



Integrated Access to Care and Treatment

Content Training Appendix



SOUTH AFRICA PARTNERS



health

Department:
Health
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Training Agenda

Pre-Training

Begin at 16H00 – 20H00

- Introductions
- Pre-Test (30 minutes)
- Dinner

Agenda Day 1

Begin at 08H00 – End at 17H00

- Section 1 Introductions and Expectations
- Section 2 Wise Words
- Section 3 HIV Progression without Treatment
- Section 4 HIV Transmission

Agenda Day 2

Begin at 08H00 – End at 17H00

- Section 5 Treatment Literacy
- Section 6 STI Transmission and Treatment
- 7 STI and HIV Prevention

Agenda Day 3

Begin at 08H00 – End at 17H00

- Section 8 Opportunistic Infections and Tuberculosis
- Section 9 Understanding Risk
- Section 10 HIV Counselling and Testing

Agenda Day 4

Begin at 08H00– End at 17H00

- Section 11 Acceptance of HIV Status
- Section 12 Disclosure Strategies

Agenda Day 5

Begin at 08H00 – End at 17H00

- Section 13 Hygiene
- Section 14 Exercise and Nutrition
- Section 15 Closing Activities and Assignment

*Morning and afternoon tea and lunch will be provided. Break times will vary depending on program agenda for the day

Wise Word Definitions

Acquired Immunodeficiency Syndrome (AIDS) When the immune system is weakened and a person is susceptible to numerous opportunistic infections or diseases.

Antibody Your immune system produces antibodies in reaction to an infection. Antibodies cannot fight off HIV remains in the blood once someone is infected.

Antiretroviral (ARV) Medications that stop or slow down the replication of HIV.

Antiretroviral Treatment (ART) When 3 or more ARVs are used in a treatment regimen. ART interferes with HIV's ability to copy itself, allowing the immune system to maintain or recover its ability to fight opportunistic infections.

CD4 A white blood cell that helps to keep the body healthy. CD4s are attacked by HIV.

CD4 count The level of CD4 cells in one's blood. When a person is weakened by HIV, the CD4 count falls. The normal range of CD4 count is between 500 and 1500.

Confidentiality Keeping information private. It is essential to keep participants' personal information discussed in I ACT programmes confidential. Examples of confidential information include HIV status, sexual orientation, marital status, income, health status, drug use, sexual history, date of birth, address, telephone number, email, and place of employment.

Disclosure Sharing information about one's HIV status with others.

Disclosure by Association When one is assumed to be HIV positive because their partner is HIV positive or they work in the HIV/AIDS field.

Full Disclosure Sharing that we are living with HIV with everyone we know including family, friends, co-workers, and others.

Indirect Disclosure Talking indirectly about the fact that you are living with HIV/AIDS, e.g., giving a talk about living with HIV without disclosing your HIV status, or making HIV/AIDS-related artwork. Indirect disclosures may prepare for actual disclosure and acceptance of HIV status.

Wise Word Definitions (continued)

Involuntary Disclosure When someone else tells others about a person's HIV status without permission or when a person feels forced to disclose their status, e.g., to get a job.

Non-disclosure Not telling others one's HIV status.

Partial Disclosure Sharing HIV status with only one or a few people. This may be part of a gradual disclosure process.

Personal Disclosure Disclosing to those who are closest to us including our partner, family members, friends and others.

Public Disclosure Disclosing to the public including our community, workplace, or in the media, such as in newspapers, on the radio or TV, or on the Internet.

Voluntary Disclosure Choosing to disclose one's HIV status without coercion.

Exposure Contact with body fluids containing HIV. Exposures do not always result in HIV infection but one must be exposed to HIV to become infected.

Gender The social roles we are expected to take on as men or women.

Human Immunodeficiency Virus (HIV) The virus that causes AIDS. HIV destroys CD4 cells to prevent normal function of the immune system.

HIV and AIDS Discrimination Unfair or unjust actions against people living with HIV and AIDS as a result of stigma, e.g., denying health care, evicting someone from housing, or firing someone from a job.

Homophobia The strong fear or hatred of lesbians and gay men.

Immune System The body's defence system which fights illnesses. Much of the immune system is located in a person's bloodstream.

Infection When the body is invaded by a germ that multiplies and can make people sick.

Opportunistic Infections (OIs) Infections that take advantage when the immune system is compromised.

Wise Word Definitions (continued)

Post Exposure Prophylaxis (PEP) The short-term use of the HIV ARV treatment given up to 72 hours after a possible high-risk exposure to HIV to try and prevent infection.

Pre-Exposure Prophylaxis (PrEP) is the use of ARV treatment to prevent infection for HIV negative persons with ongoing HIV risk exposure

Seroconversion The development of a detectable level of antibody in the blood. HIV seroconversion takes from 4 to 12 weeks after becoming infected for HIV antibodies to be detectable. Following the seroconversion period, a person will test positive based on the presence of antibodies.

Sexual Orientation The way we express our sexuality – whether we are heterosexual, bisexual, homosexual (lesbian or gay), or transsexual.

Sexually Transmitted Infection (STI) Infections transmitted through sexual contact.

Stigma A sign or labelling on the character of an individual that evokes blame, shame, disgrace, dishonour, sully or stain.

HIV/AIDS Stigma The negative thoughts, attitudes or beliefs that people have about people living with HIV or AIDS

Double (multiple) Stigma When people hold negative thoughts, attitudes or beliefs about people living with HIV and AIDS who are also members of groups that are stigmatised because of other reasons like gender, race and sexual orientation.

Tuberculosis (TB) A disease spread through the air. TB usually affects the lungs but it can also affect other parts of the body such as the brain, the kidneys, or the spine.

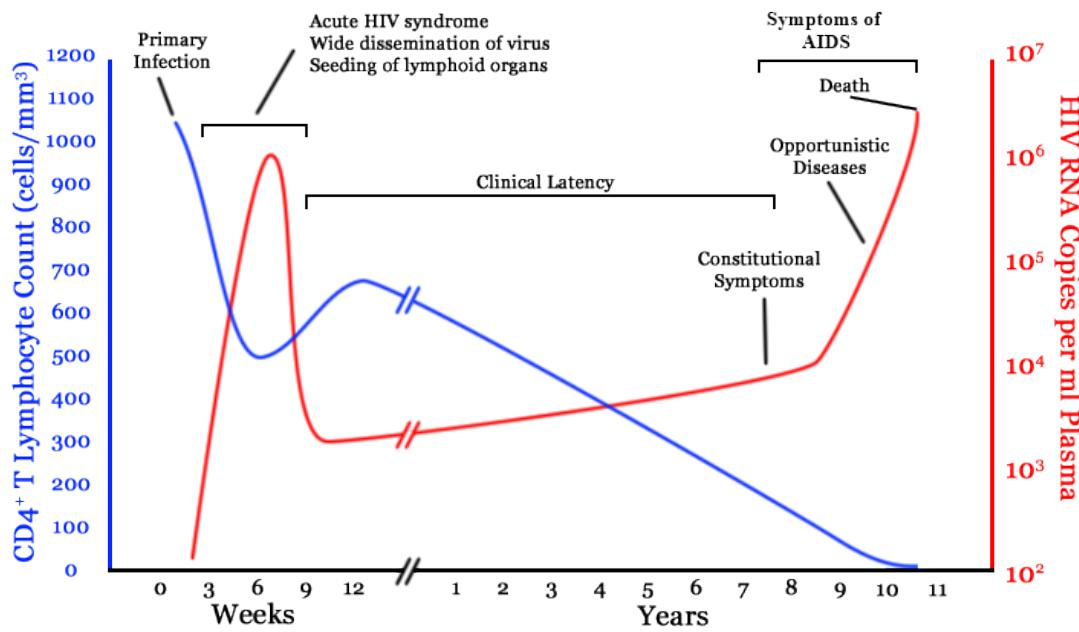
Multi-drug Resistant TB (MDR TB) TB that is resistant to two first-line, anti-TB drugs, **isoniazid** and **rifampicin**.

Extensively-Drug Resistant TB (XDR TB) A multi-drug resistant TB that is resistant to **isoniazid** and **rifampicin** and to two injectable drugs used to treat TB.

Viral Load The amount of HIV in one's blood. The higher the viral load, the more rapid the disease can progress.

The Bartlett Chart

Source: Figure 1 in Pantaleo, G et al. (February 1993). "New concepts in the immunopathogenesis of human immunodeficiency virus infection". New England Journal of Medicine 328 (5): 327-335. PMID 8093551



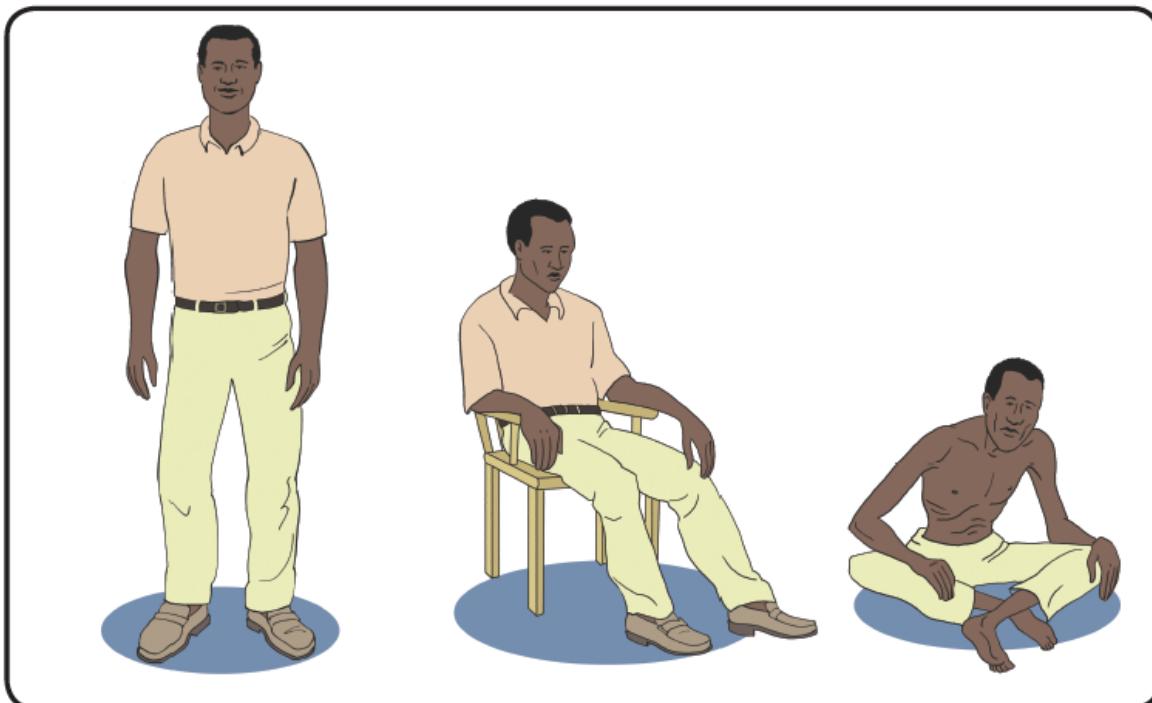
A generalized graph of the relationship between HIV copies (viral load) and CD4 counts over the average course of untreated HIV infection; any particular individual's disease course may vary considerably.

CD4⁺ T Lymphocyte count (cells/mm³)

HIV RNA copies per mL of plasma

WHO Clinical Stages

Excerpted from the Participant Manual for WHO Basic ART Clinical Training Course: www.who.int/hiv/pub/imai/en/partmanualbasicartfinal.pdf



Not significant
immunosuppression
 $CD4 > 500/\text{mm}^3$

Mild
immunosuppression
 $CD4 = 499 - 350/\text{mm}^3$

Advanced/Severe
immunosuppression
 $CD4 = 350 \text{ or less}$

As a person's CD4 cells and immunity decline, the risk of getting opportunistic infections increases.

Treatment initiation is recommended as soon as one is diagnosed irrespective of the CD4 count.

The World Health Organisation (WHO) provides clinical stages of HIV/AIDS to describe the degree of immune deficiency.

People at WHO clinical stage 1 or 2 usually do not have a very serious immune deficiency.

People with symptoms of WHO stage 3 or 4 usually have serious immune deficiency: their CD4 count is low.

WHO Clinical Stages (continued)

Certain conditions need a diagnosis by a doctor or medical officer and should be referred for appropriate diagnosis and treatment. These conditions are marked with an asterisk * in the following table.

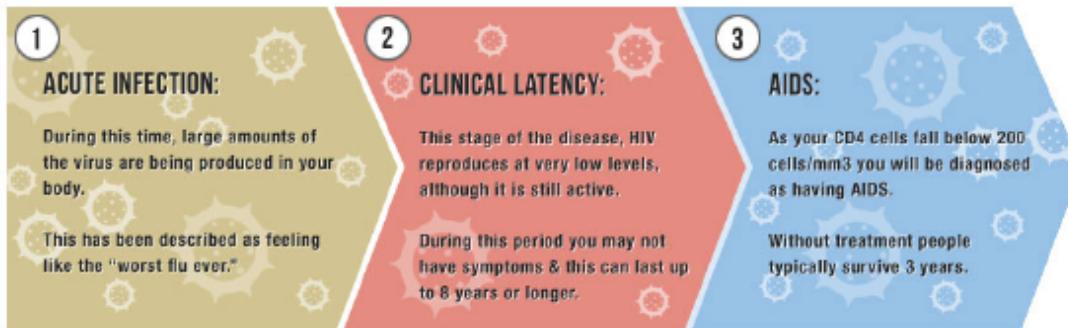
WHO Adult HIV Clinical Stages

STAGE 1 No Symptoms	STAGE 2 Mild	STAGE 3 Advanced	STAGE 4 Severe (AIDS)
No symptoms OR Persistent generalized lymphadenopathy: multiple small painless lymph nodes	<p>Weight loss 5 – 10%</p> <p>Sores or cracks around lips (Angular cheilitis)</p> <p>Small lesions at the corners of the mouth</p> <p>Scaly skin eruption on the border between face and hair and side of the nose (seborrhea)</p> <p>Itchy skin eruption on the arms and legs (Prurigo)</p> <p>Herpes zoster: painful blisters on a region of one side of the body, face, or extremities</p> <p>Recurrent upper respiratory infections: repeated throat infections, sinusitis, or ear infection</p> <p>Recurrent mouth ulcers</p>	<p>Weight loss >10%</p> <p>Oral thrush: white patches covering areas in the mouth</p> <p>Oral hairy leukoplakia: non-painful, white vertical lines on the side of the tongue, which cannot be scraped off</p> <p>More than one month of:</p> <ul style="list-style-type: none"> • Diarrhoea: sometimes intermittent • Unexplained fever: sometimes intermittent <p>Severe bacterial infections:</p> <ul style="list-style-type: none"> • Pneumonia, • Muscle infection • Pulmonary TB • TB lymphadenopathy <p>Acute necrotizing ulcerative gingivitis, periodontitis (gum inflammation and bleeding)</p>	<ul style="list-style-type: none"> • HIV wasting syndrome: extremely thin with chronic fever and/or chronic diarrhoea • Oesophageal thrush: severe pain when swallowing • More than one month of herpes simplex ulcerations: large and chronic painful wounds on the genitals and/or anus • Lymphoma* • Kaposi's sarcoma: dark (purple) lesions on the skin and/or mouth, eye, lungs, intestines, often accompanied by a hard oedema • Invasive cervical cancer* • <i>Pneumocystis pneumonia*</i> severe pneumonia with shortness of breath on exertion and dry cough • Extrapulmonary TB* • Cryptococcal meningitis* meningitis which can present without neck stiffness • <i>Toxoplasma</i> brain abscess* collection of pus • Visceral leishmaniasis* an infection accompanied by fever and abdominal pain • HIV encephalopathy* significant neurological impairment interfering with independent functioning and not due to other cause, will sometimes improve on ART

Explaining HIV/AIDS

Excerpted from AIDS.gov available at <http://aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/hiv-in-your-body/stages-of-hiv/>

The Stages of HIV



What Does HIV Do When it Isn't Treated?

HIV disease has a well-documented progression. If you are infected with HIV and don't get treatment, HIV will eventually overwhelm your immune system—and this will lead to your being diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

Here's what typically happens:

Acute Infection: Within 2-4 weeks after infection with HIV, you can experience an acute illness, which is often described as “the worst flu ever.” This is called *acute retroviral syndrome (ARS)* or *primary HIV infection* and it’s the body’s natural response to the HIV infection. (Not everyone develops ARS, however—and it can take up to 3 months for it to appear in some people who do.)

During this period of infection, large amounts of virus are being produced in your body. The virus uses CD4 cells to replicate and destroys them in the process. Because of this the *CD4 count* can fall rapidly. Eventually your immune response will begin to bring the level of virus in your body back down to a level called a *viral set point*, which is a relatively stable level of virus in your body. At this point, your CD4 count begins to increase, but it may not return to pre-infection levels.

Clinical Latency: After the acute stage of HIV infection, the disease moves into a stage called *clinical latency*. This period is sometimes called *asymptomatic HIV infection* or *chronic HIV infection*. During this phase, HIV reproduces at very low levels, although it is still active. You may be able to maintain an undetectable *viral load* and a healthy CD4 cell count without the use of medication during the earlier years of this phase. You may not have

Explaining HIV/AIDS (continued)

symptoms or opportunistic infections. This period can last up to 8 years or longer.

Some people progress through this phase faster than others. It is important to remember that you are still able to transmit HIV to others during this phase.

Toward the middle and end of this period, your viral load begins to rise and your CD4 cell count begins to drop. As this happens, you may begin to have constitutional symptoms of HIV as the virus levels increase in your body.

AIDS: As the number of your CD4 cells begins to fall below 200 cells per cubic millimetre of blood (200 cells/mm³), you will be diagnosed as having AIDS. (Normal CD4 counts are between 500 and 1,600 cells/mm³.) This is the stage of infection that occurs when your immune system is badly damaged and you become vulnerable to opportunistic infections. Without treatment, people who are diagnosed with AIDS typically survive about 3 years. Once someone has a dangerous opportunistic infection, life expectancy falls to about 1 year.

Opportunistic infections (OIs) are signs of a declining immune system. Most life-threatening OIs occur when your *CD4 count* is below 200 cells/mm³. OIs are the most common cause of death for people with HIV/AIDS.

Opportunistic Infections

The CDC developed a list of more than 20 OIs that are considered *AIDS-defining conditions*—if you have HIV and one or more of these OIs, you will be diagnosed with AIDS, no matter what your CD4 count happens to be:

- *Candidiasis* of bronchi, trachea, oesophagus, or lungs
- *Invasive cervical cancer*
- *Coccidioidomycosis*
- *Cryptococcosis*
- *Cryptosporidiosis*, chronic intestinal (greater than 1 month's duration)
- *Cytomegalovirus* disease (particularly CMV retinitis)
- *Encephalopathy*, HIV-related
- *Herpes simplex*: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis
- *Histoplasmosis*
- *Isosporiasis*, chronic intestinal (greater than 1 month's duration)
- *Kaposi's sarcoma*
- *Lymphoma*, multiple forms
- *Mycobacterium avium complex*
- *Tuberculosis*
- *Pneumocystis carinii pneumonia*
- *Pneumonia*, recurrent
- *Progressive multifocal leukoencephalopathy*
- *Salmonella septicemia*, recurrent
- *Toxoplasmosis* of brain
- *Wasting syndrome* due to HIV

HIV Re-infection

Because they can be so dangerous to your health, it is essential that you understand the signs, symptoms, prevention, and management of OIs.

There is still a debate in the scientific community regarding HIV re-infection and super-infection. Basic information is provided here as background in case I ACT participants would like more information or access to resources.

Re-infection involves:

- Infection with 2 different strains of HIV
- Being infected with a strain of HIV that is different than the one first contracted

Super-infection involves:

- Reinfection
- Infection with recombinant HIV, a virus made out of two different strains
- **Super-infection resistance** is the capacity of cells to prevent a second viral infection closely related to the virus that has already established an infection

There is some controversy about the words “re-infection” and “super-infection.” Some people living with HIV/AIDS criticize the word as fear instilling because they are frequently used to scare clients into changing risky behaviours. Using this approach goes against I ACT’s harm reduction framework and client-centred approach.

Reinfection can happen with some viruses but not all:

- Influenza – A person can have multiple infections of influenza; people who’ve previously had influenza may contract a new strain because it mutates and they do not have protection against the mutated strain
- Herpes – Infection with Herpes Simplex I offers some protection against infection with Herpes Simplex II (genital Herpes); a person who is co-infected with both might have less symptoms of HSV II
- Measles – The measles virus mutates/changes a lot but it does not change in a way in which people lose immunity to it; Most people cannot get the measles again – it very rarely happens
- Hepatitis B – Once infected with HBV, a person is never infected with it again

Background Information on Re-infection Studies

One study looked at 718 individuals over several years and found no cases of dual infection. [*Journal of Infectious Diseases*. 2003;188:397]. A second study found that no cases of co-infection occurred after 3 years of the initial infection. [SF AIDS Foundation]

Definitions and Benefits of Treatment Literacy

Definitions of Treatment Literacy

Healthlink Worldwide

Treatment literacy means people, both individually and in communities understand what anti-retroviral drugs are, why they are needed and what they can and cannot do.

Network of African People Living with HIV/AIDS

Treatment literacy is the possession of knowledge, skills and attitudes based on sound scientific evidence to actively participate in one's own treatment decisions and to contribute to the training of other HIV+ people and their advocates.

Treatment literacy is crucial to:

- Understand both physical implications of treatment and the effects of HIV on the body, as well as, psychological and physical
- Make informed choices about treatment modalities, such as ART
- Ensure effective adherence through community and family support
- Understand the links between treatment, prevention and care as necessary components of a continuum of care
- Combating stigma and discrimination by dispelling myths about HIV/AIDS
- Counter false claims by under-trained healthcare workers

Treatment Action Campaign

Many treatment activists have learnt the science and medical treatments of HIV/AIDS. Many of us educate our communities on these issues. We must know our medicines by name, how they were found to be effective, how and where in the body they work. We must know their side effects and how they can be managed, how to monitor the safety of these medicines, and what foods you should eat and not eat with them. We must also follow new scientific research on how best to use the drugs we take. All these things are part of what we call treatment literacy. This knowledge lets us have control over our health and participate in health policy formulation process.

Benefits of treatment literacy

- Improved health outcomes
- Better adherence to drug regimens
- Active participation of people living with HIV in their care
- Encouragement of community participation
- Reduced stigma and discrimination
- Dispelling of myths
- Better linkages between HIV prevention and care

Combination Treatment for HIV/AIDS

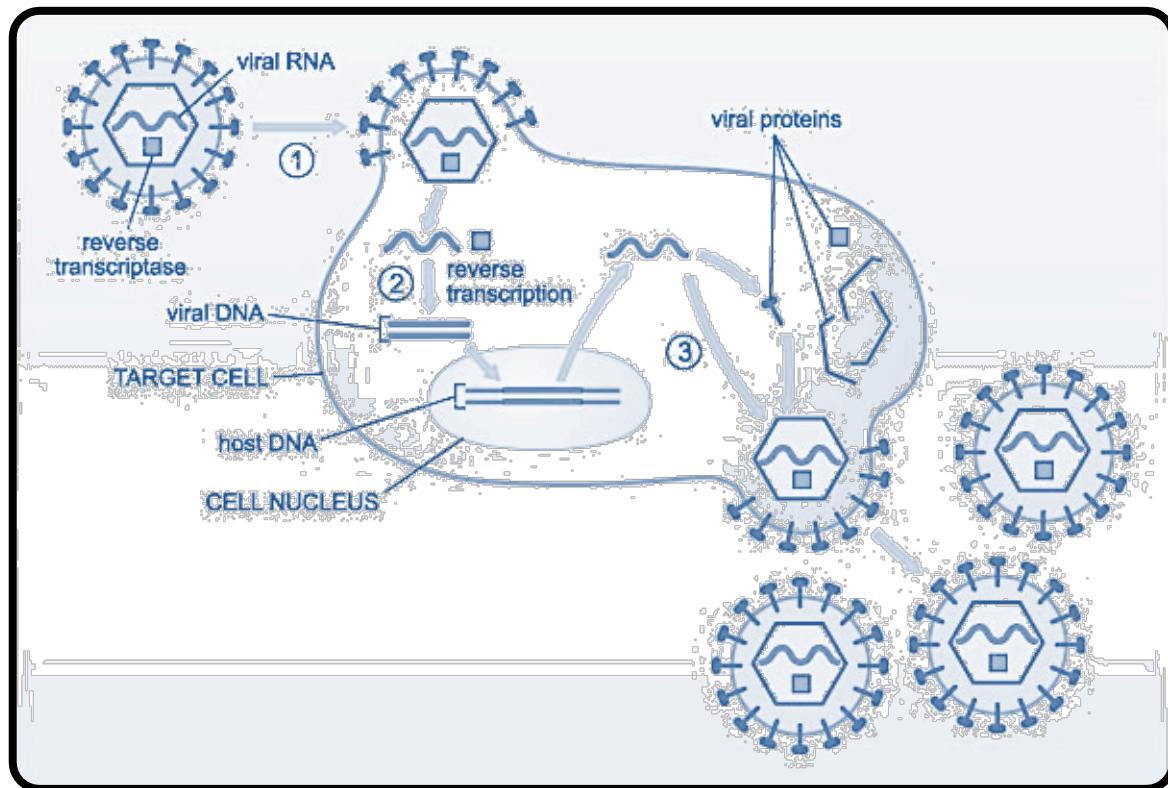
ARVs are usually taken in combination. People usually take 3 medications, not just one.

Why treat in combination?

- It takes a lot to stop HIV because everyday billions of HIV copies made
- HIV ARVs from different classes attack the virus in different ways
- HIV ARVs attack the virus in different types of cells and in different parts of the body
- If combined correctly, side effects are not increased
- Combinations may overcome or delay resistance – Combination therapy is like having multiple layers of nets; if one medication is not able to stop HIV multiplication, there is another “net” HIV has to go through to be able to replicate

HIV Lifecycle without Treatment

Graphic source: The Open University: www.open.edu



Steps in the HIV Replication Cycle

- Entry, Binding and Fusion – key and door lock.** HIV needs to enter a CD4 cell to start the replication process. It attaches to a receptor to enter. HIV fits the CD4 like a key and a doorlock. After attaching, HIV fuses with the cell.
- Reverse Transcription – Transcriber – Transcriptase disguise.** The CD4 cell has all its genetic information in its DNA. HIV needs to change its single-stranded RNA into a double-stranded DNA. It uses the reverse transcriptase enzyme to change its RNA into DNA. To transcribe is to write; going from one line to two.
- Integration.** To integrate means to become one. HIV needs to integrate its DNA into the CD4 cell DNA in the nucleus of the cell. For integration, HIV uses the integrase enzyme.
- Translation – Copier.** HIV makes thousands of copies of itself. The copies are made in a long chain.
- Assembly – Scissors.** HIV RNA and proteins are cut by the protease enzyme and assemble into functioning virus.
- Budding.** New copies of the virus leave the infected cell. These new copies go on to infect other CD4 cells

HIV Lifecycle without Treatment (continued)

HIV uses CD4 cells to make copies of itself. It **cannot** multiply on its own without CD4 cells.

Stages of the HIV reproduction:

1. HIV enters the human body through the bloodstream.
2. HIV looks for CD4 cells.
3. Entry – HIV attaches and enters CD4 cells.
4. Reverse Transcription - HIV RNA is converted into DNA (the genetic material of cells) using the reverse transcriptase enzyme.
5. Integration – HIV is integrated into the infected cell's DNA by the integrase enzyme.
6. Translation – HIV makes thousands of copies of itself.
7. Assembly – HIV RNA and proteins are cut by the protease enzyme, and assemble into functioning virus.
8. Budding – New copies of the virus leave the infected cell. These new copies go on to infect other CD4 cells

HIV medications and the HIV Lifecycle

- ARVs try to stop the process of HIV multiplication (replication)
- Combination therapy: medications are used in combination to try to stop HIV replication at different points of the HIV lifecycle

Where do different classes of medications do their work?

- Entry Inhibitors – Stage 3
- Nucleoside Reverse Transcriptase Inhibitors – Stage 4
- Non-Nucleoside Reverse Transcriptase Inhibitors – Stage 4/Integrase Inhibitors – Stage 5
- Protease Inhibitors – Stage 7

Known Classes of Medications Used in HIV Retroviral Therapy

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (Nukes):

- Also called “nukes” or “NRTIs”
- Eight agents are currently available in this class (Zidovudine/AZT, Lamivudine/3TC, Didanosine/ddI, Stavudine/d4T, Emtriva, Viread, Hivid, and Ziagen)
- Five agents currently in development
- Work by blocking the viral enzyme reverse transcriptase, preventing HIV RNA from changing its chemical message into a form that can easily be replicated in the DNA of newly infected cells

HIV Lifecycle without Treatment (continued)

Non-nucleoside Reverse Transcriptase Inhibitors (Non-nukes):

- Also called “non-nukes” or “NNTTIs”
- Four agents are currently available in this class (Nevirapine, Efavirenz/Sustiva, Intelence, and Rescriptor)
- Work by blocking the reverse transcriptase enzyme directly; similar to “nukes”, but bind with a different portion of the molecule

Protease Inhibitors (PIs):

- 10 agents currently available in this class (Kaletra, Agenerase, Aptivus, Crixivan, Fortovase, Invirase, Norvir, Prezista, Reyataz, and Viracept)
- 6 agents currently in development
- Stop HIV replication by preventing the enzyme protease from cutting the virus into shorter pieces that it needs to make copies of itself in newly infected cells. New copies of HIV are still produced and push through the wall of the infected cell, but these new copies are defective – not completely formed – so they can not infect other cells

Entry Inhibitors:

- Also called “fusion inhibitors” and “attachment inhibitors”New class of drugs with only two agents (Fuzeon, Selzentry)
- Five new agents currently in development
- Work by stopping HIV from getting into CD4 cells
- Used in salvage regimens

Integrase Inhibitors:

- New class of drugs with only one agent (Isentress)
- Work by interfering with the integrase enzyme, thus preventing the integration of the HIV genetic material into the DNA of human CD4 cells making it difficult for the infected cell to make new copies of HIV
- Used by patients failing their regimens or with any degree of resistance to other classes of medications

ART Goals and Objectives

Source: *The South African Antiretroviral Treatment Guidelines (2013) and Universal Test and Treat Strategy for HIV positive Patients and Differentiated Care for Stable Patients (2016)*

These are the goals of the programme:

- a. Save lives and improve the quality of life of people living with HIV
- b. Achieve best health outcomes in the most cost-efficient manner
- c. Implement nurse-initiated treatment
- d. Decentralise service delivery to PHC facilities
- e. Integrate services for HIV, TB, MCH, SRH and wellness
- f. Diagnose HIV earlier
- g. Prevent HIV disease progression
- h. Avert AIDS-related deaths
- i. Retain patients on lifelong therapy
- j. Prevent new infections among children, adolescents, and adults
- k. Mitigate the impact of HIV and AIDS

Objectives:

- a. Ensure timely initiation of ARVs for treatment and prevention according to the Presidential mandates
- b. Contribute to strengthening of the public and private health sectors' capacity to deliver high quality integrated health and wellness services
- c. Implement cascade management and continuum of care
- d. Minimize unnecessary drug toxicities
- e. Improve clinical outcomes, promote adherence and improved retention of patients in care
- f. Optimize the benefits of treatment as prevention by increasing coverage and annual HCT
- g. Introduce fixed dose combination of highly effective ARV and improve adherence to treatment, care and support

Specific Objectives:

1. To initiate all newly diagnosed patients on treatment irrespective of CD4 count as long as they are willing and ready and prioritise initiation of ART for 1.1 Patients with CD4 counts <350 cells/mm³ or with severe HIV disease (WHO 3 or 4) irrespective of CD4
2. Patients co-infected with drug sensitive or resistant TB who should be initiated with ART irrespective of CD4 count
3. Pregnant women with CD4 < 350 cells/mm³ for lifelong ART and CD4 >350 cells/mm³ for prophylaxis
4. Introduce fixed dose combination (FDC) ART for patients initiated with ART for the first time

6. Introduce FDC ART for HIV positive pregnant women irrespective of CD4 count during pregnancy and during the breastfeeding period
7. Phased introduction of FDC to patients with other co-morbidities (diabetes, hypertension and respiratory diseases, including TB)
8. 1.7 Phased introduction of FDC to patients who require switching due to drugs toxicity or switching from Stavudine (d4T) based regime
9. Phased introduction of FDC to patients who are stable of ART and VL suppressed
10. To test all HIV exposed children under-five years and treat all those found to be infected with HIV.
11. To standardise first and second line therapy for children, adolescents, and adults in the public and private sector.
12. To move patients currently on Stavudine-containing regimens to Tenofovir-based FDCs, once creatinine clearance has been checked. Stavudine (d4T) to be used only under specific circumstances.
13. To strengthen capacity of nurses to initiate ARVs for treatment of pregnant women who are HIV positive for their own health and to prevent mother to child transmission.
14. To strengthen PHC facilities to initiate, manage, monitor and refer patients.

ART Eligibility Criteria for Adults and Teens

Source: *The South African Antiretroviral Treatment Guidelines (2013), Universal Test and Treat Strategy for HIV positive Patients and Differentiated Care for Stable Patients (2016)*

Eligible to start Lifelong ART:

- All Newly diagnosed patients Irrespective of CD4 count
 - All types of TB (In patients with TB drug resistant or sensitive, including extra pulmonary TB)
 - WHO stage 3 or 4 irrespective of CD4 count

Require fast track (i.e. ART initiation within 7 days of being eligible):

- HIV positive women who are pregnant or breast feeding
- OR**
- People with low CD4 less than 200
- OR**
- Patients with WHO Stage 4, irrespective of CD4 count
- OR**
- Patients with TB/HIV co-morbidity with CD4 count less than 50
- (Patients with Cryptococcus meningitis or TB meningitis (defer ART for 4 – 6 weeks))

Patients not yet willing and ready to be initiated on ART.

- Transfer to a wellness programme for regular follow-up and repeat CD4 testing 6-monthly
- Advise on how to avoid HIV transmission to sexual partners and children
- Initiate INH prophylaxis if asymptomatic for TB
- Provide counselling on nutrition and contraception and do annual pap smear

Treatment Readiness Guidelines

Source: 2010 South Africa National Guidelines for Treatment Readiness Assessment; National Adherence Guidelines for Chronic Diseases

Process of treatment initiation

Clinical:

- : clinical (WHO stage) and laboratory (CD4 count) Testing for TB and pregnancy confirmed.
- Opportunistic infections are treated
- Patient's records are completed
- Patient meets with healthcare workers involved in care
- Treatment counsellor or patient advocate discusses treatment (promote adherence) with patient
- Start on Cotrimoxazole or INH as indicated
- Initiate ART if patient is willing and ready
- Promote PMTCT
- Patient is given a date for next appointment

(Sub-heading) Fast-track Treatment Initiation Counselling

- Information on Education on illness
- Counsellor discusses treatment adherence using Patient Adherence plan
- Evaluate Psychosocial support
- Patient sets treatment goals
- Assess patient's readiness and willingness to initiate treatment

Take only the medicines that are prescribed for you

Special Considerations for ART

Source: The South African Antiretroviral Treatment Guidelines (2013)

TB Patients

Suspect TB if 2 or more of the following symptoms are present:

1. Cough any duration
2. Sputum production which may occasionally be blood stained
3. Fever
4. Drenching night sweats
5. Unexplained weight loss
6. Loss of appetite, malaise, tiredness
7. Shortness of breath, chest pains
8. New palpable lymphadenopathy

The patient that presents with TB before commencing ART:

HIV positive TB patients qualify for lifelong ART regardless of CD4 cell count.

Complete 2 to a maximum of 8 weeks of TB therapy before commencing ART (and as soon as possible if CD4 count is less than 50 cells/mm³)

In general, ART should be initiated as soon as the patient is tolerating their TB therapy; this is usually within 2-4 weeks.

Special Considerations for ART (continued)

INH Prophylaxis

- a. All people living with HIV should be screened for active TB
- b. Those who are eligible should be started on ART.
- c. TB preventive therapy is an effective intervention for HIV infected individuals.
- d. All people living with HIV, in whom active TB has been reasonably excluded, should be started on IPT (as soon as practically possible after initiation of ART in those who are eligible for ART).
- e. In patients with no TB signs or symptoms, TB prophylaxis with Isoniazid Preventive Therapy (IPT) should be started, unless alcohol abuse, adherence or side-effects are a concern, 5mg/kg to a maximum dose of 300mg daily, with pyridoxine 25mg/day. A **TST (Mantoux) test is required**.
- f. Pregnancy is not a contraindication to INH prophylaxis.
- g. If no TST is done IPT should be continued for 6 months as per existing guidelines but all effort should be made to perform TST as soon as possible after starting IPT.

Summary Recommendations		
	Pre-ART(CD4>350)	On ART
TST not done*	IPT for 6 months	IPT for 6 months
TST negative	IPT for 6 months	IPT for 12 months
TST positive	IPT for at least 36 months	IPT for at least 36 months

Adherence and Resistance

Excerpted from Frank 1997 as cited by Figueroa 2003

What is adherence?

Adherence means to take the medications as prescribed.

To be adherent includes the following:

- To take all the medication doses as prescribed
- To take the medications at the same time every day
- To follow the dietary instructions and recommendations

Adherence requires skills and learning, people taking ARVs must be able to:

- Understand the regimen
- Believe they can adhere
- Remember to take the medication
- Integrate regimen into lifestyle
- Problem solve changes in schedule and routines

Why is adherence important?

- To avoid treatment failure
- To prevent the development of resistance

What is resistance?

- When HIV develops the ability to “resist” medications; medications no longer work
- Resistance occurs when HIV changes (mutates) and medications cannot stop it from multiplying
- Resistance often develops when one does not take their medications as prescribed

Adherence Fact Sheet

*Excerpted from the AIDS InfoNet Factsheet available at
www.aidsinfonet.org/fact_sheets/view/405*

How much adherence is enough?

Adherence means taking your medications correctly. If you don't, HIV might multiply out of control. Several research studies have measured how much adherence is "enough." They found that, for the best viral load results, people had to take over 90% of their pills correctly. The 90% figure came from studies of regimens containing protease inhibitors. Recent studies suggest that adherence levels to regimens based on non-nucleoside reverse transcriptase inhibitors (NNRTIs) may be lower than 90%. However, the fewer doses you miss, the better the chances of keeping HIV under control and the lower the risk of developing viral resistance.

How Do AIDS Drugs Work?

The HIV virus can make millions of copies of itself every day. Antiretroviral drugs (ARVs) can't kill the virus, but they can almost stop it from multiplying.

A "viral load" test measures the amount of virus in your blood. If you take ARVs, the amount of virus in your blood should go down. If your viral load is very low, you probably won't develop any AIDS-related illnesses.

What is resistance?

The HIV virus is sloppy when it makes copies of itself. Many new copies of HIV are slightly different from the original (mutations). Some mutations can multiply easily even though you are taking drugs that stop "normal" HIV. This is called "developing resistance" to the drugs. If your virus develops resistance, it will multiply faster and your HIV disease will probably get worse.

Sometimes, when HIV becomes resistant to a drug you are taking, it will also be resistant to other ARVs – even if you haven't used them yet. This is called "cross-resistance." Many ARVs are at least partly cross-resistant. If your virus develops resistance to an ARV, you might not be able to use any other drugs of the same type. To avoid using up your treatment options, take all of your medications according to instructions.

Keep Pressure on the Virus

When you take medications, they get into your blood and are carried around your body. Then your liver and kidneys start to clean the drug out of your system, and the amount of medication in your blood goes down.

Adherence Fact Sheet (continued)

Some drugs get into your bloodstream better if there is no food in your stomach. You take these medications on an empty stomach. Other drugs get into your bloodstream better if your stomach is full. You should take these drugs with food. With some drugs, food doesn't matter.

The instructions for taking each drug tell you how many pills to take, when to take them, and how to take them, in order to keep enough medicine in your blood. If you skip a dose, reduce your dose, or don't follow the eating instructions, the drug levels in your blood will drop.

If there is not enough medicine in your blood, HIV can continue to multiply. The more HIV multiplies, the greater the chance that resistance will develop.

The best way to keep pressure on HIV is to take all the pills you're supposed to, every time you're supposed to, and follow the directions about food.

Make it Easy on Yourself

It can be difficult to take your medications the way you're supposed to. Make it as easy as you can!

- When you choose medications, tell your health care provider about your daily schedule so that you can use the medications that will be easiest for you to take.
- Adherence is easier when all of your medications are on the same schedule (twice a day, or once a day.)
- Make sure you understand your medications:
 - Which medications to take
 - How many pills to take, and how many times a day
 - Whether to take your pills with food, or on an empty stomach
 - How to store your pills
 - Side effects you might have, and what to do about them
- **PLAN AHEAD** for refills or trips so you don't run out of any medications. Also, be sure you know what's going to happen if you change medical insurance plans.
- Use a pillbox and count your pills out ahead of time. Some boxes hold enough for a week or two.
- Set a timer or alarm to go off when you have to take pills.
- Choose a regular daily activity to help you remember to take pills:
 - Making your morning coffee
 - Getting out of bed
 - A favourite TV show
 - Coming home from work
- Make sure your family members know how important it is for you to take your pills. Ask them to help you remember.

Adherence Fact Sheet (continued)

You might have problems with side effects, or it might be difficult to take your pills as prescribed. **Don't cut back or stop taking your medications until you have talked to your health care provider.** You might be able to change your medications and get some that are easier for you to take.

Pill Fatigue

Several research studies showed adherence declining over time. This happened even to people who took their medications very successfully. This is called "pill fatigue" or "treatment fatigue."

Good adherence is not a one-time event. It has to continue as long as you are taking medications. Anyone taking anti-HIV medications may need help to keep taking their pills correctly. However, a recent large study showed very high adherence that actually increased over time.

The Bottom Line

In order for your medications to work, you need to take them according to the instructions. If you don't, your virus might develop resistance to drugs you are taking. If your virus becomes resistant to one drug, it might also be resistant to other ARVs. For the best results you have to take over 90% of your pills correctly.

Be sure that you understand which medications your health care provider has prescribed. Make sure you know how many to take, when to take them, and whether you need to take them with food or when your stomach is empty.

Work with your health care provider to make it as easy as possible to take your medications. Use whatever you need to keep on your medication program: pillboxes, timers, friends, or support groups. Be sure to talk with your health care provider **before** you make any changes in your medications or how you take them.

Side Effects Fact Sheet

*Excerpted from the AIDS InfoNet Factsheet available at
www.aidsinfonet.org/fact_sheets/view/550*

What are side effects?

Side effects are what a drug does to you that you don't want it to do. Medications are prescribed for a specific purpose, such as to control HIV. Anything else the drug does is a side effect.

Some side effects are mild, like a slight headache. Others, like liver damage, can be severe and, in rare cases, fatal. Some go on for just a few days or weeks, but others might continue as long as you take a medication, or even after you stop. Some occur within days or weeks of starting a drug. Others may only show up after months or years of therapy.

Who gets side effects?

Most people taking antiretroviral medications (ARVs) have some side effects. In general, higher amounts of drugs cause more side effects. If you are smaller than average, you might experience more side effects. Also, if your body processes drugs more slowly than normal, you could have higher blood levels and maybe more side effects.

Some side effects become worse if the drug is taken on an empty stomach. Others may increase if the drug is taken with fatty food or drink such as whole milk.

Each medication comes with information on its most common side effects. **Don't assume that you will get every side effect that's listed!** Most people have only minor side effects when they take their ARVs.

How to deal with side effects

There are several steps you can take to prepare yourself to deal with side effects.

- Learn about the normal side effects for the medications you're taking.
- Talk to your health care provider about what side effects to expect. Ask when you should get medical attention because a side effect goes on too long, or has gotten severe.
- Find out if you can treat mild side effects with home remedies or over-the-counter medications.
- In some cases, your health care provider can write you a prescription for something you can take to deal with a side effect if it gets severe.
- Stock up! If you're having stomach problems, make sure you have plenty of food that you like to eat and that's easy on your stomach. Don't run out of toilet paper!

Side Effects Fact Sheet (continued)

Do not stop taking any of your medications, or skip or reduce your dose, without talking to your health care provider! Doing so can allow the virus to develop resistance and you might not be able to use some ARVs. BEFORE side effects make you skip or reduce doses, talk to your health care provider about changing drugs!

Which Side Effects are the Most Common?

When you start antiretroviral therapy (ART), you may get headaches, hypertension, or a general sense of feeling ill. These usually improve and disappear over time.

Fatigue: People with HIV often feel tired at least part of the time. It's important to find the cause of fatigue and deal with it.

Anaemia can cause fatigue. Anaemia increases your risk of getting sicker with HIV infection. Routine blood tests can detect anaemia, and it can be treated.

Digestive Problems: Many drugs can make you feel sick to your stomach. They can cause nausea, vomiting, gas, or diarrhoea. Home remedies include:

- Instead of three big meals, eat small amounts, more often.
- Eat mild foods and soups, not spicy.
- Ginger ale or ginger tea might settle your stomach. So can the smell of fresh lemon.
- Exercise regularly.

Don't skip meals or to lose too much weight! Marijuana can reduce nausea. Be careful with over-the-counter or prescription nausea drugs. They can interact with ARVs.

Gas and bloating can be reduced by avoiding foods like beans, some raw vegetables, and vegetable skins.

Diarrhoea can range from a small hassle to a serious condition. Tell your health care provider if diarrhoea goes on too long or if it's serious. Drink lots of liquids.

Lipodystrophy (Body Shape Changes) includes fat loss in arms, legs and face; fat gain in the stomach or behind the neck; and increases in fats (cholesterol) and sugar (glucose) in the blood. These changes may increase the risk of heart attack or stroke.

Side Effects Fact Sheet (continued)

High levels of fats and sugar in the blood, including cholesterol, triglycerides and glucose. This can increase the risk of heart disease.

Skin Problems: Some medications cause rashes. Most are temporary, but in rare cases they indicate a serious reaction. Talk to your health care provider if you have a rash. Other skin problems include dry skin or hair loss. Moisturizers help some skin problems.

Neuropathy is a painful condition caused by nerve damage. It normally starts in the feet or hands.

Mitochondrial Toxicity is damage to structures inside the cells. It might cause neuropathy or kidney damage, and can cause a build up of lactic acid in the body.

Osteoporosis shows up frequently in people with HIV. Bones can lose their mineral content and become brittle. A loss of blood supply can cause hip problems. Get enough calcium from food and supplements. Weight-bearing exercise like walking or weight lifting can be helpful.

The Bottom Line

Most people who take ARVs have some side effects. However, don't assume you will get every side effect you hear about!

Get information on the most common side effects and how to treat them. Stock up on home remedies and other items that can help you deal with side effects.

Be sure you know when to go back to your health care provider because a side effect may have gone on too long or gotten severe.

Don't let side effects keep you from taking your medications! Do not assume that taking ART means you have to put up with the side effects. If you can't deal with them, if they continue for more than a few months, or they affect your quality of life, talk to your health care provider about changing your drugs.

Immune Reconstitution Syndrome

*Adapted from “Antiretroviral treatment, A Health Worker’s Guide,”
Khomanani, Soul City*

Soon after starting ARV medication, the immune system begins to recover. The body vigorously starts to fight infections such as TB and cytomegalovirus (CMV). These infections may have been present before, but because there was no immune response, there were no signs or symptoms.

The newly recovering immune system’s response to these infections can result in a massive inflammatory response with severe symptoms.

This is called the Immune Reconstitution Syndrome.

In South Africa, the Immune Reconstitution Syndrome happens often with TB. When ART is started, a patient gets all the following signs and symptoms of active TB:

- Fever
- Wasting
- Coughing
- Lymphadenopathy
- Lung infiltrates

Other common causes of Immune Reconstitution Syndrome are:

- Shingles (new attacks)
- Herpes (new attacks)
- Cytomegalovirus (worsening blindness)
- Molluscum contagiosum (with new inflammation)
- Pneumocystis carinii (jiroveci) pneumonia (PCP)
- Mycobacteria avium (MAI)
- Cryptoccocal meningitis (worsening headaches)

The Immune Reconstitution Syndrome can be fatal. The treatment is to identify the infection and treat it.

Patients with Immune Reconstitution Syndrome need to be identified and treated.

Links to STI Fact Sheets

The following links are to fact sheets published by the Centres for Disease Control and Prevention (www.cdc.gov).

The Role of STD Detection and Treatment in HIV Prevention

<http://www.cdc.gov/std/hiv/STDFact-STD-HIV.htm>

STDs and Pregnancy

<http://www.cdc.gov/std/pregnancy/STDFact-Pregnancy.htm>

STI Specific Fact Sheets:



Chlamydia: <http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm>



Genital Herpes: <http://www.cdc.gov/std/Herpes/STDFact-Herpes.htm>



Genital Warts (HPV): <http://www.cdc.gov/std/HPV/STDFact-HPV.htm>



Gonorrhoea: <http://www.cdc.gov/std/Gonorrhea/STDFact-gonorrhea.htm>

Scabies and Pubic Lice: <http://www.cdc.gov/parasites/lice/pubic/index.html>



Syphilis: <http://www.cdc.gov/std/Syphilis/STDFact-Syphilis.htm>



Trichomoniasis: <http://www.cdc.gov/std/Trichomonas/STDFact-Trichomoniasis.htm>

Male and Female Condoms

This worksheet was prepared by the Massachusetts Department of Public Health, Bureau of Communicable Disease Control, <http://www.mass.gov/eohhs/docs/dph/cdc/factsheets/condoms.pdf>

Learn the facts. Protect yourself. Get tested.



Be safer, use condoms.

Condoms can help prevent pregnancy, HIV and STDs

Condoms come in a variety of types and sizes. They can be used for vaginal, anal and oral sex. There are condoms for men and for women.

Latex – Most condoms are made out of latex, a kind of rubber.

Polyurethane – There are also plastic (polyurethane) condoms. These are good for people with allergies to latex.

Lubricated – Lubricated condoms contain slippery stuff (lube) that may make sex feel better and may prevent irritation. Most lubes are water-based and are safe to use with latex. Lubes that contain oils like Vaseline and lotion cause latex condoms to break, so they should not be used. Some lubes may contain a chemical that kills sperm (spermicide). Note: Nonoxynol-9 (N-9) is one spermicide used in some condoms that may cause allergic reactions for some people and increase their risk of getting HIV infection. Condoms or lube with N-9 should not be used. If condoms have N-9 in them, it will say on the label, so be sure to check.

Non-lubricated – Condoms that are used for oral sex may be flavored and most are not lubed.

Flavored and joke condoms – Some condoms, like ones that glow in the dark or have funny pictures on them, are made as jokes and should not be used for vaginal or anal sex.

Internal condoms – Condoms that are typically marketed for women that are inserted into the vagina for vaginal sex or inside an anus for anal sex.

Condoms are easily available in a wide variety of places.

You can find condoms at grocery stores, drugstores, health centers and online. There may even be places near you where you can find free or low-cost condoms.

Condoms only work when you use them correctly.

Carry condoms with you and put one on before having sexual contact. Practice putting them on and try to talk with your partner about condoms before you have sex. Do not use expired condoms.

Protect yourself

Using condoms the right way, every time you have sex can help protect you from:

- unplanned pregnancy,
- HIV (the virus that causes AIDS)
- and other STDs (sexually transmitted diseases).

Enjoy yourself

Condoms may help protect you from most STDs, but work best against diseases passed through fluids (like semen and vaginal fluid) rather than those passed skin-to-skin.

For some people, condoms may make sex feel better or last longer.

Get closer

Using condoms may also help you to talk with your partner and to feel more relaxed about being together.

Massachusetts Department of Public Health, Bureau of Communicable Disease Control

Division of STD Prevention
305 South Street, Jamaica Plain, MA 02130
(617) 983-6940
www.mass.gov/dph/cdc/std

January 2007

Male and Female Condoms (continued)

How do you use condoms?

Try to use condoms every time you have sex. Put one on an erect (hard) penis before it touches your partner's genitals (sex parts).



1. Squeeze the package to make sure there is air in it.
2. Open the package - be careful not to tear the condom!
3. Squeeze the tip of the condom to keep out air bubbles and to leave room for the ejaculate (semen).
4. Unroll it onto your erect (hard) penis – all the way to the base if you can.
5. After you ejaculate, hold on to the condom so semen does not spill out and pull out while the penis is still hard.
6. Hold the base of the condom while you remove it so you don't spill any semen.
7. Tie off the end of the condom and throw it in the trash.



How do you use Reality® condoms?

These are sometimes called *female condoms* or *internal condoms*. You put them inside your vagina for vaginal sex or inside your anus (butt) for anal sex. Do not use a traditional condom at the same time as an internal condom.



1. Squeeze the package to make sure there is air in it.
2. Open the package - be careful not to tear the condom!
3. Squeeze the inner ring inside the condom and push it up into your vagina as far as it will go. For anal sex, you should take out the inner ring before you put it in your anus.
4. When you are both ready, guide the penis into the condom.
5. After your partner ejaculates, twist the outer ring and gently pull the condom out.
6. Hold the base of the condom while you pull it out so you don't spill any semen.
7. Tie off the end and throw it in the trash.



Condom Tips

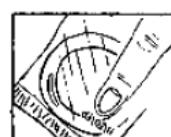
Store condoms in a cool, dry place - heat or cold can damage condoms.

Keep condoms where they won't get damaged – not in your wallet or car.

Don't reuse a condom – use it once, then throw it away.

Wear one condom at a time – wearing two won't keep you safer, and it can make it easier for condoms to break.

Check the expiration date before you use the condom. Throw away expired condoms.



Find out more...

Centers for Disease Control & Prevention (CDC)
www.cdc.gov

Sexuality Information and Education Council of the U.S. (SIECUS)
www.siecus.org

Planned Parenthood Federation of America
www.plannedparenthood.org

www.teenwire.com

Sex, Etc.
(a website by teens for teens)
www.sexetc.org



AIDS Action Committee
www.aac.org

Male and Female Condoms (continued)

General information about male condoms is available at

<http://www.plannedparenthood.org/health-topics/birth-control/condom-10187.htm>

General information about female condoms is available at

<http://www.plannedparenthood.org/health-topics/birth-control/female-condom-4223.htm>

For an informational video about male condom use please see:

<http://www.youtube.com/watch?v=tcpfZKvOFZ4&feature=plcp>

For an informational video about female condom use please see:

<http://www.youtube.com/watch?v=zjmoQIAQP4Y>

Links to Articles on Post-Exposure Prophylaxis (PEP)

Guidelines – Post-exposure Prophylaxis

Southern African Journal of HIV Medicine available at
www.sajhivmed.org.za/index.php/sajhivmed/article/download/481/382

Supporting rape survivors to adhere to post-exposure prophylaxis (PEP) to prevent HIV infection: The importance of psychosocial counselling and support

By L Vetten, S Haffejee

Southern African Journal of HIV Medicine available at
www.tlac.org.za/wp-content/uploads/2012/01/Supporting-rape-survivors-in-adhering-to-post-exposure-prophylaxis.pdf

The Ghost of AIDS Denialism: Manguzi Hospital and Dual Loyalty

By Marlise Richter and Donna Knapp van Bogaert
Southern African Journal of HIV Medicine available at
www.ehrn.co.za/publications/download/106.pdf

PEP Treatment Sites

Source: Treatment Action Campaign: <http://www.tac.org.za/content/pep-rape-survivors>

The following is a list of public health establishments where PEP treatment is available to victims of sexual offences at no cost to the victims:

MPUMALANGA

Umjindi LM Barberton Hospital	(013) 712 3011
Highlands LM Belfast Hospital	(013) 253 1184
Delmas LM Bernice Samuels Hospital	(013) 665 2086
Govan Mbeki LM Bethal Hospital	(017) 647 6341
Albert Luthuli LM Carolina Hospital	(017) 843 1121
Albert Luthuli LM Embhuleni Hospital	(017) 883 0093
Msukaligwa LM Ermelo Hospital	(017) 811 2223
Govan Mbeki LM Evander Hospital	(017) 632 2212
Thembisile LM KwaMhlanga Hospital	(013) 947 3311
Thaba Cheweu LM Lydenburg Hospital	(013) 235 2233
Bushbuckridge LM Mapulangeng Hospital	(013) 799 0214
Thaba Cheweu LM Matibidi Hospital	(013) 769 8092
Bushbuckridge LM Matikwana Hospital	(013) 708 6024
Steve Tshwete LM Middelburg Hospital	(013) 243 0999
Dr. JS Moroka LM Mmametlhake Hospital	(012) 723 2391
Mkhondo LM Piet Retief Hospital	(017) 826 2222
Mbombela LM Rob Ferreira Hospital	(013) 741 3031
Thaba Cheweu LM Sabie Hospital	(013) 764 1222
Nkomazi LM Shongwe Hospital	(013) 781 0219
Lekwa LM Standerton Hospital	(017) 712 2323
Mbombela LM Themba Hospital	(013) 796 0201
Bushbuckridge LM Tintswalo Hospital	(013) 797 0001
Nkomazi LM Tonga Hospital	(013) 253 1184
Highlands LM Waterval Boven Hospital	(013) 257 0015
Emalahleni LM Witbank Hospital	(013) 653 2000

NORTHWEST

Lekwa-Teemane LM Bloemhof/Christiana Hospital	(053) 433 1146
Madibeng LM Brits Hospital	(012) 252 3311
Merafong City LM Carletonville Hospital	(018) 787 2111
Lekwa-Teemane LM Christiana Hospital	(053) 441 2238
KagLSAno LM Ganyesa Hospital	(053) 996 3356
Mafikeng LM Gelukspan Hospital	(016) 336 2100
Ditsobotla IM General de la Rey Hospital	(016) 632 3041
Moses Kotane LM George Stegmann Hospital	(014) 556 1774
Klerksdorp LM Klerksdorp/Tshepong	(018) 406 4400

PEP Treatment Sites (continued)

Kgetleng Rivier LM Koster Hospital	(014) 543 2027
Ramotshere Moiloa Lehurutshe Hospital	(018) 363 3505
Mafikeng LM Mafikeng General Hospital	(018) 383 2005
Moses Kotane LM Moreteletsi Hospital	(014) 519 0600
Maquassi Hills LM Nic Bodenstein Hospital	(018) 596 1100
Potchefstroom LM Potchefstroom Hospital	(018) 297 7011
Rustenburg LM Rustenburg Hospital	(014) 590 5100
Mamusa LM Schweizer-Reneke Hospital	(053) 953 1291
Kgetleng Rivier LM Swartruggens Hospital	(014) 544 0751
Greater Taung LM Taung Hospital	(053) 994 1805
Ditsobotla LM Thusong Hospital	(018) 338 2418
Ventersdorp LM Ventersdorp Hospital	(018) 264 2081
Naledi LM Vryburg Hospital	(053) 927 2121
Ramotshere Moiloa Zeerust Hospital	(018) 642 1121

KWAZULU-NATAL

Newcastle LM Madadeni Hospital	(034) 374 9221
Newcastle LM Newcastle Hospital	(034) 328 0000
Utrecht LM Niemeyer Memorial Hospital	(034) 331 3011
eThekwini SD Addington Hospital	(031) 332 2111
eThekwini SD Inkosi Albert Luthuli Hospital	(031) 240 1000
eThekwini SD King Edward VIII Hospital	(031) 360 3111
eThekwini SD Mahatma Gandhi Hospital	(031) 502 1719
eThekwini SD McCords Hospital	(031) 268 5700
eThekwini SD Osindisweni Hospital	(032) 541 0323
eThekwini SD Prince Mshiyeni	(031) 907 8111
eThekwini SD RK Khan Hospital	(031) 459 6000
eThekwini SD St Aidan's Hospital	(031) 314 2200
eThekwlnl SD St Mary's Hospital	(031) 717 1000
eThekwini SD Wentwort Hospital	(031) 460 5000
KwaDukusa LM Stanger Hospital	(032) 437 6000
Maphumulo LM Umphumulo Hospital	(032) 481 7787
Maphumulo LM Untujambili Hospital	(033) 444 0818
Ndwedwe LM Montebello Hospital	(033) 506 0008
Kokstad LM East Griqualand/Usher Hospital	(039) 797 8100
Ingwe LM St Apollinaris Hospital	(039) 833 1045
Matatiele LM Tayler Bequest Hospital	(039) 737 3107
Ubuuhlebezwe LM Christ the King Hospital	(039) 834 2067
Umzimkhulu LM Rietvlei Hospital	(039) 260 0000
Umzimkhulu LM St Margaret's Hospital	(039) 259 9222
Hibiscus Coast LM Murchison Hospital	(039) 687 7311
Hibiscus Coast LM Port Shepstone Hospital	(039) 688 6000
Umdoni LM GJ Crookes' Hospital	(039) 978 7000

PEP Treatment Sites (continued)

Muziwabantu LM St Andrew's Hospital	(039) 433 1955
The Msunduzi LM Edendale Hospital	(033) 395 4911
The Msunduzi LM Grey's Hospital	(033) 897 3000
The Msunduzi LM Northdale Hospital	(033) 387 9000
Mshwathi LM Appelsbosc Hospital	(032) 294 0002
Hlabisa LM Hlabisa Hospital	(035) 838 1003
Jozini LM Bethesda Hospital	(035) 595 1004
Jozini LM Mosvold Hospital	(035) 591 0122
Umhlabuyalingana LM Mangazi Hospital	(035) 592 0150
Umhlabuyalingana LM Mseleni Hospital	(035) 574 1004
Endumeni LM Dundee Hospital	(034) 212 1111
Msinga LM ChurchHospitalof Scotland Hospital	(033) 493 0004
Nquthu LM Charles Johnson Mem Hospital	(034) 271 1900
Umvoti LM Greytown Hospital	(033) 413 9400
Emnambithi LM Ladysmith Hospital	(036) 637 2111
Okhahlamba LM Emmaus Hospital	(036) 488 1570
Umtshezi LM Estcourt Hospital	(036) 342 7000
Mthonjaneni LM KwaMagwa Hospital	(035) 450 2071
Nkandla LM Ekhombe Hospital	(035) 834 2000
Nkandla LM Nkandla Hanp	(035) 833 0012
uMhlathuze LM Lower Umfolozi War Hospital	(035) 902 8500
uMhlathuze LM Ngwelezana Hospital	(035) 901 7000
uMlalazi LM Catherine Boot Hospital	(035) 474 8403/9
uMlalazi LM Eshowe Hospital	(035) 473 4500
uMlalazi LM Mbongolwane Hospital	(035) 476 6242
Abaqulusi LM Vryheid Hos	(034) 982 2111
Nongoma LM Benedictine Hospital	(035) 831 0314
Ulundi LM Ceza Hospital	(035) 832 0081
Ulundi LM Nkonjeni Hospital	(035) 873 0013
uPhongolo LM Itshelejuba Hospital	(034) 413 2542

FREE STATE

Masilonyana LM Winburg Hospital	(051) 881 0046
Matjhabeng LM Bongani Hospital	(057) 396 6300
Matjhabeng LM Katleho Hospital	(057) 212 4221
Matjhabeng LM Thusanong Hospital	(057) 354 2111
Nala LM Nala Hospital	(056) 515 2071
Tswelopele LM Mohau Hospital	(053) 444 1912
Mangaung LM Botshabelo Hospital	(051) 533 0111
Mangaung LM Dr JS Moroka Hospital	(051) 873 2233
Mangaung LM National Hospital	(051) 405 2911
Mangaung LM Oranje Hospital	(051) 407 9911
Mangaung LM Pelonomi Hospital	(051) 405 1911

PEP Treatment Sites (continued)

Mangaung LM Universitas Hospital	(051) 405 3911
Mafube LM Mafube Hospital	(058) 813 1040
Metsimaholo LM Metsimaholo Hospital	(016) 976 0270
Ngwathe LM Parys Hospital	(056) 811 2155
Ngwathe LM Tokollo Hospital	(058) 892 3039
Dihlabeng LM Dihlabeng Hospital	(058) 303 5331
Dihlabeng LM Phekolong Hospital	(058) 303 5331
Maluti a Phofung LM Elizabeth Roos Hospital	(058) 789 1213
Maluti a Phofung LM Mofumahadi Manapo Hospital	(058) 713 1211
Maluti a Phofung LM Thebe Hospital	(058) 622 1111
Nketoana LM Nketoana Hospital	(058) 863 2806
Phumelela LM Phumelela Hospital	(058) 013 1044
Setsoto LM John Daniel Newberry Hospital	(051) 943 0434
Kopangong LM Diamond Hospital	(051) 724 0058
Mohokare LM Embekweni Hospital	(051) 673 1211
Mohokare LM Matlakeng Hospital	(051) 673 1240
Mohokare LM Stoffel Coetzee Hospital	(051) 683 1120

WESTERN CAPE

Tygerberg SD Tygerberg Hospital	(021) 938 4911
Eden DMA Uniondale Hospital	(044) 752 1068
Southern SD Victoria Hospital	(021) 799 1111
Saldanha Bay LM Vredenburg Hospital	(022) 713 1251
Matzikama LM Vredendal Hospital	(027) 213 3706
Northern Panorama Westfleur Hospital	(021) 572 3071
Central SD Somerset Hospital	(021) 402 6429
Stellenbosch LM Stellenbosch Hospital	(021) 887 0310
Swartland LM Swartland Hospital	(022) 487 9201
Swellendam LM Swellendam Hospital	(028) 514 1141
Prince Albert Prince Albert Hospital	(023) 541 1300
Bergrivier LM Radie Kotze Hospital	(022) 913 1175
Central SD Red Cross Children's Hospital	(021) 658 5111
Hessequa LM Riversdale Hospital	(028) 713 2445
Br River/Winelands LM Robertson Hospital	(023) 826 3155
Cape Agulhas LM Otto Du Plessis Hospital	(028) 424 2654
Oudtshoorn LM Oudtshoorn Hospital	(044) 272 8921
Drakenstein LM Paarl Hospital	(021) 872 1711
Br River/Winelands LM Montagu Hospital	(023) 614 1860
Mossel Bay LM Mossel Bay Hospital	(044) 691 2011
Central Karoo DMA Murraysburg Hospital	(049) 844 0053
Kannaland LM Ladismit Hospital	(028) 551 1010
Laingsburg LM Laingsburg Hospital	(023) 551 1237
Bergrivier LM LAPA Munnik Hospital	(022) 487 9201

PEP Treatment Sites (continued)

Eastern SD Hottentots Holland Hospital	(021) 852 1334
Tygerberg SD Karl Bremer Hospital	(021) 916 1911
Knysna LM Knysna Hospital	(044) 382 6666
Central SD Groote Schuur Hospital	(021) 404 9111
Overstrand LM Hermanus Hospital	(028) 312 1166
Breede Valley LM Eben Dönges Hospital	(023) 348 1100
Eastern SD Eerste River Hospital	(021) 904 8188
Southern SD False Bay Hospital	(021) 782 1211
George LM George Hospital	(044) 874 5122
Klipfontein SD GF Jooste Hospital	(021) 690 1000
Theewaterskloof LM Caledon Hospital	(028) 312 1670
Witzenberg LM Ceres Hospital	(023) 312 1116
Cederberg LM Citrusdal Hospital	(022) 921 2153
Cederberg LM Clanwilliam Hospital	(027) 482 1628
Beaufort West LM Beaufort West Hospital	(023) 415 2188

EASTERN CAPE /OOS-KAAP

Umzimvubu LSA Mary Teresa Hospital	(039) 255 0062
Umzimvubu LSA Mount Aylit Hospital	(039) 254 0231
Umzimvubu LSA Sipetu Hospital	(039) 255 0077
Amahlathi LSA Cathcart Hospital	(045) 843 1029
Amahlathi LSA SS Gida Hospital	(040) 658 0097
Amahlathi LSA Stutterheim Hospital	(043) 683 1313
Buffalo City LSA Bisho Hospital	(040) 835 2950
Buffalo City LSA Cecilia Makiwane Hospital	(043) 708 2111
Buffalo City LSA Frere Hospital	(043) 709 1111
Buffalo City LSA Grey Hospital	(043) 643 3300
Buffalo City LSA Komga Hospital	(043) 831 1013
Buffalo City LSA Nompumeleto Hospital	(040) 673 3321
Mbhashe LSA Madwaleni Hospital	(047) 131 1371
Mnquma LSA Butterworth Hospital	(047) 491 4161
Mnquma LSA Tafalofefe Hospital	(047) 498 7223
Nkonkobe LSA Adelaide Hospital	(046) 684 0066
Nkonkobe LSA Bedford Hospital	(046) 685 0043
Nkonkobe LSA Fort Beaufort Hospital	(046) 645 1111
Nkonkobe LSA Victoria Hospital	(040) 653 1141
Emalahleni LSA Dordrecht Hospital	(045) 953 1195
Emalahleni LSA Glen Grey Hospital	(047) 878 0018
Emalahleni LSA Indwe Hospital	(045) 952 1190
Intsika Yethu LSA Cofimvaba Hospital	(047) 874 0111
Inxuba Yethemba LSA Cradock Hospital	(048) 881 2123
Inxuba Yethemba LSA Martje Venter Hospital	(045) 846 0053
Inxuba Yethemba LSA Wilhelm Stahl Hospital	(049) 242 1111

PEP Treatment Sites (continued)

Lukhanji LSA Frontier Hospital	(045) 839 4001
Lukhanji LSA Hewu Hospital	(040) 841 0133
Lukhanji LSA Molteno Hospital	(045) 987 0089
Lukhanji LSA Sterkstroom Hospital	(045) 966 0268
Ngcobo LSA All Saints Hospital	(047) 248 1111
Ngcobo LSA Mjanyana Hospital	(047) 532 4496
Sakhisizwe LSA Cala Hospital	(047) 877 0129
Sakhisizwe LSA Elliot Hospital	(045) 931 1321
Camdeboo LSA Aberdeen Hospital	(049) 846 0578
Camdeboo LSA Andries Vosloo Hospital	(042) 243 1313
Camdeboo LSA Midland Hospital	(049) 892 2211
Camdeboo LSA SAWAS Memorial Hospital	(049) 836 0214
Camdeboo LSA Willowmore Hospital	(044) 923 1148
Kouga LSA BJ Vorster Hospital	(042) 288 0714
Kouga LSA Humansdorp Hospital	(042) 295 1100
Kouga LSA Sundays Valley Hospital	(042) 230 0567
Makana LSA Port Alfred Hospital	(046) 624 5752
Makana LSA Settlers Hospital	(046) 622 2215
N Mandela LSA Dora Nginza Hospital	(041) 406 4111
N Mandela LSA Livingstone Hospital	(041) 405 9111
N Mandela LSA Port Elizabeth Hospital	(041) 392 3911
N Mandela LSA Uitenhage Hospital	(041) 9951111
King Dalindyabo LSA Mthatha General Hospital	(047) 501 3000
King Dalindyabo LSA Nelson Mandela	(047) 502 4513
King Dalindyabo LSA Zitulele Hospital	(047) 575 0005
Mhlontlo LSA Nessie Knight Hospital	(047) 557 0722
Mhlontlo LSA St Lucy's Hospital	(047) 545 9831
Nyandeni LSA Bambisana Hospital	(039) 253 7803
Nyandeni LSA Canzibe Hospital	(047) 564 1346
Nyandeni LSA Isilimela Hospital	(047) 564 2805
Nyandeni LSA St Barnabas Hospital	(047) 555 1010
Qaukeni LSA Greenville Hospital	(039) 251 3009
Qaukeni LSA Holy Cross Hospital	(039) 200 2590
Qaukeni LSA St Elizabeth's Hospital	(039) 253 1111
Qaukeni LSA St Patrick's Hospital	(039) 251 0232
Elundini LSA Maclear Hospital	(045) 932 1186
Elundini LSA Tayler Bequest Hospital	(039) 257 0007
Maletswai LSA Aliwal North Hospital	(051) 634 2381
Matetswai LSA Burgersdorp Hospital	(051) 653 1882
Maletswai LSA Steynsburg Hospital	(048) 884 0241
Senqu LSA Cloete Joubert Hospital	(045) 971 0091
Senqu LSA Empilisweni Hospital	(051) 661 0037
Senqu LSA Lady Grey Hospital	(051) 603 0093

PEP Treatment Sites (continued)

LIMPOPO

Blouberg LM Blouberg Hospital	(015) 501 0505
Molemole LM Botlokwa Hospital	(015) 527 0058
Gr Tubatse LM Dilokong Hospital	(013) 214 7270
Mutale ML Donald Fraser Hospital	(015) 982 4050
Gr Tzaneen LM Dr CN Phatudi Hospital	(015) 355 3432
Greater Letaba LM Duiwelskloof Hospital	(015) 309 9241
Makhado LM Elim Hospital	(015) 558 3201
Lephalale LM Ellisras Hospital	(014) 763 2227
Modimolle LM FR Odendaal Rosp	(014) 717 2324
Mogalakwena LM George Masebe Hospital	(015) 295 9056
Gr Groblersdal IM Groblersdal Hospital	(013) 262 3024
Blouberg LM Helene Frans Hospital	(015) 505 0750
Makhudutamaga LM Jane Furse Hospital	(013) 265 1000
Greater Letaba LM Kgapane Hospital	(015) 328 3510
Lepelle-Nkumpi LM Lebowakgomo Hospital	(015) 632 6900
Greater Tzaneen LM Letaba Hospital	(015) 303 1711
Makhado LM Louis Trichardt Hospital	(015) 516 0148
Thumamela LM Malamulele Hospital	(015) 851 0026
Polokwane LM Mankweng Hospital	(015) 267 0330
Ba-Phalaborwa LM Maphutha L Malatjie Hospital	(015) 769 1520
Gr Marble Hall LM Matlala Hospital	(013) 264 9602
Gr Tubatse LM Mecklenburg Hospital	(015) 619 0208
Musina LM Messina Hospital	(015) 534 0446
Mogalakwena LM Mokopane Hospital	(015) 483 0331
Greater Giyani LM Nkhensani Hospital	(015) 812 3251
Ba-Phalaborwa LM Phalaborwa Hospital	(015) 781 3511
Gr Groblersdal LM Philadelphia Hospital	(013) 983 0112
Mogalakwena LM Potgietersrus Mogalakwena	(015) 297 3163
Maruleng LM Sekororo Hospital	(015) 383 0006
Polokwane LM Seshego Hospital	(015) 223 5141
Makhado LM Siloam Hospital	(015) 973 0004
Makhudutamaga LM Rita's Hospital	(013) 298 1000
Thabazimbi LM Thabazimbi Hospital	(014) 777 1599
Thulamela LM Tshilidzini Hospital	(015) 964 1061
Greater Tzaneen LM Van Velden Memorial	(015) 307 4475
Mogalakwena LM Voortrekker Memorial	(015) 491 2236
Bela-Bela LM Warmbaths Hospital	(014) 736 2121
Aganang LM WF Knobel Hospital	(015) 221 0002
Laphalale LM Witpoort Hospital	(014) 769 0025
Lepelle-Nkumpi LM Zebediela Hospital	(015) 662 0787

PEP Treatment Sites (continued)

NORTHERN CAPE / NOORD-KAAP

Dikgatlong LM Barkly Wes Hospital	(053) 531 0661
Hantam LM Calvinia Voortrekker Hospital	(027) 341 1205
Kareeberg LM Carnarvon Hospital	(053) 382 3036
Umsobomvu LM Colesberg Hospital	(051) 753 0771
Enthanjeni LM De Aar (Centre Karoo) Hospital	(053) 631 2123
Siyancuma LM Douglas Hospital	(053) 298 2612
Ubuntu LM Richmond Hospital	(053) 693 0112
Ubuntu LM Victoria West	(053) 621 0271
Nama Khoi LM Nababeep Hospital	(027) 713 8542
Umsobomvu LM Noupoort (Fritz Visser) Hospital	(049) 843 1448
Siyathemba LM Prieska (Bill Pickard) Hospital	(053) 353 2037
Sol Plaatjie LM Kimberley Hospital	(053) 802 9111
Nama Khoi LM Kleinzee Hospital	(027) 807 3767
Kamiesberg LM Garies (Van Rooyen) Hospital	(027) 652 1002
Khara Hais LM Gordonia Hospital	(054) 331 1580
Phokwane LM Hartswater Hospital	(053) 474 0148
Thembelihle LM Hopetown (Wege) Hospital	(053) 203 0163
Phokwane LM Jan Kempdorp Hospital	(053) 456 0126
Kai Garib LM Kakamas Hospital	(054) 431 0866
Kai Garib LM Keimoes Hospital	(054) 461 1004

GAUTENG

Johannesburg SD Chris Hani Baragwanath Hospital	(011) 933 2159
Johannesburg SD Coronation Hospital	(011) 470 9000
Tshwane North SD Dr George Mukhari Hospital	(012) 529 3111
Mogale City LM Dr Yusuf Dadoo Hospital	(011) 951 6132
Johannesburg SD Edenvale Hospital	(011) 882 2400
Ekurhuleni East SD Far East Rand Hospital	(011) 817 1426
Ekurhuleni South ISD Germiston Hospital	(011) 345 1200
Lesedi LM Heidelberg Hospital	(016) 341 2171
Johannesburg SD Helen Joseph Hospital	(011) 489 0111
Johannesburg SD Johannesburg Hospital	(011) 488 4911
Tshwane Cent SD Kalafong Hospital	(012) 318 6400
Emfuleni LM Kopanong Hospital	(016) 423 7000
Mogale City LM Leratong Hospital	(011) 411 3500
Tshwane Cent SD Mamelodi Hospital	(012) 601 1905
Ekurhuleni South SD Nata spruit Hospital	(011) 389 0500
Tshwane North SD Odi Hospital	(012) 702 2274
Ekurhuleni East SD Pholosong Hospital	(011) 738 5020
Tshwane Cent SD Pretoria Acad Hospital	(012) 354 1000
Tshwane Cent SD Pretoria West Hospital	(012) 386 5111
Emfuleni LM Sebokeng Hospital	(016) 930 3000

PEP Treatment Sites (continued)

Johannesburg SD South Rand Hospital	(011) 435 0022
Ekurhuleni South SD Tambo Memorial Hospital	(011) 892 1144
Ekurhuleni North SD Tembisa Hospital	(011) 926 0814
Tshwane Cent SD Jubilee Hospital	(012) 717 2075

PMTCT Guidelines

PMTCT is also sometimes called PPTCT, Prevention of Parent-to-Child Transmission

Excerpted from the “Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission) ” National Department of Health, South Africa; South Africa National AIDS Council. (2010), available for download at <http://www.sanacws.org.za/zu/resource-centre/download/4d05e41af0094-clinical-guidelines-for-pmtct-pdf>



Primary
Prevention

Antenatal
Care

Labour and
Delivery

Postnatal
Care

Stage 1: Primary prevention of HIV and PMTCT

Goal: Reduce prevalence of HIV among women of childbearing age

Objectives:

- Implement targeted HIV prevention programmes for women of child bearing age
- Strengthen prevention of unintended pregnancies among women living with HIV
- Support the implementation of women empowerment programmes and fight against gender based violence

Stage 2: Antenatal care

Goals:

- Improve the quality of the mother’s health and prevent mortality
- Identify pregnant women who are HIV+
- Ensure HIV+ pregnant women enter the PMTCT programme
- PMTCT
- Provide AZT from 14 weeks of pregnancy or lifelong ART as soon as possible, depending on a mother’s clinical indications

PMTCT Guidelines (continued)

Stage 3: Labour and Delivery

Goals:

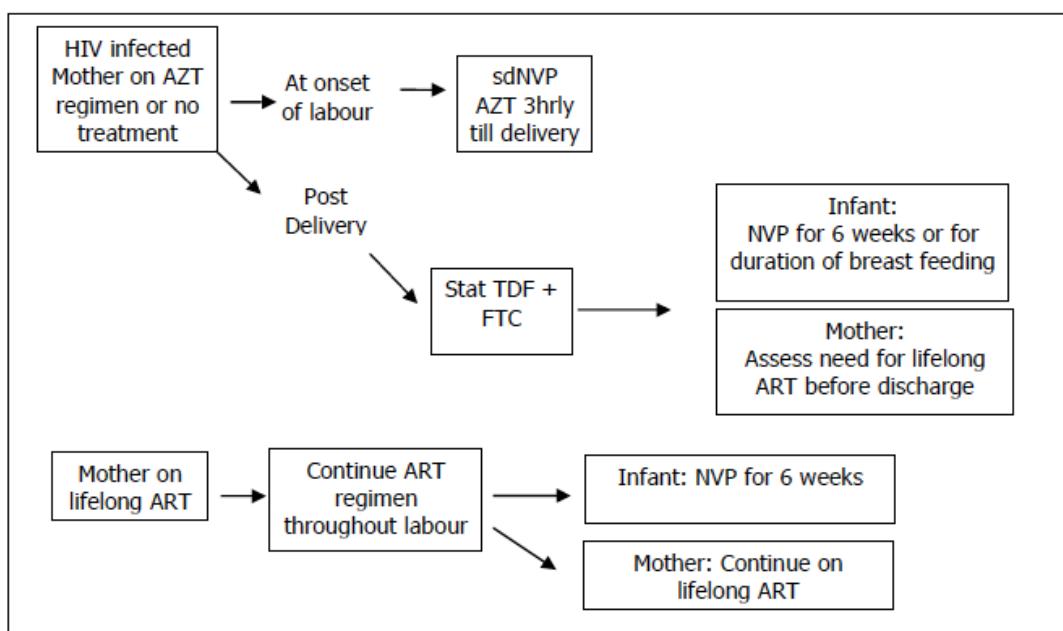
- Identify HIV positive women
- Provide adequate PMTCT coverage
- Continuity of care of prophylactic and treatment antiretroviral regimens
- Reduce maternal nevirapine resistance
- Initiate neonates born to HIV positive mothers with antiretroviral prophylaxis immediately

Stage 4: Postnatal follow-up of mother and infant

Goals:

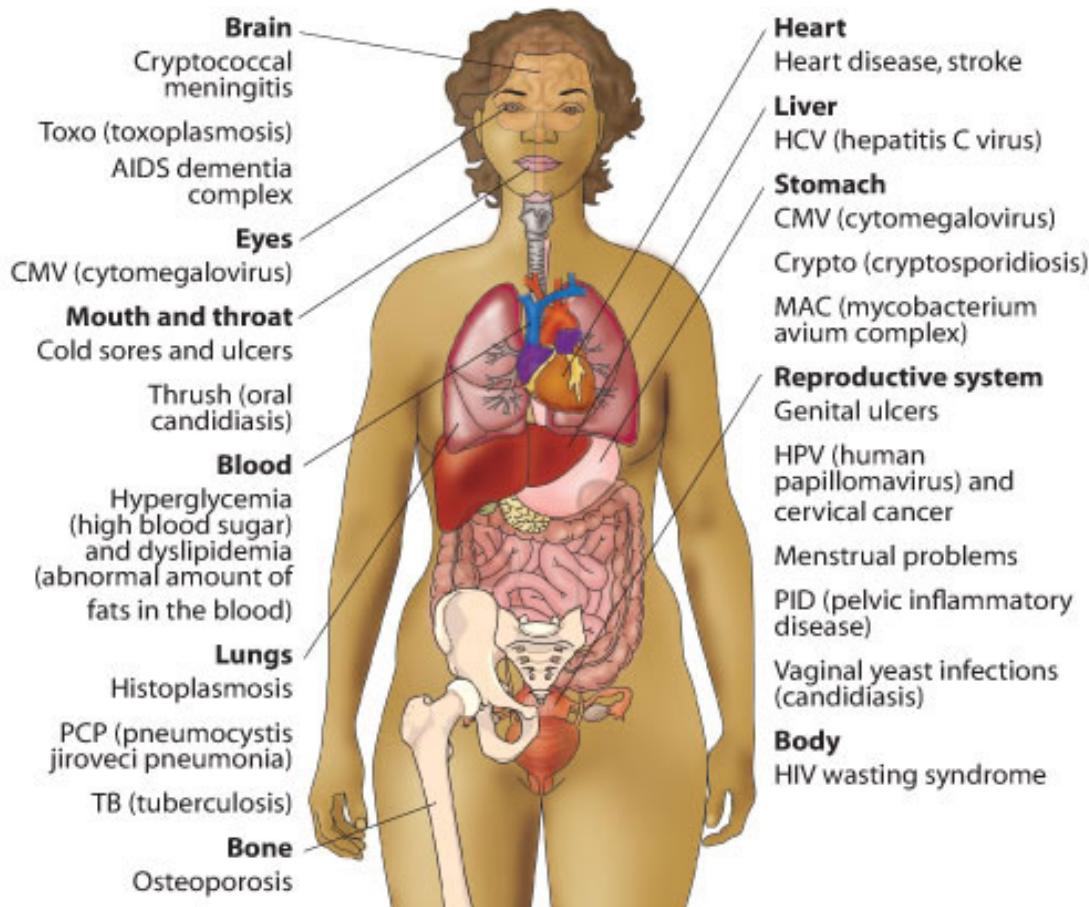
- Provide follow-up, post-partum care including a postnatal visit within 3 days
- Improve the quality of the mother's health and reduce mortality by including family planning counselling and cervical cancer screening where applicable
- Provide PEP for infants
- Reduce postnatal HIV transmission through breastfeeding
- Identify all HIV-exposed infants
- Reduce mortality in HIV-exposed infants
- Identify all HIV positive infants and start ART early

Figure 2: PMTCT Algorithm



Opportunistic Infections (OIs)

Image from “Opportunistic infections and other conditions,” available at www.womenshealth.gov/hiv-aids/opportunistic-infections-and-other-conditions/



HIV doesn't kill anyone directly. Instead, it weakens the body's ability to fight disease. Infections which are rarely seen in those with normal immune systems are deadly to those with HIV/AIDS.

People with HIV/AIDS can get many infections (called opportunistic infections or OIs). Many of these illnesses are very serious, and they need to be treated. Some can be prevented. There are medications used to prevent and treat many of the opportunistic infections that people living with HIV experience.

Medications used to prevent opportunistic infections:

- Co-trimoxazole: for the prevention of PCP, toxoplasmosis, many bacterial infections and diarrhoea caused by protozoan parasites
- Isoniazid (INH): to prevent latent TB from becoming active
- Fluconazole: to protect against recurrent cryptococcal meningitis

Opportunistic Infections (continued)

Excerpted from “Opportunistic infections and other conditions,” available at www.womenshealth.gov/hiv-aids/opportunistic-infections-and-other-conditions/

People with HIV can develop opportunistic infections (OIs). These are infections that take advantage of weakness in the immune system. OIs also include certain types of cancer. Some OIs only affect women or affect women more than men. For example, certain female health problems, like yeast infections, are common to many women. For women with HIV, these problems are harder to treat and can be more serious. If you have HIV and develop one or more OIs, you might have AIDS. The good news is that there are ways to prevent and treat many OIs. If you have symptoms of an OI, talk to your doctor right away. Your treatment might change. The drugs or combination of drugs that work best are different depending on the infection.

Thanks to current treatments, people with HIV are living longer and many are able to avoid OIs and AIDS for a long time. However, this also means that people with HIV are at risk of developing the same conditions that others develop as they get older. These include heart disease, diabetes, high blood pressure, and osteoporosis. Recent research shows that certain types of cancer that are considered AIDS-defining conditions have decreased dramatically thanks to antiretroviral therapy. However, the research showed that rates of other types of cancer in people with HIV are going up, partly because people with HIV are living longer, but more research is needed to understand if there are other links between HIV and cancer.

Living longer is not the only thing that puts people with HIV at risk of other conditions. Apart from age, people with HIV are already almost twice as likely to have a heart attack. HIV therapy can cause dyslipidemia, an abnormal amount of fats in the blood. This can also increase the risk of diabetes in people with HIV. Plus, people with HIV are more prone to having bone loss than people who don't have HIV.

It is important to keep a healthy diet and exercise, and keep cholesterol and blood pressure under control, to prevent these problems. People with HIV may need to talk to their doctor about other ways to prevent these conditions as well as OIs and AIDS. You may need additional tests or medications that are not related to HIV. Keep up with your Pap tests as often as your doctor recommends, and do follow-up testing if you have an abnormal Pap result. Watch for other infections, too. If you have flu-like symptoms, call your doctor right away. Your doctor may recommend that you get a flu vaccine or others to prevent infection. People with HIV need to prevent from getting infections your body can't fight.

Opportunistic Infections (continued)

Other vaccines, such as the measles vaccine, can be harmful to people with HIV. This type of vaccine contains live virus. In healthy people, the live virus prompts the body to make antibodies. But in people with HIV, this vaccine can make you sick. Talk to your doctor about what vaccines you need and what to avoid.

Taking care of your health right away is the best way to maintain good health with HIV for a long time.

Tuberculosis (TB)

Excerpted from the Centers for Disease Control and Prevention Fact Sheet “Tuberculosis: General Information,” available at www.cdc.gov/tb/publications/factsheets/general/tb.htm

What is TB?

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What Are the Symptoms of TB?

The general symptoms of TB disease include feelings of sickness or weakness, weight loss, fever, and night sweats. The symptoms of TB disease of the lungs also include coughing, chest pain, and the coughing up of blood. Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread?

TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What is the Difference Between Latent TB Infection and TB Disease?

People with *latent TB infection* have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to others. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing TB disease.

People with TB disease are sick from TB germs that are active, meaning that they are multiplying and destroying tissue in their body. They usually have symptoms of TB disease. People with TB disease of the lungs or throat are capable of spreading germs to others. They are prescribed drugs that can treat TB disease.

What Should I Do If I Have Spent Time with Someone with Latent TB Infection?

A person with latent TB infection cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should be tested.

Tuberculosis (continued)

What Should I Do if I Have Been Exposed to Someone with TB Disease?

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or co-workers. **If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.**

How Do You Get Tested for TB?

There are two tests that can be used to help detect TB infection: a skin test or TB blood test. The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The TB blood tests measure how the patient's immune system reacts to the germs that cause TB.

What Does a Positive Test for TB Infection Mean?

A positive test for TB infection only tells that a person has been infected with TB germs. It does not tell whether or not the person has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

What is Bacille Calmette–Guèrin (BCG)?

BCG is a vaccine for TB disease. BCG is used in many countries, but it is not generally recommended in the United States. BCG vaccination does not completely prevent people from getting TB. It may also cause a false positive tuberculin skin test. However, persons who have been vaccinated with BCG can be given a tuberculin skin test or TB blood test.

Why is Latent TB Infection Treated?

If you have latent TB infection but not TB disease, your doctor may want you to take a drug to kill the TB germs and prevent you from developing TB disease. The decision about taking treatment for latent infection will be based on your chances of developing TB disease. Some people are more likely than others to develop TB disease once they have TB infection. This includes people with HIV infection, people who were recently exposed to someone with TB disease, and people with certain medical conditions.

Tuberculosis (continued)

How is TB Disease Treated?

TB disease can be treated by taking several drugs for 6 to 12 months. It is very important that people who have TB disease finish the medicine, and take the drugs exactly as prescribed. If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the germs that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder and more expensive to treat. In some situations, staff of the local health department meet regularly with patients who have TB to watch them take their medications. This is called directly observed therapy (DOT). DOT helps the patient complete treatment in the least amount of time.

Tuberculosis and HIV

Excerpted from the World Health Organization “TB/HIV Facts 2012 - 2013,” available at www.who.int/tb/publications/factsheet_tbhiv.pdf

The Challenge:

- At least one-third of the 34 million people living with HIV worldwide are infected with latent TB.
- Persons co-infected with TB and HIV are 21-34 times more likely to develop active TB disease than persons without HIV.
- TB is the most common presenting illness among people living with HIV, including those who are taking antiretroviral treatment. There were an estimated 1.1 million HIV positive new TB cases globally in 2011. Around 79% of patients live in sub-Saharan Africa.
- TB is the leading cause of death among people living with HIV, accounting for one in 4 HIV-related deaths. In 2011 some 430,000 people died of HIV-associated TB. Although globally the numbers of HIV-associated TB deaths were similar among men and women in 2011, in the African region more deaths are estimated to have occurred among women than men, whilst in other regions more deaths are estimated to occur in men.
- People living with HIV are facing emerging threats of drug-resistant TB such as multi-drug resistant (MDR-TB) and extensively drug resistant TB (XDR-TB). Worldwide, there were an estimated 310,000 MDR-TB cases among notified TB patients with pulmonary TB in 2011.

The Response:

- Routine HIV testing should be offered to all patients with presumptive and diagnosed TB. Globally in 2011, 40% of TB patients (2.5 million) were tested for HIV and accessed HIV prevention, treatment and care services, up from 33% (2.1 million in 2010).
- Antiretroviral therapy (ART) and Co-trimoxazole preventive therapy (CPT) should be given to all TB patients living with HIV, irrespective of their CD4 counts. Of the TB patients who were known to be HIV positive in 2011, 48% (over 258,000) were enrolled on ART and 79% (410,000) were enrolled on CPT.
- The Three I's for HIV/TB (Intensified case finding for TB, Isoniazid preventive therapy (IPT), and Infection control) will reduce the burden of TB among people living with HIV and therefore must be urgently implemented by all HIV services.

Tuberculosis and HIV (continued)

- The number of people living with HIV who were screened for active TB (an element of "intensified case finding") increased from 2.3 million in 2010 to 3.2 million in 2011, representing less than 10% of the 34 million people estimated to be living with HIV. Once active TB is ruled out, people living with HIV should receive IPT. Among the 29 countries that reported data for 2011, IPT was provided to 446,000 people living with HIV more than double the 201,000 receiving it in 2010. TB infection control measures are still not implemented in many HIV service settings.
- People living with HIV need early diagnosis and treatment of active TB disease. Xpert MTB/RIF rapid test is recommended as the initial diagnostic test for people living with HIV who have suspected TB

Principles of Harm Reduction

Adapted from "Recovery Readiness: Strategies That Bring Treatment to Addicts Where They Are," by Richard Elovich and Michael Cowing and National Harm Reduction Working Group Report from October 21-23, 1993 meeting.

Definition

Harm reduction is a set of strategies and tactics that encourage individuals to reduce the risk or harm to themselves and their communities by their various behaviours.

Goal

The goal of harm reduction is to educate the person to become more conscious of the risks of their behaviour and provide them with the tools and resources with which they can reduce their risk.

Principles

- A humanistic, individualistic approach
- Does not deal solely with behaviours, but with whole person with complex needs
- Provides an alternative and challenge to traditional disease model and/or moral criminal models
- Accepts that risk is a natural part of our lives
- Places risky behaviour on a continuum within context of person's life
- Looks at person's relationship to the behaviour as defined by him/herself
- Accepts that behavioural change is often incremental
- Any positive change is seen as significant
- Interventions are not rigid, require creativity and innovation reflective of person's life situation
- Is helpful for communities most affected to be involved in creating safe places to get help by organizing harm reduction interventions and programs
- Though commonly associated with drug use, harm reduction is applicable to any social welfare and /or public health issue

Articles about Violence Against Women

The following websites are useful sources of information, legislation, statistics and action on violence against women:

- www.womensnet.org.za (links with local and international websites on VAW)
- www.saps.co.za
- www.statssa.gov.za
- www.nedlac.org.za
- www.polity.org.za/govdocs/legislation
- www.soulcity.org.za

The following articles provide background information about domestic violence, rape and femicide. They are adapted and excerpted from "Women in South Africa: A Resource for Journalists," 1999. Soul City

Understanding Violence Against Women

The United Nations Declaration on the Elimination of Violence Against Women defines violence against women as: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women – including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or in private life."

Violence becomes gender-based whenever particular acts are directed predominantly at either women or men. The fact that women are much more likely than men to experience particular crimes is no accident, indicating that beliefs about maleness or femaleness, or the circumstances of being male or female, play a significant part in violence against women.

Acts of violence overwhelmingly experienced by South African women include:

- Sexual harassment
- Rape
- Domestic violence
- Particular kinds of murder
 - Witch burnings
 - Rape-murders
 - Sexual serial killings
 - Intimate femicide (murder by a husband or boyfriend)
- Forced prostitution or trafficking of women
- Female genital mutilation/circumcision

Articles about Violence Against Women (cont.)

Why should we take Violence Against Women seriously?

- Violence against women is internationally recognised as a major human rights violation
- It has severe physical and mental health consequences for the women involved
- Relationships with families, relatives, friends and co-workers are affected. With domestic violence specifically, the violence often spills over and injures people caught in the crossfire. Families, friends and co-workers may be hurt or killed in violent attacks by abusive partners.
- Children who witness violence in the home are affected:
 - Many children experience Post Traumatic Stress Disorder similar to that observed in children who witness wars or detainees experiencing police torture and incarceration. This disorder includes nightmares, bedwetting, depression, social withdrawal, aggression, mood swings, concentration problems and poor school performance.
 - Male children are at risk of perpetuating this behaviour when they grow up
 - Children who witness it may think that violence is an acceptable way to resolve conflict or "get one's way." This contributes to broader violence in society at large
 - Some children flee violent homes, engage in destructive behaviour and live on the streets
- Violence against women has significant economic consequences
 - It places a financial burden on the health, judicial and social welfare sectors
 - Many productive hours of work are lost as women recover from injuries or take time off work to seek help from the health sector, courts and welfare system

The World Bank estimates that at a global level, the damage and costs to health from violence against women aged 15-44 years is comparable to that posed by other risk factors and diseases already high on the world agenda, including AIDS.

Gender violence affects a woman's ability to act in the world.

Articles about Violence Against Women (cont.)

Violence Against Women violates the South African Constitution's Bill of Rights

Section 9: the right to equality

Section 10: the right to human dignity

Section 11: the right to life

Section 12: the right to freedom and security

Section 13: the right not to be subjected to slavery, servitude and forced labour

Section 14: the right to privacy (stalking contravenes this)

Section 18: the right to freedom of association

Section 21: the right to freedom of movement and residence (abusers often control their partners' movements; also women curtail their movements to avoid rape)

Section 27: the right to have access to health care, food, water and social security

Section 34: the right to have access to courts

Estimates on the incidence of domestic violence and its impact

One in two women (49%) attending a Community Health Centre in the Western Cape report experiencing past or current abuse by their partners or husbands

- 84% of these women suffered significant physical or mental health consequences as a result
- 64% of women report the use of weapons as part of the abusive assault

The Department of Justice estimates that one out of every four South African women is a survivor of domestic violence

- One in six women is regularly assaulted by her partner, according to the Advice Desk for Abused women
- At least one in four women is forced to flee a life-threatening situation in her home at some point in her life, according to the Advice Desk for Abused Women
- 43% of working men interviewed in a pilot study in Cape Town reported abusing their partners
- A study of 83 women in the Western Cape found that 14% had experienced sexual assault at the hands of their partners
- 60% of teenagers in a study in the Western Cape reported physical assault by male partners
- Violence by male partners is a consistent feature of teenage sexual relationships according to a qualitative study conducted in Khayelitsha, Cape Town

Articles about Violence Against Women (cont.)

- Both Post Traumatic Stress Disorder and major depression were found to be more common in female patients with a history of domestic violence (35.3% and 48.2% respectively) than in those without (2.6% and 11.4%)

Understanding Domestic Violence

Anger, conflicts, arguments and unhappiness have probably featured in all relationships at one time or another. But their presence does not automatically imply that the relationship is an abusive one. What sets abusive relationships apart is the function or purpose of the abuse within the relationship and its impact upon the abused person.

Domestic violence is aggression with a purpose: the control, intimidation and subjugation of one's intimate partner. It is also a pattern of behaviour whose repetition provokes fear - hence its success in achieving control. Abusive behaviour in relationships takes a variety of forms, which include physical, emotional, psychological, sexual and economic.

According to the Domestic Violence Act of 1998, which provides South Africa with its first legal definition of domestic violence, domestic violence includes:

- Physical abuse
- Sexual abuse
- Emotional, verbal and psychological abuse
- Economic abuse (for example withholding money needed to survive or the confiscation of wages)
- Harassment
- Stalking (following a woman everywhere she goes, or keeping her under surveillance)
- Damage to property
- Entry into the complainant's home without consent, where the parties do not share the same home

Any other controlling or abusive behaviour where such conduct harms, or may cause imminent harm to the safety, health or well being of the complainant

Articles about Violence Against Women (cont.)

Common misconceptions about Domestic Violence

Violence against wives or girlfriends has been sanctioned for centuries by our legal systems and many religions. As a result, domestic violence has come to seem ‘normal,’ if not a man’s right. Countless misconceptions exist which trivialise and justify domestic violence. For example:

Myth: She provoked his abuse through her nagging or unreasonable demands.

Fact: While these might be annoying, they do not excuse violence. After all, it is not acceptable to hit shop assistants, motorists, colleagues or anyone else, merely because they have annoyed us.

Myth: Domestic violence is caused by alcohol or substance abuse.

Fact: While drugs and alcohol can aggravate violent behaviour, they do not cause it. Many violent men abuse regardless of whether they are drunk or sober.

Myth: Both partners are responsible for the abuse - it can't be blamed on the husband or boyfriend alone ('it takes two to tango - there are two sides to every story').

Fact: Domestic violence occurs when an imbalance of power exists in a relationship. This imbalance is maintained by behaviour designed to control or exert power over the other, through emotional and physical abuse, which undermines self-esteem and enforces subservience. For the person in the powerless position, almost anything they do - including trying to protect or defend themselves - can be interpreted as “provocation.”

Myth: Wives need to be “kept in line” by their husbands and should not try to “wear the pants” in the household.

Fact: This myth reinforces unequal relationships and justifies the use of force to maintain inequality. It also suggests that women are children who need to be disciplined.

Myth: Being the breadwinner entitles a man to behave as he likes in his own home.

Fact: There is no justification for VAW. Besides, domestic violence happens to working women and to women who are often the only source of family income. Also, women who don’t work contribute to the home in other indispensable ways.

Myth: Women are financial parasites who exploit men economically – particularly in relation to maintenance claims.

Fact: The vast majority of women applying for maintenance are desperately trying to ensure their children have the means to survive and have a chance in life.

Articles about Violence Against Women (cont.)

Myth: Men who commit violence in the home do so because they are stressed at work, through unemployment, poverty and other problems.

Fact: Everyone experiences problems and feelings of powerlessness. It is not acceptable to take frustrations out on one's wife or girlfriend, nor to attempt to reassert one's self-esteem by exerting power over them.

Myth: Men who beat their wives or girlfriends are provoked into a temporary loss of control and are not therefore responsible for their actions.

Fact: These same men often control their actions when with other people and would never consider being violent with colleagues or friends. Because abusers may be respected and well-liked community members, people often disbelieve the abused woman.

Myth: If it was so bad, the woman would just leave.

Fact: There are many reasons why women find it difficult to leave abusive relationships. Many are financially dependent on the abuser and worry about the survival of their children. Many women stay in violent relationships for the sake of their children despite the fact that children are often better off in single parent households than in violent ones.

Abusers often threaten that if the women leaves, they will kill her or themselves or harm the children or her family. Abused women often have internalised the abusers' accusations that she is to blame.

Abuse often happens in cycles during which there may be periods of apology and nonviolence. Women desperately want to believe the abuser has changed or will do so. Also, many people put pressure on women to "make their marriages work" and look down on divorced women.

Common misconceptions about Sexual Harassment

Myth: Women invite sexual harassment by their behaviour or dress

Myth: Women who object have no sense of humour, or are prudish about sex

Myth: Sexual harassment doesn't hurt anyone

Myth: A firm "no" is enough to discourage any man

Myth: Women often make false claims of sexual harassment

Myth: Sexual harassment does not apply to all cultures. It is a Western idea

Myth: Perpetrators are motivated by some bizarre lust or love for their victims

Common misconceptions about Rape

Myths exist about rape, which blame women instead of placing the responsibility for the rape on the rapist. These myths are often perpetuated in the way that rape incidents are reported.

Articles about Violence Against Women (cont.)

Myth: Only women who wear “provocative clothing” (e.g. short skirts) get raped. Also, women who wear “provocative” clothing are asking to be raped.

Fact: This implies that rape is a crime of lust provoked by the sight of women's bodies. Research with rapists indicates that their primary motives for committing rape include hatred, anger, a desire for power and a sense of entitlement to women's bodies.

Myth: Rape cannot happen in a marriage or sexual relationship in which consent has previously been given.

Fact: Any form of forced sex is rape regardless of whether consent was given on other occasions. Marital rape is against South African law.

Myth: Rapists are always strangers.

Fact: Rape is also committed by husbands, boyfriends, relatives, friends and acquaintances. More than half the survivors of rape in Johannesburg's southern metro region between 1998-99 knew their assailants.

Myth: Most rapists are psychopaths or “sick”.

Fact: US research finds that no more than 5% of rapists can be classified clinically insane.

Myth: A woman was not really raped if she doesn't fight back.

Fact: Many women don't fight back in order to protect themselves and stay alive. The shock of the attack may also leave women paralyzed with fear, and so unable to fight back.

Myth: Women accuse men of rape to gain revenge.

Fact: Approximately 2% of women lay false rape charges, which is about the same percentage for false reports of crimes generally. Unacceptable as this is, it does not justify disbelieving the other 98% of women who report being raped.

Myth: If women do not report rape immediately, their story should not be trusted.

Fact: Many women do not report immediately precisely because they fear being disbelieved. They may also be in too much shock as well as too intimidated (particularly if their lives have been threatened during the rape). Some women also do not immediately define their experience as rape when it does not fit stereotypical perceptions of what constitutes rape (as when they are raped by their boyfriends or husbands rather than by strangers).

Articles about Violence Against Women (cont.)

Myth: Unless the woman has physical injuries, she wasn't raped.

Fact: Overwhelming fear and concern to stay alive, may force women into submitting to the rapist and not resisting him. There may be no injuries in these situations. Lack of physical injury does not mean that there has been no psychological or emotional "injury" caused to the woman. It is also important to note that not all injuries (bruises in particular) show up immediately.

Femicide

Most murder victims in South Africa are men but once one starts distinguishing between murders based on the circumstances in which they occur, as well as the relationship between perpetrator and victim, differences start emerging along gender lines.

Murders specifically targeted at women have been termed femicides. As with other types of violence, femicide may take different forms.

Rape and murder

Rape that ends in murder, or a series of murders involving sex (sexual serial-killing) are forms of femicide. Although some men and boys have been killed for sexual pleasure, and a very small minority of women have also taken part in sexual murders, these crimes are committed overwhelmingly by men, predominantly against women.

No figures are currently available documenting the incidence of sexual serial killing in South Africa. However it appears that since at least the early 90's there has been an increase in serial killing in South Africa. This increase may partly be the result of improved police investigation techniques as well as their greater awareness of this phenomenon. It is just as likely, given that violence generally has increased, that there has also been a rise in serial killing. The police have, in fact, gone so far as to establish a special unit, National Special Investigations, to deal with investigations into these murders.

Intimate femicide

Far more common than the sexual serial killer, is the man who kills his female partner. This kind of murder has been termed "intimate femicide." In addition to killing their female partners, some men may also kill themselves and their children (formerly known as family murders), or other members of the woman's family, or even the men suspected of having affairs with the woman.

Articles about Violence Against Women (cont.)

Myths about Femicide

Myths about intimate femicide are similar to misconceptions about domestic violence.

Myth: Women provoke men into killing them by having affairs, or nagging too much.

Fact: This doesn't justify murder. In cases of domestic violence, murders are the culmination of a longstanding pattern of controlling behaviour.

Myth: The man who kills his intimate female partner is a tragic, Othello-like figure; femicide is a crime of passion committed by a man who loves his intimate female partner very deeply.

Fact: Femicide is motivated by the need to control and possess one's partner. This is not love.

Myth: Men who kill their intimate female partners have suffered a temporary loss of control and are not responsible for their actions.

Fact: These men are often involved in a pattern of abusive, controlling, and deliberate behaviour that has nothing to do with a temporary loss of control.

Witch burning

Accusations of witchcraft and witch-burning, which occur almost exclusively in the

Northern Province, also predominantly affect women.

- Of the 228 people killed in witchcraft-related incidents between April 1994 - April 1995, two thirds were women
- The majority of those killed were between fifty and sixty years of age

Gender and the Context of Risk

Gender-related determinants of vulnerability to HIV infection

Globally, heterosexual transmission is the most common form of transmission of HIV and in worst affected regions and countries a higher number of women and girls are infected compared to men and boys. This is due partly to physiological factors that account for more efficient transmission of infection from a man to a woman than vice versa.

But this is only part of the explanation. It is widely accepted that the risk of HIV infection can be minimised if men/boys and women/girls take steps to have safe and consensual sex. This insight has informed the mainstay of national and global responses to HIV/AIDS, which have put abstention, condom use and faithfulness at the centre. However, the discretion to choose when, with whom and how to have sex, including the decision to protect oneself and/or one's partner from HIV infection, is not merely a matter of individual choice. The ability to make such decisions is profoundly influenced by socio-cultural norms about appropriate male and female behaviour (including sexual behaviour), the unequal power relations stemming from these norms and the unequal economic conditions of men and women. These norms and power imbalances constrain the ability of women and girls to choose the terms of sexual engagement, negotiate safe and consensual sex, and leave oppressive relations for fear of losing male support. For example, in many societies the ideal of feminine behaviour and sexuality rests on the notion that women/ girls should be subordinate, dependent and obedient and that virginity, chastity and motherhood are critical virtues of women (and girls).

Gender Norms and unequal power in sexual relations:

Gender norms and inequalities influence all aspects of the HIV/AIDS epidemic: gender impacts on vulnerability to HIV infection as well as the ability of women and men to access prevention, care, treatment, and support services and information.

Norms of femininity inhibit knowledge and assertiveness, and decrease ability to negotiate safer sex. Gender norms for femininity may place a high value on sexual innocence, passivity, virginity, and motherhood. Women and girls are not supposed to be knowledgeable about sex and generally have more limited access to relevant information and services. They often, therefore, remain poorly informed about sex, sexuality, and reproduction and are less able to discuss these issues with their sex partners.

Gender and the Context of Risk (continued)

Norms of masculinity inhibit knowledge and support for shared decision-making, and promote aggression and risk taking. Gender norms for masculinity may often dictate that men and boys should be knowledgeable, experienced, and capable of taking the lead in sexual relationships. Multiple partners for men are condoned, and even encouraged in many societies, as is sexual risk taking and the early initiation of sexual activity. Boys and men sometimes remain uninformed about HIV/STI prevention because admitting their lack of knowledge in this area could be construed as a weakness. Emphasis on masculine norms of aggression and dominance also sanctions gender-based violence (GBV). The norms surrounding young men's sexual initiation and multiple partners are barriers to effective HIV/STI prevention for youth. Use of alcohol and drugs are also associated with traditional norms of masculinity, and both limit the ability to negotiate safer sex and increase the likelihood of violence

Gender and sexual identity. Traditional gender norms of masculinity and femininity contribute to homophobia and the related silence, denial, stigma, and discrimination against males who have sex with males (MSM), transgender, and bisexual persons. These norms affect access to accurate prevention information, power to negotiate consistent and correct condom use, and, if living with HIV/AIDS, access to treatment, care, and support. In particular, limited access to accurate, non-stigmatizing prevention information increases vulnerability for HIV infection among MSM, transgender, and bisexual individuals and their male and female sex partners.

Unequal power in relationships. Gender norms related to sexuality often place men in dominant roles and women in subordinate or passive roles. These unequal relations, in turn, are often further reinforced by larger social, economic, and legal inequalities. The result is that inequalities in power between men and women limit women's ability to control whether, when, and how to engage in sexual relations.

Gender Roles in Households and Communities:

Inequalities in decision-making, mobility, and access to resources.

Within households, men often control decisions regarding use of household resources, which may make it difficult for women to get the resources needed to gain access to services. In addition, both women and men tend to put greater emphasis on men's health needs and devote household resources to meeting those needs. Women may also have limited mobility due to male and community norms that preclude women from leaving their household, or may have difficulty accessing health care services where they cannot go to a clinic without the permission or approval of their partner

Gender and the Context of Risk (continued)

"Women's work" and unequal caretaking responsibilities. Within families and communities, gender norms assign women and girls the primary role of caretaking and do not view this as "work" but rather as a natural part of being female. In the context of HIV/AIDS, women's burden of care has increased, with women and girls generally assuming the primary burden of care for PLWHA. The increased burden of care, in turn, further limits women's and girls' access to productive resources. For instance, caretaking decreases women's time available for income generation and food production; it also hinders girls' ability to attend school.

Larger Social, Economic, and Political Inequalities:

Lower socioeconomic status of women and girls. The socioeconomic status of women and girls places them at greater risk for acquiring HIV and can also lead to harsher consequences of the HIV/AIDS epidemic. Women's and girls' lack of access to productive resources reduces their ability to negotiate condom use or leave abusive relationships. In some instances, lack of educational and economic opportunities may cause women to exchange sex for material goods (often called "transactional sex"). This may include relationships with visiting partners or older men or more formal sex work as a means for earning income.

Lack of legal rights to inheritance and property. Under some legal systems and customary practices, women are denied the right to inherit land and property and, further, a woman herself may be inherited by her husband's male family members following his death. HIV/AIDS has increased the number of women widowed and has led to more widows at younger ages. Loss of property and inheritance decreases the access of women and their families to productive resources, increasing their vulnerability to HIV and compromising the ability to meet their basic needs, such as nutrition and housing. Thus, with the HIV/AIDS epidemic, the scope and impact of property rights violations on women, children, and communities has increased dramatically.

Mobility and migration for work. While social and economic inequalities tend to increase women's vulnerability to HIV, gender patterns in employment also impact men's vulnerability. Due to limited access to employment and income, men sometimes leave their communities to seek economic opportunities. Men who migrate for work (e.g., seasonal agricultural labourers) or have mobile jobs that take them away from their families (e.g., truck drivers) are in environments that increase their vulnerability to HIV through unprotected sex with female or male sex workers or injecting drug use with contaminated needles. In some cases, depending on the economic situation of the community and family, the family members left behind may have to

Gender and the Context of Risk (continued)

engage in sex work to support themselves. Young women, too, are increasingly migrating for employment and face particular risks.

Cross-Cutting Gender Issues:

Gender-based violence (GBV) affects both the risk of contracting HIV and the consequences of disclosing HIV status. GBV is a leading risk factor for HIV as well as a feared consequence of disclosure for women. Research indicates that fear of violence limits women's ability to negotiate condom use or fidelity with their partners. GBV limits women's ability to decide whether, when, and how to engage in sexual relations, as well as their ability to leave unsafe relationships. Sex workers also experience very high levels of violence, with limited recourse to protection from or prosecution of perpetrators, placing them at increased risk for HIV infection. In mobile populations (e.g., refugees or displaced groups), GBV— and particularly rape, puts women and girls at an added risk for HIV/STIs. In addition, studies have shown that some women may face harsh consequences following disclosure of HIV-positive status, including the threat of violence at the same time that a majority of women may experience positive outcomes. For young women, sexual coercion is a key factor limiting their ability to prevent HIV/STI transmission. Research shows that many young women's first sexual encounters may be coerced. For example, a study in Western Kenya of an intervention to improve adolescent reproductive health found that two-thirds of the girls reported that they had not wanted to have sex at last sexual intercourse, whereas almost all boys reported that last sexual intercourse was consensual. Increased attention is also focusing on schools as a site of sexual coercion of girls and for boys, as well. GBV also affects males who have sex with males (MSM).

Within MSM relationships, gender norms often dictate that one partner is dominant and the other submissive. The submissive partner may have less power within the relationship and may face the threat of or use of violence that can be associated with such lack of power. In addition, violence against MSM by communities and police drive MSM underground, which makes reaching MSM with prevention information and supporting conditions for safer sexual practices extremely difficult.

Gender-based norms and stereotypes fuel stigma and discrimination. Gender norms blame and shame women for being "vectors" and responsible for spreading HIV, and for having engaged in assumed "promiscuous" behaviour. Gender norms often assume that if a woman has acquired HIV, it is because she has behaved in a way that has transgressed the norms of what proper women should do.

Gender and the Context of Risk (continued)

Further reading:

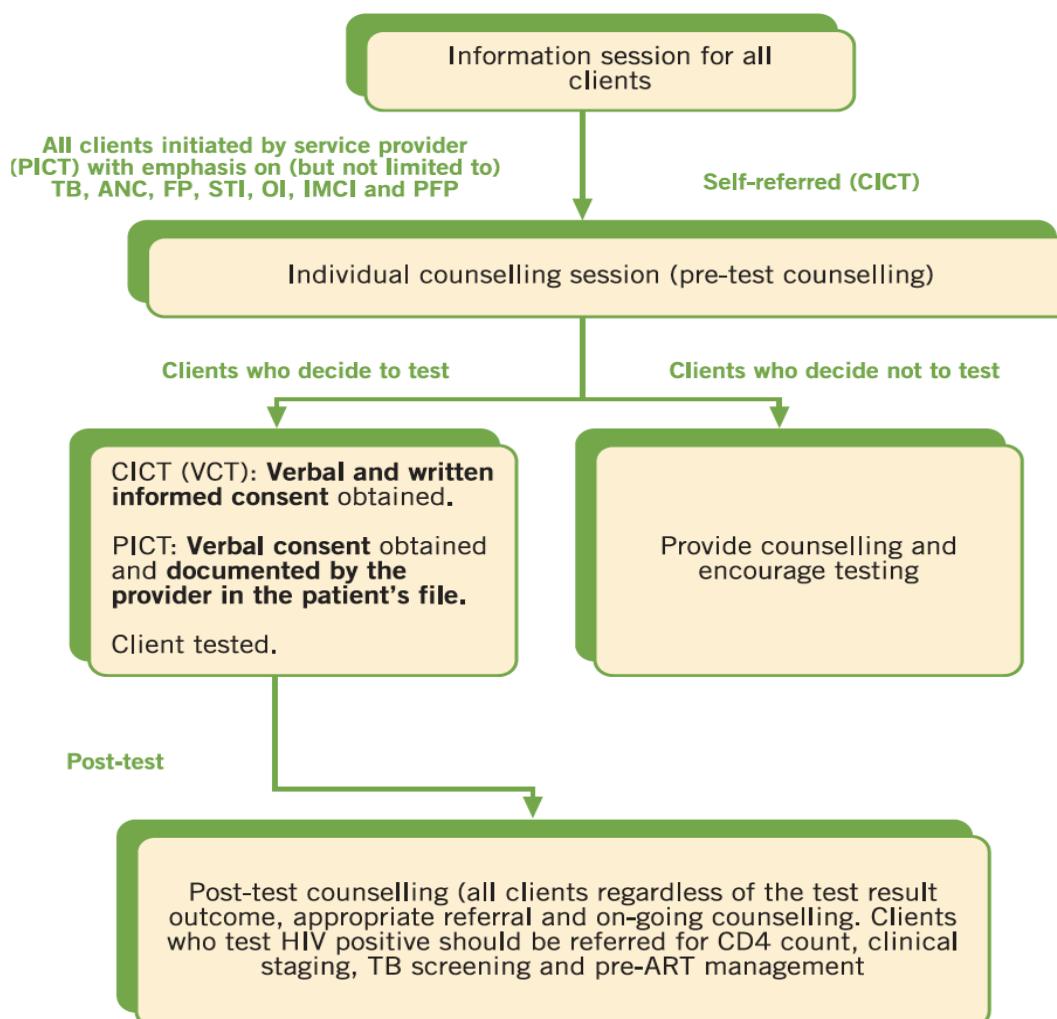
How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organizations May 2004, Gender and HIV/AIDS Task Force Interagency Gender Working Group (IGWG) United States Agency for International Development (USAID)

“Focus on Gender: Women and HIV,” (ACRIA volume 17, No. 1, Pages 1 – 20) Available at img.thebody.com/cria/2008/winter2008.pdf

HIV Counselling and Testing (HCT) Guidelines

Excerpted from “National HIV Counselling and Testing (HCT) Policy Guidelines,” National Department of Health, South Africa; South Africa National AIDS Council. (2010), p. 17 - 20 <http://ebookbrowse.com/hct-policy-guidelines-2010-pdf-d46903646>

Figure 1: The HIV Counselling and Testing Process



Explanation of Acronyms: **PICT** = Provider-initiated counselling and testing; **CICT** = Client-initiated counselling and testing; **VCT** = Voluntary Testing and Counselling; **TB** = Tuberculosis; **ANC** = ante-natal care; **FP** = family planning; **STI** = sexually transmitted infection; **OI** = opportunistic infection; **IMCI** = integrated management of childhood illness; **PFP** = prevention for positives

HCT Guidelines (continued)

Pre-Test Counselling

In public health facilities the pre-test information and education session are typically conducted in a group information session. The education session should also be followed by shorter individual counselling sessions.

Group Information Pre-test Session

A health-care worker should conduct a general group information session on general health, HIV and AIDS related issues for ALL clients including pregnant women and clients for TB, STI, FP, antenatal care (ANC), IMCI, OIs, and PEP on a daily basis. Audio-visual and IEC materials (e.g., television, videos, DVDs, posters) should be utilised when the health-care worker is not available

A group information session should include the following key components beneficial to the client, and used as appropriate to the circumstances:

- Information about HIV acquisition and transmission.
- Information about effective HIV prevention measures, including consistent and correct use of condoms, partner reduction and other options.
- Emphasis on the importance and advantages of early HIV testing to facilitate diagnosis, positive living, and healthy lifestyle.
- Information about the HIV testing process.
- Discussion on confidentiality and shared confidentiality.
- Discussion on the option not to take the test.
- Offer an opportunity to test at a later date should the client decline the test.
- The importance of TB symptomatic screening during pre and post test counselling.
- Referral to HIV and AIDS related services such as nutrition, TB screening, STI screening, CD4 count, OI management, and clinical staging.

Pre-Test Individual Counselling Session

Information sessions and IEC materials in the local language should be available to all clients considering taking the HIV test. The individual counselling session should include the following components:

- Assessment to determine whether the information provided in the group session has been absorbed.
- Opportunity to respond to unanswered questions, and attempt to clarify any misunderstandings.
- Discussion of specific issues for individual and assessment of individual risk, including determining whether there is a history of domestic violence.

HCT Guidelines (continued)

- Discussion on risk reduction and the window period should the client test HIV negative.
- Discussion of prevention strategies including delayed sexual debut, abstinence and regular use of condoms.
- Discussion on the way forward and management options including TB screening, clinical staging, CD4 count, pre-antiretroviral treatment (ART) management and healthy lifestyle, should the client test HIV positive.
- Discussion on partner involvement and referral for testing
- Discussion of the option to refuse testing.
- Obtaining written or verbal informed consent for HIV testing.

Post-Test Counselling

All clients, regardless of the outcome of the HIV test, should be offered and receive post-test counselling on an on-going basis as appropriate. All results must be given clearly.

HIV-negative clients should be offered a comprehensive post-test counselling prevention package that includes information and advantages of MMC, TB screening, risk reduction, correct and regular use of condoms. They should be encouraged to repeat the test three months after exposure to exclude the possibility of the window period. Window period should be explained.

HIV-positive clients must be given their test results and counselled post-test about their HIV status only after the second confirmatory test is also positive. Clients who test positive should be informed and counselled about possible emotional responses (e.g., denial and anger) and they should be guided as to when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices. These clients also need comprehensive information on how to reduce the risk of transmission, on-going positive living, healthy lifestyles and nutrition and on-going referral for psychosocial support (e.g., support groups), preventative package including correct regular use of condoms, and medical services when needed.

After post-test counselling, all HIV-positive clients must be referred for laboratory staging by CD4 count and clinical staging by a clinician trained in HIV and AIDS clinical management. They must also be screened for symptomatic TB signs and referred for diagnosis if suspected and either prepared and initiated on ART or referred to attend the wellness services provided (pre ART management). If they are not ready and willing to initiate treatment immediately.

HIV/AIDS Stigma

Excerpted from “The Other Side of the Mountain: The faces and voices of people living with HIV and AIDS in South Africa.” Department of Health, Pretoria, South Africa. (2003) Available for download at www.policyproject.com/abstract.cfm/2924

What is HIV/AIDS Stigma?

HIV and AIDS stigma is the negative thoughts, attitudes or beliefs that people have about us only because *we are living* with HIV or AIDS. People also have negative thoughts, attitudes or beliefs about us because *they think we are living* with or affected by HIV and AIDS. For example, there is the idea that PLHAs have low morals or have done something wrong, and so deserve to live with HIV or AIDS.

People often make links with sex or illegal activities, e.g. people think women living with HIV “have been sleeping around.” Or people think that men who are living with HIV are gay, bisexual or have had sex with sex workers.

People’s negative attitudes and beliefs around HIV and AIDS are also linked to their negative attitudes towards women, lesbians and gay men, people from different races, and foreigners. These negative attitudes have played a major role in the *stigmatisation* (to have negative thoughts, attitudes and beliefs about other people) of people living with HIV/AIDS.

Images of HIV and AIDS in the media that suggest that it is a “black, women’s or gay disease” also create HIV- and AIDS-related stigma. And these images add to *stereotypes* (fixed ideas or beliefs about a group of people). In other words, they add to the fixed ideas or beliefs that some people have about black people, about women, about lesbians or gay men, about foreigners and about PLHAs.

Internal and external stigma

There are two types of stigma that we can experience as people living with HIV/AIDS:

- **Internal stigma:** What we think or feel inside, sometimes called self- or *felt-stigma*
- **External stigma:** What others think about us, sometimes called enacted stigma

Internal stigma happens when we *internalise* (to make something part of our own values and attitudes) the negative thoughts, beliefs and attitudes that others have towards us as PLHAs. When we do this, we make these feelings a part of us. This can leave us feeling guilty, ashamed and depressed.

HIV/AIDS Stigma (continued)

Internal stigma can also be the stigma we imagine or create in our own minds. It's also internal stigma when we have negative thoughts and beliefs about ourselves – when we blame ourselves and shut ourselves off from the world, believing that no one wants to have anything to do with us.

External stigma happens when people have negative thoughts, attitudes and beliefs about us as people living with HIV and AIDS. For example, when people think we do not deserve respect or use negative names to describe us. Or when they tell us they want nothing to do with us.

What is HIV and AIDS Discrimination?

HIV and AIDS Discrimination happens when stigma leads to unfair or unjust actions against us as people living with HIV and AIDS. The negative thoughts that others have about us, as a result of our HIV status, often lead people to do things, or not to do things, that harm us or deny us things like services or jobs.

For example, we are discriminated against when we do not get health care or equal membership of medical aid and insurance schemes because we are living with HIV or AIDS. This kind of discrimination violates our human rights—our rights to be treated as equal human beings.

What is Double (or Multiple) Stigma?

HIV- and AIDS-related stigma leads to people seeing HIV and AIDS as a *woman's disease*, a *black disease*, a *gay disease*, or a *poor person's disease*. This leads to a double stigma.

Double stigma happens when people hold negative thoughts, attitudes or beliefs about us because we are PLHAs and are also members of groups that are stigmatized because of other reasons like gender, race and sexual orientation.

- **Gender** means the social roles we are expected to take on as men or women
- **Sexual orientation** means the way we express our sexuality – whether we are heterosexual, bisexual or homosexual (lesbian or gay)

So there are 2 stigmas:

- The stigma we experience as a people living with HIV/AIDS, and
- The stigma we feel as a woman, as a black or white person, or as a lesbian or gay person

HIV/AIDS Stigma (continued)

Sometimes we experience stigma in more than two of these ways (for example, a Black gay man who is living with HIV). In these cases, we have to deal with **multiple stigma**.

We will look at these 3 examples of double (multiple) stigma.

1. Women living with HIV and AIDS

Stigma and discrimination affect men and women in different ways. In many relationships, men have more power than women. This often means that women cannot say “No” to unwanted or unprotected sex. This adds to the high number of women living with HIV and AIDS.

Women often experience double stigma when:

- They are blamed, as women, for the transmission of sexually transmitted infections and HIV when they disclose that they are PLHAs. So, they are stigmatised as women and as PLHAs
- They are blamed as being “promiscuous” or for being sex workers
- They are diagnosed before the man and then blamed “for bringing HIV into the family,” or “for passing HIV on to their child”

2. Living with HIV and AIDS and Racism

Double stigma on the basis of race and living with HIV or AIDS is also common, particularly when there is widespread racism. Racism is when people believe that some races are better than others.

Some racist people believe that other races started the HIV and AIDS epidemic. They believe that PLHAs belonging to some race groups are responsible for their “misfortune” and deserve to be HIV positive.

This double stigma is made worse by the fact that HIV and AIDS are often linked to who has power and resources in society. It is often the least powerful people who are most at risk of HIV infection. With our history of apartheid, race is also often linked to power and resources in South Africa. Research shows that more black South Africans are living with or affected by HIV and AIDS than white South Africans. This makes them particularly *vulnerable* (more at risk to things like discrimination, abuse and violence) to double stigma.

HIV/AIDS Stigma (continued)

3. Lesbians and gay men living with HIV and AIDS

Disclosure can be difficult for lesbians and gay men, largely because of widespread *homophobia* (the strong fear or hatred of lesbians and gay men) and negative attitudes within families, in the community and at work. Homophobia often results in double stigma and discrimination for people living with HIV/AIDs who are also lesbians or gay men.

Examples of double stigma:

- Lesbians and gay men who previously decided to ‘come out’ or disclose about their sexual orientation sometimes find it hard to go through another whole process of disclosure about living with HIV or AIDS
- Lesbians and gay men who were not previously open about their sexual orientation often worry that disclosing their HIV status will also disclose their sexual orientation

Double (or multiple) stigma on the basis of gender, race and sexual orientation can make it difficult for many of us to look for support and care.

Strategies for Coping with Stigma

Excerpted from “Coping with HIV/AIDS stigma in five African countries,” from Journal of the Association of Nurses in AIDS care. (2008).

1. When others treat you badly because of your HIV status, remember that you are more than your disease and are deserving of respect and care. You are OK. Work to actively think positively about yourself and all your strengths. In other words, don't internalize the negative messages others may be giving you. Actively work to think about and remind yourself about all your positive attributes.
2. Dealing with a stigmatized illness can be exhausting mentally. Talk to friends and family and get emotional support to cope with your feelings. You do not need to be alone.
3. Join an HIV support group.
4. Get counselling.
5. Pray or meditate.
6. Get regular exercise and keep active. Walking and other forms of exercise have been proven to help people feel better and cope better.
7. Get enough sleep so that you feel rested. Getting enough sleep is one of the most important things you can do for your health and your ability to cope.
8. Actively work to reduce stigma of HIV by educating others about HIV, including friends, family and even government officials. Actively working to reduce HIV associated stigma may be empowering for you and can help HIV education and policy efforts on a large scale over time.
9. Disclose your own HIV status to specific people if you choose to. This may help you reduce isolation, get support and care, and be empowering.
10. Help other people living with HIV.
11. Learn more about HIV disease to better understand it and how it may affect you.
12. Work to let go of people and events that you have no control of. The Serenity Prayer: Grant me the serenity to accept the things I cannot change, the strength to change the things I can and the wisdom to know the difference.
13. Remember to laugh. Try to spend time with people who can make you laugh, or see a funny movie or TV show.
14. Make positive changes in your life

HIV/AIDS Disclosure

What is Disclosure?

- HIV disclosure means sharing information about one's HIV status with others
- Disclosure is about opening up ourselves and sharing with other people that we are living with HIV/AIDS
- Disclosure means sharing information that was previously unknown

Disclosure as a process

- Disclosure is a process rather than a one-time event. It can take years to prepare or days, weeks, or months. We may tell one person at first or tell a number of people at the same time.
- Disclosure can also be thought of as a continuum
 - Not able or ready to disclose
 - Thinking about beginning the disclosure process
 - Beginning the disclosure process
 - Anticipating the disclosure process
 - Coping with the consequences of disclosure

Major concerns of persons with HIV around disclosure

- How will this information impact the person(s) I tell?
- How will they react?
- How will they feel about and treat me?

Sources for more information:

Rabkin, M., El-Sadr, W., & Abrams, E. (2005). *Care and Treatment of HIV/AIDS in Resource Limited Settings: The Columbia Clinical Manual*. New York: The International Center for AIDS Care and Treatment Programs, Columbia University Mailman School of Public Health.

Greene, K., Derlega, V.J., Yep, G.A., & Petronio, S. (2003). *Privacy and Disclosure of HIV in Interpersonal Relationships*. Mahwah, NJ: Lawrence Erlbaum Associates.

What is Confidentiality

Adapted from “Guidelines to establish and maintain support groups for people living with and/or affected by HIV and AIDS.” National Department of Health’s Chief Directorate: HIV, AIDS and TB & USAID Funded Project.

What is Confidentiality?

Confidentiality is keeping private all information we receive from persons seeking or receiving our services.

Examples of information we keep confidential:

- HIV status
- Sexual orientation
- Marital status
- Income/assets
- Health status
- Drug use
- Sexual history
- Date of birth
- Address
- Telephone number
- Email
- Place of employment

Confidentiality and Support Groups

In a support group, confidentiality is, “A binding agreement and promise that the information regarding the person joining the group will not be divulged, discussed outside the group or given to others.

This agreement holds true even when the person is not part of the group anymore. The safety of this person is protected by the agreement of confidentiality.”

Preparing to Disclose Framework

Excerpted from “The Other Side of the Mountain: The faces and voices of people living with HIV and AIDS in South Africa.” Department of Health, Pretoria, South Africa. (2003)

Types of Disclosure

Personal disclosure	Disclosing to our partners, family members, and friends
Public disclosure	Disclosing to the broader community, workplace, or public
Full disclosure	Sharing our HIV/AIDS status with everyone we know. This often happens over a long period of time.
Partial disclosure	Sharing our HIV/AIDS status with only one or a few people. This may also be a gradual process.
Indirect disclosure	Talking indirectly about our HIV/AIDS status, such as giving a talk about living with HIV without disclosing our HIV status. Indirect disclosures may help us prepare for more direct disclosure and also help us to accept our HIV/AIDS status.
Non-disclosure	Not telling people you are HIV positive.
Voluntary disclosure	Choosing to disclose our HIV status without being forced.
Involuntary disclosure	When someone tells our HIV/AIDS status without our permission or we feel forced to disclose.
Disclosure by association	Sometimes people assume that partners HIV positive people are also positive or that people who work in the HIV/AIDS field are HIV positive.

Preparing for Disclosure

Consider these key questions and strategies as you think about disclosing your HIV status:

Who?

Use different strategies for disclosure with different people. Think carefully about who you will disclose to and their reaction. Will your disclosure be supported? You may think about disclosing your HIV/AIDS status to:

- I ACT participants
- Parents
- Brothers and sisters
- Children
- Other family members

Preparing to Disclose Framework (continued)

- Friends
- Main partner
- Non-main partner
- Doctor
- Other medical and social service providers
- Work supervisor and colleagues
- School classmates
- People from your religious community
- Political organization
- People attending an HIV/AIDS public awareness event
- Media audience

What?

You decide what information to share when you disclose your HIV/AIDS status. For example, when you disclose people may ask how you contracted HIV/AIDS. Consider whether your answer will lead to support or stigma. You do not need to answer if you prefer to keep information private. Or you can create an agreement to answer but only if the other person keeps information private.

When?

Take the time you need to prepare and be ready to disclose your HIV/AIDS status. Do not be rushed or feel pressured especially when you are newly diagnosed. Remember that some days will be more difficult for disclosure. For example, holidays, religious events, or when other personal crises are happening – these are not optimal times for disclosure.

Where?

You have a choice about the location for disclosure. Choose a place where you feel safe and comfortable. This might include: your home, the other person's home, a neutral place.

Why?

Think about why you are disclosing and what you want to get out of disclosure. What is your motivation? Do you seek support or empowerment? Or are you fulfilling a responsibility?

How?

You decide how you want to disclose information about your HIV/AIDS status.

- In person
- Alone
- With a friend or family

Preparing to Disclose Framework (continued)

- With a medical or service provider
- On the phone
- In writing
- Having someone else disclose for you
- Non-verbal
- Leaving medications or HIV-related personal information out

List the Pros and Cons of Disclosure

Take a piece of paper and draw a line down the middle: on one side, list of the benefits of disclosure; on the other side list the risks of disclosure.

Create a follow-up plan for support AFTER the disclosure

Plan in advance for different reactions and responses to your disclosure. Think about the supportive services you might need and how you will access them.

Role Play for Disclosure

Ask a friend or fellow I ACT participant to act and practice the disclosure with you. Ask them to respond in various ways based on your relationship with the person who you are preparing to disclose to.

Write a letter saying what you want to say to the person.

Practice this disclosure by writing down the words you plan to say as you disclose your HIV/AIDS status.

How Diseases are Commonly Spread

Excerpted and adapted from “Ten Day HIV/AIDS Counsellor Training Course VCT,” Participant Manual. Department of Health, Pretoria (2001).

A number of factors must occur to transmit disease:

- The disease must be present in the air, on a surface, or in body fluids
- Someone who is not immune to the disease must be exposed to it
- The exposure must occur in a way that causes an infection

This table lists ways in which diseases are transmitted with suggestions for prevention:

Exposure, Transmission	Prevention
Respiratory transmission Through droplets of moisture released into the air when talking, sneezing, coughing or drooling. This causes illnesses like colds, flu, chicken pox, measles, mumps, rubella and TB.	<ul style="list-style-type: none"> • Protect others when sneezing, coughing, or blowing noses • Proper and frequent hand washing • Prevent overcrowding • Ensure good ventilation
Faecal-oral transmission Through passing germs from the faeces of humans or animals into the mouth of a person causing illnesses like hepatitis A, cholera, shigella, polio, pinworms, salmonella and many other types of diarrhoea.	<ul style="list-style-type: none"> • Proper hand washing • Proper food safety • Using properly constructed toilet facilities (flush toilets or pit-latrines) • Disposing of human and animal excreta away from water sources • Not fertilising leafy vegetables with animal or human excreta
Direct and indirect contact With the secretions or infectious organisms on shared items or transferred directly from person causing conditions such as impetigo, lice, scabies, ringworm, chickenpox, cold sores, conjunctivitis (pink eye) and STI's	<ul style="list-style-type: none"> • Not sharing personal items such as bedding, towels, clothing, combs, or hats • Proper hand washing • Proper food safety • Regular cleaning of toilets and kitchens • Always using condoms for any vaginal or anal sexual contact
Blood-to-blood contact Infected blood may enter the bloodstream of another person through fresh cuts, broken skin or the lining of the mouth, eyes, nose, vagina and rectum causing conditions such as Hepatitis B and HIV infection	<ul style="list-style-type: none"> • Always using universal precautions when dealing with open wounds or blood-stained body fluids • Always using condoms for any vaginal or anal sexual contact

Safe Drinking Water Strategies

Excerpted and adapted from “Ten Day HIV/AIDS Counsellor Training Course VCT,” Participant Manual. Department of Health, Pretoria (2001).

Contaminated drinking water can cause a variety of diarrhoeal and other diseases.

Any water that does not come from a municipal supply should be made safe before it is used for drinking, preparing food, or washing eating utensils.

Water that should be made safe includes water from boreholes, rivers, wells or dams.

Common and effective methods to make water safe

- Boil the water for 10 minutes
- Disinfect the water with unscented household bleach to kill any germs

How to make water safe for use with household bleach

- Add 5 ml (1 teaspoonful) unscented household bleach to 25 litres of water. Allow this to stand for at least two hours (but preferably overnight) before using.

Any water that is **cloudy** should be **filtered** before it is boiled or chlorinated. After treating water for human consumption, store it in clean and covered container to prevent contamination by flies and dust.

Keys for Health

- Do not defecate or urinate near or in any water source
- Keep animals away from sources of water used for human consumption

Hand Washing Strategies

Excerpted and adapted from “Ten Day HIV/AIDS Counsellor Training Course VCT,” Participant Manual. Department of Health, Pretoria (2001).

Wash Hands Frequently

Hand washing is the single **most important** way to prevent transmission of disease.

When should hands be washed?

- Before preparing or eating food
- Before preparing a baby a baby bottle
- After visiting the toilet or after changing a nappy
- After touching any body fluids such as mucus, blood, vomit, urine or faeces, or handling items contaminated with body fluids (e.g. bibs, tissues, clothing, linen, sanitary towels or nappies)
- After wiping noses, faces or buttocks
- Before and after cleaning any injuries or sores
- Before and after giving any medicines
- After touching pets or any other animals
- After doing any cleaning
- After removing gloves
- Whenever visibly dirty

How should hands be washed?

Use soap and clean water. Do not wash and rinse hands in the same basin of water, as you will just re-contaminate your hands with the dirty water.

Use soap!

It is more hygienic to use liquid soap. Bars of soap can become grossly contaminated with microorganisms and every effort should be made to keep bars of soap dry.

One useful tip is to tie a bar of soap into the toe of a “knee-high” stocking and hang it from the tap so that it can dry between uses.

- Rub hands together vigorously with friction for at least 15 seconds and wash all areas including backs of hands, wrists and between fingers
- Rinse hands well under clean running water
- Dry your hands on a paper disposable towel or other small clean towel. Do not dry hands on a wet or dirty towel – rather dry hands in the air. Facecloths work well for drying hands – use once only and launder
- Turn off the tap using the same towel to prevent your clean hands from touching the tap and becoming re-contaminated
- Dispose of the used towel in a dustbin (for paper towel) or laundry basket (cloth towel)

Hand Washing Strategies (continued)

When water is scarce and running water is non-existent

Where water is scarce, or running water non-existent, fill a clean, empty, plastic two-litre milk or juice bottle with clean water. Make some holes in the lid of the bottle and replace the lid. Tilt the bottle so that a little water sprinkles out onto hands. This should be done over a bucket or basin so that the used water is collected in the container for later use on the vegetable garden

Universal Precautions to Prevent Exposure

Excerpted and adapted from “Ten Day HIV/AIDS Counsellor Training Course VCT,” Participant Manual. Department of Health, Pretoria (2001).

Universal precautions (“Standard precautions”)

The set of recommendations developed by the Center for Disease Control (CDC) in which blood and certain body fluids are considered infectious for blood-borne diseases such as HIV and Hepatitis B.

The purpose of using universal precautions is to prevent direct contact of non-intact skin or mucous membranes with any of these potentially infected body fluids.

Which body fluids are considered to be potentially infectious?

The body fluids to which universal precautions specifically apply are blood, semen, vaginal secretions, pus, amniotic fluid, breast milk and any other body fluid containing visible blood.

Which body fluids do not require universal precautions?

Universal precautions do not apply to faeces, nasal secretions, sputum, sweat, tears, urine and vomit unless these body fluids contain visible blood.

How do universal precautions apply in the home?

- Injuries, eczema, dermatitis, or any break in the skin should always be covered with waterproof plasters or dressings. Make sure that there is always a supply of waterproof plasters available for this use.
- Direct contact with blood or blood-contaminated body fluids should be prevented through the use of waterproof gloves or other protective material (e.g. plastic bag, folded paper towel, clothing and the like) to protect hands from contact with these fluids. This should be done when caring for injuries, cleaning up blood or blood-stained body fluids or handling items such as clothing or bed-linen contaminated with blood or blood-stained body fluids.
- Thorough hand washing with soap and water must be done whenever hands are contaminated with body fluids, after gloves are removed or after any accidental blood contact.
- If eyes or mucous membranes of the mouth are splashed with blood or blood-stained body fluid, these areas should immediately be washed with water.
- Never share items which may become contaminated with blood, such as toothbrushes or razors
- Safely dispose of items contaminated with blood or body fluids (such as sanitary towels or dressings) in a plastics bag which is securely tied. Soiled linen should be effectively laundered.

Universal Precautions (continued)

Handling Blood Spills

- If a spill of contaminated body fluid occurs, the area should be blocked to people and cleaned. For any exposure, universal precautions should be used with regard to use of gloves and hand washing. If the spill is large, ensure that the cleaners' shoes have impenetrable soles. The clothing of the person doing the cleaning should also be protected with a plastics apron.

Two possible procedures for cleaning:

- The area of the spill can be flooded with bleach disinfectant solution at a dilution of 1:10 and then mopped up with paper towels or a cleaning cloth.
- The area can first be cleaned with soap and water to remove any organic or solid matter and then disinfected with the 1:10 bleach disinfectant solution.
- Any blood-contaminated clothes, cloths and linen should be handled with gloves and these items washed with hot water and soap.

How to make a bleach solution for cleaning blood-contaminated objects

- To make a 1:10 mixture of bleach solution, mix 100ml (approximately ½ cup) of ordinary household bleach in 900ml (approximately 3½ cups) of clean water.
- This bleach solution must be freshly mixed every day because it becomes inactive within 24 hours.

Malnutrition

Excerpted from the Medline Plus Medical Encyclopaedia

There are a number of causes of malnutrition. It may result from:

- Inadequate or unbalanced diet
- Problems with digestion or absorption
- Some medical conditions

In some cases, malnutrition is very mild and causes no symptoms. However, sometimes it can be so severe that the damage done to the body is permanent and disabling. Symptoms vary and depend on what is causing the malnutrition. General symptoms include:

- Fatigue
- Dizziness
- Weight loss

Treatment for malnutrition usually consists of replacing missing nutrients, treating symptoms as needed, and treating any underlying medical condition. The treatment outcome will depend on the cause of the malnutrition. Most nutritional deficiencies can be corrected. However, if malnutrition is caused by a medical condition, that illness has to be treated in order to reverse the nutritional deficiency.

If untreated, malnutrition can lead to mental or physical disability, illness, and possibly death.

Discuss the risk of malnutrition with your health care provider. Treatment is necessary if you or your child have any changes in the body's ability to function. Contact your health care provider if the following symptoms develop:

- Fainting
- Lack of menstruation
- Lack of growth in children
- Rapid hair loss

Malnutrition continues to be a significant problem all over the world, especially among children. Poverty, natural disasters, political problems, and war all contribute to conditions of malnutrition and starvation everywhere, not only in developing countries

Nutrition

The following articles on nutrition, safe food shopping, food preparation, and food storage are excerpted and adapted from the following sources:

- **South Africa Nutrition Guidelines**
- **Choosing Safe Foods, Shopping, Handling, Preparing & Storing Food for Person Living with HIV/AIDS. (2003) Washington State University Extension.**
- **Food Preparation & Home Food Safety. (2002) South Africa Department of Agriculture.**

What is nutrition?

How food is utilized by the body for growth, reproduction and maintenance of health. Foods contain different nutrients that include water, proteins, carbohydrates, fats, vitamins and minerals.

Why is nutrition important?

- Production of energy, keeping the body temperature and movement
- Work, breathing, and the brain functioning
- Growth, development, replacement and repair of cells and tissues
- Carrying out metabolic processes such as digestion, absorption, and transportation of nutrients
- Protection and recovery from diseases

Some nutrients are needed in large amount, and these are called macronutrients and include *proteins, carbohydrates and fats*. The micronutrients include *vitamins and minerals* that are required in small amounts. Some macro- and micronutrients are essential as the body cannot synthesize them in required amounts and must therefore, be consumed from foods. They are needed in right amounts and combinations for the proper functioning of the body.

Weight loss in HIV/AIDS

Also known as “wasting,” the weight loss in people living with HIV/AIDS is one of the most common symptoms of HIV infection and can occur at any stage of infection. It needs to be taken seriously because unintentional loss of weight is often a sign that you may have an active HIV-related infection or disease. Malnutrition can also reduce the effectiveness of the immune system. Weight loss occurs when the body is using up more nutrients than it is absorbing from food. Eating enough food is really important to prevent this symptom, as the immune system slows down when it does not get enough fuel, and also fighting HIV each day requires extra calories because during this process a lot of muscles and proteins are burned up.

Nutrition (continued)

Promoting healthy lifestyles

There is no question that nutrition and dietary modifications for people living with HIV/AIDS are important for nutrition support. It is best to start taking better care of oneself as soon as one becomes aware that one is infected with HIV.

There is more than one way to eat healthy. Healthy eating means eating a variety of foods to supply all the nutrition the body needs. No single food or meal provides all necessary nutrients. A variety of food means consuming more than one type of it at each meal, eating different food on different days and preparing it in different ways. A good diet would consist of a balance of the following items:

- Starchy food such as bread, banana, cereal, potatoes, semps, and rice will provide carbohydrates for energy as well as vitamins, minerals and fibre
- Fruits and vegetables provide vitamins, minerals, fibre and energy
- Meat, poultry, fish, eggs, beans and nuts provide protein, minerals, and vitamins
- Dairy Products such as milk, cheese and yoghurt provide minerals, vitamins and calcium
- Fats such as cooking oils, butter, margarine, meat and other protein-based foods provide energy, essential fatty acids and the fat-soluble vitamins A, D, E and K as well as phosphate and calcium

Try to eat food from each of these groups every day. This ensures a balanced diet. Also, try to eat at least three times a day. Remember that eating should be an enjoyable, relaxed event. People living with HIV/AIDS often lose their appetite when they are sick. Eating enough is important to fight infections, because our bodies need energy to fight infections. If you cannot afford buying enough food to eat, find out if you can apply for a social grant.

Pregnancy and nutrition

Pregnancy is a time of increased nutritional need. The need for both absolute calories and some specific nutrients are amplified during this period. Satisfying additional nutritional needs contributes to both foetal development and maternal stores for labour, delivery, and breastfeeding. However, when pregnancy is complicated by HIV/AIDS, specific additional considerations are warranted. During the third trimester the additional nutrients are used by the foetus mainly for rapid growth and storage.

Nutrition (continued)

People living with HIV/AIDS who cannot afford buying their own food may be particularly vulnerable to nutrient deficiencies because of likely inadequate dietary intake and potentially increased nutrient requirements associated with HIV and other infections and the nutritional demands of pregnancy.

For most mothers in early stages of the HIV disease, pregnancy does not appear to accelerate disease progression.

Nutritional care and support for the pregnant and lactating mother infected with HIV may minimize the impact of the disease, delay disease progression and allow the mother to remain productive and able to take care of themselves and their families.

Micronutrients supplementation

Improving micronutrient status is an important step to reducing maternal malnutrition. This can be achieved through diet diversification, micronutrient supplementation and food fortification.

- There is no need for additional micronutrients for HIV infected pregnant and lactating women
- Women should receive micronutrients and supplements as part of their care and treatment programmes
- Multiple micronutrients supplements should be provided for all pregnant women who know that they are infected with HIV. This will help meet increased nutrient needs caused by the HIV infection and may reduce the risk of poor pregnancy outcome

Public clinics in South Africa give HIV positive patients vitamin pills. These are often useful for people living with HIV/AIDS. But, they are NOT a substitute for ARVs. You should eat lots of fruits and vegetables to ensure you get enough vitamins.

How nutrition helps us staying healthy:

Fighting HIV The on-going presence of the virus means that the immune system must always be providing the immune cells and chemicals required to fight it. Since those cells and chemicals are created from nutrients, a steady supply is a must for the body's contribution to viral control.

Protecting the body Any damage to the body caused by HIV or AIDS related infections—and by the body's immune response to the infection—must be repaired. Nutrients are the actual building materials with which the body creates and repairs itself, so there is an on-going need for those materials.

Nutrition (continued)

Improving quality of life Good nutrition is a must for feeling well. Optimal levels of nutrients are required for good energy and overall wellbeing, and for the prevention or the management of the many symptoms that nutrient deficiencies can cause (e.g., fatigue, appetite loss, skin problems, weight loss, mental changes [like memory problems or difficulty concentrating], nerve damage, muscle cramps, depression, anxiety, and many others). In addition, the presence of adequate levels of certain nutrients may actually help prevent and help reverse certain drug side effects. Thus, nutrients are an important tool for helping people to feel better and maintain a higher quality of life.

Managing co-infections Home HIV-positive people also have other chronic infections to deal with including hepatitis C and/or hepatitis B. For people with HIV and hepatitis co-infection all of the above is doubled in importance since the body must handle more than one chronic infection, and has a particular need to support the liver, and prevent it from being damaged.

How does nutrition become a problem in HIV?:

Unfortunately, research has shown that nutritional problems are among the first negative effects of HIV infection. These problems—deficiencies in certain nutrients—often get worse over time and can add to immune dysfunction and disease progression in multiple ways.

There are several reasons why these deficiencies are common:

- **Nutrients burn faster:** As discussed above, the immune system is continuously fighting HIV—even when anti-HIV drugs are being used—and repairing damage caused by the virus and other infections. This causes the body to burn nutrients faster, which can cause many nutrient levels to become low
- **Nutrients aren't absorbed properly:** The poor absorption of nutrients that may occur as the result of intestinal infections (including HIV itself) or diarrhoea. Some HIV-positive people have a difficult time absorbing fat, which can prevent the absorption of important vitamins like A, E, D and K
- **Poor diets:** Simply put, many HIV-positive people don't eat enough of the right kinds of foods. This may be due to fatigue, appetite loss, changes in the senses of smell or taste, nausea, vomiting, infections or other problems of the mouth or throat, or simply not knowing how to eat to best support health.

Nutrition (continued)

Effects of HIV on Children

Children born to HIV positive mothers need special attention to ensure that they receive adequate amounts of nutrients. They also need special care and support. They are more likely to be born with low birth weight compared to children born to HIV negative mothers. Also, they are more susceptible to common childhood illnesses such as diarrhoea, acute respiratory infection, recurrent fever, and neurological problems. They are also more likely to experience growth failure and malnutrition as they grow because of poor appetite, swallowing difficulties, and nausea.

The most common effects of HIV on Children

- Stunted growth
- Weight loss or limited weight gain
- Failure to thrive

Food security assessment

A food security assessment can be conducted in households affected by HIV/AIDS by asking questions that will help determine what the availability, accessibility and utilization of food in the household is. People living with HIV/AIDS and their household members can be linked and referred to programmes for food aid, safety nets and other services in the community.

Nutrition components of home-based care

Family members often provide care, support and general well being of their household members afflicted with HIV/AIDS. Home-based caregivers play a crucial role in supporting the family by ensuring that the infected person is washed and fed an adequate diet and are on schedule with medications.

The care and support of for people living with HIV/AIDS is not an easy task. Yet the dignity and self-respect of the infected person should be maintained and as such independence as possible should be respected in order to boost self-esteem.

Nutritional care and support of the PLWHA at home is important and involves:

- Supporting the family or caregiver to ensure the infected person has adequate intake of adequate diet
- Provide nutrient dense and culturally acceptable meals and snacks that are enticing and interesting to prevent weight loss or to replenish lost nutrients
- Practice food safety and hygiene to avoid food-borne illnesses
- To manage HIV symptoms related to nutrition so as to maintain an optimum status of the infected person

Nutrition (continued)

Dealing with the symptoms associated with HIV infection

Many of the symptoms associated with HIV can be made better or worse by the foods that are eaten. The following are suggestions on some of ways of using nutrition to deal with some of the common symptoms associated with HIV infection and medication.

The best rule to apply when managing all the symptoms is to eat small frequent meals and snacks throughout the day. It is important to always eat something whether you feel like it or not. Common symptoms that affect nutrition include diarrhoea and fatigue.

Diarrhoea is common among people living with HIV/AIDS. It can be caused by HIV itself or by infections or medicines. Diarrhoea has been reported as a side effect of all the protease inhibitors as well as some of the NRTIs and some antibiotics. With some drugs, diarrhoea goes away after the first few weeks of treatment – but some people find that it becomes a permanent feature of living with the drug. The severity of diarrhoea can also differ between people. Changes of diet seem to have only a limited impact on diarrhoea caused by medicines. But, your doctor can prescribe some treatments to help control the diarrhoea.

Fatigue or poor energy level is also very common. HIV is a chronic (long-term) infection and the body mounts a strong immune response against it. People with HIV may use a lot of energy because they are constantly battling the virus, so fatigue may slowly develop as a consequence of HIV itself. High viral load is particularly associated with fatigue. Taking ARVs often slows HIV production in the body and many people have more energy after taking them.

- Even though anti-HIV drugs may improve energy levels, some may also cause fatigue, especially in the first few weeks of therapy; if you suspect one of your anti-HIV drugs is causing fatigue, a change in treatment may help
- Drugs used to treat opportunistic infections (such as cotrimoxazole, dapsone and pyrimethamine used to treat PCP and toxoplasmosis, and ganciclovir used to treat CMV) may also cause fatigue; talk to your doctor and discuss other treatment options
- Fatigue may be caused by low levels of certain vitamins and minerals
- Fatigue may be a consequence of disrupted sleep patterns; you may want to establish a routine that balances work, relaxation, sleep and socializing; consult your doctor about medication or counselling

Nutrition (continued)

Nausea and vomiting are common symptoms, which most people living with HIV/AIDS experience at some time. Nausea and vomiting can have many different causes, commonly stomach problems such as diarrhoea, acute infections, pregnancy, travel sickness or emotional problems such as anxiety. They are also common side effects of antiretroviral drugs used to treat HIV.

Lipodystrophy is known by changes in body shape and the metabolism caused by anti-HIV drugs. Only a minority of people who take anti-HIV drugs develop lipodystrophy. Because the reasons for body fat changes in people taking anti-HIV drugs aren't properly understood, it's very hard to give clear advice about how to avoid them. Body shape changes, in themselves, do not appear to be medically dangerous. However, they can cause physical discomfort and emotional problems. If you are becoming depressed because of changes in your body shape, make sure that you tell your doctor.

Nutrition Guidelines

Excerpted from “South African National Guidelines on Nutrition for People Living with HIV, AIDS, TB and other Chronic Debilitating Conditions,” Department of Health Republic of South Africa, 2007

Good nutrition for all South Africans, especially people living with HIV/AIDS requires consumption of adequate amount in the appropriate proportions of macronutrients (proteins, fats and carbohydrates) and micronutrients (vitamins and minerals). Remember that many people from poverty stricken areas might be experiencing pre-existing malnutrition and that HIV/AIDS worsen the situation. Therefore adequate nutrition support maximizes management of HIV/AIDS and other chronic debilitating conditions and can prevent or delay loss of muscle mass. The stage of disease influences nutritional needs of people living with HIV/AIDS. AIDS-related symptoms such as fever, diarrhoea, wasting and weight loss might increase the required nutrient intake.

Macronutrients

Energy requirements

Energy required during any infection increases. In people living with HIV/AIDS the increase is according to HIV/AIDS stages. Energy requirements in people living with HIV/AIDS are recommended as follows:

- Energy requirements increase by 10% to maintain body weight and physical activity in asymptomatic HIV-infected adults, and growth in asymptomatic children.
- In symptomatic HIV-infected, energy requirements increase by 20% to 30% to maintain adult body weight.
- Energy intakes need to be increased by 50% to 100% over normal requirements in children experiencing weight loss.

Protein requirements

- There is insufficient evidence for an increased need for protein intake of people infected by HIV and AIDS over and above that required by healthy non-HIV infected persons.
- The recommended protein intake is 12 to 15% of total energy intake.

Fat requirements

- There are no special requirements for HIV infection.
- Certain symptoms such as diarrhoea, steatorrhea in adults may require changes in fat intake.
- Special advice regarding fat intake might be required for individuals undergoing ART due to hyperlipidemia and other related conditions.
- 30 – 35% of total energy needs (approximately 80g) should come from fat.

Nutrition Guidelines (continued)

Micronutrients

- Micronutrients are natural substances found in small amounts in food (e.g., vitamins and minerals). The body only requires small amounts of micronutrients, and they are important for maintaining good health.
- Many South Africans do not eat a wide variety of foods to provide all micronutrients they need.
- Vitamins and minerals, such as vitamins A, B-complex, C and E, as well as selenium, zinc are needed for the immune system to fight infections and deficiencies of these vitamins are commonly found in HIV infected adults and children.
- Micronutrient intakes at one RDA level are recommended for HIV-infected individuals

Nutritional Response to TB infection

Energy

- The body uses more energy in its attempt to fight the infection. Hence patients with active TB characteristically have a loss of body weight and appetite, thereby increasing their energy needs.
- Energy needs of TB patient are increased by approximately 35 – 40 cal per Kg of ideal body weight.

Protein

- The body responds to the TB infection by various degree of tissues breakdown.
- There is an increase in protein breakdown that leads to muscle wasting. The breakdown of protein and other reserves due to fever may also worsen under-nutrition and further impair resistance against the infection.
- The protein intake of the diet is important to prevent the wasting of body stores. Approximately 75g – 100g per day (3 to 4 servings) should be sufficient intake.

Micronutrients

- The increased expenditure and tissue breakdown associated with infection are thought to increase the requirements of micronutrients like vitamin A, E, B, C, D, and folate.
- It is also known that a decrease in blood levels of trace elements such as iron, zinc, and selenium occur during the infection.
- It is advised that a person with TB, take a multivitamin and mineral supplement providing 100% of the recommended daily allowance. This is because it is unlikely that TB patients will be able to meet the increased requirements for vitamins and minerals with diet alone due to poor appetite.

Food Safety

There are several illnesses caused by eating food on which harmful germs have grown. A foodborne illness is any illness that comes from a food you eat. Pathogens are organisms (such as bacteria and viruses) that cause the disease.

Pathogens in food can make you sick and cause mild to life-threatening illness. It is important for people living with HIV/AIDS to be careful about the food they eat. You cannot tell if a food contains germs that can make you sick. Bacteria that cause foodborne illness may not change the food's look, taste, or smell.

People living with HIV/AIDS can help themselves by following basic food safety guidelines:

- Always wash your hands thoroughly with soap and water (with preferably warm water) before touching your food; do this every time between touching raw and cooked food
- It is very important to wash your hands after touching pets and other animals, after visits to the toilet and after sneezing or blowing your nose
- Cover all wounds to prevent contamination of food during preparation and handling; if you have cuts or sores on your hands, they must be covered when working with food
- The use of a plastic plaster may keep the wound clean but can become dirty and contaminate the food; rubber gloves, if available, will keep the wound clean and protect the food
- Avoid raw meat, raw fish, raw eggs, undercooked chicken, poultry or pork
- Make sure that food is thoroughly reheated if it has already been cooked
- Avoid food that is mouldy or has passed its sell-by date
- Make sure that uncooked food is kept separate from cooked food
- Cooked stews should be kept in the fridge and eaten within two days; portions should be frozen if you wish to keep for longer than two days

Remember, sharing utensils like cups, plates, knives and forks with HIV positive people cannot spread the virus.

Purchasing safe foods

Where food comes from, how it is processed and how it is stored and prepared – all affect the risk that foods will contain pathogens.

Food Safety (continued)

Following some tips may help people living with HIV/AIDS shop for safer food and reduce their risk for foodborne illnesses:

- Do not buy food that has been displayed in unsafe or unclean conditions
- Pick up perishable foods last, including meat, milk and any other foods that support growth of bacteria; refrigerate them promptly if possible
- Read labels on foods for food safety information; look for expiration, “sell by,” “best before” and “used by” dates; do not be tempted and buy expired food even though the price is marked down
- Check the food in your kitchen and throw away any food that has reached the “sell by,” “best before” and “used by” date even if it still looks good
- Do not taste food that you think might be spoiled
- It is safer to buy your foods in amounts that can be eaten before they spoil; it is sometimes cheaper to buy food in bulk but without a fridge for safe storage this is not useful
- Do not use canned food if the can bulges or if it is dented or leaking; do not be tempted by discounts on damaged cans
- When buying cold meats and cheese, pre-packed and sealed products are safer
- Cold meats that have been in the display case for some time are not safe
- Do not buy cracked eggs; inspect the eggs in the shop before they are bought

Storing Food

Germs multiply more quickly in warm food. Storing food in a refrigerator or cool place slows down this growth. Cooking with high heat can also kill most germs. Food should be eaten as soon as it is cooked.

Here some tips for storing food safely:

- If you have a refrigerator, cooler, or icebox, it is safest to keep the temperature just slightly above the freezing point at 35°F to 40°F (2°C to 6°C)
- Label all food with the date, contents and number of servings before putting into your freezer
- Choose the oldest package first when using frozen foods
- Cover and store food in airtight containers away from insects, mice and other animals
- Clean these out thoroughly between use to avoid the growth of mould and bacteria

Food Safety (continued)

- Store fresh food in a cool place or refrigerator if available
- Potatoes should be kept in a cool, dark, well-aired place, not in plastic bags; throw away potatoes that become green or soft and shrivelled
- Serve food immediately after cooking; do not leave the food standing at room temperature, as this will allow germs to multiply
- Do not store raw and cooked foods together; use separated containers
- Avoid storing leftovers unless they can be kept in a refrigerator or a cool place (below 40° F or 6 °C); do not store leftovers for more than one or two days and always reheat them at a high temperature (over 165°F) so that the food is heated through entirely
- If you are reheating soups, stews or sauces, bring them to a boil and let them simmer for 10 minutes
- If storing hot leftovers, let cool in a shallow, small container
- Throw away mouldy cheese
- Do not keep uncovered rubbish bins in the kitchen

Other tips to keep your kitchen and dishes safe:

- Wash all work surfaces with soap and water
- Clean up immediately after spills
- Wash your kitchen floors at least once a week
- If your kitchen is used often, the floors will need to be washed more often; use separate cloths for cleaning the floor
- Disinfect cloths, sponges and scourers with bleach or dry them in the sun
- Wash your dishes in hot soapy water
- Use a cutting board for raw foods, not the kitchen sink; plastic or marble cutting boards (not wood) are the safest for raw meat products
- Clean cutting boards with soap and hot water after cutting each type of food
- Cracks in cups and dishes and scratches in plastic containers are ideal hiding places for germs and it is difficult to clean properly; replace them for your own safety

Gardening

Tips for laying out the garden

1. If your plot is on a slope the length (long axis) of the beds should always be across the slope to prevent the soil from being washed away by rain
2. The long axis of the beds should run from east to west
3. The width of beds should never be more than one metre; all garden work should be done from the pathways so that the soil in the beds is never trampled and compacted
4. Paths between the beds should be about half a metre wide
5. Mark out the beds using a measuring stick and garden lines
6. The best size for each bed is one metre wide by two or three metres long
7. Once your garden is marked out, start preparing the soil in the beds for planting

Soil preparation – the most important job

Soil must have sufficient air, water and nutrients for the germination of seeds and the healthy growth and development of the small plants. Most soils have been compacted by feet and other traffic and this makes it difficult for the roots to grow down towards the nutrients. There are many different methods for preparing the soil for planting; however most soils are poor and compacted, and, in South Africa, there is a shortage of water.

Trenching is the method we suggest for best results, although other methods will be discussed. It is good where soils are sandy, or hard and compacted, for clay soils, and in very dry areas. It is hard work at first, but you will reap rich rewards for your efforts.

Digging your first trench

After you mark your garden bed and examine the soil, collect about twelve black bags of assorted “rubbish” (organic waste), which will provide food for the soil. This could be fruit and vegetable waste from home and the supermarket, pot scrapings, egg shells, bones, feathers, cardboard, paper, lawn cuttings, dry leaves, all garden waste, manure, seaweed – anything that will rot.

1. Dig out the topsoil (one spade-head, or 30cm, deep). Place it to one side of the bed
2. Dig out the bottom soil (subsoil), also to one spade-head deep and put this soil on the opposite side of the bed
3. Remove all large stones and boulders
4. Loosen the soil at the bottom of the trench with a fork and cover with a layer of cardboard

Gardening (continued)

5. Put a layer (about 20cm deep) of coarse rubbish at the bottom and cover it with a 10cm layer of subsoil
6. Water both layers well
7. Continue with these layers, removing any tins, bottles, plastic, synthetic (manmade) materials and rubber, until the trench is full
8. Water each layer well as you go
9. Now replace the topsoil that you removed from the trench and add some topsoil from the paths to the top of the bed as well; the surface of the bed will be about 15 – 25cm higher than the path when you have finished (the bed will slowly sink as the rubbish decomposes)
10. Spread one bucket of compost (if you have it) over each square metre of bed; work it in and level the bed using a rake or a flat piece of wood
11. Use a 50cm stake to mark each corner and remember never to walk or stand on the bed
12. Cover the bed with a layer of mulch (a protective blanket for the soil and for the delicate roots of your plants); dry grass, straw, leaves, even newspaper and cardboard can be used as a mulch

Your first trench bed is now ready for planting. Once you have planted the first bed, dig and prepare the second one which you can then plant a month later. Four trench beds – each one about the size of a door – will keep your family with a constant supply of fresh vegetables and herbs. You will be surprised at how much you can plant in your door-sized beds.

Planting your food garden

Plant what you'll eat, and remember that the bigger the variety the better for your health and for the health of the soil. Plus if you plant only 1 or 2 types of vegetables in your garden, you will find that there are long periods when you have nothing to eat and short periods when you have too much! Instead choose a wide variety to plan including carrot, beetroot, turnip, radish, onions and leeks, spinach, kale, lettuce, cauliflower, broccoli, Chinese cabbage, parsley, kohlrabi, broad beans, peas and Lucerne, spinach, and soya.

Planting from seed costs you far less than buying seedlings from a nursery, however many people do not have much success when they first start. Here are a few tips for starting with seeds:

- Use fresh seeds, do not waste growing time by planting seed that won't germinate because it is old and no longer viable
- Seeds must be sown at a depth of three times their own size; be careful not to plant too shallow or too deep
- With very fine seed (carrots and lettuce) mix a teaspoon of seed with a cup of fine, dry sand when sowing to make the planting easier and thinned out

Gardening (continued)

As you plan for seeds, remember, vegetable roots will differ in length and feed at different depths. Some plants have big leaves and need room to spread; others are small. Similarly, some plants will be tall, while others are short. Place seeds in rows where the space will match their growth needs.

Sowing seeds for a bountiful harvest

- Using your hand or a stick, make partings in the mulch to expose the soil without wasting space; the partings should run across the long length of the bed
- Use a measuring card or your hand to make partings in the mulch; for many vegetables, 20cm between the rows is sufficient though larger vegetables like cabbage, cauliflower and broad beans need more space
- With a stick or your finger make a furrow in the exposed soil; the depth of the furrow depends on the size of the seeds – deeper furrows for larger seeds
- Carefully sow the seeds in the furrows – never too thickly, but always sowing a few more than you need in case some don't come up; if too many come up, then you can transplant them to another bed, eat them or give them to a friend or neighbour
- Cover the seeds with soil from either side of the grooves, press them down with the side of your hand so that they are in close contact with the soil, and water them gently with a watering can made from a tin with small holes punched in the bottom; do not use a hosepipe as the strong jet of water will wash the seeds away
- If the weather is very hot and dry, cover the areas where you planted the seeds with a very fine layer of mulch – so thin that you can still see the soil through it; remove the mulch covering the seedlings as soon as they come through the soil
- If possible, check the seeds every day to see that they do not dry out
- If you are worried about the birds eating your carefully planted seeds, or the heavy rain washing them away or compacting the soil, make a net from plastic mesh bags – the type that vegetables are sold in; open them out and stitch them together to make a cover that is big enough to protect your bed

If you have planted your seeds carefully, said a little prayer for each one, and made sure that they are kept damp you will soon have the excitement of seeing the earth stirring as the baby plants muster the strength to force their way through the soil to the warmth of the sun.

Have fun with your garden and good growing!