

HIV NURSING MATTERS



A publication of the Southern African HIV Clinicians Society



Undetectable equals untransmittable (U=U) – Implications for clinical practice

Breastfeeding with HIV – Truths and Myths

Sexuality and (mis)information among young women

Adolescent- and youth-friendly health services

Asymptomatic STIs – Consequences of not being treated

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Guest editorial



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We have just commemorated World AIDS Day on 1 December 2018 – a pioneering global health campaign first initiated by the World Health Organization in 1988. The World AIDS day global theme this year is ‘Know Your Status’, referred to locally as ‘Cheka Impilo’. Let us take the opportunity to reflect on the seriousness of the HIV epidemic – as well as the progress and breakthroughs that South Africa has achieved to date. South Africa has the largest, and one of the most successful HIV programmes in the world. The triumph of our antiretroviral programme is evident in the increasing numbers of 7.2 million people living with HIV (PLHIV) accessing antiretroviral therapy (ART), coupled with decreased HIV-related deaths and incidence of new infections. However, despite these advances, we still have a long way to go. A review of our efforts in addressing the HIV and AIDS epidemic over the past 20 years, paints a mixed picture and the journey thus far has been fraught with challenges. Reducing new HIV infections; reaching key and vulnerable populations; and addressing the social and structural drivers of HIV, tuberculosis and sexually transmitted infections are critical gaps we need to overcome to accelerate progress to UNAIDS 90-90-90 targets by 2030.

This edition of *HIV Nursing Matters* presents a range of interesting articles that go beyond HIV prevention and treatment. These articles provide much-needed contributions to shift our focus beyond viral load suppression as the ultimate goal of treatment. One common theme that emerges from this edition is that PLHIV and those at risk of transmission still contend with other intense challenges. Topics covered in this edition include: unmet sexual health information for young women; treatment for asymptomatic sexually transmitted infections; the importance of adolescent- and youth-friendly services; migration and its impact on the ART programme; breastfeeding in the context of HIV; and treatment as prevention. Compassion fatigue and self-care practices for front-line healthcare workers are also explored.

My hope is that this edition will renew our commitment to fighting all aspects of HIV care and reignite the sense of urgency in turning the trajectory of the epidemic. To sustain gains made and fast-track our progress, a person-centered chronic care for PLHIV and those who care for them is needed to expand the continuum-of-services paradigm.

Enjoy this edition.





Message from the president

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Prof. Yunus Moosa

President: Southern African
HIV Clinicians Society

HIV is a chronic disease with a near-normal life expectancy, as long as patients remain on effective treatment. Like any chronic disease, patients need to be: firmly linked to care; maintained on uninterrupted treatment; and regularly monitored for treatment response, drug toxicity and complications. With a population of nearly 8 million requiring treatment and over 200 000 new infections each year, our healthcare system is under tremendous pressure and risks buckling under the weight of these astronomical numbers. Now, more than ever, we need to galvanise **ALL** healthcare workers, irrespective of level of training or area of specialty, to learn, understand and become competent to provide basic HIV counselling and treatment. Educational platforms, such as *HIV Nursing Matters*, play a vital role in keeping healthcare workers in touch with the rapidly evolving science and treatment of HIV.

The 10- to 24-year age group (adolescents and youth) is particularly challenging to manage for any chronic disease. At this age, HIV presents unique problems that make it especially complex to handle. An article on adolescent- and youth-friendly health services in this edition of *HIV Nursing Matters* highlights the unique health challenges in this age category and provides a step-by-step guide on implementing youth-friendly services. The challenges faced by this age group are further underscored by a report, also presented in this issue, on a questionnaire-based survey of over 4 500 young women, which highlights serious gaps in the knowledge around HIV and sexual and reproductive health risk and prevention.

Breastfeeding is an essential component of infant feeding with lifesaving benefits, particularly in resource-limited settings. Unfortunately, HIV infection has thrown this important aspect of childcare into controversy often leaving both parents and healthcare workers confused. This issue contains a simple, no-nonsense, question-and-answer approach to clarifying the truths and myths of breastfeeding with HIV.

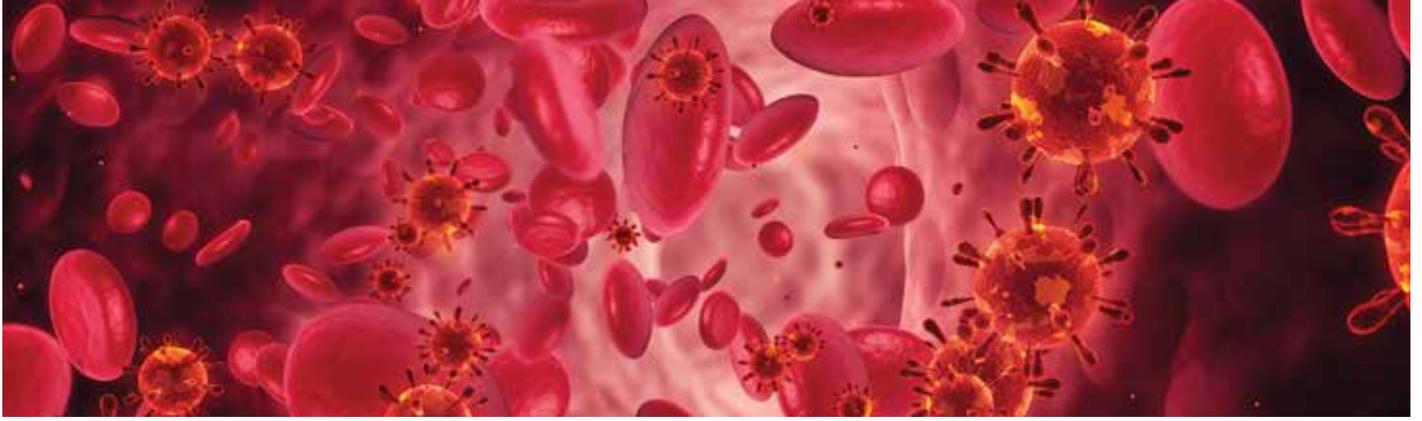
Sexually transmitted infections (STIs) – one of the drivers of the HIV epidemic – represent a largely hidden epidemic due to the high level of asymptomatic disease. Unfortunately, syndromic treatment misses a large proportion of infected subjects who remain untreated and are a source of ongoing spread. An article in this issue discusses the limitations of the current syndromic approach to treatment, and reminds us of the presenting complaints, treatment options and consequences of untreated STIs.

Another article in this issue highlights the evidence for, and the clinical implications of the slogan 'undetectable equals untransmittable' (U=U) in the HIV world. Understanding this feature of effective HIV treatment is critical to prevent reckless behaviour and resultant transmission of virus.

This issue also explores the impact of migration of people, within and between countries, on the healthcare system and highlights issues around maintaining linkage to care and the unique problems faced by non-nationals.

As rewarding as the profession of nursing might be, it can often lead to physical and mental strain. Healthcare worker mental health is a much-neglected area. This issue provides a very insightful look at compassion fatigue and offers ways to mitigate against this.

The editors have once again outdone themselves by choosing a wide spectrum of articles germane to our practice. I hope you find this issue of *HIV Nursing Matters* an engaging learning experience. Let us continue the good fight, keep our shoulder to the grind and remember that the fight is only over when it is over.



Undetectable equals untransmittable (U=U): Implications for clinical practice

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Undetectable equals untransmittable, or U=U, is the slogan on the lips of many HIV-positive people and HIV clinicians. It means that HIV-positive people who take their antiretroviral treatment (ART) as prescribed and have an undetectable viral load (VL), have effectively no risk of sexually transmitting the virus to their HIV-negative partners.^[1,2] There is now sufficient evidence to support this and the notion is endorsed by the Centres of Disease Control (CDC) in the United States.^[2] HIV treatment improves the life expectancy and quality of life of HIV-positive persons. Evidence presented at the International Aids Conference (IAS) in August 2018^[3] and in recent studies^[4,5] confirmed that ART has a profound impact on preventing sexual transmission of HIV. U=U embodies the idea that HIV treatment can be used as prevention.^[1]

This has far-reaching implications for HIV-positive persons, their family members and society. It may even enable us to turn the tide against HIV stigma that is still persisting in many communities.

What does the evidence say?

Since 2002, many studies have consistently shown no HIV transmission from a virally suppressed HIV-positive person (either male or female; homosexual or heterosexual) to an HIV-negative partner.^[1]

Results from the HPTN052 clinical trial demonstrated no HIV transmission among serodiscordant heterosexual couples when the HIV-positive partner was virally suppressed. Viral suppression in this study was defined as having a VL ≤ 400 HIV RNA copies/ml.^[6] Three recent studies, namely the PARTNER,^[4] PARTNER2^[3] and Opposites Attract^[5] studies, similarly found no HIV transmissions when heterosexual or male-male (men who have sex with men (MSM)) couples were engaging in sex without using condoms and with no pre-exposure prophylaxis (PrEP).^[2] It is important to note that in the recent studies, viral suppression was defined as having a VL < 200 copies/ml and most HIV-positive participants in the PARTNER study had < 50 copies/ml.

The CDC pooled the results of these recently published studies and estimated an annual HIV transmission risk of 0.14% when heterosexual/MSM couples engage in sex without using condoms.^[2] Although the chances of HIV transmission is statistically not zero, HIV transmission is not expected when an HIV-positive person remains virally suppressed.^[2]

Implications for clinical practice

The knowledge of U=U may enable more HIV-positive persons to accept their illness and comprehend that they can live a long and healthy life without fear of transmitting the virus to their loved ones. This message will make it easier to promote the benefits of taking treatment and may motivate people to be adherent to treatment, bringing communities closer to the 90-90-90 targets (90% of people knowing their HIV status; 90% who know their status on ART; and 90% of those on ART virally suppressed).^[1] However, it may be difficult for people to believe this message, since the opposite has been communicated for many years.

Even though this message brings hope for HIV-positive persons, it is important to consider that not all persons on ART are suppressed and some who are virally suppressed may not maintain their viral suppression. In 2017, 86% of people in South Africa were aware of their HIV status; of these, 65% were on ART (3.7 million people) and 86% on ART were virally suppressed.^[7] This is comparable to statistics reported in the United States.^[2]

Many people do not have knowledge of their VL and it is therefore increasingly important that clinicians communicate these results to their patients. In South Africa, a VL is considered undetectable if it is <50 copies/ml.^[8] In the public sector, patients only receive a VL blood test at 6 months on ART, at 12 months and then annually. Due to less regular VL monitoring, once a patient is stable on ART, we cannot be certain of continued viral suppression, especially in the context of less frequent clinic visits and adherence monitoring. This needs to be taken into consideration when providing advice to patients.

Healthcare providers should ensure that they openly communicate to their clients, and that patients understand their illness and how well they are doing on treatment. Table 1 depicts some key messages to communicate.

Does U=U for HIV-positive mothers and infants?

In South Africa, women are tested for HIV at their first antenatal booking, and in the event of HIV infection are immediately initiated on ART.^[8] If the mother is virally suppressed at birth, infants are provided with ART prophylaxis for 6 weeks. Mothers with suppressed VLs are encouraged to continue breastfeeding for up to one year and have their VL monitored every 3 months. An article published in *The Lancet HIV* in July 2018 states that there is currently insufficient evidence to support U=U in the context of breastfeeding.^[9] Mothers need to be counselled about the risks and benefits in order to make an informed decision.

Table 1: Key messages to communicate to patients

Key messages
1. People with HIV who take HIV medicine (ART) as prescribed, and who obtain and maintain an undetectable VL, have effectively no risk of transmitting HIV to their HIV-negative sexual partners. ^[2]
2. It may take at least 6 months since starting ART before becoming virally suppressed.
3. Patients have to take their ART exactly as it is prescribed.
4. It is important that patients have their VL tested. In the public sector, VL is tested at 6 months on ART, 12 months on ART, and every year thereafter. Importantly, simply because a patient is virally suppressed, it does not necessarily mean they will remain suppressed.
5. Taking ART does not protect against other STIs; therefore, patients should still use condoms to provide protection against STIs.

ART – antiretroviral therapy; STIs – sexually transmitted infections; VL – viral load.

Should a mother have viral rebound during breastfeeding, mothers should be managed aggressively according to the guidelines. Breastfed infants and children should be tested regularly as prescribed.^[8]

Conclusion

A cure for HIV is not yet on the table; however, U=U may give HIV-positive persons and society hope that we can turn the tide against the effect of the disease on the total health and wellbeing of individuals and communities. Many healthcare workers may be reluctant to communicate the U=U message to patients. However, healthcare workers have an obligation to communicate evidence-based information to their patients and ensure that they are active partners in care.

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Breastfeeding with HIV: Truths and myths

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Breastfeeding in HIV-positive mothers has been a controversial topic for many years, so it is no wonder that parents and healthcare workers are often left feeling confused. In this article we attempt to answer the common and controversial questions that patients often ask us, as healthcare workers.

Can a baby get HIV through the mother's breastmilk?

Yes, babies can get HIV from their mothers through their breastmilk, especially if the mother's HIV viral load (VL) is high.^[1-3] If the mother's VL

is suppressed (<50 copies/ml), then the risk is greatly reduced, but there is still a very small risk of the baby becoming HIV-infected.^[1,2]

Does U=U work for breastmilk?

U=U, the slogan for 'undetectable equals untransmittable', means that if a person's VL is undetectable in the blood (<50 copies/ml), then HIV cannot easily be transmitted via sexual intercourse.^[4] U=U is not 100% applicable to breastfeeding, however, as breastmilk may still contain HIV even when the mother's blood VL is undetectable.^[1,2]

This is the reason why there may still be an extremely small risk of HIV transmission even when a mother's blood VL is suppressed.^[1,2]

Should HIV-positive mothers breastfeed?

South African national guidelines support breastfeeding for HIV-positive mothers for the following reasons:^[5,6]

- Evidence shows increased HIV-free survival in infants if they are breastfed, in low- and middle-income countries where there is significant risk of malnutrition

Table 1: Key messages to communicate to patients

Benefits of breastfeeding for all mothers and babies	Risks of breastfeeding in HIV-positive mothers
<ul style="list-style-type: none"> • Provides all the correct amounts and proportions of nutrients for the baby's growth and development • Provides the baby with the mother's antibodies to protect the baby against infections • Reduces the risk of dental malocclusions in the infant • Improves brain development and long-term intelligence • Promotes bonding between mother and baby • Reduces the risk of infant diarrhoea and pneumonia and other infectious diseases which may be acquired through unhygienic replacement feeding • Reduces the mother's risk of breast and ovarian cancer • Improves birth spacing 	<ul style="list-style-type: none"> • If the mother is not on ART, then there is significant risk of HIV transmission to the baby, although 55 - 80% of babies will remain uninfected • If the mother is on ART and her VL is suppressed, then there is an extremely low risk of HIV transmission to the baby, but a few cases have been reported • There is potentially a risk of prolonged ART exposure to the baby through breastmilk, however no adverse events have been documented

and infectious diseases related to unhygienic formula feeding.^[3] HIV-free survival means that the baby is free of HIV and is healthy.

- HIV transmission risk is extremely low when a mother is taking the correct antiretroviral therapy (ART) and has a suppressed VL and/or the infant is on antiretroviral (ARV) prophylaxis.^[1,2]
- Breastfeeding may be more culturally acceptable and reduce stigma for HIV-positive mothers.^[3]

However, it is important to note that HIV-positive mothers should be counselled and given as much information as possible so they are informed about the benefits of breastfeeding and the low risk of HIV transmission. While counselling on feeding options has been removed from prevention of mother to child transmission (PMTCT) guidelines, it is still important to identify HIV-positive mothers in exceptional circumstances; e.g. in the event of an unsuppressed VL and to individualise their management, including their feeding method (see below). The potential benefits and risks for HIV-positive women are summarised in Table 1.^[1-3,7] If mothers are not taking ART, or their VL is not suppressed, then the mother and baby should urgently be managed according to national guidelines.^[5] Note: HIV-negative mothers should be counselled to breastfeed, unless they have medical or surgical contraindications to breastfeeding (noting, importantly, that there are very few contraindications to breastfeeding!)

What if the mother's VL is not suppressed?

The mother should be counselled on adherence and urgently managed according to PMTCT guidelines.^[5] If she is failing first-line ART, then: she should be changed to second-line ART, the pros and cons of breastfeeding should be weighed up for her individual situation, and the baby should receive extended antiretrovirals (ARVs) for PMTCT.^[5] If the mother is failing second-line ART, then breastfeeding is not recommended, and the mother and baby should be referred to the protein energy malnutrition scheme or to a dietician or the nutrition programme for assistance.^[5] In this instance, the mother should be managed for second-line failure as per PMTCT guidelines.^[5] Note: Updated PMTCT guidelines are expected by 2019. Please find and use the latest guidelines.

Should a mother breastfeed when her VL is not suppressed and she cannot afford formula?

When a mother's VL is not suppressed and she cannot afford to give her baby enough formula in an acceptable, feasible, affordable, sustainable and

safe manner, then it is considered safer for the mother to breastfeed as the risk of malnutrition and infectious diseases is considered greater than the risk of HIV.^[3]

Should an HIV-positive mother breastfeed when she can afford formula?

National guidelines state that all mothers should be encouraged to breastfeed, as breastfeeding is supported as a public health policy. If an HIV-positive mother can afford to give her baby the right amount of formula in a sustainable, safe, hygienic manner, then a healthcare provider may adopt an individualised approach: the healthcare provider should weigh up the benefits and risks of breastfeeding against the benefits and risks of not breastfeeding (Table 1). If the mother's VL is not suppressed, then the risk of HIV transmission is higher, and therefore avoiding breastfeeding, or pasteurising breastmilk, until viral suppression is achieved may be an individualised solution. If the mother's VL is sustainably suppressed, then the risk of HIV transmission is extremely low and breastfeeding is recommended to improve HIV-free survival.^[1,2]

Guidelines recommend exclusive breastfeeding for 6 months, followed by complementary food at 6 months and the continuation of breastfeeding up to 24 months, provided the mother continues ART reliably and maintains a suppressed VL.

Should a mother breastfeed if her baby tests HIV-positive?

Yes, if the baby is already HIV-positive then there is no additional risk and the mother should be encouraged to breastfeed.^[5] Breastfeeding in this circumstance will keep the baby healthy.

Pasteurising breastmilk or using donor HIV-negative milk may be useful while deciding on feeding choice, awaiting the VL result, awaiting the baby's PCR result; when the mother is sick, or when ART is temporarily unavailable.

What other options can you offer an HIV-positive mother who does not want to breastfeed?

Pasteurising breastmilk by heat-treating expressed breastmilk on the stove, is a method of killing HIV viruses so that an HIV-positive mother can still feed her baby breastmilk without the risk of HIV transmission.^[8] While this method is very good, it is not commonly used as it may be difficult and time-consuming for the mother to prepare the milk correctly and hygienically.^[8] This approach may be particularly useful for a short period of time: while waiting for a mother to decide on her feeding choice; while awaiting the mother's VL result; while awaiting the baby's polymerase chain reaction (PCR) test result; when the mother is sick; or in the event that ART is temporarily unavailable.^[3]

Donor HIV-negative breastmilk is also a useful option, if available, so that the baby can benefit from breastmilk without the risk of HIV transmission. This approach may also be useful for short periods of time, as mentioned above, as well as when a baby is admitted to hospital and the mother is not available to breastfeed.

Commercial infant formula (formula) can be an adequate source of nutrition for the baby as long as the mother has access to all of the following:^[3]

- safe water and sanitation
- sufficient formula for at least 6 months
- support from her family and community
- ability to prepare formula safely and regularly
- comprehensive healthcare services.



Formula should be available at public health facilities for babies of mothers who are failing second-line ART.

For how long should HIV-positive mothers breastfeed?

The 2016 World Health Organization (WHO) Guidelines and South African National Guidelines recommend exclusive breastfeeding for 6 months, followed by the addition of complementary food at 6 months and the continuation of breastfeeding up to 24 months, provided that the mother continues taking ART reliably and maintains a suppressed VL.^[3,6]

Is mixed feeding allowed?

Yes, since the risk of HIV transmission is extremely low when a mother is on ART and has a suppressed VL, it is considered more beneficial to mix feed (breastmilk with other suitable nutritive liquids such as formula milk) than not to breastfeed at all.^[3] This is why the 2016 WHO guidelines state that mixed feeding is not a reason to stop breastfeeding if the mother is on ART and virally suppressed.^[3] Note: this mixed feeding recommendation also applies to HIV-negative women. Mixed feeding for HIV-negative women is also more beneficial than not breastfeeding at all.

Should HIV-exposed babies receive ARVs?

Yes, all HIV-exposed infants must receive ARVs for PMTCT according to the latest PMTCT guidelines.^[5] If the baby is breastfed and the mother is considered

high-risk, then the baby should receive extended ARVs according to the latest PMTCT guidelines.^[5] Updated PMTCT guidelines are expected by 2019. Please find and use the latest guidelines.

What else to remember when managing mothers who are breastfeeding?

It is critical to remember that HIV-negative mothers who are breastfeeding must be tested for HIV every 3 months, and should be supported to reduce the risk of becoming HIV-positive, for example, through the use of condoms and/or pre-exposure prophylaxis (PrEP) or ensuring their partner's VL is suppressed.^[5]

It is also often forgotten that HIV-positive mothers who are breastfeeding must have their VL monitored more regularly, and should be managed for treatment failure more urgently. Similarly, the baby must be given ARV prophylaxis and cotrimoxazole, and must have a PCR test at birth, 10 weeks, 6 weeks after cessation of breastfeeding and 18 months (the timing of the last test may change to 24 months – please look out for updated PMTCT guidance in 2019).^[5] If a mother refuses to give her HIV-exposed baby ARV prophylaxis, then steps should be taken to escalate the problem to the facility manager if necessary, as it is the infant's right to receive prophylaxis, according to the *Children's Act*.^[5]

Conclusion

The WHO and South African National Guidelines support breastfeeding in HIV-positive mothers provided that mothers are adherent to and receiving the correct ART and their VL is suppressed.^[3,5,6] It is important, however, to know the truths and myths about breastfeeding so that the correct information can be given to mothers, and so that each mother is managed optimally. If ever in doubt, please call for assistance – you can call your manager or the district clinical specialist team, or clinical mentors or specialists

at your nearby hospital, or our clinical helpline on 082 352 6642.

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HIV transmission risk is extremely low when a mother is taking the correct ART and has a suppressed VL and/or the infant is on ARV prophylaxis.



What girls want to know

Sexuality and relationship (mis)information among young women in South Africa

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South Africa has the largest HIV epidemic in the world with 7.1 million people living with HIV.^[1] Young women and girls are the worst off, with a prevalence almost four times higher than that of young men and boys of their age. There are many reasons for this including poverty, gender inequality and gender-based violence.^[1] Although knowledge is not enough for the prevention of HIV in this context, it is necessary to ensure that when young women and girls do take precautions, they are effective.

The Soul City Institute for Social Justice (SCI) initiated the RISE Young Women's Clubs (RYWC) in 2014, following their success with the Soul Buddyz clubs for younger school children. The Soul Buddyz clubs proved that the club model shows positive health outcomes for children, particularly in resource-constrained settings. The RYWC programme targets vulnerable girls and young women aged 15 - 24

years residing in informal settlements and rural areas where HIV prevalence is known to be high. Note: for the purposes of this article, the population will be referred to as 'young women', although the age range includes girls. The idea behind the clubs is to build social cohesion and social support for young women who have generally been marginalised. The clubs provide information about sexuality through the RYWC magazines, Rise Talk Show and social media channels.

A survey of 4 683 young women was performed one year into the formation of the clubs (2015/6) to gain insight into their knowledge levels and to compare with an earlier survey at the start of the clubs.^[2] The second survey was not a valid follow-up survey as many of the young women had just joined the club, so a comparison to the earlier survey was not useful. However, understanding the gaps in young women's knowledge

assisted in planning the intervention. In addition, data from the social media are presented to illustrate the questions young women ask.

The three most relevant themes that emerged were 'How my body works', 'Is there something wrong with me?' and 'Dealing with relationships and emotions'.

Methods

The survey of RYWC was performed by administering questionnaires to each young woman to complete; these were then collected by fieldworkers. A total of 4 683 young women completed the

forms; 60% were from rural areas; one-third reported having no running water in the house; two-thirds were aged 12 - 18 years, while the rest were older. Most of the young women were still at school and 69% reported wanting to study further. The survey questionnaire was in English. Social media data were collected from Facebook and Mxit (a popular peer platform at the time, whereby young women spoke to each other, as well as to the SCI).

Results

Only the results relating to sexual and reproductive health (SRH) are presented here. SRH questions were presented with a statement and true or false answer. Table 1 shows the question and the percentage of young women who gave the incorrect answer.

Table 1: Percentage of young women who provided incorrect true or false answers to statements on sexual and reproductive health

Item	Percentage incorrect
You can't fall pregnant while you are menstruating	True: 47%
It is legal to have an abortion in South Africa	False: 25%
If you have sex with someone more than 5 years older than you, you are more at risk of getting HIV	False: 36%
If your boyfriend withdraws his penis before he ejaculates, you can't fall pregnant	True: 56%
You can't get HIV from anal sex	True: 46%
A contraception implant will protect you from HIV	True: 28%
You should get tested for HIV before you get pregnant	False: 28%
Women can catch HIV more easily than men	False: 46%
The contraceptive pill prevents HIV infection	True: 31%
If you are HIV-positive and pregnant, your baby can be born with HIV	False: 54%
A baby cannot get HIV from breastmilk	True: 57%

Via social media, young women asked a variety of questions covering several topics. The three most relevant themes that emerged were 'How my body works', 'Is there something wrong with me?' and 'Dealing with relationships and emotions'.

How my body works

Many questions were asked about basic biology, specifically questions about pregnancy, how one falls pregnant, and how one knows if one is pregnant, with some participants relaying stories of how they fell pregnant.

'How do you know if you are pregnant?' (Mxit comment)

'Can I get pregnant if the condom gets stuck inside me?' (Mxit comment)

'Hey, can I ask, can you be on periods and be pregnant?' (Mxit comment)

Is there something wrong with me?

There were many questions about menstruation, discharges, abdominal pain and other ailments.

'Hi girls, I am 20Yrs [years] old my period has stopped, and I don't know why, it has been 4 years now, please help me.' (Mxit comment)

'Hey, I am 13, I often have pains like period pains, but I am not sure it's them, I need an older girl to tell me what is happening.' (Mxit comment)

'I am a young woman and I get blisters after having sex. When I go to the bathroom it's so sore that I have to take a cold shower or bath to ease the pain. Is there something wrong?'

'I am 24 years old and I suffer from cramps and pains in my lower abdomen. It feels like kidneys. When I get this pain, I have a lot of discharge. I can see it when I take a bath. Painkillers help for a little while, but the pain is so strong. It goes on for two days at time.'

Dealing with relationships and emotions

The third theme focused on emotional and relationship issues; many questions arose on cheating boyfriends, having sex and family issues.

'Guys how does one cope with miscarrying and how do you move on from that?' (Mxit comment)

'I am a 23-year-old girl and my boyfriend is also 23. We have been together for 2 and half yrs [years] ... the problem is my boyfriend has cheated on me more than four times and I love him; cannot live without him, he is everything to me ... while he was cheating, he had [got]

another girl pregnant and another one aborted ... then I lost my baby.' (Mxit comment)

'I'm 17 and my bf [boyfriend] is 19 and I really adore him, so we decided to be intimate, but because I feel like he pressured me into agreeing, I decided to step back from my decision, yet I'm so confused ... pls [please] help.' (Mxit comment)

'I am a Christian and not allowed to date and have sex, but then I have already broken the law and dated and now ma [my] boyfriend wants us to have sex, what can I do and the way I see it he has power more than [over] me.' (Mxit comment)

'My boyfriend wants to sleep with me and he really loves me, but I'm scared to disappoint my family because they want to do [throw] me a 21st birthday. I'm only 18 years now and it's the 3rd year we are dating - what must I do?' (Mxit comment)

'Hi, I'm a 19 yrs [year] old girl with a 2-year-old son, but my life is not good; I want to make peace with my mom, but I can't [be]cause after my father's death she changed and made me look after my siblings at a young age, now we suffer because of her.' (Mxit comment)

'My mom always says negative things about me.' (Mxit comment)

Discussion

The high levels of ignorance and misinformation among the young women surveyed is of great concern. Miller et al.^[3] found knowledge in Soweto to be 78% among young women. In a survey in KwaZulu-Natal, van Loggerenberg^[4] suggests that young women have high knowledge levels, if one drills down close to 40% of young women didn't know that anal sex was very risky.





'... So, this club is important to me. I have learnt about my body here. I remember when I got my first period, I was very scared, and I could not tell anybody. I wish I had the SKG1 Club at the time. Now, since joining the club, at least I know about the menstruation cycle, and that you can still fall pregnant if you have sex during your period.'^[2]

The gap between urban and rural is stark. What is clear is that the 'knowledge' that we as a country provide through school and education campaigns is too superficial. Young women clearly do not have enough information at hand to protect themselves from HIV infection and pregnancy. Not understanding their risk of contracting HIV puts them in a precarious position. Alarming, almost half of the respondents believed that you cannot contract HIV from anal sex. More than half of the young women believed that withdrawal is a method

of contraception, and almost half believed that you cannot get pregnant from sex while menstruating, which means that these young women are probably at risk of teenage pregnancy. Of further concern, less than half of the respondents knew that HIV can be transmitted from mother to child during pregnancy.

Also worrisome is the types of relationships and emotional questions faced by young women; a prime example being the uncertainty expressed by a respondent when her boyfriend had cheated on her more than four times. We do not know where young women are obtaining advice, but what is clear is that they need to be able to express their concerns and be heard regarding safe relationships.

Conclusion

There are large gaps in useful knowledge around HIV and SRH risk and prevention among young women. Moreover, young women also demonstrate large knowledge gaps concerning conducting safe relationships. We need to think about how we deepen knowledge about

risk reduction and SRH, but we must also have ongoing relationships to develop curricula in an iterative way: listening to the issues of young women, responding to their needs, rather than focusing on what we think they should know. The ongoing club model is one way of doing this.

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Adolescent- and youth-friendly health services

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Adolescents and youth are defined by the World Health Organization (WHO) as individuals aged 10 - 19 years and 20 - 24 years, respectively.^[1] In South Africa, public healthcare services strive to meet the health needs of adolescents and youth aged 10 - 24 years.^[2]

Vulnerabilities of youth in South Africa

Although the adolescents and youth are presumed to be a healthy group of people, many of them die prematurely due to a number of reasons such as accidents, suicide, violence, pregnancy-related complications and other preventable and treatable illnesses such as HIV.^[1]

South Africa (SA) has a substantial number of young people living with HIV that was either acquired at birth (vertical transmission) or through behaviours that placed them at risk of contracting HIV (horizontal transmission). The most recent National HIV Prevalence, Incidence, Behaviour and Communication Survey (2017) reported a pronounced difference in HIV prevalence by gender in young adults aged 20 - 24 years, with prevalence in females (15.6%)

being three times higher than in males (4.8%).^[3] A diagnosis of HIV is very hard for a young person to deal with and includes issues related to disclosure and acceptance, stigma and clinical management and care.

Rates of teenage pregnancy in SA continue to be high, with the Demographic and Health Survey (2016) indicating that about a quarter of adolescent women aged 18 - 19 years have already begun to child-bearing.^[4] Furthermore, many young people suffer chronic ill-health and disability unrelated to sexual and reproductive health (SRH), but due to other morbidities such as poor mental health and nutrition. These are pressing issues that need timely intervention, as many serious diseases in adulthood have their roots in adolescence, which in turn leads to illness or premature death later in life.^[1]

In as much as many young people suffer from different health challenges requiring medical and/or psycho-social intervention, many of them still find it very difficult to access clinic services. A study conducted in Soweto reported that at least a quarter of the adolescents

sampled reported accessing a health-care facility in the 6 months prior to being surveyed, and about 6% of them reported the services to be sub-optimal - lack of caring staff, cleanliness and the full complement of medicine and supplies, all possible reasons for adolescents and youth to shy away from seeking healthcare.^[5] As healthcare providers, we have the opportunity to make clinic visits and consultations less difficult for young people, an endeavour that can be achieved through concerted and consistent effort in implementing the recommended adolescent- and youth-friendly services (AYFS) processes.

Policy background - AYFS in SA

'Adolescent and Youth Friendly Services (AYFS) in South Africa is a National Department of Health initiative that seeks to ensure provision of a comprehensive package of services at all facilities that is accessible and acceptable to youth.^[6] These services include prevention, risk reduction, advocacy and information-sharing on all health-related matters affecting adolescents and youth, and are intended to be delivered in a way that meets the needs of this key population.

How youth-friendly services can be implemented

'Adolescent and Youth Friendly Services (AYFS) in South Africa' is a standards-based approach.^[7] There are 10 AYFS standards, of which five (standards 1, 3, 6, 9 and 10) are specifically related to adolescent and youth management and care, and are considered to be the minimum standards required for AYFS recognition.^[8] Each of these standards contains a criterion that needs to be met in order to achieve the standard. These standards also align to specific National Core Standards and the Ideal Clinic criteria, making it feasible to leverage off health system strengthening strategies and initiatives aimed at the overall quality improvement of public healthcare facilities.

These standards can be addressed by implementing the recommended AYFS step-by-step guide in Table 1.



Table 1: Step-by-step guide on implementing AYFS in the clinic setting

Steps for AYFS implementation	Explanation
Get buy-in from management	Before AYFS implementation, it is important to gain support from the facility and sub-district management structures. These stakeholders are important in ensuring the smooth implementation and sustainability of AYFS.
Establish an AYFS team and select an AYFS team leader (champion)	An AYFS team needs to be established in the clinic. This team should have a team leader (AYFS champion) who will lead the implementation of AYFS. The AYFS team forms a crucial backbone in driving the AYFS activities in the clinic. An active AYFS team is essential in ensuring an effective AYFS programme.
Hold an AYFS orientation workshop	The aim of an orientation workshop is to introduce the concept of AYFS to all clinic staff members in order to enable them to understand the importance of implementing AYFS and how it can be achieved.
Get community support	Community stakeholder support is essential for the success of an AYFS programme. It is important to obtain community buy-in to facilitate and maintain meaningful community participation. The community needs to be informed about the services that the clinic renders to adolescents and youth, as well as AYFS days and/or times. Special awareness needs to be created for government-mandated initiatives aimed at engaging adolescents and youth in their healthcare, such as Youth Zones, BWise and innovations for HIV support and care such as integrated access to care and treatment (IACT) and adherence clubs. Adolescent and youth members should also be represented in the clinic health committee in order for them to represent the interests of adolescents and youth.
Conduct AYFS team meetings	The first AYFS team meeting should set the tone for subsequent AYFS activities that need to take place within the clinic towards rendering AYFS. The subsequent AYFS meetings need to analyse the progress of the AYFS services rendered.
Conduct a baseline AYFS appraisal	Performing AYFS baseline self-appraisal/assessments aims to determine the current level of practice of AYFS in the clinic using the AYFS audit tool.
Implement AYFS services and quality improvement plans	The AYFS scores from the baseline assessment will alert the AYFS team on gaps the clinic needs to address to improve the AYFS status of the clinic. The AYFS team can then develop action plans to address the identified gaps. Quality improvement projects (QIPs) need to be conducted to improve the identified gaps.

Examples of QIPs for the five minimum AYFS standards below:		
Quality	Standard 1: Management system support for the effective provision of AYFS	The clinic management team should endorse AYFS and support staff in the implementation thereof. An Adolescent Health Profile and service plan need to be developed to address adolescent and youth health needs. Effort should be made to include a youth member in the Clinic Health Committee.
	Standard 3: Appropriate adolescent health services are available and accessible	Adolescent and youth health services should be provided at special times that are convenient for adolescents and youth (AYFS days or youth zones, e.g. in the afternoons of a specific day so that school-going youth can access clinic services).
	Standard 6: Provision of relevant information, education and communication (IEC) promoting behaviour change and consistent with the AYFS essential service package	Pamphlets and posters that are suitable for the youth should be sourced. These should cover a number of health topics such as drugs, teenage pregnancy, contraceptives, sexually transmitted infections (STIs), HIV, among others. These IEC materials may be sourced from the Department of Health and other stakeholders such as B-Wise and LoveLife.
	Standard 9: Adolescents receive individualised care based on standard case management guidelines/protocols	Up-to-date guidelines and protocols should be available and utilised on the following: contraceptives, condoms, and STI syndromic management drugs. Nurses should be able to counsel the youth on pregnancy, HIV, sexual abuse and mental health problems.
	Standard 10: The clinic provides continuity of care for adolescents: proper referral systems are in place	Nurses should be able to provide adolescents with clear information on how to take medications, when to return for follow-up, or where to go for additional help (referral pathways to social worker services, hospitals or community-based organisations).
Monitor and evaluate AYFS	It is important to track the implementation of AYFS. The AYFS self-appraisal tool and booklet/manual should be used as a guide.	
Conduct subsequent AYFS appraisals	The AYFS team should conduct subsequent self-assessments which are meant to track/evaluate the impact of the interventions (QIPs) on AYFS implementation in the health facility. The above two steps are meant to determine whether the health facility is ready for an external assessment and recognition as an AYFS facility.	
Apply for AYFS recognition/accreditation	Once the clinic has improved on the AYFS standards, they can they apply for AYFS external assessment and accreditation.	

Conclusion

Any clinic is capable of fulfilling the mandate of the NDoH in making a clinic adolescent- and youth-friendly. All that is required is a dedicated team of professionals within the clinic that are willing to put in the work and make their clinic a better place for adolescents and youth.

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Migration: A public health priority for South Africa

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South Africa: A long history of migration

South Africa is a country long associated with the movement of people – including the historical, forced movements linked with the migrant labour system that saw people from former homelands temporarily relocated to work in the mines and urban centres. While this unjust system of forced labour is no longer in place, many within the country continue to move – migrate – in order to access work and education. Some move for long periods of time, others for shorter periods. Many will regularly return home to visit families and friends during holiday periods, particularly over Easter and Christmas.

These patterns of movement are found within many sectors across the country, including in the South African public healthcare (PHC) system. Many South Africans employed in the PHC system have moved from their home to train in nursing colleges and medical schools, moving again to undertake internships and professional training, with further (and often continuous) movements to

access jobs in different parts of the country. These movements are similar to those of other South Africans who migrate in search of work – sometimes for short periods of time, other times for longer – within the country. Most South African migrants are found in the Gauteng Province where nearly half of the population were born in other South African provinces.^[1]

Movement from other countries to South Africa

In addition to these important movements within the country, South Africa is also home to another migrant population – those who are born in other countries, mostly from elsewhere within the Southern African Development Community (SADC).^[1] This population is much smaller than the numbers of South African migrants who move within the country. According to South African Government agency Statistics South Africa (StatsSA), it is estimated that just 3 - 4% of the population of South Africa are non-citizens;^[1] this figure is far lower than often assumed. One reason for this is that the media and government

officials often exaggerate figures, or misinterpret the data. Just like South African migrants, the majority of cross-border migrants find themselves in the Gauteng Province, the most densely populated province in South Africa. The Western Cape receives the second-largest number. This means that in parts of Gauteng and the Western Cape – in central Johannesburg or Cape Town, for example – the numbers of cross-border migrants will be far greater than in other provinces, such as in the Eastern Cape or the Northern Cape. This may make it seem that there are a greater number of non-nationals in South Africa than there really are.

Migration and the public healthcare system

These population movements – both within the country and from other countries – can, if not engaged with properly, present challenges to the PHC system that need to be resolved.^[2] Based on existing evidence, there are two priority concerns that the PHC system needs to address in relation to migration.

Firstly, for healthcare users who are moving within South Africa or from another country, it becomes very difficult to maintain continuous access to care and treatment. As a result, people who move can struggle to access care and treatment, which could have negative effects for the health of everyone living in South Africa. A central concern relates to the management of TB and HIV: continued access to care is essential; however, if somebody is moving, e.g. between the Eastern Cape and Gauteng for work, it can be difficult to maintain continuous access to treatment. This could contribute to treatment interruptions and the development of resistance to first-line treatments, with subsequent impacts on the suppression of viral load. It is thought that this could be a key issue currently overlooked in HIV programming in South Africa and the region.

This is also a challenge when thinking about other chronic conditions such as hypertension and diabetes. Evidence also shows that South African migrant women who are pregnant face many challenges when they choose to access antenatal care in the city but return home to deliver. It is very difficult for these expectant women to book in for delivery and care in their home areas, and this has a range of negative consequences that can affect the health and wellbeing of the mothers and their infants.

Secondly, non-nationals often face specific challenges when trying to access PHC services, despite the fact that the law is very clear as outlined in Box 1: the denial of access to healthcare for anyone – including non-nationals – is unlawful.

If somebody is moving, e.g. between the Eastern Cape and Gauteng for work, it can be difficult to maintain continuous access to treatment. This could contribute to treatment interruptions and the development of resistance to first-line treatments.

Box 1: The legal obligation to provide healthcare to all^[3]

The law on migrant access to healthcare services is quite clear. Denial of access to healthcare services to anyone, including migrants, is unlawful. Section 27(1)(a) of the Constitution states that 'everyone' has the right to have access to healthcare services. Subsection 3 further states that 'no one' may be refused emergency medical treatment.

The **National Health Act** 61 of 2003 in section 4(3)(b) states that subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free PHC services. In addition, all pregnant or lactating women and children under the age of 6 are entitled to free healthcare services (at any level).

The **Refugees Act** 130 of 1998 provides for access to basic healthcare services by refugees (and by implication asylum-seekers).

The **Uniform Patient Fee Schedule** exempts certain categories of non-South Africans from being full-paying patients. These exempted categories include: immigrants permanently resident in South Africa but who have not attained citizenship; non-South African citizens with temporary residence or work permits; and persons from SADC states who do not have the documentation required to be in the country legally. The exemption of these categories of non-South Africans from paying full amounts for accessing healthcare services clearly implies that all health facilities, including clinics, should be providing healthcare services even to foreign nationals.

The **South African law and policy** on this issue is in line with the SADC Protocol on Health in terms of which SADC states agreed to treat citizens of other SADC states like citizens of their own country.

Notices posted in hospitals requiring 'foreign nationals' to pay for healthcare services are contrary to the policies explained above and are unlawful. The only time that a refugee, asylum-seeker or undocumented migrant from a SADC state should have to pay for healthcare services is when s/he does not qualify for free health services in terms of a means test. In that case, like for South Africans, there are sums of money that the patient can be asked to pay depending on the care required and the type of health facility.

While the law is clear, as noted above, it is often not implemented. In recent years, an increase in challenges faced by non-nationals is being reported (outlined in Box 2). These challenges may be linked to communication difficulties due to the different languages spoken, but can also be the result of the manner in which non-nationals are treated by frontline healthcare staff. Evidence points to an increased display of xenophobic and antiforeigner sentiments by healthcare

staff, which results in non-nationals facing multiple hurdles when trying to access the care to which they are legally entitled.

A key concern relates to issues of documentation. Frontline staff requesting such information may fail to communicate clearly what they need and how it can be provided. Instead, they sometimes ask for a South African Identity Document, or an asylum-seekers

or refugee permit; and if the patient is unable to provide such document, then they are turned away. These patients are not informed that they can provide other forms of identification (such as a foreign passport or affidavit). Moreover, there are problems at the declaration of income stage where some patients are not given an opportunity to declare their income – they simply become classified as the least subsidised patient.^[2-4]

Box 2: Key challenges in the implementation of law and policy^[2,3]

- A demand for the up-front payment of fees by non-nationals in need of maternal healthcare, including at the time of delivery, with reports suggesting that the babies of non-national mothers are not released to the mother until full fees are paid.
- A demand for up-front payment of fees before emergency treatment will be provided.
- The misclassification of non-nationals when calculating co-payments, including documented refugees and asylum seekers being incorrectly categorised as full fee-paying patients.
- Miscommunication when demanding proof of identification and proof of income.

The way forward

We need to find ways to respond to these challenges, to ensure that we are upholding our responsibilities to provide healthcare to all. The healthcare system needs to be responsive to the movement of people – both within the country and across borders. By doing so, we will address the problems associated with treatment interruptions, therefore improving access to healthcare for all – including migrants who come from other countries.

However, recent policy developments may undo some of the progressive policy in place: the proposed National Health Insurance (NHI) will, according to the draft NHI Bill released in July 2018, decrease access to PHC for some non-nationals. Not only could this have negative consequences for the health of all who live in South Africa if access to testing, treatment and care for communicable diseases is restricted; this will also prevent progress towards achieving the international health targets associated with achieving Universal Healthcare Coverage.^[2]

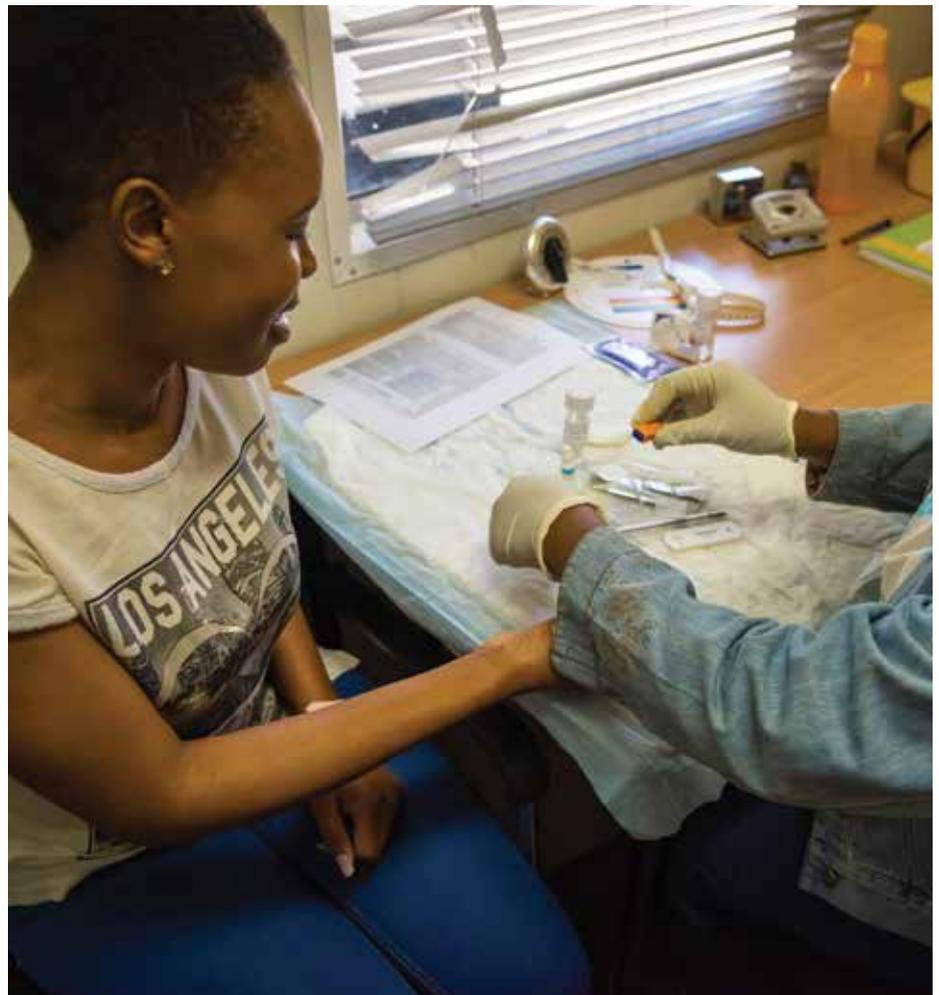


Table 1: Key recommendations for the development of a migration-aware health system in South Africa^[2]

	What is needed?	Who should act?
Health system strengthening		
<p>Improve delivery of healthcare services to migrant and mobile users (including health promotion and education, preventive care and screening, continuity of treatment for chronic conditions, curative and palliative care, and access to medical technologies)</p>	<ul style="list-style-type: none"> • Adopt a migration-aware approach: a whole-health system response whereby population movement is embedded as a central concern in the design of interventions, policy and research. • Strengthen and ensure that PHC reform initiatives integrate a migration-aware response as a key feature, including the implementation of unique identifiers. • Ensure that responses to migration and mobility are integrated into the existing healthcare system to avoid institutionalising social exclusion, to ensure quality control, and to guarantee sustainability and scale-up of responses. • Develop tailored interventions to meet the needs of certain migrant groups, where evidence indicates that this is necessary, including scaling up the provision of mobile clinic and outreach services at district level for migrant farm workers. • Work to implement a co-ordinated regional response to cross-border migration and communicable diseases, with an emphasis on ensuring continuity of access to treatment for chronic diseases regardless of immigration status. • Strengthen internal referral and cross-border referral systems, communication and co-ordination mechanisms so that migrants are not left behind. • Scale-up pilot projects and tested interventions to support continuity of access to treatment for migrant healthcare users, including patient-held records ('health passports'), standardised referral letters and treatment roadmaps. • Ensure that in all SADC countries there is no distinction or discrimination between locals and foreigners when providing health services and medical products and technologies. 	<ul style="list-style-type: none"> • NDoH (SA) • Voluntary/NGOs serving migrant communities • Private sector • Traditional health practitioners • Other Government agencies • Other SADC member states and their institutions • SADC and other SADC healthcare providers
<p>Stewardship</p>	<ul style="list-style-type: none"> • Develop a multi-sectoral approach that recognises migration as a determinant of health, based on the principle of 'equity and health in all policies'. • Develop interventions to strengthen networks between different stakeholders, such as national, provincial and local Migrant Health Forums (MHFs) (inter-sectoral forums that involve civil society and state structures). • Provide outreach to share information about the PHC system and ways to make care accessible to internal and cross-border migrants. • Foster international, bilateral and regional co-operation on health-protection mechanisms concerning migrants. • Develop a whole of government, comprehensive, consultative and evidence-based approach: a National Migration and Health Policy Framework. • Establish an Inter-Ministerial Committee that will guide, ensure effective implementation and monitor implementation of the National Migration Health Policy Framework, including development and implementation of national standards that prohibit discrimination within the healthcare system. • Establish a Migration Health Task Force comprising technical focal points from key government and non-government agencies that would contribute actively to migration health-development programmes. • Establish a Regional Migration and Health Forum comprising technical focal points from key government and non-government agencies that would contribute actively to migration health development programmes at SADC level. • Ensure participation in regional and global forums on migration health to ensure gathering, documentation and sharing of information and best practices. 	<ul style="list-style-type: none"> • NDoH (SA) • Voluntary organisations and NGOs serving migrant communities • Private sector • Traditional health practitioners • Other Government agencies • Universities, colleges, education centres and professional associations • Other SADC member states and their institutions • SADC and other SADC institutions

<p>Financing</p>	<ul style="list-style-type: none"> • Reduce financial barriers to healthcare for the less well-off by limiting out-of-pocket payments and promoting universal coverage, through implementation of National Health Insurance (NHI). • Use equity-oriented health impact assessments to help articulate the relationship between policy measures, health outcomes, costs and benefits. • Finalise and implement the Health Financing Mechanism for migrants in the SADC Region to ensure protection of the health of cross-border mobile people in the face of communicable diseases, including source, transit and destination communities. • Ensure involvement of the private sector in healthcare both as a direct provider of services, and as a provider of finance through workplace and prepayment schemes. • Ensure access to health services and financial protection for migrants through various innovative mechanisms such as portable social security schemes, employer-based health insurances or tax-based schemes. • Mitigate the burden of out-of-pocket health spending and move towards pre-payment systems that involve pooling of financial risks across population groups. • Develop or strengthen bilateral and multilateral social-protection agreements between source and destination countries, which include healthcare benefits, and the portability thereof. 	<ul style="list-style-type: none"> • NDoH (SA) • Treasury • Voluntary organisations and NGOs serving migrant communities • Private sector • Other Government agencies • Universities, and research institutions • Medical aid schemes • Other SADC member states and their institutions • SADC and other SADC institutions
<p>Health information</p>	<ul style="list-style-type: none"> • Commission a National Research Study on Migration and Health. • Develop and implement a unique identifier system that is inclusive of different forms of internal and cross-border migration. • Establish a SADC Regional Migration and Health Information and Reporting Monitoring and Evaluation System. • Roll-out of electronic unique patient identifiers to include information for internal and cross-border migrants. • Establish an integrated health-information system that will enable the NDoH to produce timely and accurate data for nationals (including those who do and do not move) and for non-South African nationals. 	<ul style="list-style-type: none"> • NDoH (SA) • StatsSA • Voluntary organisations and NGOs serving migrant communities • Private sector • Traditional health practitioners • Other Government agencies • Universities and research institutions • Other SADC member states and their institutions • SADC and other SADC institutions

MHFs – Migrant Health Forums; NDoH – National Department of Health; NGOs – non-governmental organisations; NHI – National Health Insurance; PHC – public healthcare; SA – South Africa; SADC – Southern African Development Community; StatsSA – Statistics South Africa.



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Asymptomatic STIs – consequences of not being treated

A refresher

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Sexually transmitted infections (STIs) are a major public health burden in low- and middle-income countries (LMICs) including South Africa. The risk of STIs is particularly high among sexually active adolescents and young adults. The median age of patients identified through the National STI Sentinel survey was 28 years (interquartile range (IQR) 21 - 33 years) for women and 27 years (IQR 22 - 32 years) for men with an average age at sexual debut of 17 and 18 years, respectively.^[1] STIs are often asymptomatic and can lead to various complications such as pelvic inflammatory disease (PID) and infertility, and increase the risk of acquiring HIV. The immediate goal of screening for STIs is to identify and treat infected patients before they develop complications, and

to treat their sexual partners in order to prevent re-infection.

The syndromic management of STIs as outlined in the *2015 Management Guidelines of Sexual Transmitted Infections in South Africa*^[2] is largely focussed on the diagnosis and treatment of the signs or symptoms (syndrome) of a group of diseases, rather than treating a specific disease. The limitations of a syndromic approach to the management of STIs are well described and include: inability to detect asymptomatic infections; overuse of broad-spectrum antibiotics, potentially leading to the development of resistant strains; and failure to diagnose cases of anal and pharyngeal infections as they are frequently asymptomatic.^[3-5] However,

many LMICs continue with the model of syndromic management, due to limited human and financial resources and the prohibitive costs of routine laboratory testing services.^[6] Here we discuss the consequences of untreated common asymptomatic STIs in women and men and outline screening options for asymptomatic infections.

Consequences of untreated STIs

Untreated STIs can cause serious complications for both women and men including: upper genital tract infections, infertility, chronic pelvic pain, cervical cancer, chronic infection with hepatitis viruses and increased risk of HIV infection. Research has shown that up to 40% of women who are not treated for

chlamydia, gonorrhoea and bacterial vaginosis develop PID, which in turn increases a woman's risk of developing an ectopic pregnancy.^[7] Other untreated viral STIs, such as genital warts and genital herpes, are likely to cause complications during labour.

Screening, treating and consequences of common asymptomatic STIs

- **Chlamydia trachomatis** is the most common asymptomatic STI in both women and men, yet it is easily treatable with antibiotics, provided it is detected early. If symptoms do occur, they include abnormal discharge, burning with urination and abdominal pain. In women, the primary benefit of screening and treatment is to reduce the risk of reproductive sequelae. In men, screening and treatment would be to reduce the risk of re-infection to different-sex or same-sex partners, and as a result, reduce the overall incidence of this infection. Undetected and untreated chlamydia can result in PID, infertility and ectopic pregnancy in women; neonatal pneumonia and conjunctivitis in the newborn; and epididymitis (a painful condition of the testes that can lead to infertility if left untreated), prostatitis, urethritis and reactive arthritis in men.
- **Neisseria gonorrhoea** is the second-most prevalent bacterial STI, and the majority of gonococcal infections are asymptomatic or present with mild symptoms that are easily missed. If present, symptoms include vaginal or penile discharge and/or painful urination. In women, untreated gonorrhoea can lead to serious complications including PID, infertility, ectopic pregnancy, infertility and neonatal blindness. Although genital gonococcal infections are more likely to be symptomatic in men than in women, many infections in men are asymptomatic, and if left untreated can result in epididymitis. For both men and women, untreated gonorrhoea can spread to the

blood and joints and become life-threatening.

- **Syphilis** is caused by the bacterium *Treponema pallidum* and clinical manifestations depend upon the stage of disease. Untreated syphilis can lead to serious long-term sequelae, including cardiac and neurological manifestations, which can be prevented by treatment in the early stages of disease. In addition, syphilis is associated with an increased risk for HIV transmission and acquisition. Pregnant women with asymptomatic syphilis can transmit *T. pallidum* to their unborn child for up to 4 years after infection, resulting in stillbirth, developmental delays or death.
- **Human papillomavirus (HPV)** is typically asymptomatic, but can cause genital and anal warts in both women and men. Persistent viral infection with specific high-risk HPV genotypes -6, -11, -16 and -18, causes virtually all cancers of the cervix and is associated with oropharyngeal and anal cancers. HPV infection is more prevalent in people living with HIV (PLHIV) and men who have sex with men (MSM).
- **Genital herpes simplex virus (HSV)** is often asymptomatic and the majority of infections are transmitted from individuals unaware of their infection or between outbreaks. Genital HSV infection can be associated with a multitude of constitutional symptoms and signs, such as fever, lethargy and headache, in addition to painful genital lesions with symptoms lasting 2 - 4 weeks, if left untreated. Herpes can increase the risk of HIV transmission and symptomatic HSV can be transmitted to a newborn during vaginal delivery.
- **Trichomonas vaginalis** infection is often asymptomatic and has been associated with adverse pregnancy outcomes such as premature birth or low birth weight. If symptoms are present, they include foul-smelling greenish-yellow vaginal discharge, vaginal itching and inflammation. In men, *T. vaginalis* infection is asymptomatic

in the majority of cases; however, untreated infection can persist for months. Symptoms, when present, are the same as those for urethritis from any cause and consist of a urethral discharge and/or painful urination. Untreated *T. vaginalis* in men has been associated with prostatitis, epididymitis, infertility and prostate cancer.

- Untreated **HIV infection** results in substantial morbidity and mortality for the infected individual and contributes to further horizontal and vertical transmission. Concurrent infection with other untreated STIs increases the risk of acquiring HIV and accelerates disease progression. PLHIV should actively be screened for STIs, and the presence of a STI warrants an HIV test.

Innovative screening and testing strategies are urgently required, irrespective of the presence or absence of STI symptoms, coupled with active surveillance and prevention strategies in high-risk individuals.

Screening of asymptomatic STIs

The approach to STI diagnosis and management is based upon disease or symptom-specific syndromes, including vaginal discharge syndrome, male urethral discharge, ulcerative genital disease and pelvic pain. However, many patients have asymptomatic disease, which increases the risk of complications and sustained transmission of STIs in the community. Thus, targeted screening is an important approach to identify and treat infected asymptomatic individuals who would otherwise go undetected. Routine screening for all potential STIs in all patients is cost-prohibitive; targeted screening of asymptomatic patients in specified risk groups is more feasible (Table 1).

Table 1: Screening test recommendations for asymptomatic STIs

Infection	Site/Specimen and test	Additional information
<i>Chlamydia trachomatis</i>	Nucleic acid amplification testing (NAAT) on urine (preferred for men) or vaginal swabs (preferred for women), urethral swabs, endocervical swabs and rectal swabs	Evaluation for infection at non-genital sites in MSM is important in this population
<i>Neisseria gonorrhoea</i>	NAAT on urine (preferred for men) or vaginal swabs (preferred for women), urethral swabs, endocervical swabs, rectal and oropharyngeal swabs	
Syphilis (<i>Treponema pallidum</i>)	Screen with non-treponemal tests rapid plasma reagin (RPR) and confirm with specific treponemal tests	Screening for syphilis should also be performed in: asymptomatic patients who are at increased risk of infection, pregnant women, patients with a sexual partner who has early syphilis, and MSM
Human papillomavirus	Cytology and/or HPV testing of cervical specimens or cytology of anal specimens	
<i>Trichomonas vaginalis</i>	NAAT on vaginal swabs (preferred) or urine	

HPV – human papillomavirus; NAAT – Nucleic acid amplification testing; MSM – men who have sex with men; RPR – rapid plasma reagin.

Conclusion

In resource-limited settings, symptomatic screening and syndromic management of STIs continue to be the standard of care. In the absence of diagnostic testing, asymptomatic infections are common, and if left untreated can have serious consequences for both women and men. Targeted screening for asymptomatic STIs, especially among high-risk individuals, will reduce the overall burden of disease. Innovative screening and testing strategies are urgently required, irrespective of the presence or absence of STI symptoms, coupled with active surveillance and prevention strategies in high-risk individuals.

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- Management of tuberculosis
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The use of self-care to mitigate the effects of compassion fatigue

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Nurses are exposed to the traumatic experiences and pain of their patients on a daily basis. This may cause them to be vulnerable to develop compassion fatigue, which affects their well-being negatively to the extent that they are unable to render quality care.^[1]

Defining compassion fatigue

Compassion fatigue originates from a state of compassion stress that results from over-involvement in the relationship with patients and families in which nurses are witnesses to the pain and suffering of their patients.^[2] Compassion fatigue affects the physical, emotional and spiritual well-being as well as the behaviour of nurses to the extent that nurses are unable to

demonstrate caring or an ability to empathise with the suffering of others. Thus, being empathetic and exposed to patients' trauma and pain may contribute to developing compassion fatigue. Nurses become vulnerable to compassion fatigue because they may keep on giving of themselves and do not practise self-care.^[3] The consequences of compassion fatigue can result in poor quality of care and a high turnover rate among nurses.^[1]

Empathetic caring as a risk factor for developing compassion fatigue

Nursing is rewarding and demanding, both physically and professionally. Nurses alleviate their patients' suffering

through therapeutic actions and acts of caring. Nurses engage in caring relationships with their patients from a stance of moral obligation that involves commitment to preserving human dignity and humanity.^[4] The process of caring is made up of empathetic engagement, active involvement and felt separation and it is important for nurses to keep on engaging in the 'the caring cycle'. However, the need to recreate the caring cycle can negatively affect the well-being of nurses that can lead to them develop compassion fatigue.^[5] Nurses are at risk to develop compassion fatigue due to their empathetic engagement in the caring process. Unfortunately, not all nurses are equipped to protect themselves from secondary trauma, and

'If you want to give light to others you have to glow yourself.'

- Thomas S. Monson

therefore, they are at risk of developing compassion fatigue.^[6]

What is self-care?

Self-care is any activity in which individuals can engage to take care of their mental, emotional and physical health, to restore and enhance their health. Self-care is the cornerstone in preventing compassion fatigue,^[7] because it promotes a sense of compassion satisfaction that acts as a buffer against compassion fatigue.^[8] Self-care is about being in touch with one's feelings, sensations and intuition to decide what action is best in any given situation.^[9]

How can self-care prevent compassion fatigue?

Self-care allows the individual to take care of interests outside of work. Self-care helps nurses to create harmony in

all dimensions of mind, body and spirit that will enable them to care for others. Participating in self-care activities promotes nurses' well-being and their ability to be the best they can be.^[4] Self-care enables healthcare professionals to replenish their energy during the day, refuelling and revitalising the physical, emotional, psychological, spiritual, relational and professional dimensions.^[10,11]

Self-care activities that can help to mitigate compassion fatigue

Self-care can be an effective intervention in reducing the emotional exhaustion inherent in caring for traumatised patients. An awareness of stressful situations and of the signs and symptoms of compassion fatigue is important.^[7] Mind-body techniques to reduce compassion fatigue include meditation, imagery and movement. Make a list of what makes you happy



and keep it updated, it will help you to relax.^[12]

Self-care pointers

Nurses should prioritise self-care and learn to pay attention to their needs. They should take small steps that serve their well-being; for example, eat when hungry, talk to somebody you trust when upset, and take a break if tired. Follow a guide to self-care to reduce stress and in turn compassion fatigue:

- **Meet daily needs** – Nurses should nurture their physical body and pay attention to their bodily needs. They should develop and maintain healthy lifestyle habits and build resistance to stress through healthy eating habits, adequate rest and sleep, and regular exercise. Eat a well-balanced diet and drink at least eight glasses of water per day to maintain hydration. Get adequate rest and sleep. Take regular breaks during the day, move out of the ward during lunch breaks and meet with colleagues, but avoid talking about work.^[12,14]
- **Participate in health-promotion activities** – Nurses can join a gym and engage in

exercise; it relieves stress. Nurture yourself and pursue non-work-related activities that you enjoy. Include self-soothing activities in your self-care plan such as relaxing, reading a book or watching a movie. When stressed take a walk in the garden or do gardening; this is very therapeutic and will relieve your stress levels.

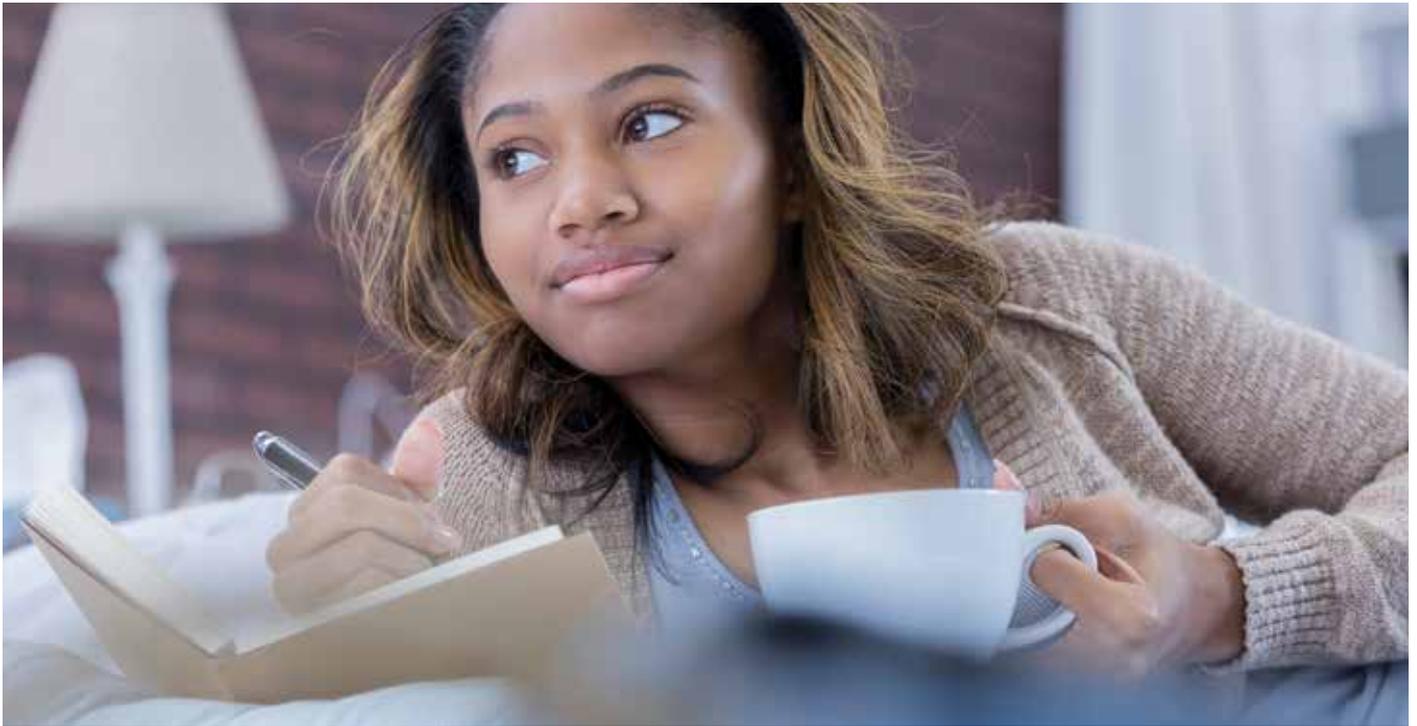
Become aware of your needs, the patients' needs, the work environment and your subjective experience. Self-awareness can be developed through journaling, discussing with others the issues that concern you, counselling, spiritual activities, meditation or other reflective practices. Participation in educational projects, peer support, mindfulness exercises and reflective writing can also be used to enhance self-awareness to allow creative responses to stress in any given situation.^[12-16] Nurses can also engage in healing activities, bring signs of life and beauty into the office such as a plant, and start painting or take a walk in the park to enjoy nature. It is important to participate in debriefing, especially after experiencing a traumatic event.

Other healing activities include bereavement rituals to help find closure, for example sending a sympathy card to bereaved family, starting a memory tree, or attending the patient's funeral, if possible.^[18]

- **Maintain work/life balance** – Nurses should set clear boundaries between work and personal life. Ensure that you do not take personal problems to work and take work problems home. Your weekly schedule should include time to rest, play, think and connect with others for your own well-being. Engage in regular activities such as sport, arts, or start a journal and write about your daily experiences. Do not take work home.^[12]

Self-care is not selfish.
You cannot give light from
an empty vessel.





Conclusion

Nursing is rewarding and can also be demanding. The demanding nature of nurses' work may limit the amount of time for self-care and can affect their well-being negatively. It is important for nurses to remember that the body is a living organism and they need to take care of it, because they cannot give light if they do not glow. Participation in self-care practices is the key to preventing compassion fatigue.

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Select option 2 to access laboratory results.

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

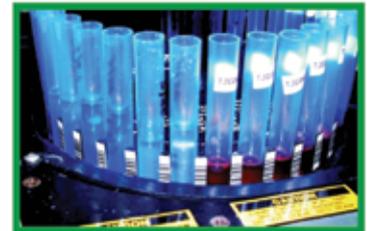
Once you have a Reference number

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





Quiz answers from the August 2018 issue

- | | |
|------|-------|
| 1. D | 6. B |
| 2. C | 7. C |
| 3. A | 8. A |
| 4. A | 9. C |
| 5. A | 10. B |



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AIDS Helpline 0800 012 322

The National Toll-free AIDS Helpline was initiated in 1991 by the then National Department of Health's (NDoH's) 'HIV/AIDS, STDs and TB Directorate'. The objective of the Line is to provide a national, anonymous, confidential and accessible information, counselling and referral telephone service for those infected and affected by HIV and AIDS, in South Africa.

In 1992, LifeLine was requested by NDoH, to take over the management of the Line by rotating it between the 32 existing community-based LifeLine Centres, and manning it with volunteer counsellors. In 2000, in response to an increasing call rate, a centralised Counselling Centre was established in Braamfontein, Johannesburg, to house the AIDS Helpline.

The AIDS Helpline a national toll-free service, operates on a 24/7 basis and is utilised by people from all walks of life in urban and rural areas, in all 11 languages at no cost from a landline telephone.

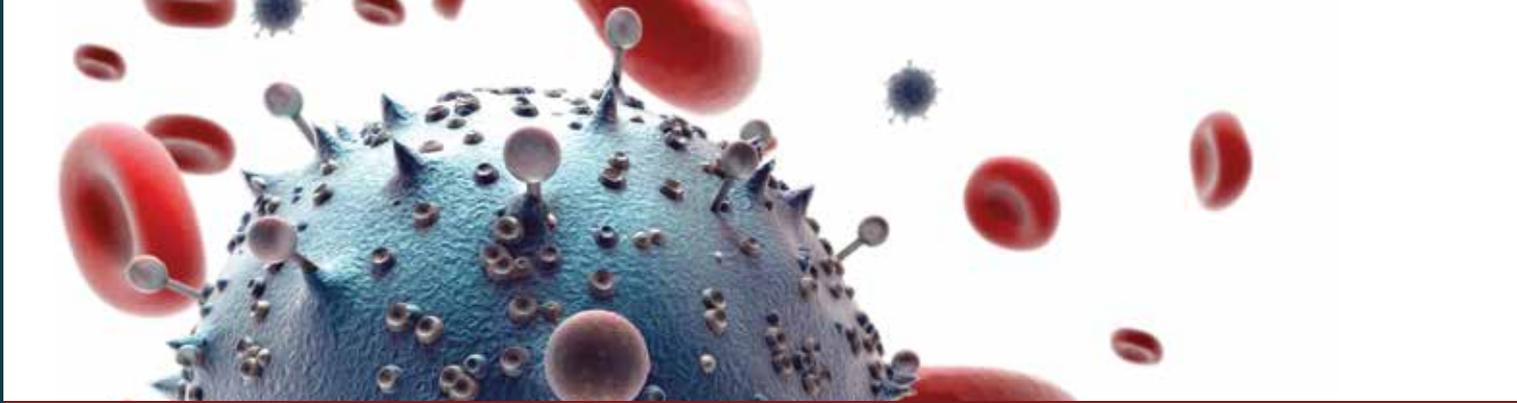
Annually, the Line provides anonymous, confidential and accessible telephonic information, counselling and referrals to over 300 000 callers.

The AIDS Helpline plays a central role in providing a deeper preventive and more supportive service to those infected and affected by HIV/AIDS, but also serving as an entry point in terms of accessing services from government, private sector and other NGOs/CBOs.

Cases presented range from testing, treatment, transmission, TB, medical male circumcision, etc.

The AIDS Helpline incorporates the Treatment Line. The treatment support services were included to complement the services provided by lay counsellors on the line. The Treatment Line is manned by nurses who provide quality, accurate, and anonymous telephone information and/or education on antiretroviral, TB and STI treatment.





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