

HIV Nursing matters

A Magazine of the Southern African HIV Clinicians Society



Preparing Nurses for Family and Community Centred Care

Sex Work Outreach Programme in Inner-City Hillbrow Johannesburg

TB/HIV Case study

June 2013 Volume 4 No. 2





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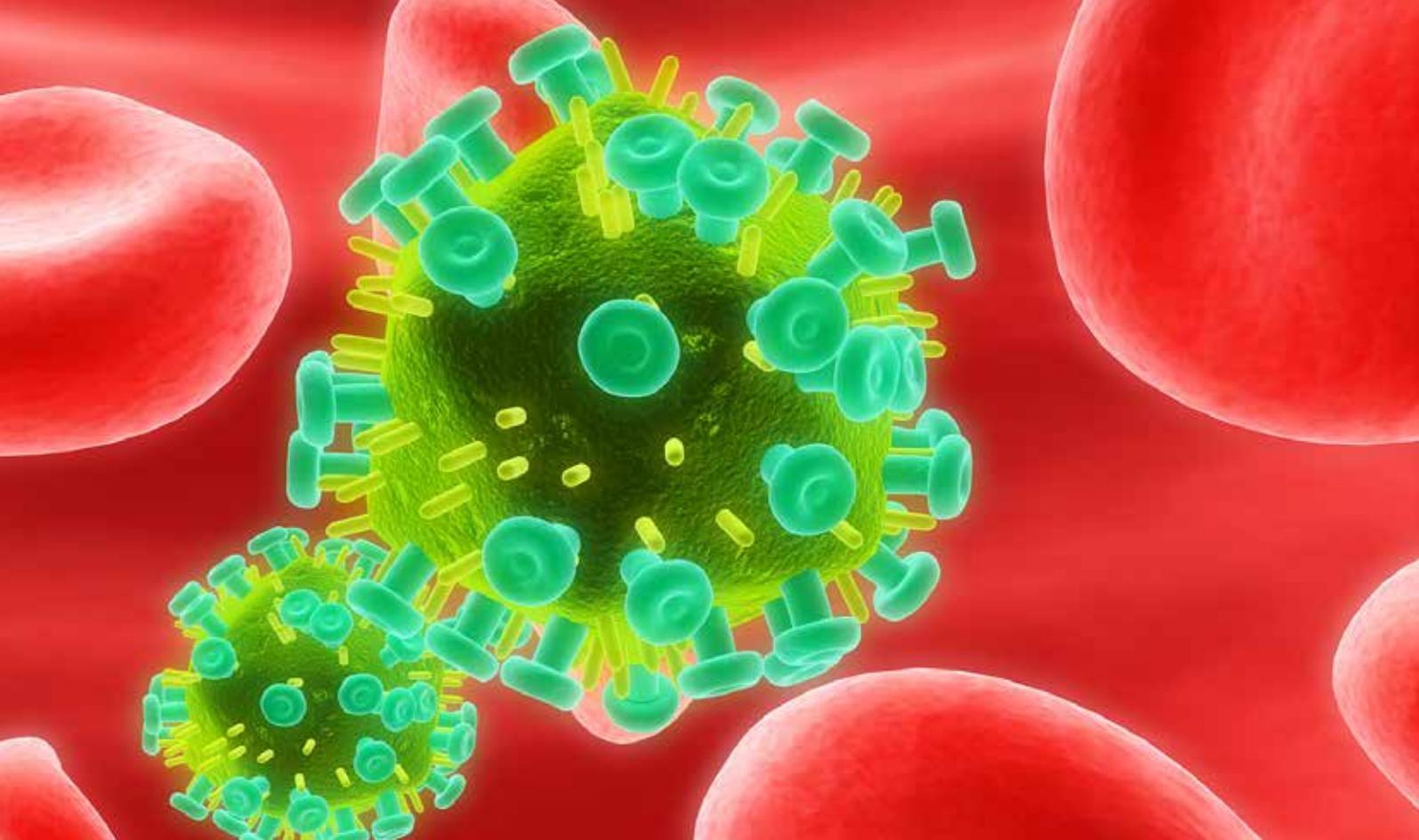
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HIV Nursing matters

focuses on Family and Community Centred Care

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Preparing Nurses for Family and Community Centred Care

Sex Work Outreach Programme in Inner-City Hillbrow Johannesburg

TB/HIV Case study

guest editorial



Dr Nokuthula Sibiya

Dr Nokuthula Sibiya (D Tech: Nursing); Head: Department of Nursing, Durban University of Technology.

There is now a shift for caring for the terminally ill community members due to diseases like AIDS or TB from hospital-based care to the family and community centered care; hence the re-engineering of PHC strategy emphasizes the importance of caring of individuals in the community.

South Africa is committed to improving the health status of the citizens and to reduce morbidity & mortality due to HIV and AIDS¹ Previously HIV/AIDS was viewed as a death sentence; however the country has moved from the era of no treatment to the provision of multiple drugs to treat the disease including programmes like HIV Counseling and Testing, Provider Initiated Counseling and Testing, Voluntary Medical Male Circumcision and antiretrovirals for Prevention of Mother to Child Transmission, among others.² Today every pregnant women and every child who is HIV infected have access to ART. One of the achievements has been the publication of the 2013 South African Antiretroviral Treatment Guidelines for implementation as from 1 April 2013.³ The guidelines highlight various strategies that the National Department of Health is putting in place

to improve HIV management and to move to more efficacious regimens. The goals of the programmes are to save lives and improve the quality of life of people living with HIV; achieve best health outcomes in the most cost-efficient manner; implement nurse-initiated treatment; decentralize service delivery to primary health care (PHC) facilities; integrate services for HIV, TB, Mother and Child Health (MCH), Sexual and Reproductive Health (SRH) and wellness; diagnose HIV earlier; prevent HIV disease progression; avert AIDS-related deaths; retain patients on lifelong therapy; prevent new infections among all age groups; and mitigate the impact of HIV and AIDS. A major stride is the fixed dose combination (FDC) which has been made available in public health institutions. The introduction of the FDC – one pill which contains tenofovir (TDF), emtricitabine (FTC) and efavirenz (EFV) – is included in the new guidelines. The FDC comes with new hopes to all affected and infected with HIV in that it reduces problems associated with pill burden and is less expensive than the individual formulations. The DoH intends to implement FDC in phases over a period of one year commencing from the 1st of April 2013.³

There is now a shift for caring for the terminally ill community members due to diseases like AIDS or TB from hospital-based care to the family and community centered care; hence the re-engineering of PHC strategy emphasizes the importance of caring of individuals in the community. This edition of HIV Nursing Matters contains articles related to social aspects of HIV and AIDS. Ms N Motlokoa and JM Sibanyoni share the activities of the sex work outreach programme which involves taking the health services to the brothels and managing the sex workers in their own environment. Masamo Lekhuleni outlines the preparation of nurses for family and community centered care since caring for clients with HIV and AIDS in their

families can be a challenging experience for health care professionals and in particular nurses as the primary care givers. An article by Ms H Mackenzie on the profile of the Topsy Foundation gives us a background of what the Foundation is all about. The Topsy Community Outreach Programme offers vital social, medical, psychological and nutritional support to hundreds of patients, the people in their lives and others infected with and affected by HIV and AIDS. Ms KE Mokoka tackles the issues on community dialogue and mobilization in order to empower the community to take charge of their health in an interactive and collective manner. Community Media Trust (CMT) as explained by D Van Zyl and JP Zeelie in their article is a non-governmental organisation (NGO) that empowers individuals and communities to increase their health seeking behaviours through increased knowledge and awareness. A TB/HIV case study presented by Stacie Stander draws our attention to the co-infection between TB and HIV. These articles emphasize a need for the community to take ownership of their own HIV and AIDS prevention, treatment and care. [®]

This edition of HIV Nursing Matters contains articles related to social aspects of HIV and AIDS

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Message from the president

HIV Nursing matters

The Team

Guest Editorial: Dr Nokuthula Sibiya

President: Dr Francesca Conradie

Editorial Advisory Board:

- Dr Elizabeth Mokoka
- Ms Stacie Stender
- Dr Natasha Davies
- Ms Laurie Schowalter
- Ms Nelouise Geyer
- Dr Michelle Moorhouse
- Ms Nonhlanhla Motlokoa

Contributors: Monument Trust

Advertising: Chriss Nyalungu
E mail: Chriss@sahivsoc.org
Tel: (011) 728 7365

Article /Letter submission:
Ms Nonhlanhla Motlokoa
E mail: Nonhlanhla@sahivsoc.org
Tel: (011) 728 7365

For more information contact
SA HIV Clinicians Society
Suite 233 Post Net Killarney
Private Bag X2600
Houghton
2041

www.sahivsoc.org

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Dr Francesca Conradie:
President Southern African
Clinicians Society
Fifteen by Fifteen.



the driving force behind HIV care and treatment, we need to come up with more innovation. How can we reach the more difficult to reach? How do we go about finding them and once we have tested the more difficult to reach individuals, how do we go about getting them into care and keeping them in care?

If you are reading this magazine, you are one of those health care workers who are interested in finding a way ahead. We need to care not only for individuals who have HIV but their whole families. And even more than that, we have to make whole communities places of safety for all- HIV infected individuals. As the old saying goes, it takes a whole village to raise a child; it is going to take whole villages to effectively care for all those who have HIV and whole villages to prevent further infections. No one will be exempt from the fight. From spiritual and political leaders, taxi drivers, shop owners, mothers, fathers, daughters, sons, teachers, nurses, doctors- we are all in this together. [®]

People no longer have to go to tertiary hospitals for the treatment of their HIV. We have undergone a paradigm shift in health care.

As the old saying goes, it takes a whole village to raise a child; it is going to take whole villages to effectively care for all those who have HIV and whole villages to prevent further infections

This is a strategy from UNAIDS to get 15 million HIV infected individuals onto antiretrovirals by the year 2015. So far, we have reached about 8 million. There is still so much work to be done. As HIV treating health care workers, we have made great strides in the right direction. We have decentralized services. People no longer have to go to tertiary hospitals for the treatment of their HIV. We have undergone a paradigm shift in health care. Task shifting means that responsibilities that used to belong to say doctors have been shifted to nurses and tasks that used to belong to nurses have been shifted to non-clinical staff. But more is going to be needed if we are going to reach our target. While innovation has been



news

Nursing Strategy: Nursing Education, Training & Practice launched

Nelouise Geyer
Member of the Ministerial Task Team on Nursing Education and Training

The uniform allowance should be phased out over a three year period and be replaced with the direct provision of contemporary white uniforms provided by employers. OSD and other allowances for nurses are to be addressed by the bargaining councils.

The revised Nursing Strategy was launched by the Minister of Health on 11 March 2013 at the Birchwood Conference Centre in Boksburg. The launch follows extensive consultation with the nursing profession.

Recognising the need for consultation

South Africa has predominantly nurse-

based healthcare system which requires nurses with the competence and experience to manage the country's challenging quadruple burden of disease. The high prevalence of HIV which impacts on human resources in the health sector, poor health outcomes for the budget spent on health and shortages of healthcare professionals are among the challenges highlighted in the HRH Strategy for the Health Sector: 2012/13 -

2016/17. Recognising the depth of the challenges facing nursing, the Department of Health convened the National Nursing Summit held in April 2011 at the Sandton Convention Centre, Johannesburg. The aim of the Summit was to *reconstruct and revitalise the Nursing Profession for a Long and Healthy Life for All South Africans*. The challenges were highlighted under seven themes, namely nursing education and training;

resources in nursing; professional ethos and ethics; governance, leadership, legislation and policy; positive practice environments; compensation, benefits and conditions of employment; and nursing human resources for health.

Developing a plan of action

The consultative Summit culminated in a Nursing Compact providing a summary of the collective decisions taken at the event. The Minister of Health appointed a Task Team (MTT) on Nurse Education and Training to refine the recommendations contained in the Nursing Compact and to develop a plan of action to address both education and practice issues relating to the profession. The MTT commenced its work in October 2011.

The MTT worked with reference groups consisting of members of the profession with relevant expertise and experience in the different themes, supported by contributions from the broader profession. The outcome is a proposed programme of action with recommendations for each of the seven thematic areas which were presented at provincial workshops to disseminate information and raise awareness of the Strategy.

Recommendations

The recommendations of the MTT are reflected in the seven thematic areas identified.

Education & training of nurses

One of the strongest and most urgent recommendations is the need for nursing colleges to be declared higher education institutions in compliance with the provisions of the Higher Education Act (as amended in 2008). Failure to do so will mean public nursing colleges, the primary training platform for nurses, will be unable to continue training after 30 June 2015, the deadline for the registration of current qualifications, with dire implications for the current nursing shortage. Nurse Education and Training is a national competence that should account to the Director General of Health. This will help to address provincial inequalities, norms and standards, quality,



From Left to Right: Dr Brigid Strachan, Ms Catherine Makwakwa, Ms. Maureen Sithole, Prof Judith Bruce, Prof Laetitia Rispel, Dr Aaron Motsoaledi, Minister of Health, Ms Daisy Mafubelu (MTT Chairperson), Dr Siphon Mkhize, Ms Nelouise Geyer

decrease fragmentation, eliminate 'fly by night' Nursing Education Institutions (NEIs), improve clinical training and enhance social accountability.

Nursing students should have the status of full student (rather than employee) while undergoing their training. They should receive funding support for tuition, books and study materials, living costs, medical aid and indemnity insurance which should be paid monthly, while tuition fees should be paid directly to NEIs. Accommodation, uniforms and transport for training should be provided. Students should undergo a rigorous selection process by NEIs to attract suitable candidates to the profession. In order to promote the quality of practical hands-on training, students are to be placed in a variety of health establishments linked to all NEIs for their clinical training. Clinical education and training must be strengthened by re-establishing

Nursing students should have the status of full student (rather than employee) while undergoing their training.

clinical teaching departments at all NEIs or hospitals, supported by a co-ordinated system of clinical preceptors and clinical supervisors. This must be accompanied by the requisite resources from the relevant authorities.

Resources in nursing

Resources should also be made available to strengthen nurse educators and nurse managers for their roles and responsibilities in addition to the revitalisation programmes already planned for healthcare and educational institutions.

Professionalism & ethics

Professionalism and ethics that emphasise caring should be core, compulsory modules at all levels of nursing and midwifery training in order to address the image of nurses and nursing. A Continuing Professional Development (CPD) system for all nurses and midwives, linked to annual licensing and professional progression, must be introduced urgently and should include professionalism and ethics as a compulsory component.

Governance, leadership, legislation and policy;

It was agreed at the Summit that an office of the Chief Nursing Officer (CNO) would be established and a permanent appointment be made as a matter of urgency. This recommendation is in progress.

Positive practice environments;

Positive Practice Environments (PPE), already partially incorporated in the national core standards, are essential for both nursing education and practice. The MTT recommends that PPE should also include orientation and induction programmes for new staff; formal education opportunities; provision and utilisation of appropriate and effective information, communication technology (ICT) for clinical practice and education.

Compensation, benefits and conditions of employment;

The uniform allowance should be phased out over a three year period and be replaced with the direct provision of contemporary white uniforms provided by employers. OSD and other allowances for nurses are to be addressed by the bargaining councils.

Nursing human resources for health

National nursing norms and guidelines are essential for healthcare planning and safe patient care. This should strike a balance between ideal staffing, what is a safe guideline and what is affordable. A combination of the World Health Organization's (WHO) population-based norms and activity based workload approach should be used to determine safe staffing norms for nursing in South Africa. This process has been initiated. [®]

Blame game begins after initiates' deaths

May 17 2013 at 10:36am
by BOTHO MOLOSANKWE



Johannesburg - The Mpumalanga Department of Health was allegedly asked to be on standby and offer assistance when the first deaths of initiates were reported in the province.

However, they allegedly took their time, and by the time they responded, it was already too late. Many more boys had died, and the number was rising.

This is according to Kgosi Mathibela

The Mpumalanga Department of Health was allegedly asked to be on standby and offer assistance when the first deaths of initiates were reported in the province. However, they allegedly took their time.

Mokoena, chairman of the House of Traditional Leaders in Mpumalanga, who said that while they won't point fingers now, they had tried to get the department involved from the beginning in order to prevent more deaths.

"When the first few deaths were reported, we called them for help to be on standby, but they took their time," Mokoena said.

So far, 23 youths, aged between 13 and 21, have died.

“When the first few deaths were reported, we called them for help to be on standby, but they took their time,” Mokoena said.

The initiation started on May 8 and more than 30 000 youths attended. The first deaths were reported on the very first day.

The numbers kept going up, with the last death reported on Saturday marking the highest number of deaths of initiates ever recorded in the province.

Everyone was left feeling alarmed.

The Department of Co-operative Governance and Traditional Affairs sent mobile clinics to the schools so that health

workers could check on the youths.

Police have opened murder dockets, but no arrests have been made.

The Department of Health is also looking into the matter, with Mpumalanga’s House of Traditional Leaders carrying out its own investigations.

People are also being sent to monitor the schools on an hourly basis.

Health Department spokesman Ronnie Masilela denied allegations that they had not responded in time.

“We were there. We went on site and we checked on them. Anyway, I can’t tell you much now, let’s wait for the report,” he said.

The deaths occurred in Kwaggafontein, Middelburg, Verena, KwaMhlanga, Belfast and Siyabuswa.

Mpumalanga police spokesman Colonel Leonard Hlathi said some of the youths had already been buried and post-mortems carried out. The causes of death have not yet been revealed. But Mokoena said their preliminary investigations had revealed that some initiation school owners could have been negligent.

While all the schools were legal, he said, the problem had been that some owners had hired young and inexperienced people to look after the youths.

“You need an elderly person to look after the initiates... We have a law that states clearly what must happen, and these owners who were negligent in these cases will face the music,” Mokoena said emphatically. [®]

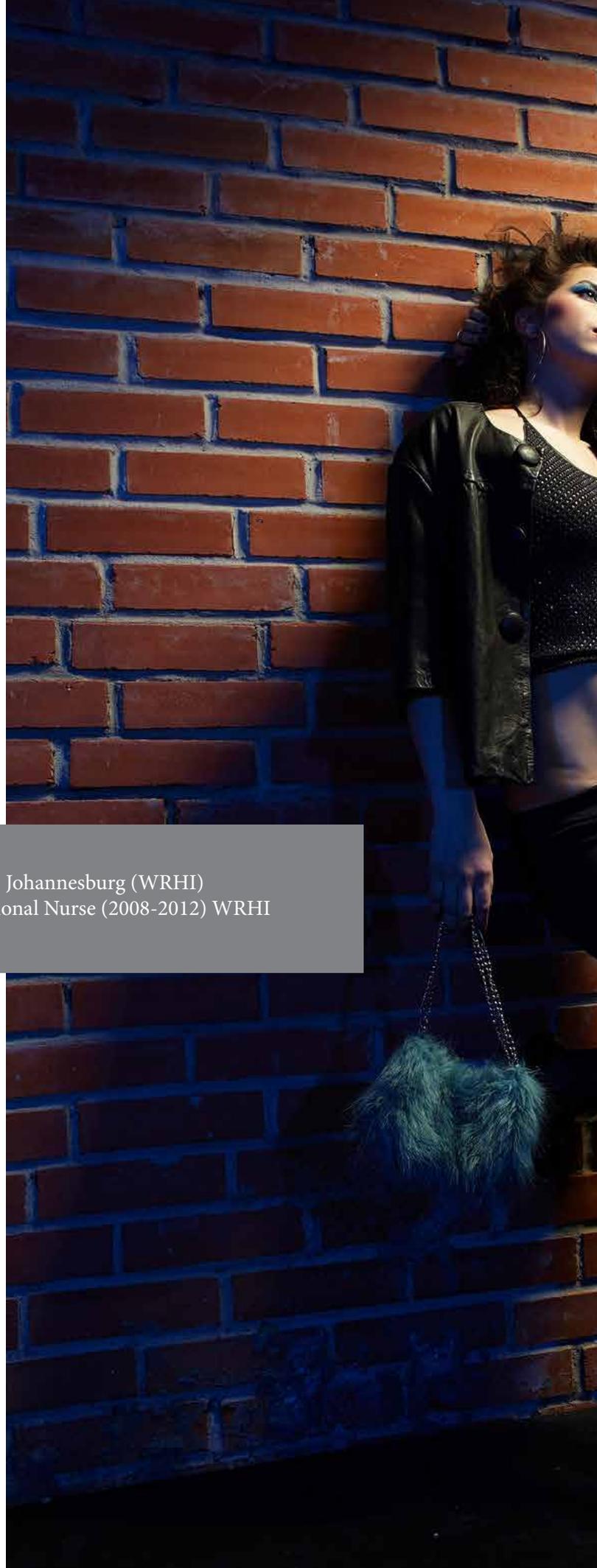
botho.molosankwe@inl.co.za
The Star



Sex Work Outreach Programme in inner-city Hillbrow Johannesburg

N Motlokoa, J.M Sibanyoni
Wits Reproductive Health and HIV Institute, Johannesburg (WRHI)
N Motlokoa, Nurse Project manager, professional Nurse (2008-2012) WRHI
J.M Sibanyoni, Nurse Programme manager

Sex worker's clients and partners were welcomed to attend the clinic whenever they needed services; therefore it became easy to counsel them as couples





Introduction

The HIV pandemic has brought the concept of “transactional sex” to international attention. Although policies and programmes usually target sex workers, less formal arrangements where gifts or money are provided within sexual relationships have been found to be wide spread and a driving force of the epidemic, particularly in Sub-Saharan Africa (Luke, 2003, Cote et al. 2004)¹

Financial arrangements between a sex worker and a client occur in brothels, bars, hotels, saunas, homes or on the streets (Steinfatt, 2002).¹ Sex workers have an almost 13 times higher risk of acquiring HIV infection than other women of reproductive age in low and middle-income countries.^{2,3} They face challenges of negotiating safer sex, have sex with multiple partners and exploitation by corrupt law enforcers is common - harassment, bribery and extortion increases vulnerability.⁴ In 1998, HIV prevalence among different female sex worker groups in South Africa ranged between 46% and 69%.⁵ In a 2004-2005 Durban study, 775 women at high risk for HIV infection- 78.8% of whom self-identified as sex workers- were screened, and 59.6% were found to be HIV positive. More recent estimates are not available.⁵

How Sex Worker Programme started

The programme started in 1994 when WRHI (Wits Reproductive Health and HIV Institute) (previously known as RHRU) was involved in research projects investigating different HIV prevention strategies (microbicides, female condoms), and all the research participants were sex workers from Hillbrow. It became evident that sex workers were not accessing mainstream STI and reproductive health services had a particular need for these.⁴ The reason why sex workers were not able to access health care is that; they feared being harassed by police officials, especially since some of them were undocumented migrants; fear of being

stigmatized by health personnel and fear of being noticed by someone they know from the community. After that realization the Sex Worker Project was initiated, collaboration between RHRU, DoH (Department of Health) and the City of Johannesburg (CoJ) was established. The fully fledged clinic which is based at Hillbrow, Esselen street clinic was set up, CoJ and DoH provided equipment, condoms and STI treatment to the project. Health services were taken to the brothels and the sex workers were treated in their own environment. The programme grew so much that the year 2000 they started hiring 2 professional nurses and 2 Community health workers. (M. Pleaner et al 2009)⁴.

Aim & Objectives

The aim of the programme is to decrease the rate of STI's and HIV transmission amongst sex workers

- To minimise the rate of termination of pregnancies and unwanted babies by providing family planning services.
- To identify potential exit opportunities for those sex workers wanting to exit the industry, through HIVSA course (Counselling and testing diploma course), beauty therapy, catering and baking skills, computer literacy and English classes.
- To provide psycho-social support in order to address emotional needs and past trauma.
- To identify younger exploited sex workers (below 16 years) and integrate them back into their families.

Sr Motlokoa was employed by RHRU from 2008-2012 as a professional nurse and later promoted to manage the project. Although she was managing the project she was still hands on providing health care to sex workers and going out to the brothels with the team members. She was working with 1 professional nurse, 4 Community Health Workers (2 males and 2 females), and 10 peer educators (who were still sex workers).

Services Offered

The clinic provides services in two sessions, the first session is between 08h00-12h00 where all the services are rendered at Esselen clinic and the second session is between 13h00-16h00 where services are rendered at the brothels, private houses and street based. The clinic was operating from Monday-Friday, a brothel roster was developed monthly which showed brothels that were to be visited and when. There were 23 brothels where the team was providing services.

The following services were offered:

- Provider initiated HIV Counselling and Testing
- Diagnosis and treatment of STI
- Initiating Antiretroviral Therapy (ARV's) to those who were eligible
- Providing Wellness Care to those not yet eligible to start ARV's
- Providing Family Planning services, including referring for Termination of Pregnancy
- Condom distribution to all brothels
- Treatment of minor ailments
- Performing PAP smears and refer all those in need of Colposcopy and Biopsy of the cervix
- Referral to other psychosocial service providers like SANCA (Alcohol & Drugs Centres), Social Welfare, Legal Aid organisations.

Brothels were accessed through the project car and the street based hot spots were accessed through the mobile van. A paramedic bag was used to carry all the medication and equipment used at the brothels, other equipment carried were sharps containers to dispose of used needles, test kits, cooler bags, files, biohazards plastic bags etc. The brothel manager organised a room for the team to provide services and the patients would queue outside the room waiting to be consulted by the team.

Sex worker's partners and clients

Sex worker's clients and partners were welcomed to attend the clinic whenever they needed services; therefore

it became easy to counsel them as couples. Educating and supporting HIV discordant couple was also easy if they come as a couple. Male Community health care workers employed recruited males from the brothel bars. Most of the males consulted for HCT and STI's and very few consulted for minor ailments. Condoms were also issued to them and they also received condom demonstration sessions, those found to be HIV positive were referred to their nearest clinic for continuity of care, although they preferred to attend the Sex worker clinic because they state that the staff is friendly and the queue is fast.

Peer Education Project

The peer education programme is a programme whereby sex workers are recruited by WRHI to be trained in health, sexual and reproductive issues and in return they educate their peers (other sex workers) about health issues more related to sex work.

For someone to join the sex work project as a peer educator, she/he needed to be a sex worker because he/she will know exactly how to approach her/his colleagues and there will be no culture shock experienced. The courses covered during training

include: STI's, condom usage, family planning, cervical cancer and HIV. On a monthly basis Sr Motlokoa used to train them on different health issues and also check competency and knowledge learnt. They were earning a stipend of R1500.00 per month worked 4 days a week and 4 hours a day.

Peer education duties range from recruiting sex workers and their clients/partners to attend the clinic, educating them on health issues and especially condom use, distribute condoms, assist with identifying new hot spots or brothels that needed health services. Health education was given everywhere at the brothel e.g. at the bar, sex worker's rooms, on the queue while waiting to be seen, on the stairs, and it was informal and mostly on a one on one basis. The peer educator's knowledge was tested on a monthly basis to make sure they disseminate correct and up to date information.

These peer educators were an inspiration to their peers, some of them end up exiting sex work and find employment within the health sector e.g. HIV Counsellor, Community Health Care worker etc.

Sex workers are part of the community, engaging in risky sexual activities with members of the community, so it is vital to provide health care to them in order to curb the spread of HIV and STI's within the community.



Sr Motloka in one of the rooms

Sr Motloka managed to find permanent employment for three peer educators while she was managing the project and they are still working there (WRHI and Sisonke Sex work Movement) and earning a salary. They self-reported that through that opportunity they have stopped sex work and concentrating on improving their lives, the whole experience made them feel important within the society and their friends envy them.

Challenges

Many challenges were encountered:

- The main one was staff shortage especially the professional nurses; most nurses were not keen to work with sex workers. This became evident when nurses from the temporary employment agency only come for few days and never finish a shift allocated to them by the agency.
- Safety at the brothels and on the streets was also another challenge, the team did not have security guards and some places that we used to work in were unsafe.
- Sometimes fights among the sex workers would erupt right in front of you and when that happens you

need to find a safe place as soon as possible.

- It was also emotionally challenging having to deal with painful stories that happened to the sex workers.

Conclusion

Sex workers are part of the community, engaging in risky sexual activities with members of the community, so it is vital to provide health care to them in order to curb the spread of HIV and STI's within the community. Health care workers should be accommodating and have a non-judgemental attitude towards sex workers⁶. It is important for health care providers to be sensitized to working with sex workers, sensitization training programmes should be introduced to health providers to prepare them on how to engage with sex workers so that they might offer quality services to the sex workers.

The study done by Marlise Richter, 2010, at Hillbrow, showed that where sex work specific clinic was operational, sex workers were less likely to have unprotected sex than those in other sites⁵. Therefore condom distribution amongst this population is very imported.

To have a successful sex work project, forging relationships with the brothel owners and other gate keepers who control access to the population is critical because most sex work in Hillbrow is conducted through brothels. Establishing a dedicated non-judgemental health care team that works in close collaboration with sex workers is crucial because that will enable them to gain trust from the sex workers. On-going consultation with sex workers in the design, planning and implementation of the programme remains fundamental to its success. Providing specialized services to a sex work population is an important strategy for the prevention of STI's/ HIV and should be expanded to other communities (M. Sibanyoni et al, 2011)⁷. 

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Giving communities a voice

Community Dialogue and

K E Mokoka. RN, PhD.

People learn, discuss and share experiences and exchange ideas about what they believe needs to change in their circumstances and how to start implementing change

In the last three decades or so, huge investments have been made in HIV/AIDS prevention, treatment and care interventions, including health education, condom distribution, HIV counselling and testing, antiretroviral treatments and care in general. However, some studies have shown that in certain communities, HIV infection rates continue to rise, stigma still prevails and non-adherence to treatment, combined with loss-to-follow up, still remain high¹

One of the reasons cited regarding the failure of implemented HIV/AIDS programmes in having marked impact on health outcomes is that planning, interventions and programme activities are conceived by external experts and imposed on communities in "top-down" ways. This might result in activities failing to resonate with the actual needs and interests of target communities^{2,3}. Too often target communities are regarded more as passive recipients of services rather than active participants working in partnership with health professionals to improve their health⁴. Community involvement is increasingly being seen as a vital precondition for creating "health-enabling" social environments, where people have a voice in matters pertaining to their health. Not having a voice, where little attention is paid to peoples' needs, social and cultural contexts, might present barriers to how people view and perceive well-intentioned interventions. Two key elements, community dialogue and community mobilisation are critical in giving a voice to



e in HIV/AIDS prevention: Community Mobilisation



target communities^{3,5}. The two elements can be regarded as mutually inclusive and cyclical, with one leading to the other.

Community dialogue

Community dialogues, also referred to as social dialogues, are a platform which brings together institutions, individual men, women and the youth to address the social drivers of issues confronting them, including HIV/AIDS and topics such as gender-based violence, crime, substance abuse and social or traditional practices which have an impact on their wellbeing or even threaten their livelihood.⁴

Importance of community dialogue

Through dialogue communities are empowered by being given the opportunity to find the words to express themselves about how they feel and think about the world around them. People learn, discuss and share experiences and exchange ideas about what they believe needs to change in their circumstances and how to start implementing change. They can identify barriers to change and can decide together what steps to take. Community dialogue builds peoples' ability to solve problems and may even lead to behaviour change from existing practices and patterns of behaviour such as unsafe sexual encounters, which predispose them to HIV infection and other Sexually Transmitted Infections (STIs). Such involvement creates the experience of belonging and being heard and often leads to taking ownership of planned actions within the community⁴

However, there is a need to support communities in establishing platforms for social dialogue.

Building community dialogue

Research on HIV-prevention strategies show that people in various communities where such studies were conducted, had relatively high levels of HIV/AIDS related knowledge, but this knowledge might have been undermined by social factors such as gender and low literacy levels. This led to people being unable to apply the relevance of this knowledge to their own lives⁶. It has also been pointed out by various schools of social psychology that behaviour change is not only influenced by information and education provided, but also by levels of self-confidence in one's ability to change one's behaviour within a society where such information or education is given. All that is required is for programme implementers to take cognisance of social dynamics such as gender, literacy levels, socio-economic status and others, which might affect programmes positively or negatively⁷.

Community mobilisation

Community mobilisation is a strategy which seeks to create social change by building awareness and empowering community members to take charge of their health in an interactive and collective manner. Reaching out and empowering communities can be through peer education and social dialogue⁸.

Strategies for community mobilisation

Several strategies have been identified for community mobilisation and were

tested in a study conducted by Project Accept across multiple site locations in Thailand, Tanzania, Zimbabwe and South Africa. The objective of the study was to test the efficacy of community mobilisation coupled with other community-based interventions will, amongst other actions, stimulate discussions about HIV and ultimately decrease HIV incidence. Community mobilisation can open communication channels and help strengthen HIV awareness in communities⁸. The study further identified seven major community mobilisation strategies, namely:

- Stakeholder buy-in - this enables implementers and partners to gain support and co-operation, especially from community leaders. It is also critical to follow correct administrative procedures and channels before accessing or approaching the community.
- Formulating community coalitions - this entails the formation of community working groups and volun-

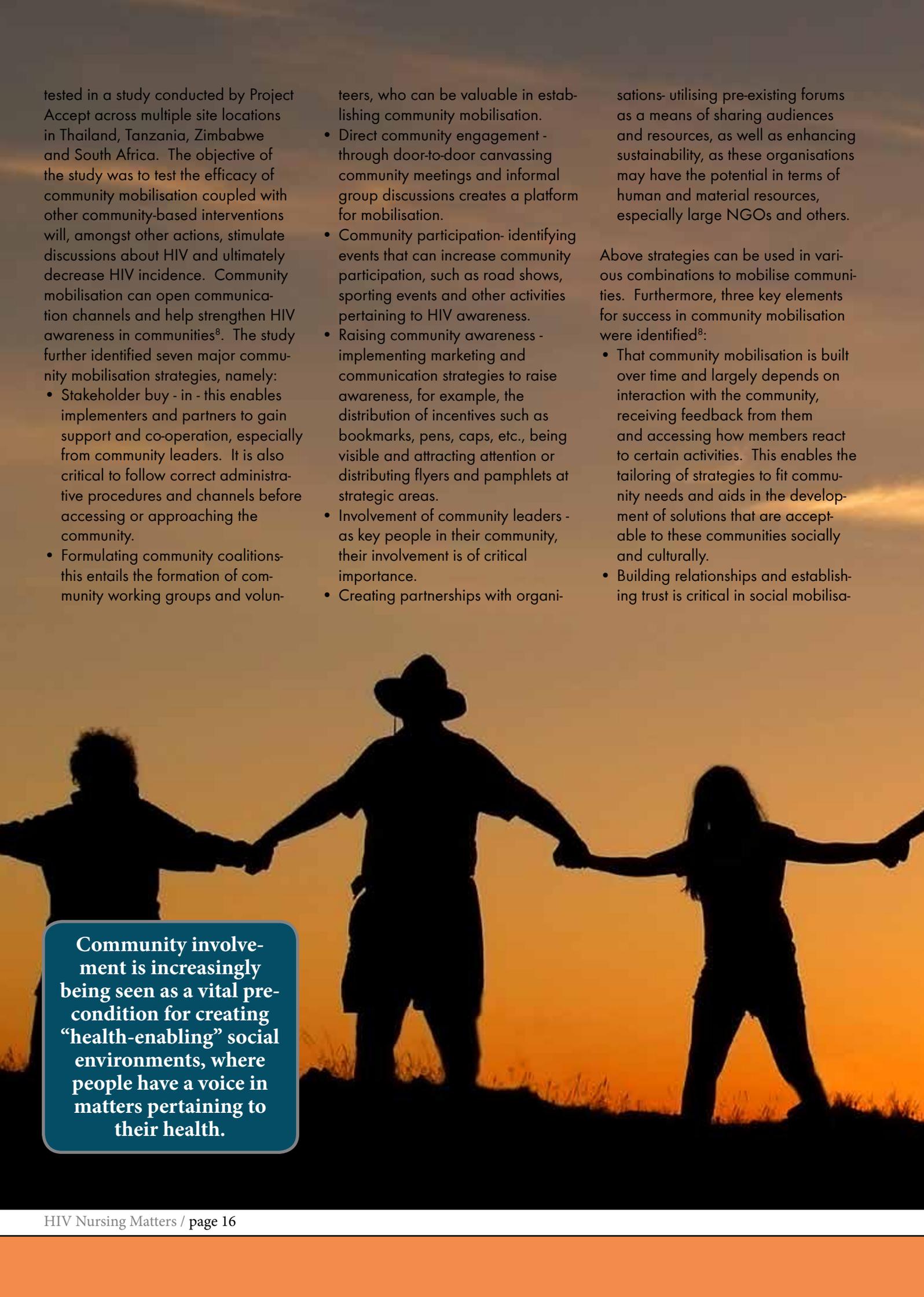
teers, who can be valuable in establishing community mobilisation.

- Direct community engagement - through door-to-door canvassing community meetings and informal group discussions creates a platform for mobilisation.
- Community participation - identifying events that can increase community participation, such as road shows, sporting events and other activities pertaining to HIV awareness.
- Raising community awareness - implementing marketing and communication strategies to raise awareness, for example, the distribution of incentives such as bookmarks, pens, caps, etc., being visible and attracting attention or distributing flyers and pamphlets at strategic areas.
- Involvement of community leaders - as key people in their community, their involvement is of critical importance.
- Creating partnerships with organi-

sations - utilising pre-existing forums as a means of sharing audiences and resources, as well as enhancing sustainability, as these organisations may have the potential in terms of human and material resources, especially large NGOs and others.

Above strategies can be used in various combinations to mobilise communities. Furthermore, three key elements for success in community mobilisation were identified⁸:

- That community mobilisation is built over time and largely depends on interaction with the community, receiving feedback from them and accessing how members react to certain activities. This enables the tailoring of strategies to fit community needs and aids in the development of solutions that are acceptable to these communities socially and culturally.
- Building relationships and establishing trust is critical in social mobilisa-



Community involvement is increasingly being seen as a vital precondition for creating “health-enabling” social environments, where people have a voice in matters pertaining to their health.

tion. These can be built over a period of time

- The uniqueness and individuality of each community needs to be taken into consideration. Different communities will see different actions as promoting social mobilisation. True too with different age groups. The youth might view certain social activities such as sport or school dramas as a platform for social mobilisation, while the older generation can be mobilised in church or other similar gatherings. Key to this is flexibility and recognition of the community's unique needs

Challenges to community dialogue and mobilisation

Successful implementation of community dialogue and mobilisation strategies depend on a number of factors, including literacy level, lack of awareness, access to information and the level of empowerment in a community². A study conducted in India

highlighted the problem where there were no community – based networks promoting dialogue and mobilisation. Rural areas in certain districts were not receiving adequate attention with regard to HIV care, despite 72% of the population in India living in rural areas, with an HIV prevalence of 0.25%^{9,10}. It was found that HIV awareness, fuelled by low literacy levels, cultural traditions such as gender inequity, considering discussions on sexual topics as taboo, limited spousal communication on sexual health and stigma, was very low in rural populations. In response, six non-governmental organisations (NGOs) developed a peer education model for rural communities. Taking the low literacy level into consideration, information, education and communication (IEC) material, was made very simple, and cartoon-based. Results showed that over 30000 rural people were reached through interactive engagement and one-to-one communication^{9,10}. Peer education, through

people from the communities can be an effective and culturally appropriate way of disseminating HIV awareness information in communities.

This is however not possible if the community is not active in participating, does not support the ideas put on the table or does not have the capacity in terms of knowledge to plan, implement and evaluate activities, not the support resources and an enabling environment to support such activities. It is evident that the community cannot work alone, but will need to be an extension of community health services.

Strengthening community dialogue and mobilisation

Community participation can be strengthened by providing information training and guiding the community to identify their own problems, examine alternative ways to solve them, implement community acceptable strategies within their specific cultural



and societal norms and the learn from their experience. Communities are best positioned to identify, challenge and transform harmful norms and practices. This can be facilitated by the NGOs or community health workers who are functional and even in these communities. Bringing people together, creating spaces where they are able to express themselves freely and supporting them to discuss and act to solve their issues, it a powerful and successful strategy of promoting self-reliance and community engagement. Community leaders have a key role to play in ensuring successful community engagement.

To address this issue, Campbell et al^{11,12} refer to "AIDS competent communities", which are defined as communities where local people work together as a collective and support one another in achieving gains in HIV - related activities such as sexual behaviour change, stigma reduction, care and support as well as cooperating with organisations working in their communities. The authors identify six characteristics or features of AIDS competent communities:

- The community has access to HIV/AIDS-related information in order to have the knowledge and skills to provide care and support and also avoid HIV-infection
- There are social spaces where social dialogue can take place, with members feel free and confident to debate issues and obstacles to issues confronting them, as a first step towards developing plans to address such issues
- Communities have a sense of ownership of the problems and the ability to take responsibility to contribute towards managing confronting issues, without wanting government or NGOs to solve the problems for them
- Community members should feel confident that they are able to contribute towards tackling issues confronting them
- Community members should be able to identify ways in which they are

able to contribute as a community and as individuals, ranging from the tiniest or smallest of gestures like accompanying a sick person to the clinic, visiting the sick, helping with housework, etc., to larger interventions such as fundraising or making a huge monetary donations or volunteering as a community health workers.

- The community must form partnerships with other communities and partner NGOs, for support and sharing of skills.

Conclusion

Community dialogue and community mobilisation are key strategies in building communities that are able to take ownership of their own HIV/AIDS prevention, treatment and care modalities as active participants and not as recipients of care. Social dialogue provides opportunities for people to discuss issues confronting them in their homes, families and communities, within a wider, social and cultural context, prioritise such issues, explore possible interventions within their means, make decisions collectively and agree on resources to the benefit of all. This leads to social mobilisation, where people take ownership and are moved to act on their own behalf as a collective. Promoting social discussions and dialogue and developing AIDS competent communities requires building knowledge and skills, creating safe social spaces for dialogue, promoting ownership and responsibility, building confidence in local strengths, mobilising such strengths, building relationships and partnerships in communities to enable them to function effectively in taking on challenges that affect their health and specifically in applying strategies on HIV prevention. 

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A photograph showing a female nurse in blue scrubs and a white long-sleeved shirt standing and smiling as she serves a tray of food and a white mug to an elderly man with grey hair sitting on a beige sofa. Another person is partially visible in the foreground, looking towards the nurse and the man. The setting is a bright, well-lit living room with large windows in the background.

Mentorship refers to the process by which Professional Nurses who are mentors pass their wisdom of caring and technical skill to the neophytes in nursing

The Preparation of Nurses for Family and Community Centred Care

ME Lekhuleni
D Cur, RGN, RGM, CHN, Admin, Nursing Education
Department of Nursing Science, School of Health Sciences, Faculty of Health Sciences, University of Limpopo

Introduction

Caring for HIV/AIDS family member has shifted from hospital-based care to the family and community centred care. The Department of Health's National guidelines on Home-based/Community centred care defines home-based care as the provision of health services by formal and informal care-givers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards dignified death¹. Caring for people living with HIV/AIDS within their families can be a challenging experience for health care professionals, and in particular nurses. Helping a person with a serious illness such as HIV/AIDS is a huge responsibility, especially as the illness progresses and the patient's condition deteriorates². Nurses should visit the patients at their homes to assess the home circumstances, support the family members regarding basic care, disclosure issues, drug storage and administration, and to address adherence and non-adherence issues. Nurses should be guided and prepared during pre-service and in-service learning regarding family and community centred care. The guiding principles in this preparation of nurses should be based on the Constitution of the Republic of South Africa, the Nursing Act, 33 of 2005, the Batho-Pele Principles, the Millennium Development Goals, the National Strategic Plan for HIV and AIDS, STIs and TB, 2011-2016, the Department of Health guidelines and the mentorship principles.

The Constitution of the Republic of South Africa

Chapter 2 of Act 108 of 1996, section 27 (1) (a) indicates that everyone has the right to have access to health care services, including reproductive health care³. Based on the afore-mentioned clause, nurses should be guided and prepared on the principles of patients' rights to access health care services.

The Nursing Act 33 of 2005

The preparation of nurses is enacted

in the Nursing Act, Act 33 of 2005; Chapter 2 stipulates the education, training, research and registration of nurses. Section 42 focuses on the education and training of nurses and the accreditation of institutions by the South African Nursing Council⁴. With regard to the nurses who are learning at an Institution of Higher learning such as a University, their learning is also controlled by the Higher Education Quality Committee which is a committee of the Council on Higher Education. The HEQC serves as accreditation body for the Nursing programmes offered at Universities⁵. SANC, through its HIV/AIDS policy, is committed to the fight against HIV/AIDS and indicates the rights of patients as confidentiality, non-judgemental, effective nursing according to personal needs, empathy for the social dilemma of AIDS and HIV positive patients, expert accompaniment for themselves, their families and communities, in order to continue a normal responsible life, protection and life, in the case of the unborn child⁵.

Pre and in-service preparation of nurses

The content of pre and in-service

preparation of nurses for family and community centred care is outlined in table 1.

Mentorship principles

Community centred and family care requires a paradigm shift from curative to primary health care and this requires mentorship of the nurses by those experienced in this approach. Mentorship is used in nursing to facilitate the professional development of nurses. Mentorship refers to the process by which Professional Nurses who are mentors pass their wisdom of caring and technical skill to the neophytes in nursing. During the preparation of these nurses, they pass through the phases of initiation and acquaintance wherein the mentor and mentee have first contact and set rules of their mentoring relationship, passage/cultivation that involves transition from not knowing to knowing, integration/accomplishment where the nurse becomes integrated with the people in the community and the family, and evaluation/termination wherein the nurse becomes independent and can manage the community centred care and family services and be a coordinator.

Table 1: The pre and in-service preparation of nurses

Pre-service preparation	In-service preparation
The Nursing process	Millennium Development Goals
Promotion of health	Strategic Plan for HIV/AIDS, STIs and TB
Prevention of diseases	Contemporary health care issues
Rehabilitation services	Primary health care principles
HIV/AIDS basic facts	Family and Community centred care
Universal precautions	Universal precautions in the family
Opportunistic infections	Treatment of opportunistic infections
Impact of HIV/AIDS	Stigma and discrimination
Immune deficiency	Caring for all age groups
Progression of HIV to AIDS	HIV Counselling and testing
HIV testing and counselling	Couple HIV/AIDS Counselling
Anti-retroviral therapy	Initiation of Anti-retroviral therapy
Adherence to ART	Disclosure of HIV status
HIV and Tuberculosis co-infection	Adherence and non-adherence to treatment
WHO staging system for HIV infection	Use of WHO staging system

The Batho-Pele principles

The eight Batho-Pele principles should also be included in the preparation of nurses. The principles are listed in the box below.

1. Consultation: Families and communities should be consulted regarding type of care
2. Service standards: Setting standards of care
3. Access: Nurses providing family and community centred care
4. Courtesy: Nurses must respect families and communities
5. Information: Families must be provided with information on care
6. Openness and transparency: Nurses should inform the families about the type of care provided and their contact numbers
7. Redress: Quick and accurate identification of standard of care provided to families and communities
8. Value for money: Services rendered by nurses must be cost-effective and valuable

The millennium development goals

The nurses should lead the efforts towards realization of the Millennium Goals and be prepared with regard strengthening and empowering communities to act, demand services and own the results⁶. The eight Millennium Goals represent a unique global compact. The MDGs are derived from the Millennium Declaration which was signed by one hundred and eight-nine countries. Each goal has targets and indicators. With regard to family and community centred care, Goal number 6 is appropriate as it indicates that combat HIV/AIDS malaria and other diseases. Target 7 indicates that by 2015 there should be a halt and begun to reverse the spread of HIV. Target 8 focuses on malaria that should have halted by 2015 and be-

gun to reverse the incidence of malaria and other major diseases. Among the indicators of goal number 6, there is indicator 23 that deals with the prevalence and death rates associated with tuberculosis⁷.

The Department of Health guidelines regarding anti-retroviral treatment

Nurses are expected to spend time with the patient explaining the goals of therapy and the need for adherence as many times as is necessary and this can best be done in the families and the communities⁸. The nurse should provide adherence tools where available such as written calendar of medications and also encourage adherence discussions in support groups and encourage links with support groups. The topics that should be included in the preparation of nurses for family

and community centred care include communication and counselling skills. These skills involve verbal and non-verbal communication that is used during interaction with individuals, families and communities. The nurses who are adequately prepared have the ability to identify the non-verbal cues and probe for more information. During Counselling the seating arrangement should be in a homely environment to facilitate communication. The findings that are done during communication should be used for the planning of the care. The principles of Primary Health Care should also be considered in provision of family and community centred care. These include equity, community participation and inter-sectoral collaboration. Provision of family and community centred care is multidisciplinary and hence the need for collaboration of services. Primary health care is



essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in community through their full participation and at a cost that the community can afford⁹. The United Nations General Assembly has identified stigma and discrimination, gender inequality and marginalization of women and children as some of the factors that hamper universal access, prevention, treatment and support of HIV/AIDS people¹⁰.

Conclusion

Community home-based care requires multi-disciplinary teams and includes family members. The availability of nurses will ensure accessibility and affordability of family and community centred care to the clients/patients. 

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Community centred and family care requires a paradigm shift from curative to primary health care and this requires mentorship of the nurses by those experienced in this approach.





Promoting Family and Community Centred Care

T Crowley¹, D Kitshoff², GMA Lourens³

Full author details

1. Talitha Crowley, MCur, Dipl Nursing Ed, PHC, BCur. Division of Nursing, Faculty of Medicine and Health Sciences, Stellenbosch University, P.O. Box 19063, Tygerberg, 7500. Tel work: (+27) 21 938 9036, Email: tcrowley@sun.ac.za

2. Danine Kisthoff, MCur, Dipl Nursing Ed, PHC, CHN, RN, RM. Division of Nursing, Faculty of Medicine and Health Sciences, Stellenbosch University, P.O. Box 19063, Tygerberg, 7500. Tel work: (+27) 21 938 9036, Email: danenek@sun.ac.za

3. Guin Lourens, MTech, Dipl Nursing Ed, Dipl HSM, PHC, OHN, B Cur. Ukwanda Centre for Rural health, Faculty of Medicine and Health Sciences, Stellenbosch University, P.O. Box 19063, Tygerberg, 7500. Tel work: (+27) 21 938 9890, Email: guin@sun.ac.za

Nurses need to be aware of what organisations and services are actively involved in the community and how they can be utilised to complement patient care.

The re-engineering of primary health care strategy in South Africa also emphasises the provision of quality health care to families in their homes as well as community participation.

Introduction

Family and community centred care means a shift in the traditional focus on the aspects of illness towards a concern with taking care of patients in the context of their families and communities and valuing what matters to them.

Diseases such as HIV/AIDS and tuberculosis do not only affect individuals, but burdens families and communities. This means that patients, their families and the community should form an integral part of the health care team if we want to combat illness and promote the health of all. Effective communication and links between healthcare, family and community resources could help to inform patients and families to cope better with the challenges of illness, leading to improved health outcomes and resource utilisation.^{1,2,3} Furthermore, community engagement, empowerment, and ownership improves the health and development of communities.⁴

The re-engineering of primary health care strategy in South Africa also emphasises the provision of quality health care to families in their homes as well as community participation.⁵ It is therefore essential that nurses increase their understanding and skills necessary to build effective partnerships with patients, families and communities.

Bio-psychosocial systems approach

The principles of family and community centred care are based on the bio-psychosocial systems approach to health care. This means that health is seen within the context of psychological, social, and physical factors. The mind, body, and environment interact in causing disease (Figure 1).⁶

Gladys is a 40 year old domestic worker who regularly attends the clinic with complaints of chronic back pain and hypertension. Today when the nurse asked her what is wrong, she burst into tears. She is the only provider in her family. Her husband is not

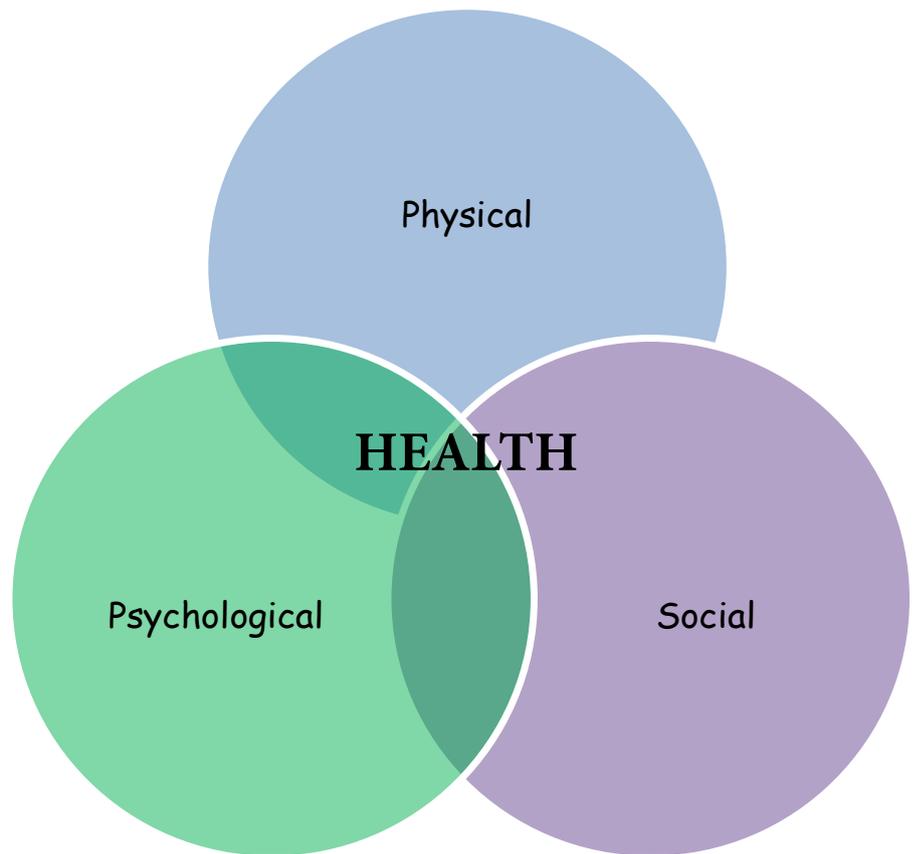


Figure 1: Bio-psychosocial model adapted from Engel 1977

working and spends many nights in the local shebeen. Her teenage daughter has fallen pregnant and she does not know how they are going to provide for the new baby since her eldest son, who used to have a regular job has recently been arrested for stabbing another boy.

Gladys' symptoms of chronic back pain and hypertension may be a complex interaction of multiple factors (personal, family and environment). Understanding and addressing these factors are necessary for comprehensive treatment.

How families and communities affect illness

The beliefs of a family and community about health and illness play an integral role when it comes to whether and how they will access health services. Furthermore, many health behaviours and risk factors are shared by members within a family or com-

munity.⁷ Most families share the same diet, which could result in diseases of lifestyle such as obesity, hypertension and diabetes.

Families and communities should be seen as a resource by the healthcare provider. It is therefore important to involve the family and make them partners in healthcare. Effective partnerships between providers, patients and families can increase the quality and safety of health care, decrease costs and improve satisfaction with care.^{8,9} It is important to understand the core concepts of patient, family and community centred care in order to promote effective partnerships.

A family and community centred approach to individual patients

A family or community centred approach does not always require the nurse to meet with the family or the community. Most of the time nurses

Core Concepts of Patient, Family and Community Centred Care

- *Dignity and Respect:* Listen to and honour patient and family perspectives and choices. Incorporate patient and family knowledge, values, beliefs and cultural backgrounds in the planning and delivery of care. What matters to the patient, family and community should be central to the treatment plan.
- *Information Sharing:* Patients, families and communities should receive timely, complete and accurate information in order to make informed choices.
- *Participation:* Support and encourage patients, families and communities to participate in the planning, delivery and evaluation of care at the level they feel comfortable with.
- *Collaboration:* Patients, families, communities, health care practitioners and health care leaders should collaborate to identify priority needs and develop programmes tailored to the needs of a community.

(Adapted from Institute for Patient and Family Centred Care, 2011)

meet with the individual and not the family or community.

Sarah is a 26 year old woman diagnosed with HIV during pregnancy and on antiretroviral therapy for 8 months. Sarah has a high viral load and admits to being non-adherent to her antiretroviral medication. Her baby died during birth and she has not been able to tell anyone that she is HIV positive, because she blames herself for the death of the baby and fears stigmatisation from her family members.

The situation with Sarah illustrates that

it may be as simple as asking a few questions about the patient's family or home situation or inquiring about the patient's history in order to broaden the lens to understand why Sarah is not taking her antiretroviral medication. It is also important to understand the beliefs and values of communities, since it can influence the health behaviour of patients indirectly, for example in the case where there is high stigmatisation of certain diseases.

There are some key questions that can be used in any patient interview that can be useful in understanding the patient's illness experience in the context of the family and community better.

5 Family/Community-centred questions

1. Has anyone else in the family or community had this problem?
2. What do family members and the people in your community believe caused the problem and how should it be treated?
3. Who in the family is most concerned about the problem?
4. Along with your illness, have there been any other recent changes or stresses in your life?
5. How can your family or friends (community) be helpful to you in dealing with this problem?

(Adapted from McDaniel, Campbell, Hepworth & Lorenz, 2005)

Involving the family in daily practice There are times when it may be beneficial to meet with the family of a patient. This may happen during a routine clinic visit, or it may require a home visit or family conference. Meeting with the family can help the nurse to make a more comprehensive assessment of the problem, determine the impact of the illness on the family, establish what is most important to them and involve the family in developing an appropriate treatment plan.⁷ Outreach into com-

munities and homes of families could further promote early identification of individuals within families at high risk and interaction with communities to identify possible barriers and enablers to improving their own health.¹

John is a 46 year old male who has been diagnosed with tuberculosis for the second time. He has missed a few of his appointments and the nurse at the clinic decides to visit his house. During the home visit, she found that John was married and that his wife recently died due to tuberculosis. He has a 3 year old son and an 11 year old daughter. His 57 year old mother and 34 year old sister also stay in the house with them. John works as a builder. His job is a very important source of income for the family and he cannot get time off from work to collect his medication. On the visit the nurse is able to screen all the family members for any symptoms of TB. She manages to arrange for John's sister to collect his medication from the clinic since she is not working, as well as the prophylaxis for the 3 year old boy. All the family members agreed to support John in taking his treatment.

Incorporating the family into clinical practice may require a change in the usual routine as well as the development of new skills, but it may be very beneficial for the treatment of patients. The use of condition-specific educational materials can be helpful¹⁰ and families can also make use of these educational materials to learn more about the disease.

At her first antenatal visit Megan is diagnosed with HIV. She expresses her concern about disclosing her HIV status to her boyfriend. The nurse asks her to invite her partner to come with her to the next clinic visit and gives Megan an educational pamphlet about pregnancy and HIV to take home.

At the next visit, the nurse thanks Megan's partner for taking the time to come with her. He explains that Megan told

him about her status and that he wants to be a part of this pregnancy. The nurse encourages him to take a test for HIV and explains the use of antiretroviral drugs in the prevention of mother to child transmission of the virus. Megan verbalises that she feels more relaxed now that her partner is involved and willing to support her.

Community collaboration

Community participation and collaboration can be promoted through identifying and supporting existing community groups or starting new groups. These groups are useful in identifying and prioritising the needs of a specific community and empowering communities to develop culturally sensitive action plans. Community health care workers are also an invaluable resource in establishing a good rapport with the community.

As a nurse working in a rural clinic, you notice that there are many babies that have been infected with HIV through surrogate breastfeeding. You decide to start a community group to help identify solutions and raise awareness in the community.

Nurses need to be aware of what organisations and services are actively involved in the community and how they can be utilised to complement patient care. Partnering with families and community organisations promotes continuity of care and expands the resources available to the patient by making important services such as social assistance, palliative care and peer support groups available to them.¹

Practical considerations for comprehensive care

There may be practical challenges in translating a family and community centred approach from theory to practice. Nurses may ask: "How will I find the time?" or "What if I get too involved?" However, some practices may be implemented without major changes to the regular routine.

Fundiswa is the mother of 1 year old Thandi. Thandi was perinatally infected with HIV and both she and her mother are taking antiretroviral therapy. Fundiswa has to visit the clinic twice every month as she has to collect tablets for herself and Thandi on different clinic days. The nurse asked Fundiswa if she would like the same date as her daughter. Fundiswa was very relieved as she did not want to seem difficult about the clinic dates.

Allowing for family members to attend the clinic on the same day could help them to save on transportation costs, as well as prevent financial losses due to work absenteeism.

Conclusion

The essence of family- and community centred care is valuing what is important to patients, their families and the community and knowing the proven benefits of collaboration. Nurses can play an important role as advocates for patients, families and communities by reinforcing a family- and community centred approach to care. 

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Practical tips for promoting family and community centred care

- Include family and community centred care as part of the mission, philosophy of care and definition of quality of your facility.
- Allow family members to accompany patients during clinic visits.
- Always ask about a patient's family situation.
- Document the family and social history of a patient in their folder.
- Make time for family visits where necessary and involve family members in the planning, implementation and evaluation of care.
- Keep a list and contact details of community partners (social worker, rehabilitation, crisis centres and palliative care).
- Appoint a family- and community centred steering committee comprised of patients, family and community members and health care providers.
- Support existing community groups or start new groups where necessary.
- Plan health promotion campaigns through collaborative partnerships between community members and organisations.

HIV/TB Case Studies

Gladys is 19 years old. Today she presents to the primary health clinic for the third time in the last 6 weeks with complaints of feeling tired and losing weight – she has dropped two dress sizes in the past two months. She reports that the last time she was at the clinic 2 weeks ago, she was told to buy vitamins and eat more vegetables. She states that this has not helped with her symptoms at all. Gladys lives with her sister, Mavis, and Mavis' three children. Tembi, the 5 year old, was diagnosed with TB three months ago and continues with treatment.

You, the astute Professional Nurse, decide to inquire more about Gladys' symptoms. Name three signs/symptoms you would ask about.

- 1)
- 2)
- 3)

You suggest to Gladys that she should test for both HIV and TB today. You tell her that your clinic recently had a new machine installed that can diagnose TB the same day. She agrees to test and to wait for the results, as she is tired of returning to the clinic. Give two reasons why you suspect TB:

- 4)
- 5)

You provide Gladys with a specimen jar and educate her on how to produce and collect sputum. Name three essential steps in collecting a good sputum specimen.

- 6)
- 7)
- 8)

You take the sample to the lab so that it may be processed while you counsel and test Gladys for HIV. Her result is positive. You support Gladys and provide her with as much information as she is able to absorb today.

- 9) What do you do next?
 - a. Discuss the need for Gladys to start antiretroviral therapy
 - b. Tell Gladys to return the following week for a blood test
 - c. Ask Gladys to wait in the clinic today until you get the TB results
 - d. Start antiretroviral treatment today



HIV/TB Case Studies

The laboratory report comes back and says

Xpert MTB/RIF: MTB+ /RIF-

Microscopy: not done

- 10) What does this mean?
- Gladys has pulmonary TB
 - Gladys has pulmonary TB resistant to rifampicin
 - Gladys does not have TB
 - Gladys has extra pulmonary TB

You collect another sputum specimen to send to the lab for microscopy before starting Gladys on TB treatment today. What drugs are used to treat her TB?

- 11)
- 12)
- 13)
- 14)

Answers

- 1-3) Fever, cough, night sweats, chest pain, enlarged lymph nodes
- 4-5) Gladys is a contact of TB since her nephew is on treatment; Gladys is reporting weight loss – a symptom of TB; Gladys is reporting fatigue – a symptom of TB
- 6-8) rinse mouth with water, take a deep breath, after exhaling inhale sharply and cough strongly, expectorate sputum into the jar, close the jar tightly, place the jar in the plastic specimen packet
- 9) The answer is c. Gladys' TB status needs to be determined before deciding what to do next. If she has TB, she will need to start TB treatment immediately. She would then be eligible for ART irrespective of her CD4 count if TB is diagnosed. However, if she does not have TB, her eligibility for ART will depend on her CD4 count.
- 10) The answer is a. Gladys has pulmonary TB. She may also have extra pulmonary TB, but even if this were true, she is still considered to have PTB, as *Mycobacterium tuberculosis* was found in her sputum.
- 11-14) rifampicin, isoniazid, ethambutol, and pyrazinamide

THE TOPSY FOUNDATION



Why is Community Care so important when it comes to HIV and AIDS

Helen MacKenzie, Communications Manager, The Topsy Foundation NPC

The very foundation of the work that Topsy does begins with family and community care, by way of Topsy's Community Outreach Programme

most under-resourced rural communities through a multi-faceted response to the consequences of HIV and AIDS and extreme poverty.

When the Topsy Foundation first began, it focused on the residential care of children who had become orphaned due to their parents' passing away from HIV and AIDS. As time went by we realised that far broader needs existed in our under-resourced, rural communities and so we evolved to meet those needs through providing additional free services.

The very foundation of the work that Topsy does begins with family and community care, by way of Topsy's

Community Outreach Programme. In the early days it was a matter of the medical team setting out into the communities carrying backpacks with some basic medical supplies such as pain killers, in an attempt to alleviate the suffering they found going door to door. Gradually community relationships were built and trust was forged. As a direct result of this, Topsy was able to gain momentum in our work. We founded the free Comprehensive HIV and AIDS Care Clinic in Grootvlei, Mpumalanga. From this clinic Topsy offers a full HIV and AIDS service to 5 communities (within a 100km reach of the clinic) - including HIV Counselling and Testing (HCT); Provision of Antiretroviral Therapy (ART); Prevention of Mother to Child Transmission (PMTCT); Post-Exposure Prophylaxis (PEP); Tuberculosis (TB) Diagnosis and Treatment; Cervical Cancer Screening and General Care for HIV and AIDS Patients.

The Community Outreach Programme Topsy offers vital social, medical, psychological and nutritional support to hundreds of patients, the people in their lives and others infected with and affected by HIV and AIDS - more than 9000 individuals per month.

With a dedicated fully qualified and employed team of fieldworkers, social workers, auxiliary social workers and nurses we are able to connect completely with the communities that Topsy serves. Through these connections we make sure that people are aware of and able to make use of the services available to them at the clinic and through the other projects.

The 3 main initiatives of the Community Outreach Programme are:

- * Home-Based Care
- * Vegetable Garden establishment
- * Support of Orphaned and Vulnerable Children

Let's take a closer look at Home-Based Care as an example of how Topsy emphasises family and community care



The Topsy Foundation NPC (hereafter referred to as Topsy), established in 2000, is a fully-registered and internationally-respected Non-Profit Organisation and Public Benefit Organisation. We rely on support from donors to bring life-saving care and treatment to our beneficiaries.

Topsy (www.topsy.org.za) provides relief services to some of South Africa's

With a dedicated fully qualified and employed team of fieldworkers, social workers, auxiliary social workers and nurses we are able to connect completely with the communities that Topsy serves

in the value of our work. We are very proud that the model for the Topsy Home-Based Care Project was a major inclusion in the establishment of best practice in this field, as determined by the state appointed NICDAM (National Institute for Community Development and Management) study in 2011.

Topsy services offered in this project extend from medical through to social – addressing all aspects of the beneficiaries' life. This continuous and multifaceted care leads to a high level of improvement in the beneficiaries' lives, including the critical aspect of adherence to medication.

There are many components to this service, including:

- Medical assessment: this is the first meeting of potential patients. At this time Topsy is given the opportunity to introduce the idea of HIV Counselling and Testing, and assess the individuals' wellbeing.

- Medicine delivery and education: we ensure our ongoing high

adherence rates (number of patients effectively and continuously taking their medication) through a variety of strategies. One such way is that fieldworkers will visit with patients in the weeks following a positive diagnosis, to ensure that they understand how to take their medicine. This can be particularly important with illiterate patients who have to take a number of different medicines.

- Care of patients and education: when people with AIDS become too frail to travel to the clinic or to care for themselves, they require assistance daily. Our fieldworkers come to their aid, and offer care and education to the patient and those who look after them. Caregivers are helped in their efforts to look after the patient and guided in the best practice for wounds dressing, medication regime, bed turning etc. During the course of this intimate interaction with patients and caregivers, our fieldworkers give guidance and support and offer a listening ear.

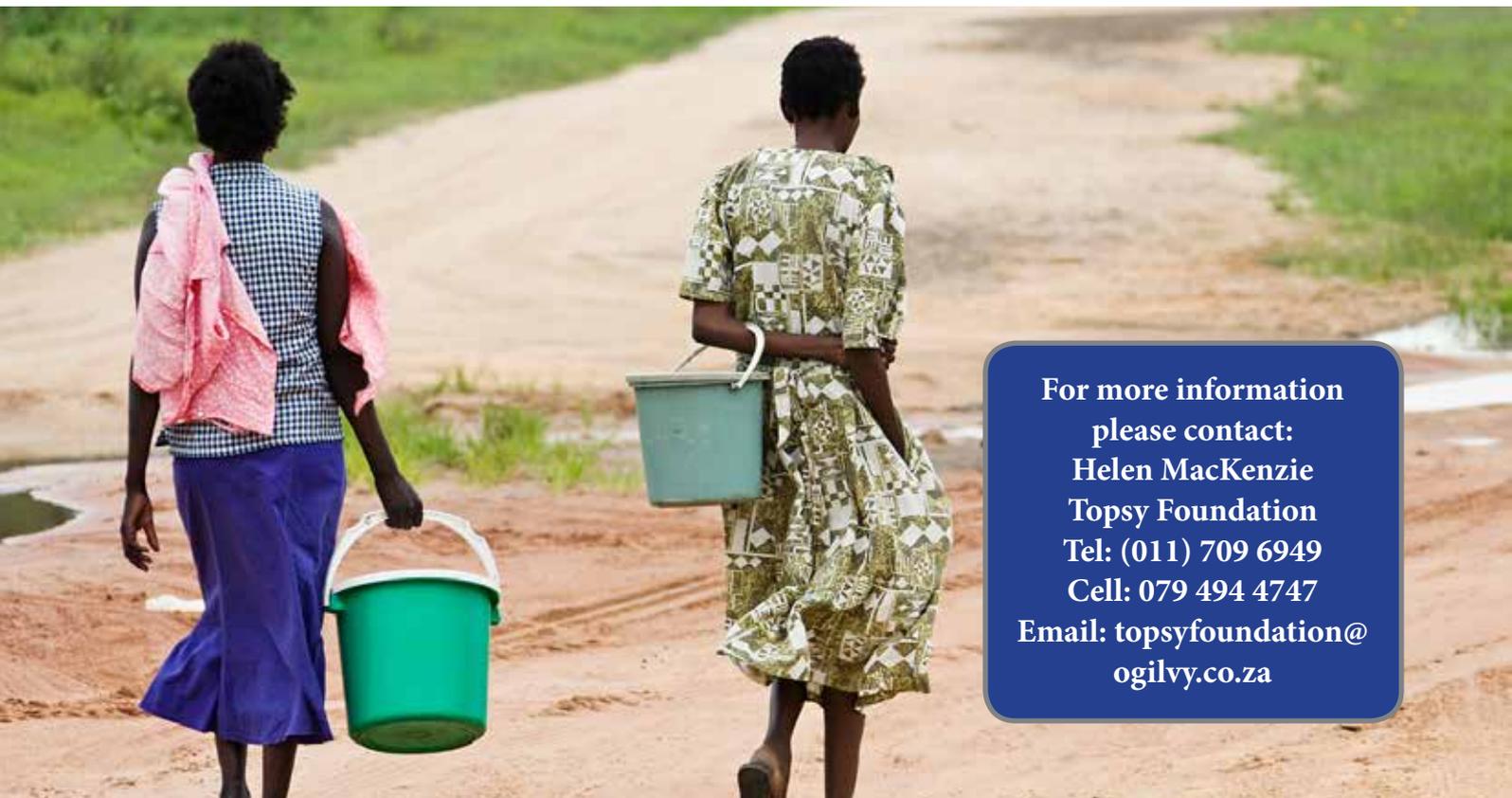
-Ensuring that patients access

the free transport via bus available from Topsy to travel to the clinic on the correct day for their appointment. We collect the patients from each community on their assigned day and bring them to the clinic where they receive 2 meals, counselling, testing, treatment etc. as per their needs before being taken back in the afternoon.

-Door to door visits

When not calling on specific patients, the fieldworkers go from house to house to offer the services of the project. They also document information about each household, such as the number of family members residing in the home, how many are employed, how many children live there, levels of wellness amongst family members and so on. This crucial information helps Topsy prepare for future needs within the area.

It is clear that without this close attention to family and community care, the work that Topsy is doing to alleviate the crisis of HIV and AIDS wouldn't be possible. [®]



**For more information
please contact:
Helen MacKenzie
Topsy Foundation
Tel: (011) 709 6949
Cell: 079 494 4747
Email: topsyfoundation@ogilvy.co.za**

Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

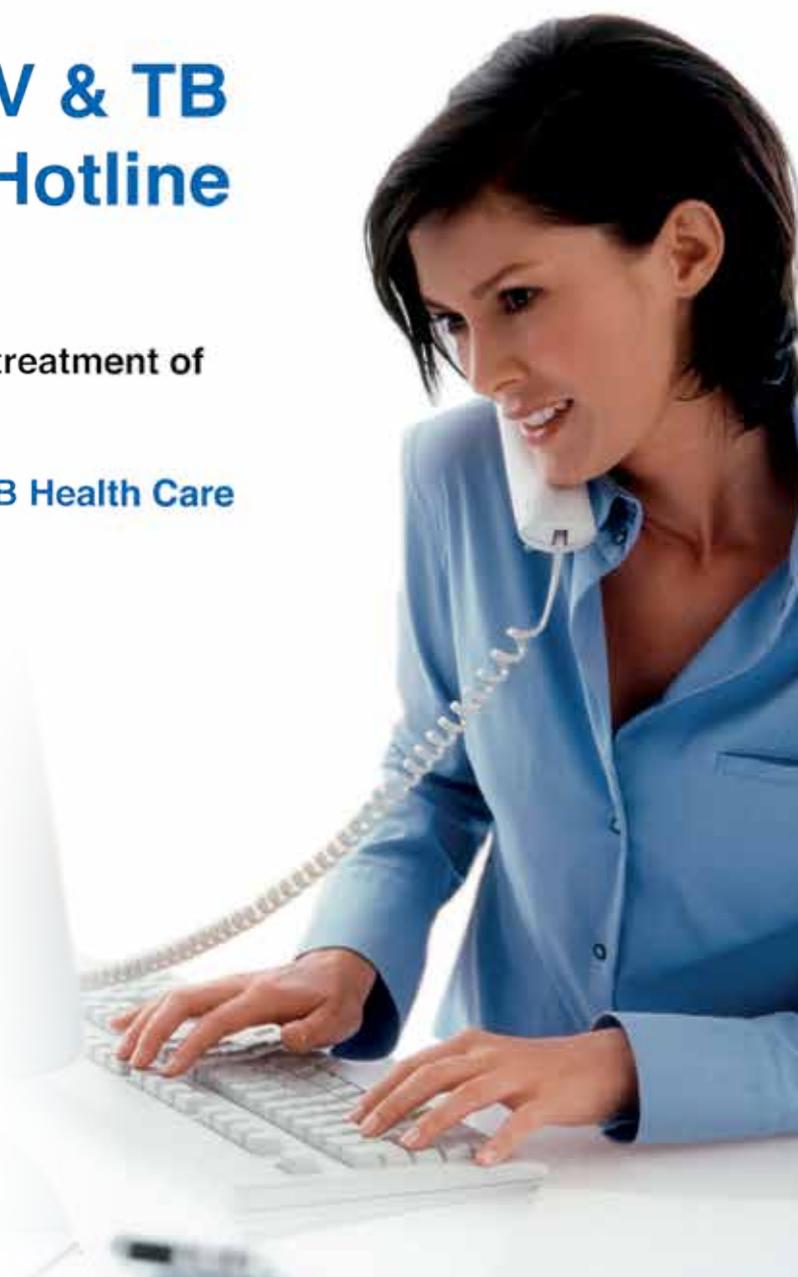
Do you need clinical assistance with the treatment of your HIV or TB patients?

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



**0800 212 506 /
021 406 6782**

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



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

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

What questions can you ask?

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

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

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

When is this free service available?

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

Who answers the questions?

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

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



**MEDICINES
INFORMATION
CENTRE**



Foot Soldiers of Primary Health Care

D. Van Zyl, JP Zeelie

Community Media Trust, Suite 6EB Tannery Park, 23 Belmont Road, Rondebosch, Cape Town

D. Van Zyl, BSc. (Physiotherapy), MPH

JP Zeelie, BA Honours (Communications), MPH Candidate (Health Economics)



The vision of CMT's Outreach programme is to provide a model of community health work in health service delivery which can be taken to scale as part of Primary Health Care re-engineering

The Minister of Health's initiative to re-engineer Primary Health Care (PHC) in South Africa is grounded in improving health service delivery and health outcomes across the country. An integral part of the plan is the inclusion of Community Health Workers (CHWs) as a formal part of the health system. Civil society organisations and the Department of Health have long included different kinds of lay or community health workers in their models, particularly in the response to the HIV epidemic. These workers are able to support various aspects of PHC, especially in managing HIV/AIDS and TB, and to improve health outcomes. CHWs are perfectly positioned to act as agents of change within their communities, and while they may have little formal medical background, they have often been intensively trained on key health issues and can provide detailed health education, patient support and advocacy.

Community Media Trust (CMT) is a national NGO that has been promoting the mass understanding of health literacy since 1998. CMT's weekly television show *Siyayinqoba Beat It!* has been recognised with popularising

the credibility of antiretroviral treatment during the decade of AIDS denialism from which South Africa has now emerged. The method of *Siyayinqoba Beat It!* is to illustrate both the application of medical protocol, as well as the vectors of transmission and prevention of the disease through documentary inserts telling personal stories of people living with HIV and their support networks across the country.

CMT's Outreach Programme began in 2006, deploying trained CHWs to support public sector clinics by providing face-to-face communication on crucial HIV issues. Over time, CMT's strategic focus shifted from direct service provision to a training focus in 6 provinces, providing HWSETA-accredited training for CHWs - whether employed through the Department of Health or through other civil society organisations.

CMT believes in the fundamental role that CHWs can play in improving health outcomes, particularly in resource-challenged settings. To this end, CMT embarked on a study to evaluate the impact of CHWs on PMTCT programme coverage and health outcomes in the Mangaung (previously Motheo) District of the Free State. The study is jointly funded by USAID and PEPFAR through Johns Hopkins Health and Education in South Africa and the Monument Trust. CMT has worked together with the University of Cape Town, and we eagerly anticipate the results as the study draws to an end in May 2013.

The vision of CMT's Outreach programme is to provide a model of community health work in health service delivery which can be taken to scale as part of Primary Health Care re-engineering. It also aims to empower individuals and communities to increase their health seeking behaviour





through increased health knowledge and awareness, and thus impact positively on health outcomes. This “health literacy” approach aims to capacitate CHWs with accurate and updated information on all aspects of HIV/AIDS and other important health topics, such as maternal and child health, and chronic non-communicable diseases so that the CHWs can, in turn, share this information in an easy-to-understand way and in the local language. In this way, accurate health information spreads through populations, mobilising communities towards understanding the scientific approach adopted by the health system, and to take an active part in preventing disease and managing their own health. CHWs are also equipped with the skills to identify those requiring social support and link them to relevant services, such as the Department of Social Development to apply for grants.

CMT’s CHW programme supports pregnant mothers accessing public health services at 16 clinics in the Free State. The overall aim is to increase PMTCT programme coverage and to reduce the number of children born

with HIV. The CHWs have been extensively trained in all aspects of HIV/AIDS, the PMTCT protocol and maternal and child health. They provide health promotion sessions in clinic waiting rooms, encouraging all pregnant women to test for HIV and to book early for antenatal care.

CHWs also work to reduce the burden on over-worked healthcare professionals through task-sharing. This involves the CHWs assisting in everyday clinic duties, with an emphasis on antenatal services. Tasks include general patient administration, weighing of babies, assisting with administering immunisations, disclosure of PCR test results, and registering new ARV patients. The CHWs have also been trained in HIV

CMT has developed a host of materials to support programme implementation, including printed flipcharts, a DVD series and detailed information pamphlets

counselling and testing to assist with achieving clinic targets. This provides the CHW with an ideal opportunity to test and counsel pregnant women, and it facilitates an early entry point into the PMTCT cascade.

Expectant mothers are offered the opportunity to voluntarily participate in the individual follow-up programme - starting with a test for HIV. Women testing HIV negative are counselled on protecting themselves and their unborn baby against HIV and are followed up to ensure re-testing at 32 weeks of pregnancy. Women testing HIV positive are intensively counselled on all aspects of the PMTCT protocol and contact information is recorded on individual follow-up schedule cards. The CHW highlights important dates, and stays in contact by SMS or phone to offer support and to provide reminders to return for PMTCT services on the specified dates. This reduces loss to follow up and increases programme coverage. At each visit to the clinic, expectant mothers are able to meet one-on-one with the CHW, who provides further information on managing HIV within pregnancy and reducing the risk of vertical transmission.

CHWs also host large awareness events at lively locations near the clinic, such as taxi ranks, shopping malls or community centres and feature entertainment and health promotion sessions. Information pamphlets and condoms are distributed, and prizes are awarded to active listeners. The events promote the CHW programme, as well as raising awareness of HCT and PMTCT services in general, thereby driving demand for access to and uptake of services. CMT partners with New Start and the clinic to provide HIV testing services at these events.

CMT has developed a host of materials to support programme implementa-

tion, including printed flipcharts, a DVD series and detailed information pamphlets. These are available in English, Sesotho, isiZulu and isiXhosa. CMT's audiovisual materials ensure accuracy of the health messaging and have the advantage of overcoming language and literacy barriers.

Placing a strong emphasis on training and support is hypothesised to be an investment in the true value of the CHW to the facility. Common criticism of CHW models is that the workers often take on menial tasks within the clinic and lack a defined role. CMT ensures this does not happen by providing regular supervision of CHWs in clinics and ensuring that relationships with clinic managers are nurtured and maintained. Accuracy of information is routinely checked by a senior trainer who observes CHWs conducting sessions. CHWs are also tasked with assignments and presentations at their weekly meetings, which provide a forum to address challenges and to provide updates on protocol developments.

CMT welcomes the recent introduction of HAART for all HIV-positive pregnant and breastfeeding women, regardless of CD4 count, through the rollout of Fixed Dose Combination antiretrovirals, and notes that the increased frequency of HIV testing of women during pregnancy, breastfeeding and thereafter that has been set out in the new guidelines, means that the role of the CHW is even more important.

Significant inroads have been made in reducing mother to child transmission of HIV in South Africa, and PMTCT treatment is considered to be highly effective when administered correctly. However, in reality many pregnant women may not enrol in antenatal services early enough, may not test for HIV or if they have tested positive, they may not access all steps of the PMTCT protocol. This presents an important area of treatment access and adherence where CHWs can play a significant role in ensuring continuity of care. If a systematic expansion of the primary healthcare workforce includes CHWs to increase enrolment in treatment programmes and uptake of services, it could dramatically alter the face of the HIV epidemic.

The programme has been well-received by the Free State Department of Health, District Management Teams, as well as the clinic sisters themselves. Sister Maloale in Thaba Nchu, attests to the support she receives from Nono Mphaloane, a CHW working at Gaongalelwe Clinic "Working with Nono has been very interesting; she has taught us all a lot, including patients. The whole process of making follow ups with patients has ensured that we do not miss out on patients. She would also remind us, during patient care, of what to do where we may have forgotten and we would immediately rectify what could have been a big mistake. She has also built a good relationship with the patients to a point where they understand each other very well. Sometimes when I can't immediately remember information about a patient that is coming for follow up, I just ask Nono and she is able to fill me in so well that I am able to go on with the session. She has not helped with only what she is supposed to do; even in the admin area she has been helpful as part of task-sharing." [®]





Eating Healthy on a Budget

Written by C Haupt RD (SA) owner of Family Kitchen

Make starch the basis of most of your meals as starch (carbohydrate) is a very important source of energy and nutrients for your body



There is a misconception that you need to have a lot of money in order to be able to eat a healthy diet. Yes you do need some money to buy food but you don't always have to buy the most expensive food in order to be healthy. In fact many of the takeaway meals that families eat on a weekly basis are very expensive for the nutritional value that you get. For example a large chicken, rice, carrots and gem squash for a family of 5 would cost approximately R55 while a take away meal for a family of 5 will cost over R100. The take away meal will not include sufficient vegetable and will be higher in fat content than is healthy.

No matter what your budget is, there are some guiding principles for healthy eating. The more money you have, the more variety you will be able to add into your shopping trolley. South Africa has a set of 10 food based dietary guidelines. They have been developed for all the different population groups that live in South Africa older than 7 yrs., both rural and urban, rich and poor. The 10 guidelines are:

- Enjoy a variety of foods
- Be active
- Drink lots of clean, safe water
- Make starchy foods the basis of most meals
- Eat plenty of vegetables and fruits every day
- Eat dry beans, peas, lentils and soya regularly
- Chicken, fish, meat, milk or eggs can be eaten daily
- Eat fats sparingly
- Use salt sparingly
- Use food and drinks containing sugar sparingly and not between meals
- If you drink alcohol, drink sensibly

The first 3 messages are general health messages. Eating a variety of foods is important as this ensures that you get all the different nutrients (macro and micro) that your body requires. For a family that cannot afford a large variety, this could then mean that instead of always buying the same vegetable

each time, to rather buy the vegetable that is on promotion and in this way buying a different vegetable each time. The same strategy can be applied to proteins and carbohydrates. There are many health benefits to being active. This could be from as small a step as taking the stairs to starting to partake in 5 km road races. Whatever your fitness level is, try to increase your heart rate for 30 minutes 3 times a week. Water is very important to regulate your body's temperature and also in the absorption of vitamins. Not only is water needed for the body to function properly; it is also the cheapest drink. Let your children learn to drink water from an early age. It is much healthier for them than carbonated beverages and 100% fruit juices.

Make starch the basis of most of your meals as starch (carbohydrate) is a very important source of energy and nutrients for your body. Try to eat the unrefined starches like whole wheat or foods that include bran. Not only does the unrefined starch provide your body with nutrients like antioxidants, vitamin E, folic acid, zinc, selenium and magnesium, but it also provides fibre. Unrefined starches are the best source of fibre. Fibre helps to regulate bowel functioning, reduces risk of developing chronic diseases such as obesity, diabetes and cardiovascular conditions. The guideline for fruit and vegetable intake is 5 a day. Not many South Africans are able to eat this much. The aim should be to increase the amount of vegetables or fruit by 1 until you are able to eat 5 a day.

Tips on how to increase your vegetable intake:

- When you dish up double your normal serving of vegetables.
- Add extra vegeta-

- bles to salads, soups, stir-fries, stews and curries.
- Add vegetables to pasta dishes. For example add sliced carrots and mushrooms to a chicken pasta
- Eat a vegetarian meal at least once a week. This is a money saver.
- Add vegetables like onion, tomato, green pepper or tomato to egg dishes (scrambled eggs or omelettes).
- Get children into the habit of eating fruit when they are hungry between meals.

Portion	Fruit or vegetable
1 cup	Fresh
½ cup	Cooked
2 cups	Raw green leafy vegetable

*** Potatoes are not considered a vegetable, but rather a starch.**

The fifth and sixth guidelines highlight some important concepts. The legume recommendation comes before the meat, poultry and fish recommendation. This is because they are considered to be very important in the diet and are also more affordable than meat products. They have health benefits like: protein, soluble fibre which helps with bowel function and to lower cholesterol. They are also naturally low





Our bodies do need salt, which is freely contained in the foods that we eat. Thus we do not need to add extra salt to our food.

Foods that are high in saturated fats include:

Palm and coconut oil
 Chocolate
 Butter
 Cheese
 Processed meats (sausages)
 Cream
 Full cream milk
 Meat
 Chicken skin

in fat. Legumes can be added to meat dishes to improve their fibre content and reduce fat content while saving money. Chicken, fish, meat, milk or eggs can be eaten daily. These are classified as high biological proteins. Most South Africans eat too much meat and chicken but not enough milk and fish. You do not need to eat high biological protein every day. Try to eat fish at least twice a week. Try to include fish that are high in omega fatty acids like tinned Pilchards. Eggs are also an excellent source of economical protein. They are nutrient packed with many vitamins and mineral (including iron). They are excellent for children. Fats are needed by our body but in general we eat much more fat than is needed. Fat is very high in energy it

has 38kj per gram compared to 17kj per gram found in protein and carbohydrates. Eating fatty foods or foods that have a lot of fat in them increases energy intake and therefore increases the risk of becoming overweight. There are different types of fat, some healthier than others. Saturated fats are fats that we need to avoid eating as their high intake is linked to overweight, high cholesterol levels, cardiovascular heart disease, diabetes and certain cancers, conditions referred to as chronic diseases of lifestyle.

Our bodies do need salt, which is freely contained in the foods that we eat. Thus we do not need to add extra salt to our food. Here are some tips to reduce the amount of salt in our diet:

- Eat fast foods or take-away foods less frequently because they usually contain high amounts of salt.
- Try to eat only a small amount of processed and canned foods (occasionally) because they usually contain a lot of salt.
- Use fewer sauces, mixes and "instant" products such as flavoured rice, pasta, and cereal. Use herbs and spices to flavour your food
- Read food labels to compare the salt content of similar foods.
- Either cook with salt or have it on the table.

From an economical and a health view point it does not make sense to consume carbonated beverages. They do not add any good nutritional value

to the diet and they are expensive. It is much healthier to drink milk (full cream for children under 3years and low fat or skim for adults) or water.

The last recommendation is to drink alcohol drink sensibly. Well, if you are on a budget alcohol is the most practical item to stop buying, as it is very expensive.

Give yourself a 30 - day challenge and see how many of the guidelines you are able to keep. Good luck and enjoy!! [®]

Which fats and oils are the best choices?

Mono-unsaturated and poly-unsaturated fats are the best choices for our arteries and our hearts.

Sources are:

- Vegetable oil (in small amounts), such as canola, olive and sunflower oil. Canola oil is good substitute for olive oil as its price is comparable to sunflower oil.
- Soft 'tub' margarine (thinly spread).
- Oily fish, such as pilchards, tuna, sardines, mackerel, salmon. These fish types supply the body with the essential omega-3 fatty acids, which reduce the risk of cardiovascular disease.
- Nuts (except Brazil and Macadamia nuts as high in saturated fat), unsalted peanuts and avocado.

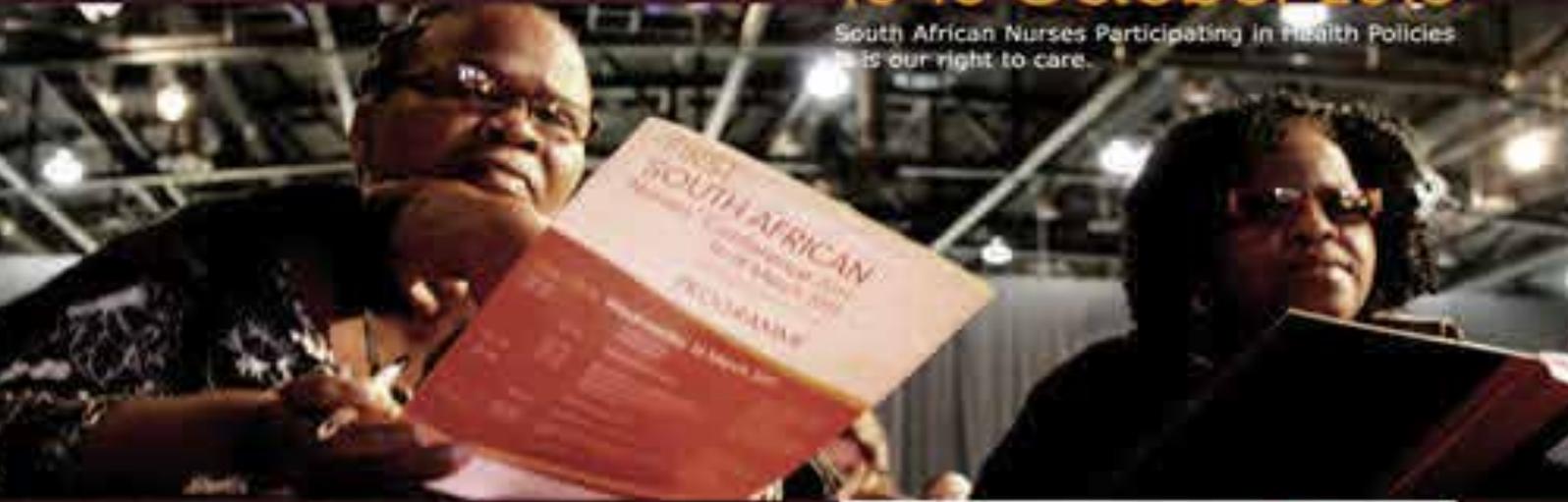
Reference:

SOUTH AFRICAN GUIDELINES FOR HEALTHY EATING

Department of Health, Directorate: Nutrition, Pretoria, June 2004.

SECOND SOUTH AFRICAN Nurses' Conference 2013 16-18 October 2013

South African Nurses Participating in Health Policies
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A conference for nurses, by nurses



Whistleblowing: Why should I do it and how am I protected?

Sasha Stevenson, Attorney at SECTION27

An employee who suffers an occupational detriment is entitled to refer his or her case, within 90 days, to the Public Health and Social Development Sector Bargaining Council. If he or she has been dismissed because of the protected disclosure, the dismissal is deemed to be an “automatically unfair dismissal” which means that no justification for the dismissal is possible

It is no secret that while many health care workers, managers and officials are working tirelessly to hold the health care system together, there are others who seem intent on bringing it down. This may be through tender manipulation, the theft of medicines and medical supplies, and corruption. These activities take funds away from the provision of health care (including the payment of staff, upkeep of facilities and dispensing of medicines) and put it into the hands of a few unscrupulous people. This is contrary to effective and accountable governance and robs the public of its right of access to health care services. From their position in health care facilities across the country, health care workers can often see this happening but don't know what, if anything, they can do about it.

Can a health care worker blow the whistle?

If a health care worker sees corruption or unlawful conduct in his or her place of work, he or she has a duty to report it and has the right to do so. The Constitution provides that everyone has a right to freedom of expression. The Code of Conduct for the Public Service places an obligation on an employee to report on certain matters and provides that, "An employee, in the course of his or her official duties, shall report to the appropriate authorities, fraud, corruption, nepotism, maladministration and any other act which constitutes an offence or which is prejudicial to the public interest." The Public Service Act (Proclamation No. 103 of 1994) provides that a complaint or grievance concerning an official act or omission should be reported to a relevant minister, premier or MEC, among others, and if the complaint is not resolved to the satisfaction of the employee, it should be referred to the Public Service Commission for investigation.

Protection for whistle-blowers

The legal provisions described above

show the importance of whistleblowing and the allowance for such whistleblowing in the public service. The question remains, how can a health care worker be expected to report unlawful or irregular conduct when he or she could risk her job and safety doing so? This is where the Protected Disclosures Act 26 of 2000 and the Intimidation Act 72 of 1982 come in.

The Protected Disclosures Act recognises the role that every person has to play in disclosing unlawful and irregular conduct, and the right of every employee to disclose such conduct or activities without fear and without being victimised or dismissed. It is designed to allow those in the public or private sector to speak out without having to fear for their jobs or safety. It provides important protection for nurses and other health care workers who want to blow the whistle to ensure the proper functioning of the health care system.

To have the protection of the Act, an employee must ensure that the disclosure is reported to the employer (if possible), to the Public Protector or Auditor-General, to a legal advisor or to the Cabinet or Executive Council. An employee can also make a general protected disclosure, for example to the media, where the issue was not raised with the employer because the employee expected victimisation, believed a cover-up by the employer would result, or where the employer took no action on the disclosure in a reasonable time. The preferred approach, where possible, is to make the disclosure internally, i.e. to the facility manager. Where this is not possible or has been unsuccessful, external disclosure is

protected. This is important as health care workers are often told that they are not allowed to speak about these issues outside of the work environment. While it is preferable that disclosures are made internally, this is not always possible or effective as problems can be covered up or ignored or employees can be victimised. If this is the case, it is within the rights of the health care worker to make an external disclosure, to the bodies or people noted above or to the media.

As long as an employee complies with these requirements and makes the disclosure in good faith, he or she gets wide-ranging protection from "occupational detriments" including protection against disciplinary action, dismissal, suspension, demotion, harassment, intimidation, altering terms of employment, being denied promotion, and threats of any of these detriments.

An employee who suffers an occupational detriment is entitled to refer his or her case, within 90 days, to the Public Health and Social Development Sector Bargaining Council. If he or she has been dismissed because of the protected disclosure, the dismissal is deemed to be an "automatically unfair dismissal" which means that no justification for the dismissal is possible.





sible. If the employee suffers any other occupational detriment, this is deemed to be an unfair labour practice. If an employee fears being subjected to an occupational detriment, he or she can request a transfer to another department or another facility and such a transfer must occur if reasonably practicable.

Referral to the Bargaining Council can be done by the employee him or herself or with the assistance of a union representative. It does not require the involvement of an attorney and the Bargaining Council procedures are designed to be easily accessible to employees.

What about protection from physical threats? The Intimidation Act 72 of 1982 makes it a crime to try and compel a person to do something or to abstain from doing something through assault, injury or the threat

If a health care worker sees corruption or unlawful conduct in his or her place of work, he or she has a duty to report it and has the right to do so.

of assault, injury, death or damage to a person or property. It is therefore possible to bring criminal charges against anyone who tries to intimidate a health care worker or any other person who wants to blow the whistle. A criminal case is brought by reporting the intimidation to the police for investigation and the formulation of charges. Bringing

criminal charges against does not require that an attorney be hired as it is the resources of the State that are used to prosecute a criminal offence.

The protection under both the Protected Disclosures Act and the Intimidation Act require action by the employee to ensure protection. If, having made a protected disclosure, a health care worker feels that as a result of this he is being side lined at work, including being passed up for promotion, transferred against his will, or suffering any other occupational detriment including suspension, demotion or dismissal, he must make a referral to the Bargaining Council. If he is intimidated, he must report the intimidation to the police. The protection of the two Acts is only available to employees who use it.

Why should health care workers blow the whistle?

Despite the protection that the Protected Disclosures Act and the Intimidation Act offer, many health care workers remain afraid to speak out. They are afraid that they will be beyond the reach of the law; that they are in areas or clinics or hospitals that aren't seen by civil society and that run according to a different set of rules. This is understandable. Nurses can feel powerless in the face of widespread corruption and it is easier to take a back seat and

hope that the problems will go away on their own. The sad truth is that they will not. Improving health care service provision depends on the bravery of those in the know: and in the case of unlawful conduct in health care facilities, those in the know are often health care workers.

South African health care workers can find inspiring whistleblowing guidance in recent history. In the campaign for a programme to prevent mother-to-child transmission of HIV, health practitioners became daring leaders and outspoken champions of the cause. In response to government's unreasonable unwillingness to provide Nevirapine to expectant mothers, health practitioners became HIV activists. The results? When the Treatment Action Campaign took the issue to court in 2001 mother-to-child transmission sat around 30%. Today it is about 3.5%. That is neither a miracle nor an accident: it required health care workers to take risks—health care workers brave enough to stand and shout or sit and testify.

Nurses work at the coalface of South Africa's health care crisis. They treat real people, engage real problems and make people healthier on a daily basis. Many nurses see themselves as advocates for each individual patient that comes to them. But this is not enough. First-hand experience equips nurses with unique insights into the health needs of the country and what is happening to hamper them. Fortunately, the Protected Disclosures Act and Intimidation Act protect nurses and allow them to stand up for quality health care services and to speak out against those trying to undermine the health service. Without nurses standing up to corruption and unlawful conduct in our health facilities, the battle for better health care services for all in South Africa will be difficult to win. [®]



Test your knowledge Quiz

1. When should nurses be guided and prepared for family and Community Centred Care?

2. Which Act supports the preparation of nurses for family and Community Centred Care?

3. Health is seen within the context of psychological, social and physical factors. True or False.

4. Incorporating the family into clinical practice may require a change in the usual routine as well as the development of new skills. True or False.

5. Which television show is broadcasted weekly by Community Media Trust to promote the credibility of antiretroviral treatment?

6. Which fats and oils are the best choices for our arteries and our hearts?

7. Which Act protects the whistle-blowers?

8. Which ways are used to reach out and empower communities?

9. To make sure that the implementation of community dialogue and mobilisation is successful, which factors must be considered first?

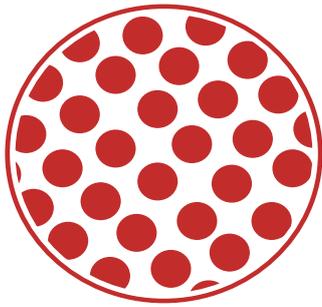
10. One of the characteristics or features of AIDS competent communities is: that the community must form partnerships with other communities and partner NGO's for support and sharing of skills. True or False.

Get all the answers on the next page (Page 46)



Answers to the Quiz questions

1. *Nurses should be guided and prepared during pre-service and in-service learning regarding family and community centred care.* From this Article: **“THE PREPARATION OF NURSES FOR FAMILY AND COMMUNITY CENTRED CARE”**
2. *The preparation of nurses is enacted in the Nursing Act, Act 33 of 2005; Chapter 2 stipulates the education, training, research and registration of nurses.* From this Article **“THE PREPARATION OF NURSES FOR FAMILY AND COMMUNITY CENTRED CARE”**
3. **True:** *This means that health is seen within the context of psychological, social, and physical factors.* From this article: **“Promoting Family and Community Centred Care.”**
4. **True:** *Incorporating the family into clinical practice may require a change in the usual routine as well as the development of new skills.* From this Article: **“Promoting Family and Community Centred Care”.**
5. *CMT’s weekly television show Siyayinqoba Beat It! has been recognised with popularising the credibility of antiretroviral treatment.* From this Article: **“Foot Soldiers of Primary Health Care”.**
6. *Mono-unsaturated and poly-unsaturated fats are the best choices for our arteries and our hearts.* From this Article: **“Eating healthy on a budget”.**
7. *The Protected Disclosures Act 26 of 2000 and the Intimidation Act 72 of 1982,* From this Article **“WHISTLEBLOWING: WHY SHOULD I DO IT AND HOW AM I PROTECTED?”**
8. *Reaching out and empowering communities can be through peer education and social dialogue⁸.* From this Article: **“GIVING COMMUNITIES A VOICE IN HIV/AIDS PREVENTION: COMMUNITY DIALOGUE AND COMMUNITY MOBILISATION.”**
9. **Challenges to community dialogue and mobilisation**
Successful implementation of community dialogue and mobilisation strategies depend on a number of factors, including literacy level, lack of awareness, access to information and the level of empowerment in a community.
From this Article: **“GIVING COMMUNITIES A VOICE IN HIV/AIDS PREVENTION: COMMUNITY DIALOGUE AND COMMUNITY MOBILISATION.”**
10. **True,** *The community must form partnerships with other communities and partner NGOs, for support and sharing of skills.* From this Article: **“GIVING COMMUNITIES A VOICE IN HIV/AIDS PREVENTION: COMMUNITY DIALOGUE AND COMMUNITY MOBILISATION.”**



FIDSSA 5

Changing Attitudes



10-12 October 2013

5th FIDSSA CONFERENCE **Champagne Sports Resort Drakensberg** **KwaZulu Natal, South Africa**

-
- ▶ Antibiotic stewardship
 - ▶ HIV and TB
 - ▶ Multi-resistant Gram negatives
 - ▶ Insights from the microbiome
 - ▶ Infectious Diseases in marginalised populations and mass gatherings
 - ▶ Current vaccination challenges and controversies
 - ▶ New therapeutics
 - ▶ Frontiers in diagnostics
 - ▶ Workshops and training

For further information contact the FIDSSA Conference Office

Tel: +27 (0)11 463 5085 Fax: +27 (0)11 463 3265

email: erna@soafrica.com, janice@soafrica.com

www.fidssa.co.za

NDOH/SANAC Nerve Centre Hotlines

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

Nerve Centre Hotline and, specific emails for each province:

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



AIDS Helpline 0800 012 322

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

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

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

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

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

Cases presented to the range from testing, treatment, transmission, TB, Medical Male circumcision, etc.

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





**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.



9th Public Health Association of South Africa (PHASA) conference and the inaugural conference of the African Federation of Public Health Associations (AFPHA)

Africa's Public Health Legacy - Beyond the MDGs
24 - 27 September 2013

The 9th Public Health Association of South Africa (PHASA) conference and the inaugural conference of the African Federation of Public Health Associations (AFPHA) will be held jointly in Cape Town at the International Convention Centre.

CONFERENCE DATES

24 September 2013	Student Assembly World Federation of Public Health Association's Workshop
25 September 2013	Skills-building Workshops
26-27 September 2013	Main Conference

CALL FOR ABSTRACTS *(Conference official language is English)*

PHASA & AFPHA are now calling for abstracts for the 2013 Conference. Authors should submit abstracts online by no later than **21 May 2013**.

- Track 1: Leadership for a lasting legacy
- Track 2: Social determinants of health
- Track 3: Burden of disease, disability and population health
- Track 4: Improving the performance of the health system
- Track 5: Policy advocacy and Community action for public health
- Track 6: Public Health Education, Teaching and Training

SPECIAL CONFERENCE FEATURES

- Abstract Mentorship Programme
- Student assembly
- Satellite sessions
- Saving our planet-climate change focus
- Taking stock - Thinking futures – A moderated panel discussion

REGISTRATION

Early registration: 5 March – 30 July 2013
Late registration: 1 August – 13 September 2013

EXHIBITION

Do not miss the opportunity to network with industry innovators. Get in touch to learn more about exhibition opportunities at this event.

For more information, please visit the website at www.phasaconference.org.za

CONTACT DETAILS

MRC EVENT MANAGEMENT OFFICE
TEL: +27 21 938 0237
EMAIL: deon.salomo@mrc.ac.za



SAVE THE DATE
24 – 27 SEPTEMBER 2014



CONFERENCE

2014
24-27 SEPTEMBER AT CTICC

**Southern African HIV Clinicians
Society 2nd Biennial Conference
International Convention Centre,
Cape Town, South Africa**

Following on from the success of our inaugural conference in 2012, our second SA HIV Clinicians Society Conference will be taking place from 24 – 27 September 2014 at the CTICC.

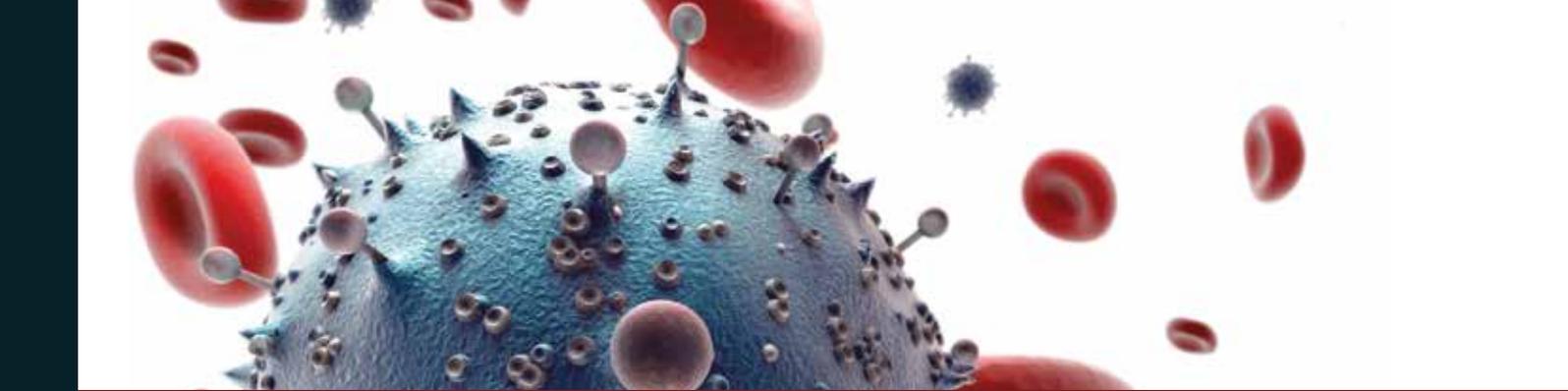
Focusing on clinical content, our conference is aimed at doctors, nurses and pharmacists, and will be fully CPD accredited.

Please diarise this event and keep an eye on our website: www.sahivsoc2014.co.za, for the latest updates.

We look forward to welcoming you in Cape Town.

Contact: Scatterlings Conference & Events
Tel +27 (0) 11 463 5085 Email: fiona@soafrica.com





UNITING NURSES IN HIV CLINICAL EXCELLENCE, BECOME A MEMBER.



Who are we?

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

1 LEADING • PIONEERING

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

2 CONNECTING • CONVENING • ENGAGING

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

3 ADVOCATING • INFLUENCING • SHAPING

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

Member Benefits

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

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

SOCIETY CONTACT DETAILS:

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

Email: sahivsoc@sahivsoc.org

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

www.sahivsoc.org

