Volume 2. No 1. March 2011

HIV Nursing

Southern African HIV Clinicians Society Nursing Magazine

Living with HIV
Stigma in the workplace
PEP for health workers

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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Nelouise Geyer

ed's note

With 2011 well on its way by now, we eagerly await not only the upcoming AIDS conference in Durban, but also the Nursing Summit scheduled to take place early in April 2011. All of us have been aware of a few changes in the air – NIM-ART has taken off – not without its own challenges, but it appears that the nurses who have undergone training are starting to make a difference. The dilemma for nurses and midwives remain that the Nursing Act, 2005 has been fully operational since 2008, but most of the supporting regulations to enable the legal framework and support for service delivery are still outstanding. If there has been progress with the Nursing Strategy that is now about 6 years old, then the message did not reach us all. We have been promised that many of the challenges will be addressed at the Nursing Summit. The profession have to ensure that this does not become another very expensive talk shop that bears no fruit!

Another important event on the nursing calendar before the AIDS conference in June, is International Nurses' Day that is celebrated on 12 May every year. The theme for 2011 is "*Closing the gap: Increasing Access and Equity*" – something that has been happening with the implementation of NIM-ART in South Africa. Where the gap remains though, is the fact that there appears to be no support structures for nurses/midwives or other health workers living with HIV. This issue of *HIV Nursing* focuses on HIV in the workplace, including the nurse or midwife living with HIV and it was really difficult to access information on support available for healthcare workers living with HIV – this seems to be a gap in the HIV care arena.

So our request is for nurses, midwives and other health workers to share their knowledge and experiences with us so that we all can learn from it – we had one person who was brave enough to do this. And there certainly are a few lessons to learn!

HIV Nursing

The Team

Editor
Nelouise Geyer

Message of the president
Professor Francois Venter

Contributors
Monument Trust

Advertising
Fatima Shaik
SA HIV Clinicians Society
Tel (011) 341 0162

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

www.sahivsoc.org
Tel: +27 (0) 11 341 0162
Fax: +27 (0) 11 341 0161
e-mail: sahivsoc@sahivsoc.org

Article/letter submissions:
nelouise@sahivsoc.org

talk to us

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

Prof Francois Venter

Message from the president

NURSES' experience in giving treatment is skyrocketing

The giant AIDS conference in Durban looms in June, and promises to be one of the most important networking and training events for nurses this year. We have arranged a series of workshops, skills building seminars and talks that will help you treat your patients more efficiently and better, while exploring many of the ethical and social debates around HIV.

The impetus of NIM-ART has meant that attention to nurse training needs has never been higher; nurse experience in giving treatment is skyrocketing, so it is imperative that you get to the conference and share your thoughts on how to get more people into HIV testing and ARV programmes. You can find all the details at http://www.dirasengwe.org/5thsaaidsconference.html. In addition, if you can't afford to get there, there is a competition being run through the Sunday Times, using a camera on your cell phone to document your experience of HIV testing that will allow you to get there. For details, visit the Society's website at www.sahivsoc.org

5th SA AIDS Conference 2011

7-10 June, Durban

Letters to the editor

Sir or madam
I am a registered nurse (Occupational Health Nurse) currently practicing in Zimbabwe. I came across your informative magazine through a friend on a bus and felt I need to know more about your HIV Clinicians Society.

Here in Zimbabwe I work with the infected and affected workers and I found out that your society is rich in information about HIV, opportunistic infections and anti-retroviral therapy.

How can I get connected and help in the fight against the spread and control of HIV?

Langton Gurure

Dear Langton,
Membership of the SA Clinician's Society will give you access to the magazine your friend had, as well as a research journal and bulletin that will provide you with a wealth of information. We will send you a copy of the membership form.

Also on the website we have a whole range of materials that can assist you in the work you do. The website is www.sahivsoc.org
Ed

I have seen your magazine [Southern Africa HIV Clinician Society Nursing magazine] which I borrowed from my work mate nurses who receive the magazine regularly from your organisation and I found it very interesting and helpful to all people who deal with health related issues particularly to the professionals who deal with HIV patients. I am a psychologist working at psychiatric hospital with various psychiatric problems including HIV/aids and psychiatry patients. What I need now is I am asking to share your practical experience in the field of psychiatry and HIV. We have real problem in treating such cases. So that your contribution in managing this problem will be greatly appreciated and I hope it will alleviate challenges in this field.

Thank you in advance for your cooperation.

Yemane at psychologist at Saint Marry
neuro psychiatri hospital

Asmara, Eritrea.

Dear Yemane,
Your request for assistance will be forwarded to the office for further attention. Also note that membership of the SA Clinicians Society gives members access to The Southern African Journal of HIV Medicine and the HIV Nursing magazine. As indicated to the previous reader guidelines accessible on the website can also assist you in the work you do.
Ed

Me. Nelouise Geyer
I'm MCWN Health Co-ordinator and I really enjoyed the article around the MDG goals, this also assisted me a lot with my operational plans.
Regards
Mariette Beer

Dear Mariette
Thank you for taking the time to respond – it is always good to hear that we are on the right track and provide the information that nurses can use!
Ed

Hello Ms.Nelouise
I am Jalarjue, Abel II of Liberia. Today, I read a magazine on HIV which came from the Southern African HIV Society. I took names, numbers e-mails etc. I search on this organization web and found a whole lot of informations about this organization. I even saw and read the letter that this organization President (Francois Venter) wrote to the Minister. I got interested and decided to e-mail you. I wish to be a member of this organization. I am a Health Worker (Lab Tech, A Sc) and wish to receive e-mails from this organisation. I wish to hear a reply from you.
Have a nice day. Thank you very much.

Truly Yours,
Abel

Hello Abel,
Thank you for your positive response. We will send the membership application form by e-mail.
Ed

Thank you very much for having such an informative journal for nursing professionals and any other person who can be willing to improve their knowledge on issues of HIV.

What is good is that through reading this journal we will learn about the latest issues that can even assist in improving quality health care. For me this is very important for all nurses working at PHC (primary health care) level. Nurses form the pillars of health care services. We can only be safe practitioners if we are lifelong readers and have a quest for knowledge and then use it effectively and brighten every corner where ever we are.

This is excellent. The clinical update, current issues and research will be improving the knowledge of nurses and clinicians.

Thank you very much.
Looking forward to the next issue.

By Lynette Baloyi
Thulamahashe
(Bushbuckridge) Mpumalanga

Dear Lynette,
We agree with the responsibility of nurses to be lifelong readers. We strive to continue assisting in this regard.
Ed

news

52% of farm workers infected with HIV

Results of a HIV&AIDS Study in Limpopo and Mpumalanga announced by the International Organisation of Migration (IOM) indicate that more than half of farm workers in their 30's are living with HIV. The study was done on farms where HIV programmes are already implemented suggesting that the picture could be much worse in the rest of the province.

Dr Mark Colvin, principal researcher, said that the study indicates that 39,5% of 2 798 workers on 23 farms in Malalane, Tzaneen and Musina, with 52,2% of workers between 30 and 39, are infected with HIV.

- Prevalence of HIV amongst farm workers in Malalane was 49% as compared to 28,1% in Musina and 26,3% in Tzaneen.
- Only 14% of farm workers in Malalane are married. In Tzaneen and Musina it is 50%+.
- 18% of farm workers in Malalane in co-habitant relationships said that they were forced to have sex against their will during the previous year.
- In Malalane 51,3% of South African farm workers were HIV positive, 52,3% and 43,2% of Swazi and Mozambique workers, respectively, were HIV positive. The study indicated that migrant workers are infected at 2 -3 times the rate of their counterparts in their home countries. This suggests that migrant workers are exposed to HIV when they come to work on South African farms.
- HIV prevalence cannot be blamed on the migrant workers says the researchers.

Researchers are unclear about the reasons for the high HIV prevalence and could not even find any strong relationship between condom use or alcohol abuse. Just more than 50% of respondents did use a condom during their last sexual encounter. Married persons were slightly more protected against infection and those who had previous STI's were more exposed to HIV infection. They suspect that transactional sex in exchange for money, food or gifts fuelled by poor wages may play a role. Sexual violence has an influence with 12,8% of men and 14,4% of women indicating that they were forced to have sex the previous year. These persons tend to more often be HIV positive (48% as opposed 39,4%). Many young men indicated that they were raped by other men. ®

Antoinette Pienaar
Wednesday, 24 November 2010
Beeld

More health workers needed to achieve HIV&AIDS targets

With the current number of health workers worldwide, most developing countries will not be able to achieve Millennium Development Goal 6, which includes universal access to HIV&AIDS treatment by 2015, according to a 2011 WHO report which viewed progress in 5 countries. ®

Bangkok, 2 February 2011
PLUSNEWS
Full report available at http://www.plusnews.org/report.aspx?ReportID=918113

talk to us

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

Revolutionary device to diagnose TB

The World Health Organization (WHO) has underwritten a revolutionary device that will have a significant impact on the diagnosis of TB, particularly in poor countries. The device can diagnose TB and X-DR TB within 100 minutes. It can be used in the doctors' rooms or clinic without the assistance of laboratory technicians. Generally patients have to wait for days to get the result of their tests resulting in terminally ill patients dying before they could get the right treatment.

This is a device that was originally developed in the USA to detect anthrax. About three years ago a group of scientists adapted it for TB. The WHO indicated that their endorsement follows rigorous testing over the last 18 months.

Provisional results indicate that three times more cases of persons with XDR TB would be detected and twice as many cases with HIV related TB in areas where the disease is rife.
The developers, FIND (The Foundation for Innovative and New Diagnostics) and Cepheid have announced that the price will be decreased with 75% for countries worst affected by TB.

Antoinette Pienaar
8 December, 2010
Beeld

ARV's cheaper

A drastic decrease of 53,1% in the price of ARV's was announced by the Minister of Health, Dr Aaron Motsoaledi, in Pretoria in December 2010. This decrease represents a saving of R4,7 billion over a 2-year period due to contracts that government has concluded with 10 pharmaceutical companies. This decrease was the result of a very thorough tender process followed by the Department with the same companies that currently provide ARV's to the state sector, the Minister said. The decrease will allow government to treat double the number of patients with ARVs in future.

The three largest providers are Aspen Pharmacare (40,6%), Sonke (21,9%) and Cipla Medpro (10,1%).

Fanie van Rooyen
Wednesday, 15 December 2010
Beeld

	2008	2011	Saving
Efavirenz (600mg)	R 107.70	R 39.22	63%
Lamivudine (150 mg)	R 29.77	R 18.22	39%
Nevaripine (200mg)	R 31.53	R 22.99	27%
Tenofir (300mg)	R 155.60	R 54.82	65%

SOUTH AFRICA: Sihle Motha, "You have this person's life in your hands"

JOHANNESBURG - Sihle Motha, a nurse at Malvern Clinic, in Johannesburg, is among the first to have been trained in the management and initiation of patients on antiretroviral (ARV) treatment. She will soon be joined by thousands more as the government rolls out nurse-initiated ARV treatment at primary healthcare clinics across South Africa.

15 December 2010
PLUSNEWS
http://www.plusnews.org/report.aspx?ReportID=91382

Drug-Resistant

High Incidence of Hospital Admissions with Multidrug-resistant and Extensively Drug-Resistant Tuberculosis among South African Health Care Workers

Background: Nosocomial transmission has been described in extensively drug-resistant tuberculosis (XDR-TB) and HIV co-infected patients in South Africa. However, little is known about the rates of drug-resistant tuberculosis among health care workers in countries with high tuberculosis and HIV burden.

Objective: To estimate rates of multidrug-resistant tuberculosis (MDR-TB) and XDR-TB hospitalizations among health care workers in KwaZulu-Natal, South Africa.

Design: Retrospective study of patients with drug-resistant tuberculosis who were admitted from 2003 to 2008 for the initiation of drug-resistant tuberculosis therapy.

Setting: A public tuberculosis referral hospital in KwaZulu-Natal, South Africa.
Participants: 231 health care workers and 4151 non-health care workers admitted for initiation of MDR-TB or XDR-TB treatment.

Measurements: Hospital admission rates and hospital admission incidence rate ratios.

Results: Estimated incidence of MDR-TB hospitalization was 64.8 per 100,000 health care workers versus 11.9 per 100,000 non-health care workers (incidence rate ratio, 5.46 [95% CI, 4.75 to 6.28]). Estimated incidence of XDR-TB hospitalizations was 7.2 per 100,000 health care workers versus 1.1 per 100,000 non-health care workers (incidence rate ratio, 6.69 [CI, 4.38 to 10.20]). A higher percentage of health care workers than non-health care workers with MDR-TB or XDR-TB were women (78% vs. 47%; P < 0.001), and health care workers were less likely to report previous tuberculosis treatment (41% vs. 92%; P < 0.001). HIV infection did not differ between health care workers and non-health care workers (55% vs. 57%); however, among HIV-infected patients, a higher percentage of health care workers were receiving antiretroviral medications (63% vs. 47%; P < 0.001).

O'Donnell et al.
19 October 2010
Source: Ann Intern Med. 2010 Oct 19; 153(8):516-22.

talk to us

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

5th SA AIDS Conference 2011

2010 was an exciting year for most South Africans who celebrated the hosting of the FIFA World Cup with great enthusiasm. Just imagine what success the country can achieve during 2011 and beyond if just half of that energy and passion could be channelled into getting **HIV/AIDS** under control.

Our scientific knowledge about HIV has improved enormously, and we have excellent treatment available for HIV, yet inadequate health systems and dwindling funding are hampering our progress.

The programme for the **5th SA AIDS Conference from 7 - 10 June 2011** in Durban makes provision for input at all levels: from science, research and epidemiology to ethics and community involvement.

Ensure that you submit your abstract before **28 January 2011**, in any of the six tracks that suits your area of expertise and experience.

* **Track 1: Basic Sciences**
* **Track 2: Clinical Sciences**
* **Track 3: Epidemiology, Prevention and Public Health**
* **Track 4: Social and Economical Sciences, Human rights and Ethics**
* **Track 5: Best Practices and Programmes**
* **Track 6: Community Exchange Encounters**

Visit **www.saaids.com** for more information about the scientific programme, track descriptions, and step-by-step guide to submit your abstract online. Delegate registration is also available online.

Regards
Prof Francois Venter
Chairperson
5th SA AIDS Conference

Living with HIV Life is Good!

Very few stories are written up of HIV positive nurse practitioners who still practice in clinical healthcare. HIV Nursing has spoken to one such practitioner to get a glimpse of the thoughts and experiences such workers have when diagnosed and living with HIV. For confidentiality real names are not included. On behalf of HIV Nursing and all of our readers, thank you for sharing your experience with us!

Living with HIV is a chronic disease like any other potential chronic disease that one can contract in life.

Initial concerns

My greatest concern when I was first diagnosed was what are folk going to say about me, will I be able to continue to work, do I want to live with this "thing" in me, why is no-one hugging me? The first couple of days after the diagnosis were the most difficult because I knew about HIV (or so I thought) - I had nursed patients who were positive, a close friend had died of HIV related illnesses in 1992.

I was really worried about what others would say if they knew. I was not in a permanent job at the time of diagnosis (or should I say confirmation of diagnosis). I had resigned from a position in the healthcare environment that I had held for many years after a "scare" and a negative HIV test. I needed to live my life, I thought, now that I was reprieved of having HIV.
At the 6 month follow up, all that changed. I was positive. The new millennium was not starting too well for me. I had "dodged the bullet" for many years, I had taken all the precautions and been extra careful. I had asked the right questions. How could I have been so blinded by trust? Would I be able to have a relationship, what will happen to my partner, what if illness hits us before we have found our feet financially, what if I cannot work.. what if.... ... what if ? What do you tell a potential partner or friend when you meet them? When do you tell them that you are HIV Poz, do you need to tell them? Will all future dealings I have in health only be related to HIV? Can I work? Can I work in health? Will I be able to deal with the comments that take place in healthcare institutions between health professionals? Oh damn, what had I done to myself! My confidence took a huge knock. I would rather have gone to work in some far off place where no one knew me and I could hide away than continue in the current healthcare environment I found myself in. I wanted to go away and just fade into anonymity.

Over the past decade – learning to live with my positive status - things have changed for me. I have become the confident person I was before the diagnosis of HIV. I am more open about my status, when required, and my work life has become much more rewarding. Being able to talk from a "been there" perspective, adds a very different twist to providing care and support to many people in the same position as me.
I have found that some folk who work in the HIV field have a caring manner with a sting in the tail. They are part of a community that cares, but then the silent judgment of a person living with HIV as having "done something wrong" emanates into the room. Folk do not realize that a person living with HIV is hypersensitive to non-verbal "words", actions and vibrations. But, without the caring folk who provide very necessary and important services for us, we, the people living with HIV, would not be as advanced in receiving care as we are.
My perception of living with HIV has really become much more positive. I still do the things that I always have done, but have added a bit more value to living life to the full. I am comfortable with my own company, developing a relationship with myself that is empowering and energizing. Giving myself a pep talk when I need it is so much easier now.

Work is an important component of my life, and I do things that make a difference to many other people and communities. "Making things happen" is a motto I had before HIV and I am grateful I have it back.

I live with a Poz status in a very positive way. Life is good, and I know that I will be here for many more years.

Influence of treatment

I commenced meds in 2007. I recall that I was going to be traveling to Europe later in the year, and my CD4 count had dropped to 289 from 600+ in a period of 6 months. My VL was in the 300 000's and I did not want to get sick while away from home. The Dr who was looking after me at the time, suggested I go onto meds, even though there was no clinical evidence of any problems with my health, except the counts. The choice at that time was – take meds from now and never be able to stop, go through the side effects (if any) while travelling, get really healthy and live many productive years into the future – or – do not take meds and wait till I get back and reassess. I took the meds and have not looked back since.

I am lucky to be on an ARV regime that needs to be taken once a day. I have programmed my cellphone alarm to beep at 21h30 every night to remind me to take my meds. If I happen to be visiting friends or out somewhere, I have pills with me and I take them while out of the room where folk could not see me. Making a display has never been my mode of operation. And opening myself to questions from folk who do not know my status would just be a bit much. I have always felt that there is a time and place for an HIV lesson. No matter how passionate I happen to be about living positively with a Poz diagnosis, folk must be ready to listen to be receptive to the messages.

Taking ARV's enables me to do my work without the fear of contracting all sorts of infections. I work in some really dingy places and worry about TB, etc. Being on meds has pushed my CD4 count above 1000, and the VL has been undetectable for a long time. This gives me the confidence to be able to practice my profession without fear of unnecessary exposure or susceptibility to infections.

Certain meds need to be taken with or after a meal. This can be a challenge as a meal is not always available. I try to explain to the folk on these meds that a meal can be defined as something to eat. (A slice of bread, a couple of biscuits, etc could do the trick).

I was lucky not to have had real side effects to the ARVs I am taking (Truvada and efavirenz). There were the usual gastro intestinal discomforts for the first couple of weeks, but that soon passed and I was able to pass a loo without stopping. The efavirenz has not caused major issues in my life, luckily. Some folk have reported some really interesting side effects and 3D movie like dreams! I have never had these.

I have always enjoyed working night duty, and taking meds has limited my ability to do this. Stocrin (Efavirenz) is a drug that tends to give one a "buzz" about 1 to 2 hours after taking them. It is short in duration, but the best way to get over this is to sit down and not be in

company of others because they may think you are drunk. Thus any practical issue.

It is so easy to fall into the trap of saying "I am sick" and expecting all the bad things to happen to you, and then expecting "special" treatment. Focusing on the positive issues: a job to go to, a roof over my head, food on the table, waking up in the morning, a friend to talk to, the ability to touch others in a way that heals them..... all help to get me to work in the morning.

Disclosure to key people in your life is an important step. It has taken me many years to get to a point where I am comfortable to do this. I still live with the belief that I do not need to walk around with a "label" but can decide when and who I wish to disclose to.

In my work environment, I am often required to talk to other PLHIV (People living with HIV) about life choices, encouragement, etc. During these discussions, it is often intimated that I too have HIV. If the situation is right, I will disclose to the group and move on with discussions. If the situation is not right, I will continue to discuss issues with as much empathy as is needed from an informed (and personal) point of view.

An important aspect of disclosure is to ensure that you do not "set yourself up" for rejection. Trusting your own instincts is important. When the time is right, talk. If it is not right, wait. I have never benefited from being hasty, rather the opposite.

I was asked by a good friend why I did not tell my parents and other family members about my status. I responded by saying that I had no need to burden my aged parents, or family members, with the extra worry about what could happen to me. It might be news to some out there that, even though there is a lot of information about HIV, many people still believe that if you have HIV, you are a "dead man walking". These misconceptions do not change easily, even after a lot of discussion and explanation.

My family and friends are there to be with me in the same way they always have been, and when the time is right, I will tell folk who I think need to know.

Discrimination and stigma

I have been lucky not to have experienced any major discrimination or stigma related to my having HIV. One of the most difficult things I have found to deal with is comments that are made unwittingly by friends, family and colleagues about "those people with AIDS" in my company.

Usually it is folk who do not really understand what HIV is and how it affects a person. I will use this as an opportunity to talk and explain things that may just allow the people in the group to understand better what living with HIV could be like. Usually I raise a question related to not knowing who has HIV and that there could be someone in the close vicinity of the discussion that could be positive.

I have found that within a work environment discrimination or stigma is very seldom direct. It is in the way colleagues talk about someone who they assume to be HIV positive.

Stigma is something that can be hurtful. The general assumption is that folk who get HIV are promiscuous. This is often not the case.

Again I have been lucky in that stigma has not affected me much and I think that is because I do not wear my status on my sleeve. I am who I am, and I am comfortable with my life and choices I have made.

Stigma is a big issue in the life of an HIV positive individual. How one maneuvers through life can be a scary situation for many people. Ignorance is still a big problem in the general public. Many people have no idea that HIV is a manageable disease and that folk with HIV could live a long and healthy life. This adds to the discrimination and stigma many people living with HIV have to deal with.

Disclosure to supervisor

My point of view on this could be considered a bit controversial, but Healthcare workers in clinical practice should be treated the same as any other employee and should not have to disclose their status to a supervisor. It is always advisable to tell someone

senior that you work with and trust, but the reaction could be one of "what should I do with you now?" I must add though, that I have seen a change in this over the past few years. Many more supervisors and managers have a better understanding of HIV.

Healthcare workers who are HIV positive need to understand their responsibility to take care when undertaking any clinical practice with the public. This responsibility is the same when they are in any other public place, or their own home with their family. The responsibility to prevent possible exposure to others is something that does not go away, ever.

Healthcare workers should be encouraged to go onto ARVs as it has been found that a low viral load is a form of prevention. This can be a form of "prevention with positives".

The choice to tell your employer that you are HIV positive is a personal one. There are very few work environments that require an individual to make health declarations. But it is key that an employee is responsible and also not unrealistic about their abilities and job choices.
Another key to ensuring that you as an HIV positive employee receive fair treatment (as any other employee) is to understand that you do not have any "right" to different treatment. You have to be at work on time, every day, make plans for Doctor's and clinic appointments outside of working hours and just be considerate to others. What you give, you receive, is a good motto to remember.

Informing patients of workers' status

I do not think my patients need to know what medical conditions I may have. I have never had to tell patients of any other condition, so what is different about this one?

My philosophy has always been that it is my responsibility to take care not to infect a patient with any illness that I could be a carrier of, be it the flu, gastro, the common cold, there are many more that one could list here.

Patients need care, they need nurturing. They do not need extra stress about the fact that their nurse has HIV or any other illness.

Nursing Summit 2011

The Minister of Health will host a national Nursing Summit from 4 - 6 April 2011 to provide a timely opportunity for the nursing profession to convene and share ideas and energy relating to the long-term challenges confronting our nursing and health workforces. The presence and contribution of many nurses across different levels of service, different districts, provinces and contexts will enhance the guidance and direction of the nursing profession in South Africa.

The aim is for the summit to highlight issues that are of central concern to the future of the profession as well as to the success of the Government's health reform agenda. Of particular importance at this time is the call for a National Nursing Workforce Strategy to provide a framework to strengthen the development of a flexible and sustainable nursing and midwifery workforce that is educationally prepared to continue to meet the health care needs of the population.

Outcomes
It is envisaged that a Social Compact will be the result of the Nursing Summit, representing a collective call for greater attention, investment and integrated action to build capacity, professionalism and commitment within the nursing workforce in relation to teaching, service, research, leadership, governance, and mentoring of the next generation of nurses.
The Nursing Summit will bring together a collection of the most dynamic and visionary nurses in the country representing diverse groups from within the nursing profession. The aim is to bring those at the coalface, in teaching, service and research, together to harness the diversity of ideas, experiences, and ideas in order to guide the development of the nursing profession.

Main theme of the summit
Reconstructing and revitalising the nursing profession for a long and healthy life for all South Africans.

Objectives
1. Reflect critically and discuss key issues affecting nurses and the nursing profession.
2. Discuss the role of nurses in major health policies and transformation initiatives (Revitalizing PHC; NHI; MDGs; NSDA).
3. Identify, showcase and learn from successful models and best practices in nursing education, research and service.
4. Examine how nursing education and training can be improved to ensure alignment to patients and community needs.
5. Examine critically and discuss the draft nursing scopes of practice.
6. Discuss how nursing research can contribute to the priority areas identified at the summit.
7. Reflect critically on how the conference recommendations could inform the revision of the National Nursing Strategy in order to represent the aspirations of all nurses in South Africa.

Sub-themes
- Nursing education and training
- Nursing practice
- Leadership, governance, Policy and Legislation
- Ethical and value system of nursing
- Planning, resourcing and financing nursing and creating an enabling environment
- The role of the nurses in the achievement of positive health outcomes

Participants

Up to 1500 participants drawn nationally from students and practitioners at facilities at different levels, Directors of nursing in provincial departments of health, Associations, unions, and NGOs involved in the nursing profession, institutions involved in the training, supply and utilization of nurses. Nurses in different aspects of teaching, service and research in the public and private sector, nurses in critical areas of specialization, and in rural facilities. Nurses involved in the implementation of the 6 dimensions of quality will play a critical role, as will nurses from the diaspora and in international settings.

Organising committee
An organising committee has been convened by the Department of Health to work on the hosting of the National Nursing Summit to be held in April 2011.

The organising committee represents experience in the nursing profession in the country in different fields and has developed reference groups related to the different themes of the Summit as a way to more broadly consult with stakeholders during the organising process. In addition provincial consultative meetings will take place to broaden consultation. The committee is accountable to the Director-General of Health.

The organising committee will develop discussion documents for the Summit that will be made available to delegates attending the Summit by the middle of March 2011.

Venue
A large conference centre will be used, following normal procurement processes, after approval by the Minister of Health, and will be anounced in due course.

Detailed programme, themes and discussion structures
The organising committee will be expected to develop and refine the programme with the approval of the Department of Health. An issues paper on the state of the profession has been developed by the Department of Health and may assist in the preparation of inputs.

In preparation for the national summit, provincial consultations will be convened during February and March 2011.

The consultative workshops in each of the provinces will be arranged by the provincial departments of health. The schedule for the provincial consultative meetings are as follows:

14 February, Gauteng
Birchwood – Boksburg
16 February, Limpopo
Bolivia Lodge - Polokwane
18 February, Eastern Cape
Premier Hotel - East London
21 February, Mpumalanga
Ingwenyama Lodge - Nelspruit
23 February, Free State
Kopano Nokeng Lodge - Bloemfontein
24 February, Northern Cape
TBC or The Tabernacle - New Park, Kimberley
28 February, Kwazulu Natal
Elangeni Hotel – Durban
2 March, Western Cape
To be confirmed
4 March, North West
To be confirmed

Other communication
Those who have not had an opportunity to attend one of the workshops or to provide input can also find information on the Nursing Summit on Facebook and Twitter.

HIV Stigma and Discrimination in the Workplace:

Recent Findings and How Healthcare Providers Can Help

Stigma and discrimination in the workplace remains a challenge to people living with HIV and AIDS and counteracts the progress made in the AIDS response in many countries. In this article Laurel Sprague and colleagues consider stigma and discrimination in the workplace with recommendations on ways in which healthcare workers can assist others in managing their health within the workplace.

Laurel Sprague[1]*, Courtenay Sprague[2] and Sara Simon[3]
[1] *Department of Political Science, Wayne State University*
[2] *Graduate School of Business Administration, University of the Witwatersrand*
[3] *Communication Facility of the NGO Delegation to the UNAIDS Board*
**Corresponding author's email:* lsprague@wayne.edu

Stigma and accompanying discrimination have long been associated with the HIV epidemic, and their impact on access to prevention, treatment, care and support is now undisputed[1]. Efforts to expand access to antiretroviral treatment globally have realised substantial gains over the last five years. Nonetheless, success hinges on the willingness of individuals to undergo HIV testing; and, if the result is positive, to access treatment, care and support services. On-going stigma directed against people living with HIV counteracts the progress made thus far in the AIDS response. It does so by creating incentives for people to avoid testing and treatment, stymieing national HIV responses, threatening the well-being of those who are HIV-positive, and violating the human dignity of those infected and affected by HIV and AIDS.

In this article we discuss the results from three surveys of civil society organizations and people living with HIV about stigma and discrimination in the workplace. We present results from Africa as a region and from the countries of Kenya and Zambia. We conclude with a set of targeted recommendations to address the results, focusing on ways in which healthcare workers can assist their HIV-positive patients in managing their health within the workplace.

Role of the workplace

Recent research indicates that the workplace is an important setting where stigma and discrimination can be addressed. Expectations of fair and supportive treatment provide incentives for individuals to access prevention, testing, treatment, and care services, and to disclose their status when it feels appropriate to them, while expectations of discrimination create disincentives. Because people rely on employment for their livelihood, workplace responses to HIV can be particularly powerful influences on attitudes and behaviours.

The important role of the workplace for the well-being of people living with HIV is demonstrated by the protective laws and regulations established in many countries, including South Africa, Namibia, Botswana, Malawi, Mozambique, and Zimbabwe[2], and the commitments to prohibit employment discrimination based on HIV status adopted by the 192 member states of the UN[3]. Despite these prohibitions, these survey results reveal high levels of stigma and discrimination in workplace settings.

The research

Three recent surveys inform our understanding of the current state of HIV-related stigma and discrimination in the workplace. The first study comes from the NGO Delegation to the UNAIDS Board who, in early 2010, invited civil society organizations to share their experiences with HIV-related stigma and discrimination: its extent, its forms, and how it affects prevention, treatment, care and support services[4]. Survey responses were received from 1 521 respondents. This article focuses on the 328 responses from the African region.

The remaining two studies come from the People Living with HIV Stigma Index: a joint initiative of the Global Network of People Living with HIV (GNP+), the International Planned Parenthood Federation (IPPF), the International Community of Women Living with HIV (ICW), and UNAIDS. In projects led by the national networks of people living with HIV, Kenyan and Zambian people living with HIV were interviewed about their experiences of stigma or discrimination within the previous twelve months. The number of respondents was 1 086 (68% women) in Kenya and 854 (57% women) in Zambia.

Summary of Findings[5]

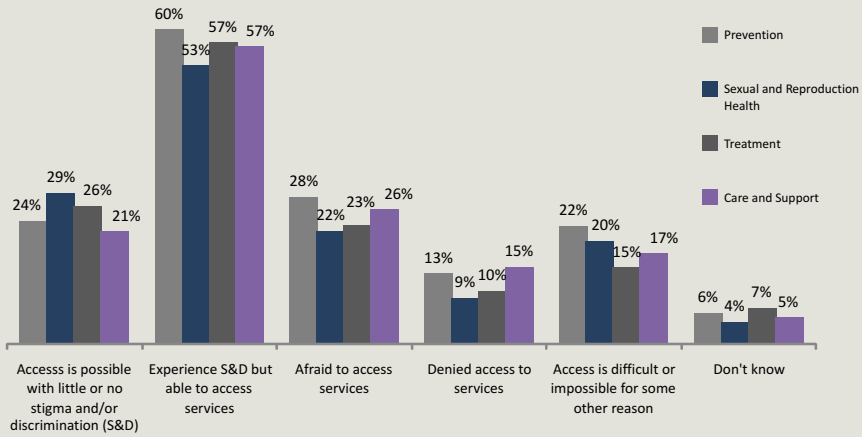
The research findings reveal that stigma and discrimination based on HIV status are pervasive globally and throughout Africa. A broad overview of the responses of African civil society organizations, including PLHIV, NGOs, health providers, and religious, labour, and grassroots organizations, demonstrates that:

Stigma and discrimination are substantial barriers to scaling up HIV prevention, treatment, care, and support services

This is particularly true for members of groups who are discriminated against because of their real or perceived membership in marginalized groups, such as men who have sex with men, transgendered people, refugees, displaced people, prisoners, sex workers, and drug users.

- Only 21% to 29% of African respondents indicated that people are able to access prevention, sexual and reproductive health services, treatment, care and support free from stigma and discrimination.
- The main barriers to services were cited as lack of confidentiality (53-62%), health worker discrimination (36-50%), identification with a discriminated group (39-48%) and discrimination based on gender identity or sexual orientation (34-41%).

Figure 1: Effect of Stigma and Discrimination on Access to Prevention, Sexual and Reproductive Health, Treatment, and Care and Support Services



N= 285, 260, 247 238. Percent is the percentage of African respondents who provided each answer when asked how much stigma and discrimination impact each service area. Multiple answers possible.

People living with HIV face job termination, exclusion (shunning

Selected Recommendations
The results from the three studies highlight the importance of confidentiality, education, effective legal remedies, and safe and supportive services that meet the real needs and circumstances of people living with HIV. With the exception of direct legal remedies, healthcare practitioners can assist their patients in each of these domains.

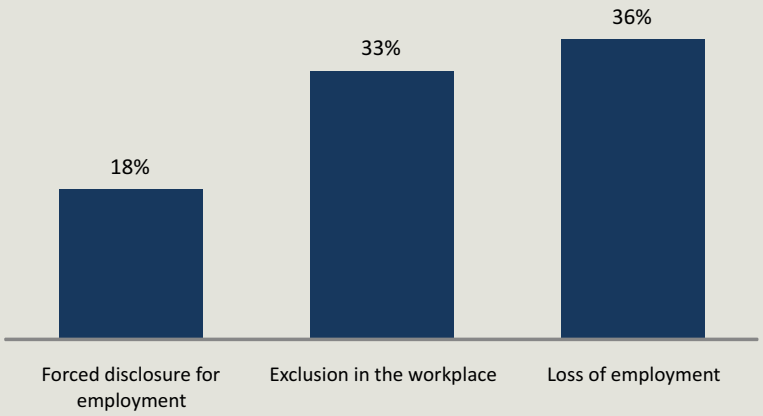
Confidentiality
People living with HIV express strong fears about confidentiality violations. These survey results demonstrate how high the stakes can be for patients. To maintain confidentiality:

1) Never disclose the HIV status of any patient, even to your co-workers, without the patient's consent.
2) Maintain and enforce clear standards for patient privacy for everyone with access to medical records.
3) To gain patient trust, explain the confidentiality policies of your health facility.

Education
1) Consider using your clout as a health professional to engage in advocacy and address misinformation that stigmatizes people living with HIV (for example, that a positive HIV test should be a barrier to employment).
2) Recognize that workplaces can be places of support for people living with HIV. Offer to educate and reassure employers, for example, to dispel fears of casual infection.

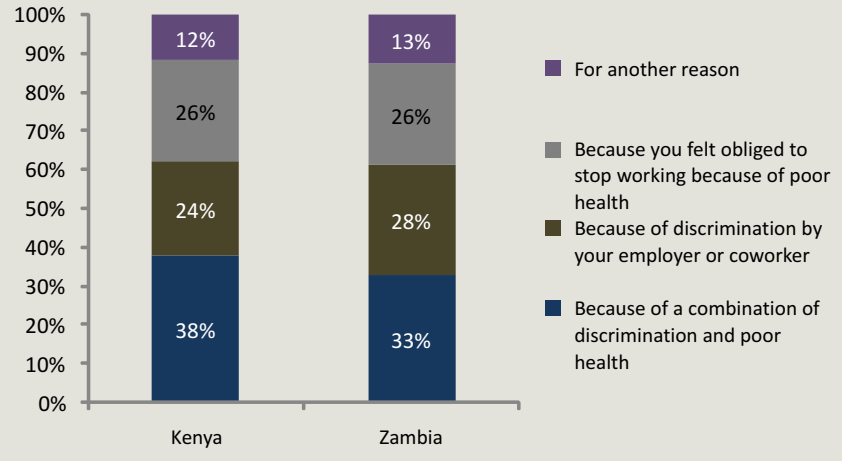
Safe, Supportive Services
1) When prescribing medications, discuss the working conditions and hours of your patients and how to manage their dosing schedules and other care needs.
2) Evaluate the physical layout of your clinic to ensure that people can access your services confidentially.
3) Consider undergoing training to better address the needs of sexual minorities and other vulnerable populations in order to offer appropriate services to everyone in your care.

Figure 2: Workplace Discrimination Because of HIV Status



N=213. Percent is the percentage of African respondents who indicated that they, or members of communities they work with, face each kind of discrimination.

Figure 3: If you lost work or income because of HIV status, was it?

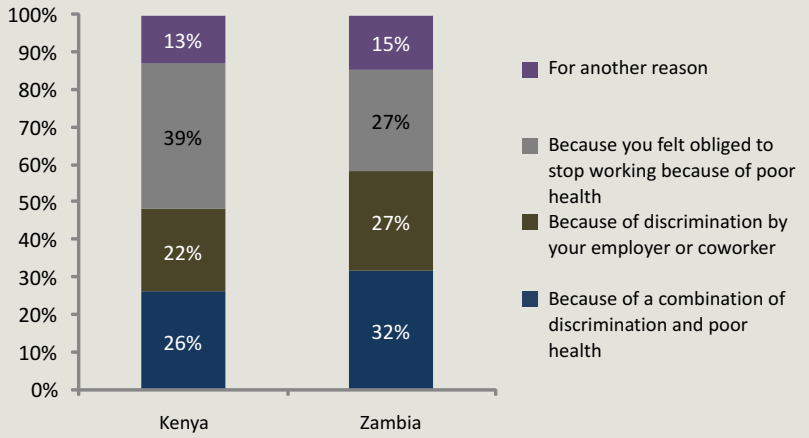


N=207, 121

Acknowledgements:
The authors wish to thank the coordinators of the People Living with HIV Stigma Index: Kenly Sikwese and the Network of Zambian People Living with HIV/AIDS, Rahab Mwaniki and the National Empowerment Network for People with HIV and AIDS in Kenya, as well as Julian Hows, of the Global Network of People Living with HIV (GNP+), for their gracious access to the data used for this report, and Natalie Siniora and Evan Collins for their support in the compilation of the UNAIDS NGO Delegation report.

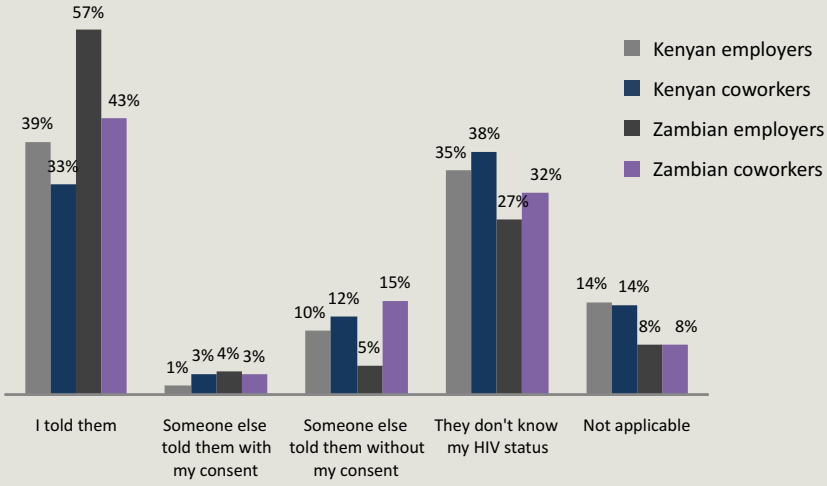
[1] *WHO, UNICEF and UNAIDS (2010). Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2010. Geneva, World Health Organization. Available at: http://www.who.int/hiv/pub/2010progressreport/report/en/index.html, accessed 17 October 2010.*
[2] *AIDS Rights Alliance for Southern Africa (2008).*

Figure 4: If your work changed or you lost a promotion because of HIV status, was it?



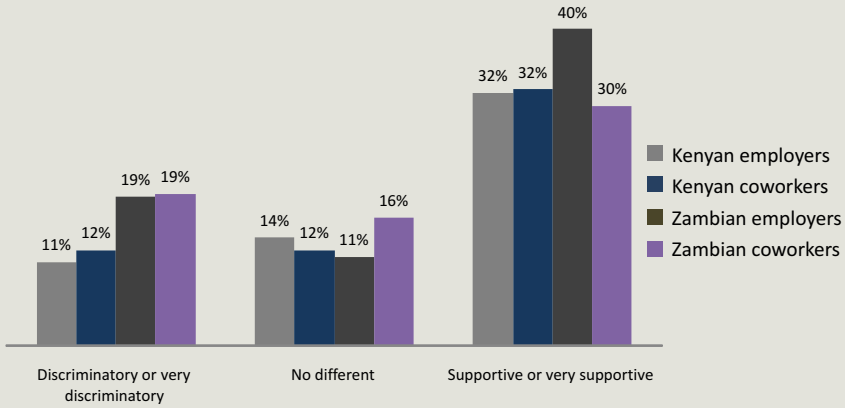
N=191, 136

Figure 5: Disclosure of HIV Status to Employers and Coworkers



N=201, 214, 217, 219

Figure 6: Reactions by Employers and Coworkers to Disclosure of HIV Status



N=199, 198, 215, 213. An additional 31% to 44% marked this question as "not applicable".

HIV/AIDS and Human Rights in Southern Africa: An Advocacy Resource and Training Manual, p 106. Available from http://www.arasa.info, accessed 11 January 2011.

[3]United Nations General Assembly (2006), Resolution 60/262, June, 2006.
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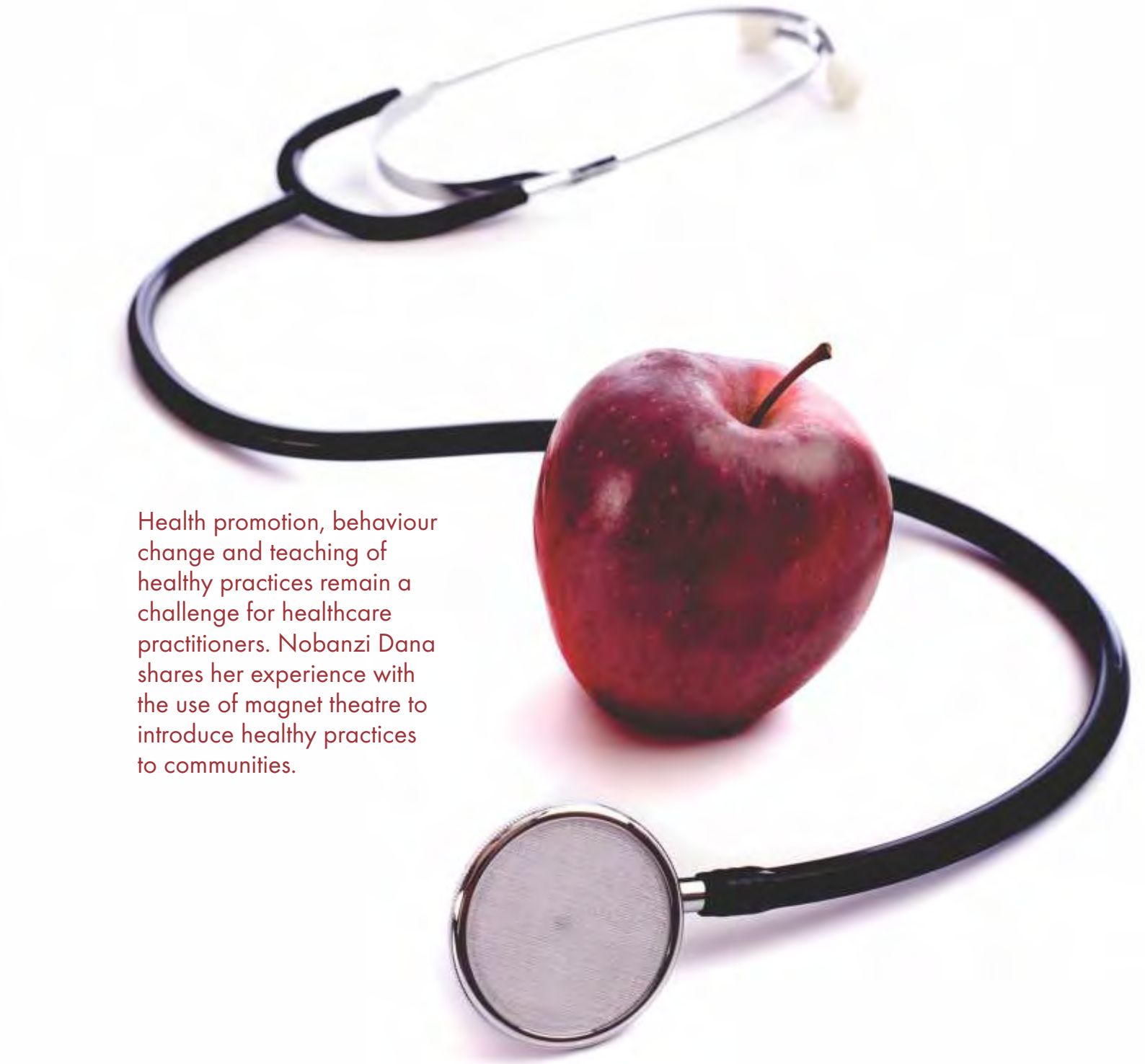
[4]UNAIDS (2010) 26th Meeting of the UNAIDS Programme Coordinating Board: Report by the PCB NGO Representative. 22-24 June. Geneva, Switzerland, UNAIDS.
UNAIDS (2010) 26th Meeting of the UNAIDS Programme Coordinating Board: Non-discrimination in HIV responses. 22-24 June. Geneva, UNAIDS.

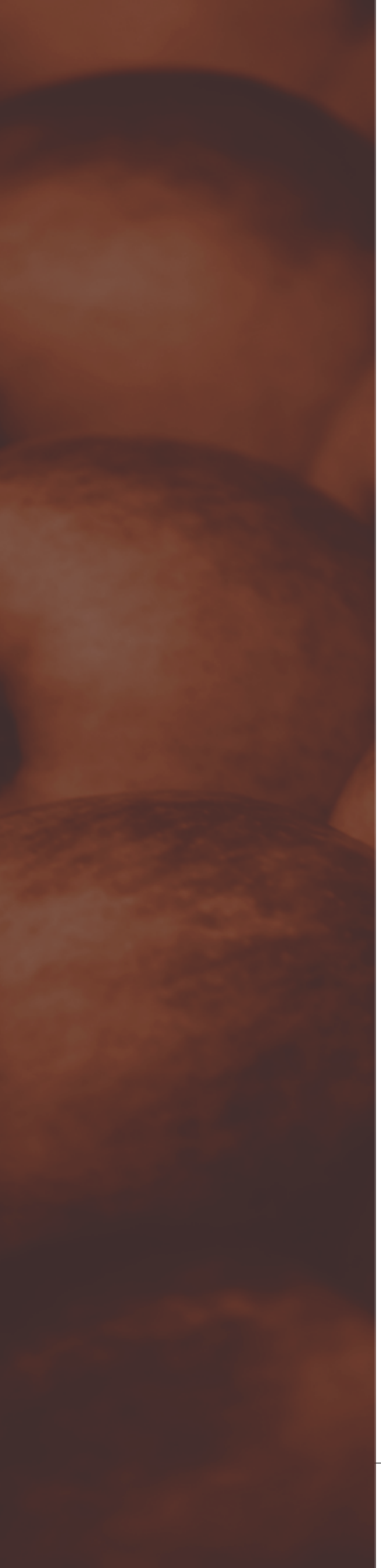
[5]For more information on the content and methods of the three surveys cited in this article, please contact Laurel Sprague, lsprague@wayne.edu.

Attracting a crowd:

how magnet theatre introduces audiences to healthy practices



Health promotion, behaviour change and teaching of healthy practices remain a challenge for healthcare practitioners. Nobanzi Dana shares her experience with the use of magnet theatre to introduce healthy practices to communities.



On an ordinary weekday morning, actors with a Khusela Magnet Theatre troupe are going door-to-door in a village in South Africa's Eastern Cape Province. While handing out pamphlets advertising their performance, they boisterously invite people to gather later in the day to discuss two important health issues affecting their community: HIV and prevention of mother-to-child transmission (PMTCT) of the virus.
As performance time draws near, a crowd made up of the elderly, pregnant women, mothers, fathers, and youngsters (most followed by their dogs) makes its way to the designated meeting place. Today, the magnet theatre troupe will act out an absorbing story - one that will abruptly stop just as a main character faces a dilemma. The actors will turn to their audience and ask a simple question: What happens next?

Magnet theatre, interactive dramatic performances by troupes of actors trained in health issues, encourages critical reflection among audience members by presenting dramatizations of common dilemmas in the community that stop - or freeze - before problems are resolved. The performances aim to:

- Provoke community discussion about health.
- Promote critical reflection on aspects of HIV including personal risk, prevention, care, and stigma.
- Encourage discussion and increased understanding of issues related to mother-to-child transmission of HIV, HIV prevention, child survival, and infant feeding.
- Magnify examples of desired behaviours to stimulate and motivate behaviour change in the wider community.

Magnet theatre and the Khusela project

Prevention of mother-to-child transmission is a critical intervention for Eastern Cape, where an estimated 28 percent of pregnant women are living with HIV. Working together as the Khusela project, three organizations - PATH, Health Information Systems Programme, and South Africa Partners - have joined with the Eastern Cape Department of Health to integrate PMTCT into the continuum of antenatal, maternal, and paediatric care. The Khusela project, active in three sub-districts, is strengthening Eastern Cape's health system, increasing the capacity of facilities and providers, and amplifying community demand for services.

To guide the design of a culturally relevant PMTCT awareness programme, in 2008 the Khusela project conducted a formative assessment of local factors that influence the uptake of voluntary counselling and testing for HIV by pregnant women. The assessment consisted of focus-group discussions with pregnant women, male partners, mothers-in-law, and traditional birth attendants. The discussions' aim was to determine community perceptions regarding issues in providing PMTCT services, including voluntary counselling and testing, infant feeding decisions, and reproductive health. Participants were asked to comment on existing PMTCT and HIV services, both within health facilities and within the community, and to recommend changes if necessary.

One of the most revealing findings came from pregnant women. They reported that most men are unwilling to use any existing HIV services, including tests for HIV. “You can beg and plead him to get tested” one participant said, “but men ignore when you ask.” Others said that “men never go to the clinic,” and that they “take our status as their own.” Mothers-in-law agreed with pregnant women that “men see HIV as a woman's thing.” One focus group even noted that the majority of advertisements for HIV prevention and testing - on TV, billboards, or posters - showed only women. They said men used this fact to justify their feelings that HIV is a women's disease.

Getting men involved

For PMTCT to be effective, both partners must be involved in testing and counselling services. Pregnant women who test positive for HIV sometimes face pressure both from their partners and their in-laws. Many are accused of having brought the infection into the marriage; an accusation that can lead to physical abuse, divorce, or abandonment. Their opinions on many issues affecting their babies - including how the newborn should be fed, which can affect transmission of HIV - may be disregarded. When partners get counselling together, however, blame is

dispelled and support is greater.

The Khusela Magnet Theatre began as a strategy to increase engagement and promote use of PMTCT services by the entire community. When the project began, acting troupes were largely dominated by women. In some traditional cultures, men are reluctant to take direction from women. As a result, the project team observed that men were distancing themselves from the magnet theatre. At performances, men would gather next to a nearby kraal - an enclosure for animals - and watch from a distance. Very few would take part.

In response, the project team began to add more men to magnet theatre troupes. These actors would talk to men in the village before performances, encouraging them to attend. Teams developed scripts that focused on men and PMTCT. Male characters began to play larger roles. Gradually, male involvement started to increase as men in the communities began to see themselves in the actors and their stories. By the end of the project year, male attendance and participation increased from 33 percent to almost 50 percent (figure 2).

What follows are some of the lessons we have learned in organizing and enacting successful magnet theatre interventions.

Recruiting magnet theatre troupes

Candidates from rural villages in which the Khusela project is active are invited to audition for a contract with the project. They receive a monthly stipend of R1000. Recruiters consider people who show acting ability, knowledge of HIV, and, at minimum, an attempt at completing grade 12. After the troupe is recruited, a consultant trains the members in the magnet theatre process and in facilitating discussions. Project staff conducts regular in-service training on PMTCT and HIV&AIDS for the troupes.

Developing scripts

Every month, the Khusela community team develops scripts based on the topics covered by comprehensive PMTCT. Issues that are common or currently playing out within the community form the basis of the script. Scripts may be based on a number of current concerns, for example, myths, beliefs, or attitudes about HIV or infant feeding practices. The scripts are designed to keep the audience interested and participating; they are left open-ended to allow community members to discuss as many solutions as they can.

Scripts are used simultaneously in the three sub-districts supported by the Khusela project. Each script is performed twice in each sub-district, once in a single venue. After performances, staff members review each script, evaluating them for effectiveness and modifying them when necessary.

Mbana Village MT session

Zwelichumile village MT session

Holding the performance

Before each session, the magnet theatre troupes undertake activities to generate a "magnetic effect" - pulling curious people from the community to attend the performances. Singing and dancing are examples of magnetic activities. Once the audience arrives, the troupe

engages them in games to break the ice and prepare for participation. When

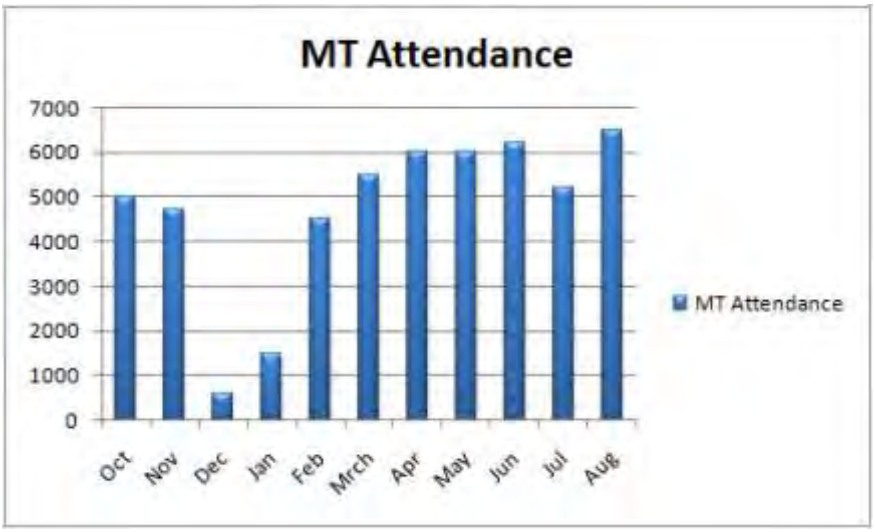


Figure 1 Number of community people reached for period Oct '09 – August '10

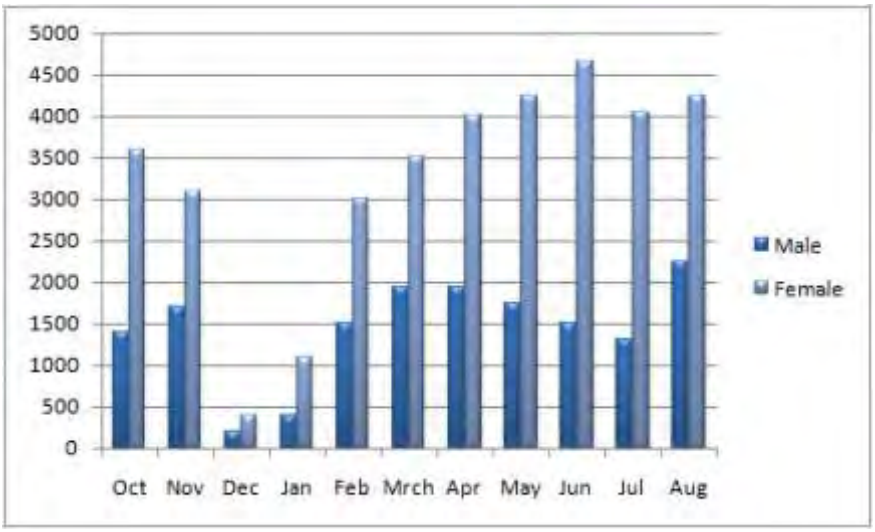


Figure 2 MT attendance by gender segregation for period Oct '09 – August '10

Nobanzi Dana, Project Director, PATH South Africa Country Programme can be contacted at ndana@path.org

Blood - borne diseases in the workplace

Healthcare employees generally do not report occupational injuries and diseases. It is important to know what you should do in the event that you contract one of these. Needlestick, other sharps injuries and HIV are not included in the schedules with the legislation governing compensatable occupational injuries and diseases, but must be reported to the employer.

Have you ever had a needlestick or sharps injury? This could include cutting yourself with an ampoule you opened, a nick with a sharp or broken instrument at work. Probably no healthcare professional will say no to this question. However, fewer of us have reported such an incident and in fact research indicates that more than 50% of staff do not even report needlestick or sharps injuries. As part of preventing such injuries, it is essential that the determinations of the Occupational Health and Safety Act, 85 of 1993 and infection control measures be implemented to protect employees and patients in the workplace.

What does the legislation determine?[1]

Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993) as amended, provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases. Schedule 2 to the Act provides a breakdown of the percentage of permanent disablement that employees can get compensation for and schedule 3 the occupational diseases that qualify for compensation.

The Act applies to all employers; and casual and full-time employees who, as a result of a workplace accident or work-related disease are injured, disabled, killed; or become ill. This excludes -

- employees who are totally or partially disabled for less than 3 days;
- domestic employees working at home. A domestic worker in a boarding house, an apprentice or trainee farm worker or a worker paid by a labour agency are eligible for compensation.
- anyone receiving military training;
- members of the South African National Defence Force, or the South African Police Service;
- any employee guilty of wilful misconduct, unless they are seriously disabled or killed;
- anyone employed outside the RSA for 12 or more continuous months; and
- employees working mainly outside the RSA and only temporarily employed in the RSA.

Occupational injuries

Occupational injuries are injuries sustained by employees in the workplace or while performing any activities related to the business of the employer. Employees must notify their employers of an accident immediately. Employers must submit certain documents to the Compensation Commissioner within 7 days of being notified. Compensation claims for occupational injuries are then calculated according to the degree of disablement of the employee. Disablement caused by the employer's negligence may result in increased compensation.

Employees, or someone on their behalf, must report an accident and any injuries, verbally or in writing, to the employer immediately. If an employee does not report an injury to her/his employer, the Commissioner or mutual association within 12 months of being injured, s/he will lose any right to benefits.

All employers must report any accidents that result in medical expenses and/or an employee's absence from work for longer than 3 days by submitting the required documents to the Compensation Fund within 7 days. Employers who delay in reporting an accident are guilty of a criminal offence, and will have to pay a penalty.

Occupational diseases

An occupational disease is a disease caused by an employee's job. Employees who contract a Schedule 3 disease can claim compensation. An employee, or someone on his behalf, must report a disease, in writing, to the employer as soon as possible after a doctor's diagnosis. If an employee does not report a disease to his employer, the Commissioner or mutual association within 12 months of being diagnosed, s/he will lose any right to benefits. Employers must fill in the required forms and submit them to the Compensation Commissioner within 14 days.

Compensation Commissioner

Once the Commissioner receives the forms, a claim will be registered and the decision to accept liability or not will be made. Central to this decision is proof of causalty. An acknowledgement card or postcard will be sent to the employer informing them of the Commissioner's decision.

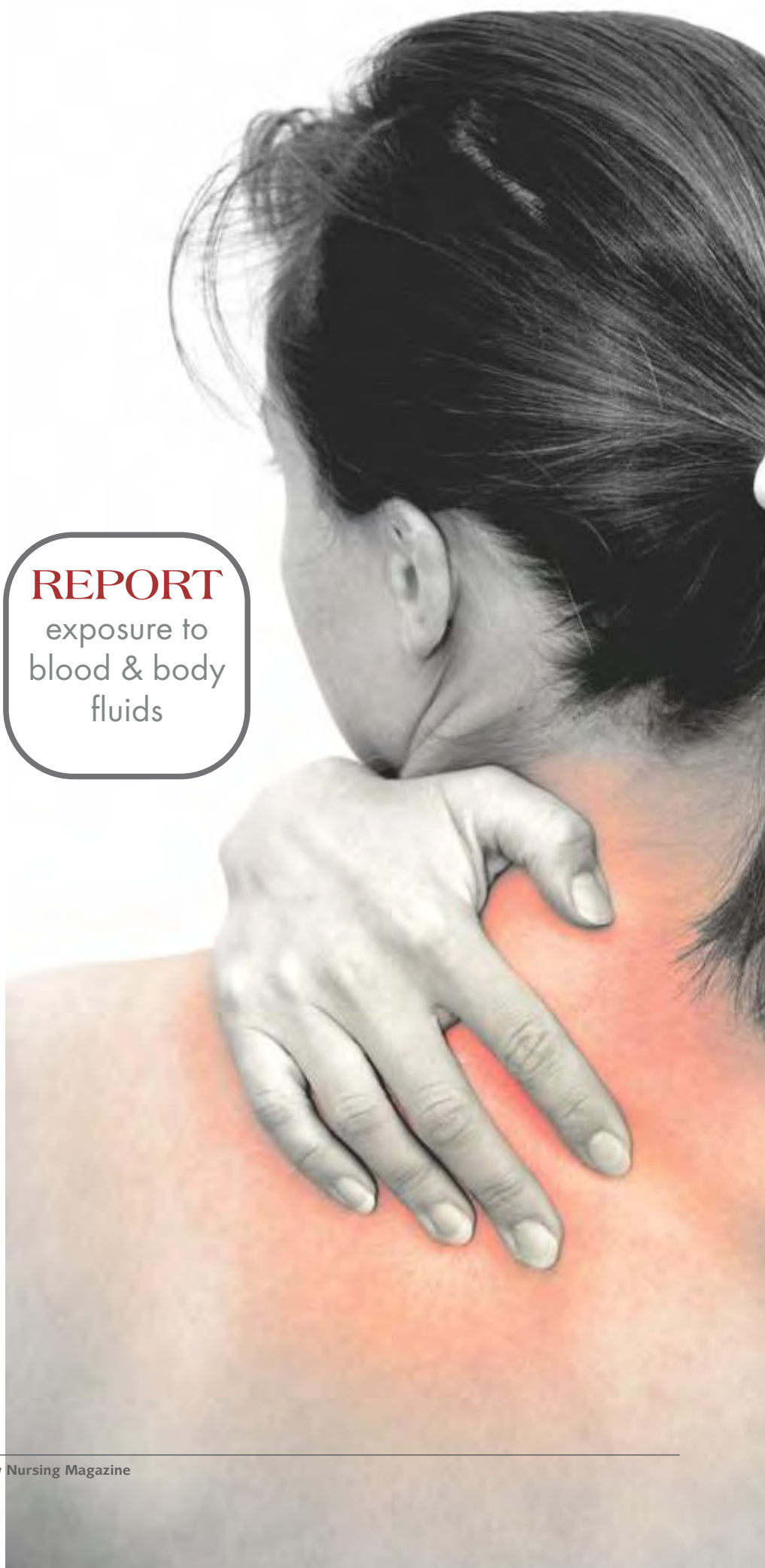
How do you claim?[2]

- Inform your supervisor or employer as soon as possible (verbally or in writing). Make note of anyone who witnessed the accident. The form that needs to be completed is WCL 2: Notice of Accident and Claim for Compensation.
- The employer must then report the accident to the Compensation Commissioner, even if they don't believe the employee's story, by submitting Form WCL 3: Employer's Report of Accident. The employer must report a workplace injury within 7 days or within 14 days of finding out that the employee has an occupational disease. The employee should check that all the details on the form are correct.
- Within 14 days of seeing the employee, the doctor must fill in form WCL4 stating how serious the injury was and how long the employee is likely to be off work. This is sent to the employer who sends it to the Commissioner. The employee does not pay for the doctor's fees. But if the employee wants a second opinion, s/he will have to pay for this.
- If the injury will take a long time to heal, the doctor must send a progress report (WCL 5) to the Commissioner every month until the condition is fully stabilised. This informs the Commissioner of how long the employee is off work.
- Finally the doctor must submit a final doctor's report (WCL5) stating either that the employee is fit to go back to work or that the employee is permanently disabled. The doctor must send this form to the employer who sends it to the Commissioner.
- When the employee goes back to work, the employer must send a resumption report (WCL6) to the Commissioner stating when the employee went back to work and how much the employee was paid in compensation.
- The employee and the employer

should keep copies of all the forms.
- When the first doctor's report has been submitted with the accident report, the Compensation Commissioner will consider the claim and make a decision. A claim number will also be allocated. This number should be used for all paperwork relating to a claim.
- If the employee disagrees with the decision, they can appeal the decision within 90 days by submitting form W929 to the Commissioner.
- All forms that need to be submitted to the Commissioner can be sent to: Compensation Commissioner PO Box 955, Pretoria, 0001
- All forms can be found at http://www.labour.gov.za/find-more-info/all-about-workmens-compensation

Who pays the claim?
The Compensation Commissioner is appointed to administer the Fund and approves employees' claims. Employers pay into the Compensation Fund once a month. Employees do not pay anything to the Fund and employers cannot deduct money from employees' wages as contributions to the Fund. The employee gets money from the Fund and not from the employer. BUT the employer has to pay the injured employee for the first 3 months after the injury was sustained. The Compensation Fund will pay the employer back. If the employee is off for more than 3 months, the Compensation Commissioner takes over the monthly payments.
If the employer has insurance against workplace injuries then the insurance company will pay the compensation. In these cases, claims are still made to and decided by the Compensation Commissioner. Please note that payment of claims can take a very long time to process.

What about HIV and AIDS?
The percentage of healthcare staff that sero-convert following a workplace injury is low. Of the illness amongst health workers 39% of HBV and HCV infections and 4.4% HIV infections are attributable to occupational injury. Risk of susceptible workers without post-exposure prophylaxis for infection after needlestick injury is 23 – 62% for HBV and 0 – 7% for HCV.[3] First aid measures



if the mouth or eyes are involved include washing thoroughly with water. If it is the skin that has been punctured, free bleeding should be gently encouraged and the wound should be washed with soap or chlorhexidine and water, but not scrubbed or sucked. For post-exposure prophylaxis see that article on the guidelines for PEP in this magazine.

Exposure of patients

Globally[4], there are four recorded cases of transmission from a healthcare employee to a patient. In several of these reports, key details and the exact route of transmission are unclear. The most recent was reported from Spain in 2006. In this case a female patient was infected by an obstetrician when he performed an emergency caesarean on her in 2004. The surgeon, a gay man, did not know he had HIV and had never been tested. After it was realised he might have infected his patient, he said he recalled pricking his finger on a needle during the operation. He took an HIV test, which was positive, seven months after the caesarean.

Phylogenetic analysis of the HIV of both doctor and patient revealed that the viruses they had only differed by 3%, whereas three unrelated samples taken for comparison were different by 23%. This is the first case where there appears to be relatively strong evidence for the exact route of transmission. The three previous transmissions of HIV from a healthcare employee to a patient were:

- The 'Florida dentist', David Acer, who in 1990, somehow infected six of his patients.
- A French surgeon who transmitted HIV to an elderly patient during a hip replacement operation in 1992.
- A French nurse who transmitted HIV to a patient during a hospital stay in May 1996, though it's not known exactly how.

Almost all follow-up studies of surgeons known to be HIV-positive have failed to find any cases of HIV infection. Provided infection control precautions are adhered to, the majority of procedures in the healthcare setting pose no risk of HIV transmission from an infected healthcare employee to a patient. Transmission could only take place during 'exposure-prone procedures' in which injury to the healthcare employee could result in the employee's blood contaminating the patient's open tissues. These procedures involve a combination of sharps (scalpels, needles, etc.) and the employee's hands being in a body cavity. As the mouth is included as a body cavity, many dental procedures are defined as 'exposure-prone'. Exposure-prone procedures are defined as those invasive procedures where there is a risk that injury to the employee may result in the exposure of the patient's open tissues to the blood of the employee. (This is described as 'bleed-back'.) These include procedures where the employee's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. fragments of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

Disclosure of HCW status

Szabo and colleagues[5,6] explored the views of practising surgeons in South Africa regarding aspects of HIV and its impact on surgeons. The perceived risk to patients appeared to have been overstated, especially in view of the advent of antiretrovirals that reduce viral load and infectivity. Most surgeons were against informing patients or colleagues of HIV status. Such attitudes appear to be contrary to a patient centred approach whereby such information could be deemed to be in the best interests of the patient. However, patient knowledge of surgeon HIV status could deter the patient from undergoing a procedure by a surgeon who may be uniquely skilled. Therefore it seems that such information should not be shared, and to do so would probably do more harm than good.

References

[1] *Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993) as amended (South Africa)*

[2] *Claiming compensation for occupational injuries and diseases. Information accessible at http://www.capegateway.gov.za/eng/directories/services/7296/21409*

[3] *WHO Best practice for injections and related procedures toolkit, 2010*

[4] *AIDSMap http://www.aidsmap.com/HIV-positive-healthcare-employees/page/1320703/*

[5] *Szabo CP, Dhai A, Veller M, Kleinsmidt A. Surgeons and HIV: South African attitudes. S AfrMed J 2009; 99: 110-113.*

[6] *JP Van Niekerk. Editor's choice. S AfrMed J 2009; 99:71.*

MIDWIVES AIDS ALLIANCE

What is Midwives AIDS Alliance (MAA)?

The Midwives AIDS Alliance (MAA) serves as a platform for midwives to advocate for the full integration of HIV prevention, treatment, and care into maternal, child, and women's health. Their goal is to effectively respond to the health needs of the mother, her child, and her family. The MAA was formed to add the voice of midwives to the HIV debate and advocacy work in South Africa.

Organized by PATH and their partners, the MAA was officially launched at the 8th Annual Congress of Midwives of South Africa in Limpopo, South Africa in December 2008. The alliance has a nationwide presence, with members in all nine provinces. To date, the MAA has branches in six provinces. The alliance works closely with the National Department of Health's Maternal, Child, and Women's Health department, Society of Midwives of South Africa, and other health-related organizations.

Background

Most pregnant women in South Africa see a health care provider, mainly midwives, at least once during their pregnancies. More than seven out of ten see a provider five times before they give birth. Nonetheless, the maternal death rate in the country is high and rising, due largely to HIV and AIDS. At least one in three pregnant women in the country is HIV positive. Between 2005 and 2007, the rate of maternal deaths in South Africa increased by 20 percent. The main cause of death was AIDS. Midwives are a vital link to those at risk of HIV infection because they provide many health care services to women, children, and their families.

What does the MAA do?

The MAA mobilizes midwives to be catalysts for action. The alliance motivates and empowers midwives to take the lead and expand their role in HIV prevention, treatment, and care for mothers and children and to improve maternal and child health care service.

How is this done?

The MAA organizes workshops, discussion groups, and working forums with specific midwife groups, such as maternity managers, midwifery educators and practicing midwives. The alliance uses reports, Facebook, text messages, and emails to get the message out. The MAA's advocacy work involves engaging in HIV and maternal health-related debates and getting midwives involved in policy formulation and implementation. In addition, the MAA identifies and recognizes midwives who have shown innovation, leadership, and commitment in HIV prevention, treatment, and care during their practice.

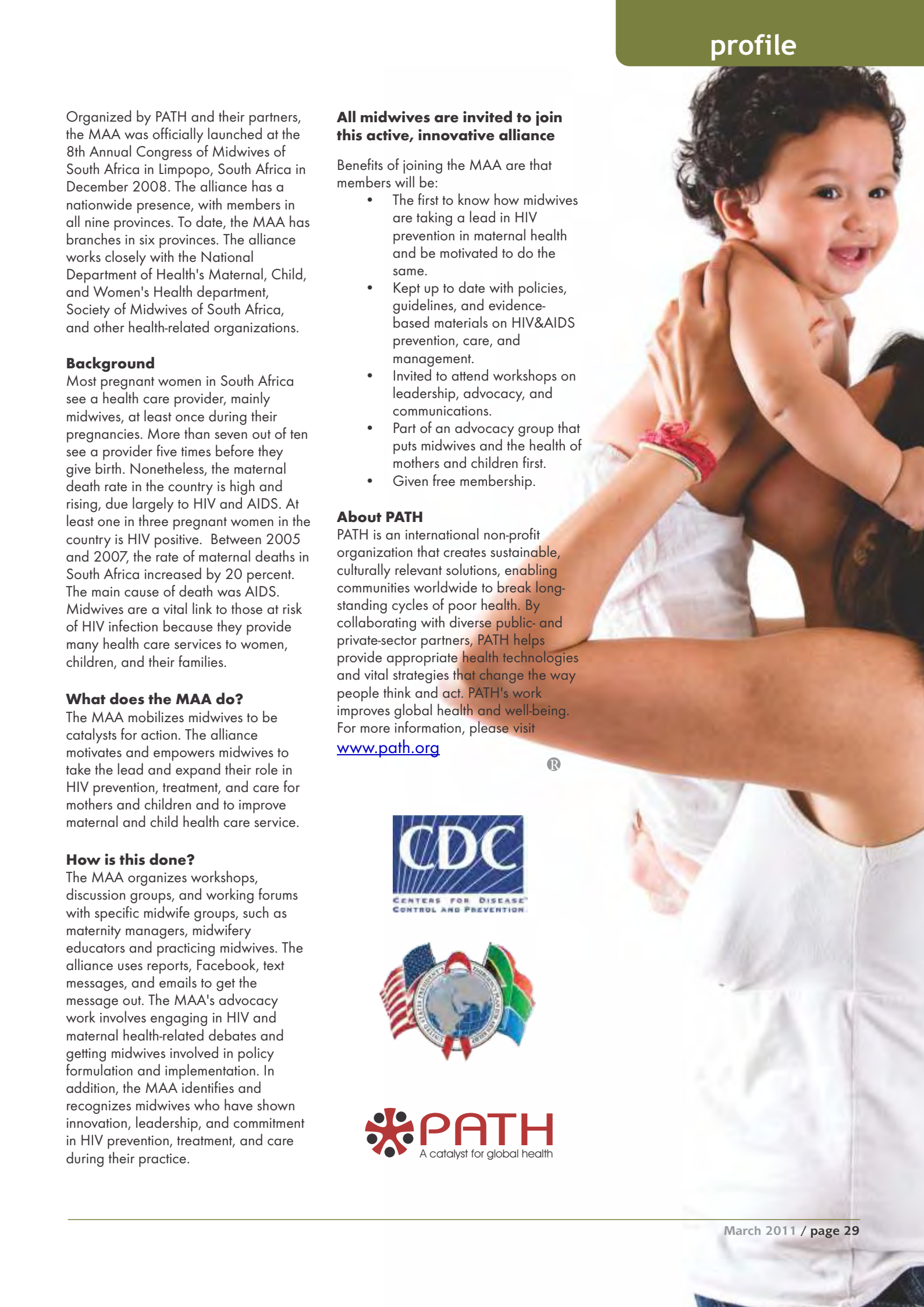
All midwives are invited to join this active, innovative alliance

Benefits of joining the MAA are that members will be:

- The first to know how midwives are taking a lead in HIV prevention in maternal health and be motivated to do the same.
- Kept up to date with policies, guidelines, and evidence-based materials on HIV&AIDS prevention, care, and management.
- Invited to attend workshops on leadership, advocacy, and communications.
- Part of an advocacy group that puts midwives and the health of mothers and children first.
- Given free membership.

About PATH

PATH is an international non-profit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break long-standing cycles of poor health. By collaborating with diverse public- and private-sector partners, PATH helps provide appropriate health technologies and vital strategies that change the way people think and act. PATH's work improves global health and well-being. For more information, please visit www.path.org



CDC
Centers for Disease Control and Prevention

PATH
A catalyst for global health

Post Exposure Prophylaxis for health workers

All health workers fear exposure to blood - borne diseases in the workplace. The SA HIV Clinicians Society developed PEP guidelines for Southern Africa which apply to all types of exposure to blood - borne diseases. This article is an extract of the guidelines specifically focusing on workplace or occupational exposure. The complete set of guidelines is available at www.sahivsoc.org

Reported occupational exposure to HIV in the USA alone exceeds half a million health care workers (HCWs) per year, with estimates that over 50% of these exposures are unreported. Data from the southern African region are poor. The largest study from three West African countries documented that 45% of HCWs had sustained at least one accidental blood exposure, over 60% of which went unreported[1].

In 2001, 69% of interns at Chris Hani Baragwanath Hospital in Gauteng, South Africa, had sustained at least one percutaneous injury and 45% had sustained a mucocutaneous blood risk exposure[2]. Again in this cohort over 60% of exposures were not officially reported. At Tygerberg Hospital, 91% of junior doctors reported needlestick exposures in the prior year, three quarters of these 'after hours' or during calls[3]. Despite regulatory frameworks in some countries, management oversight of occupational accidental blood exposure is largely lacking in Southern African institutions, especially in the handling of sharps disposal and training in safe exposure practices.

Core principles for PEP

Occupational exposure prevention requires strong management oversight in all settings.

- Non-occupational exposure requires an understanding of core transmission principles, combined with clinical common sense.
- In the southern African setting, all unknown source exposure should be assumed to be HIV infected.
  - › Evidence regarding occupational and non-occupational risks of transmission is limited.
  - › Triple antiretroviral (ARV) regimens in treatment and PMTCT settings have been proven superior to mono or dual therapy regimens.
  - › It is recognised, however, that additional ARVs increase the potential side-effect and adherence burden. Risk of adverse effects and toxicities must be weighed against benefit in administering ARVs in the PEP setting. Side-effects must be treated rapidly, effectively and prophylactically.
- PEP should be administered as soon as possible after exposure; efficacy after 72 hours is highly unlikely.
- All PEP regimens must be administered for 28 days. Animal and case control studies suggest that administration for less than 2 weeks is associated with minimal efficacy; administration for more than 28 days confers no added benefit.
- Regimens need to be selected using locally available ARVs.
- A comprehensive infrastructure of counselling and support for the injured party is necessary to facilitate adherence to PEP regimens. Exposure is associated with substantial anxiety for the majority of people. This must be actively dealt with. In many cases, this is most significant for those who do not need PEP.
- Counselling must be available to deal with side-effects on an ongoing basis. Zidovudine (AZT) and protease inhibitors (PIs) are commonly associated with side effects.

Prevention of exposure in the workplace

Awareness of the risks and activities related to transmission of HIV as well as availability of PEP and support is critical, especially in an occupational setting. Healthcare workers in traditional exposure environments often receive training regarding this hazard. Other potential areas where PEP should be available include, but are not restricted to, home-based carers, day centres and crèches, schools and prisons, where PEP exposure and treatment training are often poorly available. Exposure to HIV occurs in a bewildering variety of situations. Exposures often take place where the source HIV and hepatitis status is unknown.

Examples of types of exposure to blood borne diseases:

- Human bites or exposure to bloody phlegm during bar fights
- Exposure at schools, including biting in crèche
- Contact sports with blood exposure, such as rugby and boxing
- Sharing needles during recreational drug use
- Assaults with several people being stabbed with the same knife
- Bullets travelling through one person and lodging in another
- Animal attacks with repeated blood exposures on several people at once
- Roadside and emergency services exposure - often not just by ambulance staff; police, bystanders who help
- Exposure during home deliveries or during home based care
- Consensual sexual exposure, burst condoms, mucosal exposure during non-penetrative sex
- Families, home-based carers
- Catering, preparation and serving of food with blood contamination
- Sitting on a needle in a movie theatre
- 'Venoterrorism' - public attacks with needles
- Unconscious drug addict found in a room
- Sex toy exposure.

Prevention of exposure to HIV and other blood-borne viruses in the workplace is the responsibility of both employer and employee. It is a legal requirement in many southern African countries for employers to provide a safe working environment and to ensure that employees are adhering to workplace guidelines for infection control.

South Africa has an extensive legal framework and comprehensive codes and guidelines dealing with this issue. Employers have specific and numerous responsibilities with regard to workplace safety and support of staff. The meticulous recording and reporting of incidents is critical and this responsibility usually rests with a medical practitioner. An example of legislation that covers exposure to blood-borne viruses is 'an employer is obliged to provide, as far as is reasonably practicable, a safe working environment'.

A broad range of professionals practising within healthcare services are at occupational risk of blood-borne viral exposure, the most prevalent being hepatitis B and C and HIV.

Healthcare workers at risk of occupational exposure to blood-borne viruses

- **Doctors**
- **Dentists**
- **Nurses**
- **Traditional healers**
- **Phlebotomists**
- **Laboratory workers**
- **Physiotherapists**
- **Occupational therapists**
- **Paramedics**

Occupational exposure involves potentially hazardous exposure to blood-borne viruses in the workplace.

- All occupational exposure should be regarded as preventable and hence deserving of investigation until proven otherwise.
- Standard precautions should be practised in every setting where blood or infectious body fluid contact is possible. Gloves should be worn, and where appropriate, protective eyewear.
- Clean water or saline should be available to immediately irrigate any mucosal exposure or percutaneous injury. Non-caustic soap should be used unless the exposure involves the eye.
- Needles should NOT be re-sheathed, and manipulation of the needle following withdrawal from the patient must be kept to the absolute minimum.
- Wherever possible, safety equipment for blood taking should be available, particularly in the hospital and clinic setting where the risk of exposure to HIV infected blood is highest. It is imperative that the cost of cheaper equipment and disposal must be weighed against the potential increased risk of exposure that using such equipment entails.
- Needles and tools for any surgical practice, including traditional circumcision, should never be re-used without rigorous chemical disinfection/sterilisation according to national or local guidelines.
- All needles and sharp objects should be disposed of into a dedicated biohazard sharps bin. Syringes and other blunt instruments should NOT be disposed of in these bins, but rather in regulation biohazard bins for disposal of blunt biohazard objects.
- The number of sharps bins allocated to each workplace area will depend on the setting and the resources available. It is recommended that in hospital settings, designated areas of high throughput of patients who require a large number of invasive procedures, such as intensive care and casualty departments, should have a ratio of sharps bins to beds of either 1:1 or 1:2. Isolation rooms should have their own sharps bin, as should any clinic area in which blood-taking or invasive procedures are undertaken. The ratio of sharps bins to beds in open wards should ideally be 1:2, but be kept to a minimum of 1 bin per bay.
- Once ¾ full, the sharps bin should be sealed and disposed of to prevent obstruction of its orifice; overfull bins are a risk factor for injury during subsequent sharps disposal. In resource-poor settings where sharps bins are unavailable, the safest and most practical method of sharps disposal should be practised as per local or national guidelines.
- Within the hospital or clinic environment, it is the ultimate responsibility of that institution's infection control team to monitor and ensure that sharps bins are being sealed when ¾ full and disposed of correctly. However, on a day-to-day basis this responsibility falls to the nursing sister in charge of the ward or clinic. Outside of the health care setting, employers must take responsibility for such monitoring and enforce standard practice as laid out above.
- Best practice should be enforced with the aid of unions within the framework of occupational law to ensure that employers and employees are creating a safe working environment with respect to prevention of blood-borne disease acquisition.

Selecting persons for ARV intervention

1. Potentially infectious material

The following should be regarded as infectious material:

Blood (and ANY bloodstained fluid, tissue or material)

Sexual fluids

- Vaginal secretions
- Penile pre-ejaculate and semen

Tissue fluids

- Any fluid drained from a body cavity, including ascites, embryonic liquor, cerebrospinal fluid, pleural fluid, pericardial fluid and wound secretions
- Breastmilk

Such exposure requires antiretroviral PEP intervention as described in these guidelines.

In the absence of super-contamination with the above fluids, the following may be considered non-infectious:

- Sweat
- Tears
- Saliva and sputum
- Urine
- Stool.

Exposure to non-infectious material requires reassurance but no PEP. A special circumstance involves human bites and punching. Where a bite or a punch has resulted in the opening of the skin, PEP should be advocated.

2. Selecting ARV regimens for PEP

2.1 PEP ARV regimens

The choice of NRTI combinations is based on available evidence in both PEP and treatment settings (including PMTCT), side-effect profiles, ease of use, local guidelines and availability.

Twice a day:

- Stavudine (d4T) + lamivudine (3TC)
- AZT† + 3TC

Once a day:

- Tenofovir (TDF) + emtricitabine (FTC)

2.2. Third agents for PEP regimens

Twice a day:

- Lopinavir/ritonavir

- Saquinavir/ritonavir (400/100 bd).

Once a day:
- Efavirenz
- Atazanavir/ritonavir
- Lopinavir/ritonavir (800/200).

NOT recommended:
- Nevirapine – owing to high risk of hepatotoxicity.
- Indinavir – this PI is associated with significant side effects.
- Abacavir – risk of hypersensitivity reaction.

All PEP ARV regimens must be administered for a full 28 days.

2.3 Justification for three over two drugs, and for alternatives to AZT

This guideline is a significant departure from previous PEP recommendations, particularly in as much as where PEP is offered, 3 drugs should be administered. This recommendation is predicated on the following:

1. Current North American [Centers for Disease Control (CDC)] and UK guidelines are based on risk assessments in low-prevalence settings, with presumed exclusive clade B data. In contrast, the Southern African situation is one of extremely high HIV prevalence (clade C), high volumes of patients, and an attendant very high number of exposures. The individual and cumulative risk of HIV transmission in this setting has never been quantified. There are limited data suggesting that clade C is more infectious in the sexual exposure setting. We assume that this risk is significantly higher than in other settings, and the person who has been exposed should therefore be treated appropriately.

2. While previous guidelines advocate two or three drugs based on clinician assessment of risk, this guideline recommends three drugs in all situations. There is no evidence backing the use of two drugs over the single agent AZT. We further note that the PMTCT trials suggest no added advantage of adding lamivudine to AZT, a finding replicated in various cohort PMTCT studies. However, the use of triple therapy HAART regimens has been shown to have significant benefit in comparison with dual therapy in treatment and PMTCT settings. While no evidence exists to support the use of such combinations in humans in PEP scenarios, all current PEP guidelines advocate triple therapy regimens in 'high-risk scenarios'. The argument is therefore not one of two or three drugs, but of what constitutes 'high-risk scenarios'.

3. Of particular contention are mucocutaneous exposures and oral sex scenarios, which are attributed with lesser risk. The current CDC guideline is based on a single known transmission out of almost 10 000 reported incidents. Once again, no evidence of risk is available in our setting, but evidence of significantly increased exposures in comparison to the US setting (blood spatters on eyeglasses, masks in low-, medium and high-risk procedures) is available. Furthermore, blood risk exposures are chronically under-reported, a factor that is likely to be particularly true of injuries that are deemed to carry a lesser risk. Hence the incidence may be greater than we think. For these reasons, coupled with the known high background HIV prevalence, we advocate three-drug PEP in these scenarios.

4. Finally, the risk of side-effects increases when additional agents are added to PEP regimens. Three-drug regimens carry more risk of side-effects than simpler drug regimens, although arguably zidovudine-containing regimens carry such a significant side-effect profile that this agent should be avoided if possible. As there is no evidence that prevention of HIV transmission by AZT in the setting of PEP is due to anything other than its inhibition of viral replication, the use of d4T or tenofovir, the potency of action of which is equivalent to AZT, yet which is far better tolerated over 28 days of therapy, should be recommended as first line whenever possible. While the risk of adverse events is undeniably real, it must be balanced against the unquantifiable but equally real risk of transmission associated with high HIV prevalence, high individual viral load levels, and high levels of exposures in the occupational and non-occupational settings.

5. The guideline's powerful emphasis on appropriate choice of agents to minimise side-effects, on close management of the

recommended that formal laboratory testing be done in all cases. Confirmatory testing of a positive result should be undertaken as per standard guidelines.

Follow-up testing for HIV seroconversion should be undertaken at 6 weeks and 3 and 6 months. We do not advocate routine testing of an exposed worker at 12 months as seroconversion after 6 months is very rare. However, exposed individuals should be properly counselled in this respect and testing provided if the individual requests it. Viral load or p24 antigen testing is not recommended in the setting of PEP. Quantitative viral loads may yield false-positive results, and may cause substantial anxiety. Seroconversion on PEP is extremely rare and any exposed individual thought to be experiencing a seroconversion illness on PEP should be discussed with an HIV specialist physician for advice.

2. *Hepatitis B virus (HBV) testing*

If the exposed worker has had natural HBV infection or has been vaccinated and is a known responder, then no investigation or post-exposure therapeutic intervention for HBV is required.

If the source individual tests HBsAg negative and the exposed individual is not vaccinated or does not know their vaccination/antibody status, they should be referred to a local facility for testing and vaccination.

	Source		Exposed			
	Baseline	**Baseline**	**2 weeks**	**6 weeks**	**3 months**	**6 months**
HIV	✓	✓		✓	✓	✓
HBV	✓	✓				✓
HCV		✓				✓
Hb, WBC PMN		If AZT part of PEP	If AZT part of PEP			

Table 1: Timing of bloods Pre & Post PEP

In the case of exposure to an HBsAg-positive source, the options for management of unvaccinated individuals or those whose status is unknown are as detailed in Table 3.

3. *HCV testing*

In resource-limited settings, HCV testing should be undertaken at baseline and 6 months only. There is no known prophylaxis.

4. *Other blood-borne pathogens*

Syphilis.
Routine testing of source should NOT be performed.

Malaria.
Routine testing of a health care worker who has been exposed to a source is NOT recommended unless the source is symptomatic.

Monitoring for adverse drug reactions

1. *Co-morbidities*

Patients with significant co-morbidities should have regular monitoring of any relevant investigations during therapy. No additional investigations are warranted in otherwise healthy individuals.

2. *Medical co-morbidities and ARV selection for PEP (Table 4)*

Although many of the co-morbid conditions listed in Table 4 do not preclude the use of certain ARVs, increased monitoring of the co-morbid condition may be necessary during the 28-day course of PEP. Moreover, whenever a safer regimen is

	Status of the Source		
	HIV Positive	**Unknown**	**HIV Negative**
Percutaneous exposure to blood or potentially infections fluids	**Triple therapy**	**Triple therapy**	**No PEP**
Mucocutaneous splash or contract with an open wound, with blood or potentially infectious fluids	**Triple therapy**	**Triple therapy**	**No PEP**
Percutaneous exposure, mucocutaneous splash or contact with an open wound, with non-infectious bodily fluids	**No PEP**	**No PEP**	**No PEP**

Table 2: Selecting patients for PEP interventions

available with equal efficacy, that regimen should be used in preference.

Key issues re counselling

1. Anxiety management

Anxiety should not simply be dismissed as baseless with simple reassurance. HIV remains a 'dread disease', despite the success of ART, because it is sexually transmitted, still accounts for significant mortality and morbidity, and has extensive stigma associated with it. Anxiety management must be part of the adherence or follow-up support, and may need several interventions.

Simple telephonic contact and reassurance is almost always adequate. The intervention must be individualised, but broadly the following approaches should be integrated:
Contextualise the risk: emphasise that acquisition of HIV is unusual through a single exposure, unless the injury is severe (sexual assault, blood transfusion of an infected unit, severe penetrating injury with infected tissue).

2. Risk-taking interventions

PEP is an ideal time to deal with risk-taking environments, whether unsafe sex (e.g. a one-night stand with unprotected sex), poor occupational health (e.g. overfull sharps bins) or other (e.g. injecting drug use). Counselling should be non-judgemental. Addressing occupational risk must be practical (report over-full bins to infection control; do not tell an exhausted nurse to 'be more careful'). Harm to others (e.g. risk to a spouse after sex with a third party) must be solution focused.

A copy of the full document is available in The Southern African Journal of HIV Medicine Winter 2008 Edition pages 36 – 45 and can be accessed at http://sahivsoc.org/index.php?option=com_docman&Itemid=67

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1. Tarantolaa A, Koumare´b A, Rachlinea A, et al., the Groupe d'Etude

Table 3: Management of worker exposed to an HBsAG-Positive or unknown source*

Vaccinated status of exposed worker	Anti-HBs	HBIG (0,06ml/Kg)	HBV vaccine	Comment
Previous vaccination and known responder	None	None	None	
Not vaccinated	If anti-HBs >10 mUI/ml, no treatment	If anti-HBs <10 mUI/ml, give stat HBIG and repeat at 1 month	1st dose stat and proceed to accelerated schedule 1-2-12 months	HBIG and HBV vaccine can be administered concomitantly at different sites
Incomplete vaccination or unsure	As above	Single dose stat	Complete depending on documentation or restart 0-1-2-12 months	As above
Vaccinated, but unknown response	As above	As above	Single booster stat	As above
Non-responder to primary vaccination	No	1 dose stat repeated after 1 month	1st dose stat and proceed to accelerated schedule 1-2-12 months	As above
Previously vaccinated with 4 doses or 2 completed vaccine series but non-responder		As above	Consider alternative vaccine	

*Adapted from European recommendations for the management of health care workers occupationally exposed to HBV and HCV (Euro Surveill 2005; 10(10): 260-264).

Table 4: Co-morbidities affecting choice of antiretorvirals for PEP

Co-morbidities	Drug	Complication
Pregnancy	Efavirenz	Avoid in the 1st trimester due to teratogenicity
	Indinavir	Hyperbilirubinaemia and nephrolithiasis
Tuberculosis	Kaletra	Additional ritonavir dose of 300 mg bid needed or increase Kaletra dose to 6 tablets bid
Epilepsy	PIs	Increase levels of a number of commonly used anticonvulsants
	Efavirenz	Increased risk of seizure
Psychosis	Efavirenz	Increased risk of psychiatric symptoms
Insomnia	PIs	St John's Wort reduces all PI levels
Migraine	PIs	All PIs increase risk of ergotism with ergotamine co-administration
Renal failure	NRTI	Dose adjustments for AZT and D4T. Avoid tenofovir if creatinine clearance <60 ml/min
Hypertension	PIs	All PIs increase levels of calcium channel blockers. RTV increases beta blocker levels
Diabetes mellitus	PIs	May precipitate hyperglycaemia. Increase monitoring
Asthma	PIs	Decrease levels of theophylline
DVT/PE	PIs	Increase warfarin levels leading to risk of bleeding

PEP must be initiated within 72 hours and should consist of triple therapy

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to advertise in HIV Nursing

Wellness in the workplace

At global and national level strategies aimed at retaining staff to strengthen health systems have started to emerge. This article provides a glimpse of policy documents that provide guidance on wellness for healthcare workers – an important factor for staff retention.

Occupational health and safety, particularly in the health sector, has received limited or no attention over the last 20 years even though health services are labour intensive services with human resources being their most important asset. This is one of the main reasons for the loss of experienced staff from the health services.

Employee Health and Wellness Strategic Framework for the Public Service, 2008[1]

The Department of Public Service and Administration (DPSA) has, in consultation with stakeholders, developed a strategic framework with an integrated approach to employee health and wellness. The Framework was launched for implementation in the Public Service with effect from 1 April 2009[2]. The Framework is based on the legal framework of the country and underpinned by a variety of international instruments that influence employee health and wellness. It recognises the importance of linking individual health, safety and wellness, organisational wellness, environmental sustainability, quality management to productivity and improved service delivery outcomes. This will be effectively achieved through critical, common strategic interventions in priority areas, or the four *functional pillars,* namely HIV&AIDS and TB management; health and productivity management; safety, health, environment, risk and quality management (SHERQ); and wellness management.

The implementation of the Framework will be driven by the four *process pillars* which are cross cutting issues, namely initiatives for capacity development; organisational support; governance and economic growth and development. A set of core principles has been developed for implementation of the Strategic Framework.

Operationalising the pillars

A framework has been developed for the implementation of each of the four *functional pillars*. As an example the *HIV&AIDS and TB pillar* is shown in Figure 1[1]. The implementation framework is clearly aligned with the National Strategic Plan on HIV&AIDS 2007 – 2011 and other strategic framework policies of government. Each of the sub-objectives seen in this framework will have critical success factors and proposed activities that will be included in the generic implementation plan found in the document. A detailed implementation structure is provided as well the components required for an effective employee health and wellness system.

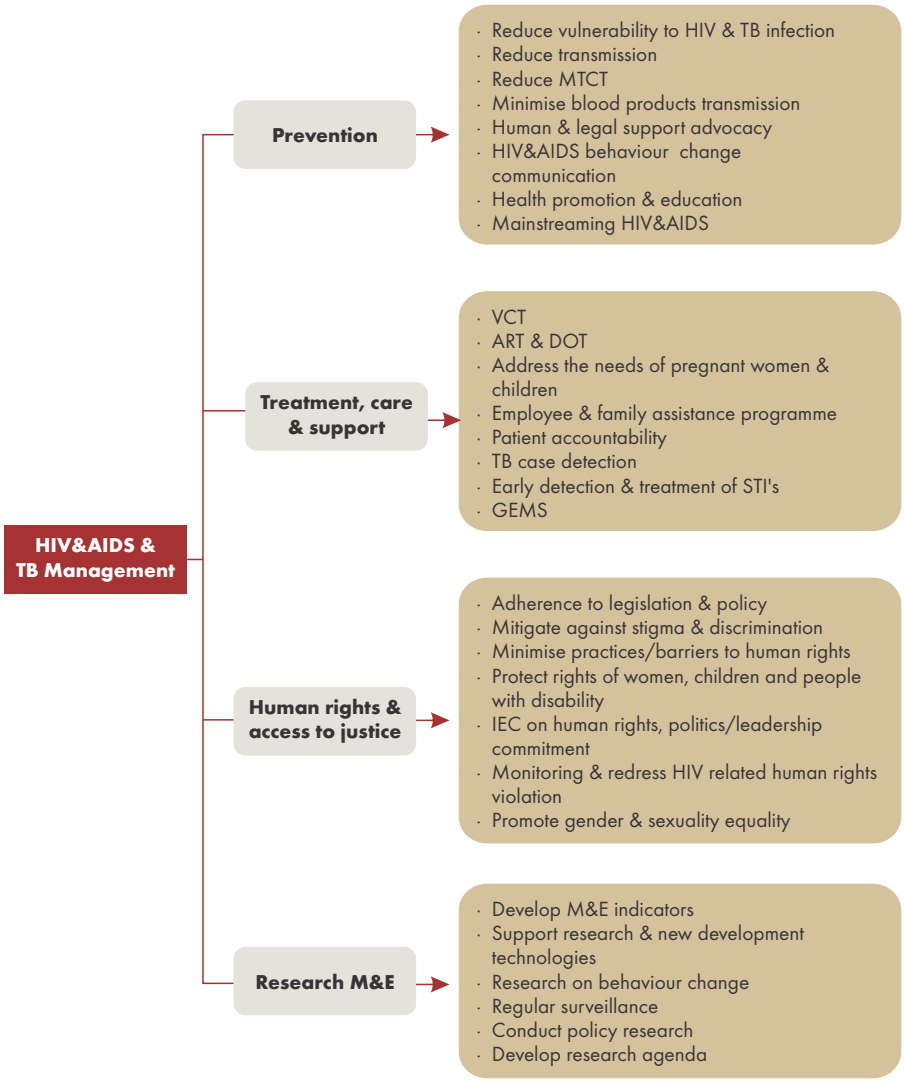


Figure 1: Framework for operationalizing PILLAR 1: HIV&AIDS & TB management

HIV&AIDS and TB Management Policy[3]

This policy was approved with effect from 1 April 2010[2]. It aims to provide a framework that supports effective operationalization of three national strategies, namely the Employee Health and Wellness Strategic Framework

2008, the HIV&AIDS and STI Strategic Plan 2007-2011 and the National Tuberculosis Strategic Plan for South Africa, 2007-2011 in the Public Service. It recognises HIV&AIDS and TB as a workplace issue where employees are a target audience for advocacy work to reduce stigma and discrimination and to promote protection of the health and rights of health workers.

M&E Plan for HIV&AIDS Response[4]

In July 2010 a monitoring and evaluation (M&E) plan for the HIV&AIDS response in the government sector was drawn up. The Government Sector M&E plan is based on the national M&E framework for NSP 2007-2011. The purpose of this M&E plan is to establish an effective and coordinated Government Multi-Sectoral M&E response for HIV & AIDS. The plan sets out the goals and indicators that will be monitored and provides guidance on the implementation of this plan.

WHO-ILO-UNAIDS policy guidelines[5]

The shortage of healthcare workers coincides with the increasing dual HIV and TB epidemic and while they are the frontline workers in the response to HIV and TB, they themselves do not have access to HIV and TB services. For this reason the WHO, ILO and UNAIDS have developed joint policy guidelines in 2010 on improving health workers' access to HIV and TB prevention, treatment, care and support services. These guidelines are based on a systematic review of the literature in the field, an assessment of current practices in 21 countries, and on the results of consultations with international experts and tripartite constituents (report June 2010 Magazine). They also complement and synthesize other ILO, UNAIDS and WHO guidelines related to HIV&AIDS, TB, health system strengthening, reproductive and occupational health. These guidelines will be used to adapt the DPSA employee wellness policy.

The Guidelines consist of 14 points that can be implemented as one package and a Guidance Note has been developed to facilitate the implementation thereof. The guidelines are divided into three categories for ease of reference as indicated in Table1.

Table 1WHO-ILO-UNAIDS Policy Guidelines: Improving HCW access to prevention, treatment, care and support[5]

	Category	Guidelines
A	**National Policies**	1. Introduce new national polices or refine existing ones that **ensure priority access** for health workers and their families to services for the prevention, treatment, care and support for HIV and TB. 2. Introduce new policies or reinforce existing ones that **prevent discrimination** against health workers with HIV or TB, and adopt interventions aimed at **stigma reduction** among colleagues and supervisors. 3. Establish schemes for **reasonable accommodation and compensation**, including as appropriate, paid leave early retirement benefits and death benefits in the event of occupationally-acquired disease.
B	**Workplace Actions**	1. Develop, strengthen existing **occupational health services for the entire health workforce** so that access to HIV and TB prevention, treatment, care and support can be attained. 2. Develop or **strengthen** existing **infection control** programmes, especially with respect to TB and HIV infection control, and collaborate with workplace health and safety programmes to ensure a safer work environment. 3. Develop, implement and extend programmes for **regular, free voluntary and confidential HIV counselling and testing and TB screening**, including addressing reproductive health issues, as well as intensified TB case finding in the families of health workers with TB. 4. Identify, adapt and implement **good practices** in occupational health and the management of HIV and TB **in the workplace** in both public and private healthcare sectors, as well as other sectors. 5. Provide information on benefits and risks of **post-exposure prophylaxis (PEP)** to all staff and provide free and timely PEP for all exposed health workers, ensuring appropriate training of PEP providers. 6. Provide **free HIV and TB treatment** for health workers in need, facilitating the delivery or these services in a non-stigmatizing, gender sensitive, confidential and convenient setting when there is no staff clinic and/or their own facility does not offer ART, or where health workers prefer services off-site. 7. In the context of preventing co-morbidity**, provide universal availability of a comprehensive package on prevention and care for all HIV-positive health workers,** including isoniazid preventative therapy and co-trimoxazole prophylaxis, with appropriate information on benefits and risks. 8. Develop and implement **training programmes for all health workers that include** pre-service, in-service and continuing education on TB and HIV **prevention, treatment, care and support**; workers' rights and stigma reduction, integrating these into existing programmes including managers and worker representatives.
C	**Budget, monitoring and evaluation**	1. Establish and provide **adequate financial resources** for prevention, treatment, care and support programmes to prevent both occupational or non-occupational transmission of HIV and TB among health workers. **2. Disseminate** the policies related to these guidelines in the form of codes of practices and other accessible formats for application at the level of health facilities and ensure provision of budgets for the training and material inputs to make them operational. 3. Develop and implement mechanisms for **monitoring** the availability of the guidelines at the national level, as well as the dissemination of these policies and their application in the healthcare setting.

References:
1.Employee Health and Wellness Strategic Framework for the Public Service. Final Draft: November 2008. Department of Public Service and Administration. Complete document accessible at http://unpan1.un.org/intradoc/groups/public/documents/cpsi/unpan034886.pdf
2.E-mail message 31 January 2011 from Dr Sipho Senabe, Chief Director Employee Health and Wellness, DPSA
3. HIV&AIDS and TB Management Policy for the Public Service. Annexure A.
4. FINAL Draft-Government Sector M&E Plan for HIV&AIDS response, JULY 2010.
5. The joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services. A guidance note. November 2010. Complete document accessible at http://ilo.org/aids/Publications/lang–en/docName–WCMS_149714/index.htm

Workplace HIV&AIDS activisim

The Public Sector Unions Fighting AIDS in Southern Africa (PSUFASA) Project is a unique project aimed at strengthening trade unions to tackle HIV&AIDS in the workplace. The project was initiated by UNISON in partnership with Public Services International (PSI) and currently funded by DfID.

The HIV&AIDS pandemic in Southern Africa has severely affected the population of this region. Trade unions in southern Africa have developed a limited response to this issue despite the fact that a lot of their members are being affected by the pandemic. This is in part due to lack of capacity, skills and resources to address the issue but also due to their lack of experience in integrating it into their core trade union work.

Potential role of trade unions

Trade unions have the potential to be an important part of an effective response to HIV&AIDS in southern Africa. Public sector trade unions are uniquely placed to tackle HIV&AIDS among the working population and their families. The public sector unions organise members of the working population who are sexually active but who may also be more open to information on prevention and treatment. Employees known or suspected to be infected with HIV&AIDS frequently suffer discrimination and stigmatisation at work, including loss of promotion opportunities and often dismissal. This frequently results in employees being reluctant to be tested for HIV&AIDS. A key element of the project is to protect the rights of employees against such discrimination, and to enhance their rights to supportive measures. These rights would be pursued through campaigns directed at governments to guarantee those rights through legislation, and through collective bargaining which would guarantee these rights from employers.

Trade unions have direct access to the work force and are uniquely placed to disseminate information and educate people about HIV&AIDS at the workplace. Organising education and training is a core trade union activity. Public sector trade unions in the region recognise they have a critical role to play in responding to the impact of HIV&AIDS on the daily lives of workers and their families.

Project goal and main objectives

The goal of the project is to strengthen the public sector trade union response to HIV&AIDS in the workplace in Southern Africa.
The main objectives are:

- Trade union development of HIV&AIDS policies and programmes /projects, and an increase in the number of collective bargaining agreements which include HIV&AIDS provisions.
- Establish a resource centre to service the education, training and information needs of public sector trade unions in southern Africa
- Organising regional seminars on skills sharing and good practices.
- Organising national in-country seminars.
- Provide one-to-one support to trade unions.
- Increase unions' participation with civil society organisations/NGOs in campaigns/fora addressing the socio-economic implications of HIV&AIDS in the region.

Participating countries

The union members of the 32 public sector trade unions in 11 Southern Africa countries will be the direct beneficiaries of the project. The breakdown is as follows: Angola (5 unions); Botswana (3 unions); Malawi (3 unions); Mauritius (3 unions); Mozambique (1 unions); Namibia (1 union); South Africa (9 unions); Swaziland (2 unions); Zambia (5 unions); Zimbabwe (6 unions). According to PSI, the combined membership of these unions is 753,000. It is quite difficult to provide an exact number of direct beneficiaries to the project but the aim is to directly reach at least 1% of these members through information dissemination, campaign work, education and members' participation in any of the HIV&AIDS projects and activities of their unions

Project activities

A variety of project activities have been implemented to achieve the objectives of the project.

A Resource and Information centre with project staff has been established in the Southern African sub-regional office of PSI. The staff members

of the resource centre provide one-to-one support, advice and information about how to develop and implement HIV&AIDS policies and activities to the public sector unions in the 11 countries covered by this project. The resource centre developed an information bank of materials produced and used by unions, and other relevant organisations. A quarterly newsletter is produced and circulated to every union. Regular mailings also keep unions in the region informed of HIV&AIDS issues and events in the region. A series of "How to do" guides was published on core trade union HIV&AIDS issues. The main purpose is to improve support and assistance provided to selected public sector unions that can best meet the needs of those infected or affected by HIV&AIDS among members. These activities facilitate networking and campaigning between unions nationally and across the region, and between other organisations working on HIV&AIDS prevention, treatment and advocacy.

A National seminar is organised in each one of the participating countries. These three-day workshops aim to familiarise the unions with the HIV&AIDS activity among the unions in their country, identify strategies of working together and provide specific training on a variety of core HIV&AIDS issues, including developing model union HIV&AIDS policies, how to include HIV&AIDS policies in collective bargaining agreements, using the ILO/WHO guidelines to develop codes of conduct on HIV&AIDS for health and safety of workers and how to campaign on HIV&AIDS issues. The main purpose is to improve cooperation, networking and campaigning between unions and relevant NGOs nationally and regionally on their response to tackling HIV&AIDS.

Regional seminars will be organised. The regional skills-sharing and best-practice seminars are organised by the HIV&AIDS regional coordinator and project assistant. These will involve representatives from all participating countries and will take place in the middle and towards the end of the project. They are an opportunity for regional sharing of skills and best practice and will focus on detailed aspects of HIV&AIDS policies, activities

and the trade union role. Its main purpose is to established mechanisms for sharing good practice amongst public sector unions in the region.

Specialist support is provided by resource centre staff to assist unions with taking forward their programme of HIV&AIDS work. Trainers, consultants and advisers experienced in trade union education and training, and having technical knowledge on HIV&AIDS, are identified to assist trade unions with this important task. The project allows for specialist support in the form of consultants, for one day per country.

An **Activity fund** will be set up to improve the support and assistance provided to selected public sector unions. The fund can be used by unions to undertake local small-scale HIV&AIDS activities using the skills, training and information gained from the national and regional seminars.

Project oversight

A ***Project Board*** consisting of a representative from each of the participating countries. Their primary responsibility is to oversee the implementation of the project in southern Africa. Each member will establish an in-country network for the project and liaise with the country's National Coordinating Committee (NCC) - the in-country constitutional structure for PSI.

Project Implementation

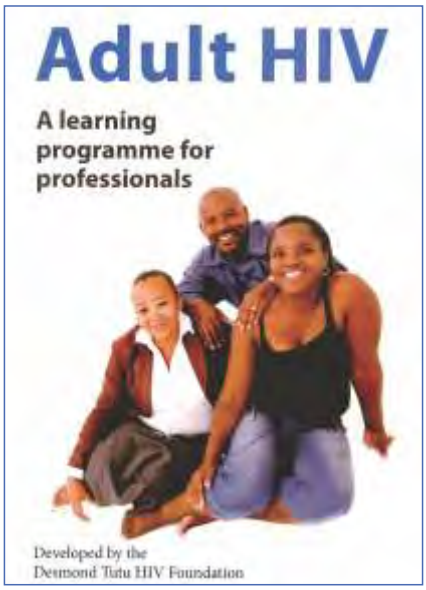
The ***Project Coordination Team*** consists of five experts from southern Africa in HIV&AIDS work in the trade union environment. This Team, together

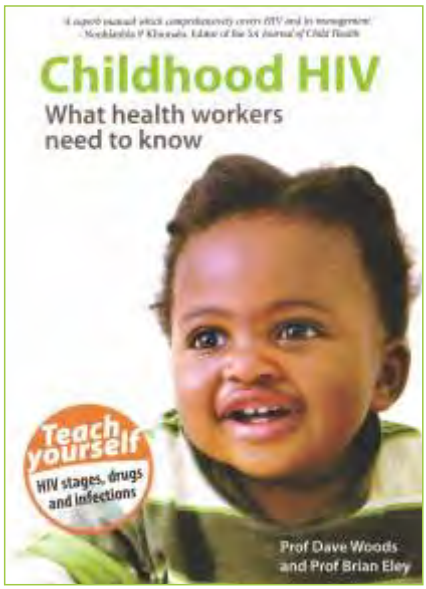
Book review

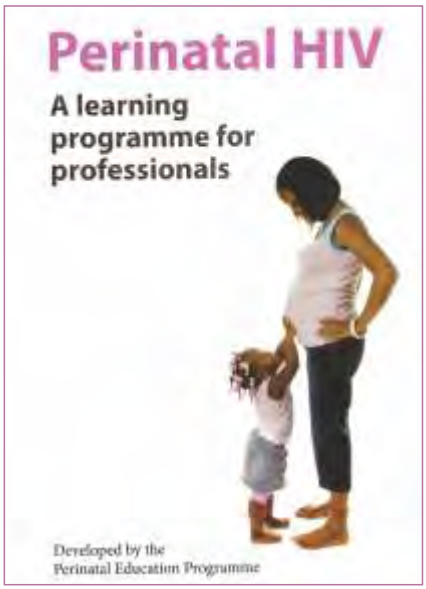
Three publications from EBW Healthcare are presented here. The EBW Healthcare publishes an innovative series of distance-learning books for healthcare professionals, developed by the Perinatal Education Trust , Eduhealthcare, the Desmond Tutu HIV Foundation and the Desmond Tutu TB Centre with contributions of numerous experts.

The format of the books is similar and offers healthcare practitioners the opportunity to study and develop themselves. Each chapter of the publication has learning objectives clearly stated at the start of chapter. The chapters presents the definitions of the various terminology used followed by the information that participants require to understand and apply in their clinical practice. Theoretical knowledge is presented in a question-and-answer format which encourages the practitioner to actively participate in the learning process and takes them systematically through the learning material. Important information and practical lessons are highlighted in the text. Each chapter closes with case studies which encourage the participant to consolidate and apply what was learned in the chapter.

On completion of the course, participants can take a 75-question multiple-choice examination on the EBW Healthcare website when they are ready to. The contact details of the company are included in all the publications. Participants have to achieve at least 80% in order to successfully complete the course. Courses have not yet been accredited for nurses, but doctors can earn CPD points for completing the course.







Adult HIV. A learning programme for professionals
Developed by the Desmond Tutu HIV Foundation as part of the Adult HIV Education Programme
EBW Healthcare
www.ebwhealthcare.com
Updated July 2010, 118 pages

The content of the book includes information on HIV infection, managing people with HIV infection, preparation for antiretroviral treatment, antiretroviral drugs, initiation and management of patients on antiretroviral drugs, and the approach to opportunistic infections. The last chapter contains skills workshops and multiple-choice tests of 20 questions for each chapter that can be used for pre- and post-testing that the learner can use to evaluate their progress.

This publication is a balanced and up-to-date guide that was developed by doctors and nurses with wide experience in the care of adults with HIV. It is presented in an easy-to-read way with clear step-to-step guides through definitions, causes, diagnosis, prevention, treatment, care, dangers and management which allow the participant to work through the material in a systematic way. The case studies presented in a story-telling format assist participants to apply their knowledge to solve the problems presented in the case study.

Childhood HIV. What health workers need to know
Prof Dave Woods and Prof Brian Eley
EBW Healthcare
www.ebwhealthcare.com
Updated August 2010
119 pages

The content of the publication focus on the needs of children with HIV – an area that is widely regarded as the clinical area where very few practitioners know what to do. The aim of the book is to promote and improve the care of all HIV-infected children, especially under resourced communities in Southern Africa. The first chapter therefore provide an introduction to childhood HIV infection followed by clinical and immunological diagnosis of HIV infection, the management of children with HIV infections, antiretroviral drugs and the management of children on antiretroviral treatment, HIV-associated infections and end-of-life care. The publication addresses all the important aspects such as mother-to-child transmission and breast feeding. References include the *Handbook of Paediatric AIDS in* by the African Network for the Care of Children Affected by AIDS. Where possible the WHO, South African and Red Cross War Memorial Children's Hospital HIV prevention, diagnostic and management protocols have been included.

Perinatal HIV. A learning programme for professionals
Developed by the Perinatal Education Programme
EBW Healthcare
www.ebwhealthcare.com
First published in 2008
92 pages

The aim of the Perinatal Education Programme and this publication is to improve the care of pregnant women and their newborn infants in all communities, especially in poor peri-urban and rural districts of Southern Africa and is a good source for midwives and any other healthcare professionals. To be most effective the Perinatal Educational Programme should be used under the supervision of a co-ordinator. Using part of the programme out of context will be of limited value only and should be kept in mind when participating in the programme.

The content of the publication includes an introduction to perinatal HIV, skills workshop on HIV Rapid Test, HIV in pregnancy, HIV during labour and delivery, HIV in the newborn infant, HIV and counselling.

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

APPLICATION / RENEWAL FORM ASSOCIATE MEMBERS
(see reverse side for Doctor Membership form)

MEMBERSHIP FEES 2011

Annual Membership Fees: R120 for Associate Members (i.e. healthcare workers other than doctors)
Renewal fees are valid for 12 months from date of receipt of payment. Payments may be made by cheque or electronic transfer payable to: 'Southern African HIV Clinicians Society', Nedbank Campus Square, Branch code: 158-105, Account No: 1581 048 033.
Please fax or email of proof of payment to 086 682 2880 or kerrysolan@global.co.za, or post to:
Suite 233, PostNet Killarney, Private Bag X2600, Houghton, 2041. Tel: 071 868 0789 Website: www.sahivsoc.org

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

First name: ☐☐☐☐☐☐☐☐☐☐☐☐ Initials: ☐☐☐
Surname: ☐☐☐☐☐☐☐☐☐☐☐☐ Title: ☐☐☐☐☐☐

Profession (please tick one): Professional Nurse ☐ Enrolled/Staff Nurse ☐ Nursing Auxiliary ☐ Midwife ☐
Pharmacist ☐ Social Worker ☐ Community Health Worker ☐ Researcher ☐ Other..........................

Practice address

Postal address

City

State/Province

Country Postal Code

SANC or other Council No.

Tel No Cell

Fax

Email

Please tick relevant box:

- Do you work in rural ☐ or urban ☐
- Would you like your quarterly journal, the *Southern African Journal of HIV Medicine*, to be posted to you? Yes ☐ No ☐ (I will read the journals on-line, on the Society website: http://www.sajhivmed.org.za)
- Would you like to receive information from the Society via sms ☐ email ☐ or both ☐
- Names of HIV training courses successfully completed..

Optional demographic information (for reporting and BEE accreditation purposes):

- Race: Black ☐ Coloured ☐ Indian ☐ White ☐ Other.......................................
- Gender: Male ☐ Female ☐
- Date of Birth: Day ☐☐ Month ☐☐ Year ☐☐☐☐

Method of payment: Electronic transfer ☐ Direct deposit ☐ Post/Cheque ☐ Cash ☐

Amount Paid: **Payment Date:**

SOCIETY SERVICES:

Quarterly issues of the *Southern African Journal of HIV Medicine*
Quarterly issues of the *HIV & Nursing Magazine* (applicable to nurse members only)

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

NDOH/SANAC Nerve Centre Hotlines

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

Nerve Centre Hotline and, specific emails for each province:

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

AIDS Helpline 0800 012 322

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

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

Services Offered by the AIDS Helpline:

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

Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

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

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

NATIONAL HIV & TB HEALTH CARE WORKER HOTLINE
0800 212 506

0800 212 506 / 021 406 6782

Alternatively send an SMS or "Please Call Me" to 071 840 1572

www.hivhotline.uct.ac.za

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

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

What questions can you ask?

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

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

When is this free service available?

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

Who answers the questions?

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

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

MIC MEDICINES INFORMATION CENTRE

USAID FROM THE AMERICAN PEOPLE

FPD

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

This service is brought to you as a result of the generous support of the American people through USAID/PEPFAR

NATIONAL HEALTH LABORATORY SERVICE

RESULTS HOTLINE

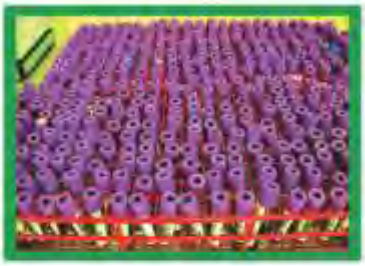
0860 RESULT 737858

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

Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

Dial the HOTLINE number 0860 RESULT (737858)
Follow the voice prompts and select option 1 to register to use the hotline
A hotline registration form will be sent to you by fax or e-mail.
Complete the form and return it by fax or e-mail to the hotline to complete your registration process.
Once you are registered, you will be contacted with your unique number. This number is a security measure to ensure that the results are provided to an authorized user.



To use the hotline dial 0860 RESULT (737858)

Select option 2 to access laboratory results.

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

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

Once you have a Reference number

Select option 3 to follow up on a reference number
Should the requested results not be available, a query reference number will be provided to you.
A hotline operator will call you within 48 hours of receiving the laboratory results.

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

2011 PROGRAMMES

Midrand, Gauteng
25 February 2011

Session Time	What's on?
07h00 – 08h00	**Registration**
08h00 – 08h15	**Opening**
08h15 – 10h45	**Putting Third Stage First** **Plus** other obstetric mythbusters
	Midwives, Moms & Multiples How to help in pregnancy & beyond
	Infant Digestive Discomfort Understanding colic and nutritional solutions
10h45 – 11h15	**Tea**
11h15 – 13h00	**Neuroscience to Improve Neonatal Care** With Nils & Jill Bergman
	The Alpha & Omega of Essential Fatty Acids
	Message from DENOSA
13h00 – 14h00	**Lunch**
14h00 – 16h45	**The Permanent Impact of Gentle Babycare**
	Monitoring Mothers & Unborn Babies **Plus** Obstetric concerns Q&A with Prof Justus Hofmeyr
	Breastfeeding, Sexuality & Contraception
16h45 – 17h00	**Conclusion & prizes galore!**

Port Elizabeth, Eastern Cape
20 May 2011
Rustenburg, North West Province
28 October 2011

Session Time	What's on?
07h00 – 08h00	**Registration**
08h00 – 08h15	**Opening**
08h15 – 10h30	**Handling HIV in NICU** A sensitive issue
	Intuitive Perinatal Errors Evidence supports parent power
	A Mom's Story
10h30 – 11h00	**Tea**
11h00 – 13h30	**Contagious Disease Management in Pregnancy**
	Breastfeeding with Joy, Confidence & Success Help launch mothers onto the journey of lactation
	Putting Pressure on Postpartum Haemorrhage
13h30 – 14h30	**Lunch**
14h30 – 16h45	**Gastro-Intestinal Health** Central to a baby's well-being
	Understanding Pain in Labour **Plus** Lesser practiced but proven relief techniques
	Supplementation Safety in Pregnancy
16h45 – 17h00	**Conclusion & prizes galore!**

Nelspruit, Mpumalanga
29 July 2011
Somerset West, Western Cape
9 September 2011

Session Time	What's on?
07h00 – 08h00	**Registration**
08h00 – 08h15	**Opening**
08h15 – 10h30	**The Essentials of Aromatherapy**
	Message from DENOSA
	Respiratory Distress in Neonates **Plus** a mini-resuscitation course
10h30 – 11h00	**Tea**
11h00 – 13h30	**The Significance of the Partograph** Expertise update
	Percentiles, Growth Curves & Baby Development Use, don't abuse!
	Breastfeeding When Everyone Says 'Impossible' Adoption, multiples, breast surgery, HIV infection
13h30 – 14h15	**Lunch**
14h15 – 16h45	**An Inspiring Midwifery Story**
	Making Normal Birth & Postnatal Care Natural Improve patient & professional experience
	Mental Health in Mothers Essential for a healthier family & nation
	Understanding how Parents' Brains Work With Nils & Jill Bergman
16h45 – 17h00	**Conclusion & prizes galore!**

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FPD

FACULTY OF HEALTH SCIENCES

ACCREDITATION

Registered with the Department of Education as a private institution of Higher Education under the higher education act, 1997 (Registration number: 2002/HE07/013).

FPD was established in October 1997 by the South African Medical Association and has since then placed a high emphasis on developing the clinical skills and leadership ability of SA's Nurses. Below are a few courses that will be beneficial to Nurses.

DISTANCE COURSES

DISTANCE COURSE IN DISPENSING

INTRODUCTION

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 health care 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 presented in association with the Health Science Academy.

STRUCTURE: 6 month distance based course with no contact sessions
COURSE FEE: R 1 539

DISTANCE CLINICAL MANAGEMENT OF TB FOR HEALTHCARE PROFESSIONALS (NURSES)

INTRODUCTION

The World Health Organisation (WHO) declared TB a global emergency in 1993. It is estimated by the WHO (2004) that about 1/3 of the world's population is currently infected with M. Tuberculosis. The WHO also determined that there were about 8.7 million new cases of TB and 1.9 million deaths due to the disease in 2000. According to these statistics it can be deduced that 2 people are infected every second! About 95% of TB cases and 98% of all TB deaths occur in developing countries, mainly among the poor, and mostly in the economically productive age group of 15-20 years of age.

STRUCTURE: 3 month distance based course with no contact sessions
COURSE FEE: R 800

NEW!

COURSE IN THE FUNDAMENTALS OF PROJECT MANAGEMENT AND PMBOK®

INTRODUCTION

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.

STRUCTURE: 6 month distance based course with no contact sessions
COURSE FEE: R 4 950

WORKSHOPS

NURSE INITIATED MANAGEMENT OF ANTI-RETROVIRAL THERAPY (NIMART)

INTRODUCTION

The NIMART course has been developed as a response to the call to action by the South African Government to strengthen the response to HIV and TB epidemics and is specifically developed for and aimed at professional nurses working in the field of HIV and TB. The 5-day course is a stand alone intensive programme that focuses on the management of TB, HIV and STI's as well as strengthening counselling skills, monitoring and evaluation of HIV and TB programmes. Participants should follow the course with a practical mentorship programme that is linked to an experienced HIV and TB clinician.

STRUCTURE: 5 Day workshop
COURSE FEE: R 5 700

CLINICAL MANAGEMENT OF HIV / AIDS FOR NURSES

INTRODUCTION

This course is presented in association with the South African HIV Clinicians Society and will enable participants to acquire or update skills with regard to:

- The diagnosis of HIV / AIDS and STD's
- The management of HIV / AIDS and STD's
- All aspects of counselling (pre- and post test, therapy compliance)
- Having empathy with people "Living with AIDS"
- Fulfil their role as health care professionals in community mobilization
- Understand vaccine development and clinical trials

STRUCTURE: 3 day workshop
COURSE FEE: R 3 700

REGISTRATION

DANIELLE DANIELS / MELANY MANOHARUM / VUYISILE KHUMALO

Tel: 012 816 9000 / 9101 / 9100 / 9107
Fax: 012 807 7165
Email: enquiries@foundation.co.za
Website: www.foundation.co.za

PLEASE VISIT OUR WEBSITE FOR INFORMATION ON OTHER COURSES

A member of the SAMA group

Foundation for Professional Development (Pty) Ltd Registration number 2000/002641/07

ICM 29th Triennial Congress

Midwives Tackling the 'Big 5' Globally

www.midwives2011.org

Congress Secretariat: The Conference Company
Tel: +27 31 303 9852 • Fax: +27 31 303 9529
Nina Freysen-Pretorius - nina@confco.co.za
Claire Cummings - claire@confco.co.za

19 - 23 June 2011, Durban, South Africa

ICM 29th Triennial Congress
International Confederation of Midwives

International Confederation of Midwives
Strengthening Midwifery Globally

The Society of Midwives of South Africa