

# COMMUNITY IMPLEMENTERS GUIDE TO HIV AND TB RESEARCH

Key Outcomes from the 4th SA AIDS Conference,  
2009 and 2nd SA TB Conference, 2010



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## ACRONYMS

- AIDS** Acquired Immune Deficiency Syndrome  
**ART** Antiretroviral treatment/therapy  
**ARV** Antiretroviral  
**BCC** Behaviour change communication  
**CBO** Community based organisation  
**DOTS** Directly observed treatment short-course  
**FBO** Faith based organisation  
**FC** Female condom  
**HAART** Highly active antiretroviral therapy  
**HCT** HIV counselling and testing  
**HCW** Health care workers  
**HIV** Human immunodeficiency virus  
**ICF** Intensified case finding  
**IPT** Isoniazid preventive therapy  
**LTBI** Latent tuberculosis infection  
**MCP** Multiple concurrent partners  
**MDR-TB** Multidrug - resistant tuberculosis  
**NGO** Non governmental organisation  
**NIM-ART** Nurse initiated management of ART  
**NSP** National Strategic Plan for 2007-2011  
**PEP** Post exposure prophylaxis  
**PLHIV/PLWHA** People living with HIV and AIDS  
**PMTCT** Prevention of mother-to-child transmission  
**SANAC** South African National AIDS Council  
**STI** Sexually transmitted infection  
**TAC** Treatment action campaign  
**TB** Tuberculosis  
**TST** Tuberculin skin test  
**UNAIDS** Joint United Nations Programme on HIV and AIDS  
**WHO** World Health Organisation  
**XDR-TB** Extensively drug-resistant tuberculosis

## ***What is the 'Community Implementers Guide to TB and HIV Research'?***

The Community Implementers Guide to TB and HIV Research is part of a larger initiative to assist community implementers to engage with HIV and TB research. This Guide documents key crosscutting research outcomes from the 4th SA AIDS Conference and the 2nd SA TB Conference. It also features key local and international institutions and websites as resources and information gateways for those interested in learning more about implementing research outcomes.

## ***What is the purpose of this guide?***

The purpose of this guide is to highlight some of the key themes and research outcomes that emerged at the most recent SA AIDS and TB conferences. This document aims to share key messages from some of the research presented at these conferences in order to enhance and strengthen the delivery of the TB and HIV services within community NGO sector. Knowledge sharing is a powerful way to ensure that HIV and TB service delivery is evidence based and therefore effective.

## ***Who is this guide for?***

This guide is primarily developed for use by the NGO sector as well as civil society leaders, key decision makers, people living with or affected by TB and HIV, and community health representatives.

## ***How should this guide be used?***

This guide is meant to be used as a learning and reference tool for those organisations who want to keep up to date with the latest developments in research on TB and HIV in South Africa in order to implement key findings, ensure that their work is evidence based and enhance their service delivery. The Guide is structured so that:

- It introduces some key HIV and TB issue areas;
- Highlights the latest research finding under these areas; and
- Provides other resources, websites and tools to increase understanding and ability to effectively respond to HIV and TB

## INTRODUCTION - continued

### ***What are the main topics covered in this guide?***

The issue areas covered in this guide include HIV and TB integration, TB Advocacy, Community and Social Mobilisation, and some of key topics that emerged from the Durban II Declaration at the 3rd South African AIDS Conference in 2007 in support of the National Strategic Plan on HIV, AIDS and STIs for 2007-2011.

These include: Multiple Concurrent Partnerships, HIV Counselling and Testing, Social and Behavioural Interventions, Infant Feeding, Male Circumcision, Female Condom, and Long Term Effects of ART.

### ***Who are the FPD and the Compass Project?***

The Foundation for Professional Development is a private higher educational institution registered with the South African Department of Education with the vision to build a better society through education and development. It is currently one of the largest self funding private higher educational providers in Africa.

The Compass Project is an FPD initiative which assists communities to respond effectively to HIV/AIDS through identification of the need, mapping of service provision and capacity building activities to improve response.

## KNOWLEDGE SHARING AND HEALTH COMMUNICATION: A CONVERSATION WITH SUE GOLDSTEIN

The Compass Project interviewed Sue Goldstein who is a senior executive at Soul City, a public health specialist and a well known health promotion and health communication expert. Since 1995 she has worked with Soul City: Institute for health and development communication, in a number of different roles, from managing the Soul City series, to researching, developing and managing Soul Buddyz, a children's series.

Through the interview, Sue has shared some of her insights on knowledge sharing and communication with us. Here are some excerpts:

Q

*What are the various ways and mechanisms through which an organisation can get a message across to communities?*

Sue

There are a whole range of different communication mechanisms. People who do research should report back to the communities through feedback meetings or workshops. That's the first kind of level of communication and knowledge sharing. And, then there are records, reports that people can get. Communities can have feedback on community radio stations. One of the organisations that I think you can get involved with is Fusion—they do research in an area and then they have a radio talk show where they give feedback on what the results of the research are to communities. And, then of course there are booklets, pamphlets, factsheets, and the web. So there's a whole range different things that communities do to access the information that they need in order to operate.

Q

*What about taking information that they gain from a conference or for example the 'Community Implementers Guide to TB and HIV Research' and taking it to their constituency?*

Sue

Well depending on what the information is of course: some of it may mean that people have to re-examine how they do their own intervention, so you might have to reorient the intervention according to what the new information is telling you. For example: If the TB Conference is saying that what we should be doing is streamlining ART and DOTS and we shouldn't have two separate systems. If you are an NGO working in that area then you need to go back and think of how one practices this.

On the other hand there is information that may need to be transmitted to ordinary people on the ground so for example perhaps, it's important that people must know that they need to ask for INH prophylaxis when they are

## A CONVERSATION WITH SUE GOLDSTEIN - continued

diagnosed HIV positive. That kind of information can be distributed in a whole range of different ways: through community meetings, in face to face interpersonal interventions, through pamphlets or booklets, through radio, a range of different ways. And, a lot of these are not expensive. The booklets and radio are.

However, generally, a lot of radio stations if one approaches them and if they're local they'll give you some airtime to have a discussion or an interview about the issue. Pamphlets, if you do just quite simple ones that aren't too fancy they might also work. Calling community meetings are not expensive if you don't feed people. You know these are all ways that are not very expensive and yet quite effective.

Q

*One of the challenges we face is that we have a hard time sometimes connecting research with community, so while there are various forms available I think that sometimes NGO's for example at the conferences stick to looking at only the community track and may not interact that much with academics and researchers and sometimes it is quite important for these two to work together.*

Sue

Well I think that the issue is not really about the community organisations. It's about how to present the research in a way that people understand the implications it has for their own practice. For example, even some of the plenary sessions at the TB Conference were quite technical – 'they talked about this new thing and that new thing.' Then, it's hard for people to understand what the implications are for their own practice and policies.

Also, (one has to consider) when does one then communicate this information with one's constituency? For example: Would you be creating a demand for something that is just not feasible financially? So I think there's a layer missing. I think there should be ways of simply trying interpret the research for ordinary people on the ground. But, it should only focus on a few topics. What one needs is somebody to take from this conference the information that was scientific, but had policy implications for NGO's, for government and so on and then communicate those particular issues. But, for me the interpretation of how to take it forward is very important.

## A CONVERSATION WITH SUE GOLDSTEIN - continued

Q

*Let's talk about messaging and communication specifically. What makes people listen? And what will make messages stick?*

Sue

Well I think what makes people listen is really a whole range of things: The first thing is that it has to resonate with the people; it has to have meaning in their lives. If you put out a message that says: "you should only plant Jacaranda trees in autumn". It doesn't say much for people that are not involved in planting trees. There's no resonance - It isn't important in people's lives. So you have to kind of find a way to make it interesting and make it relevant in people's lives and make sure that that remains interesting enough.

We (at Soul City) believe very strongly that the 30 second ads are very limited and short-lived in how people engage with messaging, so in our messaging process we believe that you have to engage people over a longer period of time, that's why we do the drama so that people kind of really look at the different emotional aspects. Emotion is very important. Also the drama takes people through a process because change is a process. You don't kind of wake up one morning and say: ok now I'm going to stop eating unhealthy food, generally it takes a while to plan how you're going to do it and then you'll have some relapses and you'll eat healthy some days and won't some days. You know that's how life is and I think that trying to take people through a process and helping them to understand that life and change is process and that change needs to happen in a prolonged way.

What else makes it that important? I think another very important part of what we do is that with whatever material and the messages we decide on, and whatever comes out of the research... for example, if the message is that 'people should believe that they can have long term sexually satisfying relationships with one partner', but we do not know how to express what we say to them, we test the material to make sure they come out with the message we want them to understand by our material. So, we test for whether people get the messages or not. That's also very important because we all think we're very good at how we express ourselves and generally we aren't. So, I think that's also a very critical aspect.

## A CONVERSATION WITH SUE GOLDSTEIN - continued

Q

*This is a similar question, but how do we know if we're conveying the right message?*

Sue

You don't always know that you're conveying the right message and that may be in connection to that particular stage in time you are conveying the message. For example what happened in the AIDS field where the key message was always, 'use condoms' because a lot of people just didn't believe people would stop having sex with many partners. I think that then after many years people realised it (this strategy) wasn't enough. Then people started looking at having less (number of) partners. I think, keeping in mind (these kinds of changes), the best you can do is to broadly consult with as many people or experts in the area as you can and get a consensus over what the messages should be.

Q

*Finally, what can community organisations and NGOs working in HIV learn from Soul City's experience and your experience?*

Sue

From our experience, there are two things that we believe: Communication is mostly, about listening rather than telling, you need to be listening to your audiences and you need to listen to the experts. Really trying to hear what other people are saying and being flexible. Sometimes you're wrong and you need to be able to understand that and shift strategy and try and do the best that you can.

The other big thing that we believe is that even a brilliant intervention if it only reaches very few people; it is not going to be very effective. So, scale is important – how many people you can reach, but it depends on what kind of organisation you are.

**Thanks Sue!**

## **SECTION 1**

# **TUBERCULOSIS AND INTEGRATION OF TB AND HIV SERVICES**

## **Key Thematic Areas for Implementation**

## TB FAQs

### ***What is tuberculosis and what causes it?***

Tuberculosis (TB) is a disease caused by an organism called mycobacterium tuberculosis, commonly called the TB bacillus. The mycobacterium tuberculosis bacteria can attack any part of the body, but most commonly attacks the lungs. Tuberculosis is a slow growing disease and although many people are infected by the TB bacillus, the disease only develops among a few, especially among those who are immunocompromised (because of HIV or other causes) or have other co-existing diseases as well as among children under 5 and the elderly.

### ***How does TB spread?***

A person can have active or inactive TB. Active TB means the bacteria are active in the body and the immune system is unable to stop them from causing illness. People with active TB in their lungs can pass the bacteria on to anyone they come into close contact with through coughing, sneezing or spitting. TB is spread by inhaling the bacteria which is floating in the air from someone with active TB.

### ***What are the most common TB symptoms?***

***The most common symptoms of TB are:***

- Cough
- Shortness of breath
- Fever
- Night sweats
- Chest pain
- Weight loss
- Loss of appetite
- Coughing up of blood

### ***How is tuberculosis treated? Is there a cure for tuberculosis?***

Active TB can be cured with a combination of antibiotics. Effective treatment quickly makes the person with TB non-contagious. Achieving a cure for TB takes about six to eight months of daily treatment.

### **How is TB diagnosed?**

**The most current Department of Health TB management guidelines state that:**

- All individuals suspected of having tuberculosis should have at least two sputum specimens examined for bacteriological confirmation of disease.
- The client's HIV status influences the diagnostic algorithm. Hence, the standard of care is to provide HIV counselling to all TB suspects. Clients should be given enough information to help make an informed choice about the test. All clients should be strongly advised to have an HIV test and consent sought for testing.

**TB is diagnosed in different ways depending on the available resources and the patient's condition:<sup>1</sup>**

1. Clinical examination: A clinical assessment will determine whether patient is a TB suspect based on the symptoms detected.
2. Sputum smears: Microscopic examination of stained sputum is the most rapid method for confirming a TB diagnosis. Two samples are collected for this examination: spot collection which is done at the health facility under the supervision of a health care worker (HCW) and at home the following day by the patient. A spot specimen followed by an early morning specimen gives the best yield in the diagnosis of TB. However, there are many situations where clients are unable to return to facilities with an early morning specimen. In these situations, it is recommended that two spot specimens be collected at least 1-hour apart.
3. Sputum Culture: Culture is more sensitive than smear microscopy, detecting a higher proportion of cases among clients with symptoms. However, it is an expensive and slow diagnostic technique, not accessible to some clients and takes at least 4 weeks to provide a definitive result. Culture is however an important diagnostic tool for those who are HIV positive clients with smear-negative pulmonary tuberculosis.
4. Chest x-rays: The primary method of TB diagnosis is smear microscopy and culture. Whilst chest x-rays are quick and convenient, reliance on them as the only diagnostic test results both in over-diagnosis of TB and missed diagnosis of TB. Many diseases mimic TB on chest x-rays and this may lead to an incorrect diagnosis. Chest x-rays are necessary in TB suspects who cannot produce sputum or who have negative smears. They must be interpreted in the light of the client's history and clinical findings.

5. Tuberculin skin test: The tuberculin test has limited value in clinical work, especially where TB is common. The test shows hypersensitivity to proteins of the TB bacillus, as a result either of infection with *M. tuberculosis* or induced by Bacille Calmette-Guérin (BCG) vaccination. A positive TST does not indicate TB disease, only infection. A negative result does not rule out the diagnosis of TB disease as various conditions, including HIV, may suppress the reaction.

A person with a positive skin test, a normal chest X-ray, and no symptoms is most likely to have inactive TB which is not contagious. In HIV positive people Isoniazid (INH), an antibiotic, is generally used to prevent inactive TB from becoming active. A person with a positive skin test along with an abnormal chest X-ray and sputum evidencing TB bacteria has active TB and is contagious. As mentioned before, active TB usually is accompanied by symptoms, such as a cough, and weight loss.

### ***How does Tuberculosis affect those who are HIV positive?***

TB is an HIV related opportunistic infection. It is vitally important for people with HIV to have treatment if they have active TB. Treatment with ART and TB medicines can ensure a complete cure. The combination of HIV and TB treatment is more complicated as there are many drugs involved.

### ***What is Multi-drug Resistant TB (MDR-TB) and Extreme Drug Resistant TB (XDR-TB)?***

When a TB bacillus is resistant to two or more 'first-line' antibiotic drugs it is called multi-drug resistant TB or MDR-TB. When it is resistant to 'second-line' antibiotics as well, it is classed as extreme drug resistant TB, or XDR-TB. XDR-TB is very serious as the bacillus is resistant to virtually all effective anti-tuberculosis drugs. Drug resistance usually arises when TB patients do not or cannot take their medicine as prescribed and the TB bacillus mutates to be resistant to the drugs. MDR TB can also be transmitted the same way other TB bacilli are transmitted.

### ***Can Multidrug-resistant Tuberculosis be treated?***

Multidrug-resistant TB (MDR-TB) can often be treated successfully. However, treatment needs to continue for up to two years, the medicines used often cause more side effects. MDR TB has been shown to be almost twice as common in people with HIV compared to those without. MDR-TB and XDR-TB have high mortality rates (over 90%), particularly among those living with HIV.<sup>2</sup>

### **What is DOTS?**

DOTS stand for Direct Observed Treatment Short-course Strategy. It is the provision of short-course TB treatment under the supervision of a health worker or lay health worker. DOTS is at the core of WHO's STOP TB Partnership strategy. It is currently thought to be the most effective strategy available for controlling TB. DOTS supporters can be co-workers, lay health workers or even neighbours.

### **What are the 3 I's of preventing Tuberculosis among people living with HIV/AIDS?**

**The following 3 I's form the priority public health actions to prevent and treat TB in people living with HIV:<sup>3</sup>**

1. **Intensified TB case finding:** Intensified case finding (ICF) for TB means regularly screening all people with or at high risk of HIV or in congregate settings (such as mines, prisons, military barracks) for the symptoms and signs of TB, followed promptly with diagnosis and treatment, and then doing the same for household contacts. Simple questionnaires to screen for TB can be performed when people first seek HIV services (e.g., care, voluntary counselling and testing, etc.) and/or by community based organisations supporting people with HIV. ICF serves as the important gatekeeper for the two other I's facilitating rapid identification of TB suspects acting as the necessary first step for health care providers to confidently prescribe Isoniazid Preventive Therapy to people living with HIV who do not have active TB.
2. **Infection control:** TB infection control measures are essential to prevent the spread of *M. tuberculosis* to vulnerable patients, health care workers, the community and those living in congregate settings. Fundamentally, TB infection control is about safety – people receiving or offering HIV care should not have to worry about being exposed to and infected with *M. tuberculosis* in the process. In light of the crisis of drug resistant TB in countries with a high burden of HIV, establishing facilities that are safe from TB has become an emergency situation for health services, prisons and other congregate settings, in general, but especially for HIV programmes.
3. **Isoniazid preventive therapy:** Isoniazid preventive therapy (IPT) for TB can safely be given to people living with HIV without TB disease, reducing the risk of developing TB by 33–67% for up to 48 months. It is currently recommended

## TB FAQs - continued

for all people living with HIV in areas with a prevalence of latent TB infection >30%, and for all people living with HIV with documented latent TB infection or exposure to an infectious TB case, regardless of where they live. More recently, evidence has shown that the combined use of isoniazid preventive therapy and antiretroviral therapy among people living with HIV significantly reduces the incidence of TB; and the use of IPT in patients who have successfully completed a course of TB therapy has been shown to markedly reduce the risk of subsequent TB cases.

### ***Useful Resources for General Tuberculosis Information***

General information on TB: This site connects you to basic information on Tuberculosis. It is a useful resource for readers who are not familiar as well those who want link to research and other resources on tuberculosis:

<http://www.sahealthinfo.org/tb/tbgeneral.htm>

For some in depth current information and research on Tuberculosis see the Centre for Disease Control and Prevention website:

<http://www.cdc.gov/tb/>

Department of Health, National Tuberculosis Management Guidelines, 2009  
[http://pdf.usaid.gov/pdf\\_docs/PNADR720.pdf](http://pdf.usaid.gov/pdf_docs/PNADR720.pdf)

Department of Health TB Resources:  
<http://www.doh.gov.za/tb/>

## INTENSIFIED CASE FINDING FOR TB

Intensified case finding (ICF) for TB means regularly screening all people with or at high risk of HIV or in congregate settings such as mines, prisons, and health care institutions for the symptoms and signs of TB, followed promptly with diagnosis and treatment. A simple questionnaire (see Fig 1) can be used to screen TB among those who are seeking HIV services by health care institutions or by community based organisations supporting people with HIV. ICF acts as a gateway for the two other I's: infection control and isoniazid preventive therapy (IPT). ICF facilitates rapid identification of "TB suspects" enabling the implementation of infection control or identification of those who do not have active TB and qualify for IPT.

	Yes	No
1. Has the individual had a cough for >2 weeks?	[ ]	[ ]
2. Has the individual had a fevers for >2 weeks?	[ ]	[ ]
3. Has the individual had an observed weight loss >3 kg in last 4 weeks?	[ ]	[ ]
4. Has the individual had night sweats for >2 weeks?	[ ]	[ ]
5. Has the patient been in close contact with someone with TB in the past year? (optional)	[ ]	[ ]
6. If done, does the patient have a Tuberculin Skin Test induration of >5mm? (optional)	[ ]	[ ]
If 'YES' to Question 1, patient is a pulmonary TB suspect, regardless of answers to other questions, begin evaluation for TB		
If 'NO' to Question 1, but 'YES' to any other question, patient is a TB suspect. Begin evaluation for TB.		
If 'NO' to all questions, patient is not a TB suspect. Repeat TB screening in 3-6 months time.		

**Figure 1: Tuberculosis screening questionnaire<sup>4</sup>**

## INTENSIFIED CASE FINDING FOR TB - continued

### **Key Issues:**

1. High incidence of TB among Health Care Workers: Health care workers (HCWs) in high TB-incidence, low income countries are at high risk of latent tuberculosis infection (LTBI) and active TB disease. Despite this, occupational screening is not standard practice, partly due to difficulties with interpretation of tuberculin skin tests (TST), and repeated exposures to patients with active TB. Health Care workers therefore need to be screened for TB annually and tested for HIV.<sup>5</sup>
2. Current South African Occupational Health Guidelines stress the following:
  - Education of Health Care Workers and staff on signs and symptoms of TB;
  - Annual TB symptom screening;
  - Offering of Voluntary Counselling and Testing and encouraging staff to know their HIV status;
  - Provision of INH preventive therapy (IPT) and ART for HIV-positive HCWs; and
  - Reassigning of HIV-positive HCWs and staff to low TB risk settings.
3. An initiative by the Medecins Sans Frontieres – Khayelitsha to improve case detection of Drug Resistant Tuberculosis (DR-TB) found that household contacts of those infected by TB do not always go for screening and if they do, those who test negative in initial screening do not return for following up screenings.<sup>6</sup> Moreover, screening children who are contacts of TB cases is often neglected in routine TB programmes and even more so for drug-resistant TB (DR-TB) where children are under-represented among those receiving treatment.

### **Key messages and areas for implementation:**

- High incidence of TB and HIV in congregate settings and among HCWs necessitates annual occupational screening as well as stronger emphasis on TB prevention by implementing infection control measure and provision of prophylaxis to HIV co-infected. Occupational exposure to TB is an important occupational hazard for HCWs and the use of an onsite Occupational Health nurse can better facilitate annual TB screening and HIV counselling and test within drug-resistant TB hospitals. There is a crucial need for the strengthening of Occupational Health services.<sup>7</sup>
- Outreach clinics and education around TB transmission directly to households has been seen to be more effective in supporting case detection. There is a need for transfer of skills and expertise to local clinicians and health workers to enable case detection and diagnosis among household contacts particularly among children.<sup>8</sup>

# TUBERCULOSIS INFECTION CONTROL

Tuberculosis is a contagious disease which can spread to anyone who shares air with a person with TB disease of the lungs in the infectious stage. People who have TB disease in their lungs can release tiny particles called droplet nuclei which contain the TB causing *M. tuberculosis* bacteria. Droplet nuclei are invisible to the naked eye and can remain airborne in room air for many hours, until they are removed through ventilation. Anyone who inhales one or more droplet nuclei can get infected with TB.

As we know, TB is the most common opportunistic infection and a leading cause of death in persons living with HIV/AIDS around the world. Moreover, the chance of progression from latent to active TB is increased from 10% in a lifetime to 10% per year among PLWHA. Health care workers and other staff are also at particularly high risk of infection with TB because of frequent exposure to patients with infectious TB disease. Therefore infection control (especially in health care facilities and other congregate settings such as prisons) is a key strategy for TB prevention.

## **There are 4 levels of mechanisms for infection control in health care facilities:**

1. Supporting structures and activities to ensure implementation of TB infection control:
  - Formation of an Infection Control and Prevention Committee and Plan
  - Training of staff in TB infection control interventions
  - Education of the community in TB/HIV awareness and prevention
2. Administrative controls reduce the production of infectious TB particles in health care facilities:
  - Screen clients for coughing as they enter facility
  - Education on cough hygiene
  - Provision of masks/tissues to coughing clients
  - Separation of clients who cough from those who don't (Triaging)
  - Reduction of waiting times for coughing patients
  - Early referral & investigation
  - Safe environment for sputum collection
3. Environmental controls eliminate infectious TB particles in health care facilities:
  - Well ventilated waiting areas for clients
  - Maintenance of good air circulation by opening windows and use of fans in waiting areas and consultation rooms
  - Use of ultraviolet germicidal radiation units

## TUBERCULOSIS INFECTION CONTROL - continued

4. Personal risk reduction to reduce the inhalation of infectious TB particles by staff and clients, and reduce risk for TB disease:
  - Use of N95 respirator/masks to prevent inhalation of TB
  - Encouraging clients and staff to know their HIV status, and to take INH prophylaxis if appropriate
  - Training of staff in infection control strategies

### **Key messages and areas of implementation:**

1. While TB infection Control measures guidelines have existed for some time now, and several studies have found that they are not adhered to due to lack of training, complacency, absence of “proof” of effectiveness and the lack of tools for monitoring and evaluation.<sup>10</sup>
2. The Reproductive Health and HIV Research Unit (RHRU) of Wits University has devised and tested a tool to evaluate critical TB infection control interventions which measure the reduction, removal of particles formed by people with TB disease and keep people from inhaling these particles. The study concluded that “the tool was simple to comprehend, and quick to apply, and easily highlighted poor performance of the most simple, low cost measures to affect TB infection control”.<sup>11</sup> This tool can be found in the RHRU publication: Implementing TB Infection Control in Health Care Facilities (see useful resources below).
3. Administrative control measures have the greatest impact on reducing TB infection in health care settings and therefore, should be prioritized.<sup>12</sup>
4. Infection control measures need to be routinely externally audited and there is a need for investment in renovations and equipment as well as better design for ventilation and airflow in health-care facilities.<sup>13</sup>

### **Useful Resources for TB Infection Control:**

TB Infection Control in health care facilities, RHRU, First Edition, November 2009. This is a manual on TB Infection Control with several useful tools and information on infection control. [http://pdf.usaid.gov/pdf\\_docs/PNADS681.pdf](http://pdf.usaid.gov/pdf_docs/PNADS681.pdf)

# ISONIAZID PREVENTIVE THERAPY

Isoniazid is an antibiotic used to treat TB. Isoniazid Preventive Therapy or IPT is used to prevent active TB disease among those who have a latent infection with the TB bacteria *M. Tuberculosis*. HIV is the strongest risk factor for the progression of latent infection into active TB. A study of community wide IPT among gold miners in South Africa suggests that IPT is feasible, tolerable, safe, does not cause resistance and result in the reduction of mortality among those who are HIV positive when combined with ART.<sup>14</sup>

IPT is typically administered for 6 months, however more recent research is suggesting that long term IPT can prove to be more effective. However, it has also been found that long term IPT (>36months) is effective only among those who test positive for the Tuberculin Skin Test (TST) where as a positive TST test is no longer a requirement for IPT according to South African policy.

## ***The current IPT policy in South Africa states the following:<sup>15</sup>***

### ***I. The Pre-requisites for administering Preventive Therapy are:***

- Availability of quality HIV counselling and rapid testing
- Effective screening for active TB before initiating TB preventive therapy (includes HIV +ve pregnant women)
- Capacity for monthly follow up and monitoring of patients to encourage adherence
- The local HIV/AIDS Programme must take responsibility for implementation of preventive therapy
- Strong collaboration between HIV/AIDS and TB programmes

### ***II. While all HIV positive people with no signs and symptoms of TB are potentially eligible for TB preventive therapy, the following populations are eligible:***

- Miners, prisoners, TB contacts, HCW's
- Pregnant mothers without symptoms of TB
- IPT and ART:
  - Patients who receive IPT and need ART can complete IPT even if ART is started
  - There is evidence that IPT is well tolerated and effective in patients on ART
- IPT can also be given to patients who had TB in the past

## ISONIAZID PREVENTIVE THERAPY - continued

### ***Key Message:***

Isoniazid Preventive Therapy (or INH prophylaxis) is a safe and effective way of reducing TB among those who are HIV +. All those who are diagnosed HIV positive are eligible for and should request IPT provided they do not have active TB.

### ***Useful Resources on Isoniazid Preventive Therapy:***

A policy document prepared by the Treatment Action Campaign on the use of Isoniazid Preventive Therapy to reduce mortality:

<http://www.tac.org.za/community/files/TACIPTPolicy%282%29.pdf>

## ADVOCACY, COMMUNICATION AND SOCIAL MOBILISATION

***Despite a global strategy as well as policy and community level interventions tuberculosis control continues to present many challenges such as:***

- Delayed detection and treatment;
- Lack of access to TB treatment;
- Difficulty in completing treatment;
- Lack of knowledge and information about TB that can lead to stigma, discrimination and delayed diagnosis and/or treatment;
- Stigma and discrimination that can prevent people from seeking care and diagnosis;
- Misunderstandings and myths surrounding TB, including the belief that it is “untreatable”;
- Weak political support for TB programmes; and
- Insufficient funding for TB programmes.<sup>16</sup>

Civil sector organisations play a key role in advocating for policy change and funding as well as community mobilisation and knowledge dissemination.

A study in Zambia suggests that the development of more targeted, continuous and interactive communication interventions around TB issues needed to be developed.<sup>1</sup> Another research study conducted by South African civil society organisation Community Action examined the challenges of TB and HIV awareness programmes and has successfully piloted a model to address some of these challenges. The model focussed on establishing “Street Committee Members (SCMs)” who were trained in TB and HIV material. Each of these members was assigned 40 households with whom they established a relationship and worked with to identify and map the needs in the community. Following this, households were referred to local resources and provided with regular support and monitoring to generate awareness and ensure compliance with medication.<sup>1</sup>

## ADVOCACY, COMMUNICATION AND SOCIAL MOBILISATION

- continued

### **Key messages and areas for implementation:**

- While it is well known that poverty and TB health are linked, the Zambian study also revealed that most communities consistently expressed preoccupation with economic hardship. It is crucial that health awareness is tied up with poverty alleviation activities.
- Interactive communication interventions, especially those that focus on working directly with households, such as the SCM model highlighted above, are especially effective in awareness, education, prevention and compliance. A survey conducted by TB Free revealed that 71% of the rural audience surveyed found door-to-door campaigns most useful as it allowed them one-on-one interaction with health care workers giving them the opportunity to discuss their queries and concerns.<sup>17</sup> The success of the above mentioned Street Committee Member model also supports this finding.
- Radio has been seen to be the most useful (and affordable) medium among rural populations followed by branded Taxis as they are seen regularly by commuters.<sup>18</sup>

### **Useful Resources for Advocacy, Communication and Social Mobilisation:**

Stop TB Partnership: There is a wealth of information, tools and best practices on advocacy, community and social mobilisation (ACSM) including a handbook on ACSM available on this website.

<http://www.stoptb.org/countries/acsm/resources/tools.asp>

## THE 4<sup>TH</sup> 'I': INTEGRATION OF TB AND HIV SERVICES

"When a patient is infected with both *M.tuberculosis* and HIV or AIDS, the 2 pathogens interact synergistically, speeding the progression of illness and increasing the likelihood of death. The presence of HIV makes a person more vulnerable to developing TB disease, and having TB disease accelerates HIV disease progression. TB is the most common opportunistic infection among persons infected with HIV."

"In 2007, 1.37 million people infected with HIV were estimated to be coinfecting with TB, according to the World Health Organisation, and 1 of 4 deaths from TB is now HIV related"<sup>19</sup>

TB is the main cause of death of people with HIV. There was a 335% increase in TB deaths from 1997 to 2005 (an increase from 22,071 TB deaths in 1997 to 73,903 in 2005). South Africa has 28% of the world's population with dual HIV & TB. The integration of HIV and TB services is imperative. The previous sections highlight the 3 I's which are crucial to this process.

A recent assessment of TB and HIV Services in Sub-Saharan Africa<sup>20</sup> suggests that the integration of TB and HIV services is feasible while infrastructural, and resource challenges continue to exist.

### **The study points to the following measures to integrate HIV and TB services:**

- Intensified Case Finding: Integration of a simple TB screening questionnaire can be introduced into routine HIV care and services.
- Infection Control in Health Care Setting: As highlighted in the section on Infection control administrative, environmental and personal protection measures can go a long way in ensuring infection control in resource limited settings.
- Isoniazid Preventive Therapy: the efficacy of IPT among persons with HIV infection has been well demonstrated.
- Initiating ART: early comprehensive care for those detected with HIV or TB for example, providing HIV testing and counselling to all those with TB infection can ensure timely initiation of ART and prevent complications and reduce mortality.
- Nutrition Intervention Services: Nutrition assessment, education and counselling are crucial for all those diagnosed with HIV and/or TB since those infected are at risk of nutritional deficiency at all stages of HIV.

## THE 4<sup>TH</sup> 'I': INTEGRATION OF TB AND HIV SERVICES

- continued

### ***Useful Resources on TB and HIV Integration:***

The article Integration of Tuberculosis and HIV Services in Sub-Saharan Africa: Lessons Learned can be accessed at

[www.ncbi.nlm.nih.gov/pubmed/20397954](http://www.ncbi.nlm.nih.gov/pubmed/20397954)

Interim policy on collaborative TB/HIV activities.

Geneva, World Health Organisation, 2004

[http://whqlibdoc.who.int/hq/2004/who\\_htm\\_tb\\_2004.330.pdf](http://whqlibdoc.who.int/hq/2004/who_htm_tb_2004.330.pdf)

A Guide to Monitoring and Evaluation for TB and HIV Collaborative Activities (WHO Publication):

[http://whqlibdoc.who.int/publications/2009/9789241598194\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241598194_eng.pdf)

The Global Health Initiative of the World Economic Forum, with support from the Lilly MDRTB Partnership and inputs from key partners, has developed a toolkit especially designed to help South African companies plan and implement workplace and community-based TB control programmes.

[http://www.weforum.org/pdf/GHI/TB\\_toolkit2pg.pdf](http://www.weforum.org/pdf/GHI/TB_toolkit2pg.pdf)

## **CASE STUDY** (Abstract)

Successful Integration of Tuberculosis and HIV Treatment in Rural South Africa:  
The Sizonq'oba Study

Neel R. Gandhi et al on behalf of Tugela Ferry Care and Research Collaboration

**Background:** Tuberculosis (TB) is the leading cause of death among HIV-infected patients worldwide. In KwaZulu-Natal, South Africa, 80% of TB patients are HIV coinfected, with high treatment default and mortality rates. Integrating TB and HIV care may be an effective strategy for improving outcomes for both diseases.

**Methods:** Prospective operational research study treating TB/HIV-coinfected patients in rural KwaZulu-Natal with once-daily antiretroviral (ARV) therapy concurrently with TB therapy by home based, modified directly observed therapy. Patients were followed for 12 months after ARV initiation.

**Results:** Of 119 TB/HIV-coinfected patients enrolled, 67 (56%) were female, mean age was 34.0 years, and median CD4 count was 78.5 cells per cubic millimetre. After 12 months on ARVs, mean CD4 count increase was 211 cells per cubic millimetre, and 88% had an undetectable viral load; 84% completed TB treatment. Thirteen patients (11%) died; 10 (77%) with multidrug-resistant or extensively drug-resistant TB. There were few severe adverse events or immune reconstitution events. Adherence was high with 93% of study visits attended and 99% of ARV doses taken.

**Conclusions:** Integration of TB and HIV treatment in a rural setting using concurrent home-based therapy resulted in excellent adherence.

The article on this study can be accessed  
<http://hivinsite.ucsf.edu/InSite?page=jl-46-04>

## **SECTION 2**

### **HIV/AIDS**

#### **Key Thematic Areas for Implementation**

## SOCIAL AND BEHAVIOURAL INTERVENTIONS

The National Strategic Plan for HIV/AIDS (NSP) still requires revision around the area of prevention – especially in the area of communication. To make a significant contribution to social and behavioural change, government, community researchers, civil society, and other stakeholders are required to put available evidence forward to use in the most strategic manner possible. Although much work remains to expand the evidence base for HIV prevention, the urgency is to address scaling up of programmes to change behaviour to prevent HIV infection. The central problem in HIV prevention is not lack of evidence but failure to bring to scale programming that addresses the major drivers of HIV infection, while incorporating cultural diversity.

### **Key behavioural strategies that prevent HIV:**

1. Promoting safer sex through delayed sexual debut
2. Reducing multiple concurrent partners
3. Use of condoms (male and female)
4. Decreasing drug and substance abuse
5. Providing access to needle exchange programmes
6. Promoting male circumcision

### **Key elements of successful behaviour-change programmes:<sup>21</sup>**

- Combination prevention: Successful HIV behaviour-change programmes deliver a combination of scientifically proven risk reduction strategies, such as one-on-one counselling, small-group programmes, and community education to encourage people to adopt safer sexual behaviours and avoid risky drug and substance abuse.<sup>22</sup>
- Access: Successful behaviour-change programmes achieve sufficient coverage, intensity, and duration to have a long-term impact. For example, a study on HIV prevention among South African youth suggests that it is key to engage schools by "developing new approaches for schools, including interventions that target school-level factors and engage schools as active partners, including mobilising the broader 'school community' of students, teachers, parents and community members."<sup>23</sup>
- Tailored strategies: The most effective behaviour-change strategies address the main drivers of HIV transmission, and are tailored to specific needs and circumstances of groups at high risk.
- Community support: Successful behaviour-change programmes have strong community involvement and support.

### **Key messages and areas for implementation:**

1. Behaviour change communication (BCC) is an interactive process with communities (as integrated with an overall programme) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours.
2. BCC is an essential part of a comprehensive programme that includes both services (medical, social, psychological and spiritual) and commodities (e.g., condoms, needles and syringes). Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV/AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services.

### **Useful resources for behaviour change strategies:**

Global HIV Prevention Working Group's report 'Behaviour Change and HIV Prevention: (Re) considerations for the 21st Century' as well as other materials for critical HIV prevention issues can be found on:

<http://www.globalhivprevention.org/reports.html>

For a practical guide to HIV prevention and other resources and information see UNAIDS page on Social and Behaviour Change:

<http://www.unaids.org/en/PolicyAndPractice/Prevention/IECbehaviChange/default.asp>

SAHARA is an alliance of partners established to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate the impact of its devastation in sub-Saharan Africa. SAHARA believes that well-researched and proven African intervention models are needed to halt the spread of the HIV pandemic.  
[www.sahara.org.za](http://www.sahara.org.za)

## MULTIPLE CONCURRENT PARTNERSHIPS (MCP)

It is now quite well known that Multiple Concurrent Partnerships (MCP) is a major contributor to the AIDS pandemic. A clear message from the SA AIDS conference in 2009 was that being involved with MCP's is described as "automatically becoming part of a sexual network of people whose status is unknown". The threat of one person in the network being HIV-positive will mean that it will be spread to the rest of the network.

A Medical Research Council study found that people living in urban, informal settings are particularly at risk of infection.<sup>24</sup> In particular, people who have high levels of sexual partner turnover and concurrency are seen as important drivers of the epidemic, especially in situations where males are five or more years older than their female sexual partners.<sup>25</sup>

The study continued to highlight that men with more than one, usually younger, female sexual partner make up a hard-to reach, high-risk sub-population. This is largely due to them not being captured through conventional HIV surveillance methods. Traditionally-used surveillance systems, such as household surveys are designed to track HIV infection in the general population and are unable to capture high-risk groups in sufficient quantities to make accurate conclusions about them.

### ***Key messages and areas for implementation:***

- Addressing multiple concurrent partnerships in HIV prevention requires NGOs to develop locally informed and culturally relevant messages to raise personal awareness of risk and challenge socio-cultural norms. Increased effort and resources should also be redirected to engage both young and older men in any MCP Programme. See resources listed below for local campaigns and messaging with regards to MCP and other behavioural interventions.
- NGOs should ensure that MCP programmes do not judge cultures "from outside". Interventions should understand the cultural dynamics to ensure their Programme is not met with resistance.
- NGOs should foster partnerships with community leaders and elders as they possess a cultural knowledge that can be drawn upon to make meaningful sense of the situation. Expert knowledge alone (often western and medical) is not sufficient to influence behaviour; it must be integrated with the local knowledge to reach consensus that works for all.

### ***Useful Resources for Multiple Concurrent Partnerships:***

The One Love Campaign is one of the largest and well known campaigns around Multiple Concurrent Partnerships. There is a wealth of information, resources and messaging on this issue available on

**<http://www.onelovesouthernafrica.org/>**

The One Man Can Campaign supports men and boys to take action to end domestic and sexual violence and to promote healthy, equitable relationships that men and women can enjoy - passionately, respectfully and fully.

**[www.genderjustice.org.za/onemancan/](http://www.genderjustice.org.za/onemancan/)**

UNAIDS (Regional team for Eastern and Southern Africa): This link has several research articles and reports from key meetings around Multiple Concurrent Partnerships.

**<http://www.unaidsrstesa.org/addressing-multiple-and-concurrent-partnerships-southern-africa>**

## MALE CIRCUMCISION AND HIV PREVENTION

Observational and epidemiological data have long suggested an association between male circumcision and reduced risk of HIV infection in men. Results from three randomized controlled trials have provided evidence that male circumcision reduces the risk of HIV acquisition in men through heterosexual sex, demonstrating at least a 60% reduction in risk.<sup>26</sup> This is a significant breakthrough in HIV prevention, and the international public health community and countries are therefore translating these research findings into public health policy and practice.

As with any surgical procedure there are risks associated with male circumcision. Complications are rare, usually minor and quickly resolved when circumcision is performed by trained and well-equipped providers under aseptic conditions. However more serious complications have been reported when male circumcision is performed by unqualified practitioners without the appropriate equipment or hygienic conditions. Ensuring the safety of male circumcision services is critical to successful scale up.

### **Key messages and areas for implementation:**

1. Male circumcision works: Scientific evidence clearly shows that male circumcision reduces the risk of HIV infection – providing partial protection against HIV for men. Studies show that male circumcision reduces the risk of HIV acquisition in men by about 60%.
2. Male Circumcision does not replace other HIV prevention methods: Whether circumcised or not, men are at risk of HIV infection during sexual intercourse. It is important that they limit their number of sexual partners, use condoms consistently and correctly and seek prompt treatment for sexually transmitted infections to further reduce their risk of infection.
3. Healing period: Newly circumcised males should abstain from sex for about six weeks to ensure the penis is fully healed as they could be at increased risk of infection during this time.
4. Potential harm to women: Male circumcision has no direct benefit for women and programmes need to establish ways of best conveying this information. Moreover, there is need for research around male circumcision in relation to violence against women, their ability to negotiate condom use, changes in the sexual behaviour, and increase in unwanted pregnancies. There is also potential for confusion with female circumcision (i.e. female genital mutilation) and stigmatization and blame in communities and families.

## MALE CIRCUMCISION AND HIV PREVENTION - continued

5. HIV counselling and testing: Ensure that all male circumcision services provide HIV testing and counselling as part of the recommended minimum package and that information and counselling on male circumcision are included in HIV testing and counselling services.
6. Pre and post male circumcision counselling: Ensure that male circumcision scale-up includes effective counselling so that the behaviour of circumcised men does not put women at greater risk of gender- based violence and HIV infection. This requires the development of clear counselling messages about complex issues, e.g. the partial effectiveness of male circumcision and the lack of direct HIV risk reduction for women.
7. Service integration: Establish integrated programmes with male circumcision as one component of the minimum package. Explore innovative models to promote male circumcision through key health services for women, e.g. family planning and maternal and child health services.

### ***Useful resources on male circumcision:***

The Clearinghouse on Male Circumcision for HIV Prevention is a collaborative effort to generate and share information resources with the international public health community, civil society groups, health policy makers, and Programme managers.

**[www.malecircumcision.org](http://www.malecircumcision.org)**

Communications Guidance: Male Circumcision & HIV Prevention in Eastern and Southern Africa.

**[http://www.malecircumcision.org/programmes/documents/mc\\_hiv\\_prevention\\_eastern\\_southern\\_africa\\_5\\_15\\_08.pdf](http://www.malecircumcision.org/programmes/documents/mc_hiv_prevention_eastern_southern_africa_5_15_08.pdf)**

## INFANT FEEDING

The perinatal HIV transmission rate in South Africa was found to be as high as 20% in 2007 and continues to remain high making an understanding of infant feeding in the context of HIV extremely important.<sup>27</sup>

A study in South Africa has confirmed earlier findings that exclusive breastfeeding results in a lower rate of postnatal HIV transmission compared to mixed feeding. This study, undertaken in a rural area in KwaZulu-Natal Province, found a cumulative postnatal HIV transmission risk of 4.04% after five months of exclusive breastfeeding. Infants who were fed both breast and formula milk at age twelve weeks were twice as likely as exclusively breastfed infants to be infected. Based on the research and findings of the study the authors recommended that exclusive breastfeeding for six months is recommended as the preferred infant feeding method for HIV positive women in the first 6 months until replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants.<sup>28</sup>

**More recently the World Health Organisation has released updated guidelines on infant feeding in the context of HIV. The WHO recommendations are as follows:<sup>29</sup>**

1. Ensuring mothers receive the care they need: Mothers known to be HIV-infected should be provided with lifelong antiretroviral therapy or antiretroviral prophylaxis interventions to reduce HIV transmission through breastfeeding according to WHO recommendations
2. Which breastfeeding practices and for how long: Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first 6 months of life while introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
3. When mothers decide to stop breastfeeding: Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped. Stopping breastfeeding abruptly is not advisable.

## INFANT FEEDING - continued

4. What to feed infants when mothers stop breastfeeding: When mothers known to be HIV-infected decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development. Alternatives to breastfeeding include:
  - a. For infants less than 6 months of age: - Commercial infant formula milk as long as home conditions outlined in #5 below are fulfilled, - Expressed, heat-treated breast milk (see #6 below),
  - b. For children over 6 months of age: - Commercial infant formula milk as long as home conditions outlined in #5 below are fulfilled, Page7 - Animal milk (boiled for infants under 12 months), as part of a diet providing adequate micronutrient intake. Meals, including milk-only feeds, other foods and combination of milk feeds and other foods, should be provided four or five times per day. All children need complementary foods from six months of age.
5. Conditions needed to safely formula feed: Mothers known to be HIV-infected should only give commercial infant formula milk as a replacement feed to their HIV uninfected infants or infants who are of unknown HIV status, when specific conditions are met. There they need to be given continuous guidance and support when ceasing breastfeeding.
6. Heat-treated, expressed breast milk: Mothers known to be HIV-infected may consider expressing and heat-treating breast milk as an interim feeding strategy:
  - In special circumstances such as when the infant is born with low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; or
  - When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; or
  - To assist mothers stop breastfeeding; or
  - If antiretroviral drugs are temporarily not available.
7. When the infant is HIV-infected: If infants and young children are known to be HIV-infected, then mothers are strongly encouraged to exclusively breastfeed for the first 6 months of life and continue breastfeeding as per the recommendations for the general population that is up to two years or beyond.

### ***Useful resources on Infant Feeding:***

The 2010 Department of Health Guidelines on Prevention of Mother to Child Transmission which have taken into account the new WHO guidelines can be downloaded from <http://www.crc-sa.co.za/site/files/6592/2010%20PMTCT%20Guidelines.pdf>

The Yezingane Network's (The Children's Sector HIV/AIDS National Network) 2010 PMTCT brief is available at [http://www.crc-sa.co.za/site/files/6592/PMTCT\\_Brief\\_June\\_2010\\_FINAL.pdf](http://www.crc-sa.co.za/site/files/6592/PMTCT_Brief_June_2010_FINAL.pdf)

Summary of current WHO Infant feeding guidelines:  
<http://www.unicef.org/Programme/breastfeeding/feeding.htm>

## THE FEMALE CONDOM

The Female Condom (FC) has been the subject of extensive research, both in clinical settings and in “real life” projects and South Africa is among the largest distribution sites for FCs. The SA Female Condom Programme was introduced into SA in 1998 and is hosted in the STI and HIV Prevention sub directive of the NDoH. Although FCs are available at 249 sites, provinces have been advised to plan further expansion efforts to ensure at least one site per sub district and to include FC training in the services that they offer, as well as including this in their respective budgets.

In 2005 the makers of the FC female condom announced a new product called FC2. This has the same design as the original version but is made of nitrile, which makes it cheaper to produce. These condoms were said to have been distributed in South Africa by the Female Health Company during the World Cup in 2010. The benefits of expanding FC use could be very great. A study in 2006 found that countrywide distribution (equivalent to 10% of condom sales) of the FC2 female condom in Brazil and South Africa would be “useful and cost-effective” for preventing HIV.

However, even though the FC is becoming an option of choice, in some societies women have few rights within sexual relationships and have little or no say in their own protection. Often men make the majority of decisions, such as whom they will marry and whether the man will have more than one sexual partner. This power imbalance means that it can be more difficult for women to protect themselves from getting infected with HIV.

Having said this, during the 4th South African AIDS Conference a range of acceptability studies in many countries and in many different social and economic settings were presented that show the FC is acceptable to a considerable number of men and women.

### **Results indicated that the benefits offered were as follows:**

- Opportunity for women to share the responsibility for the condoms with their partners
- That a woman may be able to use the female condom if her partner refuses to use the male condom
- That the FC will protect against most STDs and pregnancy if used correctly
- That the FC or FC2 female condom can be inserted up to 8 hours before intercourse so as not to interfere with the moment
- That the FC and FC2 female condoms are made of polyurethane and nitrile, which are less likely to cause an allergic reaction than latex. These materials can be used with oil-based as well as water-based lubricants.

### **Key messages and areas for implementation**

1. NGOs are key to introducing the female condom to communities and have an active role to play in a number of ways, including advocacy, building community support, ensuring local participation and actually developing and delivering prevention messages and even the product itself.
2. Where DoH sites are providing FCs, NGOs and especially women's organisations should strategically plan in advocating for the scale up of FC programmes and for addressing broader cultural and political issues around FCs.
3. To ensure a successful introduction of the FC, it is important that NGOs first discuss any newly developed programmes with a wide range of groups, including decision makers, programmes managers, service providers, community leaders and women and youth groups. These groups should be involved in all planning and implementation stages of FC programmes. All programmes should consider and respect the users' values, attitudes and needs while taking into account the imbalance of women's rights in the choice of condom use.
4. An essential strategy for NGOs to consider is how to integrate the female condom into existing reproductive health programmes. Different strategies and approaches should be considered to integrate the FC for both family planning and prevention programmes.
5. The following list includes examples of projects where the female condom can be integrated:
  - Community based distribution of contraceptives
  - STI clinic services
  - Family planning clinic services
  - HIV/AIDS/STI prevention programmes with vulnerable populations
  - Adolescent and reproductive health programmes
  - Social marketing
  - Work-place initiatives
  - Peer education programmes
  - Male motivation programmes
6. Wider use of the FC (and eventually the FC2) depends on the commitment of the government and key stakeholders including major donors. To achieve its full potential, much greater efforts are needed from communities and advocacy groups to promote the FC and to make it more accessible, affordable and acceptable.

## THE FEMALE CONDOM - continued

### ***Useful resources on the Female Condom***

The Barrier Methods & Contraception Programme supports and strengthens the reproductive health services through research, training, policy development, development of information and education materials, networking and provision of technical assistance on contraception and barrier methods in the KwaZulu-Natal region, within South Africa and internationally.

[www.rhru.co.za/programmes/barriermethodscontraception](http://www.rhru.co.za/programmes/barriermethodscontraception)

"The Female Condom: A guide for planning & programming"

[http://whqlibdoc.who.int/hq/2000/WHO\\_RHR\\_00.8.pdf](http://whqlibdoc.who.int/hq/2000/WHO_RHR_00.8.pdf)

## HIV COUNSELLING AND TESTING

The policy announcements on World AIDS Day 2009 marked a turning point for HIV/AIDS policies in South Africa with regards to ART initiation especially among pregnant women, children and those co-infected with HIV and TB. These changes were coupled with a massive nationwide HIV Testing and Counselling Campaign which aims to test 15 million sexually active individuals by June 2011. However, the key focus of this campaign is to affect positive behaviour change among individuals and communities.

### *The HCT Campaign seeks to achieve the following broad objectives:*

- To mobilise people to know their status;
- To support people with key prevention messaging in order to encourage them to take proactive steps towards a healthy lifestyle - irrespective of HIV status;
- To increase the incidence of health seeking behaviour;
- To increase access to treatment, care and support services.

### *The HCT Campaign is part of the government's new measures in the fight against HIV and AIDS and constitutes a package of interventions which include the following:*

- All children under one year of age will now receive antiretroviral treatment (ART) if they are HIV positive, irrespective of CD4 count;
- All patients co-infected with TB and HIV will receive ART if their CD4 count is 350 or less (as opposed to the previous cut-off point of 200);
- All pregnant HIV positive women with a CD4 count of 350 or less (or with symptoms of HIV disease irrespective of CD4 count) will receive ART. All other HIV positive pregnant women with CD4 counts above 350 will be put on treatment at 14 weeks of pregnancy to help prevent mother-to-child transmission of HIV; and
- All health institutions in the country should be able to provide HCT and ART.

## HIV COUNSELLING AND TESTING - continued

### **Key messages and areas for implementation:**

1. The messaging for the campaign revolves around the theme: "I am responsible. We are responsible. South Africa is taking responsibility" This theme emphasises both individual and collective responsibility South Africans need to take towards stopping new HIV infections and providing treatment, care and support to those living with HIV. (See the campaign Key Messaging Booklet among other resources listed below.)
2. Community organisations have a key role to play in this campaign specifically with regards to building awareness and mobilizing communities to "Know Your Status." Organisations can:
  - Raise community awareness and engagement with the campaign by distributing HCT material which is available at the Department of Health offices around the country through door to door campaigns, electronic distribution, distribution at places of service and workplaces etc.
  - Mobilize communities to test and refer people to testing facilities. Testing sites in the area can be found by SMSing HIV and your postcode to 31771 or on <http://compass.mapservice.co.za>
  - Support monitoring, evaluation and reporting by reporting their HCT related activities to districts.
  - Organisations can support districts and provinces in HCT activities by participating in the local nerve centres, which are being set up in provincially and at the district level to coordinate this campaign.

### **Useful resources on HCT Campaign:**

Access HCT sites in your area at  
<http://compass.mapservice.co.za/>

Basic information on the Campaign and other related information can be found at  
<http://www.sanac.org.za/HIV-counselling-and-testing>

The HCT Campaign 'Frequently Asked Questions', Key Messaging Booklet, and nerve centre contact information can be found on  
<http://www.hiv911.org.za/0860-HIV-911/hiv-911/hiv-911>

## LONG TERM EFFECTS OF ART

Antiretroviral Therapy (ART) was initiated in the public sector in 2004. There are now currently approximately 900,000 people living with HIV on treatment. In the next 2 - 3 years, the government proposes to initiate treatment for another 1.2 million people and the country is bracing itself for this scale up by raising the CD4 thresholds for access to treatment and scrapping the antiretroviral site accreditation process, as well as introducing nurse initiation and management of patients on ART (NIM-ART). The effects of these policy changes, especially NIM-ART need further examination.

The majority of PLWHA are still on first line regimens and have positive immunologic and virologic outcomes, although it is felt that the absolute number of PLHIV failing first line will increase with overall patient numbers. Studies have indicated that treatment failure is not only a problem of adherence but also poor absorption, wrong dosage, host genetics and drug interaction. Structured counselling programmes on adherence may help people with HIV adhere to their antiretroviral regimens. However, programmes should be designed to ensure monitoring of adherence over the long term.

For patients with access to ARV therapy, HIV and AIDS have the potential to become a manageable, chronic disease. However, there are many prices to pay for this, including a lifetime need for complex medical regimens associated with acute toxicities. In the last few years, we have learned that there are chronic complications of both ARV therapy and prolonged survival with HIV infection.

### ***Key messages and areas for implementation:***

1. NGOs should develop a greater understanding of patient's emotional needs around long term use of ARVs and should be prepared to intervene with psycho-social support programmes. Adherence programmes should include education on adverse drug interactions. Adherence and support programmes should include information on:
  - Preparing to start treatment
  - Dealing with side effects
  - Variation in side effects
  - Duration of side effects
2. NGOs should ensure that all information on ARV treatments is user friendly and in a language that clients understand. Moreover, updated treatment guidelines should be made available and that NGO and community workers should have access to these guidelines.

## LONG TERM EFFECTS OF ART - continued

3. A recent study in Johannesburg has found that there is a relatively high early mortality rate and high loss to follow up in the first months of treatment. The authors suggest the need to strengthen strategies that promote early HIV diagnosis, early access to care, and rapid initiation of highly active ART (HAART) in the very ill patients.<sup>30</sup> There is also a crucial need to develop a wellness support package for those who test HIV+ but do not need ART immediately.
4. The role of families and other social support systems in ensuring treatment adherence should be assessed. Safe sex and drug use practices, adherence to medication and beliefs about viral load reduction and infectivity need to be understood within an individual's support system.

### ***Useful resources on ART:***

The new South African ART Guidelines as well as other resources on ART can be found on the SANAC website at

**<http://www.sanac.org.za/resources>**

SA HIV Clinicians Society: The Society represents a powerful and independent voice within Southern Africa, with key representation from the most experienced and respected professionals working in the fight against HIV.

**[www.sahivsoc.org](http://www.sahivsoc.org)**

Article from CME - Continuing Medical Education journal:

**[www.cmej.org.za/index.php/cmej/article/view/654/450](http://www.cmej.org.za/index.php/cmej/article/view/654/450)**

Southern Africa HIV and AIDS Information Dissemination Service ([www.safaids.net](http://www.safaids.net)).

See specifically:

**[www.safaids.net/files/LEM2.pdf](http://www.safaids.net/files/LEM2.pdf)**

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## **ADDITIONAL RESOURCES** (South African HIV/AIDS and TB Organisations):

### **AIDS Consortium**, Johannesburg

**T** 011 403 0265 **E** info@aidsconsortium.org.za

**W** www.aidsconsortium.org.za

### **The AIDS Foundation of South Africa**, Durban

**T** 031 277 2700 **E** info@aids.org.za **W** www.aids.org.za

### **ARK** (Absolute Return for Kids)

**T** 031 701 9992 **E** admin@arkonline.org

### **CABSA-CARIS** (Christian AIDS Resource and Information Service)

**T** 011 796-6830 **E** info@cabsa.co.za **W** www.cabsa.org.za

### **Children in Distress Network** (CINDI)

**T** 033 345 7994 **E** info@cindi.org.za **W** www.cindi.org.za

### **Child Rights Centre** (and the Yezingane Network)

**T** 031 307 6075

**W** http://www.childrightscentre.co.za/

### **Dance for Life**

**T** 031 202 0555 **E** mvanbe@sa-dance4life.org.za

**W** www.dance4lifesa.org.za

### **HIV-911**

**T** 086- HIV (448) - 911 **W** www.hiv911.org.za

From mobile: \*120\* 448#

### **Lifeline Southern Africa**

**T** 011 715 2000 **W** www.lifeline.co.za

### **loveLife**

**T** 011- 523-1000 **W** www.lovelife.org.za

Youth line: 0800 121 900

Parent line: 0800 121 100

### **Medical Research Council**

**T** 021 938-0911 **E** info@mrc.ac.za **W** www.mrc.ac.za

### **NACOSA** (The Networking HIV/AIDS Community of South Africa)

**T** 021 552 0804 **E** info@nacosa.org.za

**W** http://www.nacosa.org.za

### **NAPWA SA** (National Association of People Living with HIV and AIDS)

**T** 011 872 0975 **E** info@napwa.co.za **W** www.napwa.co.za

### **Red Cross Hospital** (The Children's Hospital Trust)

**T** 021 686 7860 **E** cht@chtrust.org.za

**W** www.childrenshospitaltrust.org.za

### **RHRU** (Reproductive Health & Research Unit)

**T** 011 358 5800 **E** info@rhru.org **W** www.rhru.co.za

### **SAHARA** (Social Aspects of HIV/AIDS Research Alliance)

**W** www.sahara.org.za

### **SANGONET and NGO Pulse**

**W** www.ngopulse.org

### **Soul City**

**T** 011 341 0360 **E** soulcity@soulcity.org.za

**W** www.soulcity.org.za

### **The Southern African HIV Clinicians Society**

**T** 011 341 0162 **W** www.sahivsoc.org

### **TB and HIV Care Association**

**T** 021 425 0050 **E** info@tbhivcare.org

**W** http://www.tbhivcare.org

### **Treatment Action Campaign**

**T** 021 422 1700 **E** info@tac.org.za **W** www.tac.org.za

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