

HIV NURSING MATTERS



A publication of the Southern African HIV Clinicians Society



Focus on patient-centred care

HIV and Non-Communicable Disease Management in Primary Health Care

Psychosocial support intervention improves adherence and retention in care for adolescents on antiretroviral treatment during the COVID pandemic in Mpumalanga, South Africa

Living with HIV: A young woman's perspective

A look into the Adolescent and Youth Friendly Services at Gqeberha Community Health Centre

PAVE: paving the way to paediatric HIV cure: A glossary of terms

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It is now almost 40 years since HIV became a major public health concern. We have seen the extraordinary development of testing, prevention and treatment modalities for people living with HIV PLWH. Yet, up to half of PLWH present to care with advanced HIV disease (AHD). Contributing factors to AHD include patients not testing for HIV, or not adhering to their antiretroviral treatment and this may be due to health care providers behaviours towards patients. Patients avoid coming to the clinic if they feel stigmatised or judged. Underlying prejudices appear in the way people use language. If a nurse believes that a PLWH “deserved” it, or only sees the disease and not the patient, it will appear in the language that they use. Appropriate language is a particular challenge in specific groups of people; they have conflict between own values and patient values. This issue covers some elements of the South Africa’s national strategic plan 2023-2028 for HIV, TB and STI including sex workers, transgender and gender diverse (TGD) people and people who use drugs, to be more vulnerable to contracting HIV, or dying from AHD.

This issue of *HIV Nursing Matters* we have articles that will look at the ways to care and support patients in spaces that are more patient friendly; as well as guidelines that guide health practitioners in the delivery of quality healthcare. The model of patient-centred care is about treating a person receiving healthcare with dignity and respect and involving

them in all decisions about their health. It is an approach that is linked to a person’s healthcare rights. A person-centred approach means focusing on the elements of care, support and treatment that matter most to the patient, and the practice of caring for patients (and their families) in ways that are meaningful and valuable to the individual patient. It includes listening to, educating and involving patients in their care. The article by Dr Madeleine Muller provides tips on appropriate language for nurses in improving access to care for the prevention and treatment of HIV, this goes to ensure that patients are treated with dignity by using words that encourages non-judgemental communication. Furthermore, this article does not propose that a person compromise their own beliefs or ideas as per religion, cultural or ideological backgrounds. Rather, it focusses on how a nurse provides best, non-judgemental care to each and every patient regardless of their illness, behaviour, work, gender identity, sexual orientation and so forth. The role of the clinician is to serve the health care need of the patient and to provide the best possible care. To do this each clinician needs to be aware of their own prejudices and subsequent language use. South Africans have shown to be particularly able to be accepting of others, even if they differ from themselves. Appropriate language recommendations to assist nurses in their daily practice and the article outlines some tips on appropriate language to ensure patients feel safe to share important

information that may pertain to their health, without fear of judgement. The focus is on PLWH, taking a sexual health history in person who identifies as lesbian, gay, bisexual or transgender (LGBTQIA+) and use of language with TGD people. Healthworkers, partly out of habit, and sometimes out of laziness, can sometimes classify patients according to their disease e.g. using terms such as diabetic patients, HIV patients or drug users. If we use this language often, it creates an impression in our own minds, as well as those around us, that the patient's identity is linked to their disease. A more helpful term is that of 'person living with HIV or "person who uses drugs". Supporting self-management in persons with HIV and non-communicable diseases (NCDs) in order to take responsibility for their own health, PLWH and other NCDs require support from their family and healthcare workers. This means that they need knowledge about their chronic diseases (e.g. medication, side-effects, drug-drug or drug-food interactions, healthy lifestyle habits, normal values for blood pressure, blood glucose, viral load) and skills to manage the day-to-day tasks required, for example, taking treatment on time, managing side-effects or symptoms (e.g. hypoglycaemia), managing chronic disease stigma and lifestyle changes. Healthcare workers need to assess whether people living with chronic diseases are ready for self-management and remember that supportive self-management is a continuous process. One way that healthcare workers can encourage self-management is by following the 22 5A's approach during a consultation. Initially, it may take some time, but once the healthcare worker is competent in applying the principles, it can go quickly. It assists in building a rapport with people living with chronic diseases and making them feel heard and supported.

Sr Lwandile Tokwe looks at HIV and Non-Communicable Disease Management in Primary Healthcare, with the quadruple burden of disease in South Africa and the largest ART programme in the world with TB/HIV leading the pack; HIV and NCDs follows right behind PLWH are prone to developing NCDs as co-morbid diseases it only makes sense that patients are educated

and supported in self-management. Most of the South African population will have a significant exposure to TB, and there is a high risk of developing TB disease amongst PLWH, immunocompromised people, people in congregate spaces, miners, inmates, healthcare workers, pregnant women, and people with silicosis. Dr Ndiviwe Mphothulo gives us an update on the eligibility of TPT. He covers important points about TB Preventive Therapy (TPT) in the new guidelines, the role of symptom screening, the role of testing for TB disease, he covers the current options in South Africa, clinical monitoring of people on TPT and the monitoring and evaluation of the programme. There is a need for a comprehensive strategy to prevent TB disease in the country. TPT is a TB disease prevention strategy and a critical component of the World Health Organization (WHO) End TB Strategy. TB prevention and treatment are therefore important tools for South Africa to reduce the burden of TB and achieve the 2025 End TB Strategy targets of reducing the TB incidence by 50% and the TB mortality by 75%. To help with the dual plan of prevention and diagnosis of TB, the National Department of Health (NDOH) released Guidelines on the treatment of Tuberculosis infection in March 2023. These guidelines were revised from previous TPT guidelines based on guidance by World Health Organization (WHO), local evidence and experience with TPT. The new guidelines are designed to guide healthcare workers at the coalface to implement the TPT program by identifying people eligible for TPT, initiating and managing people on TPT, and to monitor and evaluate the programme.

The article by Dr Jeanette Wessels and Dr Lynne Wilkinson focussing on the NDOH 2023 ART guidelines give guidance on optimised regimens with specific changes to improve access to ART regimens. The summary touches on the importance of patient-centred approach to improve engaging the patient taking ART so as to reduce unnecessary visits to the facility and offer convenience while offering quality care; this in return enables the healthcare workers to give the patients ownership of their own clinical outcomes. New guidelines from the South African HIV

Clinicians Society, on managing sexually transmitted infections, is summarised by Prof Remco Peters and Prof Nigel Garret, and covers screening, diagnostic tests to use, recommended treatment and way forward.

With the recent news articles according to the Northern Cape education department, about 900 pupils between the ages of 15 and 19 fall pregnant every three months in that province, this requires for collaboration between stakeholders like health facilities and schools to work together. Sr Portia Makhabane and Sr Charity Modau share their work with Adolescent and Youth friendly services in Gqeberha Community Centre, where they offer comprehensive Sexual and Reproductive Healthcare. Dealing with young people requires a dedicated team without judgement and working together with the parents, families, partners and the community at large. The article by Sr Wonder Hlongwane links with Adolescent Youth Friendly Services; we have a personal life story of a young woman living with HIV. It is critical to hear the experiences of our patients to use their voices to motivate us as we do our best with the resources at hand to enable us to have the best human experience. While we hear the experiences of our patients it is also equally important to hear the voices and experiences of our healthcare workers.

Sr Dimakatso Mofokeng gives us her experience of working with the Primary healthcare reengineering outreach programme. As the health system tries to lessen the traffic in health facilities, retired healthcare workers are called back to form part of teams where patients that are stable in chronic illnesses are visited at home as well as be part of the schools vaccinated programmes. It is these community health workers that support patients in taking ownership of their own lives. Lastly, the SAHCS team has put together a glossary of terms in the Paediatric Cure space, this article links to the December 2022 issue.

This issue is a catalyst for more articles that bring personal experiences to the fore and encourage us to engage in patient-centred care.



HIV and Non-Communicable Disease (NCD) Management in Primary Health Care

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Introduction

Globally, there were approximately 38.4 million people living with Human Immunodeficiency Virus (PLWH) in 2021.¹ While the number of PLWH is increasing annually, HIV-related deaths have decreased, and HIV is considered a chronic manageable disease.² Approximately 8.5 million people in South Africa were living with HIV in the year 2022.³ The country also has the largest antiretroviral therapy (ART) programme in the world.⁴ Access to ART has improved the life expectancy of PLWH. Hence, they become prone to developing

non-communicable diseases (NCDs) as co-morbid diseases.⁵ Supporting this, it is reported that South Africa is experiencing a quadruple burden of disease and HIV and NCDs form part of this increasing burden of disease. Generally, multimorbidity is 30-87% among HIV positive older adults in South Africa.⁶ In a Kwazulu-Natal study, 87% of participants in a community-based study had one or more of HIV, hyperglycaemia, hypertension, hyperlipidaemia and/or depression while 56% had two or more of these diseases.⁷

People living with HIV have an increased

risk of developing NCDs due to a variety of risk factors such as the inflammatory and infectious sequelae of HIV infection, the effects of ART and ageing.⁸ Similarly, Kamkuema et al.⁹, argue that HIV and ART have been linked to several NCDs. Sedentary lifestyle and smoking have also been reported as risk factors for NCDs in PLWH.¹⁰⁻¹¹

Furthermore, Tsuda et al.¹² argue that although the life expectancy among PLWH has increased dramatically as a result of their enrolment in ART, NCDs are now a major cause of morbidity in PLWH.¹³ This increased longevity among PLWH, combined with HIV's

premature ageing effect, is increasing the prevalence of NCDs comorbidities such as Diabetes Mellitus Type 2 (DM) and hypertension.¹⁴ While there is an increase in NCDs in PLWH, a study conducted by Biraguma et al.¹⁵ reported a low health-related quality of life in PLWH due to the factors associated with NCDs. In addition, a study conducted by Oliveira et al.¹⁶ highlighted that PLWH have a poor quality of life as a result of the NCDs such as hypertension and DM. Therefore, this burden of HIV and NCDs comorbidities necessitates a person-centred self-management approach that will ensure that the patients are able to self-manage their chronic diseases to increase their quality of life, especially in the primary health care (PHC) setting.

Promoting person-centred self-management

According to the South African National Department of Health¹⁷, a differentiated care model for stable PLWH was introduced to promote patient-centred self-management since 80% of people living with HIV and other chronic diseases can be managed within the community. Differentiated care is a patient-centred approach to improving the quality of ART service delivery in PLWH.¹⁸ Self-management means the person living with a chronic disease takes responsibility for their behaviour and well-being. Given the rising burden of HIV and NCD comorbidities, PLWH can benefit from existing adherence clubs, spaced fast-lane appointments, and centralized chronic medication dispensing and distribution (CCMDD). In addition, Maskew et al.¹⁹ argue that differentiated models of care aim to improve treatment outcomes, including ART retention, by simplifying HIV service delivery options.

A study conducted in Malawi which made use of a similar strategy highlighted that these person-centred self-management approaches enhance the self-management of PLWH and have the potential for improved treatment

outcomes for patients.²⁰ Furthermore, Akosile et al.¹⁸ highlight that the guiding principle for differentiating care is to deliver chronic medication in a way that recognizes specific barriers identified by patients and empowers them to manage their disease with the help of the health system. Therefore, healthcare workers working in all PHC clinics can consider implementing the existing 'assisted self-management' care model to improve the quality of life in PLWH and NCDs in South Africa.²¹ Figure 1 reflects the assisted self-management model that can be adopted in all PHC clinics.

Supporting Self-Management in persons with HIV and NCDs

In order to take responsibility for their own health, PLWH and other NCDs require support from their family and healthcare workers. This means that they need knowledge about their chronic diseases (e.g., medication, side-effects, drug-drug or drug-food interactions, healthy lifestyle habits, normal values for blood pressure, blood glucose, viral load) and skills to manage the day-to-day tasks required, for example, taking treatment on time, managing side-effects or symptoms (e.g., hypoglycaemia), managing chronic disease stigma and lifestyle changes. Healthcare workers need to assess whether people living with chronic diseases are ready for self-management and remember that supportive self-management is a continuous process. One way that healthcare workers can encourage self-management is by following the 5A's approach during a consultation.²² Initially, it may take some

time, but once the healthcare worker is competent in applying the principles, it can go quickly. It assists in building a rapport with people living with chronic diseases and making them feel heard and supported.

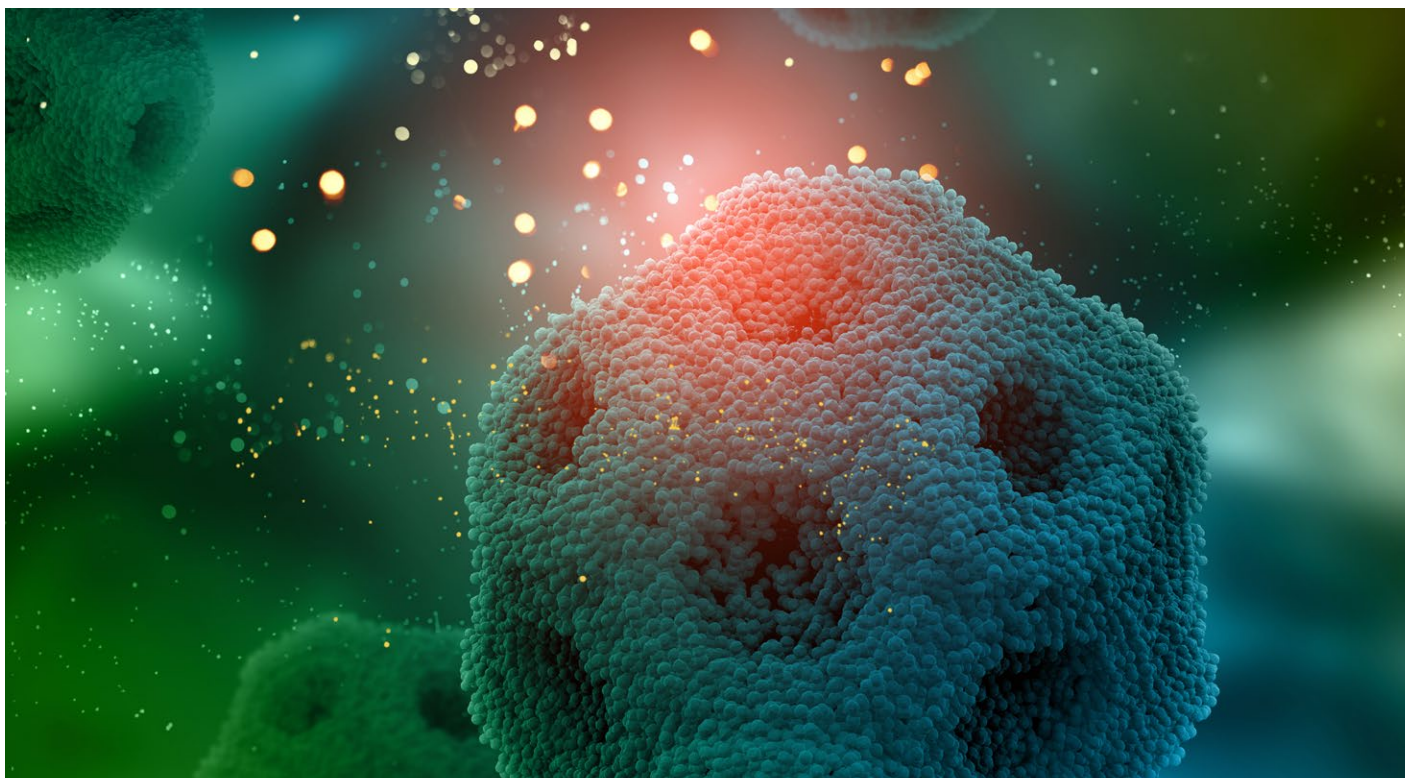
Figure 1 Assisted Self-Management Components (Integrated Clinical Services Manual)



According to the South African National Department of Health¹⁷, a differentiated care model for stable PLWH was introduced to promote patient-centred self-management since 80% of people living with HIV and other chronic diseases can be managed within the community.

Table 1: Summary of healthcare context improvements and disadvantages of cotrimoxazole prophylaxis.

Step	What to ask
Assess	<ul style="list-style-type: none"> • <i>Knowledge:</i> What do you know/understand about your chronic disease [e.g., HIV, hypertension, diabetes]? • <i>Beliefs:</i> What do you believe about [e.g., HIV, diabetes, and hypertension]? Would you say you have accepted your disease/ do you feel comfortable that other people know about your disease? Do you think taking treatment helps? • <i>Self-efficacy:</i> Do you think you can manage your disease on your own? What help do you need? • <i>Support:</i> Does your family or friends or employer support you to take care of your chronic disease? • <i>Clinical:</i> How is your health? Do you find it easy/hard to take your treatment / make lifestyle changes? Do you know if you are doing well on your treatment e.g., do you know what your [e.g., blood pressure, glucose level, and viral load] is and should be?
Advise	<ul style="list-style-type: none"> • Is there anything about your health or treatment you want to know more about? • I am concerned about [name the problem e.g., adherence, high body-mass-index (BMI), high blood sugar levels, high blood pressure]. Can I offer you some information about what I think we can do to help improve your health? • OR I am very happy about your health. You are doing very well.
Agree	<ul style="list-style-type: none"> • How important is it for you to be healthy / address the problem we identified (on a scale of 0 – not important at all to 10 – very important)? • What do you think we can do to address this? What would work for you? • Can we agree that you will do [e.g., eat less salt, exercise 30 minutes per day]? Set specific goals.
Assist	<ul style="list-style-type: none"> • Is there anything that will prevent you from reaching your goal? • What will help you achieve your goal? • Is there anything that can help you e.g., pill boxes, phone reminders, need to join a support group etc?
Arrange	<ul style="list-style-type: none"> • Do you have the contact number of the clinic in case you need to contact us? • Do you know when your next appointment is to see the health care worker/collect medication/ attend the support group? • What would be a convenient time for you for your next appointment [e.g., collecting treatment early in the morning or after work, from CCMDD]?



Patient knowledge and skills for self-management

Table 2 illustrates some key knowledge and skills people living with various chronic diseases should have.²³

Table 2: Patient knowledge and skills for self-management.

Disease	Knowledge	Skills
General and preventative measures for all chronic diseases	<ul style="list-style-type: none"> • Benefits of taking medication • Names of medication (or a card with the information) • Date of next clinic appointment • Healthy lifestyle habits • Risks of smoking • Risks of alcohol/drug use • Signs and symptoms of depression / mental health problems • Signs and symptoms of STIs and TB • Safe sexual practices / family planning 	<ul style="list-style-type: none"> • Taking treatment as prescribed • Planning to take enough treatment when going on holiday. • Managing symptoms and side-effects • Acceptance and disclosure of chronic disease to supportive partner/family member/friend • Managing stress • Preparing healthy meals • Daily moderate exercise • Managing sexual dysfunction
HIV	<ul style="list-style-type: none"> • Latest viral load • U=U (an undetectable viral load mean you cannot transmit the virus) • How to safely fall pregnant/have a family 	<ul style="list-style-type: none"> • Consistent condom use
Diabetes	<ul style="list-style-type: none"> • Current/daily blood sugar levels (and normal values) • Foot care to prevent ulcers. • Dietary restrictions e.g., sugar, honey, carbohydrates/starch • Regular meals 	<ul style="list-style-type: none"> • Measuring blood sugar levels • Injecting insulin (if required – injection technique, disposal of sharps) • Managing hypo/hyperglycaemia • Managing wounds
Hypertension	<ul style="list-style-type: none"> • Current/regular blood pressure (and normal values) • Dietary restrictions e.g., salt • Medication interactions e.g., avoid NSAIDs (e.g., ibuprofen) and combined oral contraceptives. • If on hydrochlorothiazide limit exposure to sunlight and use sunscreen 	<ul style="list-style-type: none"> • Managing symptoms of high/low blood pressure
Chronic respiratory diseases	<ul style="list-style-type: none"> • Mechanism of inhalers e.g., salbutamol relieves acute attack whereas corticosteroid prevents an attack. • Rinsing mouth to prevent oral candida (if using inhaled corticosteroids) • Medication interactions: avoid aspirin, NSAIDs (e.g., ibuprofen) and beta-blockers (e.g., atenolol) in asthma. • Reducing/stopping smoking • Identify and remove/avoid allergens/triggers. 	<ul style="list-style-type: none"> • Correct technique of using an inhaler • Increasing daily activities/moderate exercise
Chronic musculoskeletal diseases	<ul style="list-style-type: none"> • Reduce weight and be active. • Reduce alcohol (especially beer) • Dietary restrictions e.g., in gout, low fat intake; avoid fasting and dehydration. • Medication interactions: hydrochlorothiazide, furosemide, ethambutol, pyrazinamide, and aspirin may induce a gout attack. • Avoid overuse of pain medication 	<ul style="list-style-type: none"> • Home exercises • Managing an acute flare-up or acute pain

Conclusion

Healthcare workers in PHC settings play an important role in helping persons with HIV and NCDs to manage their chronic diseases. The burden of HIV and comorbid NCDs is increasing and people living with chronic diseases need the knowledge and skills to self-manage their disease in collaboration with healthcare workers. Healthcare workers should make use of the various strategies for differentiated care delivery and use every opportunity to support people living with chronic diseases with self-management.

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Psychosocial support intervention improves adherence and retention in care for adolescents on antiretroviral treatment during the COVID pandemic in Mpumalanga, South Africa

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Introduction

Adolescents living with HIV (ALHIV) face complex psychological and social challenges as they navigate their treatment trajectory, which includes the issue of disclosing their HIV status to others and coming to terms with the importance of persistent adherence to antiretroviral therapy (ART).^{1,2} In addition, mental health issues, such as neurological side effects, cognitive deficits and depressive disorders, are common amongst ALHIV due to the efavirenz component of ART.^{3,4}

Review of psychosocial support interventions for adolescents on HIV treatment.

Our review of psychosocial support (PSS) interventions that aimed to improve adherence and retention in care among adolescents on ART, identified six studies - conducted in Uganda, Kenya, South Africa, and Zimbabwe.⁵ The psychosocial support interventions included psychosocial education, group adherence or individual counselling, family and peer-support. Only three studies reported

significant improvements in retention in care up to 24 months and adherence to medication. The other included studies did not find significant improvements in adherence or retention in care in the intervention group compared to the control group.

Towards a biopsychosocial model for adolescents on HIV treatment

The management of ALHIV on ART requires a recognition of the complex biological, psychological and social



issues peculiar to adolescents, i.e. a biopsychosocial perspective.⁶ The biological components include routinely screening ALHIV for TB, regular taking weight for age biometrics to maintain appropriate antiretroviral treatment, in addition to improving access to medication through medication pre-packs and tracking of adolescents who have missed their support group sessions. Regular viral load monitoring is imperative to identify ALHIV with high viral load for enhanced adherence counselling.

The *psychological* wellbeing of ALHIV should be addressed through training in adaptive strategies (such as seeking social support, problem-solving, positive re-appraisal, acceptance, humor, journaling and spirituality).

The *social* support component of interventions utilises peers and dedicated clinicians to provide HIV treatment and support for ALHIV; thereby strengthening the relationship between treatment supporters/clinicians and ALHIV. In addition, parents/caregivers of ALHIV are provided with training on how to support the ALHIV in their treatment journey.

The interactions of these components in an intervention empower ALHIV to be resilient, and to have improved self-esteem and self-efficacy to take charge of their health by regular clinic visits and adhering to ART.

Adolescents living with HIV (ALHIV) face complex psychological and social challenges as they navigate their treatment trajectory, which includes the issue of disclosing their HIV status to others and coming to terms with the importance of persistent adherence to antiretroviral therapy (ART).^{1,2}

Implementation of a psychosocial support intervention in Mpumalanga

Right to Care (RTC) implemented a PSS intervention for adolescents on ART in Ehlanzeni district of Mpumalanga in 2019. The intervention components included (1) facilitated full disclosure of HIV status to adolescents, supported treatment adherence through health education, peer support, health care provider- and client relations, and quick access to health service delivery.⁷ The intervention was implemented in the time of the COVID-19 pandemic, with

its concomitant lockdown restrictions and regulations, which challenged the implementation of the intervention in various ways.

At baseline, viral suppression (<1000 RNA copies/mL) of ALHIV, aged 10 – 19 years, on ART for at least two years in 136 public healthcare facilities in the Ehlanzeni District Municipality was 74% - which failed to meet the UNAIDS 90 90 90 target.⁸ Similarly, retention in care rates among ALHIV were 90.5%, 85.4%, 80.8% and 76.2% at 6, 12, 18 and 24 months, respectively, which indicate a regressive failure to keep ALHIV engaged in treatment in Ehlanzeni.⁹

However, the qualitative assessment demonstrated that the PSS intervention was successful in:

- facilitating [the process of] full HIV disclosure to these adolescents with support from their parents or guardians,
- motivating adherence through peer support groups and health education for improved treatment literacy.¹⁰

It was found that the PSS programme improved the ALHIV's understanding of HIV and its treatment and enabled them to build stronger bonds with peers, parents/caregivers, and clinicians. Participants reported positive health systems experiences,

improved healthcare provider-client relations, and prompt access to health services. The PSS programme was successful in keeping ALHIV engaged in ART and care despite health service disruptions encountered during the COVID-19 pandemic.¹⁰

Health systems practice and policy implications

The findings from our evaluation of a PSS programme in Ehlanzeni district demonstrate that PSS interventions can play a role in improving adherence to ART and retention in care among adolescents on ART care in the African context, even amidst disease pandemic such as COVID-19 pandemic.¹⁰ Several implications arise from this research project for implementers and policymakers.

1. A holistic and integrated suite of approaches is needed to improve adherence

Adopting a combination of approaches to address the biological, psychological and social needs of ALHIV in an integrated way may be necessary to improve adherence. These approaches may include, for example, providing social and psychological support in conjunction with a high standard of care in clinics; adherence monitoring (viral load and weight monitoring); ensuring the availability of medication through differentiated care methods, such as fast track or adherence clubs. A combination of these may bolster their self-esteem and self-efficacy, which in turn will improve their self-management regarding medication adherence and retention in care and subsequently improve their treatment outcomes.

The World Health Organization (WHO) recommends 'full' disclosure

of HIV-positive status to adolescents who acquired HIV perinatally by the age of 12 years.¹¹ In our PSS intervention disclosure was made using an age-specific and culturally sensitive approach to offer disclosure support to ALHIV, and these ALHIV were subsequently recruited into the PSS support group after learning their HIV status.

2. High viral loads may persist among ALHIV on ART due to poor clinical care practice

The PSS programme supported treatment adherence through four mechanisms: routine viral load monitoring, enhanced adherence counselling for defaulting adolescents, routine body weight monitoring, and regimen switching for ALHIV who failed first-line treatment.⁷ Routine body weight monitoring helped identify adolescents on ART who were under-dosed because of their rapid growth and enable dosing to be corrected. Similarly, adolescents on ART who were resistant to the first-line regimen were timeously switched to a second-line regimen. These mechanisms are crucial to ensuring effective management of ALHIV adherence to ART. Reliance on enhanced adherence counselling (EAC) alone to correct unsuppressed viral loads is insufficient to achieve the third 95 - i.e. 95% of all ART patients having effectively suppressed viral loads.

3. A gap in treatment exists for older adolescents

There exists treatment gap among older adolescents (ages 15 to 19 years) as they transition from paediatric care to adult care: retention rates are lower for older adolescents.⁹ While few studies have reported on the transition outcomes of ALHIV in southern and eastern Africa, those that have addressed this aspect have noted that

barriers such as a lack of adequate clinic infrastructure, inadequate staff training and communication between paediatric and adult clinicians, as well as fear of stigma, have been found to hinder successful transitioning of adolescents from paediatric care to adult care.¹² While the South Africa Department of Health¹³ has adopted a blueprint for action to improve the transition from paediatric to adolescent adult care and down referral as part of the National Adolescent and Youth Health Policy, there is at the time of writing no implementation guideline on how the transitioning should be done.

4. Parents and caregivers play a crucial role in the disclosure of HIV status to ALHIV and treatment support

The role of parents and caregivers cannot be overemphasized. A recent study reported that family members play a key role in providing transportation to appointments and pill reminders for ALHIV as well as emotional support to encourage ALHIV to adhere to their medication regimen by reflecting upon the importance of this to their futures.¹⁴ In our study we found that involving parents/caregivers in the disclosure process assisted by a trained health care worker helped the parent/caregiver overcome their fear of being blamed by their children and to support the ALHIV through their treatment journey.¹⁰

Conclusion

To ensure no population is left behind in treatment, continued focus on ALHIV is needed to achieve the UNAIDS second 95 (95% of all people living with HIV initiated on ART), and third 95 (95% of all ART patients having effectively suppressed viral loads) targets by 2030.¹⁵ The PSS programme, when coupled with peer support, enhanced clinical care, social support for "full" disclosure and peer support, was found to be successful in keeping ALHIV engaged in ART and care despite the health service disruptions encountered during the COVID-19 pandemic, as also confirmed by more recent reviews.^{16,17}

A holistic and integrated suite of approaches is needed to improve adherence.

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Living with HIV: A young woman's perspective

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Introduction

There are approximately 8.2 million people living with HIV (PLWH) in South Africa. For adults aged 15 to 49 years, an estimated 19.5% of the population is living with HIV.¹ The high numbers of PLWH may result in healthcare workers treating people as just a number, not considering their perspective of living with HIV. In order to be person-centered in our approach, healthcare workers should have knowledge of the experiences of PLWH.

In South Africa, young women are at a high risk of acquiring HIV. In 2019, 21% of adolescent girls aged 15 – 19 died due to HIV/AIDS, making it the number one cause of death amongst adolescent girls.²

As part of a larger study exploring people's experiences of managing a chronic disease, we interviewed a young woman living with HIV using a semi-structured interview guide. The aim of the interview was to explore her experiences of living with HIV.

Nomsa (pseudonym) is a 24-year-old woman who was diagnosed with HIV in 2018 when she was 19 years old. She lives in a small town in Mpumalanga. Nomsa consented to be interviewed on her experiences of living with HIV.

What was your experience of being diagnosed with HIV?

Nomsa explains her experience: "I was diagnosed in 2018. When I found out it did not sit well with me, I

did not believe it hence I came back again to test but still it was positive, then I started with treatment. When I started taking the treatment, I had dizziness, I asked what was happening, they said it was the side-effects. Then I decided to share with my partner regarding my HIV status. He did not believe it. He then asked if I would like to accompany him to go test. I did at the clinic they asked how he would feel if he tested positive. He said he will deal with it when it happens and is not the end of the world. So, he has been supportive from 2018 until now."

Even though most people have knowledge that being diagnosed with HIV is not a death sentence, people still find it difficult to accept their diagnosis. Therefore, support and understanding



from healthcare workers are important. Disclosure is key to further obtaining support from partners, family members and friends, but it can sometimes be detrimental. Healthcare workers should recognise that disclosure is a choice and encourage disclosure, depending on the situation of the client.

What has been your experience since you were diagnosed with HIV?

"Nothing has changed about me, just that it is sometimes difficult to accept that I am and will be HIV forever."

Accepting to have a chronic disease is a process for most people and requires continuous encouragement and support. Sometimes people, like Nomsa, think that they "are HIV", meaning that they make the diagnosis part of their identity. It is important for healthcare workers to help people understand that living with a chronic disease such as HIV does not change who they are as a person.

Did your partner treat you differently after you were diagnosed?

"No, he [partner] has not changed, he still treats me the same way as

before diagnosis."

The process of acceptance is facilitated when supportive partners or family members treat PLWH the same as before they were infected.

How do you navigate your life while knowing you have you are living with HIV?

"It is not that difficult especially because it is only me, my partner and, my mother who knows about my condition, I live a normal life just like everyone."

People living with HIV want to live a normal life as far as possible. Disclosure beyond close family is unnecessary and may enable people to continue their normal daily living. Healthcare workers can assist by encouraging PLWH to continue to live a long and healthy life and do everything they planned for their life if they adhere to taking their medication as prescribed, which will result in viral load suppression.

What challenges do you encounter?

"The only challenge I have encountered so far is a guy who asked my partner how he feels being with someone living

with HIV. It really got to me, to a point where I asked myself how he found out I was positive, but my partner has been supportive, and I appreciate it."

HIV stigma is still very common in communities and one of the major challenges PLWH encounters. A person's HIV status should be treated as confidential in order to prevent such stigma in communities. Healthcare workers should be mindful of any structural stigma in healthcare facilities such as managing PLWH in a separate section in the facility or speaking in a way that may disclose a person's status to other people in the facility.

What about your social life, do you have friends and what are their views about HIV?

"I do have friends; we don't really talk much about HIV, and they do not know my condition and I am not planning to share though they sometimes start unusual conversations about HIV, and it makes me wonder if they do not know my condition. My social life has changed because before knowing my status. I would spend my weekend in clubs drinking with friends but now, I have to think about medication, so I do not do it more often and if I do, I do not spend the whole night."

"For someone who is not living with HIV, I would advise them not to trust anyone and use protection during sexual activities. For someone who is living with HIV, I would advise them to accept the situation and try to live their best life and stop blaming themselves."

Living with HIV requires people to navigate their social life differently, such as making time to live a healthy lifestyle. Most people become more responsible and are conscious of making sure they take their medication as prescribed.

What are your experiences with the facility that you go to for HIV management?

"I have not had any bad experiences with the facility, from 2018 until now, I feel like they always try their best to make sure that we get better as patients."

It is very important that healthcare facilities make an effort to accommodate young people living with HIV. Good experiences and satisfaction with services will assist in keeping people, especially young people, in care. Healthcare workers should try as far as possible to provide differentiated care options for young people such as extended facility hours, fast-tracking lanes, or community clubs. Such efforts will make it easier for people to access their treatment.

How are your experiences in the community?

"It's not easy at all, though they always educate us how HIV is not as dangerous as it was back then but, when people find that you are positive, they treat you differently, but it has never happened to me except the guy who tried to embarrass me in front of my partner."

We are all responsible for combatting HIV stigma in the community. It is important that as healthcare workers, we are advocates for our patients and that we promote a stigma-free community by educating the community regarding HIV.

What message do you have for those living with HIV and those not living with HIV?

"For someone who is not living with HIV, I would advise them not to trust anyone

and use protection during sexual activities. For someone who is living with HIV, I would advise them to accept the situation and try to live their best life and stop blaming themselves."

Preventing HIV is still better than lifelong treatment. Healthcare workers should reinforce HIV prevention messages on every occasion such as sexual reproductive health visits and the use of pre-exposure prophylaxis (PrEP). For those who are taking treatment, messages such as Undetectable (viral load) equals Untransmittable (U=U) is an important motivation for adherence. Using other young people as ambassadors will help convey the message in a more effective manner as young people are more likely to listen to their peers. Peer-to-peer support should be reinforced in healthcare facilities

and in communities so that young people living with HIV can encourage one another.

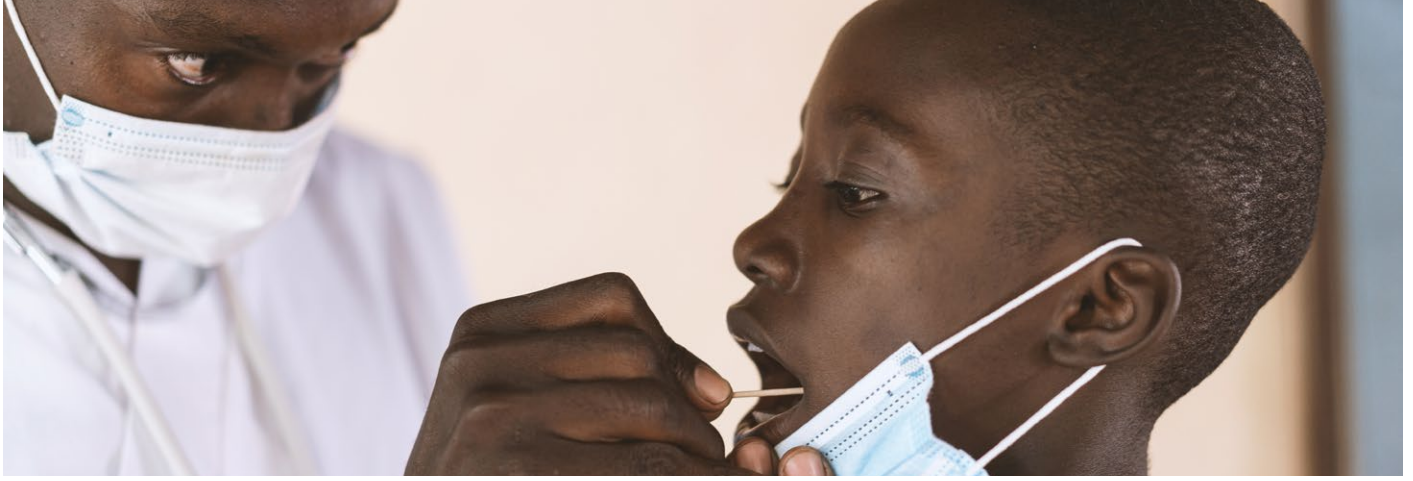
Conclusion

We have presented a short interview with Nomsa, a young woman living with HIV on her experiences. Being aware of the lived experiences of PLWH makes healthcare workers more empathetic to their situation and may motivate them to be advocates and improve the quality of care delivered to PLWH.

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A look into the Adolescent and Youth Friendly Services at Gqeberha Community Health Centre

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Health services for adolescents are increasingly recognised as a priority in low- and middle-income countries (LMICs). The Adolescent and Youth Friendly Services (AYFS) approach has been promoted in South Africa by the National Department of Health (NDoH) and partners as a means of standardising the quality of adolescent health services in the country.¹

In this article, we detail the evaluation of Gqeberha Community Health Centre (CHC) AYFS defined standards according to NDoH set standards, challenges incurred in implementing set standards and the plan of action that Gqeberha CHC has taken to improve these services.

The Gqeberha CHC catchment area is the Walmer Township situated in the Nelson Mandela Bay District Municipality sub district C and the Community Health Centre. Sr Portia Makhabane is the Operational Manager. AYFS were started at Gqeberha CHC in 2021, and were

assigned a dedicated Professional Nurse, Sr Dulce Mbiza. In March 2022, Sr Charity Modau took over and AYFS were officially launched. There is an AYFS committee and a number of active supporting partners, including MIET Afrika, Love Life and Rape Crisis.

AYFS rendered by Gqeberha CHC include reproductive health (family planning, cervical screening, STI screening and management), HIV services (testing, PrEP, PEP and management of clients living with IV), chronic conditions screening and management, mental health screening and referrals management of minor ailments, health talks and immunisations. These services run from Monday to Friday, 07h30 to 16h00 and cater for an average 600 adolescent and young people per month.

Inevitably, as a new service, there are challenges that are being encountered. These include:

- **Staff shortages** - this is one of the major issues that has led to

services not running smoothly and also makes it difficult to meet the set Standards dictated by NDoH. Currently, AYFS has one dedicated nurse which makes it difficult to cater for such a big catchment area. In addition, there is a shortage of supporting staff such as administrative clerks. As such, turnaround times can be long, and sometimes clients leave before they are attended to.

- **Parental involvement** - often the client's parent/s want to be involved. This can make it difficult for the AYFS clients to discuss more sensitive issues (such as pregnancy, STIs and HIV, LGBTQIA+ and sex) with the health care worker. At Gqeberha CHC, the health care workers are encouraged to educate parents on issues of privacy, one of the main reasons that AYFS was formed. Unfortunately, often the parents have a lack of respect towards the health care workers, such that experience this on a daily basis.

- **Infrastructure** – currently the waiting area is too small and the consulting rooms too few to accommodate the number of client attending the service on daily basis.
- **Client-specific issues** – some of these issues include treatment interruption, incorrect contact details making tracing difficult, peer pressure against condom use, high rate of teenage pregnancies and STIs, gender-based violence, little interest in PrEP and PEP even with education provided, high rate of alcohol and substance use, socio economic factors and cultural factors such as the need for male circumcision at a later age than preferred to reduce HIV and other STIs.

There are quality improvement steps that Gqeberha CHC management is taking to help improve some the challenges mentioned above. These include:

- Daily health talks with the assistance of supporting partners, MIET Afrika and Love Life.
- Improving involvement with the (WBOT) Ward Based Outreach Teams (are allocated in the community reporting to the Facility consist of: CHW's (Community Health Workers) and OTL (Outreach team Leader) these are the teams doing tracing, and door to door house calls.
- More AYFS training of staff
- Involvement of AYFS nurse in school health programs
- More involvement of NGOs, such as Merge for TB screening, testing and tracing of AYFS clients

Currently, there is a positive increase in AYFS client's involvement which is an indicator that Gqeberha CHC is on the right track. Well-trained, friendly staff is one of the main contributors of this positive change.

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1. Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa | BMC Health Services Research | Full Text (biomedcentral.com)

For the centre to stay relevant to its clientele, a customer satisfaction survey given to every Adolescent that accesses various medical services. The survey is within the age group of AYFS all the questions fit into this cohort, they give feedback on the services offered within the AYFS Facility.

The AYFS SURVEY/ Anonymous questions

The age range for the questions that were asked is between 15 years to 25 years of age. There were 15 candidates that were interviewed or who took the survey. Out of the candidates that took the survey 14 out of 15 were females and we only had one male Candidate. Out of the 15 candidates 13 replied that they would recommend someone to come to the facility for assistance especially the AYFS. In general, many of the candidates raised the concern of staff shortage as the most pressing issue which is affecting the effectiveness of the AYFS within the facility. Most of them were impressed by the staff members attitudes, friendliness and the willingness to help. Below are the questions asked with responses to select from:

What do you like about the clinic?

- They offer better service
- I like the service
- There's nothing to improve everything is fine
- They give better service
- They give better medicine
- It's close to where I stay
- Nothing
- They help sick people
- Their service that the sister is giving is beautiful and I like it
- I always get the service I need from the nurse next slide I like the way they help people
- The fact that you don't need transport to get to the clinic

Some people didn't answer some questions that were asked some questions were left blank.

What do you think can do better or improve?

- Understand the reasons why people are late or not coming on their given dates
- Increase the number of staff more nurses and doctors
- Get more staff members
- You have to employ more people
- To get more assistance to assist a sister working in AYFS service
- Help more people
- Get more staff to work in the clinic so that we all get help

Would you recommend this clinic to your friends?

- For this question, 12 Answered yes and 2 answered 1 and one didn't give an answer.

PAVE: paving the way to paediatric HIV cure

A glossary of terms

The Southern African HIV Clinicians Society Team

The Southern African HIV Clinician's Society (SAHCS) is working with the Paediatric Adolescent Virus Elimination (PAVE) Collaboratory Community Group to facilitate the translation of scientific findings in such a way that the complexity of the science is easy to understand by doctors, nurses, and other healthcare workers working with adolescents and children living with HIV. During February 2022, SAHCS collected baseline data using a survey to gain insight into healthcare worker understanding around key HIV CURE concepts. This data was published in the December 2022 edition of HIV Nursing Matters here and indicated that only 50% -55% of respondents (across all cadres) had some understanding of key CURE terminology, and most had little familiarity of various terms. As such, SAHCS developed a glossary of terms to aid in improving healthcare workers' understanding of these concepts and terminology. These are provided below.

Acquired Immunity	Immunity that develops during a person's lifetime. There are two types of acquired immunity: active immunity and passive immunity.
Acquired Resistance SYNONYM(S): Secondary Resistance	When a drug-resistant strain of HIV emerges while a person is on antiretroviral therapy (ART) for the treatment of HIV infection.
Active Immunity	Immunity that develops after exposure to a disease-causing infectious microorganism or other foreign substance, such as following infection or vaccination.
Adherence	Taking medications (or other treatment) exactly as instructed by a health care provider. The benefits of strict adherence to an HIV regimen include sustained viral suppression, reduced risk of drug resistance, improved overall health and quality of life, and decreased risk of HIV transmission.
Adjuvant	A substance added to a drug or vaccine to enhance its effectiveness. Also, an additional drug or other intervention that is used to bolster an initial treatment.
Antigen-Presenting Cell (APC)	A type of immune cell that enables a T lymphocyte (T cell) to recognize an antigen and mount an immune response against the antigen. Antigen-presenting cells (APCs) include macrophages, dendritic cells, and B lymphocytes (B cells).
Berlin Patient	In 2008, a man with HIV named Timothy Ray Brown was effectively cured while living in Germany. Researchers treated his blood with a stem cell transplant for leukemia, but the treatment also cured his HIV. His stem cell donor carried a mutation of an HIV-related gene called CCR5. This mutation makes a person almost completely resistant to infection. Brown was the only person to be cured of HIV until 2019, when two others were effectively cured with a similar stem cell therapy

Broadly Neutralizing Antibodies (bNAbs)	A type of antibody that can recognize and block many types of HIV from entering healthy cells. Broadly neutralizing antibodies (bNAbs) may also activate other immune cells to help destroy HIV-infected cells. Researchers are investigating whether bNAbs could be used to develop a therapeutic HIV vaccine.
Clade	See subtype
Dendritic Cell	A type of antigen-presenting cell found in many tissues throughout the body. Dendritic cells capture antigens with their threadlike tentacles and present the antigens to T lymphocytes (T cells), stimulating an immune response.
Dendritic Cell Vaccine	An experimental vaccine that uses dendritic cells to boost the immune system. Dendritic cell vaccines are currently being studied as a possible way to treat people with HIV.
Elite Controllers	A small subset of people living with HIV who are able to maintain suppressed viral loads for years without antiretroviral therapy (ART). However, because HIV continues to replicate even in elite controllers, ART is recommended for elite controllers who have declining CD4 counts or who develop HIV-related complications.
Eradication	The total elimination of a pathogen, such as a bacterium, from the body. Eradication can also refer to the complete elimination of a disease from the world, such as the global eradication of smallpox.
Fusion Inhibitor	Antiretroviral (ARV) HIV drug class. A fusion inhibitor blocks the HIV envelope from merging with the host CD4 cell membrane (fusion). This prevents HIV from entering the CD4 cell.
HIV Cure	There are two different visions of a potential HIV cure: treatment-free remission and viral eradication
HIV Cure Research Approaches	There are a few different approaches to research cures. While each is promising, as of yet, there is no cure. <ol style="list-style-type: none"> 1. Activate and eradicate – aims to flush the virus out of the reservoirs and kill any cell it infects – this is sometimes known as “shock and kill” 2. Gene editing – this is about changing cells so that HIV cannot infect cells in the body 3. Immune modulation – this method permanently changes the immune system to better fight against HIV 4. Stem cell transplants – this approach replaces a person’s infected immune system with a donor immune system
Immune Modulators SYNONYM(S): Immunomodulators	Immune modulators are a class of drugs that help to activate, boost, or restore normal immune function after HIV has damaged the immune system. Researchers are investigating whether immune modulators can help change how the immune system functions as part of a strategy to treat or cure HIV. Currently, the immune modulators used to treat HIV infection are still under investigation and have not been approved by the Food and Drug Administration (FDA) for patient use.

Immunity	Protection against disease caused by infectious microorganisms or by other foreign substances. Immunity can be acquired through vaccination, by contracting the disease, or by transfer of antibodies produced by another person or animal. Immunity also includes the protective barriers that a person is born with, such as the skin and mucous membranes.
Innate Immunity	Immunity that a person is born with. Innate immunity includes certain physical barriers, such as skin and mucous membranes, and fast-acting immune cells, such as natural killer cells.
Latency-Reversing Agents	One of the main obstacles to curing HIV infection is that the virus can remain hidden and inactive (latent) inside certain cells of the immune system (such as CD4 cells) for months or even years. While HIV is in this latent state, the immune system cannot recognize the virus, and antiretroviral therapy (ART) has no effect on it. Latency-reversing agents reactivate latent HIV within CD4 cells, allowing ART and the body's immune system to attack the virus. Currently, latency-reversing agents are still under investigation and have not been approved by the Food and Drug Administration (FDA).
Latent HIV Reservoir SYNONYM(S): Reservoir	A latent HIV reservoir is a group of immune system cells in the body that are infected with HIV but are not actively producing new virus. Resting CD4 cells (or other cells) that are infected with HIV but not actively producing HIV. Latent HIV reservoirs are established during the earliest stage of HIV infection. Although antiretroviral therapy (ART) can reduce the level of HIV in the blood to an undetectable level, latent reservoirs of HIV continue to survive. When a latently infected cell is reactivated, the cell begins to produce HIV again.
Long-Term Nonprogressors (LTNP) (Fig. 47)	A small group of people with HIV who do not take antiretroviral therapy (ART) and still maintain CD4 counts in the normal range indefinitely.
Memory Lymphocyte SYNONYM(S): Memory Cell	A type of lymphocyte. Memory lymphocytes can recognize an antigen introduced into the body during a prior infection or vaccination. Memory lymphocytes mount a rapid and strong immune response when exposed to an antigen for a second time. Both T lymphocytes (T cells) and B lymphocytes (B cells) can become memory cells.
Post Treatment Controller	HIV post-treatment controllers (PTCs) are a rare group of people with HIV (PWH) who are able to control their rebound HIV to a very low level during analytical treatment interruption (ATI).
Recency Assays	Recency assays use one or more biomarkers to identify whether HIV infection in a person is recent (usually within a year or less) or longstanding.
Relapse	The recurrence of a disease after a period of remission or apparent recovery.
Remission	The period during which symptoms of a disease diminish or disappear.
Sanctuary Sites	The existence of sanctuary sites for human immunodeficiency virus type 1 (HIV-1) may potentially endanger the efficacy of antiretroviral therapy in the long term and may even make eradication of HIV-1 from the infected body impossible. Potential 'classic' sanctuary sites for HIV-1 are the central nervous system and the testes, but long-lived cell populations (such as macrophages) or latently infected (resting) CD4 cells may also be considered a sanctuary for HIV-1.

Stem Cell	Stem cells are the body's raw materials – cells from which all other cells with specialized functions are generated. Under the right conditions in the body or a laboratory, stem cells divide to form more cells called daughter cells.
Subtype SYNONYM(S): Clade	A subgroup of genetically related HIV-1 viruses. HIV-1 can be classified into four groups: M group, N group, O group, and P group. Viruses within each group can be further classified by subtype. For example, the HIV-1 M group includes the following subtypes: A1, A2, A3, A4, A6, B, C, D, F1, F2, G, H, J, and K.
Therapeutic HIV Vaccine SYNONYM(S): HIV Therapeutic Vaccine	A vaccine to slow the progression of HIV infection or delay the onset of AIDS. To date, no therapeutic HIV vaccine exists, but research is underway.
Treatment-Free Remission	The virus is controlled without the need for ART drugs, which a person has to take every day for life. Millions of people who have HIV can't afford ART, so other treatments are needed. This idea of an HIV cure is also called a functional cure.
Visconti Cohort	In 2010, a baby born with HIV in Mississippi began ART soon after birth and was in remission for 2 years after they stopped, but the virus did come back. A trial called the Visconti Cohort studied 20 people with HIV in France. They also started ART within weeks of infection. They were able to stop taking the drugs and still have low levels of HIV years later. Another trial of 15 children with HIV in Thailand had similar results.
Vector	In genetically engineered vaccines, a vector is a bacterium or virus that transports antigen-coding genes into the body to provoke an immune response. (The vector itself does not provoke an immune response or cause disease.) A vector may also refer to an organism, especially an insect, that transmits disease-causing agents.
Viral Control	Many viral diseases are controlled by reducing exposure to the virus by (1) eliminating nonhuman reservoirs, (2) eliminating the vector, and (3) improving sanitation.
Viral Eradication	Viral eradication is another way of looking at a potential cure. It's also known as a sterilizing cure. Scientists believe it would take a two-part treatment to wipe out HIV in a person's body. The first part would involve drugs that make the cells in the HIV reservoir multiply and express proteins that are like a signal to your immune system. The second part would include drugs that detect those protein signals, then seek out and kill the virus.
Viral Latency	When a virus is present in the body but exists in a resting (latent) state without producing more virus. A latent viral infection usually does not cause any noticeable symptoms and can last a long period of time before becoming active and causing symptoms. HIV is capable of viral latency, as seen in the reservoirs of latent HIV-infected cells that persist in a person's body despite antiretroviral therapy (ART).



Primary healthcare reengineering outreach programme

Dimakatso M Mofokeng

My story

I was trained at Bophelong Nursing College between 1977-1980, obtained my certificate of Midwifery in 1981 and Community Nursing Science in 1996. I later obtained a Clinical Nursing Science Health Assessment Treatment and Care certificate in 2004 and a Baccalaureus Technology Occupational Nursing from the Tshwane University of Technology. I worked in various sections of Thusong Hospital Itsoseng Clinic, Bodibe Clinic within the The New Health Center in Itsoseng. I also provided Health care

Services in a mobile unit/vehicle in rural communities. The rural communities could not reach facilities since were more than 35km away. I retired in the year 2012.

In 2013 The Dept. of Health employed retired nurses to provide Primary health Care Re-Engineering. **I was amongst the professional nurses whom were recruited.** I was offered a contract to immunise 9yr old girls in Grade 4 for a Human Papilloma Virus campaign prevent girls from contracting cancer of the cervix. The campaign is

usually conducted annually during the months of February and March and again in September & October. Here I offer my insights into the PHC re-engineering outreach programme.

Implementation of the PHC re-engineering programme

The National Health Council (NHC) mandated that in order to improve health outcomes significantly, steps should be taken to restructure the health system. This was one of the 10 points in the five-year Health Sector 10 Points Plan

Primary Health Care Re-engineering has had a remarkable impact in the lives of our communities. There had been a drop in children malnutrition and children mortality rates. The under 5 years child immunization improved dramatically this was because of the campaigns initiated by Primary Engineering Out-Reach Teams.

noted as overhauling the healthcare system. Minister and MEC's visited Brazil in 2010 and came back with a vision for the re-engineering of primary health care. Brazil was able to improve health outcomes by inter alia expanding the role of community agents working in teams with health professionals in designated catchment areas. Upon returning home the Minister of Health established a small team to elaborate a South African model to strengthen Primary Healthcare.

This team produced the first narrative document and presentation to an extended NHC meeting the basic concept presented was adopted with the caveat that we build a South African model based on the ward system, as had been started in Kwazulu-Natal.

The discussion with the minister and after the debate in the National Health Council a three-stream approach to primary health care (PHC) re-engineering by the Department of Health. The model contains three streams of PHC- re-engineering:

- A ward-based PHC outreach team for each electoral ward.
- Strengthening school health services.

- District based clinical specialist teams with an initial focus on improving maternal and child health.

The ward-based PHC outreach team

This team comprised one Professional Nurse and six (6) community health workers (CHW). Each CHW was allocated 270 household families. The team also included health promotion practitioners and environmental health practitioners.

The role of the professional nurse

The professional nurse has multiple responsibilities, including to:

- Assume responsibility as a Team Leader.
- Allocate, assign tasks, supervise and manage team members.
- Develop capacity of CHW's to deliver services.
- Promote teamwork amongst team members
- Train, mentor and coach PHC team members.
- Manage performance of team members (set performance standards, assess, evaluate, correct and improve performance)
- Monitor and evaluate team performance.

The role of the Community Health Worker

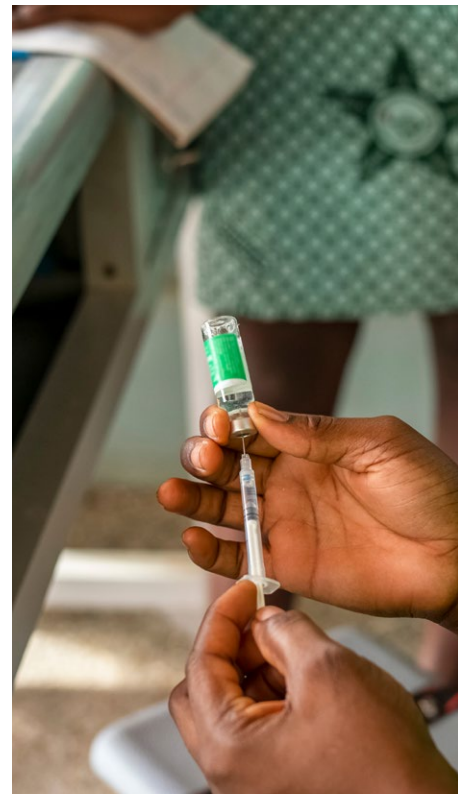
The community health worker has responsibilities as part of this PHC outreach team, including:

- Facilitate entry into the community for the PHC Outreach team.
- Conduct a community assessment and compile a profile and diagnose the health needs of the community.
- Initiate a community-based PHC outreach service to household, their inhabitants and to school, crèches, and day care centers in a designated geographic area.

- Establish and maintain collaboration and liaison with local community and local service providers.
- Map household, school and crèches/day care centers in the geographic areas serviced by the PHC outreach team.

Primary Health Care Re-engineering has had a remarkable impact in the lives of our communities. There had been a drop in children malnutrition and children mortality rates. The under 5 years child immunization improved dramatically this was because of the campaigns initiated by Primary Engineering Out-Reach Teams.

A large intake of patients dropped tremendously in clinics and hospitals since Primary Out-Reach Teams delivered pre-packed medication to various households in the community. Chronic patients are grouped in clubs and are given return dates according to respective clubs. The waiting periods improved in clinics and hospitals. The death rate of immunosuppressed patients is now rare since the defaulter rate is now very low.





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Tips on appropriate language for nurses in improving access to care for the prevention and treatment of HIV.

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There is an age-old saying: 'Sticks and stones will break my bones, but words will never hurt me.' But this is not true. It is well known that verbal abuse can be as harmful as physical abuse. Even a misplaced word can make someone feel unsafe or excluded. So how does our use of language impact the health outcomes of our patients?

It is now almost 40 years since HIV became a major public health concern. We have seen the extraordinary development of testing, prevention and treatment modalities for people living with HIV (PLHIV). Yet up to half of PLHIV present to care with Advanced HIV disease (AHD)¹ Contributing factors to AHD include patients not testing for HIV, or not adhering to

their antiretroviral treatment and this may be due to health care providers' behaviour towards patients.

Patients avoid coming to the clinic if they feel stigmatised or judged. Underlying prejudices appear in the way people use language. If a nurse believes that a PLHIV 'deserved' it, or only sees the disease and not the patient, it will appear in the language that they use. Appropriate language is a particular challenge in specific groups of people. The South Africa's National Strategic Plan on HIV, STI and TB, identified key populations such as gay, bisexual and other men who have sex with men (GBMSM), sex workers, transgender and gender diverse (TGD) people and people who use drugs, to

be more vulnerable to contracting HIV infection, or dying from AHD.²

Much research has been done to establish why key populations are more vulnerable to HIV infection. The Ritshidze report of 2023 raises concerning data regarding the contribution of health care workers' attitudes to patients not accessing care. In the study a significant proportion of patients from key populations had been refused access to health services because of who they are (5% of GBMSM, 12% of sex workers, and 9% of transgender people). Only 37% of GBMSM respondents reported that facility staff were always friendly and professional, 24% of people who use drugs, 46% of sex workers, and 41%

of transgender people. Discriminatory behavior was experienced across the different areas of the work place; including the clinic gate, the waiting room and the consultation room.³

Understanding prejudice

All human beings have prejudices. It is part of our evolutionary survival mechanism to view anyone different than ourselves with suspicion. When we encounter a new or unknown situation or person, our natural defence mechanism leads to an increase of adrenalin production, and a change in how our brain processes and view information. This type of thinking can save our life when under physical threat, ensuring fast decision-making based on minimal information. Even when slightly stressed, one tends to make assumptions, have black-and-white thinking, and become more paranoid and vigilant. Stressed thinking tends to be more emotional and inconsistent and there is tendency to engage in emotive judgement (such as in social media). Although this type of reasoning may be useful when walking through a dangerous neighbourhood, it could be counter-productive when engaging with complex issues or dealing with relationship dynamics. Whenever someone harshly judges someone different from themselves, based on little evidence or expertise, they are functioning from the level of the survival system. This is the basis of prejudice.

But human beings do not only have survival system. The pre-frontal cortex dominates thinking when a person is relaxed and not under threat. This type of creative thinking is able to be empathic, flexible, tolerant, generous and humble. A person is able to see an issue in context and with perspective and can make decisions by using logic and critical reasoning. This 'creative brain' makes it possible to notice that emotive judgements (prejudice) are driven by fear, and a broader perspective becomes possible. It is only

when prejudices are not overridden by the kinder, more sophisticated part of the brain, that behaviours arise that are rude, racist, homophobic and so forth.

The conflict between own values and patient values

This article does not propose that a person compromise their own beliefs or ideas as per religious, cultural or ideological backgrounds. Rather, it will focus on how a nurse provides best, non-judgemental care to each and every patient regardless of their illness, behaviour, work, gender identity, sexual orientation and so forth. The role of the clinician is to serve the health care need of the patient and to provide the best possible care. To do this each clinician need to be aware of their own prejudices and subsequent language use. South Africans has shown to be particularly able to be accepting of others, even if they differ from themselves.

In 2012 the Human Sciences Research Council and The Other foundation, did a survey of attitudes towards homosexuality & gender non-conformity in South Africa. The report was named *Progressive Prudes*, because it found that 'the majority of South Africans think that gay and lesbian people should have the same human rights as other people and should be part of the cultures and traditions of South Africa,

even though the majority also think that sex between people of the same sex is morally wrong'.

This is the spirit of *ubuntu*; the ability of South Africans to respect the rights of others, even when they do not necessarily understand or agree with another person's way of life.⁴

Appropriate language recommendations

To assist nurses in their daily practice we will outline some tips on appropriate language to ensure patients feel safe to share important information that may pertain to their health, without fear of judgement. We will focus on PLHIV, taking a sexual health history in person who identify as lesbian, gay, bisexual or transgender etc. (LGBT+) and use of language with TGD people.

People living with HIV

Partly out of habit, and partly out of laziness, we sometimes classify patients according to their disease e.g. using terms such as diabetic patients, HIV patients or drug users. If we use this language often, it creates an impression in our own minds, as well as those around us, that the patient's identity is linked to their disease. A more helpful term is that of 'person living with HIV' or 'person who uses drugs'. See table 1 for additional preferred words or phrases.

Table 1: Guide to talking about HIV

Problematic word or Phrase	Preferred word or phrase
AIDS (when referring to virus, HIV)	HIV, HIV and AIDS (when referring to the virus and/or the disease)
To catch HIV, to pass on HIV	To be diagnosed with HIV. To acquire HIV. To transmit HIV.
Victims, sufferers, contaminated, sick	People / person with HIV
AIDS patient. HIV patient. Patient. HIV carrier/s	Person with Aids, Person with HIV, Person living with HIV, HIV-positive person

Source: **Centre Disease Control and Prevention (CDC) Guide to Talking about HIV⁵**



LGBT+: Taking a sexual health history

In the Rithidze report of 2023 only 14% of GBMSM and 14% of TGD people felt “very safe” using the facility³. In a study of TGDs people’s experiences of accessing reproductive health care in KZN, participants reported hostile encounters with clinicians, both intentional and unintentional⁶. Most of these experiences can be explained by underlying uncertainty and fear, resulting in prejudice that lead to language use that make the patient feel unsafe. It is important to become mindful of these populations as LGBT+ patients make up a significant part of our society.

The average share of LGBT+ persons of the population comes to 9%.⁷, which is almost one in ten patients visiting our facilities. GBMSM and TGD people have different and specific health and sexual health needs, and it is important that we provide accessible services for these populations.²

We need patients to be open and truthful when answering questions about aspects of their life such as sexual behaviour. To ensure that our patients

share openly, we need to create a safe environment to do so. This is particularly important when taking a sexual health history as advised in the CDC’s ‘A guide on how to take a sexual history’.⁸

The CDC recommends that a clinician needs to be mindful not to make assumptions, and to make inquiries in such a way that reassures the patient that they would not be judged. It is helpful to practice a set of stock questions. Start with an opening question such as: ‘*May I ask you a few questions about your sexual health and sexual practices? I understand that these questions are personal, but they are important for your overall health.*’ This helps the patient to understand that this is not an interrogation, but simply information gathering. When asking about partners do not assume but rather ask ‘*What is the gender/s of your sex partners?*’. The tone of the question is important to ensure the patient feels safe to answers truthfully. A similar sensitivity is important when asking about sexual practices: ‘*What kind of sexual contact do you have?*’ and ‘*What parts of your body are involved when you have sex?*’ If a nurse finds it difficult to discuss certain practices, such as anal sex, it is

important to identify at least one other colleague in the clinic they can refer to when needed.

Transgender and gender diverse (TGD) people

Knowledge around language use is needed when caring for TGD people, as there is still much confusion around managing this population⁶ and the use of names and pronouns. Below is a quick overview of some of these new and possibly unfamiliar concepts.

This is the spirit of *ubuntu*; the ability of South Africans to respect the rights of others, even when they do not necessarily understand or agree with another person’s way of life.⁴

Transgender is a term that describes a person who does not identify (wholly or partially) with their sex assigned at birth. A **transgender woman** (TGW) is someone who was assigned male at birth, but who identifies as a woman and usually uses the pronouns she /her. A **transgender man** (TGM) is someone who was assigned female at birth, but who identifies as a man, usually using pronouns he/him⁹. **Gender diverse** is a general term and relates to a person whose gender identity or gender expression does not conform to socially defined male or female gender norms, and includes those that identify as gender fluid or non-binary. Gender fluid or non-binary people often use the singular they / them pronoun, which is commonly used when referring to gender neutral persons such as "Help your child to put on **their** shoes." Gender identity is different from sexual orientation, which refers to the gender of the person that one is attracted to, or the absence of attraction. In the last decade our understanding of TGD people has changed.

In 2018 the WHO published the International Classification of Disease (ICD-11), in which 'gender identity disorder' was removed from the section of mental health disorders, reflecting the 'current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health'.¹⁰ Essential to the management of TGD individuals is gender affirmation, which can be defined as an 'interpersonal, interactive process whereby a person receives social recognition and affirmation for their gender identity and expression'¹¹. Gender affirmation starts with the clinician affirming and accepting the patient's gender identity. We need to train all the staff in our clinics, including the security guard at the front gate, the filing clerks, the nurses and the doctors as well as the wider multi-disciplinary team on using the client's true name (the name with which a person identifies, which may be different from a person's given or legal name) and correct pronouns, and the correct use of gender terminology. We may have to be innovative with

our administration systems, e.g. highlighting the true name and pronouns on the folder cover. Addressing the TGD person correctly will go a long way to creating safety and acceptance in our facilities.

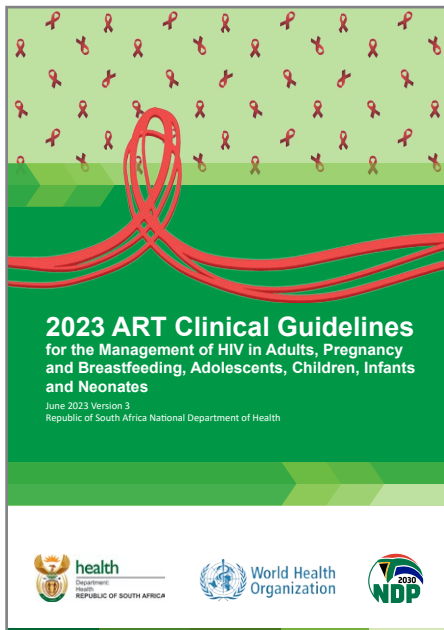
Conclusion

Nurses care deeply about their patients, and truly want the best for each person they meet. The clinician has to be mindful to ensure that underlying fears and uncertainties do not present as prejudices and behaviours that may make a person feel unsafe, or possibly even unwilling to visit our clinics. By being sensitive in the use of language around HIV, gender identity and sexual orientation, nurses can ensure that patients feel confident to visit their facilities and accessing care.

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What's new in the NDoH 2023 ART Clinical Guideline?

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As the antiretroviral therapy (ART) programme in South Africa grows and matures, almost 6 million people living with HIV (PLHIV) on ART need to remain engaged in care and virally suppressed. The South African National Department of Health 2023 ART Clinical Guideline¹ provides two main strategies to ensure that taking ART and remaining engaged in care is as convenient as possible for PLHIV, while also being efficient and cost-effective for the health system. These are 1) the use of **optimised ART regimens** containing dolutegravir, and 2) promoting a **patient-centred approach** that differentiates care according to the needs and preferences of PLHIV.

Optimised ART regimens

ART optimisation using dolutegravir (DTG) containing regimens allows PLHIV to receive the best-available ART in the most efficient and cost-effective manner possible.² Optimising ART 1) simplifies regimens with reduced pill burden and dosing frequency, 2) enhances tolerability and reduces drug-toxicity, 3) reduces potential drug-drug interactions, and 4) maintains viral suppression without jeopardising future treatment options through the development of drug resistance.

Specific changes in the guideline to improve access to optimised ART regimens

Dolutegravir (DTG)-containing regimens are preferred for all adults, adolescents, pregnant women, and children beyond the neonatal period. All clients already on ART and not on DTG, whether on first-line or second-line regimens, should be evaluated for a switch to a DTG-containing regimen. New paediatric DTG (pDTG) formulations have made DTG accessible to younger children from four weeks of age and 3kg, in combination with abacavir and lamivudine. Evolving evidence has found no significant difference in the risk for neural tube defects between DTG and efavirenz (EFV) exposure at conception³, enabling women of reproductive age to use DTG, regardless of their intentions to conceive, their pregnancy status, or whether using contraception or not.

The preferred optimised regimen for adults, adolescents and pregnant women with normal renal function is tenofovir disoproxil fumarate-lamivudine-dolutegravir (TLD). The weight-related eligibility criteria for tenofovir disoproxil fumarate-(TDF) has been decreased from 35kg to 30 kg. New evidence has shown that

TDF may safely be reused in 2nd-line therapy following 1st-line failure with TDF-containing regimens.^{4,5} TLD can therefore be used as both first (TLD 1) and second (TLD 2) line regimens. The ability to “recycle” TDF also simplifies the switch from TEE to TLD, with this switch no longer dependent on viral load (VL). This means that clients on TEE can switch to TLD immediately, regardless of their VL result. However, an unsuppressed VL in the last 12 months will still need to be assessed and managed, even though the switch from TEE to TLD has already been made.

Resistance to DTG is very uncommon; therefore, suboptimal adherence remains the most probable cause for non-suppression for clients on a DTG-based regimen.⁶ As such, the 2023 ART guideline has a strong focus on enabling optimal adherence. Where adherence is sub-optimal, while identifying and addressing the underlying root causes of non-adherence, it is better to keep a PLHIV on a once-daily, well-tolerated, fixed-dose combination regimen (TLD) than switching to a less well-tolerated regimen with more complex dosing schedules. For this reason, no regimen changes should happen unless DTG has been proven to be ineffective through a resistance test. However, resistance tests will only be considered for clients

on TLD 2 (failed a previous regimen), and in whom there is some indication of good adherence. Resistance tests can only be authorised by a member of the National Third-line committee, one of the helpline consultants, or a nominated provincial expert.

A patient-centered approach

Improving engagement in ART care requires a patient-centred approach which recognises the diversity of PLHIV and adapts HIV service delivery accordingly.⁶ The 2023 ART guideline therefore aims to reduce any unnecessary visit burden and increase convenience for clients while providing quality clinical management.

Specific changes in the guideline to improve patient-centeredness

With DTG ensuring earlier viral suppression, the first VL monitoring has moved from 6 to 3 months on ART. This will support healthcare workers to identify and action adherence challenges earlier. PLHIV with a suppressed viral load are immediately eligible for enrolment into their choice of South Africa's repeat prescription collection strategies (RPCs) - external pick-up points, fast-track facility pick-up points or adherence clubs with a maximum of two drug refills from a 6-month script. PLHIV not eligible for RPCs, can also be given longer drug refills to fully cover periods between clinical review dates - these include

children from 6 months of age, post-natal women, people with concomitant TB, clients with elevated viral loads and those travelling or re-engaging in care. Recognising that many PLHIV who re-engage in care after a treatment interruption, do not need increased clinical management but more flexibility, care for "welcome back" clients is differentiated based on clinical stability and time since a missed appointment.

Care for PLHIV with a concomitant illness, requiring a preventative health service (such as contraception) or responsible for a child, should be integrated into the same service delivery model or at a minimum, different health need visit dates should be aligned.

All updates are summarised in Table 1.

Conclusion

Improving PLHIV engagement in care and viral suppression in PLHIV will require the implementation of optimised ART regimens containing dolutegravir and a patient-centred approach.

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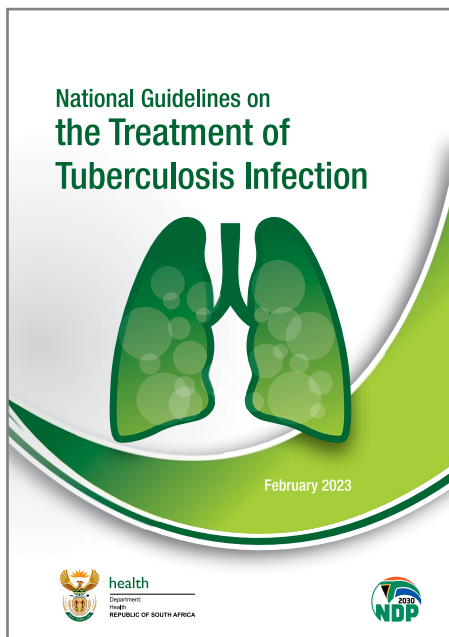


Table 1. What's new in the 2023 ART Clinical Guideline

Terminology	TLD 1 (or ALD 1 in children)	Clients on a DTG-containing regimen, who have never failed any other regimen (previous "first-line" terminology)
	TLD 2 (or ALD 2 in children)	Clients on a DTG-containing regimen, who have failed an earlier regimen (previous "second-line" terminology)
	Dispensing cycle	A dispensing cycle (DC) is defined as the number of days for which a client would have treatment if a single standard "monthly" quantity of tablets were dispensed. The term DC is preferred to the previously used term 'month' due to the potential discrepancy that may arise between the days of treatment dispensed (if 28-day pack sizes are used) and the days in a month (on average, 30 days)

Continued onto next page

ART Regimens	<p>All adult and adolescent clients > 30 kg and > 10 years of age, including pregnant and breastfeeding women</p>	<ul style="list-style-type: none"> The preferred first-line ART regimen is tenofovir disoproxil fumarate-lamivudine-dolutegravir (TLD) for those adult and adolescent clients initiating ART. TDF weight-related eligibility criteria decreased from 35 kg to 30 kg All clients already on ART and not on dolutegravir (DTG), whether on first-line or second-line regimens, should be evaluated for a switch to a dolutegravir-containing regimen.
	<p>New formulations</p>	<ul style="list-style-type: none"> TDF may safely be reused in 2nd-line therapy following 1st-line failure with TDF-containing regimens. TLD will therefore be used as both first (TLD 1) and second (TLD 2) line regimens and in certain cases, 3rd line regimens as well Simplified switching from TEE to TLD not dependant on VL
	<p>Children ≥ 3 kg and ≥ 4 weeks of age until 29,9 kg or 9 years of age</p>	<ul style="list-style-type: none"> The preferred first-line ART regimen is abacavir-lamivudine-dolutegravir (ALD). All paediatric clients already on ART and not on dolutegravir (DTG), whether on first-line or second-line regimens, should be evaluated for a switch to a dolutegravir-containing regimen.
	<p>Other antiretrovirals</p>	<ul style="list-style-type: none"> Abacavir is the preferred alternative agent if TDF cannot be used. Zidovudine (AZT) no longer part of any standard ART regimen. AZT will be reserved only for cases with both renal failure and ABC hypersensitivity. Atazanavir/r replaces lopinavir/r as the preferred protease inhibitor except when on TB treatment
Monitoring on ART	<p>VL monitoring</p>	<ul style="list-style-type: none"> First VL after ART initiation to be done after 3 dispensing cycles. Allows for earlier detection of factors influencing viral suppression. Allows for earlier decanting for suppressed clients to minimise visits and promote continued engagement in care
	<p>Creatinine and eGFR</p>	<p>eGFR previously done at 'month' 6 moves to 'month' 3 (i.e. after 3 dispensing cycles) to align with the new VL monitoring schedule</p>
Virological Failure	<ul style="list-style-type: none"> Definition: two or more VLs ≥ 1000 c/mL taken two or more years after starting a DTG/PI-containing regimen and adherence > 80% Focus on improved adherence: Resistance to DTG is very uncommon. If other reasons for an unsuppressed VL (including drug interactions) have been addressed or excluded, suboptimal adherence remains the most probable cause for non-suppression. The highest probability of improving adherence would be to remain on a once-daily, well-tolerated, fixed-dose combination regimen (TLD) while identifying and addressing the underlying root causes of non-adherence. No regimen changes without a resistance test: Switching off a DTG-containing regimen should only happen if InSTI resistance has been confirmed by a resistance test. Resistance testing can only be authorised by a member of the National Third-line committee, one of the helpline consultants, or a nominated provincial expert 	
Service delivery specific changes, including differentiated models of care standard operating procedures (DMOC SOPs)	<ul style="list-style-type: none"> 2 high-quality counselling sessions at ART start and at follow-up a month later Reduces health facility visits in the first year on treatment to support continued engagement in care. 'Time on ART' removed from repeat prescription collection strategies (RPCs) eligibility criteria, enabling access as soon as the first VL is suppressed, and other criteria are met (from 4 months on ART). Reduces visits once enrolled in RPCs with a maximum of 2 visits (1 facility + 1 RPCs) per 6-month scripting cycle. Enables multi-month dispensing (MMD) by the facility between clinical visits for people including those not eligible for RPCs - children from 6 months of age, post-natal women, people co-infected with TB or with elevated viral loads or travelling or re-engaging in care. Revises the differentiated approach to patient management on re-engagement. Integrates Family planning and TB preventative therapy into all service delivery models. Aligns visit schedules supporting integrated services for people co-infected with TB and mother-baby pairs living with HIV. Incorporates tools for: <ul style="list-style-type: none"> child disclosure counselling enhanced adherence counselling mental health assessment 	



Taking a look at the new National TB Preventive Therapy guidelines

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South Africa's first national TB prevalence survey¹ showed that in 2018 an estimated 390 000 people became ill with tuberculosis (TB) in the country. This survey indicated that even though nearly 400 000 people fell ill with TB, only 235 652 were diagnosed with TB and a staggering 154 384 were not. These findings imply that South Africa has huge problem of a continuing and unbroken cycle of TB transmission. South Africa has one of the highest TB prevalence rates in the world, with the prevalence of pulmonary TB in people 15 years and older estimated to be 852 (range 679-1026) per 1000 people, and an estimated prevalence of all types of TB in all ages estimated to be 737 per 100 000 people.¹

Most of the South African population will have a significant exposure to TB, and there is a high risk of developing TB disease amongst people living with HIV (PLHIV), immunocompromised people, people in congregate spaces, miners, inmates, health care workers, pregnant women, and people with silicosis. There is therefore a need for a comprehensive strategy to prevent TB disease in the country. TB Preventive Therapy (TPT) is a TB disease prevention strategy and a critical component of the World Health Organization (WHO) End TB Strategy. TB prevention and treatment are

therefore important tools for South Africa to reduce the burden of TB and achieve the 2025 End TB Strategy targets of reducing the TB incidence by 50% and the TB mortality by 75%. To help with the dual plan of prevention and diagnosis of TB, the National Department of Health (NDoH) released Guidelines on the treatment of Tuberculosis infection in March 2023.² These guidelines were revised from previous TPT guidelines based on guidance by World Health Organisation (WHO), local evidence and experience with TPT. The new guidelines are designed to guide healthcare workers at the coalface to implement the TPT program by identifying people eligible for TPT, initiating and managing people on TPT, and to monitor and evaluate the programme.

These National Guidelines have expanded the eligibility of TPT. Previously TPT was offered to a limited group of people (only offered to those who were at highest risk of progressing to TB disease after exposure to a person with TB) i.e., children younger than 5 years of age, and all people living with HIV, regardless of age. The new 2023 guidelines have expanded the TPT eligibility by offering TPT to everyone with significant TB exposure and all other individuals at high risk of

TB. Significant TB exposure is defined as a documented exposure to a person (adult or adolescent) with pulmonary TB who shared the same enclosed space for one or more nights, or for frequent or extended daytime periods during the three months before the index patient started TB treatment.

Another new element added to the guidelines is a concept of the TB test and treat approach. With this TB test and treat approach, all TPT-eligible people (adults, adolescents, and children) should be evaluated for TB disease before initiating TPT, including testing for active TB disease. A person with significant TB exposure will therefore either be offered TB treatment (if there is TB disease) or TPT. In addition, all people considered for TPT should undergo a clinical evaluation (TB symptom check and physical examination) and be tested with GeneXpert even if asymptomatic.

Most of the South African population will have a significant exposure to TB.

Who requires TPT?

The following groups of people are eligible for TPT once active TB has been excluded:

- TB Contacts
- People living with HIV (PLHIV)
- Other high-risk groups, including:
 - Inmates in correctional or other congregate facilities
 - Health care workers
 - People who have previously had TB
 - People with silicosis

Important points about TPT in the new guidelines

The following points are highlighted by the new guidelines:

- TPT is an effective and safe intervention to reduce the risk of developing TB for all people with TB exposure.
- TPT is effective in reducing the risk of developing TB in PLHIV and those with silicosis, regardless of known exposure.
- TPT should be offered to all people (regardless of age and HIV status) after significant TB exposure and to those who are immunocompromised (regardless of known exposure), after TB disease has been excluded.
- TPT is recommended to those who have previously completed TB treatment, should they have exposure to TB again, or become immunocompromised.

The role of symptom screening in the new guidelines

People who are being evaluated for TPT should be screened for TB symptoms prior initiation of TPT.

In adults, adolescents and older children contacts, symptoms used to screen for TB disease includes one or more of the following:

- current cough (regardless of duration)
- weight loss

- Fever and/or night sweats
- haemoptysis

Symptoms used to screen for TB disease in younger children (< 25 kg) include the following:

- current cough (regardless of duration)
- poor weight gain or failure to thrive, or documented weight loss
- fever and/or night sweats
- lethargy/fatigue (decreased playfulness)
- a visible neck mass or swelling

The role of testing for TB disease in the new guidelines:

Tests for TB infection include the Tuberculin Skin Test (TST) and Interferon-gamma release assay (IGRA). These tests for TB infection are useful to detect TB infection (TB infection occurs when a person has inhaled TB bacillus but does not get sick with TB. The person will be asymptomatic) but are not a requirement to start TPT. In the new guidelines, these tests for TB infection are no longer listed in the algorithms to initiate TPT and any lack of availability should not impact whether a person is offered TPT or not.

In adults, adolescents, and children, the following tests are recommended to exclude TB prior initiating TPT to exclude active disease (regardless of the presence of symptoms):

- Sputum sample for GeneXpert
- If no sputum sample can be collected, a chest x-ray should be obtained

Current TPT options in South Africa:

The following are the TPT options available in South Africa. Which option to use will be dependent on patient factors:

- 3HP: Three (3) months of isoniazid and rifampentine given once weekly
- 3RH: Three (3) months of daily rifampicin and isoniazid
- 6H: Six (6) months of daily isoniazid

- 12H: Twelve (12) months of daily isoniazid.

Clinical monitoring of people on TPT

The new guidelines recommend monitoring of people on TPT. This should include:

- Education and counselling of eligible individuals
- Follow-up visits
- Monitoring for and management of adverse events
- Understanding and managing drug-drug interactions
- Managing of individuals who interrupt preventive therapy

Monitoring and evaluation of the TPT programme

The new guidelines recommend monitoring of the programme which is defined as the periodic assessment of programme activities to determine whether they are proceeding as planned. Monitoring of the programme provides managers with continuous feedback on implementation, to make informed decisions regarding service delivery and to ensure effective and efficient use of resources for maximum impact.

The guidelines also recommend evaluation which is defined as periodic in-depth time bound analysis which aims to assess performance and overall impact of the programme systemically and objectively.

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New guidance on managing sexually transmitted infections from the Southern African HIV Clinicians Society

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Introduction

There are high burdens of sexually transmitted infections (STIs) in Southern Africa. The most common clinical presentations of STIs are male urethral discharge syndrome (MUDS), vaginal discharge syndrome (VDS) and genital ulcer disease (GUD). Untreated STIs are associated with morbidity, reproductive tract complications and adverse pregnancy outcomes, and increase the risk of HIV transmission and acquisition.

The article reflects the latest advice from the Southern African HIV Clinicians' Society (SAHCS) 2022 guidelines for the management of STIs,¹ which provide additional information to the National Department of Health's syndromic management guidelines,² and constitute 'best practice' recommendations when resources are available.

Which infections cause these STI-associated syndromes?

Most cases of MUDS are caused by *Neisseria gonorrhoeae* and/or *Chlamydia trachomatis*; these STIs are both covered by the current syndromic

treatment regimen. Other causes include infections with *Trichomonas vaginalis*, *Mycoplasma genitalium* and less commonly non-STI bacteria. In contrast, women with VDS have a more diverse and mixed aetiology. Bacterial vaginosis (BV) and vulvovaginal candidiasis (VVC) are the most common causes of VDS with only 40-50% of cases caused by an STI (*C. trachomatis*, *N. gonorrhoeae*, *T. vaginalis*).^{3,4,5} Mixed aetiology is common with one in three women with BV or VVC also having an STI, and one in four women with an STI having multiple STIs. This has important implications for counselling patients, as BV and VVC are not considered STIs. Also, this diverse and mixed aetiology is the reason that the VDS and MUDS syndromic treatment regimens differ, and that recurrent or persistent VDS is common.

Comprehensive sexual and reproductive health services should include history taking, physical examination, contraception, an HIV test and STI screening.

GUD is generally caused by either herpes simplex virus (HSV) or *Treponema pallidum*, the causative agent of syphilis. Chancroid and lymphogranuloma venereum (LGV) are rare and should only be considered in specific cases.

How can we best screen for STIs?

Comprehensive sexual and reproductive health services should include history taking, physical examination, contraception, an HIV test and STI screening. Healthcare worker-initiated symptom screening is a good approach to address the unmet need for STI services, because a substantial proportion of symptomatic individuals do not consult for their symptoms, due to various patient-, provider- and healthcare system-related factors.⁶ Therefore, actively asking patients about STI symptoms will help close this gap.

If resources are available, STI screening of asymptomatic individuals using diagnostic tests is recommended. Most of the *C. trachomatis* and *N. gonorrhoeae* infections remain asymptomatic and are thus left untreated with the syndromic management approach. Diagnostic

STI testing of first-void urine in men and vaginal swabs in women can identify these asymptomatic infections and prevent complications. Syphilis antibody screening can be done using a rapid diagnostic test (RDT) or through laboratory-based testing.

What diagnostic tests can be used for STIs?

Except for HIV and syphilis, there are no rapid affordable point-of-care (POC) tests for STIs available with acceptable diagnostic performance. The *T. pallidum* RDT can be used for screening asymptomatic individuals but cannot rule out syphilis in people with GUD, because it may be false-negative in the early stages. Furthermore, a positive *T. pallidum* RDT should be followed by laboratory-based testing so that a rapid plasma reagin (RPR) titre can be established. This is important for monitoring the response to treatment and to interpret future diagnostic tests, e.g., reinfection, because the RDT remains positive after treatment.

Molecular tests of first-void urine and vaginal swabs are preferred to diagnose *C. trachomatis*, *N. gonorrhoeae* and *T. vaginalis*. Vaginal swabs may be self-collected or healthcare-provider collected. Vaginal smear microscopy can be performed to diagnose BV and/or VVC. *Neisseria gonorrhoeae* and/or fungal culture are only indicated in patients with suspected treatment failure.

If resources are available, molecular testing of ulcer swabs is recommended to diagnose HSV but HSV antibody testing is not recommended in the clinical work-up of GUD. Sensitivity of molecular testing of *T. pallidum* in ulcer swabs is approximately 80%, which may help to confirm the diagnosis, but cannot rule out syphilis.

What treatment is recommended for STIs?

Syndromic management is currently



the mainstay of treatment for STIs in Southern Africa. The treatment algorithm differs slightly between countries, but all recommend an empirical combination of antibiotics that covers the most likely causes. Most algorithms recommend azithromycin 1g single dose for *C. trachomatis*, 250mg ceftriaxone intramuscular (IM) injection for *N. gonorrhoeae*, and a 2g single dose or 7-day course of 400mg or 500mg metronidazole for *T. vaginalis* and to manage BV. VVC treatment is recommended based on signs observed during examination.

The SAHCS 2022 guidelines are aligned with these treatment recommendations, except for the dose of ceftriaxone for the treatment of *N. gonorrhoea*. Ceftriaxone 500mg rather than 250mg is recommended due to the global increase in the minimum inhibitory concentrations (MICs) of the drug against the organism, and the paucity of data on its effectiveness amongst key populations, like men who have sex with men (particularly for oropharyngeal and rectal infections). Furthermore, a course of 7 days of metronidazole has been shown to be more effective than single dose treatment for *T. vaginalis*, and should be considered, if good adherence is likely.

Benzathine benzylpenicillin (BPG) 2.4 MU IM injection is the recommended treatment for syphilis, with one injection for primary, secondary and early latent infection, and three injections in the case of late latent syphilis. Doxycycline 100mg twice daily for 14 or 28 days, dependent on the syphilis stage, provides an

alternative option, but is not recommended in pregnancy. Azithromycin is also not recommended, given worldwide emergence of macrolide resistance in *T. pallidum*, and because it does not cross the placenta during pregnancy leaving the exposed foetus untreated. To cover for HSV infection, acyclovir 400mg is combined with BPG in the syndromic regimen of GUD.

If an aetiological diagnosis is established through diagnostic testing, targeted treatment should be provided. Pathogen-directed therapy would be 500mg IM injection of ceftriaxone for *N. gonorrhoeae*, a 7-day course of 400mg or 500mg metronidazole for *T. vaginalis*, BPG 2.4 MU injection(s) for *T. pallidum* and 400mg acyclovir for HSV infection. In the case of pathogen-directed therapy of *C. trachomatis*, a 7-day course of 100mg twice-daily doxycycline should be recommended over azithromycin in all non-pregnant individuals because of its superior efficacy.

All people treated for an STI should be offered comprehensive sexual health services, including condom use, discussion of sex partner treatment, HIV testing, and HIV pre-exposure prophylaxis if indicated. Cervical cancer screening should also be offered.

Table 1 provides the SAHCS 2022 guideline the recommended first-line regimens for STI management, and Table 2 provides the recommended antimicrobial drugs for pathogen-directed treatment of uncomplicated STIs.

Table 1: Recommended first-line antimicrobial treatment regimens for STI syndromic management.

	Preferred regimen	Alternative regimen
Male urethral discharge syndrome	Azithromycin 1g, orally, single dose ^a PLUS Ceftriaxone 500mg, intramuscularly, single dose	Azithromycin 1g, orally, single dose ^a PLUS Cefixime 800mg, orally, single dose
Vaginal discharge syndrome	Azithromycin 1g, orally, single dose PLUS Ceftriaxone 500mg, intramuscularly, single dose PLUS Metronidazole 400mg or 500mg, orally, twice daily for 7 days ^{b,c} OR Metronidazole 2g, orally, single dose ^{b,c}	Azithromycin 1g, orally, single dose PLUS Cefixime 800mg, orally, single dose PLUS Metronidazole 400mg or 500mg, orally, twice daily for 7 days ^{b,c} OR Metronidazole 2g, orally, single dose ^{b,c}
Symptoms and signs suggestive of candidiasis	Miconazole vaginal pessaries, 200mg, inserted at night for 3 nights OR Clotrimazole vaginal tablet, 500mg, inserted at night single dose	Fluconazole 150mg or 200mg, orally, single dose ^c OR Nystatin, 200–300-unit vaginal tablet, inserted at night for 7 nights
Genital ulcer disease	First episode^e Acyclovir 400mg, orally, three times a day for up to 10 days PLUS Benzathine benzylpenicillin 2.4 MU, intramuscularly single dose Recurrent episode^e Acyclovir 400mg, orally, three times a day for 3 days PLUS Benzathine benzylpenicillin 2.4 MU, intramuscularly single dose	First episode^e Acyclovir 400mg, orally, three times a day for up to 10 days PLUS Doxycycline 100mg, orally, twice daily for 14 days ^d Recurrent episode^e Acyclovir 400mg, orally, three times a day for 3 days PLUS Doxycycline 100mg, orally, twice daily for 14 days ^d

^aIn the absence of diagnostics, azithromycin is preferred over doxycycline in syndromic management of symptomatic individuals. ^bAvoid metronidazole in first trimester of pregnancy. ^cIn case of good adherence, a course of metronidazole is preferred over single-dose treatment as it has higher efficacy for *T. vaginalis* than single-dose metronidazole and has the added benefit of treating concurrent BV. ^dDoxycycline for men and non-pregnant/non-breastfeeding women; avoid in pregnancy. ^eTreatment may be restricted to acyclovir if the patient reports no sexual contact in the previous 3 months, and in individuals with recurrent vesicular ulcers in same site and with a recent history (<3 months) of syphilis treatment (RPR monitoring to be done).



Table 2: Recommended antimicrobial drugs for targeted treatment of uncomplicated sexually transmitted infections.

Pathogen	Recommended regimen	Alternative regimen
Chlamydia trachomatis	Doxycycline 100mg orally, 2 times per day for 7 days	Azithromycin 1g orally, single dose
Neisseria gonorrhoeae	Ceftriaxone 500mg single intramuscular injection ^a	Cefixime 800mg, orally, single dose
Trichomonas vaginalis (women)	Metronidazole 400mg/500mg, orally, 2 times per day for 7 days ^b	Metronidazole 2g, orally, single dose OR Tinidazole, orally, 2g single dose
Trichomonas vaginalis (men)	Metronidazole 2g, orally, single dose	Metronidazole 400mg/500mg, orally, 2 times per day for 7 days ^b
Mycoplasma genitalium	Doxycycline 100mg, orally, two times per day for 7 days followed by: <ul style="list-style-type: none"> Azithromycin 1g initial dose followed by 500mg, orally, daily for 3 additional days if unknown resistance profile or macrolide-susceptible Moxifloxacin, orally, 400mg daily for 7 days if macrolide-resistant 	To discuss with specialist
Herpes simplex	Primary infection: Acyclovir 400mg, orally, 3 times per day for up to 10 days Recurrent infection: Acyclovir 400mg or 800mg, orally, 3 times per day for 3 days	Primary infection: Valaciclovir 500mg, orally, twice daily for up to 10 days Recurrent ulcer: Valaciclovir 500mg, orally, twice daily for 3 days
Treponema pallidum (syphilis)	Early syphilis: ^c Benzathine benzylpenicillin 2.4 million units, intramuscularly, single dose Late syphilis: Benzathine benzylpenicillin 2.4 million units, intramuscularly, single dose, once weekly for three consecutive weeks	Early syphilis: ^c Doxycycline 100mg, orally, twice per day for 14 days OR Late syphilis: Procaine penicillin 1.2 million units intramuscular injection once daily for 20 consecutive days OR Doxycycline 100mg, orally, twice per day for 30 days

^aIncrease dose to 1g intramuscular injection in case of confirmed oropharyngeal infection. ^b400mg or 500mg based on local availability. ^cEarly syphilis: primary, secondary, or early latent (<2 years ago); late syphilis does not include management of neurosyphilis.

What about treatment of recurrent or persistent symptoms?

There are various reasons for STI-associated symptoms to recur or persist. Sex partner dynamics play an important role as reinfection may happen from an untreated partner. Also, a new STI can be acquired from the same or a different sex partner. Patients with an STI should be counselled and provided with a notification slip to give to each sex partner so that partners can access treatment, even if they are asymptomatic. Expedited partner therapy, i.e. providing patients with pill pack to give to their sex partner(s), provides an effective alternative to the system of notification slips but, while implemented in other countries, is currently not supported by South African prescribing law.

Treatment failure may also occur when the aetiological causes of symptoms are not covered by the syndromic treatment regimen (e.g. *T. vaginalis* infection in men with MUDS and VVC in women with VDS). Also, treatment efficacy of metronidazole for *T. vaginalis* and BV may be suboptimal resulting in recurrent or persistent symptoms. Antimicrobial resistance in STIs is still

relatively uncommon in Southern Africa and is mainly relevant to *N. gonorrhoeae* infection and VVC. Therefore, gonococcal and fungal cultures are recommended in case of treatment failure without other obvious explanations.

The way forward

The World Health Organization's Global health sector strategy on sexually transmitted infections 2022 – 2030 provides important programmatic direction towards STI epidemic control, including the switch from syndromic to aetiologic treatment of STIs.⁷ In line with this global strategy, the recently released South African National Strategic Plan on HIV, TB and STIs - 2023-2028 has specified the ambitious objectives to: a) increase detection and treatment of four curable STIs through system strengthening, service integration and diagnostic testing, b) achieve elimination targets of vertical transmission of syphilis, and c) scale-up HPV vaccination and cervical cancer screening.⁸ The SAHCS 2022 STI guidelines contribute to these efforts by providing recommendations that aid strengthening of STI case management and improving treatment outcomes.

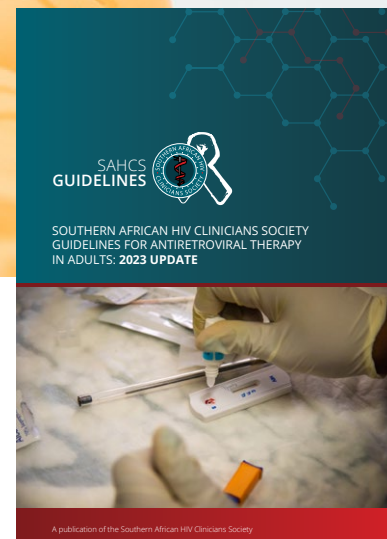
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WHAT'S NEW IN THE SOUTHERN AFRICAN HIV CLINICIANS SOCIETY GUIDELINES FOR ANTIRETROVIRAL THERAPY IN ADULTS: 2023 UPDATE?



This 2023 update to the Southern African HIV Clinicians Society guidelines for Antiretroviral Therapy in Adults reflects the changing treatment paradigms of the current era, specifically the consolidation towards dolutegravir- and darunavir-based treatment regimens, rather than efavirenz- or lopinavir-ritonavir based ones.

Numerous other changes have also been incorporated to ensure that these guidelines remain up-to-date and helpful to the healthcare workers who use them. These include, but are not limited to:

Key updates

- Recommendation to shift most patients to a dolutegravir-based regimen if possible.
- For patients requiring a protease inhibitor (PI), recommendation for darunavir as the PI of choice, and for lopinavir/ritonavir to only be considered where a PI is required to be coadministered with rifampicin-based tuberculosis treatment.
- New recommendations on the move away from routine use of zidovudine (AZT) in second-line therapy in favour of recycling tenofovir or, in patients with renal dysfunction, abacavir.
- Advice on how to assess the increase in serum creatinine seen with dolutegravir/tenofovir fixed dose therapy.
- Guidance on the role of tenofovir alafenamide; TAF.
- Inclusion of enhanced baseline screening for tuberculosis and sexually transmitted infections.
- Expansion of the module on HIV and mental health.

While many antiretroviral therapy (ART) guidelines are available internationally, the current guidelines have been written to address issues relevant to Southern Africa. Only treatment and diagnostic options available in Southern Africa are included.

These guidelines also consider affordability, since countries in the region vary between low- and middle-income settings. We recognise the need to bridge the gap in treatment recommendations between public and private sector programmes, considering that many patients transition between the two sectors for treatment, and have borne this in mind when providing our own guidance.

Access both the digitized version and downloadable pdf here:
WWW.SAHIVSOC.ORG - RESOURCES - GUIDELINES



Clinical tips

1. Interruptions to HIV, TB and NCD treatments is an increasing challenge and can result in poor health outcomes. Support adherence!
2. Interruptions to any chronic treatment increases overall health care costs. Providing services that meet the differing needs of our patients saves lives
3. Always ask about and manage ART side-effects as they can negatively affect adherence.
4. TDF in the short to medium term is a safe drug regarding renal clinical safety, and is easy to monitor.
5. When initiating DTG a slight raise in creatinine may occur, this is not renal dysfunction.
6. DTG absorption is significantly decreased by polyvalent cations (calcium and iron supplements, antacids, laxatives, buffers). Always check other medications.
7. Viral load (VL) is an important adherence marker. If the VL at 6 mths on ART is $>50\text{c/mL}$, provide enhanced adherence support and repeat VL in 3 mths.
8. A suppressed VL can prevent sexual transmission of HIV. Remember U=U.
9. TPT should be given to all pregnant women with HIV, regardless of their CD4 count.
10. DTG increases metformin levels. Maximum metformin dose is 500mg 12 hrly.
11. All women with HIV must have a VL test done at the time of delivery.
12. Rifampicin cannot be given with ATV/r or DRV/r
13. If VL $>50\text{c/mL}$, assess ABCDE: adherence, bugs, correct dose, drugs, resistance.
14. If on TLD < 2 yrs and ≥ 2 consecutive VLs $\geq 1000\text{ c/mL}$, continue TLD & repeat VL in 6 mths.
15. Ensure stable patients on ART are provided with multi-month dispensing.
16. Pregnant women on ART should continue their current ART at usual dosing times during labour.
17. Remember to repeat the infant HIV PCR 6 weeks after breastfeeding cessation for all HIV-exposed breastfed infants if <18 mths or repeat HIV rapid/ELISA test if ≥ 18 mths.
18. Counselling and education are vital for successful treatment and care of children living with HIV and their families.
19. Always ask at every visit about TB contacts and TB symptoms in all children and their caregivers.
20. With access to new DTG dispersible formulations, most children $>3\text{kg}$ and >1 mth of age can be on a DTG-based regimen.
21. For children on rifampicin and a DTG-based ART regimen, ensure DTG dose is increased from daily to 12 hrly.
22. Currently available tablet formulations of AZT must be swallowed whole and not chewed, divided or crushed.
23. TLD is preferred first-line ART for all children $\geq 30\text{ kg}$ and ≥ 10 years.
24. There should no longer be any client (> 1 mth old and $> 3\text{ kg}$) using a NVP-containing ART regimen.
25. The preferred first-line regimen from birth to 4 weeks of age is AZT+3TC+NVP.
26. All HIV-exposed infants must be given dual prophylaxis AZT+NVP until the mother's delivery VL is known.

Abbreviations: ART – antiretroviral therapy; ARV – antiretroviral; CD4 – cluster of differentiation 4; IPT – isoniazid preventive therapy; PrEP – pre-exposure prophylaxis; TB – tuberculosis; U=U – undetectable = untransmissible; UTT – universal test and treat; VL – viral load.

Please contact valencia@sahivcs.org if you would like to receive our bi-monthly clinical tips

National HIV & TB Health Care Worker Hotline

This is a free service for all health care workers



What questions can you ask?

The National HIV & TB Health Care Worker Hotline provides information on queries relating to:

- Pre-exposure prophylaxis (PrEP)
- Post exposure prophylaxis (PEP)
- HIV testing
- Management of HIV in pregnancy
- PMTCT
- Drug interactions
- Treatment/prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of DS and DR tuberculosis
- Antiretroviral Therapy (ART):
 - When to initiate
 - Treatment selection
 - Recommendations for laboratory and clinical monitoring
 - How to interpret and respond to laboratory results
 - Management of adverse events

We are available Monday to Friday 08:30 - 16:30



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JOIN US AS A MEMBER! WE ARE A COMMUNITY OF HEALTHCARE PROVIDERS DEDICATED TO DELIVERING EVIDENCE-BASED, HIGH-QUALITY HIV CARE

The Southern African HIV Clinicians Society (SAHCS) is a community of healthcare professionals that work in a variety of spaces, including public, private, and allied healthcare organisations. Our commitment lies in empowering our community to deliver evidence-based, up-to-date, and patient-centred HIV healthcare of the highest quality.

We strive to support and strengthen the capacity of our members. We achieve this through the development of our clinical guidelines and job aids, offering training courses and conferences, publishing the SAJHIVMED scientific journal and the HIV Nursing Matters publication, organizing regular Continuous Medical Education meetings and webinars. We are dedicated to fostering collaboration across cadres and borders to improve the lives of all those affected by HIV.

As a member of SAHCS, you will have access to trusted clinical knowledge, enabling you to enhance your clinical practice and provide high quality HIV prevention, treatment, and care.

SAHCS MEMBERSHIP BENEFITS INCLUDE:

- Free access to CME meetings and webinars
- CPD certificates for courses and webinars completed
- Free access to previous webinars to enable you to learn when it suits you
- Preferential registration to SAHCS workshops and conferences
- The opportunity to network and collaborate with other healthcare providers who have an interest in HIV
- Free access to:
 - the DHET PubMed® accredited Southern African Journal of HIV Medicine (SAJHIVMED)
 - SAHCS HIV Nursing Matters Publication
 - HIV and related diseases clinical updates and articles
 - Evidence-based SAHCS and NDoH clinical guidelines

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UNITING HEALTHCARE WORKERS IN HIV CLINICAL EXCELLENCE