HIV NURSING MATTERS

A publication by the Southern African HIV Clinicians Society

HIV Nursing Matters focuses on rights-based care

UNAIDS 2024 report

Eliminating HIV in children

Person-centred HIV care

HIV stigma: a lived experience

Re-imagining the role of nurses in pharmacies

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inside

HIV Nursing Matters focuses on rights-based care

HIV NURSING MATTERS

Summary of articles from our Guest Editor

Sharon Vasuthevan
(PhD Nursing, MSc Health Sciences,
BCur Honours (Nursing Education) & BCur)
Research Associate (Nelson Mandela University), Healthcare Consultant

The theme for this edition of HIV Nursing Matters is "Taking the rights path to end AIDS" based on the UNAIDS 2024 World AIDS Day report. The articles cover topics on the decriminalisation of sex workers, eliminating HIV in children, HIV stigma and discrimination, reimagining the role of nurses in pharmacies in integrating comprehensive HIV prevention services in Primary Health Care (PHC), person-centered care and differentiated models of PrEP delivery.

In the article on decriminalisation of sex workers, research has shown that the criminalised sex work context increases the risk of sex workers to HIV and other health challenges. UNAIDS notes that the risk of acquiring HIV is 30 times higher for female sex workers compared to other women of reproductive age. Sex workers and sex worker allies have fought for more than three decades for changes to old-fashioned laws that continue to give rise to human rights violations, and that undermine the dignity of sex workers. Currently, two simultaneous legal processes – through the Department of Justice and through a court challenge - are underway that could make decriminalisation of sex work in South Africa a reality.

There have been significant strides made in preventing pediatric HIV, reflected in the article on eliminating HIV in children. Since 2000, approximately 4 million infections have been averted among children aged 0–14 years, mainly due to increased ART access for pregnant and breastfeeding women. Eliminating HIV in children by 2030 is achievable but demands a comprehensive, collaborative effort. Success will require sustained political commitment, gender-responsive policies, ongoing healthcare personnel training, strengthened health systems, scientific innovation, and community engagement.

Treatment gaps are highlighted in the article on HIV stigma and discrimination. South Africa is estimated to have approximately 8,0 million people living with HIV, with an estimated 5.7 million

The Team

For more information
SA HIV Clinicians Society
Suite 233 Post Net Killarney
Private Bag X2600
Houghton
2041
www.sahivsoc.org

Tel: +27 (0) 11 728 7365
Fax: +27 (0) 11 728 1251
E-mail: sahivcs@sahivcs.org

on treatment. In review of this data, it is clear that HIV treatment gaps in South Africa remain a significant public health challenge despite the expansion of antiretroviral therapy access. These treatment gaps are attributed to stigma, socio economic challenges, and systemic health issues.

Kruger and colleagues' article on person-centered HIV care clarifies that it is not just beneficial, but essential. The article explores what person-centered care entails and offers practical examples to help nurses provide person-centered care to people living with HIV. Nurses play a critical role in person-centered HIV care. Small changes in everyday practice can improve health outcomes, patient engagement and work satisfaction in the workplace. The key to this approach is building trust, respecting patient autonomy, providing holistic support, addressing stigma and offering personalised care solutions. With these strategies in mind, we can help PLHIV navigate the complexities of HIV with dignity, confidence and improved quality of life.

The article on re-imagining the role of nurses in pharmacies in integrating comprehensive HIV prevention services into PHC services in community services emphasises the role of community pharmacies and the need to incorporate HIV prevention services into the same. Beyond HIV management, nurses play a crucial role in PHC, often serving as the first point of contact with patients. Integrating HIV services into PHC settings has been shown to improve health outcomes and is recognised as a key strategy in combating HIV. PHC serves as the first level of healthcare in the community, providing accessible, continuous and comprehensive care to meet a range of health needs. With the shift in focus of HIV care to long-term well-being, and the growing emphasis on person-centered care, integrating HIV services into PHC settings offers the opportunity to better address the diverse needs of individuals. Expanding these services beyond traditional public facilities can further enhance access to care. As such, community pharmacies are increasingly being recognised as vital service delivery points for PHC, particularly in the prevention of HIV.

Sekalo and colleagues in their article on differentiated models of PrEP delivery provide a variety of potential advantages to both PrEP users and providers. Differentiated service delivery (DSD) models aim to make treatment more patient-centric, reduce costs for patients and the healthcare system, while enhancing clinical treatment results by easing the burden of frequent clinic visits. Despite its challenges, the FastPrEP project has found this model of PrEP delivery to be effective, and continues to routinely implement lessons learned, enabling appropriate and accessible PrEP delivery for young people.

SAHCS WELCOMES **PROF MAKHADO TO THE EDITORIAL BOARD OF HIV NURSING MATTERS**

The Southern African HIV Clinicians Society would like to officially welcome Prof Makhado from the Department of Public Health at the University of Venda. He brings with him a wealth of knowledge in Community Nursing and Public Health.

Prof. Lufuno Makhado is a Full Professor of Public Health in the Department of Public Health, Faculty of Health Sciences, at the University of Venda, South Africa. He holds a PhD in Nursing - Community Nursing Science. He is the recipient of the Hall of Fame for Research Excellence in Nursing Award (2022), conferred by the Forum of University Nursing Deans in South Africa (FUNDISA), and is a Y2 NRF-rated researcher (2021-2026).

Makhado's research focuses on the psychosocial implications of healthcare provision, particularly in HIV care, tuberculosis management, sexual and reproductive health, epilepsy, gender-based violence, and health system strengthening. His work extensively explores the psychosocial well-being of healthcare workers, including burnout, depression, and stress among nurses managing people living with HIV (PLWH). He has developed conceptual models addressing the psychosocial impact of caregiving, specifically targeting nurse-initiated management of antiretroviral therapy (NIMART), to foster psychosocial resilience and well-being among healthcare providers.

He is the Principal Investigator of the GENIUS-CARE Project (Genotyping Integration: Enhancing RR-TB-HIV Co-infection Management in South African Primary Care Clinics), funded by the South African Medical Research Council (SAMRC), and he is Co-PI for UCSF-led Study VIII, which examines the psychosocial impact of COVID-19 on PLWH.

Makhado has held multiple leadership roles, including Deputy Dean: Research and Postgraduate Studies at the University of Venda, where he spearheaded research capacity-building initiatives. He serves as Associate Editor and Section Editor for leading academic journals, including BMC Nursing, PLOS One, Curationis, and Health SA Gesondheid.

With over 100 peer-reviewed publications, Makhado has supervised over 35 postgraduate students (PhD and Masters candidates). His research has influenced policy, program implementation, and healthcare delivery models, emphasizing psychosocial support frameworks for healthcare workers and vulnerable populations in underserved communities.

The 2024 UNAIDS World AIDS Day report, entitled "Take the Rights Path to End AIDS": Summary by the Southern African HIV Clinicians Society

The 2024 UNAIDS World AIDS Day report, entitled "Take the Rights Path to End AIDS," emphasises the critical role of upholding human rights in achieving the global goal of ending AIDS as a public health threat by 2030. The report highlights that while significant progress has been made in the fight against HIV/AIDS, the pandemic persists, and its continuation is closely linked to human rights violations and systemic inequalities. To effectively combat AIDS, the report advocates for the removal of harmful laws and the implementation of policies that protect the rights of all individuals, especially those living with or at risk of HIV.

Current State of the HIV/AIDS Epidemic

Despite decades of efforts, the HIV/AIDS epidemic remains a significant global health challenge. The report highlights that the world is not on track to meet the 2030 target for ending AIDS as a public health threat. Factors contributing to this shortfall include persistent stigma, discrimination, and punitive laws that marginalize vulnerable populations, hindering their access to essential HIV prevention, treatment, and care services.

The Intersection of Human Rights and HIV

The report suggests that human rights violations are both a cause and a consequence of the HIV epidemic. Stigmatising attitudes and discriminatory practices deter individuals from seeking testing and treatment, thereby facilitating the continued spread of the virus. Moreover, laws that criminalise behaviours associated with HIV, such as same-sex relationships, sex work, and drug use, exacerbate the vulnerability of key populations. The report calls for a paradigm shift towards a rights-based approach, recognising that protecting human rights is indispensable for effective HIV responses.

Legal and Policy Reforms

A key recommendation of the report is the urgent need to revoke laws that criminalise HIV transmission, exposure, and non-disclosure, as well as those that target marginalised groups. Such legal reforms are essential to reduce fear and stigma, encouraging more individuals to access HIV services. The report also advocates for the enactment of protective laws that safeguard the rights of people living with HIV and key populations, ensuring they are free from discrimination and have equitable access to healthcare, education, and employment opportunities.

Community-Led Initiatives

The report highlights the pivotal role of community and civil society organisations in advancing human rights and combating HIV. These organisations have been instrumental in advocating for rights-based approaches, providing services, and

The report highlights that the world is not on track to meet the 2030 target for ending AIDS as a public health threat.

holding governments accountable. The report emphasises that empowering communities and supporting grassroots movements are vital strategies in the global effort to end AIDS.

Global Solidarity and Shared Responsibility

Achieving the goal of ending AIDS by 2030 requires a collective commitment from all sectors of society, including governments, international organisations, the private sector, and civil society. The report calls for increased investment in HIV programs, particularly those that adopt rights-based approaches. It also stresses the importance of international cooperation and solidarity to address the structural inequalities that fuel the epidemic.

Conclusion

The "Take the Rights Path to End AIDS" report calls for a renewed focus on human rights in the global HIV response. By dismantling discriminatory laws, implementing protective policies, and empowering communities, the world can overcome the barriers that perpetuate the HIV epidemic. The path to ending AIDS is intrinsically linked to the path of upholding human rights for all.

In the wake of President Trump's "stop-work orders" and the dismantling of key global health initiatives, including reduced support for UNAIDS, the "Take the Rights Path" report highlights the urgent need to reaffirm a rights-based approach as the foundation for ending AIDS. The recent rollback of funding, political will, and multilateral cooperation has demonstrated the devastating consequences of deprioritising human rights in global health. Rebuilding and strengthening commitments to human rights, legal protections, and community-led interventions is not just a moral imperative–it is an essential strategy to regain lost ground and accelerate progress toward ending AIDS by 2030. The report makes it clear: only by centering human rights in policy and practice can the world dismantle systemic barriers, restore trust in health systems, and ensure that no one is left behind in the fight against HIV.

Download the full report here:
https://www.unaids.org/sites/default/files/media_asset/take-the-rights-path-to-end-aids_en.pdf

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20. Paediatric HIV Management
21. Differentiated Care
22. Preventing Drug Stockouts
23. Adverse Drug Reactions and Reporting
24. ART Data Management

Eliminating HIV in children: progress, challenges, and strategies for an HIV-free generation

L.Kampiire[1], MMed, MPH, MBChB; **M.Archary**[1,2,3], PhD, FC Paeds, MBChB
[1]*Africa Health Research Institute, Durban, South Africa*
[2]*Department of Paediatrics and Child Health, University of KwaZulu-Natal, Durban, South Africa*
[3]*Victoria Mxenge Hospital, Durban, South Africa*

Introduction

The global response to the HIV pandemic has achieved remarkable progress over the past few decades. Expanded access to antiretroviral therapy (ART), widespread prevention campaigns, and global partnerships have contributed to significant reductions in new infections and AIDS-related deaths. According to the 2024 United Nations Programme on HIV/AIDS (UNAIDS) report, new HIV infections were reduced by 39% globally in 2023 compared to 2010[1]. Despite this progress, the world remains 29% short of the 2025 target[1], underscoring the need for intensified efforts to close the gap. Recent reductions in global funding for HIV and tuberculosis (TB) care in low- and middle-income countries (LMICs) are likely to widen the gap further.

Progress in Paediatric HIV Prevention

Significant strides have been made in preventing paediatric HIV. Since 2000, approximately 4 million infections have been averted among children aged 0–14 years, mainly due to increased ART access for pregnant and breastfeeding women[1]. Between 2010 and 2023, new paediatric HIV infections declined by 62%, from 300,000 [220,000–440,000] to 120,000 [83,000–170,000], due to the success of vertical transmission prevention (VTP) programs in Eastern and Southern Africa1. In the same period, the Eastern and Southern African region experienced a 73% reduction in new paediatric HIV infections[1]. However, this progress has plateaued, and paediatric HIV remains a persistent public health challenge, with the global prevalence estimated at 1.4 million [1.1 million–1.7 million] children affected[1]. This highlights the

need for renewed efforts and innovative strategies to sustain momentum and accelerate progress toward elimination. Furthermore, adolescent girls and young women in Eastern and Southern Africa aged 15–24 years remain disproportionately affected, with a 2.3% higher median HIV prevalence compared to other adults. This being a reproductive age group, their vulnerability to HIV increases the risk of vertical transmission to children. Moreover, this special population is also disproportionately affected by socioeconomic disparities, gender-based violence, harmful gender norms and cultural practices, and limited access to preventive measures such as pre-exposure prophylaxis (PrEP), which further exacerbates the problem[1-3].

Recognising this, the Global Alliance to End AIDS in Children was launched in July 2022 to accelerate global efforts toward eliminating paediatric HIV by 2030[4]. This initiative unites women living with HIV, their families, national governments, and global partners to mobilize leadership, funding, and action. However, achieving this goal will require urgent, coordinated efforts in high-burden regions, supported by a sustained commitment from less-burdened high-income countries.

This article reviews the progress made in paediatric HIV prevention and treatment, highlights ongoing challenges, and proposes strategic approaches to eliminate paediatric HIV by 2030.

Ongoing challenges to eliminating HIV in children

Impact of the COVID-19 pandemic: In some countries, the restriction of non-essential health services and the redeployment of healthcare personnel to support the COVID-19 response significantly disrupted HIV service delivery, including a decline in viral load monitoring[5,6]. In other high-burden settings, such as the KwaZulu-Natal (KZN) province in South Africa, the pre-pandemic low viral load testing rates and suppression persisted during the pandemic[7], delaying progress towards achieving the UNAIDS 95-95-95 targets for HIV epidemic control. This disruption also impacted ART coverage among vulnerable populations, including pregnant and breastfeeding women, impacting progress in VTP[8].

Gaps in VTP programs: VTP programs have significantly reduced HIV vertical transmission rates. However, systemic challenges such as geographic barriers, financial constraints, and inadequate healthcare infrastructure continue to delay or prevent timely access to antenatal care (ANC) services where VTP support is provided. This delays HIV testing and ART initiation among pregnant women and predisposes them to unsafe delivery, which further increases the risk for vertical transmission of HIV to their babies. Social and cultural factors, including stigma surrounding HIV and gender inequality, further complicate pregnant women's ability to seek early and regular ANC services[9,10]. This delay compromises the overall health and well-being of the mother and child 9. Health system inefficiencies, such as ARV drug stockouts, poor staffing leading to long queues[11-13], gaps in HIV re-testing, viral load monitoring, and birth HIV PCR testing14 also impact the success of VTP programs, increasing the risk of vertical transmission of HIV from mother to child.

Delayed diagnosis of HIV in children: Many children living with HIV (CLHIV) remain undiagnosed or are diagnosed very late[15]. This leads to avoidable morbidity and mortality. Contributing factors include inadequate coverage of early infant diagnosis (EID), especially for infants whose exposure to perinatal HIV is unknown, despite the availability of these services in most facilities[15,16], and a lack of integration of HIV testing into routine paediatric care. A delayed HIV diagnosis leads to delayed ART initiation. Other factors include maternal HIV denial leading to non-disclosure, fear of discrimination, and lack of knowledge about vertical transmission of HIV from mother to child, which delays infant diagnosis and prophylaxis[16].

Low paediatric ART coverage: By 2023, only 57% of CLHIV had accessed ART globally, compared to 77% of adults living with HIV[1]. This is so far below the 95-95-95 target of the UNAIDS[17]. This gap underscores the urgent need for targeted interventions, including expanding paediatric HIV treatment programs in high-burden regions and strengthening health

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The Global Alliance to End AIDS in Children was launched in July 2022 to accelerate global efforts toward eliminating paediatric HIV by 2030[4]. This initiative unites women living with HIV, their families, national governments, and global partners to mobilize leadership, funding, and action. However, achieving this goal will require urgent, coordinated efforts in high-burden regions, supported by a sustained commitment from less-burdened high-income countries.

systems to ensure sustained ART delivery.

Challenges in ART adherence and retention in care: Ensuring lifelong ART adherence is important for CLHIV. However, maintaining ART adherence in CLHIV is particularly challenging due to several factors. These include 1) delayed availability of child-friendly ARV formulations, such as dispersible dolutegravir (DTG) and fixed-dose combinations such as abacavir/lamivudine (ABC/3TC), which are crucial for improving treatment adherence, 2) social stigma surrounding HIV which discourages disclosure to families, limiting access to vital social and treatment support when needed. Additionally, the burden on caregivers, combined with logistical and economic challenges, forces them to prioritize other competing demands over ensuring their child's ART adherence[18-20].

Proposed strategies to eliminate HIV in children

Addressing the above challenges requires a multifaceted approach combining health system strengthening, innovation through research, government commitment, and improved socioeconomic policies.

The COVID-19 pandemic highlighted the vulnerability of global health systems, emphasizing the need for strengthened healthcare resilience. Strengthening the healthcare system through community-based service delivery is essential. Establishing community-led peer support groups and utilizing digital health solutions[1], for example, WhatsApp groups for peer support and treatment monitoring, could enhance ART adherence and retention in care[6,21]. Additionally, implementation of home-based HIV testing and counselling and integration of HIV services into existing maternal and child health platforms[21] at lower-level health facilities, would improve access. Some implementation research is being conducted in South Africa to evaluate the feasibility and acceptability of digital health solutions and the development of family-centered approaches for CLHIV.

Strengthening VTP programs is essential. It requires universal and repeated HIV testing for pregnant women following local guidelines, immediate and lifelong ART for those living with HIV[1,21], improved access to postpartum ARV prophylaxis for newborns exposed to perinatal HIV, and sustained maternal and infant follow-up. This will ensure maternal viral load suppression and early ART initiation for children living with HIV. Supporting sustainable infant feeding options is also vital[1]. Additionally, community outreach, mobile ANC services, reduction of stigma, and improved health literacy will ensure early and consistent access to ANC for all women.

Scaling up point-of-care EID and integrating routine HIV testing into every child healthcare visit will enable timely diagnosis and treatment, improving health outcomes[22,23]. Opportunistic HIV testing for every child who accesses the healthcare system should be encouraged at every level of healthcare, including routine services such as immunizations and child wellness clinics[21].

Innovations in paediatric ARV drug delivery, both for prevention and treatment, offer promising avenues for improving ARV administration to enhance adherence. These include long-acting ARV formulations[24] like cabotegravir and rilpivirine[24], simplified treatment regimens, for example, once-daily dispersible DTG tablets. Additionally, novel ARV drug delivery systems for children, such as microarray patches (MAPs), are being

Innovations in paediatric ARV drug delivery, both for prevention and treatment, offer promising avenues for improving ARV administration to enhance adherence.

evaluated. MAPs have the potential to reduce caregiver burden by requiring only once-weekly administration. MAPs have been evaluated in preclinical studies and shown adequate drug delivery and high acceptability by health workers and caregivers[25,26].

Policy and advocacy efforts must be strengthened to ensure equitable access to maternal and paediatric HIV services. Sustained political commitment and strong partnerships between governments, civil society organizations, and international stakeholders are crucial. The Global Alliance to End AIDS in Children represents a crucial step toward mobilizing the necessary leadership and resources for this effort. Policy reforms are needed to remove legal and structural barriers[1] that hinder access to HIV prevention and treatment for children and women affected by HIV. Advocacy efforts should address gender inequality and socioeconomic disparities affecting women.

Conclusion

Eliminating HIV in children by 2030 is achievable but demands a comprehensive, collaborative effort. Success will require sustained political commitment, gender-responsive policies, ongoing healthcare personnel training, strengthened health systems, scientific innovation, and community engagement. Key priorities include closing gaps in VTP, expanding access to EID, timely ART initiation, and leveraging new technology. Urgent action is needed to ensure no child is born with or dies from HIV and that affected families receive the support they need.

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Person-centred HIV care is not just beneficial, it is essential

S Kruger[1], BA, NHED, BEd Psych, MEd Psych, DEd Psych; **SL Barnabas**[1], MBChB, PhD.
[1]*Family Centre for Research with Ubuntu, Department of Pediatrics and Child Health, Faculty of Medicine and Health Sciences, Stellenbosch University*

Corresponding Author: **S Kruger** - Krugers@sun.ac.za

Introduction

In the landscape of HIV care, there has been a shift towards person-centred care (PCC). This approach changes patients into partners for care, allowing alignment of what we do with the patient's needs, values, preferences and unique circumstances. This improves health outcomes, patient satisfaction and enhances trust of the healthcare system[1]. For healthcare providers working in HIV care, this approach is not just beneficial but should be fundamental to patient management. This article explores what person-centred care entails and offers practical examples to help nurses provide person-centred care to people living with HIV (PLHIV).

What is person centred care?

Person-centred care places the individual at the centre of their care. The focus shifts from the disease to the person[2], acknowledging the unique being[3] as a person with complex health needs, experiences, and social determinants of health[4]. This approach focuses on the active partnership between the person-in-care and the nurse. PCC is an interplay of clinical skills, medical experience, and the values, needs, fears, and context in which the person lives to achieve the best health outcomes[5]. The PCC model is empowering, respectful and collaborative. This approach creates an environment where the person feels heard, becomes empowered[6] and is an active part of the decision-making[7] process in managing their health.

PCC can be used in all settings related to care of PLHIV. When individuals are encouraged to be active partners in their treatment and care[8], the benefits

of PCC become evident as individuals become more engaged patients[9], with improved adherence and less fear when management options are discussed. Empowered individuals make informed choices in the context of information sharing and goals setting. This improves health outcomes, work satisfaction[10] and reduces healthcare costs and visits[11].

Time spent with the individual

Time in a busy clinic is a luxury. However, the more time spent during the initial consultation, the less time will be needed in follow-up. In the context of HIV, a consultation involves more than just physical care[12] and diagnosis. It often includes exploring the emotional, psychological and social challenges the person faces as these impact health outcomes. The goal is to provide a multidisciplinary, integrated approach that is responsive to the complex needs and priorities of the person[13]. This entails active listening and asking the right questions to identify the needs of the PLHIV[14] such as 'how has your experience with HIV been – emotionally, physically and socially? Asking questions that invite dialogue helps the individual to share experiences and information that may clarify their challenges to take medication regularly. Asking open-ended questions allows the individual to discuss barriers without fear of judgment, making it easier to find solutions together. A common barrier to effective communication is medical jargon. Person-centered care involves simplifying complex information and using language that the individual understands[15]. Using the person's home language or a simple explanation such as 'the medication will help you lower the amount of HIV in your body and help keep the immune system strong' improves understanding of why medication is needed and improves adherence.

Diagram of PCC type questions

The language we use in health setting

Language is a powerful tool, especially in working with PLHIV. Our words can foster respectful and collaborative relationships or perpetuate shame, stigma and cause disengagement[16]. In the context of person-centered care, non-judgemental language is crucial in creating a safe and supportive environment. Words such as 'victim'; 'sufferer' and 'infected' perpetuate negative stereotyping[17] about HIV and may lead to shame, embarrassment and isolation of the individual. These terms intensify societal stigma. Instead, healthcare workers are encouraged to use language that focuses on the person[18], not the disease. Using phrases such as 'you are living with HIV, together we can work on managing your health and well-being' shifts the focus to the person and their active involvement in their health and well-being. Phrases like 'this medicine is difficult to take, but you need to do it' are discouraging and can rather be replaced with - 'this medicine can help keep your viral load under control and we can find strategies to help you take it more regularly'. Language should focus on the positive outcomes of adhering to treatment and acknowledge the patient's ability to manage their health. Using positive and encouraging language can help individuals feel more capable and confident in managing their health.

Respect and autonomy

Every individual has the right to make informed choices about their treatment, based on a full understanding of their options. For PLHIV this means discussing various treatment regimens, lifestyle changes and even stigma associated with HIV[7]. Some may argue that medical experience and expertise outweigh personal choice in health decisions. When an individual expresses fear about the side effects of antiretroviral treatment (ART) the healthcare worker could respond by acknowledging their concerns, explaining potential side effects clearly and offering solutions and alternatives. This shows the person that their concerns are valid and their well-being is central to the care process. In person-centred care the person should feel they have a voice in the decision-making process. Nurses can assist with making sure the individual understands their treatment options and encourage them to ask questions. Individuals may be concerned about ART adherence due to complex ART routine and discussing solution-focused strategies to simplify the regimen such as fixed-dose combinations and adherence aids like alarms or electronic reminders that help the person feel in control of their own health. It is our duty to act in the best interest of the individual thus we must respect their choices and autonomy. Sometimes this means that an individual does not want to be seen at the clinic in their community. Keeping detailed records of health plans[19] and a having shared data base enables the person to seek treatment in a space that feels safe for them.

Safe and supportive spaces

Ensuring that healthcare environments are safe and supportive is crucial for improving outcomes of PLHIV. This involves creating spaces where individuals feel comfortable in seeking treatment for or preventing of HIV[20]. A safe space includes an environment free from discrimination, judgement, and rejection[21]. It is a space where individuals are treated with dignity, compassion and understanding. PLHIV face multiple layers of stigma[21]. For many individuals living with HIV privacy is important. PLHIV are often concerned about unplanned disclosure. Strict confidentiality is essential. Assuring individuals that their information is confidential and that their space is safe is crucial in building trust. Simple statements such as "I want to make sure you know that everything you share with me about your health, including

Discrimination at healthcare centres can deter individuals from seeking care[21], delaying diagnosis and worsening health outcomes[22].

Spaces where healthcare providers are empathetic and non-judgemental in their approach facilitate improved health outcomes.

your HIV status, is private. You are in a safe space and we are here to help you." Affirming confidentiality reduces anxiety. By acknowledging stigma and offering empathetic support, healthcare workers can empower patients to fully engage in care. Societal stigma often stems from misconceptions about HIV and personal stigma can originate from fear of rejection or discrimination. Discrimination at healthcare centres can deter individuals from seeking care[21], delaying diagnosis and worsening health outcomes[22]. Spaces where healthcare providers are empathetic and non-judgemental in their approach facilitate improved health outcomes. Simple gestures such as a friendly greeting, speaking to a person in a private space, being on time for appointments and accommodating the person who arrives on the wrong date for treatment collection foster an environment of care. Healthcare worker's attitudes and knowledge about HIV greatly impact the care of PLHIV, promoting inclusive and compassionate care, and improving quality of life[23].

Integrated services

HIV affects more than the immune system. The virus and its treatment can impact mental health, social relationships, financial stability, and access to care[24]. A person-centered approach integrates mental health support, social services and holistic well-being of HIV care[7]. It helps the person to achieve overall quality of life. Healthcare workers should screen for mental health concerns, offer counselling, and connect individuals with community resources such as support groups, adherence clubs and food kitchens for further support. This shows care beyond the physical aspects of HIV. Mothers and infants are often seen on separate days or different parts of the clinic, resulting in a mother having to travel twice to the clinic, taking more time off work or spending another day accessing treatment when she could have been attended to in one visit. A person-centred approach calls on us to provide creative solutions for HIV care, considering the patient's lifestyle, work and family responsibilities. Addressing social challenges, improves adherence.

A person-centred approach calls on us to provide creative solutions for HIV care, considering the patient's lifestyle, work and family responsibilities.

Conclusion

Nurses play a critical role in person-centered HIV care. Small changes in everyday practice can improve health outcomes, patient engagement and work satisfaction in the workplace. The key to this approach is building trust, respecting patient autonomy, providing holistic support, addressing stigma and offering personalised care solutions. With these strategies in mind, we can help PLHIV navigate the complexities of HIV with dignity, confidence and improved quality of life.

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SOUTHERN AFRICAN HIV CLINICIANS SOCIETY **GUIDELINE ON PRE-EXPOSURE PROPHYLAXIS TO PREVENT HIV**

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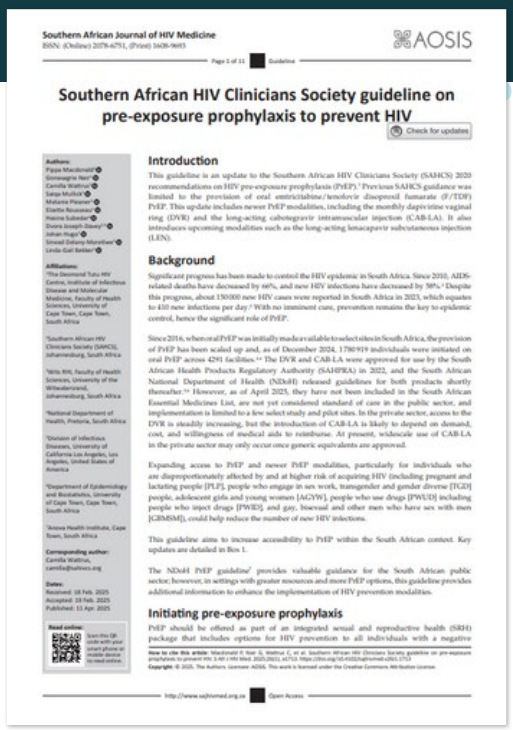
Southern African Journal of HIV Medicine

AOSIS

Southern African HIV Clinicians Society guideline on pre-exposure prophylaxis to prevent HIV

Introduction

Background

Initiating pre-exposure prophylaxis

This guideline is an update to the SAHCS 2020 recommendations on HIV pre-exposure prophylaxis (PrEP). Previous SAHCS guidance was limited to the provision of oral emtricitabine/tenofovir disoproxil fumarate (F/TDF) PrEP.

This update includes newer PrEP modalities, including the monthly dapivirine vaginal ring (DVR) and the long-acting cabotegravir intramuscular injection (CAB-LA). It also introduces upcoming modalities such as the long-acting lenacapavir subcutaneous injection (LEN).

This comprehensive guideline, authored by leading experts in the field, addresses key topics to support the effective implementation of PrEP, enhance patient outcomes, and guide healthcare providers in delivering evidence-based HIV prevention.

- Overview of PrEP
- Clinical assessment for PrEP initiation
- PrEP options and regimens Monitoring and follow-up Adherence support
- Drug resistance and safety considerations
- Special populations and considerations PrEP delivery models
- Integration with broader HIV prevention strategies
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HIV Stigma: a lived experience

Mandisa Nikita Dukashe, B Cur (Nursing)

South Africa is estimated to have approximately 8 million people living with HIV, with an estimated 5.7 million on treatment[1,2]. In review of this data, it is clear that HIV treatment gaps in South Africa remain a significant public health challenge despite the expansion of antiretroviral therapy (ART) access. These treatment gaps are attributed to stigma, socioeconomic challenges, systemic health issues, and perceived stigma associated with HIV treatment gaps in South Africa[3]. For example, a South African study revealed high levels of HIV stigma, with 75% endorsing disclosure concerns and perceiving stigma as common, and 56% endorsing negative statements about people living with HIV (PLHIV); highlighting fear, moral judgment, and rejection as key drivers of stigma[4]. The researchers further mentioned that social distancing towards PLHIV was reported to be 30.7%, with the respondents being unwilling to have relationships with PLHIV, and a significantly lower proportions were unwilling to buy from a food seller who has HIV, drink from the same tap as a person with HIV, and be friends with someone with HIV.

According to Earnshaw et al.,[5] stigma may be enacted (experience of exclusion or discrimination), internalised (acceptance or internalising the negative attributes of the stigmatising behaviour), or anticipated (expectation of future experiences of prejudice and stigmatizing behaviours). Data from a South African study found rates of internalised stigma ranging from 22% to 41%, the rate of anticipated stigma ranging from 24.4% to 43%, and the prevalence of any stigmatising experience ranging from 43.5% to 88%[6]. Stigma and discrimination

affect all ages and genders. For instance, qualitative evidence suggest that various forms of HIV related discrimination and resulting shame act as profound barriers to young people's engagement with HIV services[7] For example, fear of unintended disclosure leads to PLHIV disengaging from care if there is a perceived confidentiality risk. As such, unintentional disclosure through medication collection and use has been identified as a new HIV-related stigma that impedes adherence and retention in care services for both adults and adolescents living with HIV[8-10]. I have personally heard PLHIV indicating that they prefer to collect treatment far from home, where they will not be recognised due to internalised and perceived stigma.

Furthermore, a cohort of participants living with HIV in urban township of South Africa reported a symbolic and anticipated stigma, which was significantly common among women and people living with HIV[11]. According to the centre for disease and prevention control[12], HIV stigma is rooted in a fear of HIV. Many of our ideas about HIV come from the HIV images that appeared in the early 1980s. There are still misconceptions about how HIV is transmitted and what it means to live with HIV today. They further mention the lack of information and awareness combined with outdated beliefs lead people to fear getting HIV. Additionally, many people think of HIV as a disease that only certain groups get, leading to negative value judgements about people who are living with HIV. Additionally, studies reported that the inter connection of stigma and status non-disclosure often results to poor ART adherence, as individuals may hide their medication and avoid clinics, out of fear of being labelled as HIV positive[13,14]. Moreover, HIV and AIDS stigma is one social process that has been broadly assumed to adversely affect engagement in HIV care as well as other factors that may undermine ART adherence. For example, Alckmin-Carvalho et al.,[15] revealed that internalised and perceived community sexual stigma negatively correlate with ART adherence, potentially linked to depression. Furthermore, depressive symptoms and higher levels of education are reported as important drivers of HIV stigma, suggesting that greater social support could be protective against anticipated HIV stigma[11]. Research also identify internalised stigma as a key risk factor for more severe negative outcomes than other forms of stigma amongst PLHIV, which includes, disengagement from care and morbidity[16]. Additionally, stigma is also associated with decreased voluntary HIV testing, and non-disclosure of HIV status[17]. For example, PLHIV shy away from disclosing their HIV status others to avoid being identified as a person living with HIV and reduce the likelihood of being stigmatised[18].On the other hand, some clients may not even have stigma experiences but suffer from anticipated stigma. Manifestations of anticipated stigma include worries about being gossiped about and worries about being verbally insulted/harassed/threatened[11]. Additionally, research reports major barriers to disclosure of HIV status is fear of the stigma associated with living with the illness, fear of being outed, pointed at, and belittled by those they disclosed to, loss of support, and anxiety of being

> Notably, HIV stigma and discrimination within discordant relationships significantly affect the psychosocial dynamics and health outcomes of those involved and can manifest in various forms from societal attitudes to personal fears about disclosure which has a potential to complicate the lives of discordant couples.

rejected by their partner[19].

In fact, I am one of those who had to hide the HIV status to a number of sexual partners, resulting from previous rejections. Even with my current partner, who is now my husband, it took me more than three months before I finally found courage to disclose my HIV status. Notably, HIV stigma and discrimination within discordant relationships significantly affect the psychosocial dynamics and health outcomes of those involved and can manifest in various forms from societal attitudes to personal fears about disclosure which has a potential to complicate the lives of discordant couples. Interestingly, supportive relationship dynamics can serve as a protective factor against stigma, which data suggest that couples in supportive relationships might experience reduced stigma impacts due to open communication and mutual support[20]. PLHIV who struggle of delay accepting their HIV status may eventually develop very high viral loads, which predicts poor health outcomes such as the emergence of drug resistance, treatment failure, and disease progression. This could ultimately reinforce internal stigma because such individuals may never know the benefits of an undetectable viral load[21,22]. Consequently, the widespread discriminatory attitudes and the perceived stigma that is evident in the general population might heighten the disclosure concerns endorsed, promote non-disclosure, and increase HIV transmission[4]. Most importantly, research revealed that people who disclose their HIV status to sexual partners may receive social support, adherence to HIV care, treatment services, reduce transmission risk behaviours, and reduced stigma, both stigma of association and internalised stigma[23]. The burden of reducing stigma should, however, not fall first and foremost to the victims of stigma but should start with other parties like Health Care Professions (HCPs), policy and decision makers, the public, with the inclusion of PLHIV the discussions around potential support and interventions needed to create a safe space enough to disclose, which will lead to sustained adherence and improved health outcomes[24]. In view of the above literature, it is clear that enhanced and sustained efforts are needed to eliminate HIV stigma in all forms using evidence-based strategies that recalibrate social norms in the society, in order to close the treatment gaps in South Africa, improve health outcomes and curb the spread of HIV.

It is clear that enhanced and sustained efforts are needed to eliminate HIV stigma in all forms using evidence-based strategies that recalibrate social norms in the society, in order to close the treatment gaps in South Africa, improve health outcomes and curb the spread of HIV.

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Re-imagining the role of nurses in pharmacies in integrating comprehensive HIV prevention services into Primary Health Care services in community pharmacies, South Africa

Siphokuhle Tinzi[1], **Angela Tembo**[1], **Tsitsi Nyamuzihwa**[1], **Mantsi Mkansi**[1], **Lettie Makola**[1], **Tarryn Collings**[1]

[1]*Wits Ezintsha, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg*

Introduction

Human immunodeficiency virus (HIV) remains a major health burden in South Africa where, in 2023, around 50,000 people died of HIV-related causes, and around 7.8 million were living with HIV, of whom 5.9 million were on antiretroviral therapy (ART)[1]. Due to the magnitude of the HIV epidemic, the role of nurses in HIV management has expanded to include tasks that doctors traditionally performed[2,3]. Nurses represent over 50% of the global healthcare workforce and are often the sole providers in many low-income countries[4]. As such, they have become a necessity in the provision of ART and HIV prevention services[5].

Beyond HIV management, nurses play a crucial role in primary health care (PHC), often serving as the first point of contact with patients[6]. Integrating HIV services into PHC settings has been shown to improve health outcomes and is recognized as a key strategy in combating HIV[7]. Primary health care serves as the first level of healthcare in the community, providing accessible, continuous and comprehensive care to meet a range of health needs[8]. With the shift in focus of HIV care to long-term well-being, and the growing emphasis on person-centered care, integrating HIV services into PHC settings offers the opportunity to better address the diverse needs of individuals[7] Expanding these services beyond traditional public facilities can further enhance access to care[7]. As such, community pharmacies are increasingly being recognized as vital service delivery points for PHC, particularly in the prevention of HIV.

Community pharmacies already provide a range of healthcare services, including medication dispensing, HIV testing, diabetes care, weight management and dietary advice, and reproductive health, making them well-positioned to support a comprehensive approach to HIV prevention. Furthermore, pharmacies offer several advantages over public sector clinics, such as more convenient operating hours and shorter waiting times[9]. The Ezintsha PPrEPP-SA project is assessing the delivery of PrEP through community pharmacies. PPrEPP-SA is a research study in 10 community pharmacies in Gauteng and Western Cape, South Africa. Due to an ongoing legal process affecting the implementation of Pharmacist Initiated Management of Antiretroviral Therapy (PIMART), and limiting the ability of pharmacists to prescribe PrEP, the PPrEPP-SA delivery model includes a collaborative team of nurses and pharmacists with the nurse playing an integral role[10].

Prior to the implementation of the project in April 2023, a qualitative assessment was conducted to evaluate the competency of pharmacy staff (nurses, pharmacists and pharmacy assistants) in delivering pre-exposure prophylaxis (PrEP) services. The results from the in-depth interviews highlighted several gaps and areas requiring improvement. These included inconsistent levels of knowledge about PrEP, lack of experience among the nurses in initiating PrEP and limited prior training on PrEP[11].

This paper describes 1) the training activities undertaken following this assessment, 2) the procedures conducted by nurses in delivering a comprehensive HIV service prevention package to participants enrolled in PPrEPP-SA and 3) provides recommendations for streamlining integration.

Training Activities

To mitigate the identified gaps, training sessions were conducted with all 10 implementing pharmacies in Gauteng and Western Cape provinces as presented in table 1 below. Pharmacists, pharmacy assistants and nurses received training on oral PrEP guidelines facilitated by Ezintsha. Training on Dapivirine ring (DVR) and Post-Exposure Prophylaxis (PEP) was provided by the National Department of Health and was attended by Ezintsha staff, pharmacist and pharmacy nurses. Additionally, Pharmacists and nurses completed both a PIMART and Good Clinical Practice (GCP) basic course, online.

Table 1: Training provided to Health Care Workers

Training course	Provider	Health Care Worker	
		Nurses	Pharmacists
National Oral PrEP Guidelines	Ezintsha	20	20
National Dapivirine Ring Guidelines	National Department of Health	20	16
National PEP Guidelines	National Department of Health	20	20
PIMART	SAHCS (Southern African HIV Clinicians Society)	20	220
Protocol related training (incl GCP)	Academic Advance	20	N/A

The Ezintsha team also provided ongoing mentorship and coaching through frequent site visits to the implementing pharmacies. This team comprised of the provincial managers in Gauteng and Western Cape, as well as the lead project pharmacist. Provincial managers rotated through participating pharmacies daily for the first two months. They spent a whole day in each pharmacy, providing oversight of implementation processes, including recruitment, PrEP initiation, and integration of HIV prevention services during participant-nurse consultations, counseling and education, telephonic scripting, dispensing, and overall management of patient flow. In parallel, the nurses were provided with clinical guidelines, job aids, and information, education, and communication (IEC) material to strengthen their competency. Provincial managers also held regular feedback and support sessions with nurses, typically meeting for one-hour sessions at least twice a week to discuss challenges and identify solutions.

The results from the in-depth interviews highlighted several gaps and areas requiring improvement. These included inconsistent levels of knowledge about PrEP, lack of experience among the nurses in initiating PrEP and limited prior training on PrEP[11].

Key findings from nurse-delivered clinical services

During implementation, clients identified in pharmacies who consented to participate in the project were referred to a nurse to receive PrEP services. The services included initiation and follow-up of participants on oral PrEP, DVR, PEP, oral and injectable contraceptives, as well as sexually transmitted infections (STI) screening and treatment. Participants enrolled in the projects are followed up for 13 months through scheduled follow-up appointments facilitated by a nurse. The study is currently ongoing.

We analysed data collected from participants who had a nurse consultation at study enrolment and during the 13-month follow-up period. Data on services rendered was extracted from the study database (REDCap) and included all clinical procedures conducted by the nurses at the initiation visit of either oral PrEP, DVR, PEP, as well as follow-up visits. In addition, in depth interviews were conducted with the nurses to explore their experiences in providing PrEP services, and selected quotes have been included to illustrate key insights.

The findings on the procedures conducted by nurses, based on data collected from participant's consultation records, were categorised into three primary areas: PrEP screening and initiation, screening and management of reproductive health needs, and adherence support and continuation of care.

PrEP screening and initiation

A total of 1906 participants were screened for study involvement during the 12-month screening period. Of those, 1703 participants were started on PrEP. Nurses were responsible for conducting the comprehensive screening assessments in line with the national PrEP guidelines. This included collecting demographic information, assessing HIV risk, obtaining medical history, and performing STI screening and physical examinations. In addition, nurses carried out all necessary investigations, including rapid HIV testing, pregnancy testing for female participants, and blood draws for hepatitis B surface antigen (HBsAg) and serum creatinine when required. Each nurse independently completed the full screening and initiation process for their assigned participants within the same consultation room. Once a participant was deemed eligible for PrEP, the nurse facilitated a telephonic consultation with a doctor, who provided the prescription. Following this, the nurse conducted PrEP adherence counseling, ensuring that participants understood how to use PrEP effectively before medication was dispensed. The entire consultation, from initial screening to PrEP initiation, had an approximate mean duration of one hour. Insights from nurses and participants highlight the positive impact of PIMART training in enhancing PrEP knowledge, clinical skills, and HIV prevention education. Some pharmacy based HCW's spoke about the positive impact of the training as illustrated by this quote.

"I don't think I would have been so comfortable with enrolling it. But after PIMART and also being with the study programme, with Ezintsha on the PrEP programme, it really helped a lot to broaden your knowledge and your skills on PrEP initiation, even post-exposure initiation and ARV initiation. So, yes, very comfortable" [PA-07-05]

Another HCW further supported this as stated below.

What also helped a lot was the PIMART programme. It really gives you a lot of background on why we do things, why we do certain tests, what's important for follow-up visits...." [PA-07-05]

Screening and management of reproductive health needs

At both the initial and follow-up visits, nurses conducted symptom-based STI screening for all participants. To date, 164 participants have received syndromic treatment based on identified symptoms. Additionally, nurses advised on reproductive health. Their responsibilities include counselling participants on safe sex practices, performing pregnancy tests, and assessing contraceptive needs. As part of the study, both oral and injectable contraceptives are offered. Among the 520 female participants that received contraceptives, 497 (95%) chose oral contraceptives while 23 (5%) opted for injectable contraceptives administered by the nurse.

"What also helped a lot was the PIMART programme. It really gives you a lot of background on why we do things, why we do certain tests, what's important for follow-up visits...."

Adherence support and continuation of care

Participants were followed up through scheduled PrEP visits at months 1,4,7,10,12 with the final exit visit at month 13. Appointment reminders were sent to participants 7 days before their visit date, facilitated by the Research Assistants (RA) who support implementation of the project. During these visits, nurses provided adherence support through a structured set of questions designed to assess PrEP use and identify any challenges faced by the participant. Nurses conducted repeat HIV testing and pregnancy testing for female participants during these visits.

They also reassessed contraceptive needs, screened for STIs and evaluated the need for post-exposure prophylaxis based on adherence questionnaire responses. PrEP refills were facilitated through a virtual consultation with a doctor. The mean duration of follow-up consultations, including all procedures, was approximately 45 minutes. Appointments were scheduled beforehand to manage waiting times and improve participant flow in the clinic. These services are offered per pharmacy operating hours, which typically extend after 4 pm and include weekends.

Discussion

Nurses in community pharmacies are capable of not only initiating and monitoring PrEP but also addressing broader sexual and reproductive health needs as part of an integrated service delivery package. Integrating STI screening and family planning into PrEP delivery enhances the value of community pharmacy-based services and promotes comprehensive care. Similarly, Zhao et al.[12] reported pharmacy-based programme should consider integrating a sexual health programme inclusive routine HIV/STI testing, diagnostic and treatment of STI's should be considered as part of a pharmacy-based PrEP programme. A one-stop shop can help address multiple needs in one visit, which is more efficient for the client. In the future, integrating additional services like childcare or screening and management of chronic conditions can further enhance this[7].

However, given the extra workload and skills associated with these services, some of which providers may not be familiar with, adequate training, staffing, and infrastructure must be considered for sustainable implementation without compromising quality of care. In this project, coaching and mentoring were provided to strengthen the capacity of nurses in pharmacies to initiate PrEP, resulting in providers feeling more confident in delivering PrEP and PEP post-training. Although the pharmacy visits were likely quicker for clients, further measures are needed to improve overall efficiency within the pharmacy setting.

Both screening and follow-up visits were seemingly lengthy; however, they included study procedures that would not typically be required in a real-world setting. Incorporating medication refills and visit reminders into existing patient communication channels within each pharmacy could further streamline services. Additionally, telehealth consultations with doctors extended visit times, as doctors needed to review all the information collected by the nurse before prescribing PrEP or PEP. Allowing nurses (and pharmacists) to prescribe directly could reduce these delays. Roche et al.[13] also reported that with proper training and oversight, healthcare providers in pharmacies are capable of safely initiating and managing clients on PrEP and maintaining their privacy.

Conclusion

Integrating HIV services into differentiated PHC models within community pharmacies has the potential to make service delivery more person-centered and comprehensive. Pharmacies are increasingly recognized as ideal sites for PrEP delivery, with pharmacy nurses playing a key role by offering a wide range of services in a single consultation. Adequate training, infrastructure, and support are essential to ensure the sustainability of this model. Allowing nurses to prescribe PrEP and other related medications could further streamline service delivery and enhance access to HIV prevention.

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The Decriminalisation of Sex Work in South Africa – where are we now and why is it taking so long?

M Richter[1,2], BA (Hons), MA, LLM, PhD; **E van Rooyen**[3], Bsc(Eng)(Civ), LLB, **C Mathe**[4,5]
[1]*The EthicsLab, Department of Medicine, University of Cape Town*
[2]*The African Centre for Migration & Society, Wits University*
[3]*Sex Worker Education and Advocacy Taskforce*
[4]*Asijiki Coalition for the Decriminalisation of Sex Work*
[5]*Sex Worker Education and Advocacy Taskforce*

Introduction

The Sex Worker Education and Advocacy Taskforce (SWEAT) was founded in the early 1990s to provide education and support to sex workers in South Africa. Since its inception, it has advocated for the decriminalisation of sex work – the removal of the criminal law from all aspects of sex work.

It has been more than three decades since sex workers, sex worker allies and human rights advocates in South Africa have started mobilising to challenge the laws that were drafted during apartheid to criminalise this form of adult, consensual sex. Many of these laws originated from British law of the Victorian era. By the time of writing this article in 2025, these laws are still on our law books. This is despite large bodies of evidence that show that criminalisation makes sex work unsafe and exposes sex workers and sex work clients to violence, exploitation and bribery by law enforcement entities and others. This, in turn, impacts on public health and on safety and compounds the deadly stigma that attaches to sex work.

The criminalisation of sex work therefore makes everyone unsafe.

The criminal law and vulnerability

Research has shown that the criminalised sex work context increases the risk of sex workers to HIV and other health challenges. UNAIDS notes that the risk of acquiring HIV is 30 times higher for female sex workers compared to other women of reproductive age.[1] This is because criminalisation forces sex workers to work in often dangerous and violent circumstances and they often have little negotiation power with clients who insist that no condoms are used during sex.

Sex workers often face prejudice and discrimination from health care workers and gatekeepers in the health setting, which causes many to avoid seeking health care altogether.[2] This is illustrated by a recent Ritshidze research report on the experiences of Key Populations in health facilities: it found that 65% of sex workers felt that

their privacy was not well respected in public health facilities, 5% felt unsafe there, and that 11% have been denied services.[3]

If the criminal law is removed, it will have a far-reaching impact on risk, vulnerability and safety. In fact, mathematically modelling suggests that decriminalisation of sex work would avert 33–46% of HIV infections in the next decade among female sex workers and their clients alone![4] Public health evidence and human rights arguments have challenged the stigma and criminality attached to sex work, and have persuaded initially recalcitrant institutions like the South African National AIDS Council and the Commission for Gender Equality of the need to support decriminalisation. Various policies and guidelines now include directives on the decriminalisation of sex work. For example, objective 1.5.1 of the National Strategic Plan for HIV, TB and STIs 2023-2028 states that sex work should be decriminalised by 2026.[5] Similarly, the National Strategic Plan on Gender Based Violence and Femicide supports decriminalisation.[6] These policy pressures together with changing public perceptions of sex work[7], have strengthened the case for decriminalisation.

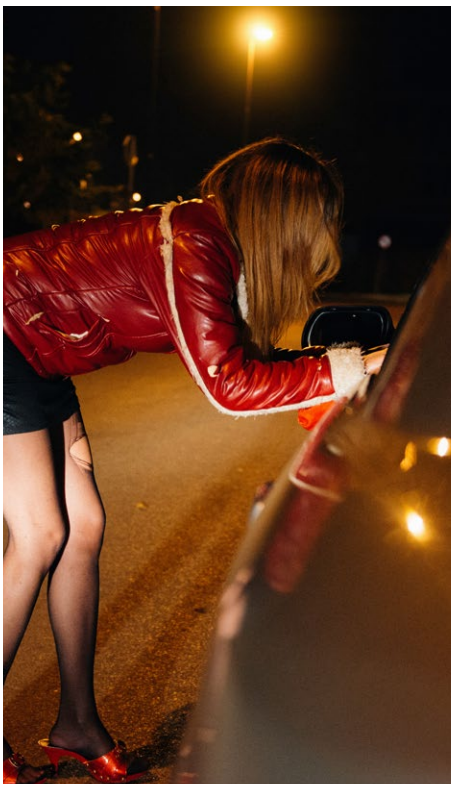
If it is clear from a public health and human rights perspective, that sex work should be decriminalised, and there are policies in place that support such change. Why, therefore, has the criminal law not been removed yet?

This question is partly answered by looking at the law reform process.

The law reform process

There are generally three main ways to change existing law or to create new law in South Africa:

1. The **South African Law Reform Commission** (a research and advisory body to the Department of Justice) compiles a research report and makes recommendations to the Department of Justice on how laws should be (re)formulated. The Minister can then send a draft Bill out for public comment before submitting it to Parliament;
2. A **Bill (a draft law) can be introduced in Parliament** by a Minister, a Deputy Minister, a parliamentary committee, or an individual Member of Parliament. This process could start off with the publication of a Green Paper (an initial discussion document setting out some of the key issues for general comment), which is then later refined as a White Paper.
3. An existing law can be **challenged through the courts**. The Constitutional Court can hold provisions of a law "unconstitutional" if it is at odds with the South African Constitution, and direct the Department of Justice to change the laws in line with the Constitution.



In South Africa, all three of these avenues have been used to attempt to reform and modernise the laws that the criminalise sex work. Essentially there are two main laws that need to be reformed for decriminalisation: the Sexual Offences Act of 1957 - that had its origins in the apartheid era Immorality Act - and the Criminal Law (Sexual Offenses and Related Matters) Amendment Act, 2007. Various municipalities also have by-laws that harass and penalise sex workers – these should also be changed. Here is a short summary of how the various law reform processes have attempted to deal with sex work laws thus far:

1. The South African Law Reform Commission process

In the late 1990s, the SALRC was tasked to investigate the criminal law around sex work. They produced an Issue Paper in 2002[8] and then a Discussion Paper in 2009.[9] Sex workers and allies provided extensive comments on the two Papers and pressed the SALRC to release its findings. This only happened in 2017,[10] and startlingly – despite the deluge of research showing how harmful criminalisation is - the Commission recommended full criminalisation of sex work with some slight adjustments.[11] Cabinet decided not to take the issue further in line with the SALRC recommendations, but for sex work law reform to be "debated" more.

2. The Minister initiates a Parliamentary process

In November 2022, the Minister of Justice announced that Cabinet approved the publication of the

Criminal Law (Sexual Offences and Related Matters) Amendment Bill of 2022. This Bill was meant to replace the old laws that criminalise sex work, and was circulated for public comment.[12] Human rights activists celebrated this Bill and believed that decriminalisation was within their reach! However, within a few months, the Deputy Minister of Justice announced that the Office of the State Law Advisor refused to certify the draft Bill as it felt the Bill "would not pass Constitutional muster" and thus had to be redrafted.[13] Where the expectation was that the Bill would be finalised before the 2024 national elections, these delays meant that the law reform process would have to be continued only after the elections.

At the time of writing this article, the new administration which was formed as a Government of National Unity, has yet to make any visible progress.

During a meeting with SWEAT and the Asijiki Coalition for the Decriminalisation of Sex Work in November 2024, the new Deputy Minister of Justice, Andries Nel, stated that the new sex work laws must also create a regulatory framework for the sex work industry - not just remove the criminal provisions - before the Office of the State Law Advisor would certify these. He confirmed that the Department was currently working on creating this regulatory framework in order to comply with the Office of the State Law Advisor's requirements.

At present, the Department was only consulting internally with stakeholders in the Department of Justice – other government departments have not been included yet. Consultation with other departments usually has to take place before a Bill can be published for public comment. In due course, the Department would also initiate a consultation process with organisations who represent sex workers that was proposed earlier by the Department of Justice.

3. Using the Courts

a.) In 2002, Ellen Jordan (a brothel owner) challenged the constitutionality of provisions of the Sexual Offences Act of 1957 in the Constitutional Court in a case entitled *S v Jordan 2002 6 SA 642 (CC)*. The case was ultimately not successful in decriminalising sex work and the Court noted that the issue would be best dealt with by Parliament. Following the judgment, government published more restrictive laws to explicitly criminalise the clients of sex workers in the form of Section 11 of the Criminal Law (Sexual Offenses and Related Matters) Amendment Act, 2007. It is worth noting that the judgement did not deal with access to health care issues and amici submissions on these

"In line with the NSP on GBV it is hoped that decriminalisation [of sex work] will minimize human rights violations against sex workers. It would also mean better access to health care and reproductive health services for sex workers, as well as compliance with health and safety and labour legislation. It would also afford better protection for sex workers, better working conditions and less discrimination and stigma."

– Minister of Justice and Constitutional Development, Ronald Lamola, 9 December 2022

issues were not adequately considered. In May 2024, SWEAT initiated court proceedings arguing that more than 20 years have passed since the Jordan judgment and that much has changed in the sex work context. In the case *S.H and SWEAT v Minister of Justice and Correctional Services and others (Case no 9229/24, High Court of the Western Cape Division)*, the Applicants asked the Western Cape High Court to declare sections of the Sexual Offences Act of 1957, the Criminal Law (Sexual Offenses and Related Matters) Amendment Act, 2007 and various municipal by-laws invalid. If the case is successful in the High Court, it will need to go to the Constitutional Court for confirmation.[14]

At the time of writing, the matter has been set down in Court in two parts due to the unprecedented number of parties who have applied to be admitted as *amici curiae* (friends of the court).

In addition three organisations want to apply for leave to join as Respondents in the case. The Court will therefore first have a process to decide on these intervention applications, and then proceed to hold a main hearing. The latter will only likely be heard in 2026.

Conclusion:

Sex workers and sex worker allies have fought for more than three decades for changes to old-fashioned laws that continue to give rise to human rights violations, and that undermine the dignity of sex workers. Currently, two simultaneous legal processes – through the Department of Justice and through a court challenge - are underway that could make decriminalisation of sex work in South Africa a reality. Whilst these two processes are underway, it is vital for sex workers and human rights activists to continue to put pressure on government by bringing to fore and speaking out against sex worker human rights violations.

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Differentiated models of PrEP delivery

Lebogang Sekalo[1], B.Sc. Medical Sciences, MSc Medical Immunology;
Pakama Samela Mapukata[1], BCur in Nursing; **F Bennin**[1], B.Sc. Occupational Therapy, MPH
[1]*Desmond Tutu Health Foundation.*

Introduction

Human immunodeficiency virus (HIV) is a virus of major importance, especially in South Africa, where in 2023, approximately 7.5 million people were living with HIV, and 210,000 new cases were reported[1]. Women and girls are particularly at risk, with 62% of new HIV infections occurring in women and girls in sub-Saharan Africa (SSA). Other key populations (KPs) particularly impacted in SSA also include transgender individuals, those injecting drugs, sex workers, and men who have sex with men (MSM)[2].

Pre-exposure prophylaxis (PrEP) has played a pivotal role in halting the HIV epidemic, which requires lifelong treatment using antiretroviral (ARV) medications (Emtricitabine/Tenofovir Disoproxil Fumarate)[3]. Oral PrEP became available in South Africa in 2016, with national roll outs from public clinics only being available from 2020[2]. The initial roll out of oral PrEP occurred in stages, with a focus on MSM and sex workers, then extending to Adolescent Girls and Young Women (AGYW) with the help of donor-funded partners. However, although substantial progress in the fight against HIV incidence and HIV-related deaths has been made, the rate is not fast enough to reach the goals set by the United Nations Political Declaration, which aims for less than 350,000 new HIV infections by 2030. Furthermore, low- and middle-income countries (LMICs) may see a decline in donor spending for financing HIV response efforts, as funding resources are directed to other diseases/pandemics. This was evident during the COVID-19 pandemic, particularly in LMICs with less robust HIV response programs[3, 4], and seen most recently in early 2025 with US government cuts to USAID and PPEPFAR funded activities. As a result, countries, funders and implementers need to find novel and efficient ways to provide and improve PrEP related service delivery[4].

FastPrEP is an implementation science project that aims to scale up oral and novel PrEP modalities through differentiated service delivery to improve uptake and optimal use of PrEP in key populations[5]. Based in the Klipfontein and Mitchell's Plain subdistrict of Cape Town, the FastPrEP project has successfully delivered PrEP for over 2 years in an integrated approach, combined with sexual reproductive health (SRH) services to the community. The project has collaborated with government facilities to facilitate PrEP delivery. Two peer navigators per clinic were distributed to 12 government facilities. Additionally, four mobile trucks go to different sites daily. The sites were mapped in such a way that they are situated in high traffic areas, where young people are most likely to hang out. These include taxi ranks, shopping

malls, and next to schools. Operating hours are also set to accommodate school goers to be able to come out of school and still have access to health services. Moreover, there is an option for a courier service where PrEP users can have their PrEP refills delivered to their homes or preferred addresses. While effective implementation of PrEP in the Klipfontein and Mitchells Plain health sub-district is feasible in practice, there have been significant challenges with PrEP uptake and continuation. This article seeks to outline the differentiated care services, their delivery methods and the key lessons learned

Differentiated PrEP modalities

FastPrEP aims to use an innovative differentiated approach to roll out and scale PrEP to AGYW, their partners and young MSM alongside offering SRH services, which include HIV and STI testing and contraception provision. The project currently offers several PrEP modalities including oral PrEP, the dapivirine vaginal ring (DVR) and the long-acting cabotegravir injection (CAB-LA) to adolescent and young people in South Africa to improve the uptake and optimal use of PrEP in key populations.

Oral PrEP is highly effective in preventing HIV acquisition when taken consistently, every day, as prescribed[6].

The DVR is a flexible vaginal ring that has been proven to be a long-acting PrEP method with low systemic absorption[8]. The monthly DVR is the first long-acting, discreet HIV prevention product created specifically for women. It provides protection over the course of 28 days and provides HIV protection within 24 hours of insertion. Young women can self-insert the ring without the assistance of a health professional. The DVR offers an alternative longer-lasting HIV prevention method, empowering young woman with a choice beyond oral PrEP.

In 2022, the World Health Organization recommended the long-acting injectable cabotegravir (CAB-LA) PrEP as another option for HIV prevention in sub-Saharan Africa[7]. CAB-LA is an injectable PrEP product that is given intramuscularly every 2 months and has proven to be safe and highly effective[8] as reported in the HPTN 084 study , a phase 3, randomized clinical trial study, which showed a 88% lower risk of HIV infection in those taking CAB-LA compared to oral PrEP[9].

Delivery methods of differentiated PrEP modality

The FastPrEP project delivers SRH services and PrEP modalities through a variety of differentiated methods including mobile clinics, local government clinics, schools, quick depots, youth clubs and a courier service as outlined in figure 1.

1. Mobile clinics

Mobile clinics offer more than just differentiated community-based services; they typically deliver integrated, key population-friendly SRH services (such as adolescent-friendly care and services for other key populations)[10]. These mobile clinics also utilise community engagement strategies to attract recipients of care[11], which assist with increasing uptake and continuation of PrEP modalities

Delivery of CAB-LA also happens in the mobile setting, and it was not as challenging in Fast PrEP project. Lessons learned from the PrEPared to Choose Study found that the successful delivery of CAB LA is possible with the appropriate resources and personnel available. The mobile units in which PrEPared to Choose was based have an air conditioning system, bathrooms to collect specimens, and refrigerators to store samples and allow for adequate storage of medical equipment. The backup power supply is in the system to ensure the continuation of services even if generators run out. The mobile units also have an emergency trolley in the nurse's room, to assist with attending to any severe adverse events if these were to occur when administering the CAB-LA injection for the first time. The mobile rooms have enough space to provide a private and safe space to engage with the recipients of care freely, and this has led the team to provide a satisfactory service to the recipients of care. However, even though the mobile has the potential to provide a quality service, challenges such as extreme weather, civil unrest and high number of participants attending services, do also present as daily challenges.

2. Local government clinics

The alternative PrEP initiation hubs are the standard government health facilities. Initially, 12 facilities were selected based on location and

Figure 1: FastPrEP hub-and-spokes model.

Pre-exposure prophylaxis (PrEP) has played a pivotal role in halting the HIV epidemic, which requires lifelong treatment using antiretroviral (ARV) medications (Emtricitabine/ Tenofovir Disoproxil Fumarate)[3].

readiness to provide PrEP. Two trained FastPrEP peer navigators were allocated to each respective facility, whereas counselling and clinical services have been provided by the existing Department of Health (DoH) facility staff. Each facility has undergone a PrEP feasibility assessment to improve PrEP client experience and efficiency. All Adolescent and Young People (AYP) starting PrEP at a 'hub' are informed of the alternative delivery sites available for their PrEP refills. Various in-facility strategies have been provided by the FastPrEP team to make PrEP access more acceptable to AYP and feasible within the government health system context. It was found that the key population that mostly get their PrEP by the clinic are young girls and pregnant women as they visit the government clinic for other services like family planning or neonatal visits. The challenge with this model is nneding to spend more time in the clinic.

3. Government schools and events

Due to FastPrEP targeting AYP who predominantly are still at secondary schools or colleges, especially during weekdays, PrEP and comprehensive SRH services are also provided at consenting schools and colleges. Visiting schools have received support from school principals and educators; however, there has been a reported preference that the services only be provided for children over 15 years old. We found that incorporating STI point-of-care testing and family planning with PrEP has increased PrEP uptake by learners.

4. Courier service

PrEP delivery does not always have to be done in a clinic setting. Recipients of care are presented with an option to have their PrEP and STI treatment delivered to their homes. This option assists in retention in care, especially for those recipients of care with conflicting working schedules or other factors limiting access to health facilities. Counselors have reported that discussing courier services with recipients of care gave them confidence as they felt that the courier assisted PrEP users in adhering to their daily PrEP intake, especially when encountering challenges that would usually hinder users from returning to the clinic for their refills. However, others reported that while the courier service was exciting at first, most PrEP users became concerned about experiencing stigma from their community, when seeing the PrEP delivered, which resulted in fewer users opting for this form of delivery.

5. Youth clubs

Youth clubs are conducted on Saturdays to encourage recipients of care to have access to PrEP outside of school/working hours. The clubs provide a peer support environment, important information dissemination opportunities and a collegial sense of mission and unity (based on attendee reports). At the youth clubs, young people who have an HIV negative test result and are eligible for PrEP can initiate PrEP or pick up PrEP refills (with HIV Self Testing (HIVST) for status confirmation). The youth clubs are led by PrEP ambassadors, and supported by a nurse for technical assistance.

6. Quick Depos

The Quick Depots are accessible points for obtaining PrEP refills aimed at ensuring swift maintenance visits at smaller mobile trailers, staffed with a nurse and counsellor/peer navigator. Each depo is stationed on one site where it offers SRH services and PrEP, as well as a PrEP pick-up service.

Key lessons learned, and barriers and enablers to PrEP provision

Each PrEP delivery method has provided key lessons for future PrEP provision. Mobile clinics generally have lower waiting times, offer services at convenient times and places for their target audiences, have more first-time HIV testing. They are more successful at drawing in younger and male recipients of care, and are favoured as

they tailor services to the individual[10,12]. Because mobile health clinics are mobile by nature and are situated in the community, they encounter wider community issues (such as riots and extreme weather)[5]. In addition, because the lives of adolescents and young people are so mobile, it can be difficult to coordinate PrEP follow-up visits. Though additional effort is required to improve retention through these services, mobile clinics are quite effective in reaching target populations for PrEP uptake[13]. The experience with FastPrEP mobiles has been similar.

One of the important lessons learned, is the importance of adolescent friendly services when providing PrEP to young people. Young people have reported that they are feeling more welcome in mobiles than in government facilities, due to the youth trained staff, which consist of peer navigators, research counsellors and nurses who are accessible to young people. Recipients of care also felt accessing SRH services on the mobiles gave them better privacy and the ability to exercise their right to choose without being judged in clinic queues by other patients/ clients and some clinic staff. This has also led to an increase in males seeking mobile clinic services, similarly due to shorter queues compared to those experiences in the government clinics. Due to unrest in the communities, unfortunately, safety has become a barrier to reaching a larger population and geographical area. Certain areas have been marked as "redzone sites", resulting in mobiles not attending to those areas. Recipients of care residing in these areas either have to use courier services or travel to the nearest available mobile clinic spot.

A lesson learned from counselling is that when people have limited options, they take whatever is available, and the availability of more than one PrEP choice allows users to choose what they prefer or what is suitable for their lifestyle. In the FastPrEP project, many individuals sought HIV prevention methods, but initially, the available options were limited. Women could choose between oral PrEP, the DVR and condoms, while men had only oral PrEP and condoms[8]. At a later stage, the introduction of CAB-LA expanded these options, and many participants, both new and existing, opted for CAB-LA, with some switching from oral PrEP to the injectable form as it better suited their lifestyle. This highlights that when choices are limited, people settle for what is available, which may not suit their needs.

The introduction of the DVR received mixed responses from both the recipients of care and the care providers. Both groups were hopeful that there was now a long-acting HIV prevention method that was also discreet. At the same time, that was followed by big hesitancy due to its efficacy, which initially was reported to be approximately 35%. After a few studies had proven the efficacy to be above 50%, hesitancy persisted, which impacted the rollout of DVR in both mobile clinics and government facilities, as there was poor or no uptake at all[10,12].

There are a couple of challenges with the courier service method of delivering PrEP to recipients of care. Project coordinators have reported that PrEP users opting for courier delivery will agree to a delivery time and place, and upon delivery they are nowhere to be found. Secondly, PrEP users may not have alternative contact numbers, making contact challenging.

As a result, a lesson learned in this method of delivery, is that it is helpful to broaden the recipient of care's contact numbers (including alternatives) and also register their emails in the event they lose their cellphone they can still stay be contacted. Having brochures on the courier service option handed to recipients of care at each visit detailing this option, could improve the use of courier services and encourage people to take PrEP as it is more accessible for them.

Conclusion

Differentiated service delivery (DSD) models of PrEP provide a variety of potential advantages to both PrEP users and providers. DSD models aim to make treatment more patient-centric, reduce costs for patients and the healthcare system, while enhancing clinical treatment results by easing the burden of frequent clinic visits[10]. Despite its challenges, the FastPrEP project has found this model of PrEP delivery to be effective, and continues to routinely implement lessons learned, enabling appropriate and accessible PrEP delivery for young people.

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Clinical tips

1. With acute kidney injury (AKI), adjust NRTI dose based on eGFR. Interrupt TDF even if it is not thought to have caused AKI.
2. Resistance testing may not detect archived mutations if the patient is not receiving the drugs at the time of resistance testing.
3. In patients with renal impairment (eGFR < 50) the alternative to TLD is 3TC + ABC + DTG.
4. DRV/r 800 mg/100 mg once daily is recommended as the first choice PI if a PI is used in second-line therapy.
5. In patients who interrupt ART and returned to care, always screen for opportunistic infections.
6. In a patient who has interrupted treatment, VL measurement should be performed 3 months after ART re-initiation.
7. When starting/switching antiretroviral drugs or concomitant medications, evaluate for potential drug interactions.
8. ATV can cause jaundice due to elevation of unconjugated bilirubin - this is benign.
9. The combination of TDF (or TAF) + 3TC (or FTC) + DTG is regarded as least hepatotoxic.
10. All patients with HIV should be screened for active hep B virus–hepatitis B surface antigen (HBsAg) screening is an appropriate test.
11. For all HIV-positive HBsAg-positive patients, the ART regimen should include TDF (or TAF) + 3TC (or FTC).
12. Antenatal syphilis seroprevalence in SA is increasing. See syphilis guidelines: https://sahivsoc.org/Files/ SAHCS%20syphilis%20 guideline.pdf.
13. Rifampicin markedly lowers concentrations of many drugs, including DR-TB drugs: always check coadministered drugs.
14. If there are DILI risk-factors, do LFTs when starting TB therapy https://sahivsoc.org/Files/SAHCS%20 DILI%20guidelines%20 -%202024.pdf.
15. Good quality specimens and correctly filled laboratory request forms are essential for receiving good quality TB results.
16. Be up to date on TB management with our TB course: https:// sahivsoc.org/Subheader/Index/tuberculosismanagement-and-control-online-course
17. Investigate for causes of diarrhoea in a patient when they have 3 or more liquid stools per 24 hours.
18. Contraindications for LP include GCS <10, papilloedema, VP shunt, unexplained seizure/new focal signs like as hemiparesis/ dysphasia, but not cranial nerve palsies.
19. PEP can effectively prevent infection in a person exposed to HIV when initiated as soon as possible and at least within 72 h post-exposure.
20. The global recommendation for PEP is a 3-drug regimen involving, whenever possible, an integrase inhibitor (usually TLD for 28 days).
21. PrEP should be offered to all HIV-negative clients identified as being at risk of HIV acquisition, and to anyone who requests it (not only to those at high risk).
22. HIV Self testing is as an option for initiation/maintenance on oral PrEP and DVR (but not for CAB-LA). An oral HIV self-test can be used as a first line screening test for HIV.
23. PrEP should be offered as part of an integrated HIV prevention and sexual and reproductive health (SRH) package
24. First-line treatment of primary (e.g. ulcer) & secondary (e.g. rash) syphilis is benzathine penicillin G 2.4 million units IM single dose.
25. All recent (< 3 months) sexual partners of a patient with syphilis should be counselled and offered treatment for early syphilis, and any further/new partners traced.
26. All cases of congenital syphilis must be reported within 7 days of clinical or laboratory diagnosis. See https://www.nicd.ac.za/diseases-a-z-index/congenital-syphillis/
27. LPV/r is the only PI combination that can be used with RIF-based TB treatment, but the dose of LPV/r must be doubled. Apart from this darunavir is the PI of choice.
28. Tenofovir can cause renal failure or a renal-tubular wasting syndrome. Serum creatinine monitoring at regular intervals is recommended.
29. DTG causes a small increase in serum creatinine (usually <30 µmol/L) due to interference with tubular creatinine secretion; however, this does not represent a decline in renal function.
30. Screening for TB, cryptococcal meningitis and other opportunistic infections prior to ART initiation is important since these conditions may necessitate delaying ART initiation.
31. The role of CD4+ count testing is to establish whether CTX prophylaxis, sCrAg testing and urine LAM testing is required, and to identify patients with AHD who may need closer follow-up.
32. In ART-naïve patients, the preferred initial regimen is 3TC (300 mg) or (FTC 200 mg) + TDF (300 mg) + DTG (50 mg) daily – available as a once-daily, one-tablet FDC.

DTG - dolutegravir; VL - viral load; U=U - undetectable = untransmittable; TB - tuberculosis; TLD - tenofovir/lamivudine/dolutegravir; AZT - zidovudine; 3TC - lamivudine; NVP - nevirapine; ART; antiretroviral therapy; PCR - polymerase chain reaction; PrEP - pre-exposure prophylaxis.

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- HIV testing
- Management of HIV in pregnancy
- PMTCT
- Drug interactions
- Treatment/prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of DS and DR tuberculosis
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  - Treatment selection
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