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1st South African Antibiotic Stewardship Programme (SAASP) Conference

On February 11th 2012, FIDSSA convened the first South African Antibiotic Stewardship Programme (SAASP) conference at the Radisson Blu hotel in Sandton, Johannesburg. FIDSSA worked with key stakeholders in antibiotic stewardship and infection prevention control in the public and private sectors to present a programme which addressed the main challenges facing South Africa and the region. Dr Debra Goff, Infectious Diseases Specialist and Clinical Associate Professor at The Ohio State University Medical Centre, joined delegates to bring her expertise in setting up and running antibiotic stewardship campaigns to the discussions.

On the 2nd day of the conference, the SAASP working group met to thrash out goals, priorities and the direction that SAASP would take in the short- to medium-term. The working group was made up of representatives from clinical microbiology, infectious diseases, infection prevention control, pharmacy, Best Care Always and private health groups. Many thanks to MSD for their unrestricted educational grant to FIDSSA which enabled us to set up this conference.



Members of the working group from left to right: Rene Snyman (non-member), Chetna Govind, Alan Karstaedt, Gary Kantor, Lesley Devenish, James Nuttall, Colleen Bamford, Gene Elliot, Yolanda van Zyl, Andrew Whitelaw, Adrian Brink (co-chair), Dena van den Bergh, Marc Mendelson (co-chair), Debra Goff, Preshnie Moodley, Olga Perovic, Sabiha Essack, Darryl Vine (non-member), Shaheen Mehtar, Adries Gous, Janjtje Taljaard. Absent: Mark Nicol.

The SAASP Manifesto - reversing the rot



Decades of injudicious antibiotic prescribing and a disregard for basic infection control practice have left the international community facing a return to the age of untreatable bacterial infections, due to the emergence of pan-resistant Gram negative infections. The rise of extended spectrum beta-lactamase (ESBL)-producing- and subsequently carbapenemase-resistant strains has left colistin as the only antibiotic left in the armamentarium for these infections, an antibiotic from the 1960s with a high toxicity profile. The recent identification and subsequent spread of New Delhi Metallo-beta-lactamase-1 (NDM-1) and *Klebsiella pneumoniae* carbapenemase (*kpc*)-producing strains of enterobacteriaceae signify the latest 'super-bugs' to threaten public health. Experience in Gauteng suggests that the number of NDM-1 infections is rising rapidly, requiring increased use of colistin. Colistin resistance has already been reported, rendering such patients untreatable.

South Africa, like the rest of the international community, needs a strong, coordinated, and urgent response to this threat. Both clinical governance of antibiotic prescribing (antibiotic stewardship) through antibiotic stewardship programmes (ASP), and infection control practice must strengthened if we are to control the situation.

Goals of the SAASP Working Group

1. Provide leadership, advocacy for, and strengthening of, antibiotic stewardship in the public and private sectors in South Africa.
2. Direct appropriate training in antibiotic stewardship and coordinate dissemination of antibiotic stewardship information to all sectors of South Africa's health care system and civil society. Engage with the Health Professions Council of South Africa to propose that antibiotic stewardship CPD becomes mandatory, as is the case for ethics.
3. Harmonize existing national antibiotic prescribing guidelines and develop guidelines for those infections not already covered, for adult and paediatric practice, incorporating principles of antibiotic stewardship and optimal diagnostic testing into one document.
4. Identify gaps in current knowledge and the necessary operational research/audit that will inform practice. Feedback the results of these studies to stakeholders, so as to implement change.
5. Engage with the National Department of Health and industry to address the economic issues and systemic obstacles surrounding antibiotic costs and stewardship.
6. Make recommendations for high quality, evidence-based antimicrobial stewardship interventions including the structure and organisation of stewardship programmes and promotion of core high-impact interventions in different settings

Pathways for engagement of key stakeholders to effect change

Accepting that public and private sector healthcare presents different health structures and challenges, the working group resolved to engage the following key stakeholders:

- In the private sector, a point person will be identified in each private health care group, who in turn will nominate a point person for contact in each private hospital or clinic.
- In the public sector, key stakeholders identified as provincial DOH, CEOs of Hospitals and Deans of University departments of Health Science will be engaged with. Provincial working groups representing all these stakeholders, such as that already formed in KwaZulu Natal, will liaise with the SAASP working group to effect change.
- The co-chairs of SAASP working group will approach the National Department of Health (DOH) to invite a representative to be part of the SAASP Working Group. This will give insight to the working group and facilitate engagement with NDOH in presenting a proposed national framework policy for antibiotic stewardship.

- Pharmacists will be engaged with through the South African Society of Clinical Pharmacists, as the society's chairman.
- In hospitals that already have adopted Best Care Always IPC bundles, BCA will move to add or further develop antibiotic stewardship programmes using tested improvement methodology..

Above all, ASPs must operate at the institutional level and this requires institutional buy-in from the start.

SAASP priorities for change

The following interventions were agreed on as priority areas to target for change in the short-medium term.

1. The appropriate use of microbiological diagnostic tests prior to initiation of antibiotics to allow de-escalation and rationalization of therapy.
2. To define (as far as is possible), the source of the infection with monitoring of response at that source and removal of any causative device such as a central line catheter.
3. To decrease the overall consumption of antibiotics in South Africa, recognizing that all antibiotic prescribing predisposes to emergence of multi-drug resistance (MDR). Decreasing antibiotic exposure of patients, including prolonged duration of prophylactic antibiotics, protects against development of MDR bacteria.
4. To decrease the duration of antibiotic therapy, by setting clear evidence-based guidelines or where good evidence is not available, use expert opinion from within the SAASP working group to define optimal duration. Develop pharmacy systems to identify and block prolonged antibiotic duration.
5. Address inappropriate dosing of antibiotics, with specific relation to use of loading doses and weight-based dosing where evidence exists, and directing the correct use of therapeutic drug monitoring (TDM).

Priority high impact start-up projects for implementation across public and private sectors

1. Hang time: the time interval between prescription of an antibiotic and administration to the patient. Although considerable challenges exist in implementing this project in the public sector due to the almost total lack of documentation of time of prescription, studies of severe sepsis have shown decreasing survival with every hour that passes without the patient receiving appropriate antibiotics.
2. Time from positivity of blood cultures in the lab to the administration of antibiotic or antifungal and Bug-drug match: Was the choice of antibiotic or antifungal appropriate to the bacteria or fungus identified?
3. IV to PO switch: the time taken between when a patient on iv antibiotics is adjudged to be able to take oral antibiotics, and the actual time that the patient receives their 1st oral dose. Use ciprofloxacin for this study.
4. Time to removal of indwelling intravascular catheter from cessation of intravenous antibiotic, taking into account requirement for iv fluids.
5. Number of patients in an ICU or other clinical unit on >4 antibiotics
6. Is the indication for antibiotic therapy documented in the notes?
7. How many patients on antibiotics had cultures taken? Were the cultures taken from the appropriate source?
8. Investigation of vancomycin dosing - Was a loading dose given, was the dose of vancomycin weight-based, define the time to TDM and the time to Creatinine follow-up.
9. Investigation of aminoglycoside dosing – time to TDM and renal follow-up.

10. Number of days of urinary catheterization and time to removal of catheter once the indication for catheterization was no longer appropriate.
11. Testing of an antibiotic prescription chart incorporating some of the above interventions. A FIDSSA template is provided on the FIDSSA website (http://www.fidssa.co.za/A_relatedSites_AStewardship.asp) and others on the BCA website (www.bestcare.org.za)

New Antibiotic Stewardship resources on <http://www.fidssa.co.za>



FIDSSA has formed a new page on its website to build a library of useful documents relating to antibiotic stewardship. The page can be found by navigating to http://www.fidssa.co.za/A_relatedSites_AStewardship.asp. Links to major international ASPs can be found, and a generic FIDSSA antibiotic prescription sheet can be downloaded from this page and adapted for use in your hospital or institution. Happy reading!

The role of the Infection Control Practitioner in antimicrobial stewardship



The role of the infection control practitioner is pivotal in the implementation of Antimicrobial Stewardship Programmes, and we would like to use this opportunity to remind everyone of some of the key activities that should be integrated with antibiotic stewardship programmes:

Surveillance of alert organisms (such as MRSA, ESBL producing Enterobacteriaceae etc) is vital in the implementation of action plans to prevent or contain outbreaks. The prevalence of these organisms needs to be monitored and suspected outbreaks should be investigated.

Hand hygiene compliance is a simple, but effective measure to prevent the spread of micro-organisms. Although all healthcare workers are aware of the importance of hand hygiene, poor compliance is both a local and an international problem. Hand hygiene compliance should be measured regularly and feedback provided.

Isolation precautions: While physical isolation of all patients with multidrug resistant organisms is not always possible due to infrastructure limitations, it is of utmost importance that contact precautions are implemented and adhered to for any patients with multidrug resistant organisms. Reducing the spread of resistant organisms is one crucial way of reducing the need for broad spectrum antibiotics. Monitoring isolation precaution compliance with feedback will help to increase adherence awareness.

Environmental cleaning: According to a study conducted in an ICU in France, prior occupation of a room by a patient with MDR *Pseudomonas aeruginosa* and *Acinetobacter baumannii* is a risk factor for the acquisition of these organisms for subsequent occupants of the room.¹ It is often cleaning personnel who are neglected in receiving the appropriate education. It is imperative that standards are set and maintained to ensure that cleaning personnel have an adequate understanding of infection, prevention and control principles.

Auditing: Through auditing we can provide feedback to relevant role players to ensure that deficiencies receive attention and that action plans are implemented and assessed. Two possible baseline audits which may help change practices are:

A] Determine the "hanging time" of antimicrobials. This refers to the time between when the prescription was written and the time the antimicrobial was administered. The goal is to administer antimicrobials within one hour of being prescribed.

B] Determine whether appropriate specimens were taken prior to the administration of the antimicrobial. Antimicrobial therapy should preferably not be administered without taking a specimen for microbial culturing, as culture results may allow for more rational selection of antimicrobials

Measuring of compliance: Once baseline audits are completed, ongoing compliance measurements should be performed regularly.

Feedback and positive reinforcement is important both to inform and motivate staff. Feedback should not be used as a tool to criticise but rather as an opportunity to inform, update and enable individuals.

Conclusion: The infection prevention and control practitioner's role is often complex and challenging. As the pivot in the healthcare team she/he is often the person who gets the team together, monitors, audits, measures and provides feedback. The implementation of antimicrobial stewardship is a team effort and nobody can implement the programme or work in isolation. Infection prevention and control is the responsibility of every one working in a hospital and the success of the implementation of an antimicrobial stewardship programme is dependent on the collaborative effort of the entire team.

Reference:

Nseir, S., et al. Risk of acquiring multidrug-resistant Gram-negative bacilli from prior room occupants in the intensive care unit. Clinical Microbiology and Infection 2010 European Society of Clinical Microbiology and Infectious Diseases, CMI, 17, 1201–1208

Briette du Toit, Mediclinic

News from the FIDSSA Office - Lea Lourens



The first months of 2012 are gone already. Welcome back to all our members!!

If you haven't already renewed your 2012 membership, this is the time to do so! FIDSSA membership has to be renewed on a yearly basis.

Invoices to all members went out by the second week of February. If you haven't received yours, we most probably do not have your correct e-mail address. Please send me your correct details at info@fidssa.co.za
The fee stays the same: R250 for medical professionals and R150 for nurses and allied health.

When you are making your payment **PLEASE** use your initials and surname as reference **AND** send through your proof of payment to one of the following:

e-mail: info@fidssa.co.za or Fax: 0866 349 839

If you do not get a confirmation e-mail with your login details I have not received your payment. Please visit the website www.fidssa.co.za and check if your details are all correct. If any of your details change please let the admin office now ASAP, especially your email address as all correspondence happens via email.

Thank you for your support!

Lea Lourens

Venous thromboembolism in travellers – Quo Vadis? - Dr Salim Parker



South African
Society of
Travel Medicine

The occurrence of venous thrombo-embolic events (VTE) in travellers remains at the forefront of any travel medicine discussion. Travellers seek their own advice from those who travel frequently, those who have had a VTE and, even worse, the internet. Factors that predispose to VTE are well known, but the true incidence in travellers is hard to determine. Some studies have indicated an incidence of close to 10% of deep venous thromboses in long haul travellers, whilst it has been as low as 1% in others. It is possible that many travellers do experience a VTE but most do not develop any symptoms or sequelae to the VTE.

The D-dimer test is the first resort (together with necessary ultrasound examinations) in establishing a diagnosis. Yet Professor Barry Jacobson, Director of the Thrombosis and Haemostasis Research Unit at the Wits Consortium, in the BEST Study showed that 12% of the business class passengers and 7% of the economy class passengers had raised D-dimer levels but no evidence of venous thrombosis on ultrasound.

If one uses the incidence of 1% in long haul travellers, and that in 2010 there were 7,893,989 international travellers to and from the OR Tambo Airport, 78,939 of these passengers experienced a VTE, equating to 216 passengers per day.

Pregnancy is a recognised hypercoagulable state, but the increased risk of developing a DVT during long haul travel has not been quantified. It is known that female travellers on oral contraception and who also smoke increase their risk of developing a DVT by a factor of 31 times! The physiological factors of increased immobility, relative dehydration, and hypobaric hypoxia due to the decreased partial pressure of oxygen inside aircrafts, though theoretically expected to increase the risks for DVT, have not conclusively been proven to do so amongst long distance travellers.

Professor Jacobson is currently undertaking research to evaluate these and other factors. He will be piloting an aircraft where a small number of subjects will be evaluated during flights of about five hour duration. Special zip-suits have been designed to facilitate the ultrasonographic evaluation of the passengers. A thrombinoscope and a thrombelastograph will also be used to measure minute changes. It is hoped that these investigations would shed some light on this very pertinent but little studied subject. The Wits Engineering Department will be conducting joint research on the seats used in the aircraft, measuring pressure points with the appropriate strain gauges and evaluating whether the designs can be improved.

What advice needs to be given to long haul travellers? Professor Jacobson will be sharing the provisional results of his research at the South African Society of Travel Medicine Congress to be held in September at the Sandton Convention Centre. It is hoped that this will shed greater clarity on the risks of long haul travel and VTE and the strategies that need to be taken to minimise such events. An opportunity that cannot be missed. Full details of the programme are available at www.sastm.org.za

Report on the 7th congress of the World Society of Paediatric Infectious Diseases (WSPID)



Southern African
Society of Paediatric
Infectious Diseases

The WSPID conference brings together Paediatric Infectious diseases colleagues from around the world. This year almost 100 countries and 2000 delegates attended the conference in Melbourne, Australia. Delegates from many developing countries attended, and benefitted from a reduced sponsorship fee to attend this biennial event.

The conference opened with one of the best presentations of the conference, given by Michael Alpers on Kuru in Children. It was a fascinating story of living with the Fore people of Papua New Guinea and learning about their rituals and customs, which led to an understanding of the epidemiology of the prion disease Kuru. In the Fore society the dead

had been eaten by their relatives in the ritual of transumption. Only women and children (boys <7 years when they left to live with the men) practiced the ritual, which was stopped by a government interdict in the 1950's. Following this the number of Kuru cases declined, being seen mostly in adults who have a longer incubation period. Children were no longer affected, including those born to infected mothers thus proving that vertical transmission did not occur. The last case of Kuru died in 2009.

The conference is sponsored by many vaccine companies and so there is always a vast number of presentations on vaccine preventable diseases, an important topic for a developing country like South Africa.

Two areas of interest were influenza and pertussis vaccination.

Influenza vaccination has again become topical following the swine flu pandemic of 2009. Peter Richmond from Western Australia described the affect of introducing the vaccine into the area. Although uptake of the vaccine is still sub-optimal, there has been a decline in the severity of disease as well as mortality. Deaths only occurred in unimmunized children. Increasing vaccine uptake will prevent morbidity and mortality in those at high risk of complications.

Pertussis vaccination remains an important topic with the changing epidemiology of the disease. Pertussis is now seen in very young infants before vaccination, as well as in adolescents and adults who have waning immunity to the disease. A. Tozzi (Italy) ascribed these changes not only to waning immunity, but also to atypical presentation or unrecognized disease, improved diagnostic testing and increased awareness and surveillance. There were a number of poster presentations from various countries on different aspects of the disease ranging from outbreaks in infants, adult vaccination and cocooning (immunizing pregnant mothers against pertussis to protect their newborn baby).

The Asian Society of Paediatric Infectious Diseases presented on their vast knowledge of Dengue fever. The recent change in the WHO Classification of disease has lead to uncertainty in classifying severity of disease as well as managing these patients. While the classification is easier to follow in areas where Dengue is common and there is good clinical expertise, Dengue is now spreading to new areas previously unaffected. It is in these areas where there is difficulty in classifying the disease and subsequent management of the patients. Speakers proposed reviewing the classification with input from multiple centres.

A separate symposium was held on Kawasaki disease, characterized by fever and rash and having long term cardiac complications if unrecognized and untreated. Jane Burns from the USA, and a world expert on the disease, presented on current approaches to treatment. Specifically on complicated disease not responding to the initial dose of IVIG. Current recommendations are a second dose of IVIG 2g/kg or Infliximab 5mg/kg or cyclosporine or steroids.

The 8th WSPID Congress will be held in Cape Town 20-23 November 2013. This will be an excellent opportunity for everyone interested in infectious diseases to attend and meet other infectious diseases colleagues from around the world.

Heather Finlayson MBChB DCH FCPaeds (SA) Cert Id(Paeds)

Tygerberg Children's Hospital, Dept. Paediatrics and Child Health Stellenbosch University

Evaluation of clinical STI services in Gauteng - knowledge, attitudes and practice amongst HCWs



Sexually Transmitted
Diseases Society
of Southern Africa

STI incidence and prevalence varies widely within the same region, within countries and between rural and urban populations. One of the key main determinants for these observed variations is access to quality STI care. In South Africa, STI care is provided in primary health care centres rather than dedicated STI clinics. In most cases, HIV services are not currently integrated and STI care among people living with HIV/AIDS who attend such services is often sub-optimal.

Within South Africa, STI diagnosis is based both on syndromic management (public sector and some private cases) and aetiological (laboratory-based) diagnosis (some private cases). Syndromic management is performed by health care providers in both public and private facilities where consistent symptoms and signs are identified and treated using appropriate flow charts, followed by patient education and counseling, risk reduction, partner notification and general health care seeking behavior. Ensuring the high quality of STI management is a public health concern and the main priority of the national HIV programme. Generally, there is a poor understanding of STI/HIV among patients seeking STI care. There is no available provider perspective in terms of knowledge, attitudes and practices together with HIV counseling and testing which may be a barrier to STI/HIV care.

Thus, an anonymous survey was undertaken among STI providers in private and public outpatient clinics that reported more than 100 STI cases to National Department of Health per year. Facility managers were contacted in advance and invited to participate to assess provider knowledge, attitudes and practices (KAP) regarding STIs and HIV/AIDS. Key study findings were that STI and HIV training was a major requirement as the majority of the providers were able to recognize STI syndromes but few were able to identify the causative agents of the syndrome. The facility manager survey showed that more than 80% of providers still required STI training and more than 60% refresher courses. STI training attendance was lower in private than in public illustrating the need for continuous refresher training in that sector.

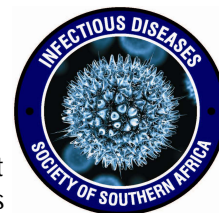
Constant supply of essential drugs was identified as a way to improve STI care services. Generally, more STI patients were seen in public than in private and more nurses were the providers of STI care. More than 90% of providers thought it was their most important responsibility to recommend HIV testing to each STI patient they saw and are willing to perform finger-prick HIV test if given proper training.

In terms of provider attitudes, it was showed that more than 70% of male STI patients in both public and private have multiple partners and are not willing to use condoms consistently with every partner while 50% of females are not willing to ask their partners to use a condom. About 15% of providers did not think it was appropriate to give male condoms to female and adolescent STI patients and do not believe that condoms can prevent HIV/STI. Provider knowledge about condoms was high in both practices while knowledge about HIV transmission was variable. The provider attitude and perception was similar in both public and private with more emphasis on willingness to perform HIV testing.

The misdiagnosis of STIs by a significant percent in both practices as well as lack of knowledge about the correct treatment was a concern, emphasizing the need for refresher training. The results of the assessment need to be disseminated to local partners and stakeholders so that improvement strategies can be implemented. There is an urgent need to evaluate STI provider training curricula and to enhance the existing and develop new training materials in order to improve quality of STI case management and prevention.

Frans Radebe, NICD

Notes from a small country - Experiences of a month in Malawi



In the crowded ward an old lady started wailing. The blanket pulled over the head of the patient made it clear that someone had just died, right there and then. Being an all female ward it was probably the old lady's daughter. The room was crowded and the grief very public; after some minutes the woman was comforted by others in the room and soon enough all the belongings were being gathered together and she prepared to leave. The bed would soon be filled by another; probably one of the patients lying on a mattress in the corridor. Attending to the next patient the consultant prescribed a course of steroids but we were told that the pharmacy was out of stock. As if by magic the intern produced a few steroid tablets from his coat pocket and instructed the patient how to take them. Just then another old lady began to wail and a scene of grief, similar to the one that I experienced earlier played out. She flung herself on the floor and cried for some minutes before being helped to her feet. Again she was comforted by those around her and was soon gathering together her belongings and preparing to leave.

First impressions can be very valuable and that first ward round at Queen Elizabeth Central Hospital in Blantyre gave me an impression of over-crowding, shortage of drugs and grief. My first impressions of medicine in rural South Africa were not so different. The death rate was very high, shortages of drugs were common and I would sometimes stockpile small quantities of essential drugs for emergencies. The greatest difference though was the overcrowding. The distance between beds at Queen's is often just enough for a doctor to squeeze between by shuffling sideways. With few nurses available the basic care of patients falls to their relatives who also live in this cramped space. Conducting ward rounds under these conditions can be precarious with team members constantly getting in each other's way as the group attempts to navigate the ward. While certainly not crowded with nursing staff there always seemed to be plenty of people in white coats or with stethoscopes. Blantyre is the main teaching hospital in Malawi and the wards are well populated with attentive medical students. Some days it was possible to see half a dozen consultants in the same crowded ward looking after patients and each teaching a group of junior doctors and students. This reminded me of my first impressions of tertiary medicine in South Africa. I was initially uncomfortable attending ward rounds with twice as many doctors as had been available to run an entire rural district hospital but soon realised that the justification was the necessity of continuing to teach students and junior doctors.

As time passed and the crowding seemed more manageable it became clear that the lack of resources was worse than I had initially appreciated. Not only were steroids out of stock but so were many basic medications. It was common to give relatives a prescription to fill at a private pharmacy if they could afford to buy whichever medication was out of stock in the hospital pharmacy. The laboratory was also short of reagents meaning that many basic biochemistry tests were also not available. It is perhaps hard to believe then that the hospital boasts a fully functioning MRI scanner and a high quality blood and CSF culture service. This is because Blantyre is also the major medical research centre for Malawi and the patients benefit considerably from the research infrastructure. The MRI scanner is principally for cerebral malaria research by the Blantyre Malaria Project but also offers a number of scans for patients. The Malawi Liverpool Wellcome Trust building is busy with research activity but also offers the microbiology service as a direct benefit to current patients.

As a result clinical care at Queen's can sometimes be a peculiar mix of high and low resource medicine. For example, a patient presenting with seizures might benefit from the opinion of an expert neurologist, have high quality CSF analysis and an MRI scan but it may not be possible to perform an HIV test or measure the electrolytes. It may be that anti-convulsants are out of stock and all the while the patient will be relying on relatives for all their basic care needs.

To experience rural medicine in Malawi I visited the 450 bed district hospital at Mulanje. There were no consultants or teams of medical students on the wards this time, as the entire hospital is staffed by just two doctors. I was shown around by the ebullient Dr Charles Chimphambano who presented an extremely positive approach to the

challenges facing the hospital. He informed me that the bulk of the clinical work including a large HIV service, a busy maternity ward and an operating theatre is performed by 18 Clinical Officers. It has been a cliché that there are more Malawian doctors in Manchester than in Malawi. Although that is not true, and probably never has been, one response to the shortages of doctors has been to develop the cadre of Clinical Officer. Trained for 3 years, Clinical Officers perform a wide range of vital services under the guidance of doctors and at Mulanje they were performing all the clinical duties normally assigned to junior doctors. I was asked many times whether South Africa also relies so heavily on CO's and people were surprised that the concept of Clinical Associates is only now being developed and that the first 25 graduates only started work this year.

The patients at Mulanje were also very sick and the shortage of both drugs and tests was similar to Queen's but there were some surprises in store. We were discussing a patient with HIV and cough whose sputum microscopy was negative for AFB's. The CO might have suggested a chest X-ray but we both knew the X-ray machine was not working. Instead, and to my great surprise he suggested a Gene Xpert test on the sputum. I visited the laboratory to see the fully functioning machine that had recently been donated by an NGO along with a supply of consumables. So while a full blood count and CRP were out of the question we were able to move directly to state-of-the-art molecular diagnostic testing.

My over-riding impression of Malawian medicine was of a range of well qualified staff, from specialists to clinical officers who were frustrated by the lack of infrastructure necessary to provide care commensurate with of their training. Meanwhile the medical school is providing an excellent learning experience for the students and the infrastructure of the research centres is filling important gaps in the clinical service. Comparisons with South Africa are tempting but Malawi has its own unique problems and solutions. One thing that is not lacking is a dedicated workforce providing the best care possible in difficult circumstances.

I would like extent my greatest thanks to Dr Theresa Allain and the members of the Department of Medicine for their time and hospitality during my stay in Blantyre.

I would also like to thank IDSSA for providing an educational grant to assist with the expenses incurred..

Tom Boyles
Senior registrar
Department of Infectious Diseases & HIV Medicine
University of Cape Town

FIDSSA - GlaxoSmithKline Research Fellowships 2012



We are delighted to announce that following the success of the 2011 FIDSSA-GlaxoSmithKline Research Fellowships, won by Drs Angela Dramowski and Warren Lowman, that GlaxoSmithKline have generously donated R200,000 as an unrestricted educational grant to FIDSSA, that FIDSSA will be using to fund the 2012 FIDSSA-GlaxoSmithKline Research Fellowship programme.

Details of the request for applications are being finalized and a call will be sent out in the next month. Only paid-up members of FIDSSA will be eligible for these awards.

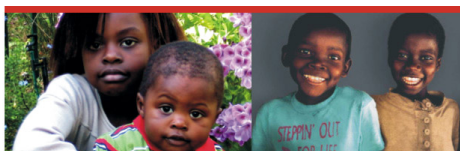
Conference watch



Conference season is already upon us and the first big HIV conference of the year kicks off in Seattle on 5th March. CROI 2012 is the 19th conference on retroviruses and opportunistic infections with plenaries on ART for prevention and AIDS and the global burden of disease amongst others. Follow the conference and its pod-casts via the FIDSSA website. If its emerging infectious diseases you want, then ICEID 2012 starts a week later in Atlanta, followed in March by the first big Clinical Microbiology and ID conference, ESCMID 2012, held this year in London.



On the local front, SASTM's conference, Travel Health Africa - The Past, Present and Future will be held at the Sandton Convention Centre in September, with David Shlim and Pat Schlagenhauf as its international invited faculty. Both are internationally renowned speakers and leaders in the field of Travel Medicine.



Later in the year, see the International African Vaccinology conference in Cape Town, hosted by the Vaccines for Africa initiative (VACFA), University of Cape Town and jointly organized by UCT and the National Institute for Communicable Diseases (NICD).

Details of these and other conferences during 2012 can be viewed at http://www.fidssa.co.za/B_events.asp

SAVE THE DATE



Cape Town, South Africa
5-10 September 2013



www.isirv.org

