



HIV AIDS NETWORK BULLETIN

International Council of Nurses • Conseil international des infirmières • Consejo internacional de enfermeras

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Meeting of the ICN HIV/AIDS Network at the ICN Congress, Durban, South Africa, 27 June to 4 July 2009

The ICN HIV/AIDS Network met during the ICN 24th Quadrennial Congress in Durban, South Africa, 27 June to 4 July 2009. This is the third meeting of the Network since its launch in 2005. About 300 participants with diverse HIV and AIDS expertise and interests attended the meeting. The session was chaired by Adele Webb, Association of Nurses in AIDS Care, USA.

Following an overview of the ICN HIV/AIDS Network's aim, scope and membership by ICN, there were brief presentations and discussions on the following areas:

- HIV transmission and prevention strategies in Mauritius: Carmen Anazor, AIDS Unit, Ministry of Health and Quality of Life, Mauritius.
- Regional networking activities and experiences of SANNAM: Philemon Ngomu, SANNAM, South Africa.
- UK National HIV Nurses Association activities and experiences: Catrin Evans, University of Nottingham, School of Nursing, Midwifery and Physiotherapy, Nottingham, UK.
- Coordinating workplace HIV services in Southern Africa: Nelouise Geyer, Public Services International, South Africa
- ICAP Nurse Capacity Initiative: A New Approach to Meeting Nursing

Challenges in the Era of HIV:
Jennifer Dohrn, Columbia University, School of Nursing, USA

The presentations were followed by open discussions addressing the following questions:

- How can the ICN HIV/AIDS Network add value to the work of nurses in AIDS care?
- What are the HIV/AIDS issues and priorities in your country and what should ICN be advocating at the international level?
- How could we stimulate involvement of Network members (e.g. Network Bulletin, website chat page)?

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The participants highlighted the importance of networking and exchanging of information and best practices to promote excellence in clinical practice, management, education and research related to HIV and AIDS. The ICN HIV/AIDS Network was seen as a sustainable forum for regular exchange of current knowledge, experiences and best practices.

Global economic crisis and HIV

A joint World Bank/UNAIDS report looked at the potential impact of the global financial crisis on HIV prevention and treatment programmes worldwide. Using data collected in March 2009 from 71 countries, the analysis looked at how the crisis could affect the 3.4 million people living with HIV on treatment, and the 7 million who need treatment but don't have access to it. The potential effects on prevention activities were also investigated.

At present, 3.4 million people are on antiretroviral treatment in the countries surveyed. Many more, however, would benefit if treatment were made available to them. However, if there are interruptions in taking the drugs, for example because of cutbacks in funding for AIDS treatment programmes, HIV replication is no longer suppressed and life-threatening conditions will develop, drug resistance will increase and there will be an increased potential for HIV transmission.

The report describes how respondents in 11% of the countries surveyed (home to 427, 000 people on treatment) reported that the global crisis had already affected treatment programmes in their countries. Respondents in 31% of countries, with 1.8 million people on treatment, reported that they expect impacts on treatment this year, while 30% of countries were unsure if treatment would be affected. Programmes were found to be especially vulnerable in sub-Saharan Africa, eastern and central Europe and the Caribbean. (Adapted from UNAIDS 2nd Newsletter 09).

High Risk Express Care reduces mortality, improves retention in Kenya

Nurse-based rapid assessment clinics in Western Kenya may improve survival and clinical retention of very sick patients beginning combination antiretroviral therapy (ART). High Risk Express Care (HREC) began as a pilot project in March 2007 in four high-volume clinics. Reducing mortality and loss to follow up in HIV-infected adults with CD4 counts below 100 cells/mm³ when beginning ART, as well as increasing clinic capacity without additional costs, were the primary goals. By June 2008 the project had been rolled out to 18 clinics.

Routine care for patients beginning ART involves a clinical officer seeing the patient at every visit and prescribing ART. Monthly visits are scheduled unless clinical indications determine otherwise. High Risk Express Care for patients beginning ART involves a clinical officer seeing the patient and prescribing ART. The patient is then referred to Express Care (EC) upon ART initiation. The clinical officer will see the patient on a monthly basis. In the interim weeks over a period of three months a nurse will either see the patient in the clinic or talk to them over the phone. Vital signs are taken and a rapid symptom assessment is done each time, with immediate referral to a clinical officer if symptoms call for it.

To assess the comparative impact of High Risk Express Care and routine care on clinical outcomes a retrospective observational study was undertaken. Criteria for inclusion included: beginning ART, having a CD4 count below 100 cells/mm³ and being 14 years of age and over. Endpoints were mortality and loss to follow up defined as absence from the clinic for at least three months without evidence of patient death.

Over a period of 10.5 months, 2,601 patients with a CD4 count below 100 began ART. A total of 14 out of the 28 clinics had begun HREC with a corresponding total of

378 (14.5%) eligible patients enrolled. Median cell count at initiation for the routine care group was 44, compared with 47 in the HREC group. The probability of remaining alive after 300 days was 95% for those in Express Care and 91% for those in routine care. The probability of remaining alive and in care after 300 days was 86% for those in Express Care and 75% for those in routine care. In both cases the results were statistically significant. The authors noted that High Risk Express Care appears to improve clinical retention and reduces mortality. (Source: Braitstein P et al. *High Risk Express Care: a novel care model to reduce early mortality among high risk HIV-infected patients initiating combination antiretroviral treatment*. HIV Implementers' Meeting, Namibia, abstract 1556, June 2009).

Africa: fewer lab tests could save more lives

Antiretroviral (ARV) treatment can be delivered safely and effectively in remote or resource-limited settings where regular laboratory monitoring cannot be carried out, according to findings from a study presented at the 5th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, in Cape Town in July 2009. The Development of Anti-Retroviral Therapy in Africa (DART) clinical trial, conducted in Uganda and Zimbabwe by the UK's Medical Research Council, with funding from the UK Department for International Development and the Rockefeller Foundation, aimed to find out whether laboratory monitoring resulted in significantly better outcomes for patients receiving ARV treatment in low-income countries.

The trial recruited 3,316 patients ready to begin ARV treatment and randomly divided them into two groups. The first group were given a CD4 count and drug toxicity tests every three months after starting treatment; the second group had the same tests but the results were only shared with their doctors if they showed a serious abnormality. Otherwise, their doctors relied only on clinical monitoring.

After five years, 90% of the first group were still alive, compared to 87% in the second group; 22% of the first group had developed a new AIDS-related illness, compared to 28% in the second group. There was no difference in drug-related side effects, and other differences between the groups did not emerge until the third year of treatment, leading the researchers to conclude that clinical monitoring alone is sufficient for patients in their first two years of treatment.

The findings have important implications for countries where the number of people started on ARVs has been limited, not only by the cost of drugs but by the cost of laboratory monitoring and the distance patients have to travel to clinics offering these services. A cost analysis of the data concluded that one-third more people could be successfully treated for HIV in Africa if expensive laboratory tests were not used routinely.

However, the DART study results conflict with a recent study in western Kenya which found that more, not less, laboratory monitoring was needed to prevent patients from being switched to more expensive second-line ARV regimens unnecessarily. While the studies seem to show conflicting results, the study in Kenya is based on a sample size of 149 patients compared to 3,316 in the studies conducted in Uganda and Zimbabwe (Source: PlusNews: www.plusnews.org/report.aspx?ReportID=85455)

Profile: Southern African Network of Nurses and Midwives

The Southern African Network of Nurses and Midwives (SANNAM) is a network of national nurses associations (NNAs) that was created in 2000 following the 13th International AIDS conference in Durban, South Africa. The organisation has a membership of 15 NNAs almost all of which are also ICN members. SANNAM is a regional structure based in South Africa.

SANNAM's vision is to improve national health services and social policies related to HIV/AIDS and other critical health

challenges in the Southern African region and it is especially committed to the promotion of "caring for the carers to care". It works for the expansion of the professional nursing response to HIV/AIDS and other critical health care challenges through networking, partnerships and capacity building.

SANNAM's strategic goal for 2009 -2012 focused on improving the quality of health care services through a comprehensive response to HIV/AIDS and other critical health care challenges in the region within the context of the Millennium Development Goals (MDGs).

SANNAM works closely with the Canadian International Development Agency (CIDA) through the Canadian Nurses Association (CNA), Norwegian Nurses Organisation (NNO), Catholic Organisation for Relief and Development Aid (Cordaid), International Council of Nurses (ICN), SADC Secretariat, Health Sector and HIV/AIDS Unit; Equity for Health in East and Southern Africa (Equinet); and the University of California San-Francisco International Nursing Network for HIV/AIDS Research. (Submitted by Philemon Ngomu, SANNAM Secretariat, South Africa)

TB Anywhere is TB Everywhere: The need for integration

There has been a harmonisation process of TB/HIV indicators among the WHO Stop TB and HIV Departments, UNAIDS, PEPFAR and the Global Fund. The question arises, is this adequate? We speak of two diseases, but the individual co-infected with TB and HIV may have care requirements beyond the two diseases such as pregnancy, chronic diseases, vaccination of family members, etc.

In areas of high HIV prevalence (>3% of the general population), innovative ways of integrating TB and HIV prevention, diagnosis, care, and treatment into primary care services is essential if Millennium

Development Goals 4 - 6 are to be reached, specifically the health indicators of reducing under-five and infant mortality rates and halting the prevalence and death rates associated with tuberculosis.

TB is the leading cause of mortality in HIV positive individuals. In Kenya, 7% of the adult population has HIV, and more than 50% of clients with TB are co-infected with HIV. Jhpiego and collaborating partners are doing their part to halt and begin to reverse the incidence of tuberculosis in a 'non-traditional' TB setting while contributing to the target of reducing maternal mortality ratio by integrating HIV and TB screening, diagnosis and referral into antenatal care. With funding from the United States Agency for International Development (USAID), support was provided to the Ministry of Health to revise the Focused Antenatal Care (FANC) curriculum, targeted largely at nurses and midwives as service providers, to include TB screening, diagnosis, treatment and referral. It is possible to integrate TB into ANC services through proper training of providers, strong recording and reporting systems, and adequate referral mechanisms. (Submitted by Stacie C. Stender, [sstender@jhpiego.net](mailto:ssstender@jhpiego.net))

A Call for Participation

The ICN HIV/AIDS Network Bulletin relies on its membership to serve its purpose of being a "market place" for the exchange of HIV and AIDS issues, trends and experiences. Please send information on HIV and AIDS prevention, care and treatment issues, policies and activities in your country or place of work and other information that would be of interest to others worldwide. Submissions will be included in the next issue of the HIV/AIDS Network Bulletin. Please send to tesfa@icn.ch.

For further information, please contact: icn@icn.ch

The **International Council of Nurses (ICN)** is a federation of more than 130 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally.

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