‘Turning the Tide Together’
Annie Parsons, Christina Zarowsky

Every other year in July, the international HIV and AIDS research community, HIV and health activists, politicians and the media converge in a major global event, the IAS AIDS Conference.

This year, AIDS 2012 was held in Washington DC from 22-27 July 2012.

The conference’s theme was ‘Turning the Tide Together’ and it issued a nine-point declaration to ‘End the AIDS Epidemic’:

- increase targeted new investments;
- ensure evidence-based HIV prevention, treatment and care;
- end stigma, discrimination and legal sanctions;
- markedly increase HIV testing, counselling and linkages to prevention, care and support services;
- provide treatment for all pregnant and nursing women;
- expand antiretroviral treatment to all in need;
- identify, diagnose and treat TB;
- accelerate research; and
- ensure mobilization and meaningful involvement of affected communities (http://www.2endaids.org).

Much of the work supported by SoPH and the HIV Centre speaks to these issues; several recent papers and HIV in Context seminars address the nine points, along with our posters and presentations at AIDS 2012. The conference was also a great opportunity for SoPH staff and students to network with other institutions and colleagues, including Professor Marleen Temmerman, who received an honorary doctorate from UWC in March 2012 and has been appointed as the new Director of the WHO’s Special Programme for Research and Training in Reproductive Health (HRP). See also: http://www.who.int/reproductivehealth/news/appointment/en/index.html

Congratulations to Prof Dr Marleen Temmerman for this important appointment.

The US hasn’t successfully hosted a large HIV conference since 1989: though the US is an important global partner in addressing HIV and AIDS, its travel ban on people living with HIV and AIDS was only lifted in 2010. However, the US still does not give visas to people who openly identify as sex workers or drug users and this meant the conference was not as inclusive as in other years; it was pointed out that excluding groups known as highly at risk of HIV infection from discussions decreases the depth of discussions. (An alternative parallel conference was held for sex workers in...
Kolkata, India to protest against their exclusion by the US and with its own agenda for ending the AIDS epidemic. Several sessions focused on “key populations” including sex workers, people who inject drugs, men who have sex with men, migrants, and detained populations. HIV Research Centre Director Prof Christina Zarowsky sought out discussions of inequality and vulnerability, particularly the few sessions on migration, health, and HIV, in line with the Centre’s emerging programme of “HIV and AIDS Research in Complex Contexts of Inequality” (HARICCI).

Overall, however, there was a lot of good news around the conference. While Africa and Africans were underrepresented, South Africa’s efforts and success were visible and lauded. SoPH’s own Professor Debra Jackson was a co-PI in some of this important work – evaluating the impact of PMTCT on reducing HIV transmission to newborns in South Africa and finding a dramatic decrease of transmission from 8% to only 3.5% (the report is available at www.doh.gov.za/docs/reports/2012/pmtcteffectiveness.pdf). Supported by a CDC grant managed by the HIV Centre and SoPH, Tulio d’ Olivieria and the SATuRN researchers presented at AIDS 2012 on their work tracking antiretroviral resistance in rural South Africa (http://pag.aids2012.org/session.aspx?s=262). Simukai Shamu presented two posters on gender based violence (see Simukai’s report below) – and along with Naema Abrahams, Tammy Shefer, Marleen Temmerman and Christina Zarowsky, he has a PLoS ONE paper in press titled: “That pregnancy can bring noise into the family”: Exploring intimate partner sexual violence during pregnancy in the context of HIV in Zimbabwe”.

On the hard science front, researchers are optimistic enough that for the first time in decades there was talk of finding a cure for HIV. Globally reported was the case of Timothy Brown, a person infected with HIV whose immune system was destroyed by leukaemia. His bone marrow transplants were from a person who was naturally resistant to HIV: five years later there remains no trace of HIV in Timothy’s body, using current medical tools. Two other patients have undergone a similar procedure and are also keeping the virus at bay – so far. Though transplants are impractical on the scale needed to reach every person living with HIV in the world, and we do not know if in the long term these patients will show signs of HIV infection again, the concept shows that curing HIV infection is probably possible.

But how can we implement such ideas when it’s unclear where future monies will come from, even for existing best practices in preventing HIV and treating AIDS? The conference’s nine points all depend on funding. There was a lot of talk about money at the conference, especially given the recent re-structuring of the Global Fund for AIDS, TB and Malaria. On the positive side, countries are increasingly funding their own treatment programmes and are less reliant on global funders, but there remains the need to address continued HIV infection rates and ensure health systems can manage the additional burdens brought by HIV and AIDS. The role of country leadership was highlighted, along with issues such as incorporating HIV into broader health systems and addressing long-term concerns around chronic conditions and aging in people receiving ART.

Recent work by SoPH and the HIV Research Centre remains at the cutting edge of such HIV-related research. In recent Bulletins we’ve highlighted the contributions of SoPH to the overall field of Health Policy and Systems Research, including important work on Community Health Workers (CHWs) which was catalysed by the need to address HIV and AIDS but is now mainstreamed across the health system. On the TB/HIV Integration front, Jeanine Uwimana, Christina Zarowsky, Harry Hausler and Debra Jackson recently published a paper in BMC Health Services Research on: “Engagement of non-government organisations and community care workers in collaborative TB/HIV activities including prevention of mother to child transmission in South Africa: Opportunities and challenges” (2012, 12:233). The two most recent HIV Centre HIV in Context seminars featured emerging practitioner-scholars and looked at “Perceptions of HIV and AIDS – Related Stigma among Employees in the Parliament of the Republic of South Africa” (Mr Buyile Bashe, Manager of the Wellness Programme in and SoPH MPH student) and “Human Resources, Health and HIV: Do districts know who’s doing what, and where?” (Ms Verona Mathews, SoPH staff). These topics illustrate the wealth and relevance of information and experience centred within SoPH. (Keep your eyes peeled for the next regular HIV in Context seminar announcements.) SoPH and the HIV Centre’s work are vital pieces of the puzzle in ensuring health systems
work in helping people live with HIV and AIDS. Get your work together and get ready to showcase it to the world!

For more on AIDS 2012, go to http://www.aids2012.org. The Kaiser Family Foundation at http://globalhealth.kff.org/aids2012/ has webcasts of many sessions. There are tabs for each day. Clicking on the session link will show you an outline of who spoke on what, with sessions also linking to the powerpoint presentations (you can access these by clicking on the link to the ‘Programme-at-a-Glance’ on each session page).

Each day was summarised by the official newsletter of AIDS2012, which you can download as PDFs from the AIDS2012 home page (http://www.aids2012.org/). Go to the Daily Bulletin and click on the picture.

There’s also a selection of blogs. The official AIDS2012 blog (http://blog.aids2012.org/); the University of California San Francisco’s blog (http://aids2012.ucsf.edu/) and for a US blog with a more activist perspective, The Body’s blog is at http://www.thebody.com/content/46169/hiv-aids-blog-central.html.

The IAS AIDS Conference 2012: Focus on Gender, Violence and HIV
Simukai Shamu

I presented two posters at the IAS AIDS Conference on 25 July on “Seropositivity: social identity, disclosure and vulnerability”: Harmony or Harm? Unpacking the effects of HIV testing and disclosure during pregnancy on intimate partnerships in Zimbabwe, and Intimate Partner Violence and HIV testing and disclosure in Zimbabwe.

The two posters, part of my ongoing PhD work as a VLIR Scholar with the HIV Research Centre at SOPH, were co-authored with my PhD supervisors, Christina Zarowsky, Marleen Temmerman and Naeemah Abrahams. They focused on intimate partner violence against women who test for and disclose HIV status to partners in Zimbabwe (see inserts). With the feedback that I received from the conference participants I am now writing a manuscript for publication that combines findings from both posters. The session also offered me an opportunity to network with established researchers including those from Zimbabwe who are keen on having this work presented in Zimbabwe at the Annual Medical Research Day in Harare in October 2012.

I attended a number of sessions on the intersections of gender, gender based violence and HIV infection during the conference where HIV, child abuse and partner violence prevention issues were discussed as a priority social determinant of HIV in many African countries. Other sessions that I attended include those that addressed the relationship between HIV and use of hormonal and injectable contraceptives; HIV and AIDS financing; HIV burden and human resources.

Attending this conference also enabled me to meet with Prof Marleen Temmerman, our
UWC SOPH partner from Ghent University and my PhD co-supervisor. We found time to discuss my PhD progress including finishing the remaining paper and integration of the papers into a whole PhD by writing the discussion and revisiting the introduction, methods and literature review.

It was also good to learn from Marleen that she will be joining the World Health Organisation in Geneva, with effect from mid-October 2012, to head the Department of Reproductive Health and Research and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP).

SECOND SOUTH AFRICAN PREVENTION OF MOTHER-TO-CHILD TRANSMISSION EVALUATION SHOWS REDUCTION IN PERINATAL (EARLY) MOTHER-TO-CHILD TRANSMISSION OF HIV
National Department of Health Communiqué, Thursday, July 19, 2012

The second national prevention of mother-to-child HIV transmission (PMTCT) evaluation shows that approximately 32.2% of infants aged 4-8 weeks attending 580 health facilities for their six week immunisation were HIV-exposed. There is evidence that the national mother-to-child HIV transmission (MTCT) has significantly reduced from 3.5% in 2010 to 2.7% in 2011.

Without PMTCT interventions, one could expect that nearly half (20% - 40%) of all HIV-exposed infants will be infected with the virus by eight weeks post-delivery1.

PMTCT Interventions in South Africa

The South African PMTCT programme, first implemented in 2001, has made great strides, and several significant milestones have been achieved:

- **2001-2008:** Implementation of single-dose nevirapine (sd-NVP) for mother at the onset of labour and baby within 72 hours of birth (2001-2008)
- **2008:** AZT from 28 weeks with maternal sd-NVP in labour or maternal antiretroviral drugs (ARVs) if the CD4 cell count ≤ 250. AZT for baby (4-28 days depending on duration of maternal AZT/ARVs).
- **April 2010:** (Option A) AZT from 14 weeks with maternal sd-NVP in labour and TDF/FTC during or immediately after labour, or maternal ARVs (HAART) if the CD4 cell count ≤350. NVP for baby for six weeks or throughout breastfeeding.

The SAPMTCT Evaluation

The second South African PMTCT evaluation (SAPMTCTE), conducted between August 2011 and March 2012, focused on the effectiveness of the South African PMTCT programme at six weeks postpartum. Research nurses visited approximately 580 facilities throughout South Africa, and interviewed consenting caregivers of infants aged 4-8 weeks. Dried blood spots (DBS) were also collected from enrolled consented infants, and these were tested for HIV exposure using ELISA. Any ELISA positive DBS were then tested for DNA PCR to detect HIV transmission. All infant test results were returned to mothers through the routine health care system and HIV-infected infants were fast-tracked into care. All mothers were encouraged to access HIV counselling and testing services.

This SAPMTCTE was conducted by the Health Systems Research Unit of the Medical Research Council (MRC), Centers for Disease Control and Prevention (CDC), National Department of Health, with the assistance of UNICEF, National Institute for Communicable Diseases, Wits Infant HIV Diagnostics, and the University of the Western Cape (UWC).

Interview and dried blood spot data were collected on 10 106 caregiver-infant pairs in 2011. Study results showed that approximately 32.2% of infants were HIV exposed. The national HIV MTCT rate, measured in these 10 106 infants was approximately 2.7% in 2011. This was a significant reduction from the 3.5% transmission recorded among 10 182 infants enrolled in the first evaluation, conducted in 2010.

At population level 117 000 infants would have become HIV infected by 8 weeks post-delivery in South Africa in the absence of any PMTCT programme (assuming a 30% transmission rate without any PMTCT interventions). In 2011, 107 000 of these 117 000 infants were HIV negative at 4-8 weeks after birth and were thus saved from early HIV infection through PMTCT interventions. The 107 000 saved in 2011 includes an additional 3 100 infants who were saved from HIV infection following the 2010 implementation of WHO Option A PMTCT programme.

**Table 1: Rates of Infant Exposure and HIV MTCT by Province**

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Infant HIV-Exposed</th>
<th>MTCT % (95%CI)</th>
<th>Infant HIV-Exposed</th>
<th>MTCT % (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010 survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>30.0 (26.3-33.7)</td>
<td>4.7 (2.4-7.0)*</td>
<td>32.0 (29.6-35.5)</td>
<td>3.8 (2.1-5.5)</td>
</tr>
<tr>
<td>Free State</td>
<td>31.1 (28.9-33.3)</td>
<td>5.9 (3.8-8.0)</td>
<td>30.9 (28.6-33.3)</td>
<td>3.8 (2.3-5.3)</td>
</tr>
<tr>
<td>Gauteng</td>
<td>30.2 (27.7-32.8)</td>
<td>2.5 (1.5-3.6)</td>
<td>33.1 (29.8-36.4)</td>
<td>2.1 (0.9-3.4)</td>
</tr>
<tr>
<td>Kwa Zulu-Natal</td>
<td>43.9 (39.7-48.0)</td>
<td>2.9 (1.7-4.0)</td>
<td>44.4 (39.8-48.9)</td>
<td>2.1 (0.9-3.3)</td>
</tr>
<tr>
<td>Limpopo</td>
<td>22.6 (20.4-24.8)</td>
<td>3.6 (1.4-5.8)</td>
<td>23.0 (19.9-26.2)</td>
<td>3.1 (1.2-4.9)</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>36.2 (33.6-38.9)</td>
<td>5.7 (4.1-7.3)</td>
<td>35.6 (33.3-37.8)</td>
<td>3.3 (2.2-4.5)</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>15.6 (13.0-18.3)</td>
<td>1.4 (0.1-3.4)*</td>
<td>15.1 (12.7-17.5)</td>
<td>6.1 (2.9-6.9)*</td>
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<td>North West</td>
<td>30.9 (28.6-33.1)</td>
<td>4.4 (2.9-5.9)</td>
<td>30.8 (28.5-33.1)</td>
<td>2.6 (1.1-4.0)</td>
</tr>
<tr>
<td>Western Cape</td>
<td>20.8 (16.8-24.9)</td>
<td>3.9 (1.9-5.8)</td>
<td>17.8 (14.8-20.8)</td>
<td>1.98 (0.6-3.3)</td>
</tr>
<tr>
<td>National</td>
<td>31.4 (30.1-32.6)</td>
<td>3.5 (2.9-4.1)</td>
<td>32.2 (30.7-33.6)</td>
<td>2.7 (2.1-3.2)</td>
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“One of the main differences between 2010 and 2011 is that access to maternal triple ARVs which increased from approximately 33% in 2010 to 43% in 2011, following adoption of WHO Option A” said Dr Ameena Goga, MRC, as she spoke on behalf of the survey principal investigators, Dr Goga (MRC), Prof Jackson (UWC), and Dr Dinh (CDC).

“In addition” said Professor Jackson, “although only 38% of mothers attending immunisation services report coming for HIV testing, less than 5% of all mothers bringing their children for immunisation refuse HIV testing for their infants when offered, heralding the feasibility and acceptability of early infant diagnosis as a provider initiated service.”

“The 2010 and 2011 surveys are testament to the fact that clinical trials on PMTCT prevention can be translated into routine programme effectiveness to scale”, said Dr Dinh, CDC. The principal investigators agree that intensified effort is needed to address gaps in access to care including HIV testing, CD4 cell count testing, access to HAART and infant HIV testing.

The National Department of Health heralds the results of this second national PMTCT survey, which was conducted after South Africa adopted WHO Option A PMTCT regimens in 2010. The significant decline in MTCT from 3.5% in 2010 (before Option A was implemented) to 2.7% in 2011, with similar declines in almost all provinces indicates that South Africa is moving closer to PMTCT elimination targets, and that with intensified effort, South Africa could reach the target of <2% perinatal HIV transmission by 8 weeks post-delivery.

The National Department of Health would like to thank all health care personnel including doctors, professional nurses, enrolled nursing assistant, staff nurses and lay counsellors for their continued commitment towards providing optimal health care in general and for intensifying HIV-related care in particular.

The National Department of Health would also like to thank civil society including non-governmental organisation, civic organisation, mothers, caregivers, partners and families for continuing to demand high quality health care services in general and services for HIV diagnosis, care, treatment and support in particular.

Let us work together and strive further so that 100% of South African citizens know their HIV status; new adult HIV infections are prevented; 100% of pregnant women know their HIV status and 100% of HIV positive pregnant women and their children receive appropriate PMTCT interventions so that we curb the HIV epidemic and virtually eliminate paediatric HIV infection.

**STUDENT PUBLICATIONS**

Dr Alexis Ntumba shares his thoughts and experience of writing up research for publication

1. **Decision to publish**

I have always wanted to publish. While my mini-thesis was being examined, a professor from the University of Namibia asked what had happened to the data that I collected as part of my Master’s degree. Then came a recommendation from my examiners to publish an article in a regional journal, and so I made the decision. I was also encouraged strongly by my SoPH supervisors, Vera Scott and Ehi Igumbor.

2. **What helped me start writing the article**

The first thing was to find a journal for publication, which was not easy. Finding a suitable journal and downloading their journal guidelines/requirements was the critical stage that
really stimulated me a lot. My supervisors’ determination in helping me edit encouraged me a lot.

3. Hard ship on the way
The beginning in most cases is very difficult. My literature review was for the most part outdated and I had to read again to get the recent journals/articles/books to update my literature review. This was time consuming, being a father, a husband and a full time worker in an organization that requires a lot of traveling within the country and far too much report writing. I drafted the article and then my supervisors made comments for me to attend to. Later the journal editor also added comments which I had to address before sending it in again for another round of improvements. This happened over and over. At a certain point, the editor gave us a deadline saying that, should we fail to submit the article with recommended changes, it will not be considered. This came at a very busy period for me and I was also unwell. I could not read and address all comments. We had to ask for an extension which was fortunately granted and all went on well after that. It was so stressful, but failure was not an option. I could not give up. I spent many hours in the office, at times up to 22:00 to get the job done.

4. New skills
In the process of writing, my writing skills improved. I learnt how to simplify the wording without necessarily compromising the meaning. I also learnt another way of referencing (which the journal required), and I learnt the automatic table of content.

5. Publishing Process
The publishing process is very long and demanding. I learnt to accept the comments and to address them. I learnt to be patient, otherwise one can give up. Patience pays.

6. Getting article published
Getting published is a dream come true. As I mentioned earlier, I always wanted to publish. When I was informed that the article was published, I felt relieved; all the hard work has finally brought about results and great satisfaction. I feel that I have contributed to the academic field and other researchers can also reference my article with my name on it. It is a great achievement.

7. Advice to the students who have just finished their mini-thesis
Collecting data is arduous. Getting a Master’s degree is one thing and very important, while publishing is a contribution to wider the scientific endeavour. You must go to the end. Do not let your data be covered with dust, write an article and you will never regret it.
You are cordially invited to a seminar, co-hosted by:
The Health Economics Unit (HEU), School of Public Health and Family Medicine, University of Cape Town
and
The Institute for Social and Economic Research (ISER)*, Rhodes University, Grahamstown

'Managed Competition and the UK NHS: a Case Study of GP Fundholding'

Speaker: Dr Rebecca Surender**, Department of Social Policy and Intervention, University of Oxford, UK

Date: 22 August 2012
Time: 11H00-13H00, with sandwiches afterwards
Venue: Barnard Fuller Building, Seminar room 3, Faculty of Health Sciences, University of Cape Town

The seminar aims to stimulate discussion and debate on issues of relevance to a National Health Insurance (NHI) system, and specifically on current South African policy proposals for a NHI, based on the extensive experience of the National Health Service in the UK.

**Dr Rebecca Surender is a University Lecturer in Social Policy at Oxford and an Honorary Research Associate of ISER at Rhodes University. Her research interests are primarily in the area of health policy and 'social protection and policy in developing country contexts'. She is currently involved in a collaborative study with the ISER, examining the medical professions' response to the proposed new health reforms in South Africa.

*The Institute of Social and Economic Research is based at Rhodes University, with Professor Robbie van Niekerk as its director. The focus of the Institute is research and teaching on critical social policy issues. These include research programmes focused on the current NHI health care reform proposals; social policy, and the developmental state and social citizenship. The ISER offers a range of post-graduate training courses, including a Masters in Social Policy and organises an Annual Winter School on Social Policy and Social Transformation for civil society organisations.

Contact person: Dr. Maylene Shung King, Health Economics Unit, UCT.
Tel: 021-4066580/0712003607 e-mail: maylene.shungking@uct.ac.za

WHO Releases Discussion papers on both the NCD Action Plan 2013-2020 and the Global Monitoring Framework

The WHO has posted both the discussion paper on the development of its NCD Action Plan 2013-2020 and the third discussion paper on the Global Monitoring Framework (GMF).

For the development of the NCD Action Plan 2013-2020, there will be an informal consultations for member states and UN agencies 16-17 August, and civil society organisations are invited to submit their comments by email by 7th September. These tracks will feed into a “zero draft” plan that will be discussed at a second informal consultation meeting on 1st November which in turn will inform the WHO’s Secretariat drafting of a plan for submission to the 66th World Health Assembly in May 2013, via the Executive Board meeting in January.

For the third discussion paper of the GMF, WHO has detailed eleven target and are distinguishing between the four that have strong support (salt, tobacco, physical activity and blood pressure) but WHO has also put up for discussion six additional targets including one on essential medicines. Formal Member State consultation will take place at the end October/early November.

# Intimate Partner Violence and HIV testing and disclosure in Zimbabwe

Simukai Shamu*, Christina Zarowsky1, Marleen Temmerman2, Naemah Abrahams1,3

1 School of Public Health, University of the Western Cape, Cape Town, South Africa
2 International Centre for Reproductive Health, Ghent University, Ghent, Belgium
3 Gender and Health Research Unit; Medical Research Council, Cape Town, South Africa

*Contact email: shamu@shamu.com

## Introduction

- Women who test HIV positive are more likely to disclose their results to their partners compared to women who test HIV negative.
- Disclosure is associated with lower risk of transmission of HIV to partners by HIV-positive women.
- The study presents the prevalence of factors associated with HIV exposed by women after disclosing their HIV status to their partners during pregnancy.

## Materials and Methods

- **Study design**: cross-sectional study of obstetric women in six public antenatal clinics in low-income areas in Harare.
- **Sample and instruments**: 2004 postnatal women were interviewed by six female-trained interviewers in Simara, HIV testing for measuring factors associated with women's adaptation to disclose HIV status to their partners during pregnancy.
- **Setting**: data were collected in 2010.
- **HIV prevalence among women who disclosed to partners was less than half (14.9%, 95% CI 12.6-16.5) of that of women who did not disclose (56.2%, 95% CI 50.5-61.4).
- **More severe and emotional violence than physical violence per disclosure of HIV status were reported (Table 2).**
- **There was no significant association between disclosure and physical (U OR 1.0, CI 0.69-1.74).**
- **Engaging in many sexual practices for women and partners and having been abused in the past were associated with HIV after disclosing HIV positive status (See Table 3).**
- **Women who were physically abused in the past were more likely to experience IPV after disclosing HIV positive status (See Table 3).**

## Results

- **Age average of women was 26.1 years (SD 7.5 years) and that of their partners was 31.5 years (SD 7.5 years).**
- **Women overwhelmingly disclosed their results to their partners (95.3%) (See flow diagram) and were less likely to disclose their HIV status if they tested HIV positive (Unadjusted OR 0.33, 95% CI 0.15-0.48).**
- **HIV prevalence among women who disclosed to partners was less than half (14.9%, 95% CI 12.6-16.5) of that of women who did not disclose (56.2%, 95% CI 50.5-61.4).**
- **More severe and emotional violence than physical violence per disclosure of HIV status were reported (Table 2).**
- **There was no significant association between disclosure and physical (U OR 1.0, CI 0.69-1.74).**
- **Engaging in many sexual practices for women and partners and having been abused in the past were associated with HIV after disclosing HIV positive status (See Table 3).**
- **Women who were physically abused in the past were more likely to experience IPV after disclosing HIV positive status (See Table 3).**

## Conclusions

- **Risks of Disclosure of HIV status, sexual and emotional violence after declining HIV status are very high.**
- **Most women who disclosed HIV status to their partners were sexually abused.**
- **Most participants were multiparous females while their partner's multiparity was protective of disclosure.**
- **Prevention of IPV in antenatal care is urgently needed.**

## Literature cited


## Acknowledgements

We acknowledge the funding agencies for funding this study: Vudu-CCOOU-Vuwani of the Western Cape, AIDPE, South Africa Medical Research Council.

We acknowledge our colleagues at the School of Public Health, University of the Western Cape for their comments and the research assistants.
Harmony or Harm? Unpacking the effects of HIV testing and disclosure during pregnancy on intimate partnerships in Zimbabwe

Simukai Shamu1*, Christina Zarowsky1, Marleen Temmerman2, Naeemah Abrahams1
1 School of Public Health, University of the Western Cape, Cape Town, South Africa
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Introduction

HIV testing and disclosure to a partner are deeply meaningful in a relationship. They are often understood in terms of trust, honesty, fairness, and loyalty (Obermeyer and Douben 2007).

HIV testing of pregnant women has significantly increased through providers initiated counseling and testing (Counseling and Testing, 2006). However, few studies have assessed the effects of this testing and disclosure on sexual relationship and partners' wellbeing.

This qualitative study explored pregnant women's experiences with their partners after HIV testing and disclosing positive HIV status to partners.

Methods

A cross-sectional ethnographic study was conducted at six public antenatal care clinics in low income urban areas in Harare, Zimbabwe in April and May 2011.

In-depth interviews were held with 7 informants (3 senior matron nurses and one HIV counselor). Seven focus group discussions (FGDs) were held with 64 women - 4 FGDs with pregnant women and 3 FGDs with postnatal women.

Interviews were audio-recorded, transcribed and translated to English.

Data were processed in Qualitative software and analyzed using thematic content analysis.

Clinical clearance was received from the Medical Research Council of Zimbabwe and University of the Western Cape Senate Research Committee.

Results

Women's perceptions of HIV testing:

Most women in the FGDs described HIV testing for HIV-negative health workers, when they were not prepared or did not want to test.

"This casual conversation with clinic's staff is not our option, we are being forced to do things" (Pregnant woman, Clinic C)

Some women felt forced to test when they were not prepared to know and accept a positive test.

"(So)now you know what type of husband you have, that he has two personalities. So you will be afraid of knowing your status. You actually know that he sleeps with many women so you know that there are no eyes on him (suspected HIV negative)" (Pregnant woman, Clinic C).

Health workers agreed that they persistently asked women to be tested for HIV - which was viewed by women as harassment to test.

"We don't force them but we have a counseling that we keep doing...saying that if she has been unfaithful through the pregnancy we will give her to another counselor. But when we keep seeing them and they are still not tested we keep asking them so it's a continuous process. Even in labour we do the test" (Maternity home, Clinic C).

Other women did not want to be tested for fear of partner's violence.

"When you are tested alone (with no partner present) the counselor and you are tested and you don't know it will be a very big issue" (Another woman responded), "That's why I will not give you that permission. He expects you to tell him first" (Pregnant woman, Clinic C).

Women who expressed support for HIV testing during pregnancy mentioned the need to "know what the future will be like" and "to protect the baby from infection".

Effects of HIV testing and disclosure of negative results:

Women overwhelmingly agreed in all FGDs that men who refuse to be tested even after women informed them about possibility of test discrepancy.

After tested - (negative) said he had no need for him to be tested. (Pregnant woman). I tried to reason with him that he should be tested but was not satisfied that he was negative as well (Postnatal woman, Clinic C).

"If they are sincere, they will not lie to you. The man usually says the results (negative) are discovered when the baby is in their lives and they do not comfortably being tested. Some don't want to know. So refusing or talking to be tested is one form of abuse" (Counselor, Clinic C).

Women who tested HIV negative reported being stalked and their movements controlled by their positive partners.

"Men are very possessive when you go out because they think you are going to sleep with someone who does not use a condom whereas you use a condom with him." (Pregnant woman, Clinic C).

Abuse of women who tested negative by HIV positive men who did not disclose results:

A negative test result assigned emotional and emotional violence from HIV-positive men who intentionally attempted to affect their partners.

"When the wife is negative the husband will go to the infidelity. There is a suspicious - the husband will go and check on her. The wife is negative, there becomes a lot of jealousy when these incidents occurred and you tend to elicit the husband. Her life is in the hands of the husband and she is looking after him and looking after his medication." (Pregnant woman, Clinic C).

Men reported that their partners did not disclose test results, but knew without women's knowledge and forced women to have sex without protection.

"(The husband) knew that he is sick and is still so he will try to sleep with her and infect her. There are men like that who do not let their wives have sex about their status. You will only find out when you come to have sex that you have HIV" (Postnatal woman, Clinic C).

"Yes he takes them (AIDS pills) at work. They will be kept in that pocket. If I will not find that drug then he can have his problem knowing he no longer has to use that medication" (Pregnant woman, Clinic C).

Women reported that husbands generally did not want to test for HIV but "cheeked" their HIV status by pretending to take their wives in pregnancy screening during which they will be tested and possibly test positive the results from HIV testing.

"The husband was sick (TB) and the wife found him after that and he recovered. Now after some years and he got married she discovered that he had no knowledge of his children, she knew his children with his nephews and nothing (HIV positive) were they doing" (The wife tested HIV positive, Clinic C).

"When suspicions arise men do not usually test the women but through having a baby, knowing that the wife is tested at the clinic." (Counselor, Clinic C).

Effects of HIV testing and disclosure of positive results:

Women who tested positive are subjected to negative comments, stigmatization and violence.

"If your test and you find out you have a disease he will blame it on you saying you are the one who instigated it. And they are afraid of it..." (Pregnant woman, Clinic C).

"Some women, if tested and were positive will be in a lot of trouble. He will be accusing you of having brought the disease not knowing that he might be the one responsible. Mostly in the men who are HIV positive..." (Counselor, Clinic C).

"If you are positive for them you become an object. They will use you as an object, even in the relations when they get to know about it. They will treat you like a slave. They also accuse you for infecting him with a disease. So the way you are treated is very bad compared to someone who does not say anything (disclose results)." (Pregnant woman, Clinic C).

"HIV counselors counseled women's reports of being beaten up after disclosing their test results to their partners.

There were reports of men interfering with women's treatment and secondary prevention such as condom use as some women reported being beaten if they brought condoms from clinic.

Social relationships and care after testing positive:

Women reported problems facing HIV positive women such as neglect, financial abuse, sexual abuse, partner murdering another woman, learning the wife in front of people including relatives and women's relations.

"He tells my parents that your daughter has a disease. All the people will then know that the child taken to you will be sick and all know that you have a disease." (Pregnant woman, Clinic C).

"(Men) can still abuse. There will be physical abuse." (Postnatal woman, Clinic C).

"In most cases you become if you test positive which is not negative, the mad angry. But if you test negative and he gets positive, it's a case for a woman to divorce his husband." (Postnatal woman, Clinic C).

Women's agency and supporting partners

However, there were reports of women's agency and power such as refusing conjugal rights to test while this resulted in further violence in some partnerships:

"(A wife) asked my partner to go for a test but he refused...saying that since I don't have the disease means the situation is normal. If I am not tested, I can't be tested." (Pregnant woman, Clinic C).

"Women got pressure to not test by their partner's saying that the baby is X's, or they are offered (money) to not be tested. I am not used to being in the clinic. I was not tested but in the end I gave in because he was not going for the tests anymore" (Pregnant woman, Clinic C).

Women sometimes avoided test, asked their partners to back them up, and who were less likely to disclose results.

"Some women would ask their partners to not disclose results for fear of violence, fear of abuse and desertion."

"There were also reports of good examples of men who cared for their HIV positive partners.

"My husband was infected (with HIV) by his husband's brother in-law and she told him and she said I'm not married to him any longer." (Counselor, Clinic C).

"We once had a case of a discordant couple: the man was negative whilst the woman was positive and this was confirm in the third test...the man was so supportive of the wife in different aspects." (Counselor, Clinic C).

Conclusions

Women who tested HIV positive and those who tested negative were abused although in different ways.

If would-be partners are obtained, testing and disclosure causes further strain, regardless of whether the test is positive or negative.

It is important that health workers identify women at risk of abuse during HIV counseling and testing and refer them to care and other appropriate care and support to prevent abuse.

Literature cited


Acknowledgements

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Presented at AIDS 2012 – Washington, D.C., USA
APPLICATIONS SOUGHT FOR POSTDOCTORAL RESEARCH FELLOWSHIPS

Collaboration for Health Systems Analysis and Innovation (CHESAI): School of Public Health and Family Medicine, University of Cape Town (UCT) and School of Public Health, University of Western Cape (UWC)

Deadline for applications: 15th October 2012

A total of four Postdoctoral Fellowships are available in the area of Health Policy and Systems Research (HPSR) within the Collaboration for Health Systems Analysis and Innovation (CHESAI) project, over the period 2012-2016.

CHESAI is a four year collaborative endeavour between the University of Cape Town (UCT) and the University of Western Cape (UWC), Schools of Public Health, funded by the Canadian International Development Research Centre (IDRC). Over the life of CHESAI a total of four Postdoctoral Fellowships are available in the area of Health Policy and Systems Research (HPSR) for the Collaboration for Health Systems Analysis and Innovation (CHESAI) research project, over the period 2012-2016.

This call is for TWO such Fellowships to commence January 2013. This collaboration is based on the understanding that Health Policy and Systems Research (HPSR) is an emerging field within the broader terrain of health research, with conceptual and methodological foundations that require substantial development. The overall aim for CHESAI is, therefore, to contribute to expanding and strengthening the health policy and systems knowledge base in Africa through building an intellectual hub for HPSR in Cape Town, South Africa, creating spaces for engagements between researchers and practitioners, supporting African HSPR capacity development and sharing/disseminating HPSR conceptual and methodological innovations.

CHESAI's overall objectives will be pursued within four complementary thematic areas which address critical areas of conceptual and methodological development for HPSR. The themes are:

1. Leveraging change in complex health systems: generating ideas about new approaches to leadership of complex health systems, recognising that health systems comprise a web of relationships amongst component parts, including organisations and individuals, that are situated within circles of contextual influences;

2. Harnessing tacit and experiential knowledge to health system development: exploring the important role of tacit and experiential knowledge in leading and sustaining health system development;

3. Catalysing multi- and trans-disciplinary inquiry to support health systems development: developing innovative concepts and ideas, frameworks and methodologies, drawn in particularly from the social sciences, to support both in-depth research and related teaching on health system development and strengthening;

4. Strengthening the research-practice interface: providing time and space for practitioners and researchers to systematically engage with and learn from each other’s knowledge, and develop new, shared understandings about HPS issues and research.

Purpose for Postdoctoral Research fellowships for CHESAI

Given the emergent nature of the field, the purpose for having Postdoctoral Research Fellows in the CHESAI research project is to contribute to:

• the support of career development of emerging health policy and systems researchers;
the establishment of a community of practice around Health Policy and Systems Research, and to building this field in South Africa, other parts of Africa and with other partners, and

the enhancement of the capacity of the UWC/UCT CHESAI hubs

**Call for applications and conditions of award**

The UCT and UWC Schools of Public Health are calling for interested candidates to apply for two Postdoctoral Research Fellowships to start in January 2013. The successful candidates will be required to register at the University of Cape Town OR the University of the Western Cape in January 2013. They will join the CHESAI team, led by Profs Lucy Gilson and Uta Lehmann, and will be expected to contribute to its work and to facilitate communication and joint learning between UCT and UWC.

Note that UCT and UWC have slightly different policies for the registration of PDRFs: at UCT PDRFs are neither students nor employees of the University (PDRF status), while at UWC they are registered as students. See www.uct.ac.za or www.uwc.ac.za for more information.

**Academic Criteria:**

Applicants must:

- have citizenship of a sub-Saharan African country, be an expatriate African, or demonstrate commitment to future work in African health systems;

- have achieved a PhD in the last five years in any suitable field, such as health sciences or social sciences;

- not have previously held permanent academic positions: however, emerging researchers, or those who have previously primarily worked in university teaching positions, or who have held health systems management positions are eligible to apply;

- show clear evidence of robust scholarly performance including a relevant publications record;

- have some relevant experience, specifically a track record of interest in health policy and systems issues, preferably including research;

- understand the relevance of their proposed postdoctoral research work to CHESAI: applicants will be asked to propose an area of work relevant to one or more of the CHESAI themes, and to show how their past research provides a basis for this proposed work and/or what additional activities are proposed to contribute to the CHESAI community of practice;

- demonstrate interest in strengthening HPSR and building a community of practice around HSPR issues, and

- demonstrate English language proficiency.

The general purpose of the PDRF is to provide an opportunity for experiential learning in research which may serve as a path for further academic and professional development, therefore

(i) The postdoctoral research fellowships are only available to individuals who have achieved the doctoral degree within the past 5 years;

(ii) The incumbents will not be expected to provide a service or services in return for the fellowship. (Although some academic activities, such as limited teaching or student support, may be required as part of the PDRF’s professional development);

(iii) No benefits or travel allowances are included in the value of the fellowship;
(iv) The successful incumbents will be required to comply with the recruiting University’s approved policies, procedures and practises for the postdoctoral sector.

**Value and tenure of the postdoctoral research fellowships**
Two Postdoctoral research Fellowships will be made available from January 2013: one at the UCT School of Public Health and Family Medicine, and one at the UWC School of Public Health.

The value of each fellowship is R275,000 per annum (tax exempt). The fellowships are tenable for one year. Renewal for a second and final year will however be considered depending on satisfactory academic progress and availability of funds. Renewals are not guaranteed. In addition, allowances of up to R80,000 for research costs and conference travel will be available, on application, by the successful candidates.

Conditions apply to these Allowances, and separate applications will be considered for approval by the Principal Investigators.

**Application requirements**
Applicants should submit the following documents:

(i) A letter of application stating the applicant’s areas of expertise, research interests, academic qualifications and work experience (an academic CV including a list of publications).

(ii) Copies of full academic transcripts, including those pertaining to both the undergraduate and postgraduate degrees. Please do not include copies of certificates. Names and contact details OR letters of reference from at least three referees (inclusive of two academics who have taught, supervised or worked alongside the applicant).

(iii) A four to five page research proposal: outlining the work to be done, the relevance to HPSR and specifically, relevance to the CHESAI themes, and potential contribution of the applicant and their work to the broader CHESAI community of practice.

**Closing date for applications: 15th October 2012**

Contact details for submission of applications and for enquiries: Please contact Jill Olivier and Thubelihle Mathole (UWC) at chesai.mail@gmail.com.

Selection of short-listed candidates will be made by the principal investigators and a sub-committee of academics from both institutions and IDRC representatives, and eligible applicants will be notified of the result of their applications by the end of November 2012. The University of Cape Town and the University of the Western Cape reserves the right to disqualify ineligible, incomplete and/or inappropriate applications.

The University of Cape Town and the University of the Western Cape reserves the right to change the conditions of award or to make no awards at all.

**Sam Caldbick interns at SOPH**

Sam Caldbick is a visiting Research Assistant from Canada. He has a Master’s degree in Public Health from the University of Saskatchewan. For the duration of his six month internship, he will be working under the supervision of Dr Thuba Mathole. He will be assisting with the writing of two papers related to Global Health Initiatives and Human Resources for Health in South Africa. Additionally, he will be conducting interviews and literature reviews for a multi-country study focused on migration of human resources. Sam has thoroughly enjoyed his time thus far in Cape Town, eating out, hiking, and learning as much as he can in his spare time about the people and history of the country.
Kashmeera Meghnath Interns at SOPH

My name is Kashmeera Meghnath. I was born in Durban, South Africa, although I grew up in Mississauga, Canada. I completed my B.Sc in Microbiology at McMaster University in Hamilton, Ontario, and my Master of Public Health at University of Saskatchewan.

I will be working at SOPH for six months, attached to the Prospective Urban and Rural Epidemiological (PURE) study under the supervision of Dr. Ehimario Igumbor and Professor Thandi Puoane. I am very excited to be a part of the team and learn about chronic disease risk factors in South Africa.

I am also quite excited to explore the beautiful city of Cape Town over the next few months!