



between three groups, namely new housing estate residents ($N = 73$), site tenure residents ($N = 158$), and a group living in informal housing ($N = 103$).

From the repeated measures analyses, estimated marginal means showed significant group and time effects for overall quality of life (Fig. 1). Although there were no differences between new housing estate and site tenure residents with regard to quality of life ($p > 0.05$), both these groups had a better quality of life than informal housing residents ($p < 0.05$). This finding was not unexpected as previous research has shown that quality of life is very poor in the latter.³ In 2001, quality of life was significantly better than in 1999 ($p < 0.01$), but returned to similar levels to 1999 in 2003 ($p > 0.05$). It is possible that changes in living circumstances in 2001 were responsible for this effect. A more likely explanation is provided by the classic study of the effects of fortune and misfortune on quality of life.⁴ The study found that lottery winners' quality of life shot up, while that of accident victims decreased dramatically immediately after the event, only to return to previous levels at a later date.⁴

There were no significant group or time effects ($p > 0.05$) for wellbeing (Fig. 1). This lack of group or time effects provides support for the model of homeostatic wellbeing.⁵ Analogous to the homeostatic maintenance of blood pressure and temperature, this model considers that wellbeing is actively controlled and maintained by psychological factors that function under the influence of personality.⁵

Overall findings revealed that access to better housing positively affects quality of life; there is habituation of quality of life in the long term, as people adapt to both positive and negative

life events; and, irrespective of living conditions, wellbeing is maintained at a homeostatic level.

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Post-exposure prophylaxis for rape survivors

To the Editor: In a recent incident in the Eastern Cape a cocaine addict was arrested on drug possession charges and put in a holding cell. Sadly, during his time in the cells he was raped. Naturally the victim was very concerned about the possibility of having contracted HIV. However, the attending district surgeon refused to provide antiretrovirals (ARVs) as part of post-exposure prophylaxis (PEP). SANCA drug counsellors were faced with this distressed and traumatised victim when he turned to them for help after his release and were quite perplexed by the failure of the district surgeon to prescribe PEP for 28 days.

Why were the ARVs not provided? One possibility is that there may have been a supposition of potential poor medication adherence. Predicting a person's adherence based on speculation would seem to be unfair. Is there in fact proof that substance dependence causes poor adherence to ARV medication? The evidence is mixed, with a review of the issue showing that 11 of 26 studies found no association with substance abuse.¹

The second possibility is that there may have been a concern around the pharmacological interaction between cocaine and ARVs. One review on the issue does mention an increased risk of a cocaine overdose with antiretroviral therapy, citing that the administration of a potent CYP 3A4 inhibitor could result in a cocaine overdose. ARVs that induce CYP 3A4 activity, such as nevirapine, may shift the metabolism of cocaine from hydroxylation to *N*-demethylation and create a higher level of the potentially toxic metabolite.² However the article does not mention the likelihood of this event occurring, and nevirapine is in any case not used in any PEP regimens.

But are any of these issues relevant considerations in this case? Shouldn't all rape survivors have the right to ARVs,

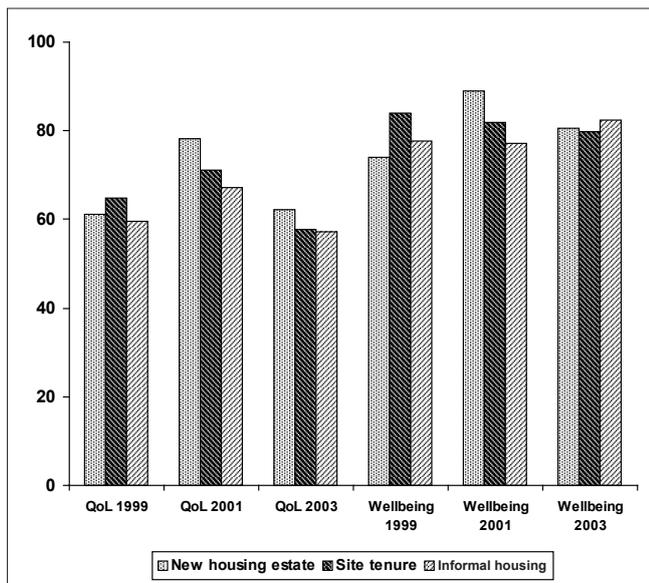


Fig. 1. Overall quality of life (QoL) and wellbeing in 1999, 2001 and 2003 among new housing estate, site tenure and informal housing residents.



whether or not they are drug dependent? In our opinion this should be a critical part of the medical and psychiatric treatment of the traumatic event.

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Triage in emergency departments

To the Editor: We value the opportunity to reply to the letter by MacFarlane and Naidoo¹ regarding triage in South African emergency departments (EDs). We note with deep regret the recent passing of Professor MacFarlane; the whole emergency medicine community will feel his absence.

The triage tool they propose is a modification of a modified tool – while both the original Australasian Triage Score and the Canadian modification have been shown to work well at identifying priorities in their settings, there is no evidence that this could be extrapolated to our setting. We are not aware of any evidence that the suggested modification is evidence based.

Furthermore, our own studies have shown that the reliability and validity of the triage scores applied are related to the complexity of the tool and the level of the triage nurse. We would argue that the suggested tool is too complex for enrolled nurse assistants (ENAs)/enrolled nurses. It is in this group of health care professionals that an available pool of triage nurses is likely to be found, and it is this group that the Cape Triage Score (CTS) is aimed at.

As the authors point out, the CTS was developed by the Cape Triage Group and reported on in this *Journal*.² This tool was

launched across all public EDs in the Western Cape in January 2006, and is also used throughout the MediClinic group nationally. The tool was validated on 25 000 patients in both the public and private sector, and has been shown to dramatically reduce ED waiting times. We have submitted the findings of one large study to this *Journal*, and a number of other articles are being written up for publication at this time. While it would be inappropriate to pre-empt these articles, we can state that the CTS clearly identifies the most ill patients, and performs well in distinguishing between other groups of acuity. It predicts death, the need for admission, resource usage and departmental length of stay. It further reduces mortality and improves waiting times. Finally, current studies show that ENAs can use the tool as accurately as doctors or registered nurses.

We held the inaugural meeting of the South African Triage Group (SATG) in Durban in June 2006, consisting of 59 representatives from all nine provinces. The SATG has the aim of introducing the CTS as a national triage tool – the South African Triage Scale (SATS) – throughout the country. The national Department of Health has been approached to facilitate this process. We will keep readers of this *Journal* informed of progress in this regard.

The SATS is a living tool. Research will continue, and if changes are required they will be made in time for the International Emergency Medicine Conference in South Africa (October 2007). In the meantime the SATS is a tool that has been developed to fit local needs, and that has been shown to have a significant positive impact on patient care.

The Emergency Medicine Society of South Africa has provided the SATG with a 'home', while the Council for Health Service Accreditation of South Africa has recognised this triage tool.

Readers wishing to receive more information on the SATS should contact capetriage@bvr.co.za or visit www.triagesa.co.za

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