Volume 1. No 1. June 2010

HIV Nursing

Southern African HIV Clinicians Society Nursing Magazine

HCT Campaign

TB in the SAN community

X-ray diagnosis of TB

ICN TB/MDR-TB Project

Adding value to life.

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

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magazine

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· T H E · M O N U M E N T · T R U S T ·

Nelouise Geyer

ed's note

It is with great excitement that the Southern African HIV Clinicians Society (SAHCS) is launching a magazine for nurses during a year with several highlights. Over the last few months the hype around the build up to the World Cup that kicks off this month was visible through little flags, mirror covers, vuvuzela's and the yellow shirts all around us. It was no different to the build up of the first edition of this nursing magazine and finally we are here!

But even more special, is that 2010 is the International Year of the Nurse – a celebration of the contribution that nurses and midwives are making globally to the health and wellbeing of our nations. The nursing magazine of the Society is visible proof of the acknowledgement by the SA HIV Clinicians Society that nurses are playing an important role in HIV/AIDS care, not only in Southern Africa, but Africa as a whole.

The magazine is launched at the TB conference, a challenge closely related to the high prevalence of HIV in our sub-region. The first magazine therefore has a focus on TB providing information and views on issues related to HIV and TB. This is a magazine for you, our nurses, and we invite you to share your views, comments, and experiences with us. In future we want to include a 'letters to the editor' section where you can share your views and comments with others. We also invite you to participate in the competition to name this magazine and win a cell phone.

The Society is grateful for the generous support from Monument Trust which enables this magazine to be published.

Happy reading – we hope you enjoy this new addition to the benefits of SA HIV Clinicians Society membership and we cannot wait to hear from you.

Nelouise Geyer

HIV Nursing

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talk to us

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

Prof Francois Venter

Message from the president

Nurses are the foundation of our healthcare system

The HIV epidemic is probably South Africa's most pressing health problem, with huge implications for hospitalisation, clinic visits, TB rates, maternal and under-5 mortality, as well as for the disruption to the country's social fabric.

Nurses have traditionally been the foundation on which our health care system has been built. Unfortunately, the public sector negligence by the previous apartheid government was compounded even further by our previous health minister, who shut nursing colleges, allowed precious health care human resources to haemorrhage overseas and into non-health professions, and contributed to the de-professionalism of medical staff.

We are fortunate to have a new and energetic health minister, who doesn't take 'no' for an answer, and already has demonstrated meaningful commitment to fighting HIV. We have a duty to help him.

We all have a collective responsibility to repair our health system, and establish something that we can yet again be proud of, as health workers. The Society has committed to supporting nurses, through the establishment of publications, training courses and other support mechanisms, so that our nurses are equipped to start treating HIV-infected patients in every possible way. In the process, we hope that nurses will start applying the lessons we learn from treating HIV to all other chronic illnesses and start providing the primary care system with appropriate referral-something we were all hopeful would arise from a new democratic government in 1994.

Prof Francois Venter

news

Train nurses before new ARV policy: Union

Cape Town, Sapa - "The government should train nurses properly before allowing them to initiate antiretroviral treatment (ART)," the Democratic Nursing Organisation of SA (Denosa) said. It said it was looking forward to the publication of proposed new ARV guidelines, which would apparently allow nurses to put people onto treatment.

This was a progressive step, because nurses constituted a large proportion of health care providers. However, Denosa had concerns about the implementation of the guidelines, particularly on the preparation of nurses for this enormous task.

"We are concerned that the necessary system is not in place to ensure that nurses render quality and effective service," it said. The law currently prohibited nurses from prescribing medication, unless a nurse was licensed to do so.

The South African Nursing Council should "come to the party" to ensure that what nurses would be doing did not conflict with the law.
In addition, ART was extremely toxic and Denosa was wary of situations where incorrect regimes were prescribed to patients. It wanted to protect its members from litigation.
"We therefore demand the government to provide full scale training for nurses prior to the implementation of the new ART guidelines," it said.

27 February 2010
Citizen

RWANDA: Nurses to help speed up ART rollout

Kigali, Plus News - Rwandan nurses will soon be authorized to start HIV-positive patients on life-prolonging antiretroviral treatment (ART), a move Ministry of Health officials say will speed up the rollout of ART in the East African nation.

"Task-shifting will reduce the number of cases requiring the presence of a doctor, thereby reducing the number of treatment-eligible patients that have not initiated ART because they have to wait for the doctor's visit," Aimable Mbituyumuremyi from TRAC Plus, the Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics, told IRIN/ PlusNews.

At present, starting on ARVs requires a medical consultation and prescription from a physician. Nurses are responsible for regular patient follow-up and can refill existing ARV prescriptions. Physicians are generally based at district hospitals and visit health centres once a week.

By September the nurses will be authorized to prescribe ART in uncomplicated cases requiring first-line drugs. Cases with significant complications that may require second-line ART will continue to be referred to physicians. Doctors and supervisors from the district hospitals will continue to monitor nurses during their quarterly formative supervision visits to health centres.

26 February 2010
IRIN / PlusNews

talk to us

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

Gauteng increases number of ARV sites

Johannesburg, BauNews - The Gauteng Provincial Government is to increase the number of anti-retroviral (ARV) treatment sites in the province from 73 to 113 this financial year.

"The total number of patients to be targeted in the new financial year is 130 000, which will see the department reaching out to 400 000 by the end of March 2011," Gauteng Health and Social Development MEC Qedani Mahlangu said on Tuesday.

She also urged HIV positive people, who were pregnant, to visit clinics to start early treatment.

In his Budget Speech last week, Finance Minister Pravin Gordhan announced an additional R3 billion to broaden access to those infected with TB and women and children with a CD4 count lower than 350.

In line with the call by the South African National AIDS Council, Mahlangu also announced that the department will be working with provincial chiefs and izindunas in hostels to promote circumcision among men.

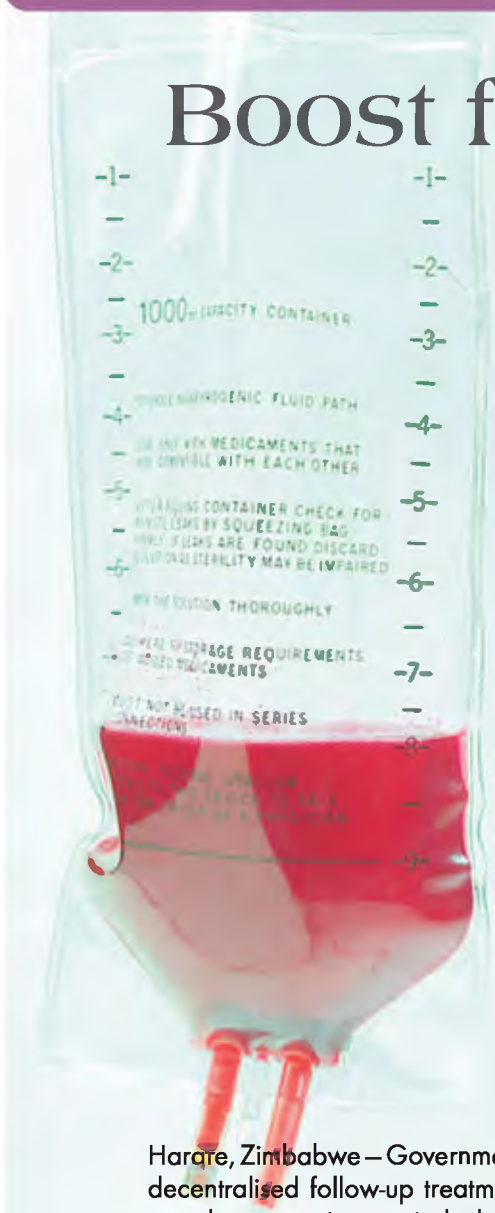
She said the message would be taken to hostels, taxi ranks, informal settlements and townships.

However, she warned that circumcision did not prevent infection but reduced chances of infection.

By Gabi Khumalo

23 February 2010

BuaNews



Boost for SA blood services

Johannesburg - A STATE-OF-THE-ART facility aimed at improving the safety of blood supply in the country was opened by Health Minister Aaron Motsoaledi.

The Transfusion Medicine Training Centre (TMTC) was launched by the South African National Blood Service (SANBS) and Western Province Blood Transfusion Services (WPBTS).

Ravi Reddy, SANBS chief operations officer, said: "The training and development of staff in blood collection, banking and transfusion is important for the country, thus the initiation of this programme. We need to collect at least 3000 units of blood every day in order to meet the requirements of the country.

We operate 79 blood banks in eight provinces. In order for SANBS to provide safe blood, we need competent staff. The TMTC will help in training staff and healthcare workers in public and private institutions," Reddy said.

Motsoaledi said: "The issue of blood safety in our country is an important component of our fight to defeat the scourge of HIV-Aids. I am pleased that organisations such as the blood services have responded to this clarion call by establishing this training centre to strengthen capacity to ensure the safe supply of blood and blood products to patients."

By Zinhle Mapumulo
23 February 2010
Sowetan

Zimbabwe Govt Decentralises ARV Follow Up

Harare, Zimbabwe – Government has decentralised follow-up treatment for people on anti retroviral drugs to ensure easy access.

HIV and TB Unit head in the Ministry of Health and Child Welfare Dr Owen Mugurungi said initiation of new patients on ART would remain within hospitals but clinics and other health centres would be capacitated to provide the drugs.

Speaking at a National HIV Partnership forum meeting yesterday Dr Mugurungi said Government took the initiative to spread the ART programme.

He said the move would also limit time spent by patients waiting to get their monthly doses.

"We have decentralised collection of monthly anti-retroviral drugs doses to make sure treatment is nearer to our patients. Patients who are now stable can thus access the drugs at centres close to them.

"As Government we are focusing on training our health workers on providing and monitoring patients on ART so that our patients can not only access the drugs but minimise transport costs and time spent queuing for the drugs," he said.

Dr Mugurungi said Government would strengthen mentorship of health workers to ensure quality retention during the programme.

He said the ministry had established 41 sites around Zimbabwe to monitor signs of drug resistance.

On the latest World Health Organisation guidelines for initiating patients on ARV, Dr Mugurungi said the implementation of the measure depended on the support of its partners.

Zimbabwe currently has more than 200 000 patients on ARVs and is targeting to put 250 000 on treatment before the end of 2011.

26 February 2010
Published by the government of Zimbabwe

Youth risky behaviour shows decline, but minister still concerned

Johannesburg, BuaNews - Although the 2008 South African National Youth Risk Behaviour Survey shows reductions in risky sexual behaviour as compared to a previous survey, Minister Collins Chabane remains concerned.

The survey, which was released today and focused on behaviours of young people between grade 8 and 11 showed that fewer school learners had ever had sex (from 41% to 38%) as compared to a previous study in 2002.

The national study conducted among 10 000 learners in 2008 also focused on risk behaviours related to infectious and chronic diseases, injury and trauma, mental health, alcohol and illegal drug use.

Of those who had sex, the number of school learners that had two or more sexual partners in their lifetime reduced (from 45% to 41%), and less learners had one or more sexual partners during the past three months (from 70% to 52%). Also, of those who ever had sex, the incidence of sexually transmitted infections reduced (from 7% to 4%), while consistent condom use increased slightly (29% to 31%).

However, the Minister in the Presidency responsible for Performance Monitoring and Evaluation is not impressed by the decrease in numbers, saying that from the 38% of learners who had reported ever having sex, 16% did after consuming alcohol and 14% after taking drugs.

"These highlight the highly unacceptable trends young people are faced with in society which all of us should protect them against.

"These are our children who still need our protection and guidance."

Minister Chabane said the programmes of government should begin to turn these figures around and develop initiatives that can discourage and detract young people from such risks altogether. The survey revealed further that 15 percent of learners carried weapons, 19 percent belonged to gangs and 9 percent carried weapons on school premises.

On suicide related behaviours, 24% reported having experienced feelings of sadness or hopelessness, 21% had considered or attempted to commit suicide. 50% of learners also reported to have ever dranked alcohol and 30% having smoked.

Medical Research Council's Health Promotion Research and Development Unit co-ordinator Professor Priscilla Reddy said the survey gave a window into the conditions young people face growing up in today's South Africa.

"Seeing where the stresses are on this vital part of the population will allow us to put precious resources to work in the best way," Reddy said.

While acknowledging a decrease in the youth behaviour, compared to the 2002 survey, Professor Reddy emphasised the need to find ways to intervene and move the boundaries further.

"We need to work hard to turn the situation around, if we intervene now, it will make a huge difference in the behaviour of the youth," she said.

By Gabi Khumalo
20 Apr 2010
Government Communication and Information System

Zambia prison conditions spreading HIV, TB -report

LUSAKA, Reuters - Poor living conditions and lack of proper medical care in Zambian prisons are encouraging the spread of HIV and tuberculosis among inmates, a study showed.

The report by three human rights groups including Human Rights Watch said the exposure of prisoners to deadly drug-resistant strains of HIV and TB in overcrowded cells threatened the lives of both inmates and the general public.

The report, "Unjust and Unhealthy: HIV, TB, and Abuse in Zambian Prisons", said some prisoners were detained for years in such conditions even before being brought to trial.

"The conditions in TB isolation cells are life-threatening, yet inmates who have completed TB treatment choose to continue sleeping in the cells with prisoners with active TB because they are less crowded than general population cells," it said.

Some 16 percent of Zambia's total population is HIV positive and 1 million have full-blown AIDS. The rate of tuberculosis infection is also 16 percent, but HIV-related TB is even higher, according to health ministry data.

Zambia's prisons service employs only 14 healthcare workers to serve 15,300 inmates, and only 15 of the country's 86 prisons have clinics or sick bays, according to the study.

"People are dying," said Godfrey Malembeka, a former prisoner and prison rights activist who heads a local human rights group that was part of the study.

Testing for HIV – last measured at 27 percent among inmates -- and treatment for AIDS have improved at some prisons, but a ban on condoms in prisons, introduced to discourage intercourse and homosexuality, makes prevention impossible, the report said.

"Sexual abuse is common, and children are particularly vulnerable to rape by adult inmates in their cells," it said.

The report said the food provided by the government was so inadequate that it had become a commodity traded for sex.

By Chris Mfula
April 2010
Reuters

Finally, the right HIV tactic

Johannesburg, Mail & Guardian - About 2 000 doctors, nurses and pharmacists have come out of retirement to provide voluntary help in a massive national drive to HIV-test 15-million South Africans.

Medical schools have also agreed to release final-year students to assist with testing, while the NGO sector has mobilised 9 000 lay counsellors as part of the programme. In an interview this week Health Minister Aaron Motsoaledi said that South Africa has little choice but to push ahead with the National HIV Counselling and Testing (HCT) campaign – despite the country's crumbling health system. "The country is going through a very serious pandemic, the biggest in the world, and we have to deal with it," Motsoaledi said this week. He said the health department has been preparing for the campaign, which kicks off this Sunday, since last year.

"For the moment we have got enough condoms and testing kits to start. To sustain it we're staggering the programme over 15 months and over two budgetary years," he said.
During the campaign, which is coordinated by the South African National Aids Council (Sanac), the health department seeks to test 15-million people – one-third of the population – by June next year.

The rollout will begin in nine high-priority districts, one in each province, before moving to the others. Under the theme of "taking responsibility for oneself", the drive will encourage people to adopt a healthier lifestyle. In addition to testing for HIV medics at the country's testing stations will offer to test for hypertension, diabetes, anaemia and TB.

Motsoaledi said this was a deliberate attempt to bring the country back to a

preventative healthcare approach. "In the past 10 years South Africa has gravitated towards a curative healthcare system, which is much more expensive," he said. Salim Abdool Karim, director of the Centre for the Aids Programme of Research in South Africa, said the HCT campaign is "absolutely" the right approach for the country.

"Of all the things that we could be doing, in my opinion, this programme is probably the most appropriate at this point," he said. South Africa already has the largest Aids treatment campaign in the world, but its impact has been limited because most people start treatment at a very late stage.

"With a million people on treatment, we should be saving lives. And we're not doing that," said Abdool Karim. He said getting people on to treatment early is a key factor in the fight against Aids and the testing drive could help to address this.

But Abdool Karim said he has doubts about whether the 15-million target is realistic. "It's an aspirational goal, but we should try for it," he said. Treatment Action Campaign general secretary Vuyiseka Dubula also questioned the state's ability to follow through with the appropriate care once tests had been administered.

"If we test 15-million people, there's a possibility that 1.5-million of those will be HIV positive. How many of those will need treatment immediately and will we be able to provide that?" asked Dubula.

Sanac chief executive Dr Nono Simelela said the health department has planned for the increased demand for HIV/Aids drugs.

"The [health] budget pronouncement by the minister of finance earlier this year was based on projections that include the number of people that will go on ARVs following this programme," she said, adding that the health department has sought assistance from aid organisations such as USAid, the US President's Emergency Plan for Aids Relief and the Global Fund to fight HIV, Aids and Malaria.

There are fears that because of the human resource crisis in healthcare, people may not receive the level of counselling and post-testing support they require.

Kevin Kelly, director of the Centre for Aids Development, Research and Evaluation (Cadre), warned that there is a danger that the campaign may create a "treadmill of processing people".

"My concern is that we might not be able to reach the numbers required without compromising on quality," he said. Many people who are tested in South Africa have no more than 10 or 15 minutes of counselling after discovering their status. This, Kelly said, can be very risky.

A Cadre study of 900 people has found that HIV-positive people who have recently discovered their status are likely to suffer from mental health illnesses and increased depression.

"While testing remains a central part of our HIV response ... the principle feature is the quality of the counselling," he said. "Discovering your HIV status is no small thing. It's not the kind of thing that can be done in casual circumstances." Sanac's deputy chairperson, Mark Heywood, agreed that ensuring quality counselling will be a key challenge, conceding that "if there is no capacity for counselling, there shouldn't be testing".

But, he said: "We can't say that because we're not 100% ready, we can't do this. We know for a fact that almost 1 000 people die of Aids on a daily basis because they're avoiding testing for HIV and they don't understand how treatment works. There is a big price to pay for doing nothing or doing too little."

Heywood said the campaign will expose weaknesses in the health system. He called on civil society to help monitor facilities to ensure that people receive counselling and treatment, and to ensure that they are not discriminated against or victimised.

Heywood said the Sanac Nerve Centre will be on hand to coordinate the effort, provide support and act as a troubleshooter in cases of understaffing or shortages of drug and test kits.

The World Health Organization's Stop TB Department has published the fourth edition of Treatment of Tuberculosis: Guidelines. The guidelines contain a number of new recommendations, including a call to discontinue regimens based on just two months of rifampicin (2HRZE/6HE). They reinforce prior WHO recommendations for drug susceptibility testing (DST) at the start of therapy for all previously treated patients, and provide guidance for appropriate treatment approaches in the light of advances in laboratory technology and the country's progress in building laboratory capacity. They also reaffirm recommendations for supervised treatment, as well as the use of fixed-dose combinations of anti-TB drugs and patient kits as further measures for preventing the acquisition of drug resistance.

By Faranaaz Parker
23 April 2010
Mail & Guardian

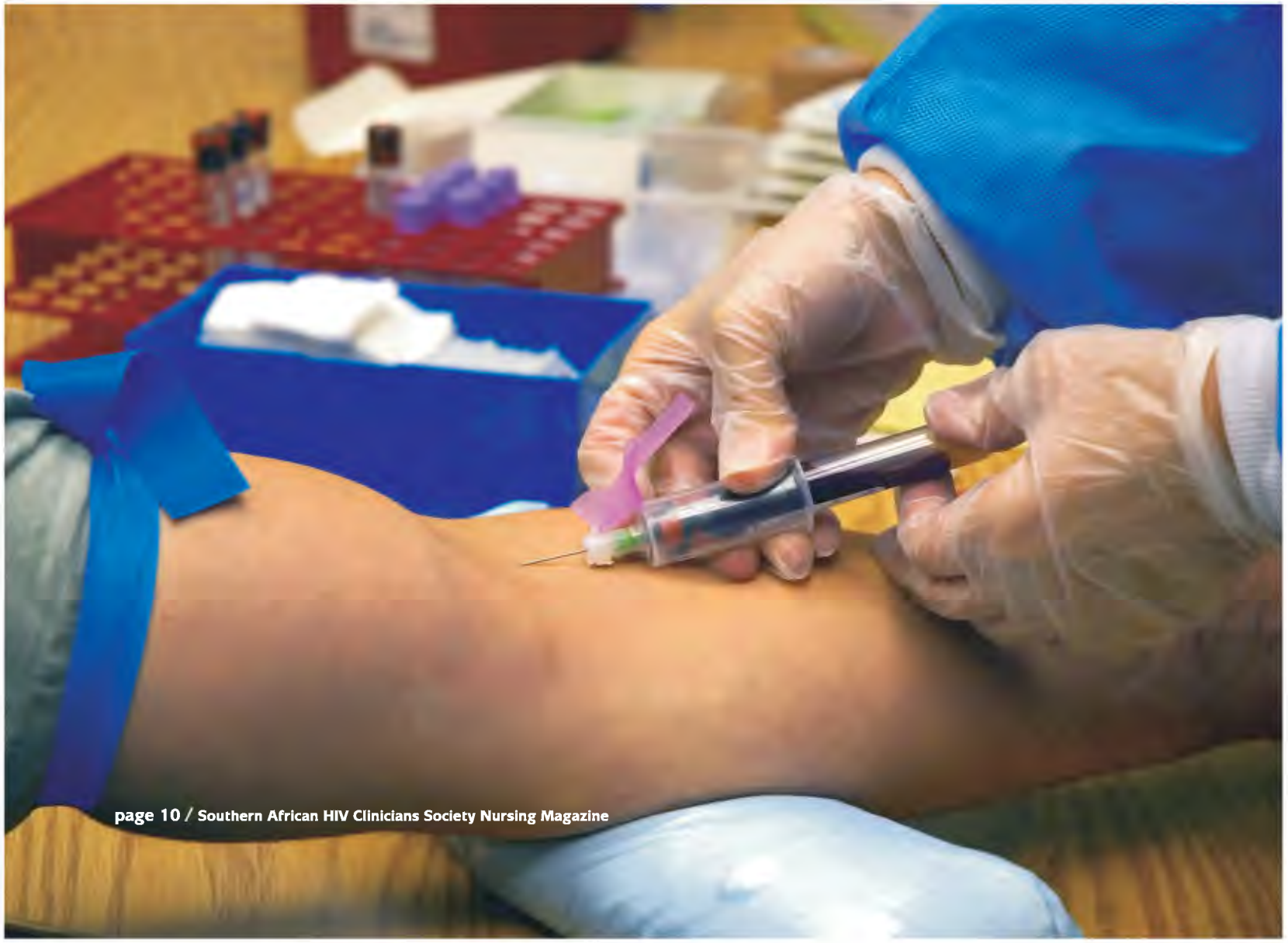
HCT Campaign – the turnaround strategy

Information obtained from the Ministry of Health and SANAC

The HIV Counselling and Testing (HCT) Campaign was launched at national level on 25th April 2010 in Gauteng followed by Provincial launches on 30th April 2010. The launches were led by political leaders who had undergone HIV testing highlighting the messages that all HIV testing is confidential and when HIV positive, it is no longer a death sentence. So this campaign is not only about testing but also about ensuring that people are referred for treatment. All sectors in society need to work together to fight the stigma attached to HIV&AIDS so that the problem of discrimination can be addressed through ending the silence and shame that is associated with HIV. For more information on the campaign go to www.sanac.org.za/hctportal/.

Everybody's privacy and dignity must be respected by health professionals and the public in general. The HIV status of all South Africans must be respected, whether positive or negative, and we must support each other to deal with this epidemic.

This turnaround strategy was initiated on World AIDS Day by the President when he announced a new approach



in the fight against HIV and AIDS. All public health facilities (fixed and mobile) will provide HIV testing and all PHC facilities will provide ART. This announcement would take effect from 1st April 2010 to meet the goals of the National Strategic Plan on HIV and AIDS, 2007-2011, namely

- To reduce the rate of HIV infection by 50% by 2011
- To ensure that 80% of people that need treatment are provided with antiretroviral treatment.

Implementation of World AIDS Day Announcements would firstly be based on a ***Prevention Strategy Package* for HIV&AIDS consisting of:**

1. Information, education, mass mobilisation
2. STI detection and management
3. Know your status – HIV testing and counselling
4. Widespread provision of condoms (male and female)
5. Prevention of mother to child HIV transmission (PMTCT)
6. Safe blood transfusion
7. Post-exposure prophylaxis
8. Life skills education
9. Medical male circumcision

The difference?

The Counselling and Testing (HCT) Campaign is different from the previous VCT campaigns as it is moving from voluntary testing, to a service delivery model to offer HCT to all patients at their entry point into the health system. It is therefore taking the HIV testing to the people. The objectives of the campaign are to:

1. **Mobilize** people to know their status;
2. Support people with key prevention messaging in order to take proactive steps to a **healthy lifestyle** irrespective of HIV status;
3. **Increase incidence** of health seeking behaviour; and
4. Increase the **access** to treatment, care and support

The campaign theme is a continuation from World AIDS Day and consists of three messages:

I AM RESPONSIBLE...

I must take responsibility for my own health and HIV status i.e. if I am HIV negative, to stay negative, if I am HIV positive, to seek support and services to ensure I am healthy and don't spread the virus to others, be they partners or children

WE ARE RESPONSIBLE

I must take responsibility for enabling those in my sphere of influence to make healthy choices (be [illegible] my children, my sexual partners, my employees etc.)

SOUTH AFRICA IS TAKING RESPONSIBILITY

Government is taking responsibility to ensure quality services are available when people present to test

Full range of services to be provided at HCT sites:

- HIV counselling and testing (HCT)
- Blood pressure (Hypertension)
- Blood sugar (Diabetes mellitus)
- HB (Anaemia)
- STI screening (questions and referral)
- TB screening (symptomatic screening, 5 questions)
- Full clinical TB screening if yes to any of the 5 questions (sputum, culture, X-ray)

Target of the campaign

The target is to reach 15 million people for HCT by June 2011.

- 3.8 million people in 9 initial launch districts
- 9.9 million in phase II (July 2010 – March 2011)
- 1.2 million in phase III (April – June 2011)
- Paying specific attention to 18 health priority districts (poorest districts)

While these targets refer to numbers of people to be reached, the real target is sustainable change in individual and community mindsets and behaviour which requires effective communication and education. The campaign is quite ambitious as it also endeavours to provide a full range of screening services to all persons at the point of entry into a health service.

Readiness of healthcare facilities

To prepare staff and health facilities for the increased uptake of health and wellness services, the following measures have been taken:

- From 1 April 2010 all public health facilities have been offering provider-initiated HIV counselling

and testing services which remain voluntary and confidential.
- To supplement current staffing capacity, the Minister has called on all retired health professionals to volunteer their services during the implementation of the campaign.
- Ongoing training of healthcare professionals on new policy guidelines.
- Test kits have been procured in advance in order to avoid stock outs.
- Accreditation of primary health care facilities has been fast tracked.

Currently there are 490 ART centres with plans to increase to 4,300 facilities providing a full package ART by March 2011. This would include provision of ART at antenatal care and TB testing and treatment centres with an additional 460 ART sites planned.

Currently less that 250 nurses are initiating ARV treatment through pilot programmes and the campaign aimed to have 1,500 nurses trained to initiate ARV by 1 April and a number of 4,800 nurses trained and initiating ARVs by March 2011.

Mobilisation of civil society

Civil society sectors have been called upon to continue the social mobilization work already underway within their respective sectors and include the HCT Campaign as a complementary activity within their sector plans. This can be done through a variety of activities such as door to door campaigns; taxi rank/malls/public gathering activations; education institution events; community events; engaging the religious sector; and linking HCT to existing community events, health and wellness days.

Nerve Centres

The Nerve Centre is the operational centre (heart) of the campaign and is headed by the SANAC Secretariat COO, Rev. Zwo Nevhutali, and Dr. Thobile Mbengashe (DoH HIV, AIDS, & STI Chief Director) and will extend to district level of service delivery. The Nerve Centre will provide direction to all stakeholders and strengthen coordination, communication and information sharing. It aims to accelerate current work plans to meet new targets. An important role that the Nerve Centre will fulfil is to promote ownership and accountability, and to monitor and evaluate the progress of the campaign. The Nerve Centre brings together and forces collaboration between acceleration of HIV prevention and scale-up of treatment, care and support.

Progress

In a Department of Health newsletter to stakeholders the progress reported related to nurses includes:

- 43 nurses were trained as HCT trainers on 8 and 9 April 2010 who would undertake further training of other nurses.
- 107 Nurses from 7 provinces had completed their training in Nurse Initiated and Managed ART (NIM-ART) in Johannesburg.
- 90% of nurses nominated attended this training; provinces did an outstanding job of mobilising their staff to attend at relatively short notice.
- During the week of 19 April 230 nurses would be trained in NIM-ART in Johannesburg and East London.
- Over 4,000 people (not all of whom are retired health care workers - many are currently employed and/or are counsellors) have phoned either the Helpline or SANAC to express interest in volunteering for the HCT campaign.
- National Department of Health will have a consolidated database of information on interested volunteers that will be sent to each District Manager by 14 April.

Retired nurses eligible for registration and who are currently not registered with South African Nursing Council are invited to register as a specially created category of nurse in terms of section 31(2) of the Nursing Act, 2005. Registration will imply:

- Valid registration for 12 months.
- Participation in counselling, testing, general health screening, referring and educating members of the public

Nurses who, on a voluntary basis avail themselves to participate and support the campaign, can obtain more information from the website (www.sanc.co.za) or phone (012 426 9542 / 012 426 9542).

Competition

Name the nursing magazine!

Win a Nokia cell phone by naming your magazine.

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

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

Rules:

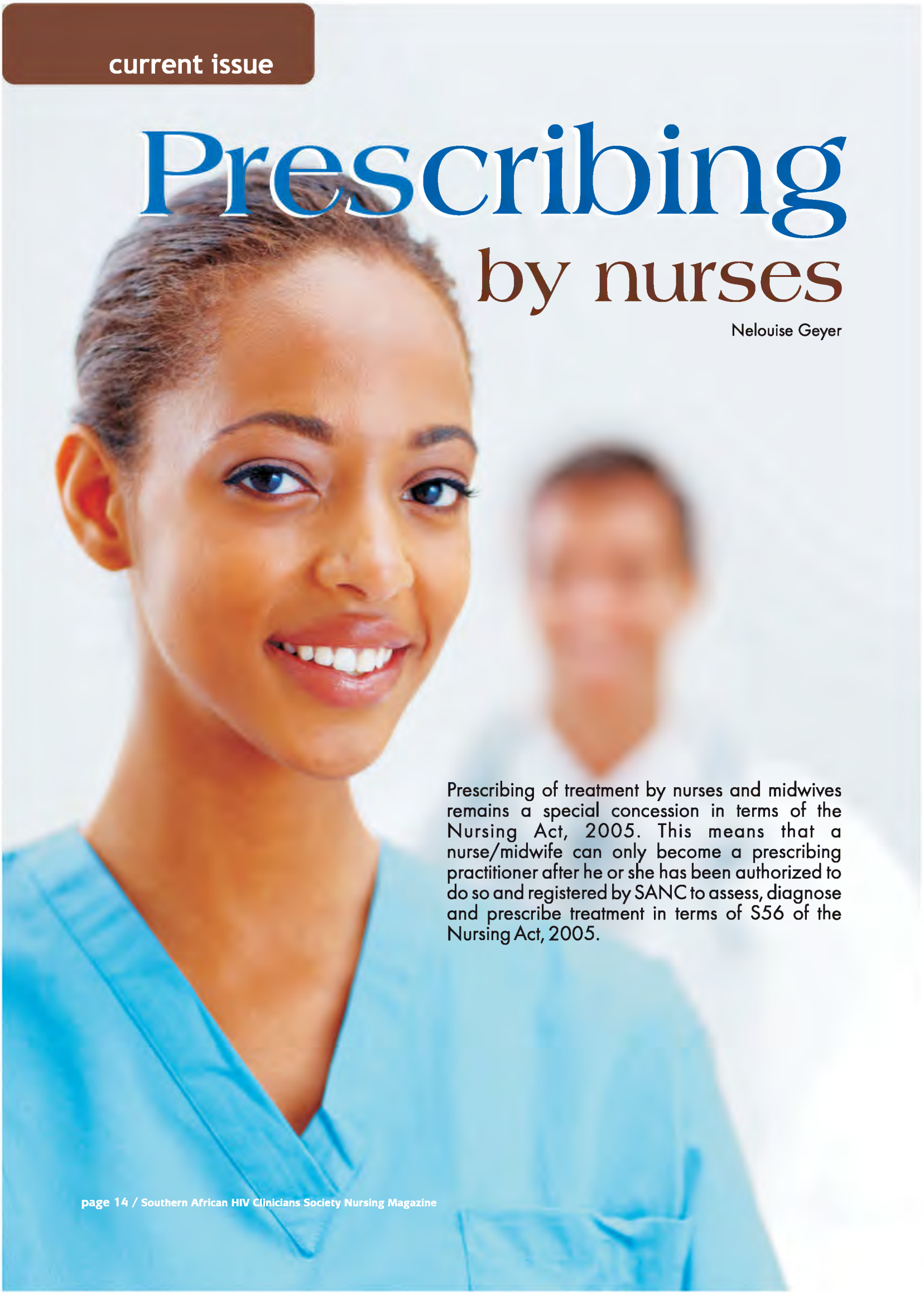
- The competition is open to paid up SA HIV Clinician Society nurse or midwife members only
- The closing date for the competition is 30 July 2010
- The judges' decision will be final

Standard sms rates apply

Competition

Prescribing by nurses

Nelouise Geyer



Prescribing of treatment by nurses and midwives remains a special concession in terms of the Nursing Act, 2005. This means that a nurse/midwife can only become a prescribing practitioner after he or she has been authorized to do so and registered by SANC to assess, diagnose and prescribe treatment in terms of S56 of the Nursing Act, 2005.

The general rule

The legislation of the country determines the general rule with regard to the use of medication in the country which determines that the medical practitioner and the dentist prescribe medication; the pharmacist dispenses medication and the nurse/midwife administers medication. All practitioners are responsible for assessing the impact and outcome of the treatment provided. The role of any of these practitioners can be extended to allow duties traditionally regarded as the scope of practice of one of the other groups, for example prescribing of treatment by nurses and midwives.

Medicines and Related Substances Act, 1965 (as amended)

The Medicines and Related Substances Act governs all manufacturing, control and use of medication in the country. It recognizes the nurse and midwife as a prescribing practitioner provided that the Nursing Council authorizes them to do so. Prescribing practitioners will have access to all schedules of medication but regulations have to be developed to indicate which drugs in each schedule nurses and midwives would have access to. The Act further determines that prescribing practitioners also have to:

- Obtaining a S 22A (15) permit to acquire, keep, use and supply medication. Such a permit will indicate which medication the practitioner has access to. Nurses and midwives are not allowed to keep an open shop or sell scheduled medication.

- Obtaining a S 22C dispensing license if the practitioner is expected to dispense medication. This license is applied for after successful completion of a dispensing course accredited by the Pharmacy Council of SA.

Nursing Act, 2005

The Nursing Act (Act 33 of 2005) determines in S56(1) that nurses and midwives who become prescribing practitioners must complete a prescribed training programme followed by registration with the SA Nursing Council to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions. This registration will be valid for three years after which the practitioner has to re-apply. The practitioner must be an employee of the state services at national, provincial or local (municipal) level where there is no doctor or pharmacist available.

Another option for authorisation is provided in the Nursing Act in S56(6) in terms of which the Director General of Health can authorise nurses and midwives to prescribe treatment without necessarily complying with the provisions of S56(1).

Nurses, Midwives and HIV&AIDS treatment

Previously the policy of the country indicated that nurses and midwives will not be involved in the initiation of antiretroviral treatment (ART). This policy has, however, changed and the HIV&AIDS and STI National Strategic Plan 2007 – 2011 clearly indicates that nurses and midwives are expected to assist with the initiation of ART for adults. The indicators provided in the National Plan states that the proportion of adults started on ART and managed by nurses/midwives must increase by 80% by 2011 and the HCT campaign is aiming to achieve this.

The country policies on treatment for HIV&AIDS states that only registered health professionals, in line with the relevant legislation and regulations, are allowed to prescribe ART according to the protocols provided. The HCT campaign would lead to more people requiring access to treatment and nurses will be trained to assist with this. Guidelines have been published recently for both HIV and TB treatment for all practitioners in healthcare. All personnel responsible for this task should have adequate and appropriate training and skills to initiate and manage persons on ART. The expected increase in persons requiring ART following the HCT campaign requires more nurses and midwives to be trained to initiate ART.

Last comments

There are many challenges to increasing the number of nurses and midwives trained in nurse initiated and managed ART (NIM-ART). The regulations required for implementation of the relevant sections in the Nursing Act are slow in development – at least one has been developed, but 2 years later not yet promulgated. This includes the regulations to the Medicines and Related Substances Act prescribing the medication that nurses and midwives could have access to which still has to be drafted.

Concern has been expressed about the ability of the current system to produce a sufficient number of NIM-ART trained nurses and midwives in a short period of time to address the need for ART in the country. As indicated in the previous article, the numbers are not on target as planned in the HCT campaign outline. The overnight switch from no nurse-initiation to NIM-ART and the limited time available for training has further raised concerns around the competence and confidence of practitioners to perform NIM-ART. From a labour point of view and worker protection, the concern is that when a mistake is made, the nurse or midwife is accountable and will stand alone.

Sputum sample for TB testing

Information obtained from the South African National Tuberculosis Control Programme Practical Guidelines, 2004, Department of Health

Individuals suspected of having pulmonary tuberculosis must have an examination of their sputum preformed to determine whether or not they are infectious cases of tuberculosis prior to the commencement of their treatment. This examination consists of microscopic examination (smear microscopy) of a sputum sample which has been spread on a slide and stained by one of two methods, namely carbofuschin methods (Ziehl-Neelsen or Kinyoun methods) and a fluorochrome procedure using auramine-O or auramine-rhodamine dyes. If micro organisms (commonly referred to as acid-fast bacilli or AFB) are detected by this method then the individual is said to have smear positive tuberculosis. Smear microscopy is essential to correctly and effectively identify the cases which are infectious and therefore have the highest priority for care.

The ideal situation is that at least two sputum samples should be taken from any person suspected to have tuberculosis.

The first sample should be collected at the first interview with the patient when a "spot specimen" is collected. This sample is obtained "on the spot" after coughing and clearing the back of the throat and this should be under the supervision of a health worker.

For the second sample the patient is then given a sputum container for the collection of an early morning sample which should be on the next day.

A third sample could be collected "on the spot" when the patient returns to the clinic to deliver the second sputum.

Sputum labelling

Correct labelling is essential and will save time and prevent errors. The information that should appear on the label is contained in the accompanying block.

Sputum collection

The collection of the sputum is an extremely important procedure. The healthcare practitioner must explain the procedure to ensure that the patient fully understands what is expected. It is essential that the sputum sample is obtained in a well ventilated area or outside without others watching.

The person must:

- First rinse mouth with water
- Hold the empty container received from the healthcare practitioner
- Cough deeply from the bottom of the chest beginning with deep breathing. Produce a sample after deep coughing even if it is saliva
- Carefully direct the sputum into the container so that the outside is not contaminated
- Give the container with the sputum sample to the healthcare practitioner
- Wash hands

The healthcare practitioner must:

- Explain the procedure to the patient
- Demonstrate a deep cough
- Give the patient the empty container without the lid
- Supervise the collection but do not stand in front of the patient
- Hold the lid ready to replace immediately after the sputum sample has been obtained
- Securely close the lid of the container by pressing the centre of the lid down until a click is heard
- Wash hands after handling the sputum sample

Labelling the sputum container

Label the container clearly with:

- Name of patient and clinic/ hospital number
- Name of clinic/hospital
- Indicate whether the sample is pre-treatment, follow-up or end of treatment sample
- Write clear instructions regarding what investigations are required
- Write the appearance of the sputum (eg mucoid, lumpy, green, offensive, etc)
- Date the sample clearly
- Label the container as the lid may get separated and mixed up

Sputum storage

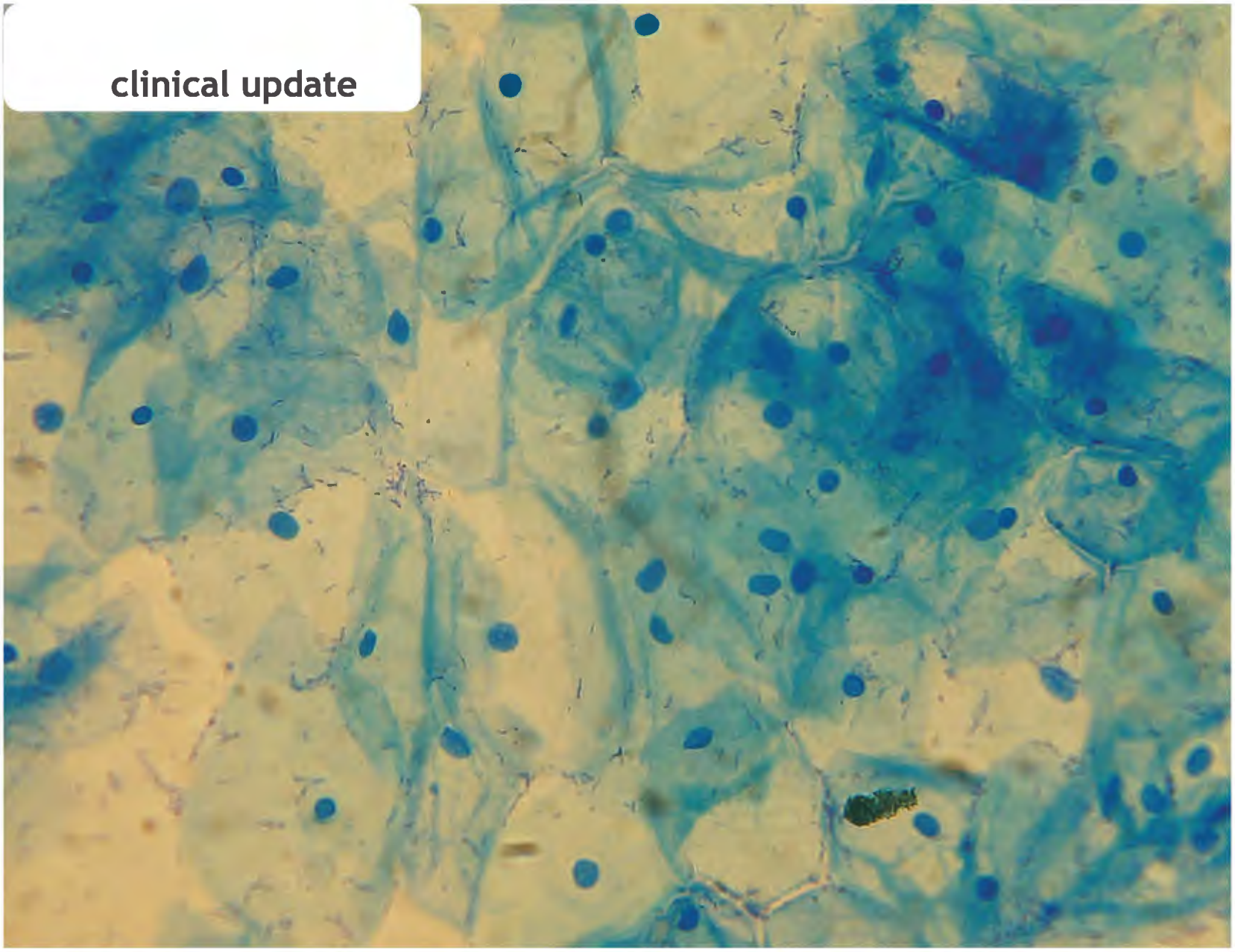
The sputum sample must be sent to the laboratory as soon as possible. Place the sputum bottle in a plastic bag, if possible, to prevent contamination. If transport is not immediately available, store the sputum sample in a fridge - do not store it in a freezer. Record the date on which the sample has been sent to the laboratory.

Transportation of sputum samples

Samples to the laboratory should be transported in a cooler bag. High temperatures during transit will kill bacilli. Samples should be protected from contact with direct sunlight at all times and should be taken directly to the laboratory. Make sure that the driver or porter understands the reasons and urgency for doing so.

Sputum results

One person must be responsible to check the sputum register to see which



results are still outstanding. These should be followed up with the laboratory to find out where the results are. Clinicians must interpret the results of the sputum samples with great care and the laboratory results should tie up with other clinical information on the patient. Should a sample come back tuberculosis negative when a patient clinically is suspected to have tuberculosis, other tests such as X-rays could be done to determine whether treatment may be required.

The number of bacilli (AFB) seen in the smear reflects the patient's infectivity. When the sample has been analysed the laboratory will record the number of bacilli detected.

When should sputum examinations be done?

Two samples are taken on three separate occasions during the course of treatment of patients with pulmonary tuberculosis.

- Pre-treatment – when pulmonary tuberculosis is first suspected send two (2) samples on consecutive days for tuberculosis microscopy. For re-treatment cases a sputum sample for culture and sensitivity should also be taken.
- During treatment – two samples should be sent for microscopy just before the end of the intensive phase of treatment [after two (2) months of treatment for new patients and after three (3) months for re-treatment patients]. Sputum samples for culture and drug susceptibility testing is only required if the patient remains smear positive at the end of the intensive phase of treatment.
- At the end of treatment – two (2) samples should be sent after the completion of five (5) months' treatment for new patients and after seven (7) months for retreatment cases.

Patients on treatment should be monitored by the healthcare practitioner and obtaining a sputum sample for laboratory assessment is part of the monitoring process.
Sputum samples sent for culture is more sensitive than smear microscopy and detects a higher proportion of cases among patients with symptoms. The specificity is also higher as each

live bacillus forms colonies on culture. The test is an expensive and slow diagnostic technique which takes about 4 weeks to provide a definitive result and is not accessible to most patients. Culture should be used for tuberculosis patients who are not easily diagnosed by microscopy, such as smear negative pulmonary and extra-pulmonary tuberculosis.

Indications for the need to use culture:

- History of previous unsuccessful TB treatment (interruption, failure, relapse).
- In cases where drug susceptibility testing is necessary.
- Patients who remain positive at the end of the intensive phase of treatment and or at the end of the treatment period.
- Patients who have two negative smears, not responded to a course of antibiotics and clinically TB is suspected.

Drug susceptibility tests are used to determine the susceptibility or resistance of a patient's bacillary strain to the different anti-tuberculosis drugs. There are two types of susceptibility testing:

- Indirect: performed after obtaining colonies in culture before testing and results are available only two to three months after sampling
- Direct: performed directly on the sample if it is rich in bacilli. In which case the results are available in 4-6 weeks

Laboratory analyses recorded.

Number of bacilli seen on smear		
No AFB	**Per 100 oil immersion field**	**0**
1 – 9 AFB	**Per 100 oil immersion field**	**1 – 9 AFB (indicate number seen), scanty**
10 – 99 AFB	**Per 100 oil immersion field**	**1+**
1 – 10 AFB	**Per 1 oil immersion field**	**2++**
>10 AFB	**Per 1 oil immersion field**	**3+++**

wash hands

after collecting and handling samples

X-ray diagnosis of TB

Dr HI Lakhi: LRCP & SI, MBBch, BAO(NUI), FCRAD (D) SA and Nadia Marais: B Rad (UP)

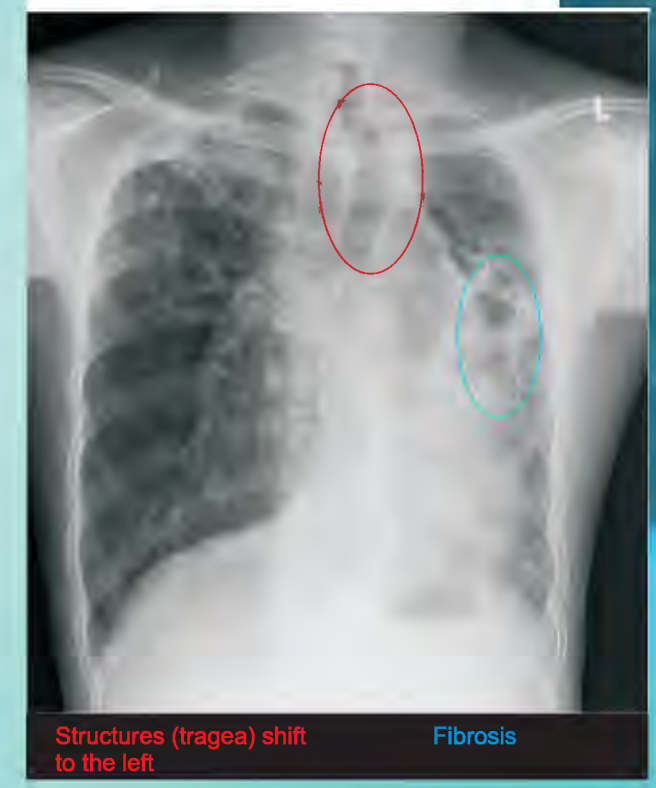
X-rays are not the primary source for confirmation of TB, even though it may be an easy and quick and convenient procedure to perform. X- rays are usually done in persons suspected to be infected with TB who cannot produce sputum and who have to be diagnosed in the light of their history and clinical findings. There are diseases that mimic TB on a chest X-ray and this may lead to incorrect diagnosis.

Indications for a chest x-ray are:

- Positive sputum results this would include suspected complications such as a breathless patient needing specific treatment (pneumothorax or pleural effusion); severe or frequent haemoptysis; when only one of the two pre-treatment smears is positive; and to assist with diagnosis other lung diseases.
- Despite negative sputum results TB is clinically suspected
- During and at the end of treatment if there are specific clinical reasons of the progress of the patient is not satisfactory.

While some radiographs are assessed in this article, it is done without the clinical history of the patients and only serves as examples to indicate what the clinician could look for.

Radiograph 1



Post primary tuberculosis – the posterior –anterior (PA) radiograph 1 demonstrates gross left lung disease characterised by extensive fibrosis and cavitation with significant volume loss and shift of the mediastinal structures to the left.

There is further extensive fibrosis of the right upper and mid zone respectively where there is elevation of the right main stem bronchus.

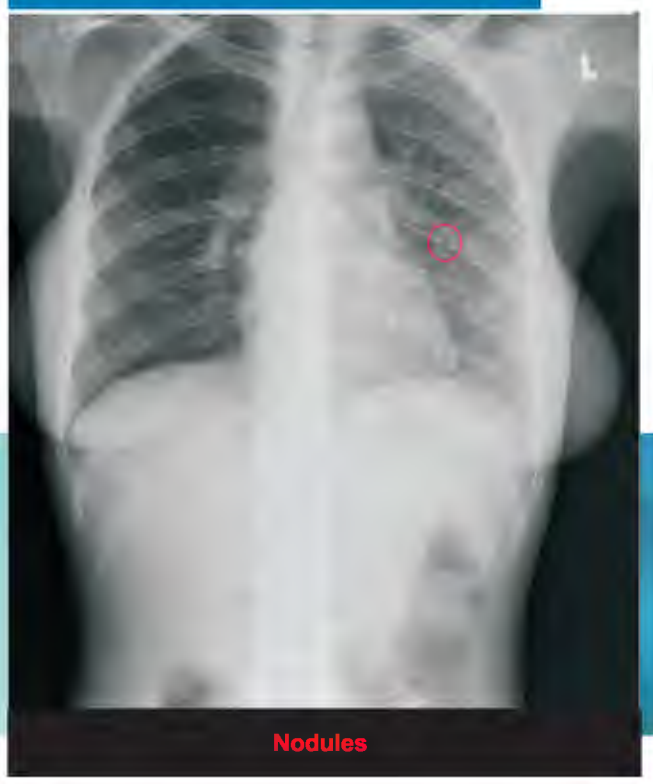
Shadowing in the right upper zone consists of ring and irregular linear lucencles (bronchiectasis) associated with pleural thickening.

The PA chest radiograph 2 of a patient with post primary tuberculosis demonstrates that diffuse nodulation is present in all zones. The nodules are well defined attesting to miliary tuberculosis.

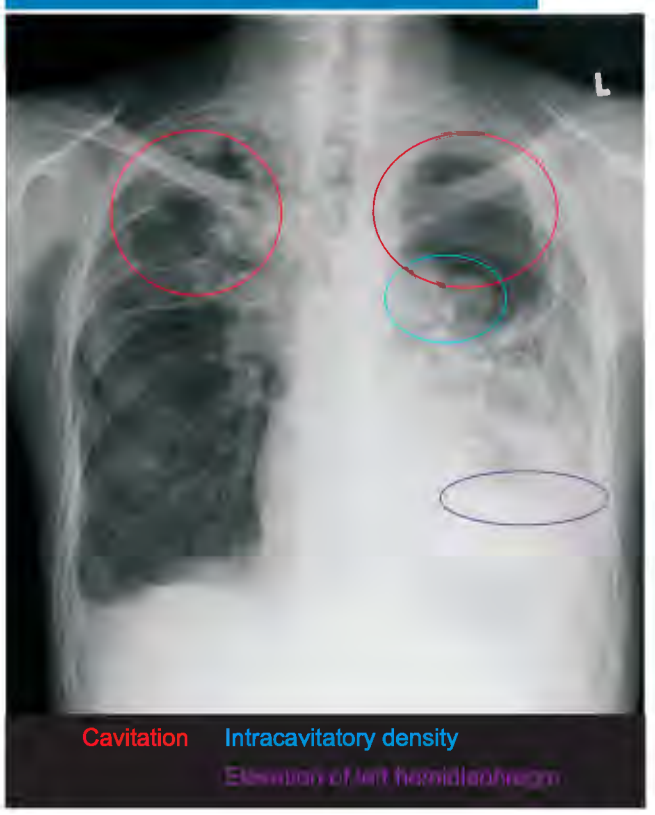
The PA chest radiograph 3 of a patient with post first degree tuberculosis demonstrates:

- Bilateral apical cavitation. The cavitation is particularly extensive on the left where an air-fluid level is noted.
- Intracavitatory density within the left apex.
- There is gross left mid and lower zone disease characterised by areas of consolidation and cavitation.
- There is elevation of the left hemidiaphragm due to the extensive fibrosis and volume loss.
- Bilateral apical and right costophrenic angle pleural thickening

Radiograph 2



Radiograph 3



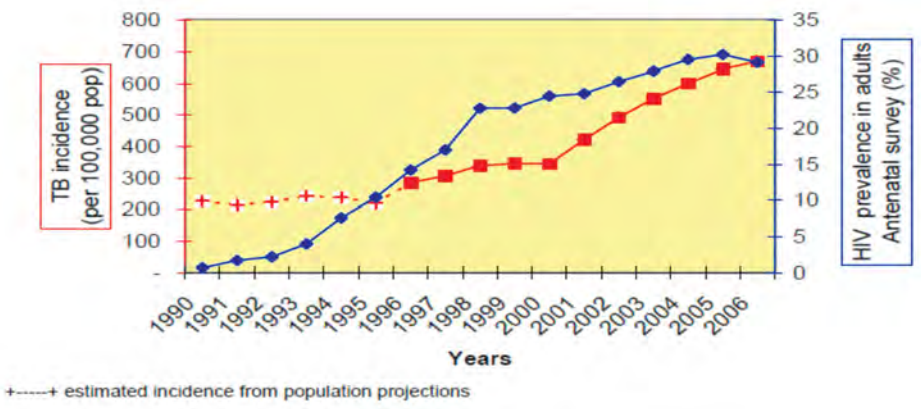
ISOLATION OF PATIENTS

WITH DRUG-RESISTANT TB AND HUMAN RIGHTS – A BRIEF DISCUSSION

Agnieszka Wlodarski: Attorney, AIDS Law Project

Introduction

Tuberculosis (TB) is an easily transmissible airborne disease, prevalent in South Africa. Collated, up-to-date statistics as to the extent of the epidemic are not available, as the Department of Health data has as not yet implemented the measures required in order for it to be in a position to have these statistics. Amongst the most recent Department of Health statistics are from 2006, which recorded that the number of new TB case notifications in SA in 2006 was 342 315.[1]



Source: Department of Health TB Strategic Plan 2007-2011

However, according to recent World Health Organisation (WHO) estimates, South Africa (SA) has the fourth worst TB epidemic in the world, and the highest prevalence at 692 people per 100 000. The HIV prevalence in incident TB cases is 73%.[2] For 2007, the WHO estimates that there were approximately 461 000 new TB infections.[3]

The HIV/TB co-infection rate is growing exponentially as illustrated in the diagram. TB has also been the leading cause of death in SA since 2001.[4]

In 2007, the Department of Health reported 7 350 new multi drug-resistant (MDR) TB cases to the WHO,[5] up from 6 716 in 2006,[6] while the WHO estimates for 2007 were closer to 8 238.[7] Globally, the WHO estimates for the number of emerging MDR-TB cases in 2008 were between 390 000 – 510 000.[8,9]

Present policy in SA requires patients diagnosed with drug-resistant forms of TB, either MDR-TB or extensively drug-resistant (XDR) TB, to be isolated in specialised DR-TB hospitals during the initiation phase of treatment – generally lasting approximately six months. In extreme cases, certain patients have been in isolation for over two years.[10] Extended periods of isolation result in patients being deprived of their freedom for the duration of the isolation, albeit - it is argued - in order to protect the public health.

Isolation is by its very nature a limitation of the human rights of patients. The reasonable legal question is whether isolation is justified as being in the public interest. This is looked at in the context of section 36 of the Constitution, which sets out the framework for determining whether any limitation of a right is justified. It is important to consider whether there are alternatives to the present system of isolation, the arbitrariness of who ends up isolated, and the negative effects of isolation on patients and health care workers (HCWs).

A human rights-based approach to isolation

The Constitution ensures that everyone is entitled to the enjoyment, fulfilment, promotion, protection and respect of their basic human rights, including the right not to be deprived of freedom arbitrarily or without just cause.

A human rights-based approach to people living with HIV has been a hallmark of successful HIV interventions in combating the spread of HIV, but has been largely absent in the development of strategies to fight the spread of TB – to the detriment of those programmes.[11]

From a legal perspective, section 36 of the Constitution sets out the requirements government must follow whenever its policies or practices limit the rights of individuals. Applied to isolation policy, isolation must be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, and isolation must be applied according to a law of general application. The factors that need to be considered include the nature of the right to be limited in relation to the nature, extent and purpose of the limitation, and whether there is not a less restrictive means of achieving the purpose.

If a human rights-based approach to the policy of isolation been adopted earlier, this would have highlighted the limited bed capacity at DR-TB hospitals, and the waiting lists of patients diagnosed with DR-TB for access to hospitals and treatment.[12] This approach would also have provided a better understanding of the effects of isolation on patients and HCWs and measures to put in place to address these.[13] What is apparent is that there is an urgent need for alternatives to the present system of isolation.

1. Limited bed capacity at DR-TB hospitals and waiting lists for access to such hospitals and treatment:

Each province has at least one specialised DR-TB hospital to which patients diagnosed with MDR-TB or XDR-TB are referred for the duration of their isolation. Nationally, in 2008 there were approximately 1 700 available beds,[14] and while the Tuberculosis Strategic Plan for South Africa 2007 – 2011 (TBSP) does make provision for more including up to 3 364 beds by 2011, it is not clear that this has happened.[15] In any event, as noted at the outset, in 2007 the National Department of Health identified 7 350 new cases of MDR-TB, far exceeding the capacity to isolate these patients in DR-TB facilities. It is likely that this gap has worsened in subsequent years.

A significant number of patients are on waiting lists to access DR-TB hospitals, and they are therefore not accessing treatment. This exclusion from treatment is arbitrary. Furthermore these patients are sent back to their communities while they wait for their admission, undermining the idea that patients must be isolated because of the threat they pose to public health.

2. Alternatives or less restrictive means to isolation

The Department of Health is in the process of reviewing the policy of hospitalising all patients diagnosed with DR-TB, and aims to introduce community-based management of MDR-TB.[16] There is apparently a draft policy on community-based MDR-TB care, which is to be discussed with key TB stakeholders during the course of 2010.[17] There are also two community-based care pilot projects, based in a peri-urban environment in Khayelitsha, Cape Town and in rural KwaZulu-Natal.

While some progress is being made in changing the present policy, and while pilot projects are being conducted, many more such projects in a variety of environments are needed. The situation of patients in isolation needs to be addressed, along with the effects of isolation on patients and HCWs.

Interim measures, such as reducing the period of isolation in order to accommodate more of those waiting to receive treatment, and to counter some of the negative effects of extended periods of isolation on

patients before the community-based care is implemented on a larger scale, could also be considered.

3. Understanding and putting measures in place to counter the effects of isolation on patients and HCWs[18]

Concerns patients have with the effects of extended periods of isolation include:

- Being removed from their families and support structures;
- Far distances DR-TB hospitals from their families, who often cannot afford to visit them;
- Concerns about losing their employment;
- Patients feel that they do not receive sufficient education about their conditions, the treatment and the side effects of the treatment, which include loss of hearing and depression;
- Conditions vary between different DR-TB hospitals. Some, like Brooklyn Chest, have better living environments and reasonable recreational facilities. Many others do not; and
- Children are isolated for extended periods of time, and not all DR-TB hospitals can ensure that their education is not interrupted, and have sufficient psycho-social support and recreational opportunities.

HCWs require support in addressing their concerns as to the effects of implementing isolation policy and working at DR-TB hospitals. This includes:

- Monitoring the health and safety of HCWs according to the legal requirements.[19] Infection levels amongst HCWs must be monitored and all measures taken to stem nosocomial infection rates amongst HCWs. The process to claim compensation should also be facilitated;
- Alleviating the difficult conditions HCWs work by ensuring proper staffing of DR-TB hospitals and providing adequate compensation to retain and to attract new staff;
- Addressing the stigma that HCWs face from other HCWs for working in these hospitals;
- Providing HCWs with better support structures for dealing with patients who are aggress or abscond. As patients get frustrated with being isolated for extended periods of time, HCWs, being the first line of interaction with these patients, bear the brunt of this frustration. Support structures should include a code of conduct and measures for enforcement of the code at hospitals, from the South African Police Services, where required.

Conclusion

While the policy of hospitalising all patients diagnosed with DR-TB is being reviewed and while pilot projects are taking place for implementing community-based care for DR-TB patients, in the meantime something must also be done to address the negative effects of isolation on patients and HCWs working at DR-TB hospitals. Consideration should be given to putting in place interim measures, such as those discussed above, to improve the situation for HCWs, patients and people waiting to receive treatment. This way we can immediately address some of the problems of the present system while we wait for a new, more comprehensive policy to be formulated and implemented.

1. Section 4.5.1 of the *National Tuberculosis Strategic Plan for South Africa* (TBSP), 2007-2011.
2. WHO, *Global Tuberculosis Control 2009*: Key points (2009).
3. WHO, *Global Tuberculosis Control 2009.*
4. STATSSA, *South Africa Mortality and Causes of Death in South Africa 1997 – 2003*. (February 2005).
5. For a more detailed discussion on these please consult the AIDS Law Project Report: Protecting Public Health and Human Rights in the Response to TB in South Africa: State and Individual Responsibilities. (Hereinafter ALP TB Report) Accessible at: http://server.alp.org.za/ProtectingPublicHealth.pdf.
6. TBSP, at 18.
7. WHO, *Anti-Tuberculosis Drug Resistance in the World Report No. 4* (2008), Annexure 8.
8. Ibid vi above.
9. The WHO defines MDR-TB as: TB caused by strains of *mycobacterium tuberculosis* that are resistant to at least isoniazid and rifampacin. See for further definitions and information WHO, *Multidrug and extensively drug-resistant TB (M/ XDR-TB), 2010 Global Report on Surveillance and Response*, 2010.)
10. ALP interviews conducted at DR-TB hospitals for the ALP TB Report.
11. UNAIDS, *HIV and tuberculosis: ensuring universal access and protection of human rights*. Paper produced by the UNAIDS Reference Group on HIV and Human Rights, March 2010.
12. See further discussion in the ALP TB Report.
13. See further discussion in the ALP TB Report on this aspect and on the only known judgment on isolation.
14. Ibid vii above.
15. TBSP, at 66.
16. Ibid vi above at 27.
17. Ibid.
18. Ibid iv above.
19. See ibid xi for a further more detailed discussion.

TB in the SAN community

Nelouise Geyer & Karin Beytell

Nelouise Geyer: Editor SA HIV Clinicians Society Nursing Magazine
Karin Beytell: Snr. Coordinator: Professional Affairs, Health Professions Council of Namibia

Acknowledgement: Health Professions Council of Namibia & Professor Cheryl Leuning, Augsburg College, Minneapolis, USA

While the SAN people indicate that they do not have any persons with HIV amongst their people, some of their people are suffering from tuberculosis. During a recent visit to three of the villages in the Nyae Nyae Conservancy in Namibia, the leadership in all three villages indicated that they have persons with tuberculosis in their midst.

The Nyae Nyae Conservancy is an area of 9003 square kilometres with an approximate population of 2 300 people that has been registered as a conservancy in the northern part of Namibia in January 1998. The name of the conservancy "Nyae Nyae" means "place without mountains, but rocky". The registration of the conservancy gives the Ju/'hoansi people the right to utilise the wildlife in the area by receiving income from a hunting concession as well as the right to hunt traditionally with bow and arrow for their own needs.

Prevalence of tuberculosis

The first village visited had 200 people of which 75 were children. In this community there were seven persons with tuberculosis of which four were hospitalised - one of the hospitalised persons had MDR tuberculosis. The second village had 100 people with an unknown number of children where there were two persons receiving treatment for tuberculosis. Both these persons were in the village and attended the meeting. The third village had about 60 people with an unknown number of children. Very few of this village's people attended the meeting as some were in town where they worked. In this village there is one man with tuberculosis and from his description through an interpreter, it appears that he also has skeletal tuberculosis. This gives a number of 10 tuberculosis cases amongst the 360 people in the three villages visited which equals 2.8% of people in these communities. They also indicated that three people have died of tuberculosis during the last three months.

Anecdotally tuberculosis has been introduced to these communities by a member working in the mines in South Africa as a migrant worker where he contracted tuberculosis. The exposure of some of the village's people to other communities where they work in town or at places where they socialise, further expose the SAN people to infectious diseases that they may previously not have contracted.

Prevalence of HIV

All three villages indicated that they do not have anyone living with HIV. This is ascribed to the SAN people being faithful to their life partners and that they are not sexually promiscuous. The healthcare staff at the clinic in Tsumkwe said that there are "maybe three SAN people" with HIV that they know of.

Access to healthcare

Each of the three villages visited has its own medicine man who treats ailments and diseases with herbs, roots and other natural products from the environment. When this treatment is not resolving the problem or when other situations make it

necessary, the SAN people go to the healthcare clinic in Tsumkwe. In only one of the villages, if someone in the village becomes very ill, the clinic can be called for assistance. Generally most of the babies are born in the village with the assistance of traditional birth attendants - it has been indicated that SAN families have 5 – 6 children. The babies are taken to the clinic for their BCG and other immunisation as soon as possible, or they are immunised during outreach services. One village reported that the first baby of all mothers is born at the clinic.

A major challenge to access to healthcare is transport. There is no public transport and some areas have poor road infrastructure making it difficult to access with a vehicle. Some of the villages are 4 – 5 hours on foot away from Tsumkwe, the main centre for healthcare service delivery. So even if a mother was transported by the authorities from the village to the clinic for the delivery of her baby, she would be expected to find her way back to the village after two days with limited or no transport provided by authorities. In one village it was reported that a mother would be dropped off at the cross roads which is about two hours walk away from the village. All the SAN people with tuberculosis receive their medication treatment and e-pap delivered to the village every month.

Nutrition

The SAN people mostly live off the land. They collect veld foods and hunt game to supplement their diet of maize porridge. However, the contact with the 'outside world' since 1950 and the uptake of land by other groups of people has limited the ability of the SAN people to live off the land. Traditionally they have a nomadic lifestyle as hunter-gatherers and one of the developments that have limited their nomadic lifestyle for example, is the permanent structures that have replaced the grass huts that they have lived in previously. With this

change, the opportunity to move around to hunt and provide food for their villages has decreased. In all three of the villages there were chickens and in one village cattle that could make provision for sustainable nutrition for the inhabitants of the village. The availability of shops and butcheries where meat and other food or commodities could be bought, have increasingly replaced hunting. Another social phenomenon influencing nutrition of the SAN people is the alcohol that has become easily available through these local shops and 'shebeens' (beer houses). Sometimes emergency aid in the form of maize meal is distributed by the government as is the case throughout Namibia.

All persons with tuberculosis receive e-pap with their monthly medication. E-pap is a pre-cooked fortified food that uses state of the art nutritional chemistry and delivers in a food portion provides 28 nutrients in a bio-available form when reconstituted with water. Nutrition food supplement is regarded as an important support tool, especially for malnourished people based on the argument that the immune system is the first line of defence against opportunistic and infectious diseases.

Economic activity

The conservancy is managed by a board consisting of various role players from the community. One of the functions of this board is to allocate the funding coming into the conservancy to the various services, such as education, that has to be provided to the villages. There is a whole range of agencies that supports the conservancy in various ways (MET, NNDFN, USAD LIFE Plus, WWF, ICEMA, KPF, LAC, CRIAA, Health Unlimited, and World Bank).
Poverty and unemployment in the conservancy is high. During the period that the SADF established bases in this area, the Ju/'hoansi were employed as trackers and received salaries. Employment opportunities in the area are limited and most people do not have a steady income. The villages receive an annual hunting concession which allows them to hunt for food or to sell all or part of the allocated concession. In addition the SAN people earn money from the sales of their crafts and Devil's Claw (Harpagophytum procumbens), an anti-inflammatory herbal medicine. People over the age of 60 receive a government pension, but the challenge is that many of the older SAN people do not know what their birth date and age are. This limits their ability to access old age pension. Old age pension have to be collected in Tsumkwe and the villagers indicated that they listen to the radio where they will be informed when it is time to collect their pension in town. They would then leave the day before to travel to town so that they are there on time. Two of the villages run a live history museum where tourists pay a fee to observe how the SAN people lived originally and how their crafts are made.

One AIDS Orphanage children's home was visited where 18 children are staying. According to one of the staff, most of the children have parents, but due to their poverty they have the children staying in the orphanage where they are schooled, fed and cared for.

As already indicated the SAN people living with tuberculosis, receives their treatment and nutritional supplement in the form of e-pap through the government services and they do not have to pay for their treatment. It appears that the availability and easy access to alcohol does consume some of the money that is available to the community leaving less money for acquiring nutritional substances to feed families and strengthen immune systems.

Education

Education for children in the SAN community was introduced during the 1960's. There are currently five village schools in the area so that children can attend school up to grade 3 in their mother tongue. Thereafter they can attend school in Tsumkwe – a town in the middle of the conservancy and for secondary education the children have to go to the bigger towns. The chief in one of the villages indicated his support for educating the children as he regarded this as an important aspect to ensure that the children can be meaningfully employed in future. During the site visits, there were children in the village not attending school and it was explained that some children do not like going to school and then come back home. They are not forced to go back to school.

Conclusion

The SAN people are aware of the symptoms of tuberculosis and that they need to go to the clinic to access treatment. Based on the discussions with the village people during the site visits, they were happy to do so. In a few of the villages, the people indicated that they had recovered from TB which indicates that the current system for treatment is effective. The prevalence of tuberculosis is low in the communities visited, but concern has been expressed that the availability and consumption of alcohol may in future have an influence on the tuberculosis prevalence. Most striking during the site visits was the warm, caring relationship between the mothers and their children.

MTNs Angie Maloka

Angie Maloka

This year has been declared as the International Year of the Nurse in commemoration of Florence Nightingale's contribution to nursing, as well as to celebrate the current contribution nurses and midwives are making to the health and wellbeing of populations globally. We find nurses and midwives in many shapes and forms in a variety of settings relating to health, social responsibility and development.

In this issue of the nursing magazine we profile Angie Maloka, Senior Manager: Health, at the MTN Foundation. The MTN Foundation supports projects which are in line with the vision of the MTN Foundation specific portfolios and have a broad community impact.

Professional background

Angie Maloka is a professional nurse who has a B Cur degree obtained at Medunsa, an M Sc Nursing degree in advanced psychiatric nursing obtained through Wits University and a Higher Education Diploma in Education (UNISA).

As with many people in high profile positions, Angie has taken a few steps to get to the position where she is today. Her working career includes a wide range of experience in nursing education and nursing management in both the public and private sector. Angie's professional experience includes lecturing at WITS and BG Alexander Nursing College; managing medical and psychiatric wards at Sebokeng Hospital followed by taking up a position as Deputy Director: Child & Adolescent Mental Health at Gauteng Department of Health. When the Department was restructured she moved to the Sedibeng Health Sub-District Office at the Gauteng Department of Health, during which period she was also seconded to act as a Chief Executive Officer of a hospital. She then was appointed as the Deputy Director, Programme: Mobile Clinical at Reproductive Health Research Unit with the responsibility to manage an out-reach team supporting the Department of Health in the implementation of the Comprehensive plan for HIV and AIDS Care, Management and Treatment including the roll out of antiretroviral therapy (ART) in two provinces. This was followed by a position as Programme Manager: HIV/AIDS at Tshikululu Social Investments where she was the programme manager at a Corporate Social Investment company, focusing on health and HIV projects.

MTN Foundation

Angie is currently at the MTN Foundation and responsible for the health programmes of MTN corporate social investment. This involves development of policies and programmes that are aligned with government health policy. Her responsibilities further include budgeting for health programmes, implementing programmes with partners in the various provinces (currently six provinces), monitoring and evaluation of the implementation of the programmes and grantmaking. The return on investment is important for the company and the company's information and telecommunication technology (ICT) is used to enhance health programmes. The Foundation is currently in partnership with the Medical Research Council (MRC) with the development of telemedicine equipment where MTN is providing the necessary funding.

The programmes also use cell phones where a 'please call me' can be sent and information on HIV/AIDS is provided. During April there was a message on Malaria and a very good response was received. The programmes developed are both internal and external, for example an internal programme focuses on the 16 days of activism against the abuse of women and children. These programmes encourage employees to participate in their communities in projects that assist others.

Challenges

"Too often as nurses we find a comfort zone and then are not prepared to venture out and to take risks" says Angie. She took a risk to leave the government position she had to take up a position in the corporate sector. She believes that nurses are privileged to have good management and leadership skills early in their careers which empower them to take up challenging positions. She has found over time that team work remains an essential element to help everyone achieve their goals.

The biggest challenge in the corporate world is that people have their own perceptions of nurses and that this perception needs to be changed. She really had to work hard to come up with meaningful programmes that people can relate to and appreciate. Through developing and implementing meaningful programmes that will bring about change in people's lives, others can be educated that being a nurse is not only about looking after sick people.

Message for nurses

Angie's message for nurses is that "People respect you if you handle yourself in a professional way. If you are serious about your business to improve the quality of people's lives, then people will take you seriously – respect must be earned."

2010

International Year of the Nurse

2010

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

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

The 2010 International Year of the Nurse seeks to engage nurses in the promotion of world health and to recognize the contributions of nurses globally, including their contributions to the UN Millennium Development Goals. South African nursing organisations has launched the "My Nursing 100 Campaign" to celebrate International Year of the Nurse and we will provide some feedback in the next magazine on the activities that took place.

2010 The World Cup, the Lung, ART, and the Nurse

Stacie C. Stender
Regional Technical Advisor, TB/HIV/Infectious Diseases
Jhpiego – an affiliate of Johns Hopkins University

2010 is the year of the first World Cup ever to be held in Africa. 2010 is the Year of the Lung. 2010 is the Year of expanded access to HIV care and treatment in South Africa. And 2010 is the International Year of the Nurse.

Need for TB treatment

In 1993 the World Health Organization declared tuberculosis (TB) a global emergency, however TB remains the single most common cause of death in adults[1] and is the most common cause of HIV-related morbidity and mortality in South Africa.[2] In 2007, there were 9.3 million new cases of the disease globally, 80% of which occurred in just 22 countries. South Africa had the **fifth** highest burden of disease (total number of cases for a country) and **second** highest estimated TB incidence (rate per capita, expressed as number per 100,000 population) in the world.[3] Table 1 illustrates the increase in TB in South Africa from 1990, as well as the corresponding HIV prevalence rate over the same time period. Today it is estimated that 73% of new adult cases of tuberculosis are co-infected with HIV,[4] and any interventions should consider the impact of each disease on the other.

Case detection and TB treatment success rates have improved since the inception of the National TB Control Programme (NTCP) in 1996, however they remain substantially below national targets and vary greatly between provinces. High mortality rates persist despite the fact that TB is a curable disease, and this is of particular concern as it indicates that patients are not being promptly diagnosed and/or provided treatment. Treatment interruption, poor cure rates, and drug-resistant TB are increasingly becoming problems and will continue to fuel the TB epidemic within South Africa if comprehensive strategies are not realized. Historically the TB control programme has been verticalized within the public health system, and new approaches to control must be considered, for this infectious airborne disease, *Mycobacterium tuberculosis*, does not stay within the confines of TB clinics. Nearly **one percent** of South Africans develop tuberculosis **every year**. In 2007 there were 354,000 reported cases of the disease, equivalent to 31% of the population of the Northern Cape.

HIV management policy

In April of this year, the South African National Department of Health (NDOH), in collaboration with the South African National AIDS Council (SANAC), released three documents for HIV management across the lifespan: 1) Clinical Guidelines: PMTCT (prevention of mother to child transmission)[5] 2) Clinical Guidelines for the Management of HIV & AIDS in Adults and Adolescents,[6] and 3) Guidelines for the Management of HIV in Children.[7] All three guidelines provide guidance to 'health practitioners', inclusive of doctors and nurses, for comprehensive management of adults and children. A specific objective is 'to enable nurses to initiate ARVs for treatment and prevention.'

Integration of services

The HIV guidelines prioritize the integration of HIV with other health services, including TB, maternal child health (MCH), sexual and reproductive health (SRH), sexually transmitted infections (STIs), EPI, nutrition, and adolescent health. PMTCT is specifically viewed to have the potential to strengthen delivery of comprehensive, integrated maternal, newborn and child health care. The majority of these services are provided at primary care level by nurses, therefore nurses are the driving force behind successful integration.

Of particular importance is the renewed emphasis placed on the prevention, diagnosis, and management of tuberculosis in concert with provision of comprehensive HIV services. Tuberculosis is mentioned 30, 72, and 62 times in the text of the PMTCT, adult, and paediatric guidelines respectively. Commitment to TB/HIV integration is conveyed: all HIV positive adults diagnosed with TB are now eligible for lifelong antiretroviral therapy (ART) when their CD4 is below 350, any individual with M/XDR TB is eligible for ART, and isoniazid preventive therapy (IPT) is now considered part of comprehensive services to be offered to HIV positive individuals. (See Table 2 for the key changes made in the 2010 HIV guidelines). IPT has been shown to prevent the progression of latent TB to active TB disease by up to

60% in HIV positive individuals and has been a policy recommendation in South Africa for more than a decade. However, it is in 2010 that implementation of the recommendation on a national scale will take place, as described in the newly released policy by the NDOH, 'Guidelines for Tuberculosis Preventive Therapy among HIV Infected Individuals in South Africa'[2].

Role of nurses

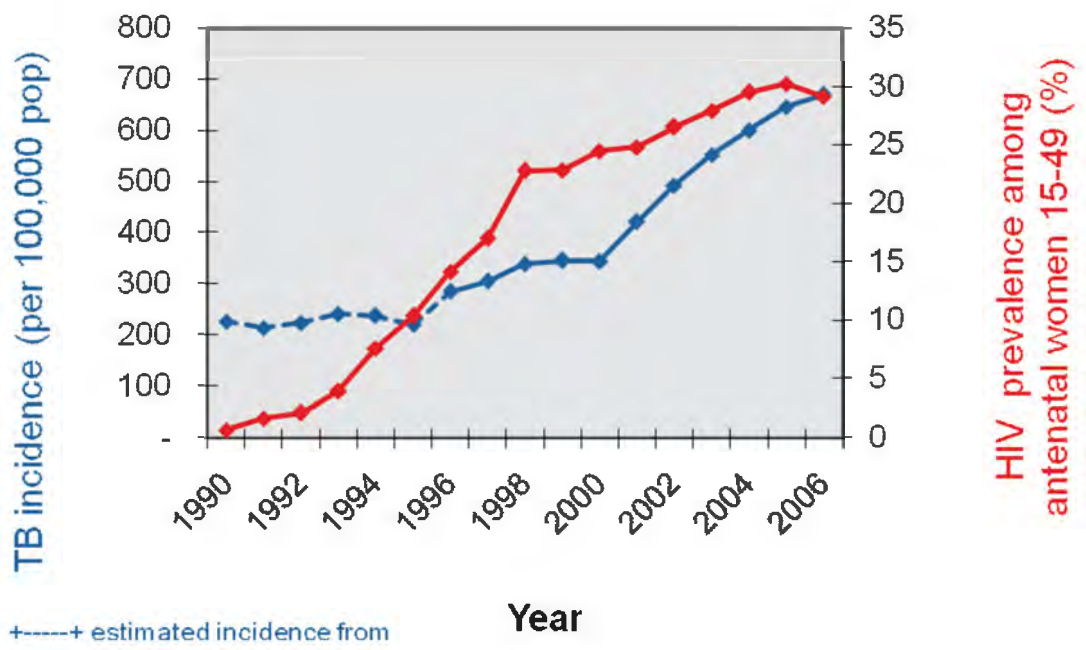
Of all healthcare workers, nurses have the potential of making the largest impact on the health of South Africans. Professional nurses and the health team they manage, consisting of nursing assistants, staff nurses, community health workers, HIV counselors, TB treatment supporters, and others, are the 'gatekeepers' of the health system and the first point of contact for individuals seeking healthcare services, whether at primary or tertiary levels of care. By remaining continually conscious of the burden of TB and HIV in communities, nurses can recognize TB suspects earlier, ensure clients are evaluated in a timely, appropriate manner (spot sputum and early morning sputum the next day must be second nature to all health practitioners), make a diagnosis, and offer appropriate treatment or refer when necessary.

A targeted health history, even for a routine visit such as for family planning, antenatal care, or immunizations, should always include questions to assess the general state of the adult or child: fever, weight loss, and loss of appetite. While TB screening tools are good reminders, they are no replacement for the provision of quality care irrespective of suspected diagnosis. With **one percent** of South Africans diagnosed with TB annually, the astute health practitioner could and should ask specifically about cough and night sweats to all of his/her patients in addition to constitutional questions mentioned above and those symptoms specific to the visit, i.e. an antenatal client should routinely be asked about foetal movement, vaginal bleeding, headache and other signs of pre-eclampsia, painful urination, and abdominal pain. Any symptoms of cough, weight loss, night sweats, or fever should trigger further investigations, based upon clinical assessment findings. The importance of obtaining and reviewing the vital signs of a patient should not be forgotten, specifically temperature, pulse, and respirations – they are frequently overlooked, yet are essential components to making any diagnosis.

Conclusion

The implementation of comprehensive integrated care is essential to improve the health outcomes of South Africans. Nurses are increasingly being recognized for the important role they have in providing quality services based upon the burden of disease in the communities which they serve. In 2006, one in eight individuals who died of natural causes died of tuberculosis.[8] 73% of TB patients have HIV. TB is curable, HIV is treatable. Every health practitioner must be clinically competent in preventing, diagnosing and managing both diseases. It's 2010.

Table 1: TB incidence and HIV prevalence in South Africa, 1990 to 2006



Source: National TB Control Programme and National HIV and syphilis antenatal sero-prevalence surveys in South Africa

Table 2: Changes 'of note' to the HIV Guidelines

Recommendation	2004 (PMTCT from 2008)	2010
Adults, including pregnant women eligible for ART	WHO clinical stage 4 OR	TB and CD4 < 350 cells/mm^3
	Cd4 < 200 cells/mm^3	Pregnant and CD4 < 350 cells/mm^3
		M/XDR-TB at any CD4
INH Preventive Therapy	Not implemented	For all HIV positive individuals including pregnant women without signs/symptoms of TB, active liver disease, or alcohol abuse
Fast track = provision of treatment within 2 weeks	Not mentioned	Eligible pregnant women CD4 < 100 cells/mm^3 Clinical stage 4 M/XDR-TB Child < 1 year
1st line ART for adults, including pregnant women	d4T + 3TC + EFV/NVP	TDF + 3TC/FTC + EFV/NVP
ARVs for pregnant women not eligible for ART (CD4 > 350 cells/mm^3)	AZT from 28 weeks + intrapartum sdNVP and 3 hourly AZT	AZT from 14 weeks + intrapartum sdNVP and 3 hourly AZT + sdTDF and sdFTC after delivery
Exposed infant ARV regimen	sdNVP + AZT for 7 or 28 days depending on maternal ARV exposure	NVP daily for 6+ weeks, depending on feeding choice and mother ART status
Children eligible for ART	Clinical stage 3 or 4 OR CD4 < 20% under 18 months or < 15% over 18 months	All HIV+ under 12 months
		1-5yrs clinical stage 3 or 4 OR CD4 < 25% or 750 cells/mm^3
		5-15 years stage 3 or 4 OR CD4 < 350 cells/mm^3
1st line for children < 3 years	d4T + 3TC + LPV/r	ABC + 3TC + LPV/r
1st line for children < 3 years	d4T + 3TC + EFV	ABC + 3TC + EFV

ABC = abacavir, AZT = zidovudine, d4T = stavudine, EFV = efavirenz, FTC = emtricitabine, INH = isoniazid, LPV/r = lopinavir/ritonavir, M/XDR-TB = multi/extremely drug resistant tuberculosis, NVP = nevirapine (sd = single dose), TDF = tenofovir, 3TC = lamivudine

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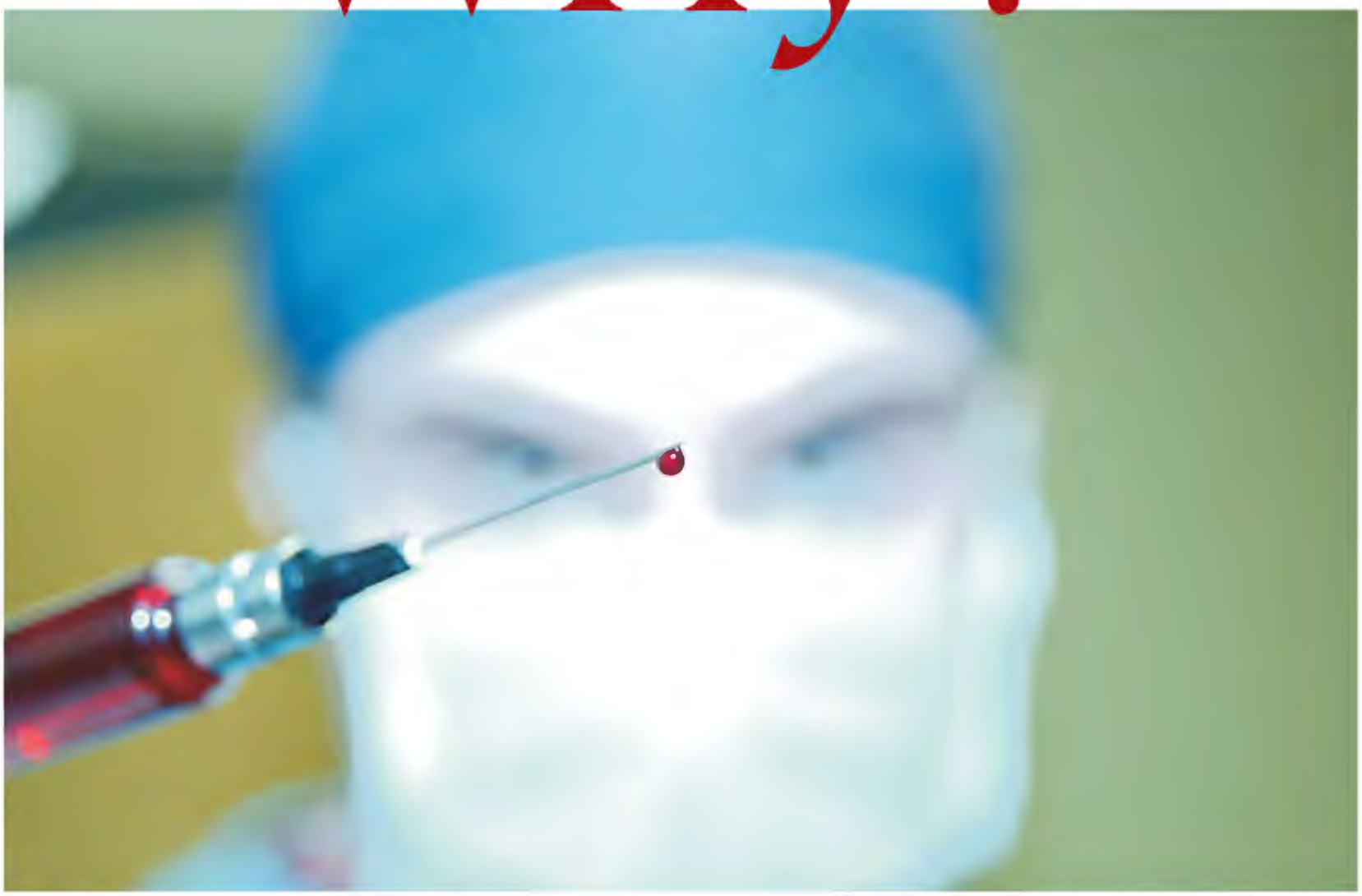
Infection control - Why?



Information obtained from the RHRU Manual on implementing TB infection control in health facilities

"Eight years later, instead of enjoying a rewarding career, marriage and motherhood, Nerissa is a paraplegic with extensive nerve damage that causes her excruciating pain." This statement refers to Dr Nerissa Pather who was 26 years old in 2002, doing her community service in Durban when she contracted TB meningitis.[1]

While not all healthcare workers get this ill as a result of caring for patients, any one healthcare worker who falls ill or become debilitated due to employment in a healthcare setting is too many. Tuberculosis cure rates in South Africa have improved, but it has become clear that treatment programmes alone are not enough to reduce the burden of TB disease. The situation is further complicated by the development of MDR-TB (multi drug resistant) and XDR – TB (extremely resistant) where strains of TB have become resistant to TB treatment. Resistance to TB drugs can develop naturally, but rarely so if treatment is taken correctly. Until recently the TB programme in South Africa was poorly supervised and as a result drug resistance developed and spread. Persons develop a drug resistant TB when they are infected with a resistant strain of TB, or if they were previously treated for TB but did not adhere to treatment as prescribed. In spite of DOTS (Directly Observed Therapy Short-course) TB continues to rise and critics of DOTS say it is due to the fact that DOTS neglect the TB/HIV co-infection, TB prevention and drug resistant TB. Prevention is essential and to this end the WHO Stop TB strategy includes the three I's

- Intensified case finding for TB;
- Isoniazid (INH) prophylactic therapy (IPT) for prevention of TB amongst people with HIV; and
- Infection control for prevention of TB.

Infection control

Infection control is an intervention required to prevent the transmission of micro-organisms from infected or colonised patients to other patients and healthcare workers. Infection control measures are based on an understanding of how different diseases are transmitted. Infection control measures include standard precautions (applied irrespective of disease or institution) and transmission based precautions applied in specific circumstances depending on the route of transmission of various diseases.

Standard precautions

- *Hand washing and antisepsis*
- *Use of personal protective equipment such as gloves, masks and gowns*
- *Appropriate handling of patient care equipment and soiled linen*
- *Prevention of needle stick or sharp injuries*
- *Environmental cleaning and spills management*
- *Appropriate handling of waste*

Microbiology

TB is caused by the organism Mycobacterium Tuberculosis – a gram positive bacterium which is transmitted by the airborne route by infectious persons. These microorganisms are transmitted by droplet nuclei or on dust particles which are <5µm in diameter. These particles are small enough to be deposited directly in the alveoli. Infection occurs when the bacteria are inhaled which leads to latent or dormant TB. Re-activation or rapid growth months or years later can lead to TB disease.

TB infection control relies on the principles of airborne precautions to prevent or reduce transmission of organisms by droplet nuclei.

Principles of infection control

On account of higher exposure to TB than the general population, healthcare workers have a higher incidence of latent or dormant TB and active TB disease. Various reviews and studies indicate that the prevalence rate of latent TB among healthcare workers in low and middle income countries ranges from 33% - 79%.[2] This makes it critically important to implement TB infection control interventions in the healthcare setting. Based on the understanding of the biology of TB, a three-fold approach to infection control is undertaken, namely personal protective equipment, administrative and environmental controls.

Infection control for airborne diseases:

- *Administrative controls = reduce the production of infectious TB aerosols in the local environment*
- *Environmental controls = eliminate infectious TB aerosols once they are generated*
- *Personal risk reduction = decrease or prevent inhalation of infectious TB particles by staff and clients and minimise individuals risk of developing reactivation TB*

(i) Creating an enabling environment

Administrative commitment to the implementation of TB infection control is essential to ensure successful TB prevention efforts. This not only refers to nursing and healthcare personnel, but also to the management of the healthcare institution, down to the cleaning services.

A functional Infection Prevention and Control Committee should be established with multi-professional stakeholder representation, including the facility manager.

Role of the Infection Prevention and Control Committee:

- *To meet monthly*
- *To produce and update a TB Infection Control Plan*
- *To review quality of TB infection control in the facility*
- *To ensure ongoing staff training in TB infection control*
- *To make any changes to ensure TB infection control is implemented*
- *To ensure that finances and budgets allow for implementation of infection control interventions. These may include costs of shelter for outside waiting areas, fans to circulate air and ultraviolet germicidal irradiation units. This would require liaison with regional managers at PHC level. If immediate funding is not available, donor funds may be sought to effect changes.*

A TB Infection Control Plan outlining the strategy used by a facility to implement infection control interventions is essential to detail what should be done to make TB infection control a reality. This plan should indicate who is responsible for what and must be updated regularly to accommodate staff changes. It stands to reason that all staff should be made aware of the details of this plan as well as the awareness of TB symptoms and the need for early diagnosis of both staff and patients. Community liaison initiatives should be undertaken to create awareness amongst members of the community that will lead to better health seeking behaviours and shorter time to diagnosis.

Due to the fact that TB patients are more likely to be HIV positive, and because HIV positive persons are more likely to acquire TB, it is important that HIV testing be made easily accessible to all people undergoing TB screening. It is therefore essential that facility managers should facilitate TB/HIV collaboration. Although a very difficult choice to make, staff who are HIV positive should inform a supervisor so that they can be placed in a unit where they would not be exposed to the potential of TB infection.

(ii) Administrative control strategies

Strategies to reduce production of infectious TB particles rely on the identification of clients who cough. This can be done by asking clients about a history of cough or by observing clients. The sooner coughing clients are identified the better. Obviously a gentle approach should be taken when doing so and client confidentiality should be maintained.

Strategies for administrative control

- *Screening all clients for cough as they enter the facility*
- *Educating clients in cough hygiene*
- *Provision of masks or tissues to coughing clients as they enter the facility*
- *Separating coughing clients from those who don't (triaging), in waiting areas or queues particularly*
- *Reduction of waiting times for clients who are coughing to limit the amount of infectious particles generated*
- *Early referral and investigation for TB of clients who are coughing when cough was not the primary reason for attending the healthcare service*
- *All healthcare professionals should be familiar on how to diagnose TB in patients with HIV who have negative smears*
- *Provision of a safe environment*

for colleting a sputum sample where staff and other clients are not exposed (see article on sputum collection)

Infection

control strategies protect practitioners and patients

(iii) Environmental control strategies

Well ventilated waiting areas must be available for clients and natural ventilation is better than mechanical ventilation (air conditionning). Where outside waiting areas are used, sufficient provision of covered areas should be made in case of rain, heat or sun. Where inside waiting areas are used, good ventilation must be maintained by opening windows. Air mixing should be maintained through natural means such as an air current through wind, or by mechanical means with fans. When air is still, pockets of air may contain higher numbers of infectious droplets which incrase risk to clients and staff. Where finances permit ultraviolet germicidal radiation (UVGI) units could be used.

(iv) Personal risk reduction strategies

All staff should regularly attend in-service training on TB infection control to ensure that staff understand the importance of correct application of infection control strategies.

Staff and clients should be encouraged to know their status and to take INH prophylaxis if appropriate. The current HCT campaign discussed elsewhere in the magazine creates the ideal opportunity for all citizens to know their status.

The use of N95 respirator/masks are useful where strategies to limit the production of infectious aerosols are only partially effective. Corrrect use of these masks are essential and a policy on the use of N95 masks could be included in the TB infection control plan where it is available.

N95respirator/masks are expensive and should be used in high risk sistuations only, such as where MDR or XDR patients are treated or where administrative or environmental controls are not likely to be effective. The N95 mask has a tight facial seal with a filter size of 1µm that will capture TB particles and prevent infection. The mask may be reused by the same person. It will not work properly when:

- *It is not properly fitted*
- *The wearer has a beard that prevents proper fit*
- *It is damaged or crushed*
- *The filter is saturated (reused until filter capacity exceeded)*
- *It gets wet (even if dry again)*

Surgical masks are different from respirator masks as they have a 50% filter efficiency and do not have a tight face seal. Infectious patients should use surgical masks to reduce the number of infectious particles in the air. Surgical masks are useful to catch larger respiratory droplets and to prevent droplet nuclei from forming

Why infection control?

Prevention through adequate prevention control measures is essential to protect healthcare practitioners to prevent such tragedies as Dr Pather. This article provides a short synopsis of the wealth information and clinical tools in the RHRU manual that will guide the implementation and monitoring of infection control measures in institutions.

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[2]RHRU HIV Management Cluster. 2009. Implementing TB Infection Control in health facilities: page 11 Manual available online

(Photo: DENOSA)

ICN TB/MDR-TB Project

Gini Williams
TB Project Director
International Council of Nurses

The International Council of Nurses (ICN) is one of the organizations participating in the comprehensive public-private partnership set up by Eli Lilly and Company to stop the spread of MDR-TB and save lives. This article describes how the ICN aims to strengthen the health care infrastructure by equipping nurses to contribute effectively to the care and control of TB and MDR-TB.

The ICN-Lilly partnership began in 2003 when Lilly reached out to ICN to participate in the first phase of its Partnership program. TB, so often a stigmatizing, infectious and debilitating disease, relies on prompt diagnosis and uninterrupted treatment, and is a prime example of where good quality patient care is just as important as laboratory facilities and effective drug therapy. In most of the countries where TB and drug resistant TB thrive, nurses constitute the vast majority of health care workers and are therefore an essential strategic target when aiming to improve the care of patients requiring diagnosis and treatment.

Project workstreams

1. Training of trainers

The central activity of the project is the training of trainers (TOT) program which aims to equip nurses with the knowledge and skills they need to prevent, treat and control TB. Interactive 3-5 day TOT seminars are run in countries with a high burden of TB and MDR-TB and cover the clinical context, disease management strategies, best practice for patient care and the principles of adult teaching and learning. Often training is only part of the story so the program encourages participants to use problem-solving techniques to implement what they have learnt and improve practice in their places of work.

The national nurses associations, in the countries where the courses are held, make all the local arrangements for seminars, select participants and local co-trainers and monitor subsequent training activities. This is done in collaboration with the National TB Program. All participants attending the seminars commit to training at least ten nurses and ten allied health workers according to the most pressing priorities in their work environment.

To date 855 nurses have attended seminars which have been run in fourteen different countries and have themselves gone on to train an estimated 18921 nurses and allied health workers. Nine countries have been involved in Africa including South Africa, Malawi, Swaziland, Lesotho,

Groupwork Uganda 2009 (Photo: International Council of Nurses)

Site visit Philippines 2008 (Photo: International Council of Nurses)

Facility visit Philippines 2008 (Photo: International Council of Nurses)

(Photo: DENOSA)

Mozambique, Kenya, Uganda, Ethiopia and Zambia with 430 African nurses attending the seminars and themselves going on to train nearly 14000 additional nurses and allied health workers.

2. Recognizing excellence and strengthening nurse leadership

Nursing expertise in countries with a high burden of TB and MDR-TB is rarely visible at an international level which is a great loss to the development of international strategies to combat TB. Nurses who have to implement disease control strategies on the ground in high burden low resource situations, have an invaluable understanding of the challenges involved and useful ideas about potential solutions. The project has developed two important mechanisms for strengthening leadership and recognizing excellence among nurses working in the most challenging situations:

a) Developing skilled nurse trainers: Skilled nurses with expertise in the field of TB are being identified and developed at a local level to lead the seminars in their part of the world as the project expands. So far there are three in Africa, one in Russia and one in the Philippines. These trainers meet annually at an international TB or nursing event in order to feed back on their activities and take advantage of additional professional development opportunities.

b) ICN-Lilly Award for Nursing Excellence in TB/MDR-TB: The ICN Lilly Award, consisting of a specially designed medal and an educational grant to continue the recipient's professional development in TB, was launched on World TB Day 2007. The Award aims to motivate and encourage nurses in their TB related work; showcase nursing's contribution to TB prevention, care and treatment; and recognize nursing expertise. One Award is given annually in each country where ICN and Lilly are collaborating. 34 awards have been presented so far including 24 in participating countries in Africa.

3. Developing training and reference materials

TOT manuals: The curriculum for the TOT and the training manuals have been specially crafted by ICN, with input from experts (WHO, CDC, PIH, etc.) and feedback from users. The training and the materials are accredited for nursing continuing education credits and have been translated into Russian, Chinese and Portuguese. In order to assist them in their future training activities, each participant receives all the materials used during the course in hard copy and on CD-Rom.

ICN TB/MDR-TB Guidelines: As well as being part of the training material used for the TOT seminars, the ICN's TB Guidelines offer nurses around the world essential information about TB and MDR-TB from individual patient care to implementation of internationally recognized TB control strategies. It sets out a nursing approach to planning and delivering patient care, aimed at improving access and quality of care throughout the treatment period.

4. Making information available on-line

a) A web-based "Global TB/MDR-TB Resource Centre": This Resource Centre makes extensive information about TB and MDR-TB available in real time for the more than 13 million nurses working worldwide. It is currently populated with 35 pages of the latest resource material on TB and drug resistant TB and is continuously updated. This is available to all nurses at http://www.icn.ch/projects/TB-/-MDR-TB/.

b) E-learning products: Work is underway to develop and pilot the initial module for an online, accredited TB/MDR-TB learning course for nurses. The e-learning products will offer ongoing support to those who have attended ICN TOT seminars as well as make training available to countries where the seminars are not being run. They will be available on-line as well as on CD-rom and will be designed to be accessible in countries with less well developed communications systems.

5. Working with partners

Great benefits have already been gained from working with organizations often representing different cadres of health professionals, patients, voluntary workers and community activists to develop inter-professional, multi-agency approaches to address the challenges posed by this persistent and complex disease. One important outcome of the project has been the strengthening of partnerships at a country level with National Nurses Associations now being involved at a more strategic level in National TB Control Programmes and collaborating with other organizations involved in delivering care to patients with TB such as the Red Cross .

Conclusion

This ambitious far-reaching program aims to strengthen the capacity of the nursing workforce at all levels to meet the challenges posed by TB with ever-growing numbers of MDR- and XDR-TB. The risks of not succeeding are high. Great strides may be made in developing fast diagnostic methods but if patients do not receive the care they need at the point of entry to the service their diagnosis will still be delayed. Advances may also be made in reducing the treatment period but, again, if patients do not receive the care they need they will not complete even a shortened course of treatment. The push to increase the treatment of MDR-TB is essential but without good patient care, the chances of success are severely reduced and cases of XDR-TB will rise. With perseverance and ongoing investment patient care will improve, more cases will be detected promptly and more patients will receive a full uninterrupted course of treatment.

(Photo: DENOSA)

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

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(see reverse side for Doctor Membership form)

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Quarterly issues of the *Southern African Journal of HIV Medicine*
Newsletter *Transcript*
CPD points for questionnaires and branch meetings
Information on training courses
HIV Advocacy
Conference information and bursaries
Internet discussion groups
Local and international guidelines

to advertise in HIV Nursing

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

Rates for 2010 are as follows:

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

Rates are subject to change

Inserts & promotional articals

The same rate as for advertisements applies to articles and inserts
Small advertisements: Available on request
These prices exclude VAT and advertising agency commission.

Digital advertising material formats.

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

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

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

SA HIV Clinicians Society
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Private Bag X2600, Houghton, 2041
www.sahivsoc.org
Tel: +27 (0) 11 341 0162, FAX: +27 (0) 11 342 0161

Article/letter submissions: nelouise@sahivsoc.org

NDOH/SANAC Nerve Centre Hotlines:

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

Nerve Centre Hotline.

- There are three nerve centre phone lines:
  (012) 312-5674
  (012) 312-5416
  (012) 312-5030

And, specific emails for each province:

- Western Cape:
  sanacwesterncape@gmail.com
- Northern Cape:
  sanacnortherncape@gmail.com
- Eastern Cape:
  sanaceasterncape@gmail.com
- KZN:
  sanackzn@gmail.com
- Free State:
  sanacfreestate@gmail.com
- Mpumalanga:
  sanacmpumalanga@gmail.com
- Gauteng:
  sanacgauteng@gmail.com
- Limpopo:
  sanaclimpopo@gmail.com
- North West:
  sanacnorthwest@gmail.com

AIDS Helpline 0800 012 322

The National AIDS Helpline (0800-012-322) provides a confidential, anonymous 24-hour toll-free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

The helpline was initiated in 1991 and is a partnership of the Department of Health and LifeLine Southern Africa. The Helpline, manned by trained lay-counsellors, receives an average of 3,000 calls per day, and is seen as a leading telephone counselling service within the SADC region.

Services Offered by the AIDS Helpline:

- Information: The Line creates a free and easy access point for information on HIV and AIDS to any member of the public, in all of the 11 official languages, at any time of the day or night.
- Telephone Counselling: Trained lay-counsellors offer more than mere facts to the caller. They are able to provide counselling to those battling to cope with all the emotional consequences of the pandemic.
- Referral Services: Both the South African Government and its NGO sector have created a large network of service points to provide a large range of services (including Voluntary Counselling and Testing, medical and social services) to the public. The AIDS Helpline will assist the caller to contact and use these facilities.The National AIDS Helpline works closely with the Southern African HIV Clinician's Society to update and maintain the Karabo Referral Database. www.sahivsoc.org
- Treatment Line: A specialised service of the AIDS Helpline, the Treatment Line is manned by Professional Nurses. They provide quality, accurate and anonymous telephone information and/or education on antiretroviral, TB and STI treatment. They also provide relevant specialised medical referrals to individuals affected and infected by HIV and AIDS in South Africa.

TOLL-FREE NATIONAL HIV HEALTH CARE WORKER HOTLINE

Are you a doctor, nurse or pharmacist?

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

Contact the Toll-free National HIV Health Care Worker Hotline

0800 212 506 / 021 406 6782

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

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

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

What questions can you ask?

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

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

When is the service available?

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

Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 46 years of drug information experience between them. They have direct access to:

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

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

what's happening

FPD

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

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

Course in the Management of HIV/AIDS for Healthcare Professionals

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

Course in the Management of Tuberculosis for Healthcare Professionals

Ranking 7th in reported TB cases, South Africa is among the 22 high-burden countries targeted as part of the World Health Organisation's Stop TB Initiative. In 2002, 224 420 TB cases were reported. Of these, 182 583 were pulmonary TB cases, of which 98 800 cases were new infectious cases. The incidence rate in 2002 was 494 per 100 000 population. The increase in TB is closely related to the HIV epidemic; a recent study revealed that 58% of TB patients were co-infected with HIV.

Advanced Training Course on Tuberculosis Infection Control in Healthcare Facilities

The purpose of the course is to improve TB infection control practices in TB control by offering participants up-to-date knowledge and practical skills on how to:

- assess,
- plan,
- organise and implement,
- monitor and evaluate implementation of

TB infection control at facility levels, within the framework of the Stop TB Strategy. This training also aims at strenghtening cooperation among different sectors involved in TB-control.

Dispensing Course

This course is based on the recommended standard for the dispensing course for prescribers in terms of Act 101 of 1965 as amended, which was developed by the South African Pharmacy Council, in consultation with the other statutory health councils. Licensing with the relevant authority as a dispensing healthcare professional can only take place once a certificate from an accredited provider has been awarded. This course will enable health professionals to dispense and ensure the quality use of medicines prescribed to the patient. The Dispensing Course is available through the Foundation for Professional Development (FPD) in association with the Health Science Academy.

Short Course in Monitoring and Evaluation

This course will enable you to:

- explain the attributes of good information
- apply the most effective ways of collecting information for your organisation
- present information to others effectively
- the principals of practical research with regards to: research design, research methods, data collection, data verification, data analysing, data summarizing, data use/dissemination plan, data / information management systems, research documentation, reporting mechanisms and report writing.

Course in the Fundamentals of Project Management and PMBOK®

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

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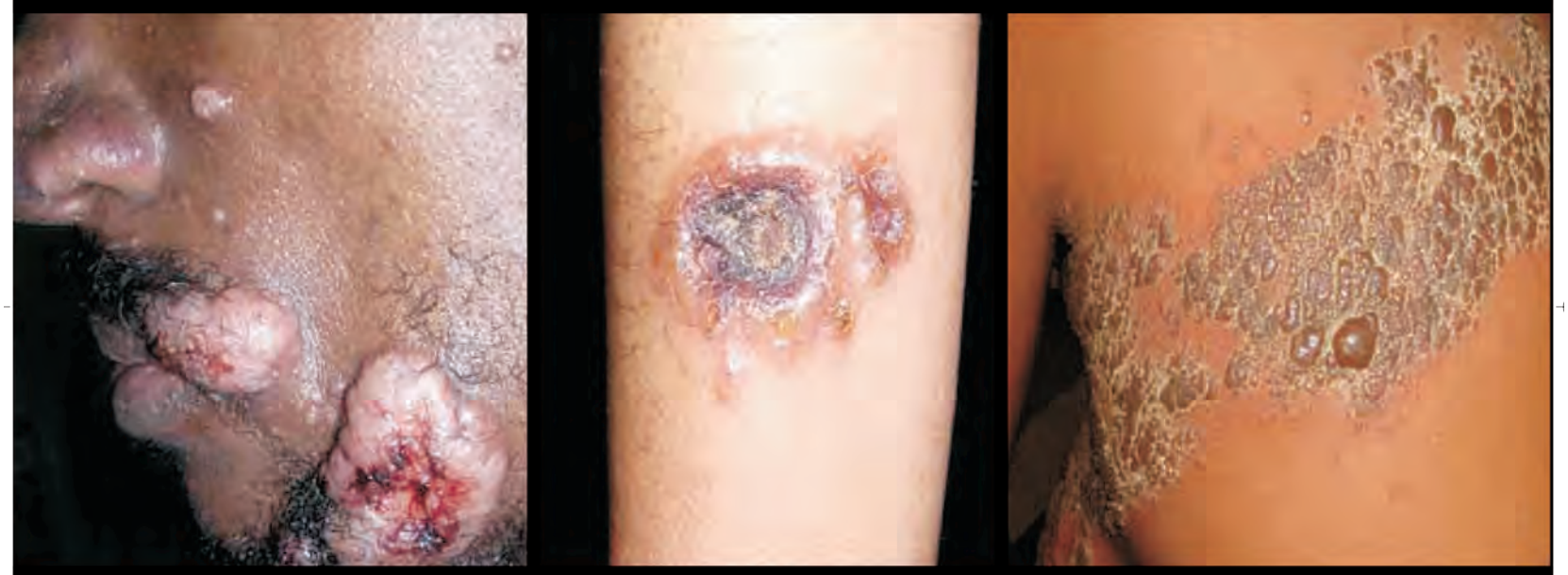
UNIVERSITY OF
KWAZULU-NATAL

The Department of Dermatology
Nelson R Mandela School of Medicine
University of KwaZulu-Natal

presents

"A CLINICAL ATLAS OF SKIN CONDITIONS IN HIV & AIDS"

BY Ncoza Dlova and Anisa Mosam



FEATURES

- New updated second edition - essential guide for all clinicians managing patients with HIV/AIDS
- More than 150 colour illustrations of HIV/AIDS related skin conditions
- Comprehensive coverage of HIV infected black paediatric and adult patients
- Therapy aimed at primary level care; tertiary level care included for first world settings
- New sections on immune reconstitution and skin reactions to ARV's

" An essential tool for clinicians working with HIV"
- Prof Jerry Coovadia

" A very practical and well organized atlas with remarkable photos"
- Prof Neil Prose, internationally acclaimed dermatologist

SALE OF CLINICAL ATLAS - R280 (excluding postage)

BANKING DETAILS
ABSA Moneymarket account
Branch number: 632005
Account number: 9234566045

Enquiries: Dermatology, UKZN 031- 2604531

FOR FURTHER INFORMATION

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www.midwives2011.org

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19 - 23 June 2011, Durban, South Africa

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Strengthening Midwifery Globally