Blazing carrots/cracking whips – the HIV prevention answer?

Whether the 'carrot' HIV (and drug/alcohol) testing lottery initiatives and 'take personal responsibility or else' stick approach of Western Cape Premier Helen Zille prove sustainable or not, she has single-handedly moved the locus of the HIV prevention debate – and re-ignited it.

Wading into the contested fields of behavioural economics and 'choice architecture' to shore up and supplement existing 'get tested' campaigns, she seems to have covered her bases on the medico-legal and counselling fronts – where many of her traditional critics launched attacks. Decreasing expenditure on preventable diseases is a national goal. Dangling 'carrots' (albeit in front of mostly hungry people) while cracking the legal whip at those HIV-positive folk who claim it as their right to have sex with multiple concurrent partners (often across generations) without condoms or revealing their status both beg debate around the contextual question 'Where's the harm?'

Zille's tactics touch deep psychic wounds in a society still sharply divided by income and race. Proponents could even argue that the pandemic is begging us to get over ourselves, but is that too simplistic? Izindaba's Chris Bateman reports on arguments for and against the initiatives and cites local and foreign examples of where campaigns with incentives have succeeded.[1]

HIV management by nurse prescribers compared with doctors

In these days of increased antitretroviral access and cover it is essential that the roles of prescribing and managing those living with HIV be spread between nursing staff and doctors. Gadzikanani Monyatsi and colleagues compare compliance with national paediatric HIV treatment guidelines between nurse practitioners and doctors at a paediatric referral centre in Gabarone, Botswana.[2] They conducted a cross-sectional study at the Botswana-Baylor Children's Clinical Centre of Excellence using stratified random sampling of 100 physician and 97 nurse practitioner encounters and retrospectively reviewed the successful documentation of pill count charted, chief complaint listed, social history updated, disclosure reviewed, physical exam, laboratory testing, WHO staging and paediatric dosing. There was little difference in correct documentation between the two groups – nurse prescribers correctly documented 96.0% of the time compared with 94.9% for the physicians. These findings support continued investment in programmes that employ properly trained nurses throughout southern Africa who are able to provide high-quality care and follow-up of antiretroviral therapy to children who are stable on therapy. This is particularly important in areas where the numbers of doctors are limited.

Hypertension in goldminers

The link between hypertension and cardiovascular disease is well known, and information about the prevalence of the condition in different geographical regions is essential for prevention and optimal control. However, there is a dearth of information about the prevalence, impact, treatment and control of hypertension among urbanised black African men. Maepe and Outhoff conducted a retrospective, descriptive 1-year hypertension prevalance study among miners in Gauteng Harmony Mine Operations in South Africa.[3] Patient profiles and blood pressure measurements were taken from company electronic records, including those from the various health facilties that serve the mining population. They found that 39.5% of the 4 297 subjects examined in the study (100% of the mining population in the study period) had hypertension and that 42% of these patients were being treated. Of these, only 31% were adequately controlled (BP <140/90 mmHg). The relatively low numbers being treated and the even lower numbers reaching their target blood pressure suggest that detection, treatment and adequate control of hypertension should receive high priority from the mining authorities.

Treating crush syndrome in the rural setting

Poor policing and overloaded courts in KwaZulu-Natal have led to vigilante justice – local community protection groups beat those suspected of criminal behaviour. The intention is not to kill, but to warn potential perpetrators. However, these beatings are often severe and lead to traumatic rhabdomyolysis (crush syndrome), and patients commonly present to rural emergency departments that have limited access to dialysis services. Rosedale and Wood describe a retrospective study of patients admitted with a diagnosis of crush syndrome to the emergency department of a government hospital in rural KwaZulu-Natal between November 2008 and June 2009.[4] They looked specifically at early adverse parameters used to identify poor prognosis, the importance of early recognition, and appropriate management with aggressive fluid therapy and alkaline diuresis to prevent progression to renal failure. All the 44 patients included in the study presented within 24 hours of injury: 27 had been assaulted with sjamboks or sticks, 43 were discharged to the ward with normal or improving renal function, and 1 patient died. The conclusions were that serum potassium, creatinine and creatine kinase levels are important early parameters for assessing the severity of crush syndrome.

Provision and need of HIV/AIDS services in a municipal area

Gerritsen, Mitchell and White[5] looked at the need for HIV/AIDS service provision in the City of Tshwane Metropolitan Municipality (CTMM) using the questionnaire developed in the Foundation for Professional Development's Compass Project. The data were collected during May - June 2010 from organisations providing HIV/AIDS services in the CTMM. The authors estimated the need for HIV counselling and testing, antiretroviral treatment, prevention of mother-to-child transmission and care for orphans and vulnerable children using data from various sources. They included 447 service providers. The majority of the prevention (70.2%) and support-related services (77.4%) were provided by NGOs, while most treatment-related services originated from the public sector (57.3%). The conclusions were that service gaps remained in the provision of HIV counselling and testing, PMTCT provision and the care of orphaned and vulnerable children. The provision of antiretrovirals also needs to be increased in line with the new treatment guidelines from the Department of Health.

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3. Maepe LM, Outhoff K. Hypertension in goldminers. S Afr Med J 2012;102:30-33.
4. Rosedale KJ, Wood D. Traumatic rhabdomyolysis (crush syndrome) in the rural setting. S Afr Med J 2012;102:37-34.
5. Gerritsen AAM, Mitchell JS, White B. Provision and need of HIV/AIDS services in the City of Tshwane Metropolitan Municipality, 2010. S Afr Med J 2012;102:44-46.