistic infection in South Africa. Atypical presentation of TB is common in HIV, eg tuberculous lymphadenitis, serositis syndromes, TB meningitis. The incidence of multi-drug resistant TB has increased with the HIV epidemic. Untreated TB causes sustained immunological stimulation allowing HIV to replicate at a much faster rate, resulting in an increased viral load and a rapid fall in CD4 count. HIV infected patients who are infected with TB should be treated according to the national guidelines. Those patients who develop multi-drug resistant TB should have a sputum specimen sent for culture and sensitivity and should be treated with as many first-line agents to which the organism is sensitive, include parenteral agents & bactericidal agents. Direct treatment observation is important.

(ii) Symptom management

There are a number of distressing symptoms that can affect people who are ill with HIV. This article briefly looks at pain management and management of respiratory symptoms.

Pain management

Thorough assessment of pain is

important to identify the cause and severity of pain and response to medication and other methods of pain relief. In a study conducted in Soweto, it was found that 97% of patients with stage 3 & 4 HIV experienced pain and that patients experienced up to 7 different types of pain. Even when on HAART patients continue to experience pain. Often clinicians neglect to ask about pain or assume that pain will resolve on ART. Patients expect to suffer pain with serious illness and may not complain about pain in a consultation that is focused on HIV and adherence to antiretroviral treatment.

Once the assessment is concluded, explain the findings to the patient and family members. Understanding the cause of pain and how it will be managed helps to engender a sense of control for the patient and makes a person less fearful and less likely to imagine more serious causes of pain. Disease modification is important – so HAART is initiated but alongside this analgesia to manage the symptom of pain. The WHO has described clear and simple guidelines to manage cancer pain which is applicable also to the management of pain in HIV. The guidelines described administering analgesics by the mouth – oral analgesia is more practical for the patient at home; by the clock – it is better to use analgesia to control pain and to keep the patient pain free than to use 'prn' analgesics. We know the condition is painful, if we give analgesics when the effect of the previous dose has worn off we are condemning patients to regular episodes of pain and higher doses of medication will be required to address each episode of pain.

The third recommendation from the WHO is by the ladder. The WHO 3-step ladder describes using a non-opioid for mild pain, a weak/mild opioid for moderate pain and a strong opioid for severe pain. Who decides whether the pain is moderate or severe? – the patient. Pain is a subjective sensation, it can be measured using patient report on a numerical or visual analogue scale but essentially it is patient report that guides us in the use of medication. We need to caution the patient regarding anticipated side effects such as nausea, constipation and temporary drowsiness and we should co-prescribe an anti-emetic to prevent nausea. We also need to assure

the patient of the safety of low dose oral morphine for pain management and explain that once the condition causing the pain has improved, we will withdraw the morphine as medication without risk of addiction.

As indicated above there are many different conditions (see box 2) that cause pain in patients who are HIV positive and these conditions need to be treated in conjunction with analgesic management. There are a number of non-pharmacological interventions that also assist in pain management.

Causes of pain in HIV

Peripheral neuropathy
 Oropharyngeal infection-
 candida, herpes viruses, CMV,
 gingivitis, ulcers
 Retrosternal pain- oesophageal
 candida, reflux oesophagitis,
 pneumocystitis jirovecii
 pneumonia
 Headache - toxoplasmosis,
 meningitis,
 cerebral lymphoma, sinusitis
 Abdominal pain - diarrhoea
 infection
 Perianal pain - herpes simplex,
 candida

Management of respiratory symptoms

Sinus and respiratory infections are common in HIV and as mentioned earlier TB is the commonest co-infection encountered in the SA setting. The first step is to initiate appropriate anti-infective management, TB medication or antibiotics. Physiotherapy is important to optimise treatment of sinus and chest problems and family members can be taught home physio to assist in patient comfort.

Symptomatic control can be achieved by using:

- Hyoscine 10-20 mg 8hrly to reduce respiratory secretions
- Codeine containing mixtures for cough suppression
- Low dose oral morphine 5mg 4hrly is effective in the management of dyspnoea.
- Tapping of pleural effusion is appropriate to relieve severe respiratory distress.

- Oxygen administration if available and patient benefits from oxygen.

Integration of prevention, treatment and care of HIV patients

Palliative Care comprehensively addresses the needs of patients and family members facing the diagnosis of life-threatening or potentially life-limiting illness. With the diagnosis of HIV, patient and family needs are often greater than with the diagnosis of other life-limiting illnesses. Thus comprehensive palliative care includes strategies of prevention, treatment and care for patients and family members.

Prevention:

- Prevention of suffering through early diagnosis and treatment of opportunistic infections and distressing symptoms such as pain, with referral to hospital or hospice in-patient unit if necessary
- Prevention of infection through family and community awareness
- Promotion of and provision of voluntary counselling and testing programmes, with referral to clinics for VCT when available

Treatment:

- Hospices are often the entry point to ART either with referral to ARV clinics or through establishment of ARV clinics within hospice programmes in areas where the ARV roll-out has not yet been implemented
- Hospice in-patient units are used for initiation of treatment for patients with very low CD4 counts (less than 50) for the management of IRIS
- Hospice home-based care programmes provide treatment support to patients on ARVs both one-on-one in the home and through support groups
- Hospice treat opportunistic infections and distressing symptoms such as pain, dyspnoea, nausea, diarrhoea, skin conditions
- Hospice refer TB patients to TB clinics and provide treatment support (DOTS) in the patient's home

Care:

- Hospice provide physical care – assessment and management of distressing symptoms for patients to



- improve quality of life
- Hospices provide psychological and spiritual support to patients and family members through counselling, which may be individual counselling, family counselling, support groups, bereavement counselling, spiritual care
- Hospices assist in poverty alleviation programmes through income generation activities
- Hospices identify and support potential orphans and vulnerable children
- Hospices assist in developing food security through nutritional advice, food parcels, and support of community food gardens
- Hospices provide compassionate care of terminal patients ensuring physical comfort through control of distressing symptoms, which assists in facilitating dignity for the dying patient; emotional support for the patient and family members and bereavement care.

HIV infection and palliative care
HAART has converted HIV infection from an inevitable terminal condition into a chronic condition and the palliative care support for HIV positive patients focuses on ensuring access to HAART and support of treatment adherence. However, people still die of HIV-related

causes. The most recent estimates from WHO are that 350,000 people died of AIDS in South Africa in 2007 - nearly 1,000 every day.

Care of the patient dying from AIDS follows the same principles as any palliative care approach at the end of life. This is to ensure physical comfort, emotional support of patient and family and a dignified and if possible a peaceful death. It is useful to have a syringe driver available to administer essential medication such as those to control pain and respiratory secretions. The palliative care team has a role in supporting the patient and family through the terminal phase in whatever setting the patient chooses for receiving palliative care. A patient does not need to be admitted to hospital to die. In fact, the majority of people choose to die at home in familiar surroundings. When patients are in hospital or in a nursing home, it is important that family members are given the opportunity to be present during the dying process. The family are facing uncertainty, emotional strain and experience the distress of watching the deteriorating condition of the patient. They need reassurance that they are doing a good job of caring for the loved one, support in adjusting to the alteration of their role.

Family members need to be with the

dying patient; they may need to care for the patient themselves; they need information about the illness, impending death and what to expect; they need to express emotions and to receive comfort. Bereavement care following a person's death is also a part of palliative care, remembering bereavement care for children as well as for adults.

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Occupational health and HIV/AIDS

Nelouise Geyer

The double disease burden of HIV/AIDS and TB has globally raised concerns about health worker protection. The ILO and WHO has jointly and independently developed a range of tools to improve protection of healthcare workers in the workplace and has now embarked on a joint venture to create a comprehensive global framework for worker protection.

The International Labour Organisation (ILO) and the World Health Organisation (WHO) established a tripartite expert working group on occupational health and HIV/AIDS for health service workers. This working group consisting of representatives from labour, employers and government met in Geneva during July this year.

WHO and ILO strongly believe that the improvement of occupational health and

Participants in the expert group:

ILO & WHO Departments and regional offices; Andrija Stampar School of Public Health; Aurum Institute, South Africa; Cairo University Hospital; Centre for Occupational and Environmental Health Research UCT Medical School Cape Town, South Africa; Hospital Personnel Trade Union of South Africa (HOSPERSA) representing PSI; International Commission on Occupational Health (ICOH); International Confederation of Midwives; International Hospital Federation; International Organisation of Employers; International Trade Union Confederation (ITUC); Joint United Nations Programme on HIV/AIDS (UNAIDS); Ministry of Public Health, Thailand; National Institute for Occupational Safety and Health (NIOSH); National Health Graduate Program, El Bosque University; Positive Practice Environments Campaign Secretariat, ICN; Royal Swaziland Sugar Corporation; Global Fund to Fight AIDS, Tuberculosis and Malaria; The University of British Columbia, School of Population and Public Health; UNISON Healthcare representing PSI; University Hospital Heidelberg; World Medical Association.

working conditions for health workers is vital. The meeting of global expert representatives provided them with an opportunity to make significant contributions to the development of a comprehensive global framework for national occupational health programmes for health workers, to review tools that will assist countries in the implementation of the framework at the national and health facility levels

and to work with other global experts to discuss and design implementation and funding strategies for these instruments. A broad mandate and a huge task for the 3½ days scheduled for the meeting. The components of the framework are contained in Figure 1. The components discussed are highlighted with stars.

Joint WHO-ILO policy guidelines for health workers

The first objective of the meeting was to review and validate the joint WHO-ILO policy guidelines for health worker access to HIV and TB prevention, treatment and care services; discuss implementation steps and roles for ILO, WHO, social partners (employers' organisations and trade unions) and other related organisations (PPE, GHWA and others) and map out implementation strategies.

The day was concluded with the government, employers and workers representatives as well as international experts unanimously endorsing the ILO/WHO joint policy guidelines. Participants suggested inclusion of monitoring, evaluation framework and advocacy tools to communicate the guidelines.

The second objective of the meeting was to consider and elaborate the establishment of a global framework for national occupational health programmes for health workers to provide countries with guidance on setting national and health workplace policies including HIV and TB. The aim of the framework is to raise policy makers' awareness of the need to improve occupational healthcare services for health workers at the national and facility level. As ministries of health develop strategic plans for managing human resources for health it is vital that working conditions such as occupational safety are included. The Framework will serve as a good entry point for considering how to comprehensively improve occupational health for health workers.

The tripartite group agreed that there is a need for such a framework and that Ministries of Health undergoing the process of defining strategic plans for the future. WHO and ILO could support the inclusion of workplace safety measures as presented in the Framework.

Elements of the global framework discussed at the meeting included the following:

1. Identify a responsible person with authority for occupational health at both the national and workplace levels.
2. Develop a written policy on safety, health and working conditions for health workforce protection at the national and workplace levels.
3. Establish and provide access to Occupational Health Service and allocate sufficient resources/budget to the programme, occupational health professional services, and the procurement of the necessary personal protection equipment and supplies.
4. Create joint labour-management health and safety committees, with appropriate worker and management representation.
5. Provide appropriate education and training to all parties, including occupational health practitioners, senior executives, front-line manager, health and safety committees, front-line workers and the general public.
6. Identify hazards and hazardous working conditions to prevent and control hazards and manage risks by applying the occupation hierarchy of controls, prioritises elimination of control at the source.
7. Provide immunisation against hepatitis B and other vaccine preventable disease and ensure all three doses of the hepatitis immunisation have been received by all workers at risk of blood exposure (including cleaners and waste handlers)
8. Promote exposure and incident reporting, eliminating barriers to reporting and providing a blame-free environment.
9. Promote health worker access to diagnosis, treatment, care and support for HIV, TB and hepatitis B and C.
10. Utilise appropriate information systems, to assist in the collection, tracking, analysing reporting and acting upon data to promote health and safety of the healthcare workplace and health workforce.
11. Ensure that health workers are provided with entitlement for compensation for work-related disability in accordance with national laws.
12. Promote research on OHS issues of concern to health workers, particularly with respect to combined exposures and applied intervention effectiveness research.
13. Green hospitals and jobs.

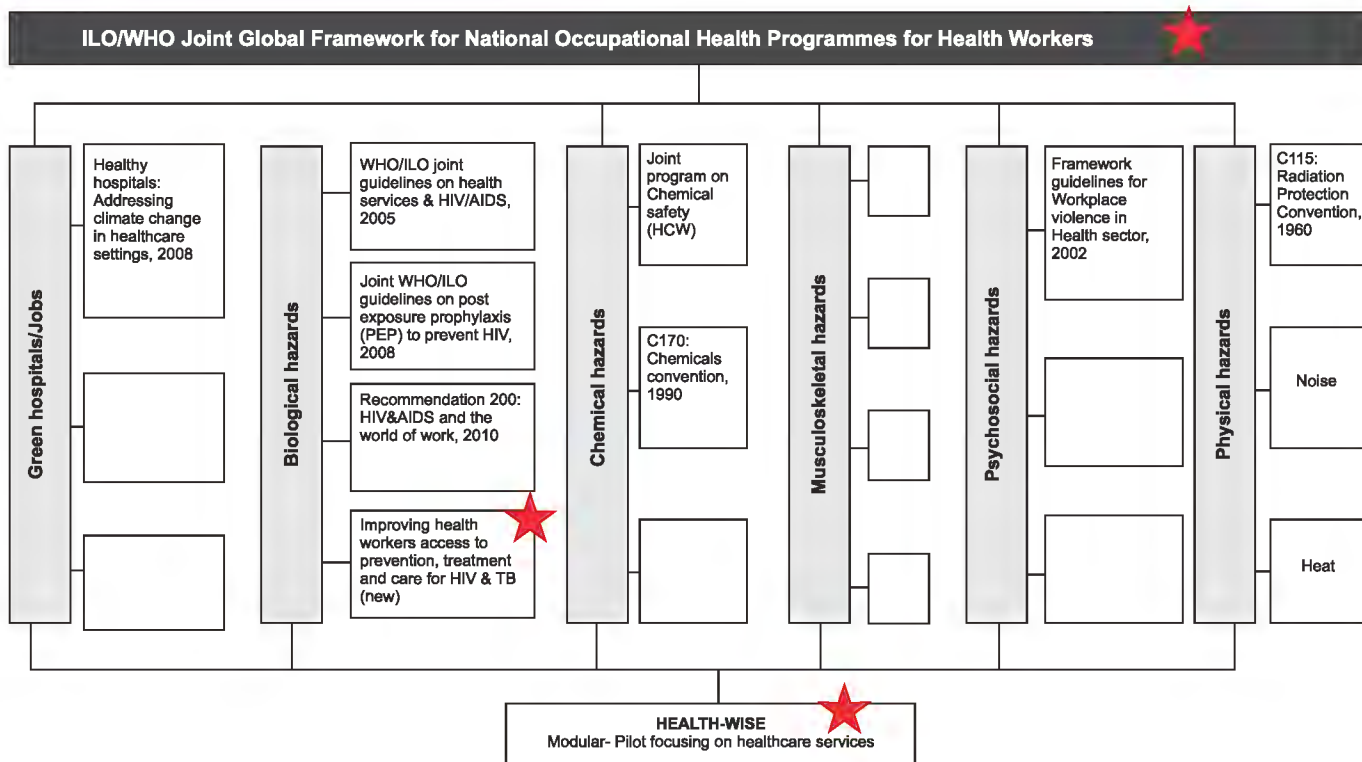


Figure 1: ILO/WHO Global Framework: OHS Programmes for Health Workers

Health-Wise tool

The third objective was to consider the development of strategies and tools to support the Framework. One of the tools currently being developed is ILO WISE+ workplace assessment tool and action manual for health facilities called Health-Wise.

The representatives discussed the broad outline, content and focus or target of the Health-WISE tool. A wide range of recommendations were made for the adaptation of the tool to ensure that it meet the needs of the healthcare sector and the framework agreed to on day one of the meeting. This manual will be accompanied by a training manual to assist trainers and the tool will be piloted in Tanzania and Senegal in a few months time before it is finalised.

Conclusion

This initiative was a big task that was pulled off in a very short time for an international initiative. The ILO and WHO, in particular the convenors Julia Lear, Lee-Nah Hsu and Myroslava Protsiv at the ILO and Susan Wilburn at the WHO must be congratulated on getting an international stakeholder



group together and a huge volume of work discussed and agreed on in a 3 ½ day workshop. The work is by no means done, but tripartite consensus was achieved on all three projects and the ILO and WHO will be responsible for finalisation of the work.

Collaborative
action for health
worker protection
is crucial



ICN CONFERENCE AND CNR
2-8 May 2011 Malta



Nurses driving access, quality and health

Deadline for abstract submissions
15 September 2010

Visit the conference website
for more information

www.icn2011.ch



competition

Competition

Competition to name the nurses magazine extended to 15 October 2010

Win a Nokia cell phone by naming your magazine

To enter a name for the magazine, send a SMS beginning with MAG (space) (Name) to 32759.

The name of the winner will be published in the next magazine.

Rules:

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

Standard SMS rates will apply.

Competition

Competition

Win some more!

Win an educational Master AIDS board game by answering these questions on the content of this magazine. The game provides the opportunity to learn, discuss and participate in information sharing on HIV/AIDS in a safe environment while having fun. The game has a reference book in which answers to the questions of the board game can be found that will assist the learning and discussion by participants.

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

GAM (space) Question number (selected answer)

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

Entries close on 31 October 2010. Only entries with the correct answers will be entered into the draw. The decision of the judges will be final.

Competition questions:

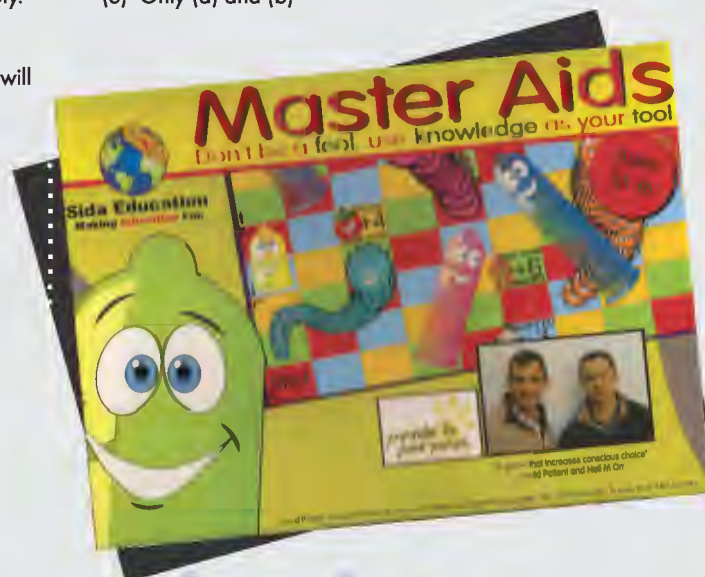
- The WHO believes that task shifting should be implemented with:
 - Pre-service education
 - Interventions to retain health workers
 - Expansion of clinical teams providing HIV services
 - Only (a) and (c)
 - All of the above
- Contra-indications for isoniazid preventative therapy (IPT):
 - Current cough for > 24 hrs
 - Fever
 - Drenching night sweats
 - Significant loss of weight
 - Lymphadenopathy >1 cm
 - None of the above

- Palliative care in HIV include:

- Pain management
- Control of opportunistic infections
- Management of respiratory symptoms
- All of the above
- Only (a)

- In Osteoarticular Tuberculosis the most commonly affected parts are:

- Spine
- Hip
- Knee
- All of the above
- Only (a) and (b)



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 kerrysolan@global.co.za, or post to: Suite 233, PostNet Killarney, Private Bag X2600, Houghton, 2041. Tel: 071 868 0789 Website: www.sahivsoc.org

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

First name: [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 []
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



to advertise in Nursing

By advertising in HIV Nursing, you reach many partners in the health industry.

Rates for 2010 are as follows:

Size	Full colour
Full page/Volblad	R 7 200-00
Half page/Halfblad	R 3 850-00
Third page/Derde blad	R 2 500-00
Quarter page/Kwartblad	R 2 030-00

Rates are subject to change

Inserts & promotional articles

The same rate as for advertisements applies to articles and inserts

Small advertisements: Available on request

These prices exclude VAT and advertising agency commission.

Digital advertising material formats.

The following are formats by which the magazine can accept digital advertisements:

- Document to be set up to advertising specifications(i.e. Ad specs)
- We don't support zip disks
- Emailed advertising material should not be bigger than 5MB (PDF, Jpeg or tiff)
- All advertising material to be in CMYK colour mode and the resolution 300 dpi
- If pictures are sent, save as high resolution (300DPI)
- Logos must be 300 dpi with a CMYK colour Breakdown
- All advertising material must have a 5mm bleed
- Press optimised PDF's on CD with a colour proof is also acceptable.
- PDFs supplied should include all fonts and in CMYK mode.

- PLEASE SUPPLY MATERIAL IN COMPLETED PDF FORMAT
- PLEASE ENSURE THE AD INCLUDES CROPMARKS!!!

SA HIV Clinicians Society

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

www.sahivsoc.org

Tel: +27 (0) 11 341 0162, FAX: +27 (0) 11 342 0161

Article/letter submissions: nelouise@sahivsoc.org



where to go

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.

where to go



**NATIONAL HEALTH
LABORATORY SERVICE**

RESULTS HOTLINE

0860

RESULT 737858

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

Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

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

Follow the voice prompts and select option 1 to register to use the hotline

A hotline registration form will be sent to you by fax or e-mail.

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

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

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

Select option 2 to access laboratory results.

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

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

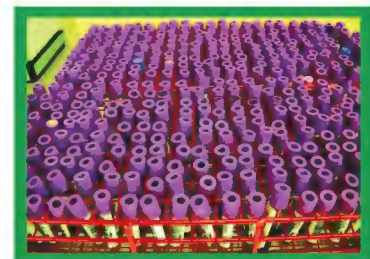
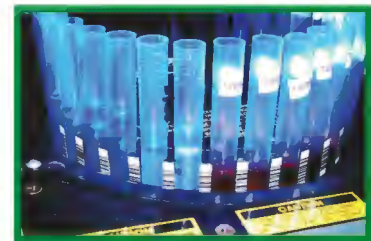
Once you have a Reference number

Select option 3 to follow up on a reference number

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

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

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





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FPD provides a comprehensive curriculum of courses in professional skills that are customised to the needs of health professionals.

- Contact us for more information on course fees and dates
- Courses are presented throughout the year and in all nine Provinces in South Africa
- Combination of self-study and facilitated workshops will be used to enable learners to master the content of the course

COURSE IN THE MANAGEMENT OF HIV/AIDS FOR HEALTHCARE PROFESSIONALS

Given the current state of knowledge on HIV / AIDS management and the fact that antiretroviral therapy is becoming more affordable, it is now feasible to approach HIV / AIDS as a chronic medical condition. This course will empower clinicians to adequately manage patients with HIV and or AIDS. This Course is available through the Foundation for Professional Development (FPD) in association with the Southern African HIV Clinicians Society. 30 CEU Points

SHORT COURSE IN MONITORING AND EVALUATION

This course aims to assist managers in producing information that is timely, accurate and relevant to a particular situation in order to make the most suitable decisions for and within their environment. The course covers the principals of practical research, the attributes of good information, the most effective ways of collecting information for your organization and how to present information to others effectively.

DISPENSING COURSE

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 healthcare 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.

HIGHER CERTIFICATE IN MANAGEMENT (HCM)

The Higher Certificate in Management is a registered qualification customised to develop the management skills of emerging managers, supervisors and team leaders. This exceptional programme develops student's management competencies and prepares them for full participation as a manager. Throughout the programme, the faculty shares important strategies in transforming the emerging manager to become effective and balanced. NQF Level 5

E- LEARNING

The FPD e-learning programmes accommodate students who find it difficult to attend workshops.

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All information on these e-learning programmes is available on our website at www.foundation.co.za

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Introduces students starting their business career, or currently in a supervisory / management position to the fundamental knowledge and skills needed in order to successfully manage diverse projects. Also suitable as preparation for students wishing to study towards the certified project management professional and PMBOK® designation. NQF Level 5

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Tel: 012 816 9000 · Fax: 086 567 0265

Website: www.foundation.co.za



FPD



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