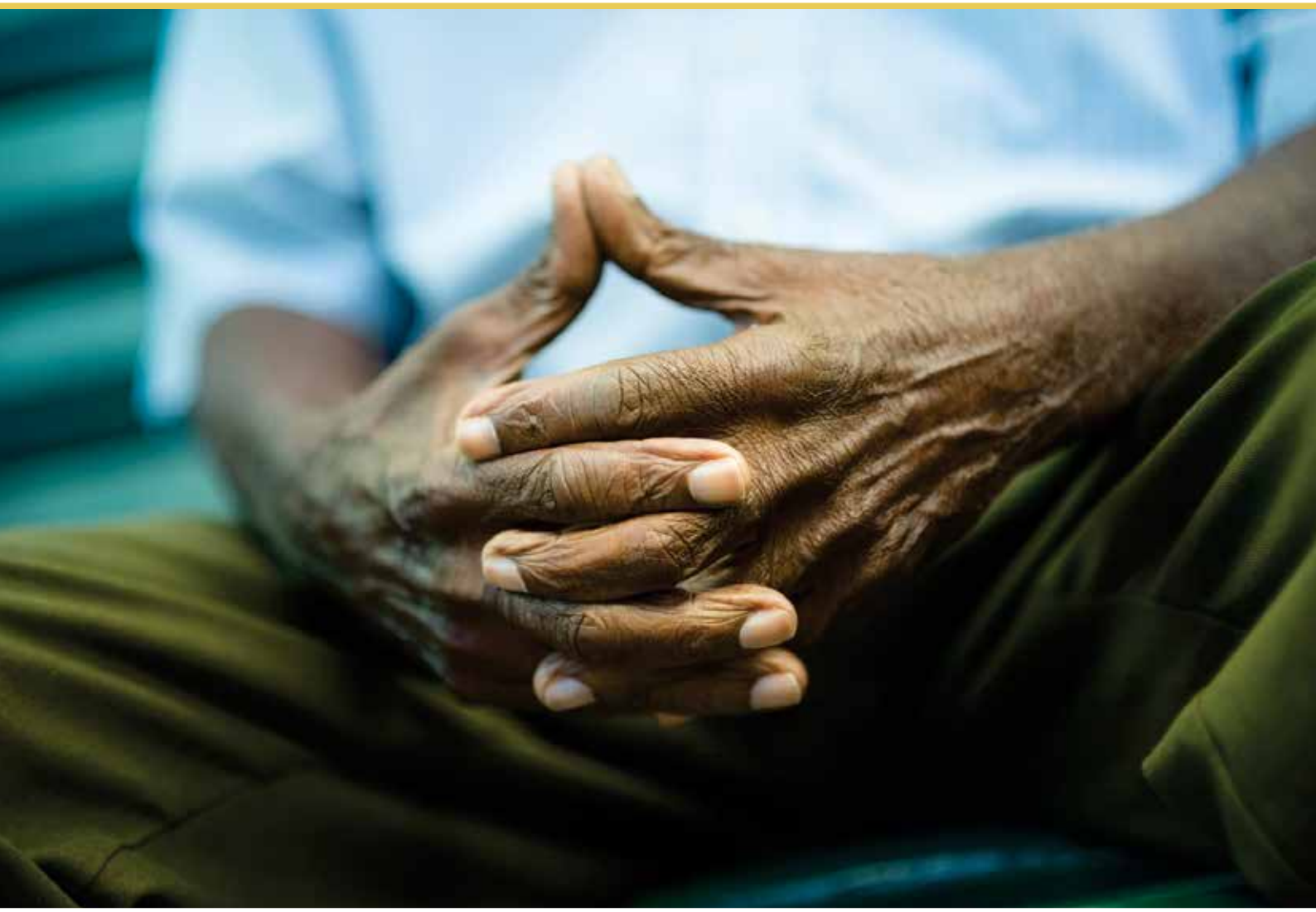
HIV Nursing matters

A publication of the Southern African HIV Clinicians Society



Mental Health and HIV in Lesotho

Psychological effects of HIV infection

The care of patients with Mental illness and HIV

September 2014 Volume 5 No. 3

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HIV Nursing matters

Focus on HIV and Mental Health

inside

guest editorial

Dr G.C. Langley, Department of Nursing Education, University of the Witwatersrand

Mental health – is this just a 'buzz word'? What exactly does it mean? Do we talk about 'physical health'? Do we actually want to deal with mental illness? The concept is complicated by the wide range of complaints and disorders subsumed under the term mental illness: among others, substance abuse and use disorders; mood disorders; cognitive disorders; mental disorders due to medical conditions; psychotic disorders; delirium and dementia; eating disorders; personality; sleep and sexual disorders.

The issue of mental illness is surrounded by stigma, fear, irrational beliefs and misinformation (for example, all psychiatric patients are dangerous; all persons suffering from depression are sad and suicidal and may be subjected to 'shock treatment'). We call persons who are receiving treatment 'users' – do we speak about surgical or medical users?

Mental illness is the third leading cause of disability in South Africa. It is also one of the least talked about, accepted or understood concepts. What we do know, is that the diagnoses and the suffering subsumed under this bland term impact upon the individual, family, community, neighbourhoods, the country and the continent as a whole. In Southern Africa, personal and community stressors such as poverty, crime and unemployment influence psychiatric morbidity. High levels of drug and alcohol abuse, interpersonal, domestic and gender based violence, rape, trauma and the mental consequences of HIV/AIDS lead to unacceptably high levels of mental illness. The latter is of particular concern as Sub-Saharan Africa is confronted with frightening HIV statistics and it is estimated that half of HIV infected patients have a mental illness.

Treatment is contested: many people opt not to take antidepressants because they consider them habit forming or an indication of personal weakness. Parents of children who would benefit from treatment for attention deficit disorders are urged to try anything but the required drugs – unfortunately, the longer the treatment is withheld, the less responsive the child's brain to the intervention with major implications for his or her future.

Despite the overwhelming burden of mental illness, the proposed new South African curriculum for professional nurse education excludes psychiatric nursing. Graduates will be registered as general nurses and midwives. Nurses will no longer be able to state that they care for the whole person. The strange concept 'mental health' will be interwoven throughout the curriculum. Psychiatric (mental health) nursing will have to be pursued post registration through a diploma or higher degree; the process has not been determined by the nursing council. The problem is that the District Health System requires professional nurses to be able to identify, diagnose and treat persons with mental disorders without clinical training or experience in psychiatric care.

Moreover, there may only be one professional nurse in a clinic. It is unlikely that s/he will be given study leave to remedy this deficiency. To date, very little opposition to this decision by the regulatory authority has been forthcoming from the disciplines involved in mental healthcare, so can we, as health professionals, actually claim to be concerned about the devastating impact of mental illness?

Some people and institutions are. This issue is concerned about psychiatry. A number of contributors examine mental illness from different viewpoints. The Anova Health Institute has initiated the integration of mental healthcare and describes this process. HIV and the assessment of mental disorders by nurses in general HIV clinics is discussed, as is the treatment of depression; Mesdames Phafoli and Lebaka discuss mental health and HIV in Lesotho. Idalia Venter urges that depression suffered by people living with HIV is treatable. Movingly, Sindi gives a detailed description of her personal experience of a debilitating depression.

Psychiatry and mental healthcare is given short shrift in Southern Africa but it is reassuring to find that the issue is being taken up in this publication. ®

Dr Gayle Langley is a senior lecturer and coordinator of the Doctoral degree programme in the Department of Nursing Education, University of the Witwatersrand. Her clinical experience as a psychiatric nurse and a midwife has engendered an enduring interest in domestic violence, rape and crisis counseling, family and couple therapy and she continues to practice as therapist in these areas. Her particular research interest is ethical care in high care and intensive care units and end of life care. Gayle is a member of Sigma Theta Tau International for Nurses.

HIV Nursing matters

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Message from the president

Dr Francesca Conradie
President, Southern African HIV Clinicians Society

I find one of the most challenging things to do in a busy clinic is to adequately assess a patient's mental health. I am sure that I am not the only one. The clinic is crowded and loud; there are many patients waiting and I feel the pressure of time. I am not always sure if the tearful patient in front of me is sad because she has just found out she has HIV or because she is suffering from depression.

I found the Society's guidelines on managing mental health disorders in HIV-infected adult patients to be extremely helpful in narrowing down the questions that I should ask all of my patients[1]. First, the authors make clear that is the health care provider's responsibility to routinely screen for common mental disorders (CMD), e.g. depression, anxiety, because patients **rarely volunteer information on their mental state**. Those words rang true to me – when has a patient opened up to me about feeling sad or anxious without me probing? Usually I only learn about a patient's sadness or fears after I've asked many questions about how well they are taking their medicines.

The following are three brief questions you can ask **every patient** to assess their mental state:

- How have you been in the past month/ since your last visit?
- Have you been feeling more stressed than usual?
- Have you been feeling down, low, heart-sore or depressed?

Patients who respond positively to one or more of the above questions should be administered a validated screening tool to assess their mental health state, such as the Patient Health Questionnaire (PHQ)-9. The PHQ-9 is included in Dr Greg Jonsson's article, An approach to assessing mental health disorders in the general HIV clinic (pg. 24).

Adolescents and children may also experience anxiety and/or depression, or have a caregiver who is impacted. In this month's *Southern African Journal of HIV Medicine*, there are guidelines on the management of mental health disorders in HIV positive children and adolescents[2]. Wits RHI will also soon publish a comprehensive handbook for healthcare providers, *Working with adolescents living with HIV: A handbook for healthcare providers*, which will cover a range of issues relevant to working with adolescents, including psychosocial. We will share these resources with you when they become available.

Finally, it's important to remember that depression/anxiety can happen to any of us. I found Dr Sindi van Zyl's personal account of dealing with depression, included in this issue, to be especially compelling. I commend her bravery in sharing her experience, and I hope that it helps readers better understand the disease and the importance of screening.

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27 August 2014

Dear Colleagues

RE: THERAPEUTIC ALTERNATIVES TO NEVIRAPINE SUSPENSION FOR USE IN NEONATES FOR PREVENTION OF MOTHER TO CHILD TRANSMISSION

The National Department of Health (NDoH) has issued a circular warning of potential supply shortages of Nevirapine suspension 100ml and 240ml (attached). The supplier anticipates resuming full supply of NVP 100 mL by end of August, and 240 mL by January 2015.

It is essential that HIV positive mothers are booked early for antenatal care and their viral loads are monitored throughout their pregnancy and during the breastfeeding period per guidelines.

If you anticipate a short supply of NVP, the following are NDoH recommended alternatives for PMTCT per circular:

Recommended alternative regimen for patients receiving 6 weeks of NVP:

Oral Zidovudine (AZT) should be given for 6 weeks at the following doses:

Weight	Zidovudine (AZT)
<2000g	2mg/kg twice daily
2000 – 2499g	10 mg twice daily
>2499g	15 mg twice daily

Please note that AZT **should not** be extended beyond 6 weeks due to concerns about toxicity (e.g. anemia). AZT is effective as post-exposure prophylaxis for intrapartum exposure but it has not been proven to be an **effective prophylaxis** for breastfeeding exposure. Mothers who are not virologically suppressed should be counselled to avoid mixed feeding.

Recommended alternative for patients receiving 12 weeks of NVP:

Oral AZT combined with Oral 3TC for 6 weeks. Discontinue AZT at 6 weeks and continue 3TC for 6 more weeks, for a total of 12 weeks of 3TC.

Weight	Zidovudine (AZT)	Lamivudine (3TC)
<2000g	2mg/kg twice daily	
2000 – 2499g	10 mg twice daily	7.5 mg twice daily
2500g -8kg	15 mg twice daily	25 mg twice daily

Clinical support:

If you have any questions about a particular case, please contact us at child_adolescent@sahivsoc.org

Medicines shortages/stock outs:

If you anticipate shortages of any essential medicines or are currently experiencing a stock out, please report to the Stop Stock Outs Project at report@stockouts.co.za or phone/SMS/please call me/WhatsApp to 084 855 7867. Your report will be followed up on and addressed.

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NOTICE TO ALL DOCTORS, NURSES AND PHARMACISTS

THERAPEUTIC ALTERNATIVES TO NEVIRAPINE SUSPENSION FOR USE IN NEONATES FOR PREVENTION OF MOTHER TO CHILD TRANSMISSION

The contracted suppliers for nevirapine suspension are experiencing supply problems. Suppliers will only be able to resume supply as follows:

- 100 mL – end August 2014
- 240 mL – January 2015

The recommended therapeutic alternative is:

- Zidovudine, oral

Infant age	Daily dosing
Birth to 6 weeks	
• Birthweight 2000-2499 g	10 mg twice daily
• Birthweight ≥ 2500 g	15 mg twice daily

The other acceptable alternative is:

- Lamivudine, oral, 2 mg/kg/dose 12 hourly

The duration of treatment is the same as set out in the nevirapine-based PMTCT guidelines. See the Standard Treatment Guidelines and Essential Medicines List for Paediatrics (2013 edition, page 9.6)

Please ensure that the contents of this circular is brought to the attention of all relevant prescribers.

MR G STEEL
CLUSTER MANAGER: SECTORWIDE PROCUREMENT
DATE: 19-08-2014

Mental health and HIV in Lesotho

S H Phafoli,[1] RN/M, B Cur (I et A), MSN, Ph.D., M N Lebaka, [2] RN/M, R Psych MH, MNSc, B. ed.
[1]Jhpiego Lesotho, [2]Ministry of Health Lesotho

The rise in HIV infection in Lesotho has prompted the country to treat the epidemic as a national crisis, given its potential to reverse the progress made over the past three decades. Similarly, the increase in MI threatens the economy of the country by depleting it of able-bodied workforce by rendering them unemployable, mainly due to stigma attached to it.

Background

Approximately 14% of the global burden of disease is attributed to mental illness (MI); however it is seen as an isolated problem in Lesotho, like most African countries. Although mental health and wellbeing cut across all the Millennium Development Goals (MDGs) from education to health, it does not appear succinctly in the MDGs. This, together with the lack of mental health champions and consistent messaging, contributes to it remaining a silent problem worldwide, including in Lesotho[1].

MI and HIV are both chronic diseases that carry stigma and discrimination worldwide[2]. MI can arise independently of HIV infection,

can predispose to HIV, or can be a psychological consequence of HIV. Patients with serious MI may be at higher risk of contracting HIV due to risky behaviours; likewise, people living with HIV (PLHIV) may develop HIV-related depression or dementia[3].

It is estimated that as many as 50% of PLWHIV have a comorbid MI [4]. Regardless of aetiology, the comorbidity of MI-HIV poses special challenges for HIV care. Individuals with both diseases face even greater barriers to care than do those with HIV or MI alone. Denial and misunderstanding contribute to decreased compliance, which impact the wellbeing of the chronically ill individual. Beyond challenges related to stigma and discrimination, pharmacologic management becomes difficult due to potential drug-drug interactions and/or similar adverse effects.

Mental Health and HIV in Lesotho

The rise in HIV infection in Lesotho has prompted the country to treat the epidemic as a national crisis, given its potential to reverse the progress made over the past three decades. Similarly, the increase in MI threatens the economy of the country by depleting it of able-bodied workforce by rendering them unemployable, mainly due to stigma attached to it.

Although statistics do not exist for all MIs in Lesotho, globally neuropsychiatric disorders are said to contribute about 4.8% of the total burden of disease[5]. MI has direct, indirect and human costs that place a burden not only on those who are ill and their loved ones, but also on employers, governments and society as a whole[6]. In the United States (U.S.) in 2006, healthcare costs reached 16% of the nation's gross domestic product, and of this 16%, mental disorders contributed about 6.2%[7]. In Lesotho, 1.8% of the total health budget is spent on mental health, 82.1% of which goes to the specialist psychiatric hospital in Maseru[8].

Psychiatric care was first introduced in Lesotho in 1959 by Dr. Ntšekhe, the first Mosotho Psychiatrist. Prior to 1964, mentally ill patients were cared for in their homes by their relatives, traditional healers and other community members, as there were no mental healthcare facilities. Often these health carers would give up and abandon their patients due to the stress of caring for the mentally ill. Following the enactment of the Mental Health Law No 7 of 1964, an arrangement was made between the Lesotho (then referred to as Basutoland) government and South Africa (SA), that all Basotho with MI would be cared for in SA: Lesotho paid 25 cents per person for care. All the "unmanageable patients" were sent to a section of the Mohale's Hoek prison, known as the Mohale's Hoek Detention Centre[9].

At the recommendation of Dr. Ntšekhe, the first psychiatric hospital in Lesotho, Mohlomi Mental Hospital (MMH), was opened in 1966. The hospital has a total bed capacity of 130 beds with provision of a sick bay for the physically ill. There are also single patient rooms when patient isolation is required. Both inpatient and outpatient services are available, including counselling, occupational therapy, gerontology, child, adolescent, and forensic services. Mentally ill patients from all the districts are referred to MMH, and this has contributed to the overcrowding, resulting in compromised quality services to the clients due to insufficient resources.

According to the 2013/14 annual joint review report for Lesotho, the leading types of mental illness seen in the outpatient department (OPD) of MMH were: 1) neurotic, stress related and psychosomatic disorders (21%); 2) epilepsy (19%); and 3) HIV and AIDS neuropsychiatric disorders (17%). MMH admitted 241 patients in the period reviewed, nearly half of whom (46%) were referred in for care. The most common reason for referral was HIV and AIDS neuropsychiatric disorders; these increased from 8% in 2012 to 17% in 2013[10].

In 1978, after the Alma Ata Declaration, Mental Observation and Treatment Units (MOTU) were built in nine of the ten districts in order to decentralize mental health services. The MOTUs have a 20 bed capacity; however, most of them are not providing inpatient services due to shortage of staff and poor infrastructure.

Lesotho has the world's second highest prevalence of HIV: 22.9% of adults 15 to 49 of age are infected[11]. HIV disproportionately affects women in Lesotho. Not only are women at higher risk of HIV acquisition due to their physiological make-up, but also due to gender-based violence (GBV) among women and children which is a prevalent issue[12]. Approximately 25% of women aged 18 to 35 years reported that they had been physically forced to have sex [13], while one in every five children aged 11 – 16 years report having been coerced into sex. In addition, women are more likely than males to be separated, divorced or widowed by AIDS [14]. As caregivers of PLWHA, women are also exposed to much stress, which predisposes them to MI. Denial, sadness, fear, anger, anxiety, grief and depression are common elements of coping with HIV and AIDS and often have a strong and negative impact on patients, their friends and relatives. PLWHA and those within their social cycles are subjected to social stigma and discrimination, which can cause neurologic deterioration leading to dementia, manic symptoms and atypical psychosis[15].

The Lesotho Orphans and Vulnerable Children Situation Analysis report from 2011 estimated that there are 1 072 974 children under the age of

18 in the country. Of these, 33.8% are orphans, and 23.6% have lost both parents[16]. HIV-affected children and children with HIV reported experiencing higher levels of stigma than children who were unaffected by HIV. A diagnosis of HIV[17] presents additional concerns of discrimination, disclosure, medication adherence, and isolation from traditional peer support networks. Many of these children drop out of school due to lack of funds or the need to stay home to care for a sick parent or to take care of siblings[18]. This poses a threat to the future economy of the country as these children who are the adults of tomorrow, will end up poverty stricken, which will predispose them to HIV infections and MI because people living in poverty are more vulnerable to MI, as well as contracting HIV infections, while those with pre-existing MIs are more likely to become trapped in poverty due to decreased capacity in carrying out everyday functions [19].

Because MI can increase the risk of acquiring or transmitting HIV, responding to the barriers to, and complex needs in care is imperative for both patients and the public health. Management of this comorbidity poses a challenge in Lesotho, as services for both conditions are not yet integrated. Psychiatric Nurses working at the MMH and MOTUs provide all mental health services; however, PLWHA are provided care and treatment services across all facilities in the country. Most mental health nurses are not included in trainings on diagnosis and management of HIV; similarly general nurses are not capacitated to provide basic mental health care services. In order to adequately address this, training of these healthcare workers should include both MIs and HIV issues.

Conclusion and recommendations

Although MIs and HIV effects pose an economic crisis for Lesotho, through appropriate social and other policy measures the situation can be corrected. Integration of mental health and HIV services can play a significant role in this case as well as establishing, implementing and supporting family support programmes. Strengthening community mental health services throughout the country would be a major strategy where communities are educated on primary prevention of HIV, MIs and other illnesses that may affect the general well-being of the people of Lesotho. To improve care for Basotho living with either or both diseases, the following are recommended:

- Increased awareness campaigns, targeted at reducing stigma and discrimination
- Integration of mental health, HIV and other primary healthcare services
- Increase budget allocation for mental health two-fold
- Revise, enact and operationalize the draft mental health policy, integrating HIV care
- Increased political will and commitment on mental health and HIV issues
- Conduct research to provide evidence of primary prevention methods for mental health and HIV
- Increase numbers of trained psychiatric specialists; engage community health workers and/or peer-based support groups
- Educate traditional healers to refer clients with MI and/or HIV. ®

The Lesotho Orphans and Vulnerable Children Situation Analysis report from 2011 estimated that there are 1 072 974 children under the age of 18 in the country. Of these, 33.8% are orphans, and 23.6% have lost both parents.

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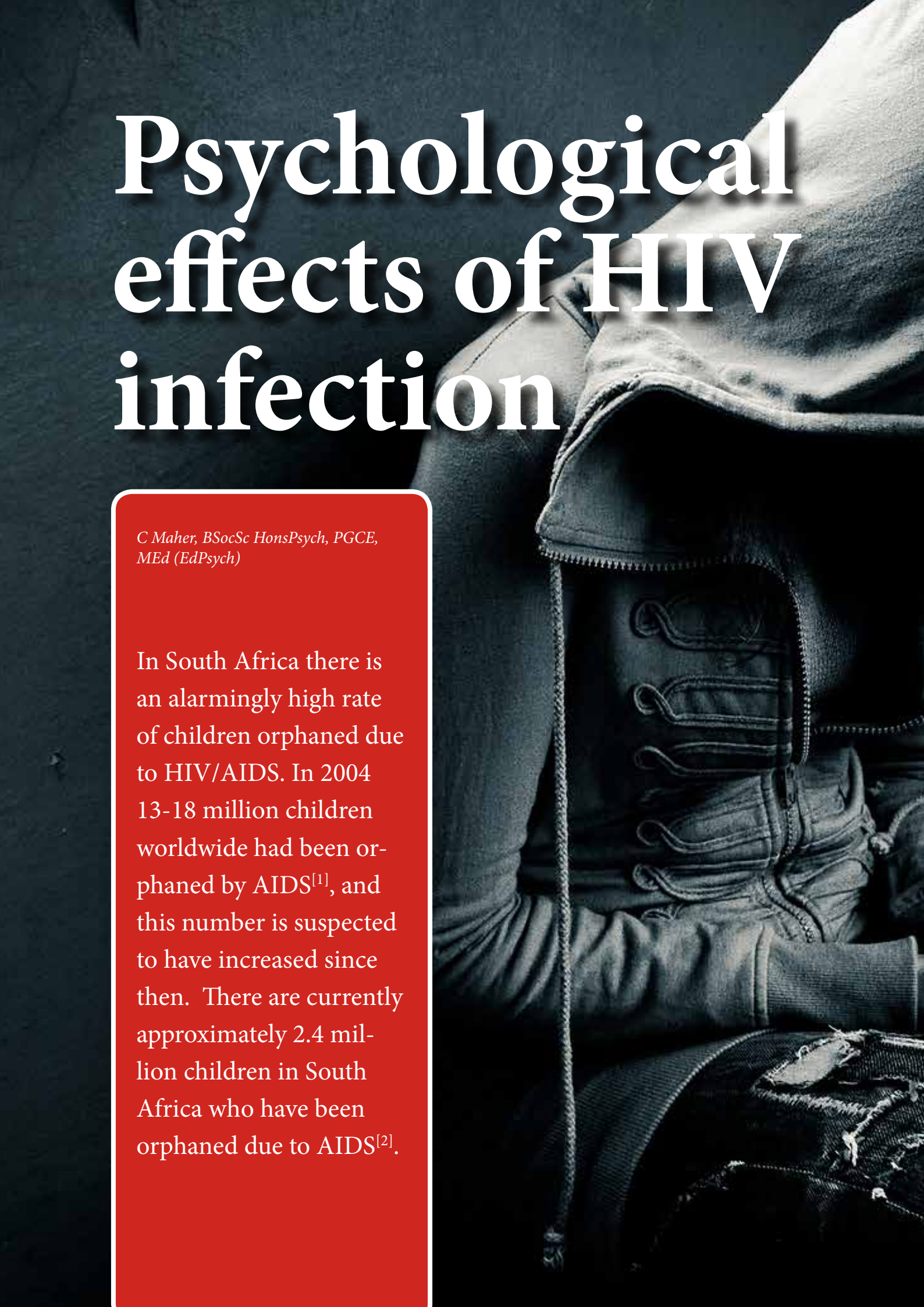
Corrections

Authors Ibeto M, Giddy J and Cox V would like to correct a mistake in their recent article, "Steps towards elimination of mother to child transmission of HIV - a review of HIV positive infants" (HIV Nursing Matters. 2014; Jun 5(2): 22-23.) The authors stated that "All infants entered in the register should have a PCR performed and recorded; the review found a significant proportion (80%), of infants with no recorded PCR test results". It's supposed to be (20%).

Psychological effects of HIV infection

C Maher, BSocSc HonsPsych, PGCE, MEd (EdPsych)

In South Africa there is an alarmingly high rate of children orphaned due to HIV/AIDS. In 2004 13-18 million children worldwide had been orphaned by AIDS[1], and this number is suspected to have increased since then. There are currently approximately 2.4 million children in South Africa who have been orphaned due to AIDS[2].



HIV and AIDS are accompanied by a range of physiological symptoms. People living with HIV (PLHIV) experience weight loss, fatigue, fever, infections, rashes and short-term memory loss, among other symptoms. Many of these symptoms can be managed with medical help, as well as correct diet, rest and medication.

Psychological Disorders associated with HIV

In addition to these physiological symptoms, PLHIV suffer from a range of psychological difficulties. Research has shown that psychological and psychiatric disorders are more prevalent in members of the population infected with HIV than those without[3]. In particular, anxiety and depression are significantly higher in PLHIV than the uninfected population. These symptoms are not always as easily identifiable as the aforementioned physiological symptoms. Psychological symptoms do not always manifest physically, making them more difficult to treat.

Anxiety and depression are the most common psychological disorders associated with HIV infection. HIV does not cause anxiety disorders itself, but PLHIV experience more anxiety than the non-infected members of the population (15.8% compared to 2.1%)[4]. While some anxiety is normal, heightened and prolonged anxiety that interferes with adherence to medication and exacerbates stress is damaging. This anxiety is usually attributed to stigma, reproductive health worries (in women) or judgment from friends or family.

Depression is common among PLHIV, but is not necessarily caused by HIV (although many healthcare practitioners report that an HIV positive diagnosis will most often result in depression)[2]. In particular, not disclosing one's HIV status, losing loved ones to HIV, treatment failure (and sometimes success) and moving into the advanced stages of AIDS are all risk factors for depression in PLHIV[2]. It is also reported that ARVs can cause depressive symptoms. In particular, Efavirenz is associated with the most psychological and brain affecting side effects such as nightmares, confusion, concentration difficulties, loss of memory, hallucinations, delusions, euphoria and depression (including suicidal ideation, paranoia and mania). These symptoms can often persist as long as treatment is taken[5]. Clinical depression has two facets that need to be considered – affective and somatic. PLHIV may present with depressed mood, loss of interest, feelings of guilt, hopelessness (affective) AND fatigue, loss of weight and/or appetite, sleep disturbances and concentration difficulties (somatic)[2]. It is important to see how a PLHIV will respond to treatment for depression in order to establish whether they are presenting with depression or other conditions associated with HIV infection.

In addition to anxiety and depression, PLHIV have been known to suffer from the following psychological disorders, among others:

- Post-Traumatic Stress Disorder (PTSD)
  - Finding out one's status is a traumatic experience. PLHIV feel that their lives are threatened and there is a fear for loss of life. While PTSD can be brought on by finding out one's status, it is usually associated with a history of physical and psychological abuse and trauma that co-occurs with HIV status. The PTSD prevalence rate in PLHIV is 42%, in comparison to 1.3 to 7.8% in the general population[6].
- Substance Abuse
  - Not only does substance abuse complicate HIV as it compromises the immune system, but it is also an unhealthy coping mechanism for PLHIV to assume. Abuse of substances can be indicative of another underlying problem such as depression and needs to be addressed in order to encourage one's physical and mental well-being.
- Delirium
  - Delirium is likely in those suffering from severe medical illnesses. Some HIV medications such as Efavirenz[3] can lead to delirium. It is characterised by changes in alertness and cognition and an inability to concentrate. Delirium affects one's energy levels and creates changes in the sleep-wake cycle. Some people may suffer from hallucinations and disorientation in the environment[2].
- Insomnia
  - PLHIV experience sleep disorders at a greater intensity. These sleep disturbances and insomnia can often be attributed to pain associated with HIV or side effects of ARVs. In addition, the stress and anxiety accompanying one's status or management of the illness can create sleep disturbances. Hypersomnia (too much sleep) is characteristic of the advanced stages of HIV infection when associated with extreme fatigue[2].

There is a perpetual cycle in which increased stress and depression levels in PLHIV can lead to a more rapid progression from HIV to AIDS, which can in turn lead to further stress and depression among those infected and affected[1]. The stress and depression associated with HIV needs to be effectively managed in order to ensure that PLHIV make use of adequate self-care, continue to take their medication and remain as healthy as possible.

Effects of HIV stigma on mental health

While the stress of being HIV positive can lead to poor mental health, the stigma associated with a positive status can similarly cause stress and poor psychological well-being. There

is a stigma associated with HIV in many countries and cultural groups. People may often be shunned by their families and friends, and in many situations, retrenched from their jobs and discriminated against in the workplace[7]. This stigma can also often be internal and is reported to correlate significantly with increased anxiety, depression and feelings of hopelessness in those infected with HIV. Vanable et al. report in their research that stigmatisation is associated with an "increased likelihood of receiving psychiatric care,[5]" which implies that stigma surrounding HIV can exacerbate one's poor mental health and the need for mental health services. Stigma also "heightens vulnerability to depressed mood and other forms of distress"[4]. A depressed mood can lead to further compromised immune systems.

As a result of stigma many people who suspect they may be HIV positive will avoid Voluntary Counselling and Testing (VCT) as they prefer to keep their status unknown – even to themselves[8]. VCT allows a space for individuals to explore their feelings and discuss their support network and strategies, should they be tested positive. Absence of this counselling creates difficulties down the line when PLHIV may not have an established supportive network and have not had an opportunity to begin facing their situation or developed strategies to assist themselves.

Social and systemic interventions need to be established in order to reduce stigma, and in turn reduce the psychological effects associated with it. Access to correct information about HIV contributes to avoiding misinformation and taboo.

Mental Health of children orphaned by HIV/AIDS

In South Africa there is an alarmingly high rate of children orphaned due to HIV/AIDS. In 2004 13-18 million children worldwide had been orphaned by AIDS[9], and this number is suspected to have increased since then. There are currently approximately 2.4 million children in South Africa who have been orphaned due to AIDS[10].

While these children may not be directly infected with HIV the mental health effects are significant and varied. Studies have shown that these children experience depression, suicidal ideation, PTSD, behavioural and social difficulties and anxiety[5]. While these experiences can be attributed to non-HIV related loss of parents, it is thought that the effects may be more severe due to stigma and other socio-economic stressors.

How to reduce psychological effects associated with HIV

The World Health Organisation recommends that attention be paid to the psychosocial needs of PLHIV. In particular, assistance with employment, income, housing, informed decision-making, coping with illness and discrimination, and prevention and treatment of mild and serious mental health problems should be addressed[11].

In addition, the following can be adhered to by individuals who are struggling psychological due to HIV.

- See a counsellor or psychologist.
- Consult your medical practitioner about medication to assist you. Anti-depressants, sleeping tablets, or anti-anxiety medication can help alleviate some of the symptoms.
- Pursue other non-pharmacological avenues such as acupuncture, meditation, self-hypnosis and muscle relaxation[2].
- Find a support network – either a personal network, or attend group support meetings.
- Exercise.
- Eat healthily.
- Get at least 6-8 hours of sleep each

night.
- Encourage children affected by HIV to attend supportive therapies and groups.
- Create awareness surrounding HIV in order to reduce stigma.

Useful links and resources

- **American Psychiatric Association**
  http://www.psychiatry.org
  hiv-and-aids
- **South African Depression and Anxiety Group** (SADAG)
  www.sadag.org / 011 262 6396
  or 0800 20 50 26
- **Lifeline**
  www.lifeline.org.za
  www.lifeline. co.za
  011 422 4242 or 0861 322 322
- **FAMSA** (Country wide)
  http://www.famsaorg.mzansiitsolutions.co.za / 011 975 7106/7
- **Living with HIV**
  www.livingwithhiv.co.za
- **AIDS Helpline**
  Braamfontein, Johannesburg.
  (011) 715 2000
- **National Aids Helpline**
  www.aidshelpline.org.za
  0800 012 322
- **NAPWA Support Group**
  (National Association of People Living with AIDS)
  Corner of Knox and Simpson Street, Germiston. 011 872 0975
- **HIV and AIDS Educational Programmes**
  Morningside, Johannesburg.
  083 381 0591

Hypersomnia (too much sleep) is characteristic of the advanced stages of HIV infection when associated with extreme fatigue[2].

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Depression is treatable

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Most cases of depression can be treated at the primary health care level. So what must be done? The first step is identification of depression.

The devastation that depression leaves in its wake cannot be ignored. Not only is it globally the leading cause of disability but also impacts greatly on the global burden of disease[1]. Although it can be treated, up to 90% of people who suffer from depression are not identified and therefore not treated.

The prevalence of depression among the general population is estimated to be 10 – 15%[2]; however among people living with HIV, prevalence ranges between 20 and 60%[3-5]. Even though there are effective treatments available, only 1 in 10 people are receiving effective treatment.

The symptoms of depression are[7]:

- feelings of sadness;
- decreased interest or pleasure in activities;
- weight loss or gain;
- sleeping more or less;
- feeling tired most of the time;
- feelings of worthlessness or inappropriate guilt;
- inability to concentrate or make decisions; and
- thoughts of death.

Causes and impact of depression

Much has been written about the causes of depression and no one clear cause has emerged. Several factors have emerged as playing a role in the development of the disease. Indications a genetic origin are there but it is not clear. Other aspects linked to depression are negative thinking patterns and life stressors. What is clear is that depression is linked to chemical changes in the brain, specifically a lack of serotonin, dopamine and nor-epinephrine, and this is what anti-depressants work on. In the final analysis whether a person develops depression or not is considered to be a complex interplay between biological factors, genetics and life stressors[8].

Depression impacts every aspect of a person's life, including the individual's physical health. The impact of depression on HIV and its management is affected in two areas. Firstly the impact of the characteristics of depression in coping with HIV and then the impact on the body. The most important person in the health care team is the client: healthcare professionals have little or no control over how the clients manage their care at home. When a client is battling with decreased concentration, tiredness and lack of enjoyment, the chances of decreased adherence to treatment is greatly increased[3]. Depression and stress impact negatively on the immune system; the impact of depression on HIV is clear. An overview of the literature shows that people with HIV and depression have an increased viral load and their chances of a more rapid clinical decline and death is greater than people not suffering from depression[2].

Most cases of depression can be treated at the primary health care level. So what must be done? Obviously the first step is identification of depression.

The Mental Health Gap Action Programme (mhGAP) of the World Health Organization is specially designed for lower and middle income countries and addresses the identification, treatment and management of depression. This document is freely available on the World Health Organization's website[9]. (http://whqlibdoc.who.int/publications/ 2010/9789241548069_eng.pdf)

Treatment

As depression has multiple causes it follows that the treatment must be holistic and a combination of approaches gives the best results. Antidepressants and psychotherapy have proven useful but the causes of the depression should also be addressed [1].

Life stressors

Find out about any stressors in the person's life. Often are there are many. Some social issues you may be able to address, but even if you can't solve their problems just the act of listening can be helpful. Assess if the person is in an abusive situation, either at work or at home. Where possible you can intervene but listening to your client is of primary importance.

Support

Possibly the best ally in managing depression is patient/client support. Explore with the client the sources of support that may work best for him/her. It can be a best friend or a family member. This person (buddy) can play a vital role in involving the client in many of the activities that counteract depression.

Tips to maintain a support system:

- Activate support systems by reaching out to family and friends.
- Attend social activities even though it is difficult. Get your buddy to go with you.
- Tell close friends and family how you feel and ask them to help you.
- Be specific like asking them to come visit you even if you don't really talk to them.
- Make weekly appointments even if it is just to have a cup of tea or go shopping.
- Help with community activities it will make you feel less helpless and worthless when you are doing something for someone else.
- Join a support group if available. It is very useful to talk to people who have gone through the same thing as you and you will meet people who have recovered which will give you hope.

Tips for activities to combat depression:

- Grooming – Make an effort with your looks, have your hair done or put on some nice clothes.
- Exercise at least three times a week. It does not have to be very strenuous – a brisk walk will elevate your mood; try to do it with someone else.
- Try to get enough sleep. Most people suffering from depression have difficulty with sleep, which can lead to feeling tired and unmotivated. Apart from taking sleep medication there are ways to enhance sleep:
  * Go to bed at the same time every day so that your body gets used to this routine.
  * Do not sleep during the day even if you are feeling very tired. You will not be able to fall asleep that night and a destructive routine is created.
- Avoid alcohol, people may feel alcohol helps them to fall asleep but alcohol affects the quality of your sleep and the next day you don't feel rested.
- Avoid caffeine and large spicy meals before bedtime.
- Do something quiet and relaxing before bedtime you can't fall asleep if you are still shaking from that horror movie you have just watched.
- Proper diet: eat fresh fruit and vegetables and avoid refined sugars; avoid alcohol as it acts as a depressant. Avoid skipping meals, as it contributes to increased feeling of tiredness – a symptom also attributed to depression.
- Relaxation is important and there are many relaxation techniques: a quick, useful method is breathing. Take slow deep breaths, try to fill your lungs fully and slowly release your breath. Just doing this for 5 minutes can be beneficial.
- Do things you used to enjoy. It may be doing a hobby or cooking or even just visiting a friend.

Self-care

Here is where the support system must come in as the things that need to be done are so very difficult for the person with depression. The support person can motivate and participate in the activities. It is important to remember it is a slow process and to start small and build from there.

Medication

There are many different medications available and each drug has its own unique side-effects and patient education. However there are general principles for patient education that apply to the majority of anti-depressant drugs. Provide the following education with patients on antidepressants:

- The medication takes about two weeks to start taking effect.
- If side-effects are very uncomfortable, the client should seek clinical care before discontinuation of the treatment
- The medication must be taken for at least 6 months. Often people start to feel better and then just leave the medication and this can lead to a recurring depression which can become a lifelong condition. Cessation of medication must be monitored and usually tapered.
- Poor adherence to treatment should be discussed. The nurse should seek to support the client to remember to take the medication. Again support is vital [12].

Working with people with depression can be very draining and uncomfortable. Often clients will be very quiet and difficult to engage.

Some do's and don'ts when caring for people suffering from depression. These are useful to you as the health care provider but you can also empower clients with this information.

DON'T say:

'Pull yourself together.' You might as well tell a paraplegic to get up and walk.

'I know how you feel.' Nobody can

experience what another is going through even if you have experienced depression. Each person is unique.
'It will be all right.' You don't know that and if you think the client will believe you it is just plain insulting.

DO say:
'Help me understand what you are going through.' It shows you care and that you are interested.
'Depression can be cured and many people have beaten it.' It gives hope based on known facts and not your guesswork.
'You are not alone in this.' Showing that you will be supportive[3].

To conclude we must remember that depression is all around us and it can affect anyone, so the important part is to be able to identify it and make sure that the affected person gets treated and supported. Non-medicinal activities are also as important as the treatment itself, so as healthcare providers we need to be capacitated in the management of depression. ®

Depression and stress impact negatively on the immune system; the impact of depression on HIV is clear. An overview of the literature shows that people with HIV and depression have an increased viral load and their chances of a more rapid clinical decline and death is greater than people not suffering from depression[2].

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Perinatal Mental Health Project
Caring for Mothers. Caring for the Future.

Alan J. Flisher Centre for Public Mental Health

HIV & Maternal Mental Illness

HIV & mental illness: HIV is a very strong risk factor for mental illness. Almost half (43.7%) of all people living with HIV/AIDS in South Africa have an identifiable mental illness which requires an intervention. This is significantly higher than the regular population (16.5%).

Common Perinatal Mental Disorder (CPMD): 'Perinatal' refers to the time from conception to the end of the first year post delivery. CPMDs include Major Depressive Episode and the anxiety spectrum disorders.

CPMD & HIV: HIV infection predisposes women to mental distress and CPMD contributes significantly to AIDS-related mortality. The enormous emotional strain of living with HIV, including its social and financial consequences, makes women vulnerable to depression and anxiety. On the other hand, those women with mental illness are more vulnerable to becoming HIV positive. A depressed woman is less likely to be able to negotiate safe sex due to low self-esteem, a sense of hopelessness or financial dependency.

Self-portrait:
Thembisa Mdatyulwe

- HIV+ mothers are particularly vulnerable to mental illness during and after pregnancy.
- **Mental illness affects how women use maternity, child health services and HIV services.**
- Mental illness has been found to have negative impacts on how HIV+ women adhere to their own and their child's HIV treatment.
- **Mental health support and social support for HIV+ mothers is vital for the general** health of women, their babies and families.

Women at risk include: Women who lack partner support, unplanned/ teenage pregnancy, past/current abuse, substance abuse in the mother or in the home, financial or housing concerns or stressful change in circumstances (e.g. recent unemployment or bereavement), previous mental health problems, previous miscarriage, abortion, stillbirth, death of a child or a frightening birth experience, a bad relationship with her mother or an absent mother, chronic illnesses or obstetric problems

HIV & mental illness related to pregnancy:

In pregnancy,

- many women learn their HIV status for the first time. They are then faced with the diagnosis as well as a pregnancy that may be unwanted
- if they disclose they are positive, they can be accused of being unfaithful, be beaten or thrown out of the home by their partners or family
- women often feel anxious or guilty about transmitting the virus to their babies
- they have to adjust to the Prevention of Mother to Child Transmission (PMTCT) programme or to taking HAART.

After pregnancy,

- women face difficult decisions about infant feeding and risk friends and family becoming suspicious that they are HIV+ if they bottle feed
- women frequently feel very anxious that their babies may be HIV+

Violence

For poor women, HIV, mental health and violence overlap in dangerous ways.

HIV + women are more likely to become victims of violence. Pregnant women are also more vulnerable to violence than non-pregnant women.

Experiencing gender-based violence places women at increased risk of both HIV and mental illness.

A special role for nurses

Nurses can play a vital role in providing empathic care to pregnant women and mothers. Gentleness and kindness from a health professional is a powerful tool in making vulnerable women feel acknowledged and not judged.

What you can do

These questions can be routinely asked of patients. They have been shown to be sensitive and specific for depression and anxiety.

1. During the past month have you been bothered by feeling down, depressed or hopeless? Y/N
2. During the past month have you been bothered by little interest or pleasure in doing things? Y/N
3. Is this something you feel you need or want help with? Y/N

If score at least 2 out of 3 questions = YES, then a careful referral should be made to mental health services. It is important to ensure these services are available and prepared before the screening can take place.

The Perinatal Mental Health Project works towards access for all women to mental health care during and after pregnancy. Free resource materials for health workers and patients care available from http://pmhp.za.org/learn/pmhp-resources.

www.pmhp.za.org

An approach to assessing mental health disorders in the general HIV clinic

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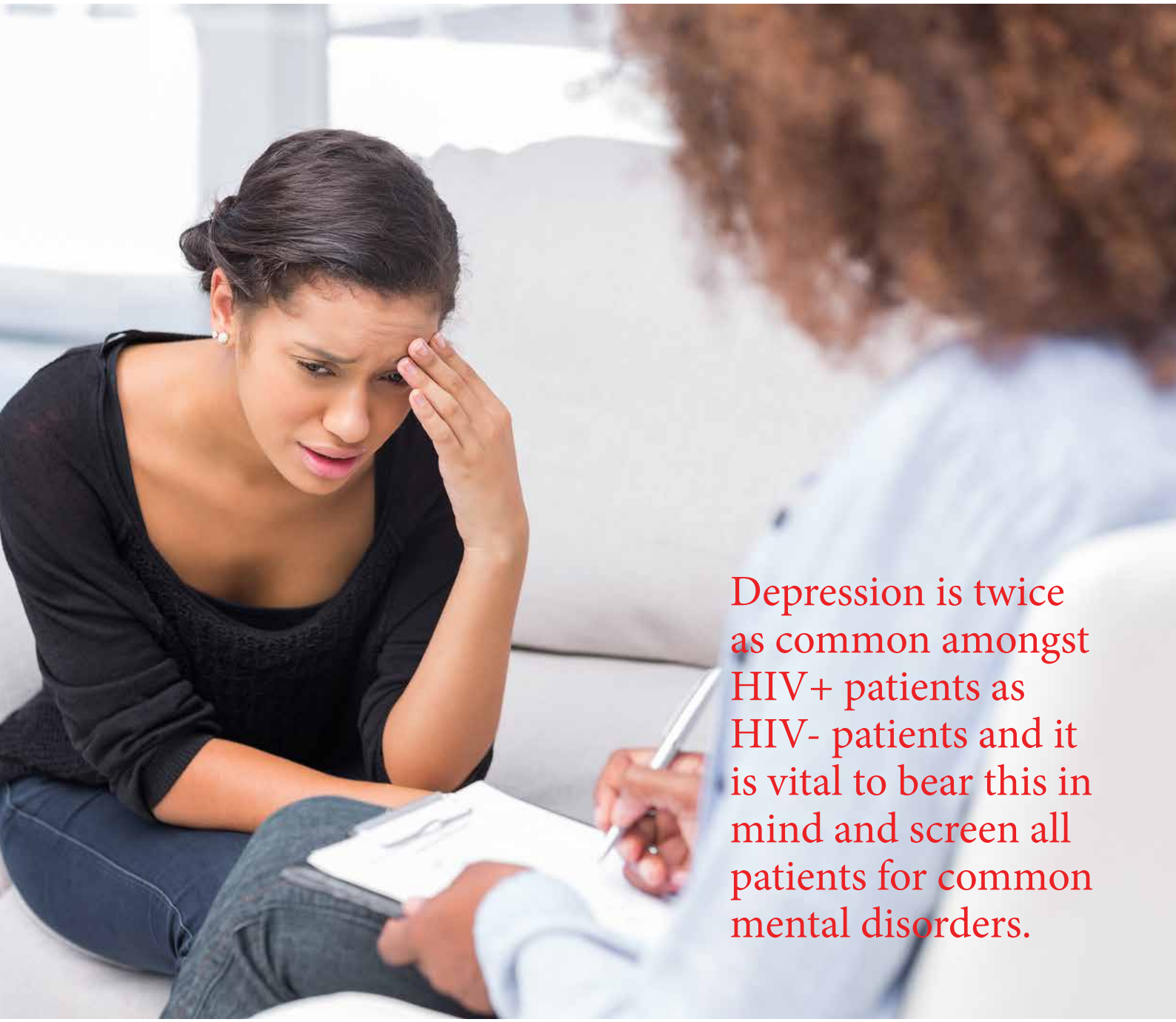

Depression is twice as common amongst HIV+ patients as HIV- patients and it is vital to bear this in mind and screen all patients for common mental disorders.

Introduction

The HIV epidemic has been referred to as a psychiatric epidemic. HIV is known to increase the risk for psychiatric illness and in turn psychiatric illness increases the risk for HIV acquisition and transmission. Effective psychiatric intervention and treatment can improve patient outcome and quality of life.

Why mental health matters in HIV?

Mental health problems can result in a decrease in adherence to medication as well as a lack of economic and social involvement. Stigma and discrimination are rife in our community and identifying the consequences of this may help improve quality of life[1].

Screening for mental health disorders

There are many advantages in screening for mental health disorders, the most obvious one is for the patient, which will result in them receiving treatment for a debilitating condition. Health care workers are often too scared to enquire about mental health symptoms, fearing opening the "can of worms" and then not knowing how to effectively deal with the patient due to a lack of training. This doesn't have to be the case. The truth of the matter is that one is able to do a huge amount without even realizing it. Just listening to a patient for a brief amount of time can do the world of good. Patients often just want a place to be heard and nurtured. A caring environment with an empathic health care provider is a good start.

Step 1

Patients rarely offer information about their mental state necessitating our enquiring about it. Patients may not wish to disclose their current mental state for fear of us judging them or perhaps admitting them. All consultations, as part of the history, should contain 4 basic questions, which enquire about common mental disorders. Asking a patient, in an empathic way, 4 simple questions may be an easy way to screen for mental health disorders. The following 4 questions are suggested:

"How are you feeling today?"
"Have you been feeling more stressed in the last while"?
"Have you ever felt sad/depressed/ lonely?"
"Have you had mental health problems before?"

If patients screen positive for any of these 4 questions, one would need to enquire further. (Figure 1).

Step 2

Once patients have screened positive for one of the above, further screening should follow. One may wish to make use of screening questionnaires. These may be patient administered or clinician administered. For example if a patient screens positive to the question: "Have you been feeling lonely/sad/ down/depressed" or "Have you been more stressed in the last while" you can make use of the PHQ-9 questionnaire to help diagnoses and grade the patient's symptoms[2]. The PHQ-9 is a quick and easy tool that was developed for use in primary care (Figure 2). It may be patient administered or clinician administered depending on your patient's level of education. One of the added benefits

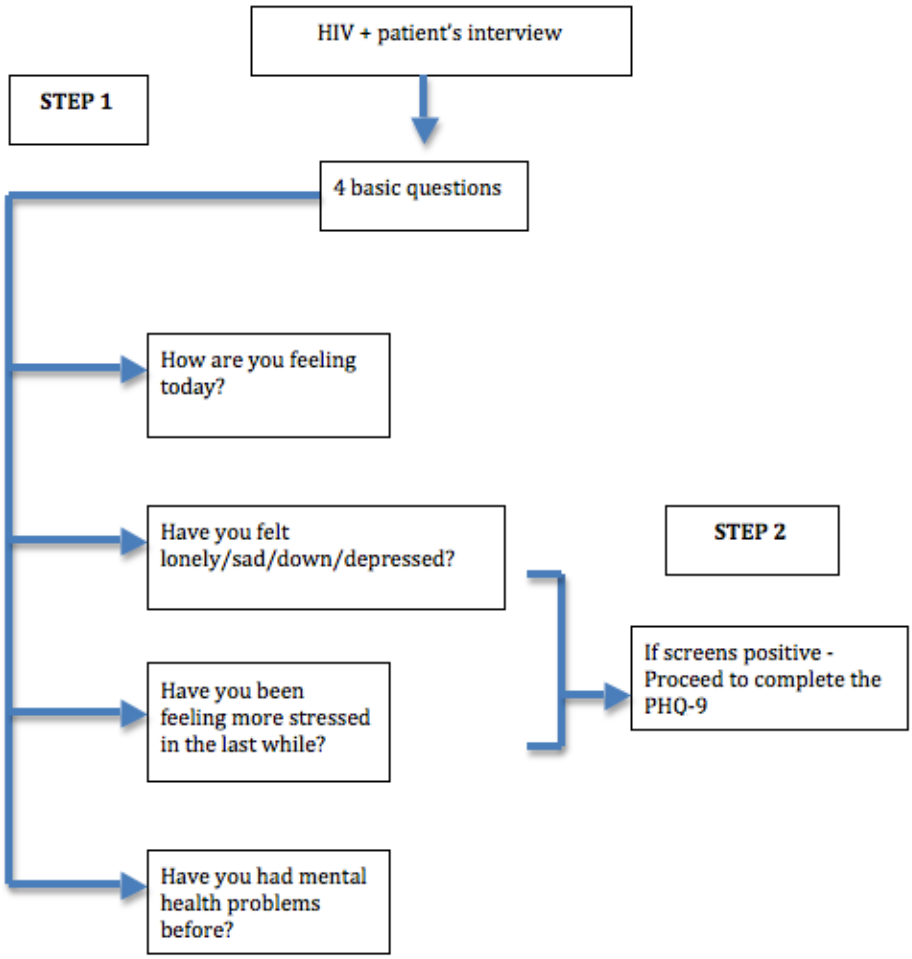

Figure 1: The 4 basic questions all consultations should contain

Figure 2: The PHQ 9

Over the past 2 weeks how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep; or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that others could have noticed. Or the opposite – being so fidgety and restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add columns				
Total:				
0-4: No depression				
5-9: Mild depression				
10-14: Moderate depression				
15-19: Moderate severe				
20-27: Severe				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people				

Total score:

Total score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderate severe depression
20-27	Severe depression

of this tool is that the severity of depression is graded which may help with response to treatment and follow up care. There are a number of other tools that may be used, one of which includes the Beck Depression Inventory version II[3].

Step 3

A further 4 screening questions surrounding mental health conditions are then asked (See algorithmic approach to diagnosis below):

"Have you thought about killing yourself lately?"

"Have you been forgetful lately?"
"Do you feel people are against you or want to harm you?"

"Have you been drinking alcohol more than usual lately?"

These questions are important for the thorough health care provider who wishes to screen for a more encompassing array of disorders (See Figure 4).

The risk assessment is important to document. This will help you make a decision in terms of either discharging the patient home, following up the patient more carefully or referring the patient for immediate admission. A user friendly tool one can easily use and remember is the sad persons

Figure 3: The SADPERSONS Scale

S	Sex: Male is at higher risk
A	Age: Extremes of age are at higher risk
D	Depression or other psychiatric co morbidity are at higher risk
P	Previous attempts: those with a past history of attempts are at higher risk
E	Ethanol/Alcohol or other substance use/abuse
R	Rational thinking loss; e.g. psychosis with command hallucinations
S	Social support: no social support confers a higher risk
O	Organized plan
N	No spouse
S	Sickness: Medical or psychiatric illness may confer a higher risk

0-2 points	The patient may be sent home but one needs to ensure follow up in the future
3-4 points	Close follow up needs to be ensured and hospitalization considered
5-6 points	Hospitalization is strongly considered
7-10 points	Ensure hospitalization and consider involuntary admission if necessary

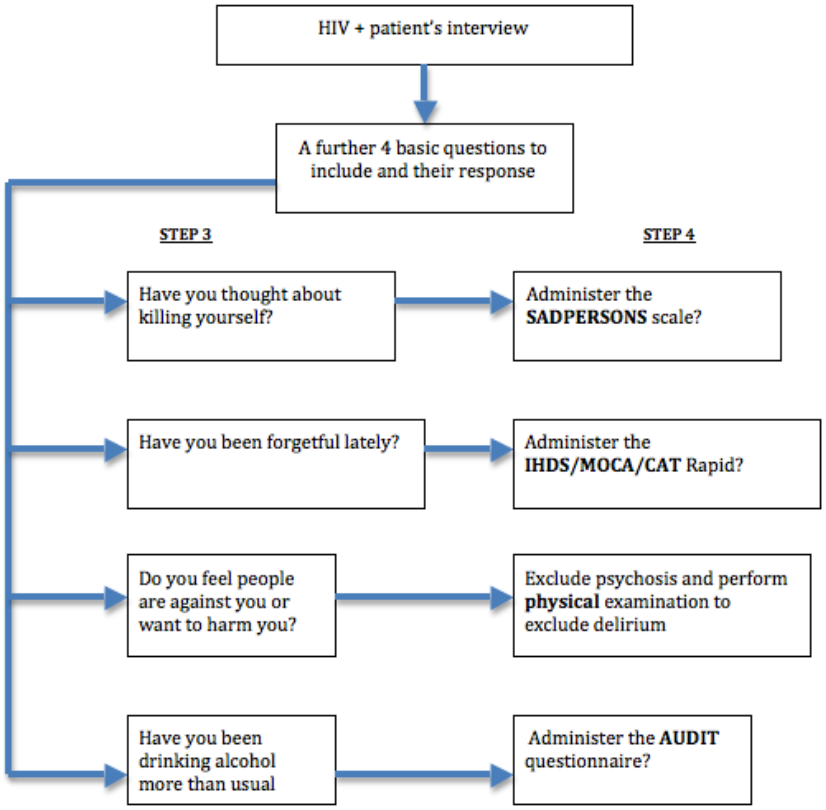

Figure 4: Algorithmic approach to a differential diagnosis

scale (Figure 3)[4]. It makes use of the mnemonic SADPERSON, where each letter reminds one of the risk factors for completed suicide. The higher the score, the higher the risk and the easier the decision to refer for admission.

Step 4

Algorithmic approach to diagnosis: Using the 4 questions to compile a differential diagnosis (Figure 4).

Compiling a differential diagnosis is often difficult and may be best left to the more experienced health care worker. This however doesn't stop one from putting down ones thoughts on paper. Two other common conditions one needs to look out for are anxiety disorders and substance use disorders. There are a number of screening tools that one can use to help diagnose and grade anxiety but one of the big issues to screen for is post traumatic stress disorder. Using the Substance abuse and mental illness symptoms screener [5], is quick and easy and has been developed for primary care and screens for generalized anxiety and post traumatic stress disorder. It is a clinician-initiated tool and is easy to score and interpret[6].(Thom, 2009)

A useful tool to use for problematic drinking is the alcohol use disorders identification test[7] (AUDIT, 2014). This tool was developed by the world health organization[8], and may be administered as an oral interview or as a self-report questionnaire. The added benefit of this tool is that it comes with a basic intervention, which includes an easy way to give feedback and provide information, establish goals with the patient, advise on limits and provide encouragement. It also encourages motivational interviewing and the stages of change which one can use in follow up interviews[9].

Finally, for the forgetful patient, in whom you need to exclude or diagnose an HIV associated neurocognitive disorder, a simple

tool that can be completed within 2 minutes in the clinic is the International HIV dementia scale [10-11]. There are a number of other tools one can use to diagnose neurocognitive problems but these may take a little longer to complete (i.e. Montreal cognitive assessment, MoCA[12] or the Cognitive Assessment tool – rapid version which requires a smart phone[13].

Step 5: Who needs referral?

The following patients should be up-referred:

- The suicidal patient
- The aggressive patient
- The psychotic patient
- The patient not responding to primary care interventions
- Any patient requiring in patient treatment

It is often better to refer if you are worried about a patient than to not refer

Step 6: The Full assessment – Compiling a mental state for referral

For the more experienced health care worker a full assessment includes a full history, provision of a mental state, compiling a risk assessment and finally a physical examination. This would be important to include in your referral note and is as important to document as your physical examination. A mental state examination is an extremely important examination as it gives you a snap shot of the patient's presentation. It includes the appearance and behaviour of the patient, the level of consciousness including orientation to time person and place and cognitive intellectual functioning of the patient. One needs to document the patient's mood state – whether it is euthymic, dysphoric, depressed or elevated. The patients flow of speech, and form of thought need to be documented. This will include the content of thought and whether the patient is delusional or not. It is important to document any perceptual abnormalities and any evidence of objective hallucinations. Finally one needs to comment on the patient's insight into their current state. Summary of the comprehensive psychiatric interview for nurses:

Modified comprehensive psychiatric interview and assessment for nurses

Take a good history and get a collateral history if possible
Based on your screening questions – ask questions around the core symptoms of the screened problem
Complete a mental state objectively looking for signs of common mental disorders
Try to eliminate other causes
Assess risk
Provide psychoeducation and encouragement.

Case Study:

A 27-year-old single male HIV+ patient not on ART with a CD4 count of 105 cells/mm3 presents to your clinic. He is looking to see if anyone can help him.

Step 1:

You begin your assessment by asking how he is feeling?: He reports that he has a two-month history of not sleeping well, has a decrease in pleasurable activities, lost his job, and his best friend died of AIDS a week ago. He feels there's no point in living as his family thinks he is a failure and his girlfriend deserted him after he became unemployed. He has some fleeting suicidal thoughts and bought a rope. He once took an overdose due to relationship problems, but was never admitted to hospital, and never saw a doctor or psychologist.

Step 2:

After screening positive to your basic screening questions, you complete the PHQ-9. The patient scores 22 indicating severe depression

Step 3 and 4:

You complete the SADPERSONS scale because he told you he sees no point in living, has fleeting suicidal thoughts and bought a rope. The patient scores 7 on the SADPERSONS scale.

Step 5:

The score card of the SADPERSONS scale delineates a clear plan and you decide to refer the patient to hospital for admission (Figure 3).

Discussion

Depression is twice as common amongst HIV+ patients than HIV- patients and it is vital to bear this in mind and screen all patients for common mental disorders. This patient warrants a closer history taking and clear assessment. Simple scales are not completely sufficient to fully diagnose major depressive disorder and suicidal intent. They are merely screening tools. A complete psychiatric history and thorough mental state examination are vital for the full diagnosis. He has

There are many advantages in screening for mental health disorders, the most obvious one is for the patient, which will result in them receiving treatment for a debilitating condition.

volunteered information of insomnia, anhedonia, psychosocial stressors and a total lack of support. It is important for you to be empathic and non judgemental in your approach. He most likely suffers from major depressive disorder and warrants further in patient assessment and treatment with pharmacotherapy and psychotherapy.

In hospital he was treated with Citalopram 20mg po daily and he received supportive psychotherapy. He was also commenced on ART and received psychoeducation about both illnesses. During his 2 week stay in hospital he voluntarily disclosed his status and mental disorder to his family and they were relieved to have heard that he was receiving the correct treatment. His sister volunteered to be his treatment supporter and accompanies him to his visits at the clinic. ®

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The care of patients with mental illness and HIV

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This article will firstly highlight some of the major barriers to care for people living with HIV and mental illness with some suggested solutions to reduce these barriers. The article will then briefly describe a few areas that require careful consideration when managing patients with HIV, mental illness or both.

I believe it is time to demonstrate the same commitment to improving mental health care that has been given to fighting the HIV epidemic, especially with respect to in-service training and post graduate training of primary health care and district hospital nursing staff. There will then be a need to supplement this with on-going mentoring.

Introduction

Inadequate organizational capacity, traditional beliefs and stigmatization are some of the main barriers to providing mental health care in the Eastern Cape of South Africa.[1] Each of these hurdles are expanded upon briefly:

Inadequate organizational capacity to manage HIV, Mental Health Care and the combination of both within a resource constrained setting.

This statement is highlighted by in the paragraph below from the World Health Organization in its document 'Workload Indicators for Service Needs (WISN)'. WISN is one of the tools currently promoted by the South African, National Department of Health to help address this problem:

"Health service managers around the world are faced with increasing challenges. Resources to respond to their populations' demand for services are often inadequate. The distribution of human resources is generally poorly balanced between urban and rural areas and between primary, secondary and tertiary levels of care. Disease-oriented programme interventions, such as those contained in the Millennium Development Goals, differ from the reinvigorated primary care approach. In contrast with the more narrow focus on diseases, the primary care approach calls for a higher degree of integration of services, better governance structures and improved partner coordination. This takes place in an increasingly complex world of partners, which is also generating new challenges for managers. Concerns about balancing the workforce within and between service institutions rank high in seeking how best to respond to challenges, such as the ones above.

Human resources – the health workers who actually deliver health services – are the most costly and least readily available resource in a health system. They are also indispensable. Managers at national and local levels struggle daily with how to manage this costly but essential resource efficiently so that they can achieve a more just distribution of workload and better productivity.

The goal of human resource management is to have: • the right number of people • with the right skills • in the right place • at the right time • with the right attitude • doing the right work • at the right cost • with the right work output

The goal of human resource management is to have: • the right number of people • with the right skills • in the right place • at the right time • with the right attitude • doing the right work • at the right cost • with the right work output"[2].

In my opinion, the successful decentralization of the national HIV treatment programme into Primary Health Care and even into rural wards is the result of a coordinated effort by the government and NGOs funded through taxation and donor funding. The extra financial Resources used to achieve this vertical programme's success are huge and the investment in training of human capital enormous. Neuropsychiatric conditions are the third leading cause of disease burden in South Africa behind HIV and TB[3]. I believe it is time to demonstrate the same commitment to improving mental health care that has been given to fighting the HIV epidemic, especially with respect to in-service training and post graduate training of primary health care and district hospital nursing staff. There will then be a need to supplement this with on-going mentoring.

Traditional cultural beliefs and myths amongst staff, patients and communities.

It is common in Xhosa communities to attribute psychosis to a phenomenon known as *amafufunyana* - (possessed by evil spirits)[1]. The family will often take the possessed person to a traditional healer rather than a clinic or hospital. The patient may then only present years later to the clinic and at this stage the mental illness may have deteriorated or be more resistant to therapy.

There are many myths (widely held

incorrect beliefs) associated with mental health[4] that need to be corrected.

Some of the common myths relating to mental illness are corrected in table 1.

Table 1. Mental illness myths and truth

Myth	Truth
Children and adolescents do not suffer mental health problems and it is just part of growing up	They do suffer mental health problems, which are often not recognized or treated.
Parents are to blame for their child's illness	Parents are not to blame for their child's illness, but need education and support to assist them in caring for their child
Mentally ill patients are dangerous and violent	Very little violence in society is caused by people who are mentally ill and in fact people with severe mental illness are more likely to be victims of violence than perpetrators
Depression is a character flaw and people should "pull themselves together"	Depression is not a character flaw and people cannot just "snap out of it"
Addiction is a "lifestyle choice"	Addiction involves a complex number of genetic and environmental factors and is not a "lifestyle choice"
Electroconvulsive therapy (ECT) is barbaric and has no place in modern medicine	Electroconvulsive therapy (ECT) is not barbaric and is an effective treatment for severe depression.
People with severe mental illness have no place in society and should be kept in institutions to protect us	People with mental illness can be useful members of society and function well in a suitable workplace
People with mental illness cannot be cured or recover	Many people can respond or recover from mental illness with the help of treatments

Stigmatization of HIV patients and mental health care users.

There are actions that can be taken. The following are seven things we can do to reduce stigma and discrimination towards both HIV sufferers and mental health care users:

As health care providers we should:

1) Know the facts and educate ourselves. This includes knowing the Mental Health Care Act.
2) Be aware of our attitudes and be haviour. Do not be judgmental, remove our prejudices and see the human being and not the illness.
3) Choose our words and the way we speak carefully by being sensitive and kind.
4) Educate others and correct their myths.
5) Focus on the positive.
6) Support people by showing them dignity and respect and encourage their efforts.
7) Include everyone by not discriminating against HIV or Mental Health patients when it comes to, for example, health care, jobs or housing.

Areas for careful consideration when managing HIV patients with mental illness

HIV prevalence amongst mental health care users varies widely. It may be higher in substance abusers, but lower in institutionalized chronic schizophrenics. However, the fact remains they coexist and HIV testing and counseling should be offered routinely to mental health care users and the diagnosis of HIV considered if risk factors (drug use and unprotected sexual intercourse) are identified or opportunistic infections diagnosed. Mental illness may contribute directly to the incidence of HIV. Low self-esteem (depression) or cognitive impairment may reduce the ability to negotiate safe sex, mania and substance abuse may promote participation in high risk sexual behavior. Mental illness may well lead to a delay in the diagnosis of HIV if the health care system is not accessible, user friendly or integrated. Interruption of HIV treatment may occur if the mental illness relapses and the patient defaults from appointments or treatments. This will have a negative impact on the patients HIV prognosis.

It is well documented that an HIV diagnosis can be a precipitant or contributing factor for a depressive illness and some form of regular screening for depression is advisable amongst any patient with a chronic illness or disability. One such screening test is the 5 item mental health inventory screening test MHI-5. (Table 2), which is explained at the end of the article.

Depression can have detrimental effects on the patient's adherence to wellness and antiretroviral therapy as well as prognosis if undiagnosed. If the depression is diagnosed and treated effectively then the HIV related prognosis improves. In one large multi-

Table 2. MHI-5 screening tool

Score each between 1 and 6 where 1 = all the time and 6 = none of the time (reversed in (iii) and (v) as they ask about positive feelings).
How much of the time in the last month have you:
(i) been a nervous person? / experienced nervousness?
(ii) felt downhearted and blue?;
(iii) felt calm and peaceful?;
(iv) felt so down in the dumps that nothing cold cheer you up?;
(v) been a happy person?

centered trial patients who had suicidal ideation or had attempted suicide were found to have higher levels of plasma HIV RNA and higher levels of current depressive symptoms.[5] It is therefore important to address suicide risk and the management thereof in patients who appear to be virologically failing HIV therapy and exhibiting depressive symptoms. This would require referral to a mental health care team.

HIV has high affinity for the brain especially the microglia and astrocytes of the basal ganglia, white matter and frontal lobes. This may lead to HIV-Associated Neurocognitive Disorders (HAND) in a spectrum from subtle deficits to pronounced dementia. HAND should be considered in any HIV patient with a history of deterioration in their ability to perform every day activities such as shopping, cleaning or even adhering to medication. If HAND is suspected then these patients should be discussed with a specialist as they may need further investigation and medication changes.

NNRTIs like efavirenz may lead to new presentations of acute psychosis or exacerbations and deterioration of existing mental health disorders. Conversely, efavirenz crosses the blood brain barrier and may also reduce or delay HIV associated dementia. It is therefore wise to prescribe efavirenz to HIV patients with mental health issues only after consultation with a specialist, preferably with an interest in neuropsychiatry. These patients should be monitored closely for improvement, deterioration or relapse in their mental health condition. This topic is currently a PhD research project taking place at several psychiatric institutions in the Eastern Cape.

When a patient has more than one condition the number of medications prescribed generally increases. This may lead to adherence issues and also increases the risk of drug interactions. Unfortunately, the essential drug list (EDL) is limited, especially with respect to ARVs and psychiatric medication. However, it is useful to have available a drug interaction reference document, website or chart to refer to. One such example is the Liverpool University website as it has printable charts available [6].

In summary, all of the principles of providing good quality care apply to both patients with HIV and those with mental illness. Well trained, knowledgeable and well-motivated health care workers can make an enormous positive impact on the lives of patients, families and communities. This can improve further if the Health Care system is strengthened, resources more fairly distributed and efficiently and effectively utilized. It is incumbent on us as health care workers to advocate for patients, to try and negotiate around the harmful effects of some traditional beliefs and to correct myths. We must also, by our behaviour at work, at home and in the community make sure we help to de-stigmatize mental illness and HIV. ®

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IS YOUR PATIENT ON ARVS?

Is their annual viral load up to date?

A viral load >1000 copies/mL is a MEDICAL EMERGENCY that requires urgent intervention

Check the ABCs if viral load >1000

A	**Adherence**: Ask about drug side effects, depression, alcohol or substance abuse, social support
B	**Bugs**: Check for infection; TB and STI screen; deworm
C	**Correct Dose**: Is patient on correct dose for weight?
D	**Drug Interactions**: TB treatment, OTC, other chronic medication, herbal/traditional preparations

REPEAT VL in 2 months

IF VL>1000 again

Does this patient need second line ARVs?

Refer or discuss **URGENTLY**

AIDS Helpline 0800 212 506

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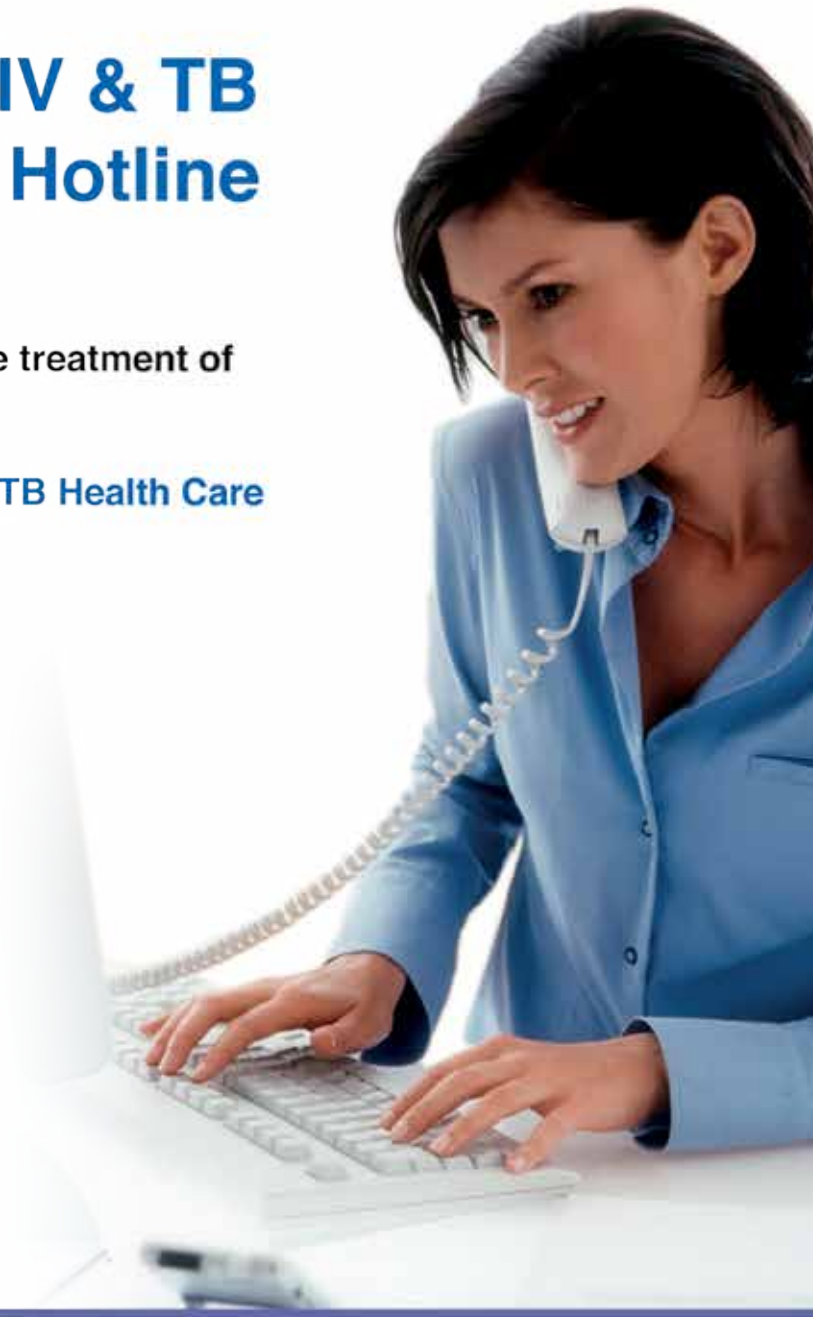
Toll-Free National HIV & TB Health Care Worker Hotline



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

NATIONAL HIV & TB HEALTH CARE WORKER HOTLINE
0800 212 506

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

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Complexities in managing patients with co-morbidities: understanding the potential side effects of mental health and HIV/TB medications

SC Stender, MSN, MSc ID, FNP
Jhpiego

There is significant comorbidity between tuberculosis (TB), HIV, and mental illness. Up to two-thirds of individuals diagnosed with TB may be living with some psychiatric disorder[1].

Contribution of TB to mental illness and mental illness to TB

TB and mental illness	Mental illness and TB
Situational effects of diagnosis (depression, anxiety)	Increased risk for exposure to TB due to higher rates of homelessness / group home living
Risk factors: co-morbidities, substance abuse, alcohol dependence	Risk factors for progression of latent TB to active disease: smoking, poor nutrition
Clinic effects, i.e. meningitis, tuberculoma	Co-morbidities: HIV, diabetes
Side effects of tuberculosis treatment	Under-diagnosis/under-treatment of mental illness

Psychiatric complications with drugs used to treat TB have been documented since effective treatment has been available[2]. Medications used to treat TB and HIV may have adverse psychiatric effects on the individual being treated for either or both diseases.

Healthcare providers should know common and serious adverse effects of all medications his/her patient might be taking. It is therefore essential that nurses review each patient's current medications, including traditional therapies, at each visit. Table 2 (on the following page) provides documented psychiatric side effects of drugs used to treat TB (including M/XDR-TB) and HIV[3,4].

In addition, the potential for adverse effects increase with polypharmacy where patients take multiple medications at the same time, and the astute clinician must also consider potential drug interactions as a cause of adverse effects (side effects, decreased efficacy of treatment, etc.). Some drugs used to treat psychiatric disorders, TB, and HIV have overlapping pharmacokinetics leading to increased or decreased levels of available drugs. Table 3 below, provides an overview of drugs most commonly used to treat mental illness (depression and schizophrenia) in South Africa[5] and their potential drug interactions with first line TB and HIV (current and previous) treatments. While you may not be the prescriber of drugs used to treat mental illness, as a primary care provider you need to be aware of the medications your patient is taking and potential drug interactions[6]. ®

Table 3. Drug interactions of common mental health medications and first line TB/HIV medications

	Rifampicin	Isoniazid	Pyrazinamide	Ethambutol	Streptomycin	Efavirenz	Nevirapine	Tenofovir	Lamivudine	Emtricitabine
Amitriptyline	X	X				X				
Fluoxetine		X								
Chlorpromazine										
Haloperidol										
Lorazepam										
Fluphenazine										

Table 2. Drug interactions of common mental health medications and first line TB/HIV medications

Drug	Side effect	Additional information
Isoniazid	Psychosis	Old data (1971) showed rates to be among 2% of patients
	Seizure	May precipitate convulsions in patients with seizure disorders, rarely cause new seizures
	Muscle twitching, dizziness, ataxia, paresthesias, stupor	Manifestations of neurotoxicity
	Euphoria, memory impairment, loss of self-control, separation of ideas and reality	Rare mental abnormalities that may appear
Ethambutol	Psychosis, mental confusion, disorientation, and possible hallucination	Psychiatric side effects uncommon
Rifampicin	Psychosis, ataxia, dizziness, behavioral changes	Psychiatric side effects uncommon
Kanamycin	Tremor, vertigo, muscle weakness	
Quinolones (Ofloxacin, levofloxacin, moxifloxacin)	Dizziness Hallucinations, delirium, seizures	Most common CNS side effect of quinolones Rare events
Cycloserine and terizidone	Mania, insomnia, anxiety, confusion, dizziness, seizure	Psychiatric effects reported in 20-33% of patients
	Psychosis	Rates reported up to 13%
Ethionamide	Depression, dizziness, convulsions, restlessness, tremors, psychosis	Rare events
Efavirenz (EFV)	Dizziness, depression, insomnia, anxiety, somnolence	Neuropsychiatric effects rather common (28%, 19%, 16%, 2-13%, and 7% respectively among those listed)
	Hallucinations, suicidal ideation, aggressive behavior	Less common effects (0.4-1%)
Lamivudine (3TC)	Depression, dizziness, insomnia	Rare
Emtricitabine	Dizziness, insomnia, abnormal dreams, depression	Dizziness and insomnia more common (20-25%)
Tenofovir	Depression	Not common
Zidovudine	Dizziness, insomnia, somnolence	Occurs among 1-10% of patients
Atazanavir	Insomnia, dizziness, depression	
Ritonavir	Dizziness, somnolence	

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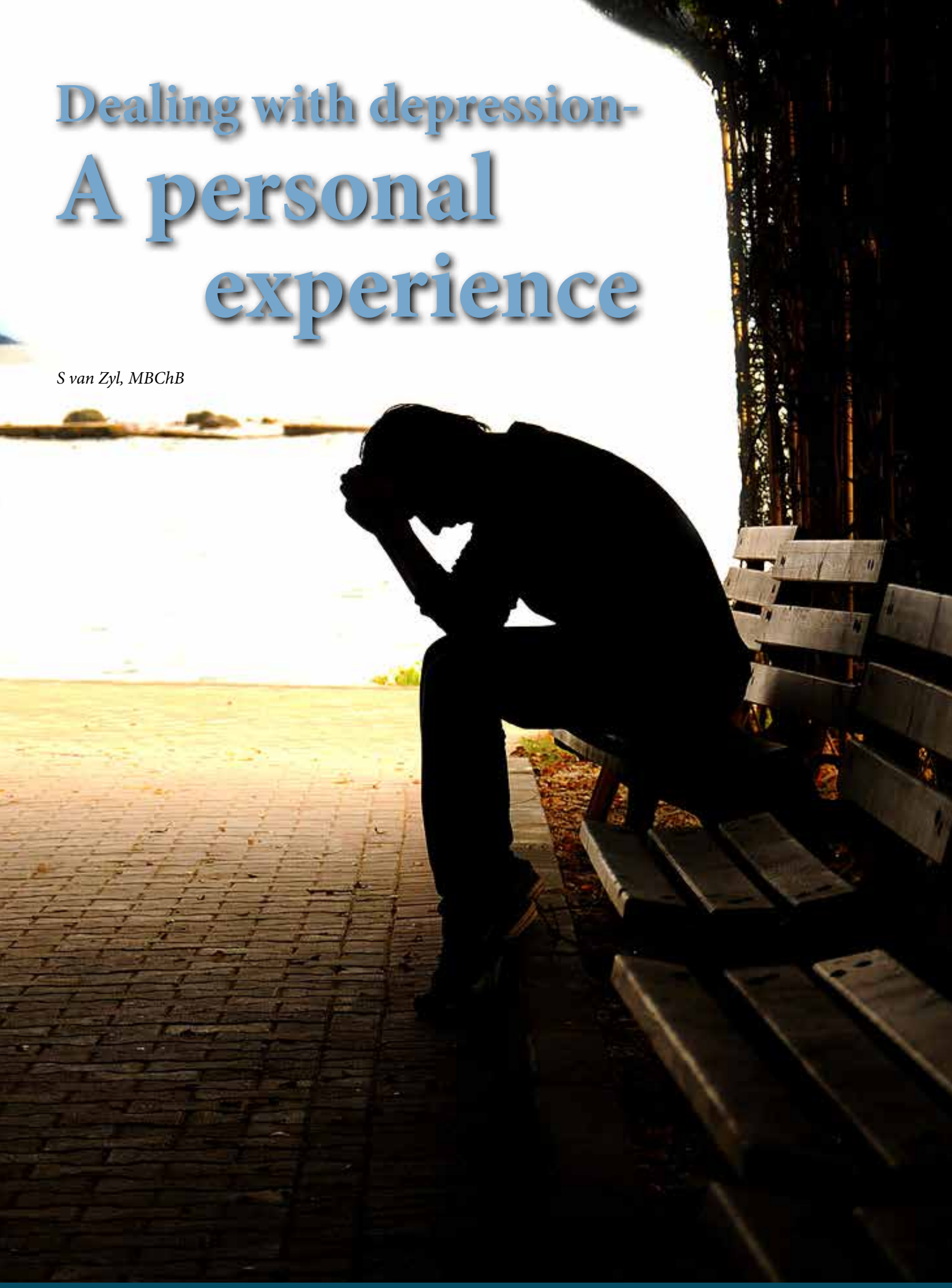
Dealing with depression- A personal experience

S van Zyl, MBChB



This personal account of depression is from Dr Sindisiwe van Zyl, a member of the HIV Nursing matters Editorial Committee (EC). Sindisiwe responded to questions from her fellow EC members about her experience with depression, in the hope that readers would benefit –by seeking help for themselves, supporting loved ones or finding compassion for the countless patients, colleagues and friends who are silently suffering. We hope that this personal story will help de-stigmatize mental illness and increase awareness that depression and other common mental disorders can happen to anyone. We are grateful to Sindi for her candidness and feel privileged to publish this story. –Editorial Committee

What did it feel like when you were depressed?

Depression is a dark and helpless place. I felt as if I was standing at the bottom of the ocean on a sunny day. I could see the sunlight streaming into the ocean, I knew that life and light were up there but I had no will to kick myself off the bottom. I wanted to but I just could not do it.

How long do you think it took you to realize you were depressed?

When I look back, I realise that I have had episodes of depression throughout my life but I was always able to snap out of them. My pregnancy in 2011 was a difficult one and I was hospitalised for bed rest. My son was born and spent some time in Neonatal ICU. I was not happy because I am such a perfectionist and I think that is when this episode started. It wasn't until late 2012 that I realised that I was not okay at all. It took long because I was so busy. I was busy doing so many things that I did not have time to notice that I was sinking.

Did you think differently about people with depression before and after you had an episode yourself? If yes, what changed?

An aunt of mine committed suicide in 2003 – whilst admitted for depression. I loved her dearly so this topic was something I was familiar with. I knew that it was serious and it was not to be taken lightly. What amazes me is the reaction of family and friends. Nobody knows how to deal with depression, especially in terms of giving support.

Was it hard to accept the diagnosis of depression?

I was fortunate to have self-diagnosed. I knew that I was clinically depressed and that I was sinking fast. It was hard to convince the people around me. I didn't even have time to think about the label. I just wanted help.

What was it like being a health care professional with a mental health issue?

The reactions from people have been the most interesting aspect. My hospital admission was great – for 3 days. And then someone found out that I was a medical doctor. Well that was the end of that! I think that the people that were admitted when I was there were blessed by this fact. It really helped them to understand that depression knows no barriers. This is the reason why I want to write and speak about my depression. I want people to come out and break their silence.

Did you experience stigma from colleagues or peers? If yes, how did you deal with it?

I have not had any stigma from colleagues or peers. I think that this is because I have been so brutally honest about my situation. If people are saying things, then it is definitely behind my back!

Who did you turn to for support during your recovery and what was most helpful?

I reached out to one colleague in particular when I was reaching the end of my tether. It was very difficult for him but at the time I had no idea. He struggled to understand what I was telling him. I reached out to my close friends as well. It was hard for them because sometimes I was fine and other times I was not fine. It did not help that I was under immense strain at work, so I guess they attributed my stress to that.

Natasha Davies, one of my colleagues, was my angel in disguise. I remember lying in the guest bedroom on 01 April 2013. I just could not get out of bed. I had been lying there for hours crying. My son was in his room whining and he needed a nappy change. I could not move. I called Natasha and I spoke to her. She advised me to call a doctor which is what I did. Dr Marlin McKay was at my house within hours. After a small chat he arranged for my hospital admission.

I was admitted to hospital on my 37th birthday 03 April 2013.

That admission saved my life. That is what I needed. Two weeks away from my family, friends, my phone, work, etc. It was very tough for my friends and family but it was the best thing for me.

How did having depression impact on your ability to do your work, relate to colleagues, friends, family?

I stopped functioning.

I stopped eating. I stopped doing all the things that I enjoyed. And I was always sleeping. There was nothing I looked forward to more than getting home, drawing the curtains and sleeping. That is all I did. My daughter Nandi would come to my room and pry my eyes open. I would get up to shower, dress up and go to bed again.

What was it like taking an antidepressant - were there side-effects and how long did it take for you to start feeling better?

I started antidepressants on the same day of my hospital admission. For the first time, I had a proper sleep. I managed to sleep and not have all the noise and voices in my head. In terms of side-effects – the worst one was the sluggishness and dry mouth. Loss of libido and weight loss came much later.

It is difficult for me to say when I started feeling better because when I did start feeling different my mother suddenly died.

Depression and grief are two separate entities so I was plunged into something else. The one tablet that made me feel more energetic was Wellbutrin. My psychiatrist prescribed it to me after 3 months because I needed a 'jumpstart'.

What changes did you make in your life to help you avoid becoming depressed again once you were better?

I am still on medication. I think that mine is going to be a long journey with antidepressants. My mother's death really took the wind out of my sails. I have also started going to the gym which has made a huge difference. The last change I made in my life was to resign from work and stay at home. I needed to find myself again and that is what I am doing right now. I am doing things that make me happy like taking rides on the Gautrain and going for full body massages. I am looking after me!

If you thought a colleague was depressed, how would you approach them to suggest they seek help?

The signs of depression are so clear. I would address the changes that I have noticed and have a frank discussion about those changes. In my case the first that everyone noticed was that I wasn't going out as much as I used to. That was a good entry point – "Sindi what is wrong? You don't come to girls' nights out any longer."

Are there any online resources that healthcare workers might find helpful if they are wondering if they're depressed?

Twitter: @TheSADAG . The South African Depression and Anxiety Group. They are a good resource.

What do you think were the main risk factors that led to you becoming depressed?

1. Work-related stress
2. Undiagnosed post-partum depression from 2011
3. Moving house
4. Promotion at work

At what stage did you realise you needed help?

I could not get out of bed on 01 April 2013.

In your experience, is there enough information, help and support for people dealing with depression as well as how to access it?

There is a wealth of information BUT the stigma around mental illness is what deters people from seeking help. We need to find ways of getting people to speak up and seek help before it is too late.

Could you identify any triggers to episodes of depression and how did you deal with them?

In my case, I am a perfectionist. I want things to be perfect and I see now that my pregnancy with my son was stressful and so was the delivery. I did not cope well with him being admitted to neonatal ICU.

Except for medication, are there any alternative ways of dealing with depression?

- Psychotherapy helps. I have a great therapist, Dr Marelize Devantier. She just listened because that is really what I needed.
- Gym. I have a personal trainer and when I do go to gym I always feel great afterwards
- Pampering time. I have learnt to put my own needs first. It is not easy but I need to fill my 'happiness' bucket before I can help others. This is why I have taken six months off to stay at home, rest and look after myself.

What would you say to someone suffering in silence?

Seek help before it is too late. The death of Robin Williams has been such an eye-opener. Seek help before it is too late. ®

You can find Sindisiwe on twitter (@sindivanzyl) where she regularly shares HIV-related information with her over 9 000 followers. She'd love to hear from you about this story, or anything else!

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

SA HIV CLINICIANS SOCIETY

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Using Quality Improvement (QI) in a healthcare facility

CJ Parker, MSc, MM, T Gaohose, R/N, P. Kgatlhanye, R/N, N. Situbeng, R/N, P. Mbalati, R/N, L De Kock, BSC Hons, MA
Quality Improvement and Training Department, the Aurum Institute, Parktown

Introduction

As a Center for Disease Control and Prevention (CDC) funded partner, the Aurum Institute has been working with the National Department of Health (NDoH) for more than two years on various Quality Improvement (QI) capacitation projects in 5 districts around South Africa.

QI methodology has been utilized by Aurum as part of a technical assistance package offered to the NDoH, with many facilities across the 5 districts are showing extremely positive results.

The Aurum Institute has just launched a series of "HOW TO" guides, forming a QI curriculum which has already received international accolades and acknowledgement. This tool is being used to facilitate learning on QI in the areas in which we work. It will be distributed with HIV Nursing matters and will also be showcased through a number of workshops at the HIV Clinicians Society conference in September this year.

Why QI?

Over the last few years, there has been increasing interest in QI among healthcare professionals internationally. Picking up on the this trend the Aurum Institute took the decision to adopt QI as a means of addressing operational gaps arising in the healthcare system in South Africa. Lauren de Kock, the head of the QI programme at Aurum, was instrumental in this decision. She explains that traditional Quality Management efforts have focused heavily on Quality Assurance (QA), especially within the South African healthcare environment. QA is vital to provide the standards to which facilities need to conform. In other words, QA deals with "what" needs to be in place to provide quality care i.e. regulations, standards, protocols and guidelines.
Quality Improvement, on the other hand, provides the health professional with the answer to the "how" question through providing a systematic approach to addressing problems that have been identified by the facility.

The emphasis of the methodology is on empowering and equipping health professionals to identify implementation gaps within their own facilities and test possible solutions in a measured and systematic way. The overarching goal is high quality, reliable care for every patient who passes through the facility[1].

How does QI actually work?

An example of how QI can be applied to address a gap in a clinical care pathway may be useful to illustrate how QI works. In the remainder of this article we therefore focus on the example of a clinic in Ekurhuleni district, where the QI methodology was applied within a Primary Health Care (PHC) facility. Their project was focused on the number of women who were less than 20 weeks gestation when attending their first antenatal visit. Their aim was to improve first antenatal visits below 20 weeks gestation from 38% to 60% by 30 July 2013.

Using data to identify the gap

Quality Improvement emphasizes the use of data to identify gaps in a care pathway as a good starting point for any facility project[2]. Having a median of 38% antenatal first visits at less than 20 weeks meant that 62% of all pregnant women were attending their first visit booking after 20 weeks of gestation. A late first ANC visit has critical consequences for pregnancy outcomes. It is identified as one of the factors contributing to the high maternal mortality rate in SA[3]. An early ANC first visits is particularly important for the success of the PMTCT programme as shorter duration of ART during pregnancy has been found to be a significant predictor for vertical transmission of HIV[4].

The importance of a thorough root cause analysis

The QI team at the clinic met to examine the root causes of why patients were attending their first ANC visit late. This is a vital and often overlooked component of QI initiatives. Without spending time uncovering the root causes of a problem, proposed change ideas lack the impact that they need to improve care. There are a number of techniques that can assist in the process, including the fish-bone (cause and effect diagram), process mapping, driver diagrams and affinity diagrams[1].

Using some of these techniques, the clinic identified a variety of root causes ranging from cultural beliefs around pregnancy, an inflexible booking system and the identification of pregnant women by staff when they were already past 20 weeks gestation.

Strategy for change

Once the root causes had been adequately explored, the QI team set about coming up with change ideas they could test to possibly address the problem. QI tools such as change concepts and process mapping, designed to understand the system and stimulate creative ideas[1], were used to generate their change ideas. Staff coming up with their own change ideas enhances buy-in and empowers them to own the change.

The team tested their chosen changes using Plan-Do-Study-Act (PDSA) cycles and used outcome and process measures to monitor the impact of their changes. PDSA cycles are designed to assist facilities to systematically test out small changes and use data and observations to see if care improves[5]. The team met every two weeks to review progress of the current change and to decide whether to adapt, adopt, scale up or try something completely new. The focus on this particular topic area lasted for four months.

Intervention

A variety of changes were tested including:

- improving health education sessions being provided in the clinic's waiting area. The contents of educational materials were re-written to include better information

on the importance of an early ANC first visit and a question and answer component was built in to test patient knowledge before and after the session.
- extending ANC services from one day to five days a week. This was done to allow women more flexibility to attend the clinic for their first ANC visit.
- asking all women of childbearing age attending the clinic about their last menstrual period (LMP). No routine questions around pregnancy were being offered to women of childbearing age before the intervention. Clients were only tested for pregnancy if they reported signs suggestive of pregnancy.

Results

Following the testing and implementation of the above changes, the antenatal 1st visit rate improved from 38% in February 2013 to a new median of 76% in July 2014. This improvement reflected special cause variation according to trend rules for run charts[2]. In other words, there was a significant improvement linked to the change ideas which were implemented in the clinic.

Effects of changes

Extending the booking hours provided pregnant women with more flexibility. They were now able to schedule ANC visits at times that suited them personally and professionally. Through feedback from staff and patients, it was noted that the increased flexibility provided the pregnant women with more scheduling options and therefore improved the likelihood that they would attend the clinic.

Additionally, asking all women of child bearing age about their LMP enabled the facility to identify pregnant women who at times had not themselves realized that they were pregnant. Identifying them on the spot enabled the first visit booking process to flow naturally and provided the expectant mother with an opportunity to ask questions and relay fears in a supportive environment.

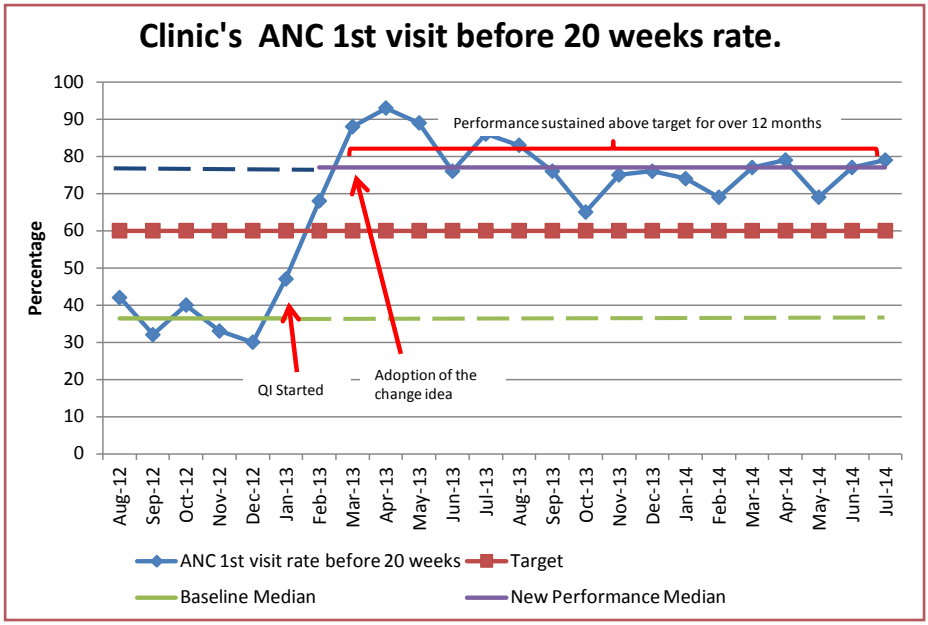

Figure 1: Run Chart showing the results of Improvement work in Dresser clinic.

The true effects of change are observed when the change is sustained within a system, as is evident in the graph provided. Dresser clinic moved beyond testing to implementing, ultimately sustaining change. All too often changes are abandoned, not because they were not good, but because they were not appropriately integrated into a system to become standard practice[1].

Conclusion

This clinic has provided us with a fantastic example of how using QI methodology can improve the implementation of essential guidelines and protocols.

Improvement is possible and everyone can do it! The clinic has shown that by appropriately identifying the root cause of a problem and being willing to test ideas on a small scale through PDSA cycles, change is indeed possible. No additional resources were provided, but through proper process analysis they were able to identify simple and sustainable changes that have had a powerful impact on the percentage of pregnant women attending their first ANC visit before 20 weeks gestation. ®

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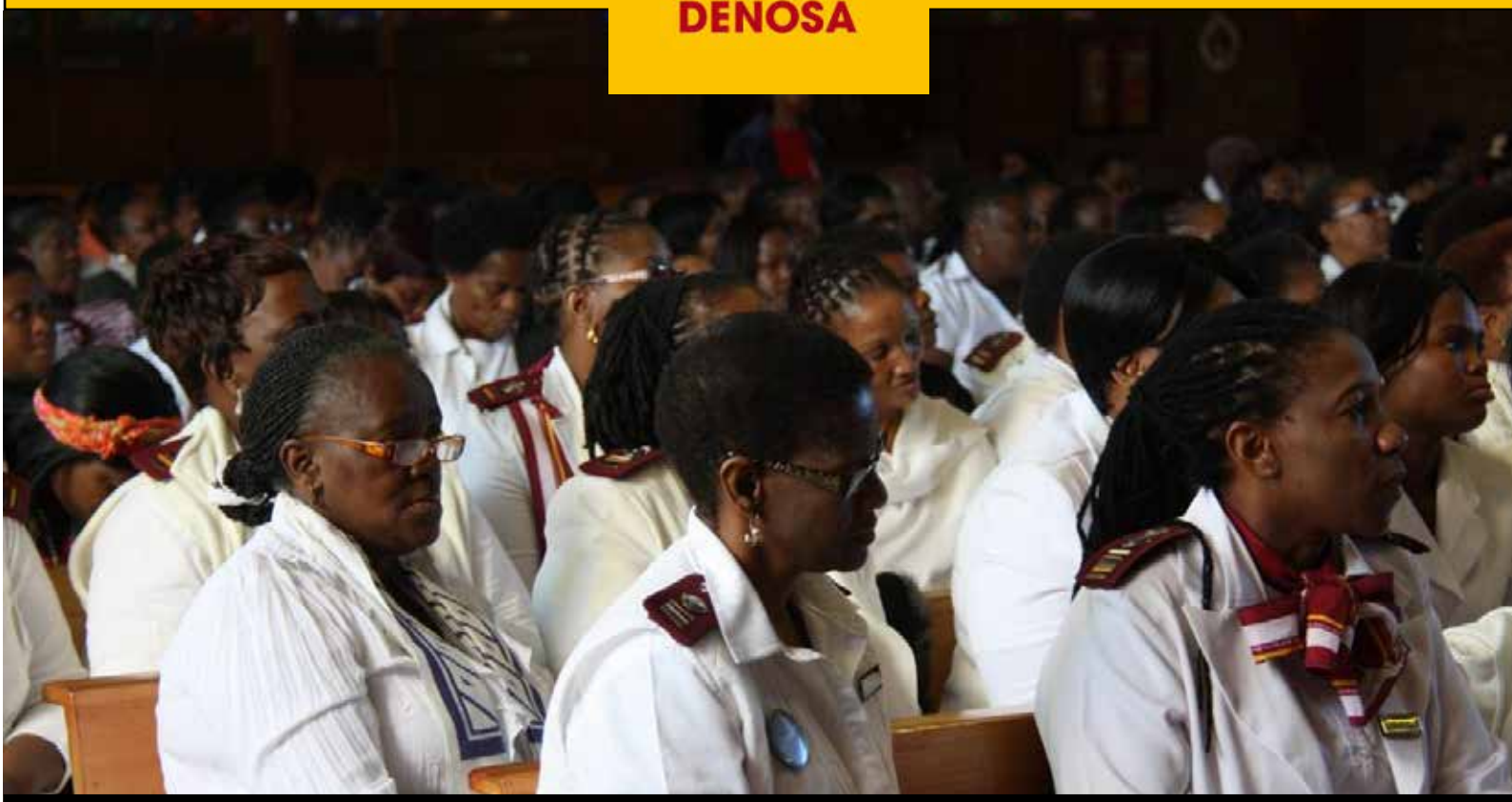
DENOSA



Explaining the DENOSA Indemnity Cover for nurses

What is DENOSA Indemnity Cover?

Indemnity insurance is the cover that all paid-up DENOSA members enjoy as a benefit. This comes in handy when there is litigation against our member on an incident that occurred while the member was on duty in which our member is charged and held liable for that incident.

How does it work?

When our member is found guilty at disciplinary processes or legal proceedings, the indemnity cover pays up to R5 million on behalf of our member. This is strictly limited to professional conduct, in other words, this cover is strictly confined to incident that occurs while the member was performing her/his duty.

It does not apply in incidences where a member is not on duty. Furthermore, it is not extended to any colleague of family member. It is strictly for DENOSA member in situations concerning the workplace.

- Members are advised to report the incident within 24 to 48 hours of occurance, and submit the incident report and supporting documents (contact details, ID number and statements) to the provincial and national offices for assessment by shop stewards.
- It is advisable to report incidents that might be regarded as minor, because they might turn out to be complex at a later stage.
- Report incidents to the provincial and national shop steward to process to the INSURER via the National Office.
- Always keep a copy for your own reference.
- All correspondence to be directed to Provincial Offices.

For more information, do not hesitate to contact Member-Service division at DENOSA on 012 343 2315.

Health and nutrition: the role of the health care worker

S Stevenson, BA (LLB), LLM
Section 27

It is widely recognized that good nutrition is key to good health. In South Africa, the South African National Health and Nutrition Survey (SANHANES), published in 2012, found that 26.0% of the population experienced hunger and 28.3% of the population was at risk of hunger. Not only are these figures extremely worrying in themselves but they do not even account for the "hidden hunger" of malnutrition: the children and adults who may be able to fill their bellies but who are not able to get sufficient micronutrients to prevent malnutrition.

Malnutrition is the outcome of a complex combination of interrelated causes. One of those causes is a lack of dietary diversity. Lack of dietary diversity is often a result of the high prices of healthy and nutritious foods that lead many to eat only unhealthy or insufficiently nutritious food. Regardless of the underlying causes, the extent of the problem of malnutrition requires a set of comprehensive actions including therapeutic interventions, rehabilitation, disease prevention and health promotion. This is where primary health care professionals come in.

Before looking at the role of primary health care professionals in nutrition initiatives, it is worth considering more closely some of the health impacts of malnutrition. Severe malnutrition early in life (including in utero and in the first two years of life) leads to stunting – the physical and mental underdevelopment of children. Mentally, this means changes to brain cell development and reduction in the "connectivity" or "branching" between brain cells. Brain underdevelopment has an obvious and serious impact on mental ability. Children (and adults subjected to severe malnutrition in the first two years of their lives) may be at a permanent intellectual disadvantage. Even with interventions later in life, they are unable to "catch up" on the missed brain development stage. They have difficulties learning and, later, participating in the economy.

In addition to the impact of malnutrition and stunting on the education of children and their mental ability to develop into productive participants in society, malnutrition also leads to increased morbidity and mortality: people who are malnourished (or were malnourished in early life) are more sick and more likely to die when they get sick.

Recognising that nutrition strategies are key to primary health care and to addressing the social determinants of health, the Department of Health has developed a programme to address some of the health impacts of malnutrition. The Integrated Nutrition Programme (INP) has three main components: facility-based nutrition programmes and strategies, community-based nutrition programmes and strategies and nutrition and HIV and AIDS support programmes and strategies.

In-facility aspects of the INP include the following:

- promotion of exclusive breastfeeding;
- growth monitoring and promotion through weight and height monitoring, accurate recording and proper use of the Road-to-Health card; and
- vitamin A supplementation, through the twice-yearly administration of a capsule to all children between 6 months and 5 years.

The implementation of these initiatives could have a significant and lasting impact on the nutritional status of South Africans.

All too often, however, the in-facility aspects of the INP are not implemented. This may be for various reasons including facilities being understaffed, primary health care professionals not being aware of their obligations under the INP and equipment not working. The impact of a lack of implementation is that babies are not properly measured or their measurements are not recorded, making it difficult to assess whether a child is growing properly. Once immunizations are finished with, children stop receiving their vitamin A supplementation capsules and there is evidence to suggest that while vitamin A supplementation has had some positive results for children under one year of age (due to it being incorporated in the vaccination schedule), the programme has had limited success in children between one and five years. The early signs of malnutrition are not picked up at health care facilities, by social workers and in communities resulting in severe malnutrition that requires expensive and resource-intensive hospitalization.

Health-sector initiatives cannot, alone, resolve the problem of hunger and malnutrition in South Africa. The implementation of current policies by the thousands of dedicated primary health care professionals around the country can, however, significantly relieve the personal and systemic burden of hunger and malnutrition. It is essential that nutrition is seen, both by policy-makers and primary health care professionals on the ground, as pivotal to primary health care and to addressing one of the key social determinants of health and causes of ongoing personal and societal under-development: malnutrition. ®

competition

HIV/TB Nursing

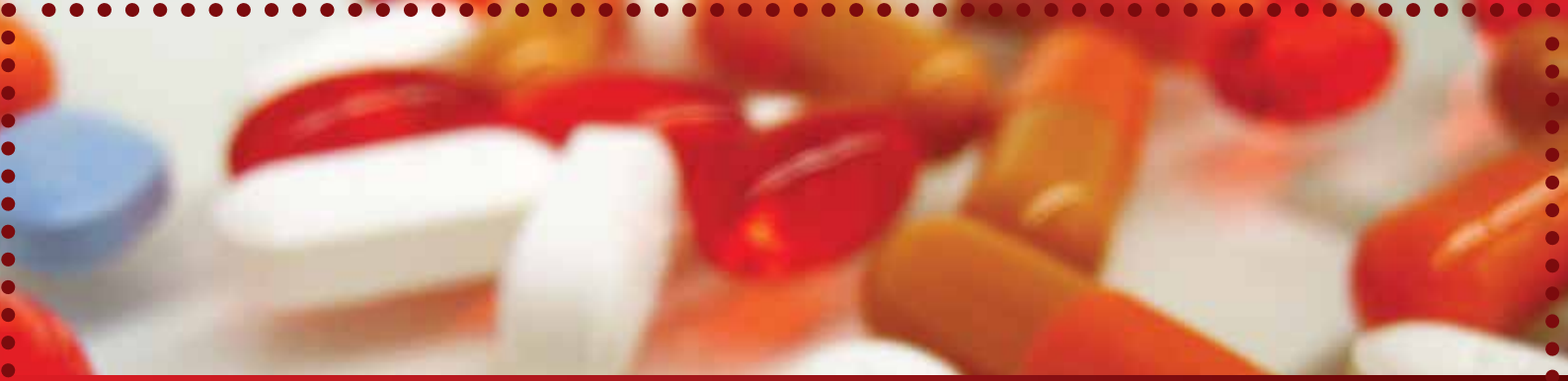
Working in the TB room as a nurse is a very challenging task because you are faced with more than TB. Most patients with TB are also co infected with HIV/AIDS, so the TB nurse has to be extremely knowledgeable about both infections. A TB nurse has to work with a high volume of patients and she/he risks becoming infected with TB her/himself.

We want to hear about your experiences working as an HIV/TB nurse. What strategies do you use to support patients through treatment for both diseases? How do you keep them motivated, ensure they come for their appointments, make sure people living in the household are investigated, etc.? We would love to publish your strategies for success in HIV Nursing Matters.

Submit your typed piece, not to exceed 1000 words, by 1 November 2014 and stand a chance to win a free one-year membership to the Southern African HIV Clinicians Society (the Society); and have your piece published in HIV Nursing Matters!

One winner will be chosen by 15 November. The winner agrees to the publication of the story in the December 2014 issue of HIV Nursing matters and to submit a picture to accompany the article. The judges' decision is final and no correspondence will be entered into. Please note that only typed stories will be considered.

Please submit via email to Nonhlanhla@sahivsoc.org.



STOP STOCKOUTS

What is the Stop Stock Outs Project?

The Stop Stock Outs Project (SSP) is an organisation that monitors availability of essential medicines in government clinics and hospitals across South Africa. The SSP aims to assist healthcare workers in resolving stock outs and shortages of essential medicines at their facilities, enabling them to provide patients with the treatment they need.

How do you report a stock out to the SSP?

Our hotline number is 084 855 7867

- **Send us a Please Call Me**
- **Send us an SMS**
- **Phone us or missed call us**

We will then phone you back to get some more information.

You can also email us at report@stockouts.co.za

What information do you need to report to the SSP?

The name of the medicine that is out of stock

The name of the clinic or hospital where you work

Reporting is an anonymous process and your name, if provided, will not be disclosed to anyone outside of the SSP.

HIV

MEDECINS SANS FRONTIERES

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

+SECTION27 catalysts for social justice

RUDASA

TAC TREATMENT ACTION CAMPAIGN

Rural Health Advocacy Project

QUESTIONS AND ANSWERS

QUIZ ANSWERS

FROM JUNE 2014 ISSUE

1. *After delivery, it is important to feed your child exclusively with breast milk for the first 6 months.*
2. *True*
3. *True*
4. *The target of 0% deaths*
5. *True*
6. *At any CD4 count*
7. *Deadline is 2015*
8. *By 50%*
9. *False*
10. *Essential Steps in Management Of Obstetric Emergencies.*

QUESTIONS

1. *Which mental health programme is specifically designed for lower and middle income countries to address the management and treatment of depression?*

   Answer.....

2. *What percent of the total health budget does Lesotho spend on mental illness?*

   Answer.....

3. *Who was the first Mosotho psychiatric doctor?*

   Answer.....

4. *What's the prevalence rate of Post-traumatic stress disorder in people living with HIV?*

   Answer.....

5. *True or False: In 2004 13-18 million children world-wide had been orphaned by AIDS?*

   Answer.....

6. *How many basic questions should mental health consultations contain?*

   Answer.....

7. *Which tool can be used to identify problematic alcohol drinking?*

   Answer.....

8. *Is it a myth or the truth that parents are to blame for their children's mental illness?*

   Answer.....

9. *Electroconvulsive therapy is still used in the modern medicine?*

   Answer.....

10. *True or False: People with mental illness can be useful members of society and function well in a workplace.*

    Answer.....

NATIONAL HEALTH LABORATORY SERVICE

RESULTS HOTLINE

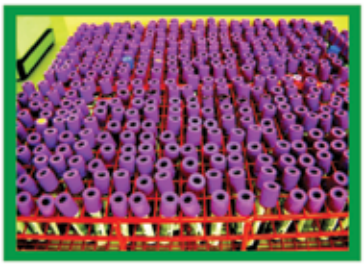
0860 RESULT 737858

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.



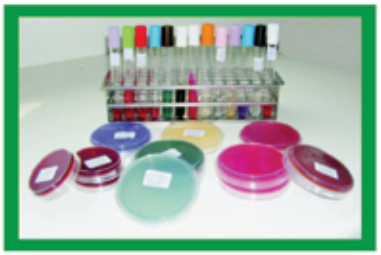
To use the hotline dial 0860 RESULT (737858)

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 assit 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.

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

If you have any HIV/TB clinical questions, Send your questions to "Ask the clinician" via Nonhlanhla@sahivsoc.org & you will get an answer in the next issue of HIV Nursing matters. If your question is urgent, please state it on your e mail & the answer will be e mailed back to you and still be published in the magazine.

Dear nurse clinician,

We recommend two different alternative regimens for infants, depending on where they are to receive 6 or 12 weeks of nevirapine.

The recommended alternative regimen for patients receiving 6 weeks of NVP is oral zidovudine (AZT) for 6 weeks at the following doses:

Weight	Zidovudine (AZT)
<2000g	2mg/kg twice daily
2000 – 2499g	10 mg twice daily
>2499g	15 mg twice daily

Note that AZT should not be extended beyond 6 weeks due to concerns about toxicity (e.g. anemia). AZT is effective as post-exposure prophylaxis for intrapartum exposure but it has not been proven to be an effective prophylaxis for breastfeeding exposure. Mothers who are not virologically suppressed should be counselled to avoid mixed feeding.

If the infant is to receive 12 weeks of NVP, the recommended alternative is oral AZT combined with oral 3TC for 6 weeks. Discontinue AZT at 6 weeks and continue 3TC for 6 more weeks, for a total of 12 weeks of 3TC.

Weight	Zidovudine (AZT)	Lamivudine (3TC)
<2000g	2mg/kg twice daily	
2000 – 2499g	10 mg twice daily	7.5 mg twice daily
2500g -8kg	15 mg twice daily	25 mg twice daily

Remember, booking HIV positive pregnant women early for antenatal care is critical. As Parker et al. found in their continuous quality improvement work (pg. 40), asking patients the date of their last monthly period (LMP) enabled them to identify pregnant women more readily and book them into antenatal care. It is also critical to monitor the mother's viral load throughout the pregnancy, to help identify those who are not virologically suppressed. A virologically suppressed mum greatly reduces the risk of HIV transmission to the baby.

SAVE THE DATE

24 – 27 SEPTEMBER 2014

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

CONFERENCE

2014

24-27 SEPTEMBER AT CTICC

Southern African HIV Clinicians Society 2nd Biennial Conference

International Convention Centre, Cape Town, South Africa

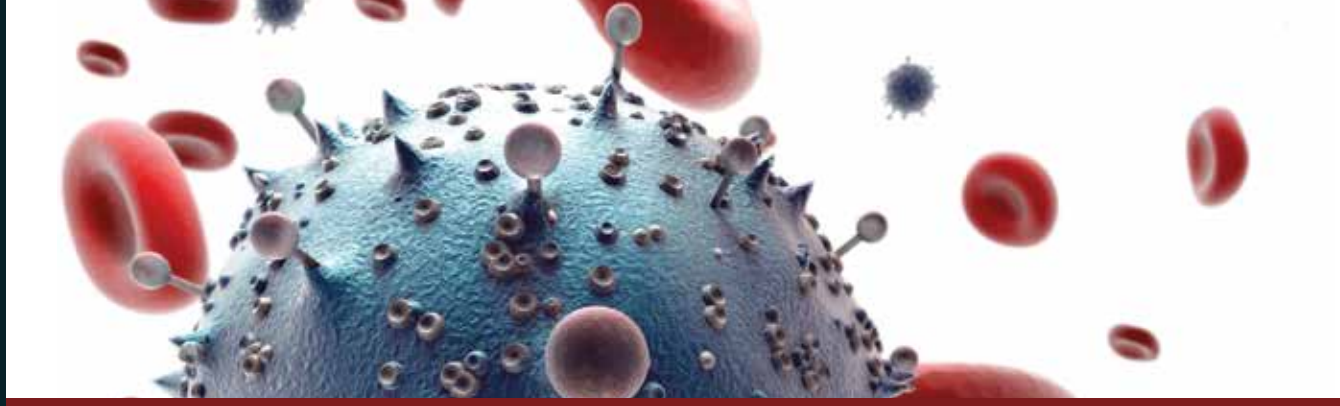
Following on from the success of our inaugural conference in 2012, our second SA HIV Clinicians Society Conference will be taking place from 24 – 27 September 2014 at the CTICC.

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:

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

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