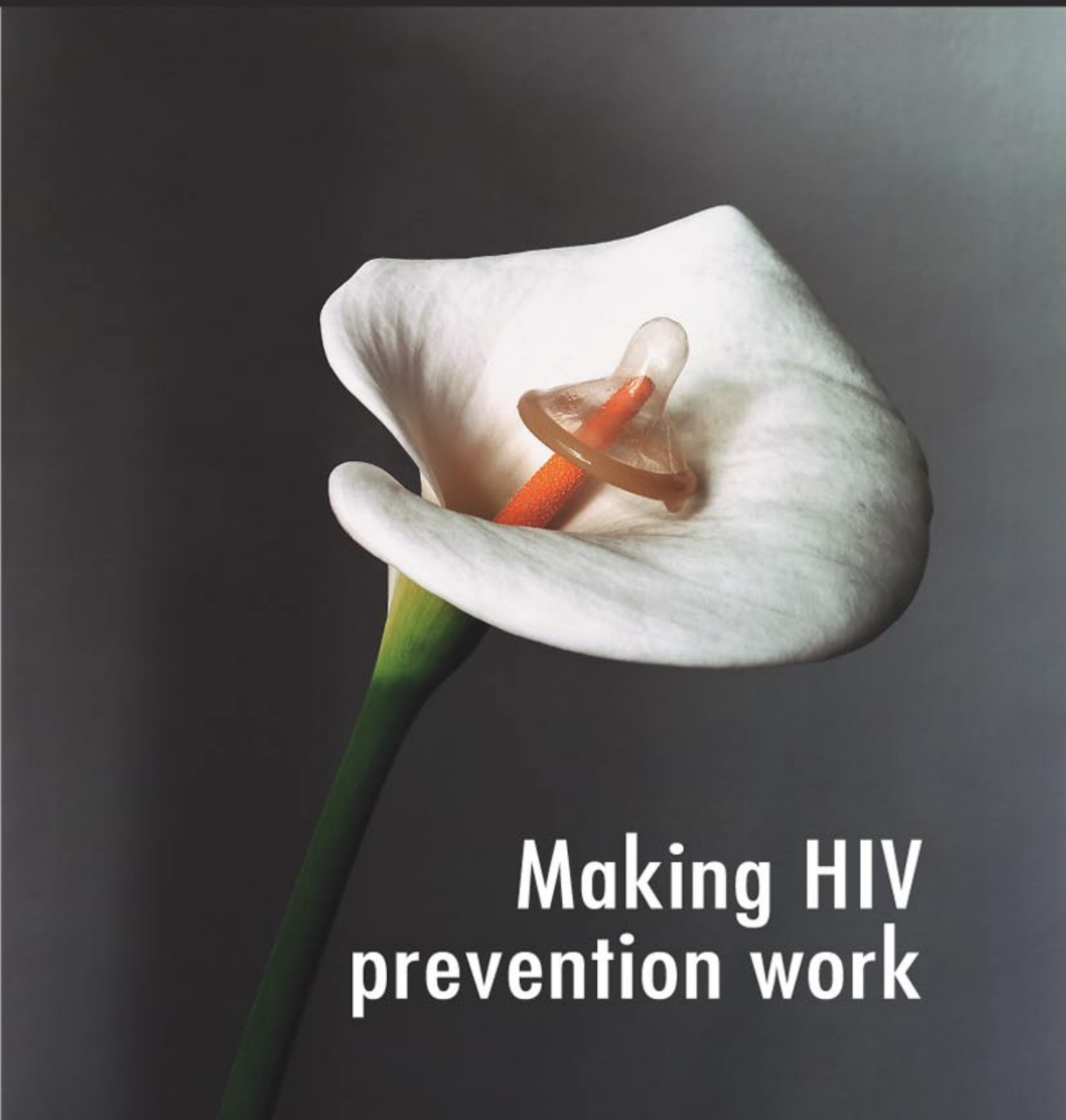
EQUAL TREATMENT

NEWSLETTER OF THE TREATMENT ACTION CAMPAIGN NOVEMBER 2006



Making HIV prevention work

This issue of Equal Treatment is dedicated to the memory of Oupa Fazi, TAC's Limpopo Organiser, who tragically took took his own life on 20 September. We urge TAC's male members to seek psychosocial support to deal with their problems. Hamba Kahle Oupa.

TAC Deputy-Chairperson, Nkhensani Mavasa addressed the UN General Assembly in May. She was the first woman living openly with HIV to do so.

TAC held demonstrations across South Africa throughout August and September highlighting the Minister of Health's failure to deal with the country's health crises. This photo is from Gauteng. Note the imaginative props.

24 August: Washington DC supporters call for the South African Minister of Health to be dismissed. Demonstrations against the South African government's failure to deal appropriately with the HIV epidemic were held in many countries.

Protesters stand behind TAC treasurer, Mark Heywood, at a plenary meeting at the International AIDS Conference in Toronto in support of Heywood's call for the Minister of Health to resign. The Minister was sitting in the front row.

TAC
TREATMENT ACTION CAMPAIGN

EQUAL TREATMENT

November 2006
Issue 21

CONTENTS

Equal Treatment is published by the Treatment Action Campaign
34 Main Road Muizenberg, Cape Town, South Africa, 7945

Tel: +27 (0) 21 788 3507 Fax: +27 (0) 21 788 3726
Email: et@tac.org.za Website: www.tac.org.za

Distribution: 40,000 copies

Editors: Nokhwezi Hoboyi and Nathan Geffen
Thanks to David Goldblatt for taking and donating the front cover photo to Equal Treatment.

Thank you to Oratile Kidd, Eduard Grebe, Gregg Gonsalves, John Butler, Mark Colvin, Marissa Mika, Christina Villegas and Brian Honermann for their essential contributions to this issue.

Administration: Faniswa Filani
Layout: Darryl Cotton
Layout consultant: Doret Ferreira

TAC is funded by Atlantic Philanthropies, Bread for the World, Public Welfare Foundation, Open Society Foundation, MSF, HIVOS, ANSA, South Africa Development Fund, Belgian Development Corporation, Ford Foundation, Netherlands Government, OXFAM Australia, SIDA, AusAID, AFSA and many individual donors.

TAC is committed to providing people with HIV/AIDS, their families and caregivers accurate information about life-saving medicines and treatment. However TAC and its leaders are independent of the pharmaceutical industry and have no financial interests with it.

editorial

ADMIT THE TRUTH AND SAVE LIVES!

"We [must] declare our schools HIV prevention zones. Children are falling pregnant and becoming HIV-positive. As parents we don't like that but we want to protect our children rather than only preach our beliefs to them. Our children are sexual beings and explore their sexuality. They need condoms and information on school premises because clinics are closed by the time school is finished."

Emma Baleka
Chairperson of SGB Joint Forum, Nelson Mandela Metro

"As a student living with HIV, I struggle. We do not receive [enough] information about HIV/AIDS. We therefore see no benefit in disclosing our status within school ... The pregnancy rate is high ... and nurses discriminate against us when we go to the clinic after school. They shout at us for wanting condoms and contraceptives. There is no support mechanism in our schools for students infected or affected by HIV."

Asanda Mofu
Rubusana High School, Queenstown

Ahead of the International AIDS Conference in Toronto, the Minister of Health claimed that South Africa has the most comprehensive AIDS programme in the world. Our country's failure on key indicators such as HIV infections prevented, premature deaths and illness speaks the truth behind our glorified statements of achievements. TAC rightfully pointed these problems out in Toronto. The recent Statistics South Africa reports on mortality shows that AIDS and its associated opportunistic illnesses account for the largest number of deaths.

The Actuarial Society estimates that there are over 1,400 new infections daily. We know there are many things that if done well could prevent new infections. For example, it is possible to end the paediatric epidemic. We are not reducing new infections and mortality in children. The Confidential Enquiry into Maternal Deaths shows that AIDS is the biggest killer of pregnant women in South Africa. There are some communities where HIV prevalence among women is up to 60%. Our country is failing women.

We need to give communities the resources they need to address the socio-economic and cultural drivers of the epidemic. Through community organising, a well functioning criminal justice system and other state machinery responsible for women's rights, we can communicate to society that violence against women is not acceptable in democratic South Africa. This will help reduce new infections.

Emma Baleka speaks as a parent who understands that in order to be effective on prevention we have to support young people and let go of our need to preach our values. Asanda Mofu's words demonstrate some of the inexcusable failures to address the epidemic. Both are leaders our country has as a national resource. It is this resource which we squander when our government fails to lead. There are thousands of them, including many in TAC and other community formations, who are ready to take our communities forward.

TAC agrees with the Deputy President's call for unity to save lives. At a recent meeting with her we expressed our willingness to be part of a united front on the basis that we sort out the implementation problems, stick to official national policy and take a forward looking approach to managing the HIV epidemic. This includes addressing related issues such as the human resources crisis in the health system.

This issue of Equal Treatment examines HIV prevention, what's causing it to fail and what needs to be done to make it work. We hope you find it useful.

Sipho Mthathi
TAC General Secretary

Equal Treatment
November 2006

THE CRISIS OF HIV PREVENTION

South Africa is failing to prevent new HIV infections. Annual surveys show increasing HIV prevalence among pregnant women who attend public antenatal clinics. In 1990 less than one percent of this group were HIV-positive. Today over 30% are. The Actuarial Society of South Africa estimates that over 500,000 people will be infected with HIV this year: about 1,400 people a day. This is a crisis.

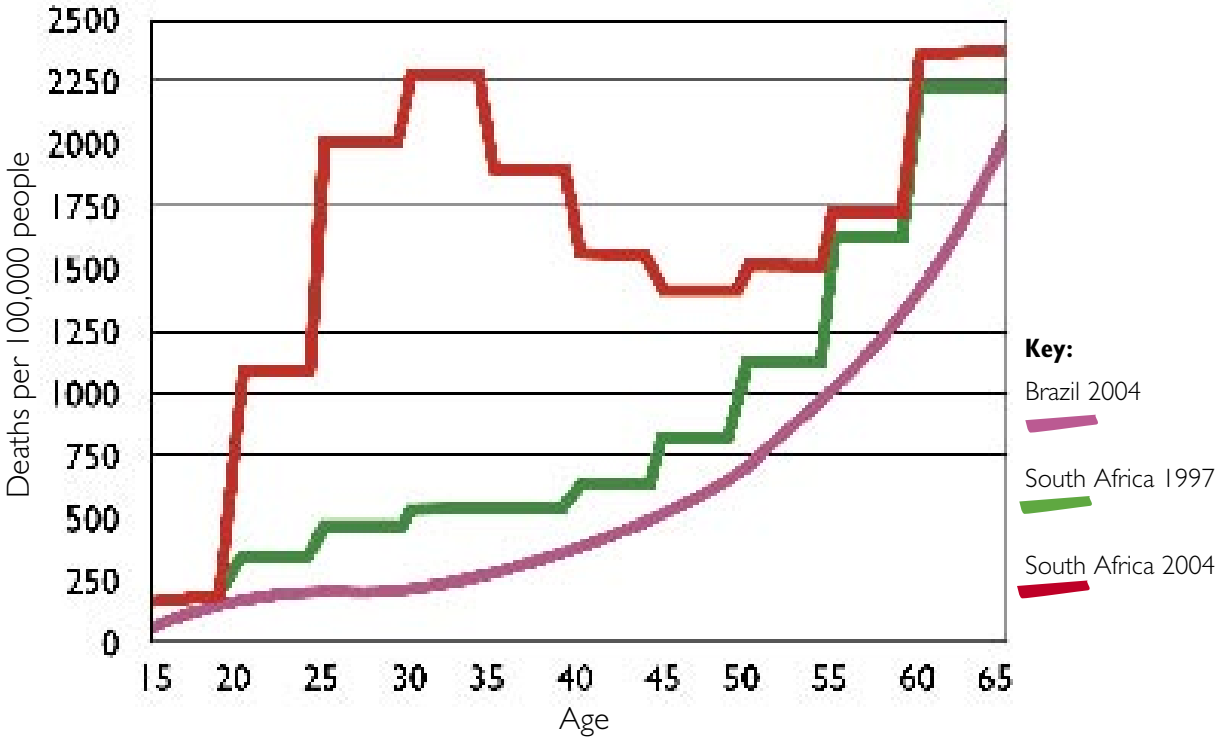
Statistics South Africa reports show a massive rise in deaths since 1997.

The number of recorded deaths increased from 316,505 in 1997 to 552,825 in 2003, a 75% increase. In 1997, the largest number of adult deaths occurred in people aged 75-79. Now the age group in which the largest number of adult deaths occurs is 30-34. This is highly unusual, since people typically die when they are older. Only the HIV epidemic can explain this.

An effective response to the epidemic requires much greater leadership to prevent new infections and roll out treatment.

An effective response to the epidemic requires much greater leadership to prevent new infections and roll out treatment.

Recorded female deaths in South Africa and Brazil for ages 15 to 64



The graph compares the age-distribution of female deaths in Brazil and South Africa. Brazilian deaths in 2004 are what one would expect: Fewer people die at younger ages. The South African deaths in 1997 show a similar (but already changing) pattern. The South African deaths in 2004 show the abnormal situation of more women dying in their 30s than at older ages.

Technical note: The graph show deaths per 100,000 people. Therefore it depicts more people dying between 60-64 than 30-34. But the absolute number of deaths in the age-group 30-34 exceeded any other age group.

Constructed using mortality data from Statistics South Africa and Instituto Basileiro de Geografia e Estatística.

HIV prevalence (2005): 10.8%

HIV prevalence in men: 8.2%

HIV prevalence in women: 13.3%

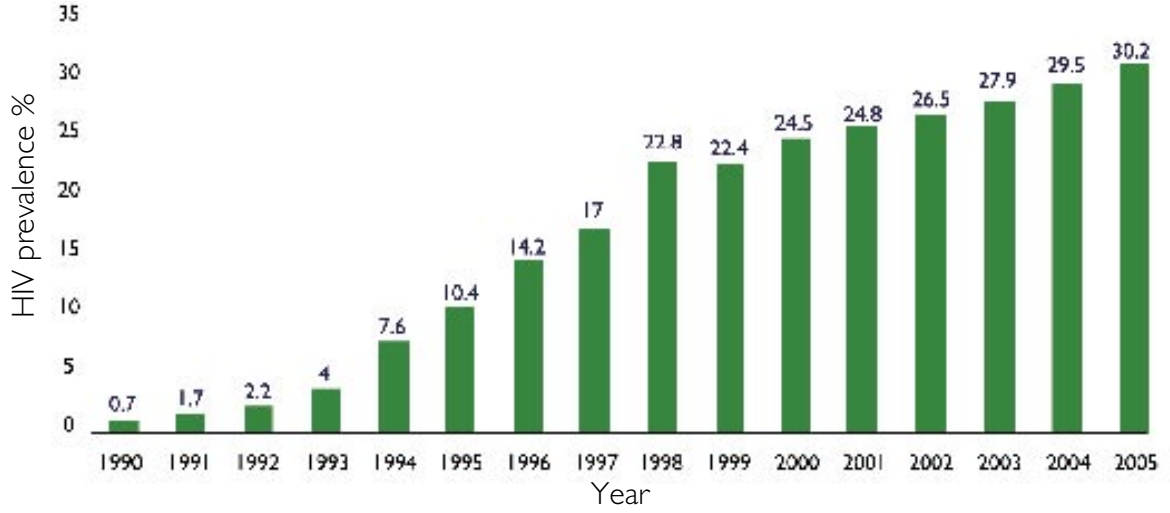
Source: HSRC Household Survey 2005

Total HIV infections (2005): ±5.2 million

Total HIV deaths (2005): ±326 000

Source: Actuarial Society of South Africa (ASSA2003 model)

HIV prevalence among pregnant women attending public antenatal clinics



This graph shows how South Africa started with a small HIV epidemic in 1990, with less than 1% of pregnant women attending public antenatal clinics testing HIV-positive. In 2005 over 30% tested positive. Interestingly, in the early 1990s Thailand had a similar HIV prevalence. Yet the South African epidemic exploded and Thailand's was brought under control. Historical, social, political and cultural differences in the two countries resulted in very different epidemics developing.

Graph source: National HIV & Syphilis Antenatal Sero-Prevalence Survey in SA 2005

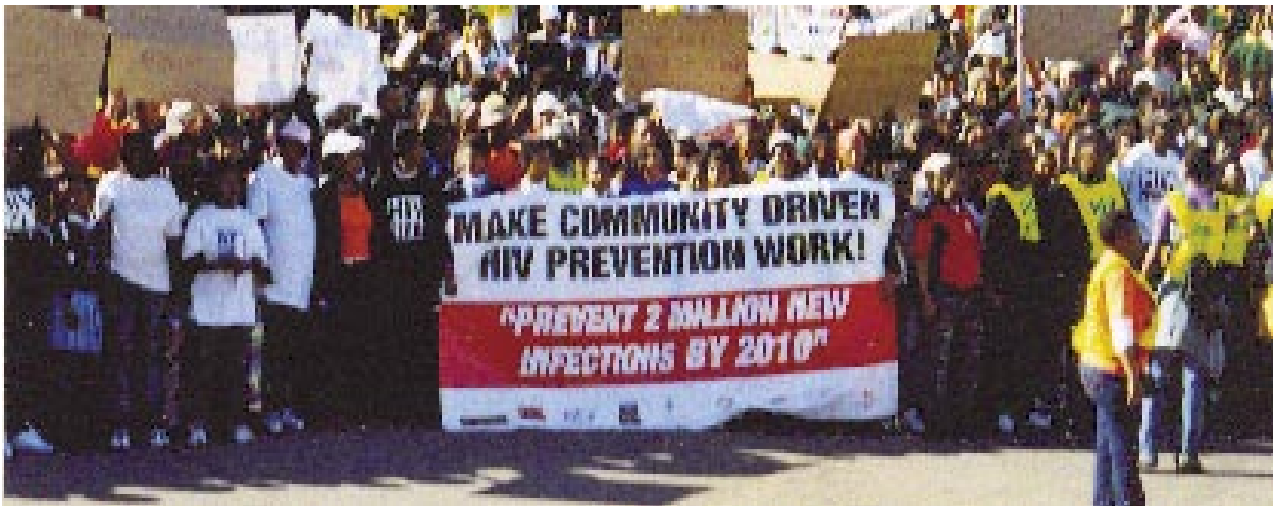


Photo by Masizole Gonyela

Over 10,000 people, mainly youths, took part in a march in the Eastern Cape on 15 June 2006 for improved HIV prevention measures, particularly condoms and sex-education in schools.

Equal Treatment
November 2006

WHEN PREVENTION FAILS

Abstinence-only programmes endanger youth. They have been around to prevent teenage pregnancy for over two decades. When the AIDS epidemic started in the early 1980s, these programmes were marketed as HIV prevention programmes. Despite evidence that they do not work, they continue to be implemented. This is largely because of conservative forces in the United States and developing world countries. They promote abstinence-only as part of a larger moral and cultural project which has nothing to do with lowering pregnancy rates or preventing HIV.

Photo by Masizole Gonyela

The US Government's President's Emergency Plan for AIDS Relief (PEPFAR) reserves a certain proportion of funding for abstinence programmes. This has resulted, for example, in the roll-back of condom promotion programmes in Uganda, supported by President Museveni.

The US Government's own research in Uganda supports the conclusion that condoms played an important role in Uganda's HIV decline, and not only for "high-risk" populations such as sex workers.

Evaluations of abstinence-only programmes in at least twelve U.S. states and a federal evaluation in 1997, indicate that abstinence-until-marriage programs show no long-term success in delaying sexual initiation or reducing sexual risk-taking behaviours.

The scientific evidence shows:

- Abstinence-only programmes do not delay the age at which young people start having sex. Some studies even show evidence of increased risk-taking behaviour among sexually active teens;
- There is no evidence showing that abstinence-only education is effective for preventing HIV, sexually transmitted infections or pregnancy.
- More comprehensive programmes, which include discussions of abstinence, but also about condoms, contraception, sexually transmitted infection risk reduction, do delay sexual debut and increase condom use;
- Many abstinence-only programmes distort information about the effectiveness of contraceptives, misrepresent the risks of abortion, blur religion and science, treat gender stereotypes as scientific facts, and contain basic scientific errors.

We must campaign for comprehensive sex education in our schools. This will give young people the tools they need to understand their bodies, the risks of various behaviours and how to prevent HIV and other sexually transmitted infections.

Sources: Human Rights Watch: The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda, http://hrw.org/reports/2005/uganda0305/UHP/MOH/UAC/MEASURE

Young people, sex and AIDS in Uganda. Singh et al. "A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline" (December 2003), Alan Guttmacher Institute Occasional Report No. 9.

HIV TRANSMISSION AND ALCOHOL

Sylvia Fynn interviewed men around KwaZulu-Natal about how alcohol abuse resulted in them taking risks that led to HIV infection. Simphiwe Ngongoshe spoke openly about his experience.

Simphiwe was born in East London. He has two brothers and one sister. He matriculated well, but due to financial troubles he was unable to go to a tertiary institution to further his studies. Being unable to further his studies drove him to alcohol, as he had nothing to do in the township. He started going out a lot and became a regular customer at all the taverns in his neighborhood. During this time he had unsafe sex with many different partners and spent most of his money on alcohol and entertaining women. Everything changed when he met one particular girl that he loved very much and decided to settle down with her. The only problem was that she also had a drinking problem and continued to sleep with other partners.

After a while Simphiwe noticed that his girlfriend had skin problems. When he asked her about the cause of her skin problems, she said that it was nothing to worry about. Later, she was admitted to hospital. He tried to speak to her parents about her illness. The girl's family told him that they didn't know what was wrong with her. She died soon after, leaving Simphiwe with many unanswered questions about the cause of her death.

He then decided to go for an HIV test, and tested positive. He denied his status for a while and drank more than before, trying to drown his sorrows. Eventually he decided to tell his family, but didn't have the courage to tell them face-to-face, so he wrote them a letter disclosing his status. To his surprise he was answered with a lot of calls giving him hope, love and support. This inspired him to change his lifestyle and join a support group, where he received a lot of information about HIV. He has since reduced his drinking and has started taking antiretrovirals.

Photo by Sylvia Fynn

Equal Treatment
November 2006

EMPOWERING WOMEN IN LUSIKISIKI

Thandeka Vinjwa interviewed Akona Ntsaluba about her work on gender rights in the Eastern Cape. Akona is a 29 year-old mother of two sons from Lusikisiki. She is lesbian, HIV-positive, survived rape and is taking antiretrovirals.

Photo by Thandeka Vinjwa

"When addressing women's issues," Akona says, "it is difficult for women to be bold and stand up for their rights; they often have an inferiority complex towards men."

Ending gender-based violence and improving women's position in society is critical in the struggle to prevent HIV, since women are often not in a position to protect themselves, for example by insisting on condom use. Women are more vulnerable to HIV infection both biologically (HIV is more easily transmitted from a man to a woman) and socially.

Akona is open about her sexual orientation to her family and the community. Despite this, "the community needs much more information on gender and sexuality," she says. She is running a campaign on gender, sexuality, rape and domestic violence in her district. She targets TAC branches, clinics, schools, stakeholders and NGOs addressing these problems. She holds workshops on gender and sexuality issues for peer educators, village support groups, lesbians, gays, bisexuals and transgendered people.

In addition to the campaign and the workshops, Akona has conducted informal research on teenage pregnancy, HIV/AIDS, sexually transmitted infections (STIs), and terminations of pregnancy by young people between the ages of 13 and 19. She did this in collaboration with other active TAC volunteers. "Through the campaigns, research and workshops I have done, I found that many women feel inferior to men. As a result they often become passive victims of domestic violence and rape." Out of 22 rape cases that she researched, 18 cases were reported to the police. But only one rapist is in prison and another one is out on bail.

"Some of my best experiences spring from being a member of the Lusikisiki Community Police Forum and working with the Lesbian and Gay Community Centre in Durban and Johannesburg."

They successfully formed an antiretroviral support group with over 70 members. One of the major issues hampering the fight against domestic and gender-based violence is the shortage of staff in the police service, which makes it difficult to follow up on cases. Nevertheless, they are trying to get women to report domestic violence and rape cases rather than keep silent about it, so perpetrators can be punished.

SURVIVING RAPE AND HIV

Georgina Booysen interviewed Sandra Laban from Robinvale, Atlantis in the Western Cape. She has been living with HIV for eleven years. At the age of 15, she was raped by four men inside her mother's house.

Sandra knew these men because they were friends of her step-father. The rape happened while her mother was working night shift. After the incident she went to her neighbours to ask for help and they called the police, but by the time the police arrived the perpetrators had fled.

After the rape, the police took her to the nearest hospital. Three months later a test showed that she was HIV-positive and pregnant as a result of the rape. At the hospital they told her that it was too late for an abortion and she had to keep the baby. The child died soon after birth. She went for counselling for the next two years.

One Sunday afternoon, Sandra had an argument with her stepfather. She tried to kill herself by taking an overdose of sleeping tablets. She was in a coma for one week at Somerset Hospital. The arguments led to her stabbing her stepfather to death in 1998. Sandra was sentenced to five years imprisonment in 2000 but was released after ten months.

Sandra became HIV-positive and pregnant as a result of rape.

In 2003 she moved to Oudshoorn where she met a man with whom she started a relationship. They did not use any protection during their sexual encounters and she fell pregnant, though her partner remained HIV-negative. During pregnancy Sandra enrolled in the prevention of mother to child transmission programme where she received nevirapine. Her baby was HIV-negative and is now a healthy three-year-old.

Last year, Sandra's CD4-count dropped to 48 and her weight dropped to 45 kg. She started antiretroviral treatment and regained some weight – she now weighs 72.5 kg. Her CD4-count has also increased. She disclosed her status to the public and has started to lead workshops, raising awareness of HIV/AIDS in schools and among the youth.

Equal Treatment
November 2006

TAILORED HIV PREVENTION

HIV prevention is difficult. Many prevention programmes start off with great expectations and yet produce poor results. No single solution fits all people. HIV prevention needs to be tailored differently for different vulnerable people.

Men who have sex with men

The extent of the HIV epidemic among men who have sex with men is unknown. This is a serious problem. A survey will soon be conducted by the Human Sciences Research Council and Triangle Project to better understand this aspect of the HIV epidemic. There has to be more safer sex messaging, condom and water based lubrication availability in gay venues, prisons and same sex hostels.

Photo courtesy of Triangle Project

Photo by Luckyboy Makhondwane

Sex workers

Sex workers and their clients are at very high risk of HIV transmission. However, because sex work is illegal, it is very difficult to reach sex workers with prevention, destigmatisation and treatment programmes.

Sex workers often cannot force their clients to use condoms. If they could organise openly, they could enforce minimum health standards for their work. It is therefore critical that sex work be decriminalised.

Prisoners

There has been a large increase in deaths in prisons over the last decade due to HIV. Prisoners probably have a higher HIV infection rate than the general population. The Departments of Correctional Services and Health need to make condoms more widely available in all prisons, promote safer sex education in prisons, conduct a survey to find out HIV prevalence in prisons, but that is respectful of prisoners' rights, and make treatment available for prisoners.

There is a lack of transparency about prison conditions in South Africa. The Jali Commission report, which examined the administration of prisons, needs to be released. HIV prevention can only be addressed if there is transparency and openness.

Photo by Thandeka Vinjwa

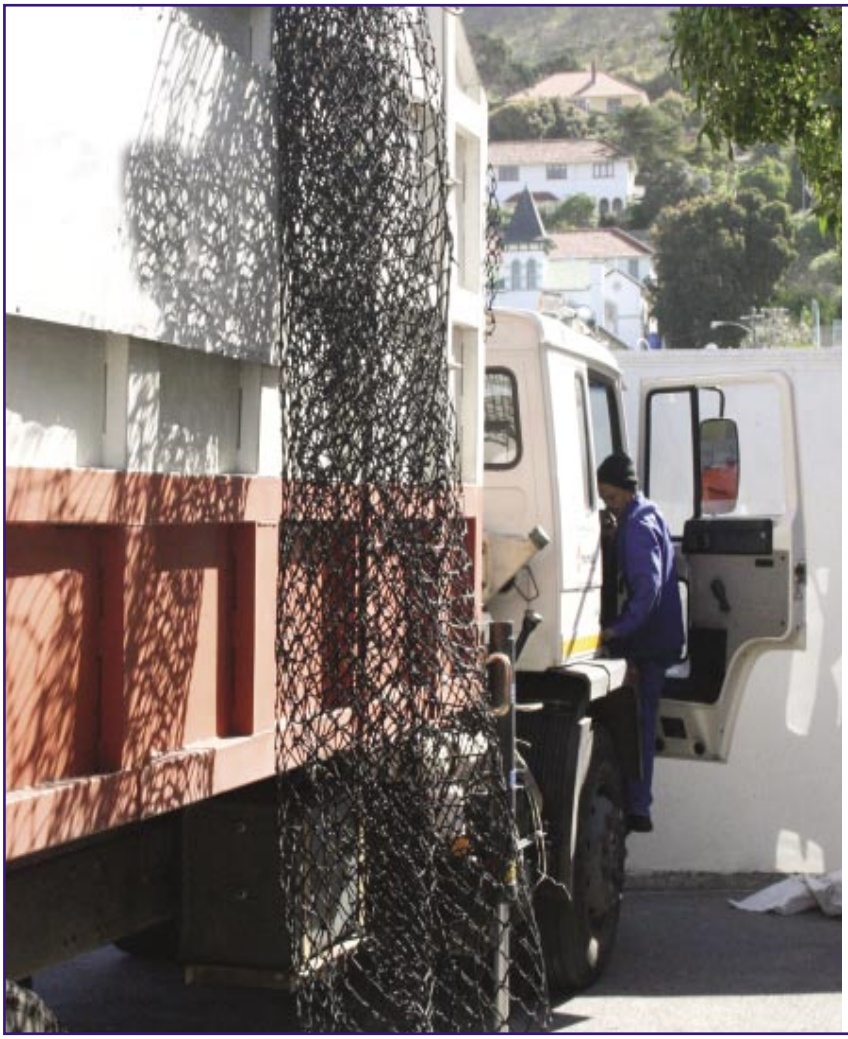


Photo by John Butler

Transport workers

Transport workers are at high risk of HIV transmission. They are away from home for long periods of time. Consequently they are likely to have relationships, including sexual ones, with many people, in many different places.

Transport companies need to implement comprehensive HIV treatment and prevention programmes. Transport workers need easy access to condoms as well as information that can protect their health and the health of their sexual partners.

Photo by Christina Villegas

Informal settlements

The Human Sciences Research Council's household survey on HIV has shown that infection rates are highest in urban informal settlements. Improving housing and living conditions will likely reduce new infections.

This photo is of Taiwan, Site C, Khayelitsha. The residents have been campaigning for the polluted marsh in the photo to be removed.

Migrant workers

The migrant labour system in South Africa has probably been a major cause of the HIV epidemic. The system has broken up families and created social conditions that cause HIV to spread.

Mining companies must phase out hostels (shown in photo) and give miners more opportunity to bring their families to live with them.

Photo by Luckyboy Makhondwane

A difficult problem: The window period of HIV transmission

People who are newly infected with HIV go through a window period of about six weeks, but sometimes longer, during which HIV cannot be detected using standard tests. Research has shown that people in the window period are highly infectious, i.e. they can easily infect other people. This is because they have a high viral load. The problem is that they are unaware of their status and in many cases continue to have unprotected sex. This is possibly one of the biggest drivers of the epidemic. It is not clear how to address this difficult problem.

MENTAL HEALTH AND HIV TRANSMISSION

Mental health problems affect a large number of people with HIV. There is evidence that it also affects HIV transmission.

The Human Science Research Council conducted a survey in 2005 that found higher rates of some mental health problems in people living with HIV/AIDS than the general population. It found that 42% of those who tested HIV-positive felt depressed, as opposed to 30% of those who were HIV-negative. The researchers attribute this higher rate to both the fact that HIV can cause depression and other mental disorders, and that people with mental health problems are more likely to contract HIV.

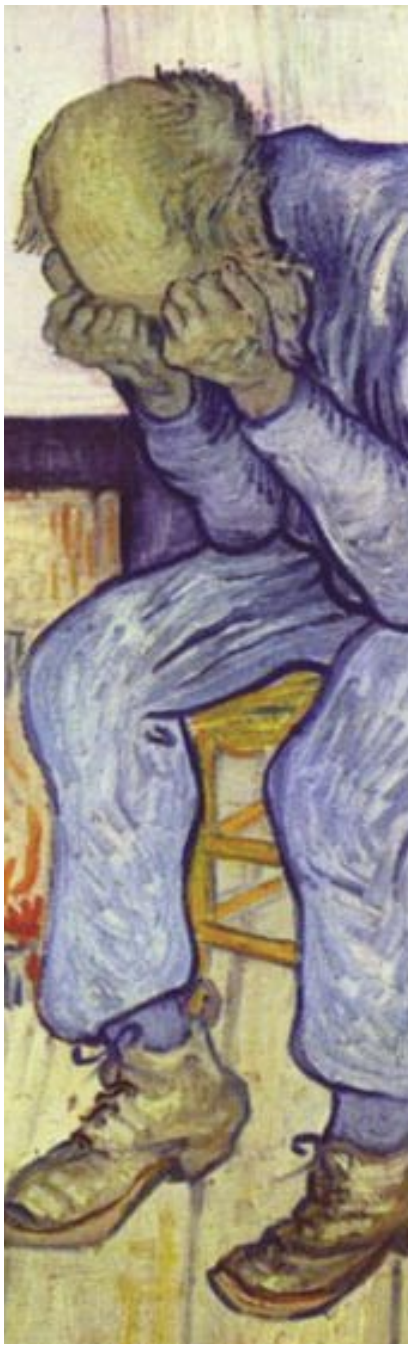
Both of these aspects are important for responding to the epidemic. The absence of an effective public health response to mental health problems undermines HIV prevention efforts. Also, it has been shown that people with both HIV and psychiatric problems progress faster to AIDS. Untreated depression in those who take antiretroviral treatment may also reduce adherence and result in worse treatment outcomes.

A number of studies have shown an increased risk of HIV infection in individuals with mental health problems. For example, a study of gay men in four American cities found that men with psychosocial health problems were more likely to take sexual risks and to get HIV. This suggests that mental health services at community level must be part of an effective prevention programme. However, most of these studies were conducted in industrialised countries and focused primarily on men who have sex with men, immigrants and sex workers. We know less about the impact of mental health in the South African context.

While we know that mental health problems place people at greater risk for HIV, it is less clear how to implement effective prevention programmes to deal with this. One study of drug users, for example, did not find a significant difference in response to HIV prevention interventions between those who had depression and those who did not. It is essential that more research is done in South Africa on the link between mental health and the risk of contracting HIV.

As for all diseases, we must encourage access to treatment and care for people with depression and other mental disorders, irrespective of their HIV status. TAC's campaign to build a people's health system must include building accessible and effective mental health services at community level.

Sources: HSRC's HIV household survey published on 1 December 2005.
Leserman (2006) "The Effects of Depression, Stressful Life Events, Social Support, and Coping on the Progression of HIV Infection" in Current Psychiatry Reports 3.
Stall et al. (2003) "Association of Co-Occurring Psychosocial Health Problems and Increased Vulnerability to HIV/AIDS Among Urban Men Who Have Sex With Men" in American Journal of Public Health 93(6).
Compton et al. (2000) "The effects of psychiatric comorbidity on response to an HIV prevention intervention." in Drug and Alcohol Dependency 58(3).



Painting by Vincent van Gogh. Copyright the Yorck Project under the GNU Free Documentation License. Obtained from www.wikipedia.org.

Equal Treatment
November 2006

THE CHURCH AND HIV PREVENTION

Reverend Teboho Klaas of the South African Council of Churches (SACC) discusses the role of the church in HIV prevention. This article is based on an interview between Klaas and Luckyboy Mkhondwane.

Photo by Luckyboy Mkhondwane

It is troubling that while HIV prevalence is on the rise, not much is being done about the problem. The church is concerned about the lack of leadership from our government when it comes to prevention of new infections, yet the church has itself not done enough.

The ABC approach has not been effective, and we should come up with new strategies. We need a clear goal that we can work towards: reduction of new infections.

The extent to which we reach out to men, particularly young men, needs to be improved. Gender equality is a major challenge: our patriarchal system has betrayed us. This needs to be addressed in order to bring down the rate of HIV infections. We need to take action on violence against women and the system of patriarchy.

Abstinence is available as a choice to only a few and should be encouraged to those who make that particular choice. However, many women do not have a choice when it comes to protecting themselves (for example using a condom) –this is also evident in the church. The SACC has called on churches to define abstinence and put it into context. We would like to see this being openly discussed, rather than simply prescribing dos and don'ts.

The Bible is open about sexual matters and we can learn much on sexuality from it. It is actually a biblical calling to discuss sexual matters.

The SACC has piloted several programmes encouraging churches to become places where people can learn about sexuality. Still there has been tension between men and women, young and old. The church has shown compassion when it comes to helping the sick and suffering through prayer and home-based care projects, but little is done for prevention. Unless prevention is at the heart of that struggle, everything will be in vain.

Many people who die from AIDS-related illnesses are buried by churches. Yet funerals are not used as an opportunity to speak about prevention. People continue to feel shame and churches continue to remain silent.

In the midst of death there is an opportunity for life. Ministers should bring messages of prevention and of hope and care.

Education on the importance of these issues should begin as early as Sunday School. Children start engaging in sex at an early age, so they should be informed of preventative measures early, rather than after it is too late.

According to resolutions taken at the SACC Triennial National Conference 2001, the SACC has resolved that "As part of its mission work, the SACC must engage with the people of South Africa to promote a return to values of sexual abstinence and faithfulness in marriage and encourage the use of measures necessary to prevent infection, denounce all forms of discrimination, including stigmatization of people living with HIV/AIDS and work to create an environment conducive for people to declare their HIV/AIDS status and to undergo voluntary counselling and testing."

Reverend Teboho Klaas can be reached on 011 492 1380 or 082 412 2960.

MAKING PREVENTION WORK FOR YOUTH

Mpho Mofokeng works on HIV prevention campaigns aimed at young people. Luckyboy Mkhondwane interviewed her.

My name is Mpho Mofokeng. I am 19 years old and I live in Duduza, Gauteng. This is what I know and think about the HIV prevention methods that are available to us as young people in South Africa.

We are told to abstain, to be faithful and to condomise. Abstinence and being faithful have their good and bad points. Firstly, abstinence is not really much of an option for many young people. The large numbers of teenage parents show that young people are having sex. It is good to encourage young people to stay virgins, but young people experiment with many things, and sex is one of them. If you have the choice of being sexually active or not, then abstinence is an option, but many people do not feel they have the choice.

As a young person, being faithful to one partner can be safe to some extent. However, we know that not all relationships will lead to marriage and most of the people you meet and get involved with have probably had sex with someone before meeting you. This means that you could be faithful to your partner and still get infected with HIV, because you don't know your partner's sexual history. Some people get infected with HIV while in a steady relationship, either because their partner is unfaithful or because their partner was infected in a previous relationship. The best way, I think, to protect yourself from getting HIV is to use a condom every time you have sex.Condoms do not only prevent HIV but they also protect you from other sexually transmitted infections and pregnancy.

If a young person chooses to be in a sexual relationship, he or she must use condoms. I think condoms should be available and promoted as a way of preventing new HIV infections. They must be available everywhere, including in schools. It is a fact that young people are having sex, so it is better for us to protect ourselves from being infected with HIV.

I also think that life-skills education in our schools should be improved and information on sexuality should be provided to all young people if we want to win the battle against HIV. Clinics should be made more youth friendly because young people are often afraid to go to clinics for condoms and sexual matters.

More choices should be made available to young people when they decide to be sexually active. I am not promoting sex among young people, but giving voice to the reality we are faced with.

Photo by Luckyboy Mkhondwane

Equal Treatment
November 2006

INFANT FEEDING AND HIV

by Mark Colvin

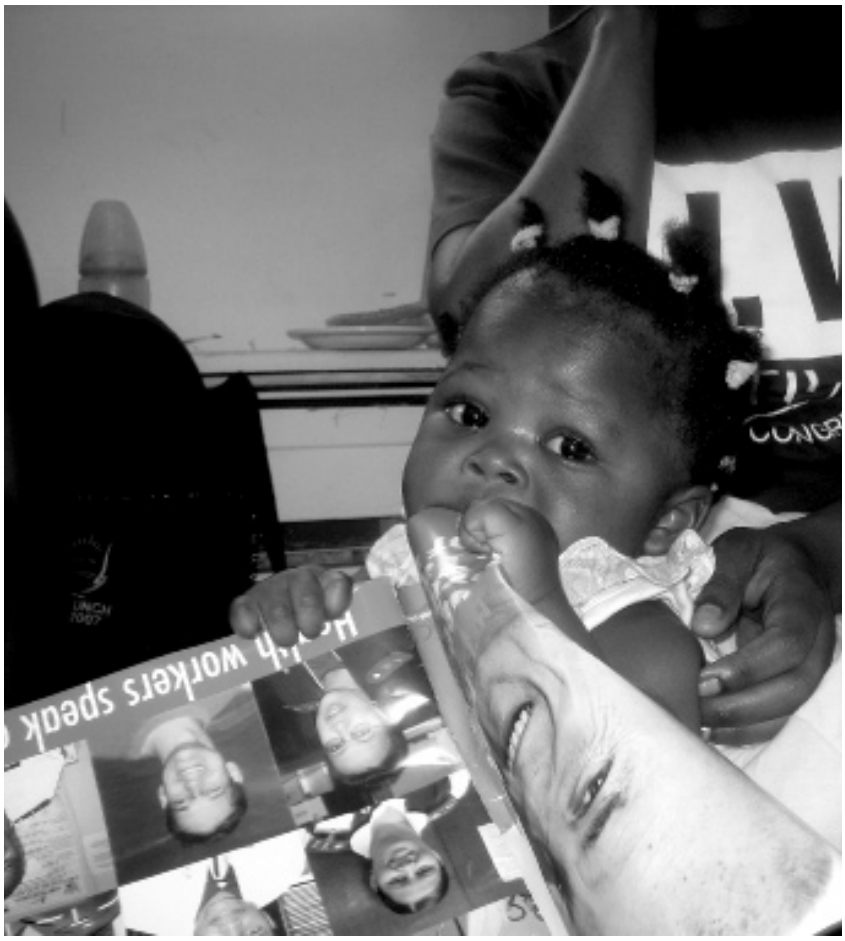


Photo by: Polly Clayden

Breast-feeding, particularly in developing countries, is an important method of improving the health and survival of newborn children. For these reasons, it is important to promote breast-feeding in the general population. However, because HIV can be transmitted to infants through breast-milk, formula milk is more appropriate for many infants of HIV-positive women.

Among HIV-positive mothers in South Africa the risk of transmitting HIV to the baby through breast-feeding ranges between 7% and 20% with about 25,000 babies being infected each year from breast milk. In Africa it is believed that about 40% of cases of mother-to-child transmission (MTCT) of HIV are due to breast-feeding.

In developed countries, MTCT has been reduced to less than two percent because of antiretroviral medicines, caesarian section births and formula milk.

The situation in poor countries is more complicated. In conditions where free formula is not available and mothers cannot afford to buy it or give it safely, HIV-positive mothers have no option but to breast-feed. In these circumstances, it is preferable for the mother to "exclusively breast feed" (EBF), i.e. give only breast milk and nothing else except prescription medicines. There is evidence that mothers who practice EBF have a slightly lower risk of transmitting HIV to their babies than mothers who mix breast feeding and other foods.

The situation is particularly complicated in South Africa, where EBF is probably more appropriate in some areas and formula milk in others. Currently the World Health Organisation recommends that HIV-positive women should exclusively formula feed their babies only if it is acceptable, feasible, affordable, sustainable and safe to do so. Otherwise EBF is recommended. In our context it means that if you are well off or have access to a clean water supply you must formula feed but many, mostly black, women must breast-feed their babies and run the risk of infecting their child with HIV.

This is an unjust situation. Instead of accepting this apartheid style status quo, organisations like the TAC should be fighting for conditions under which all HIV-positive women can safely formula feed their babies. HIV-positive women should be able to choose free formula milk, access safe water and receive support to safely formula feed their babies. Also, antiretroviral treatment options to prevent MTCT during breast-feeding need to be researched and implemented for women who choose to breastfeed.

Source: Good Start Study Results by Colvin et al.

MTCT has been reduced to less than two percent in many countries because of antiretrovirals, caesarian births and formula milk.

COMPARING MOTHER-TO-CHILD TRANSMISSION PREVENTION SITES

Mother-to-child transmission prevention was studied at three sites: Paarl in the Western Cape, Rietvlei in the Eastern Cape and Umlazi in Kwazulu-Natal. All sites used the single-dose nevirapine regimen at the time the study was done. Paarl was a well run site at which most women chose formula milk made available for free. Umlazi was a well run site at which most women chose to breast-feed. Rietvlei was a poorly run site at which women were given the option to use formula milk but supplies often ran short.

Paarl and Umlazi have similar socio-economic indicators. Rietvlei on the other hand is far less developed.

Source for statistics in this article: Good Start Study Results by Colvin et al.

Paarl
Western Cape

A well run site. Most women chose formula milk provided for free.

84.0%
of babies were HIV-negative and alive after nine months.

Umlazi
Kwazulu-Natal

A well run site. Most women choose to breast-feed.

73.4%
of babies were HIV-negative and alive after nine months.

Rietvlei
Eastern Cape

Women are given the option to use formula milk but supplies often run short.

64.3%
of babies were HIV-negative and alive after nine months.

BREAST-MILK COMPARED TO FORMULA: HIV TRANSMISSION UNTIL NINE MONTHS

Feeding method	HIV transmission rate associated with feeding option most likely used
Exclusive formula feeding	8.3%
Exclusive breast-feeding	13.2%
Mixed feeding	14.5%

The study calculated the number of additional infant HIV infections (i.e. infections that occurred after birth) associated with different feeding methods promoted at the different sites. Exclusive formula feeding was the most successful strategy. But using both formula milk and breast milk was the least successful.

Equal Treatment
November 2006

CIRCUMCISION AND HIV PREVENTION

There is evidence that male circumcision reduces the risk of HIV transmission for both men and women. However, we should wait for the results of research currently being carried out before actively promoting circumcision as a public health measure to reduce the risk of HIV infection.

In the most definitive study to date, which took place in the Orange Farm area near Johannesburg, 3,280 men volunteered to be circumcised and monitored over the course of 21 months. Half of them were circumcised immediately, the other half were to be circumcised at the end of the study. All were counselled on the need to practice safer sex.

After 12 months, testing revealed that 49 of the men who had not been circumcised had become HIV-positive, while only 20 men who had been circumcised had become HIV-positive. The study was stopped at that time for ethical reasons because a 60% prevention rate had already been observed.

Other studies have been done in Uganda and Kenya. Recent experiments have indicated that the most likely explanation of a protective effect is that the cells on the underside of the foreskin –the section of skin that is removed during circumcision– are more receptive to HIV infection and more likely to become traumatized during sex, providing a biological explanation for the results that are being seen.

However, being circumcised does not mean that men are wholly protected from HIV. Sex with a condom is still critical. Even if circumcision reduces the risk of infection during any one sexual encounter, risky behaviour, such as sex with multiple partners without using condoms is likely to lead to HIV infection.

While the balance of evidence indicates that circumcision reduces the risk of HIV transmission during heterosexual sex, the outcome of further studies must be awaited before making policy decisions.

If these studies confirm that circumcision provides some protection, a circumcision promotion campaign must be combined with safer sex messaging that discourages risk-taking and encourages condom use. Furthermore, circumcision must be carried out in hygenic conditions by doctors or properly trained and accredited people.

If current studies confirm that circumcision reduces the risk of HIV transmission, it will be important to promote medical circumcisions.

Circumcision is NOT an alternative to using condoms.

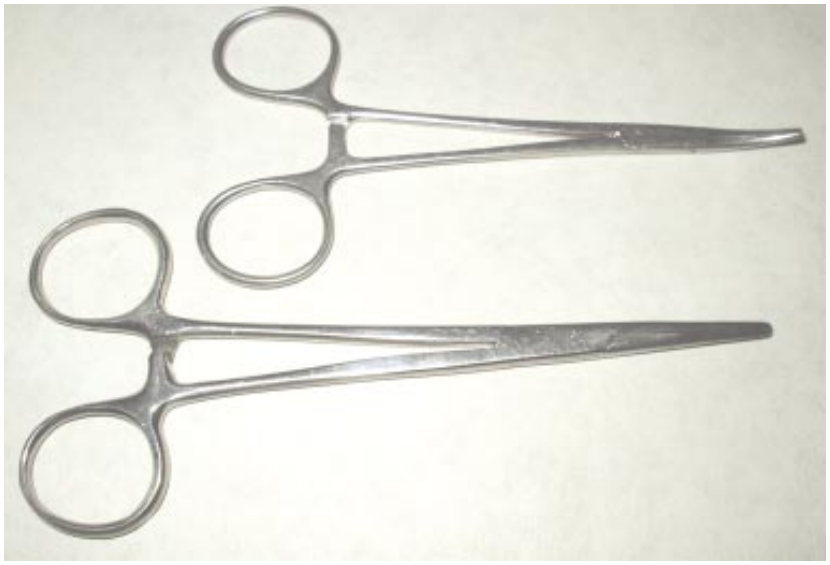


Photo of hemostats. Two of these instruments are used to remove the foreskin during a circumcision.
Only trained experts should conduct circumcisions.
Photo placed in the public domain by Splarka.

SEXUAL CHOICES AND FINANCIAL INDEPENDENCE

Many women do not have enough power in their relationships to say if they do not want sex or to insist that their partners wear condoms. This is partly caused by most women having less financial independence than their partners.

Many women cannot easily negotiate about sex because they risk losing financial security. It is likely that HIV prevention will improve if access to social grants and employment improves. Social grants are crucial for many unemployed women to gain some financial control over their lives.

Microfinance projects are also an important way to increase women's financial independence. Microfinance projects are where poor people without access to credit from banks are lent money at reasonable interests rates so that they can run small businesses.

A microfinance project in Uganda found that people on the project looked after their health and nutritional needs better than people not on the project. It also found they were more likely to take action to prevent HIV infection.

It is possible that HIV prevention will improve if access to social grants and employment improves.

A programme run by RADAR, a Wits University project, in Acornhoek on the border of the Kruger National Park is running a microfinance programme for women to provide them with greater financial security.

The project found that participants improved their household economic well being. The status of women in the project also improved and physical and sexual abuse was reduced by half. There were only small improvements in vulnerability to HIV however.

Knowledge of HIV, openness and access to testing improved for people on the programme and their dependents. Unfortunately the number of new infections was not statistically different from the general population.

My name is Hellen Motha. I'm a 36 year old mother of three living in Mpumalanga. In 1999 I visited a doctor because I had skin problems. He took blood samples and told me that I was HIV-positive. I thought it was a mistake and only people who slept around could get HIV, not people in faithful relationships.

In 2002, following another HIV-positive test result, I was referred to a support group, run by RADAR, a microfinance project in Acornhoek. I received a lot of support from its members and gained the courage to face the stigma and disclose my status.

RADAR trained me as an HIV/AIDS counsellor and facilitator. I'm currently employed as a support group facilitator and conduct treatment literacy classes for patients ready to take anitretrovirals. I also offer ongoing counselling to other members of the group.

RADAR introduced me to TAC which assisted our hospital (Tintswalo in Acornhoek) to become an accredited antiretroviral rollout site.

Equal Treatment
November 2006

WE NEED A PREVENTION PLAN

The Cabinet has said that prevention is the cornerstone of government's response to the HIV epidemic. Yet government's five-year strategic plan for AIDS, which included policies on prevention, expired at the end of 2005 and has not been renewed. We need a new prevention plan, one that is far more ambitious and progressive than before.

A prevention plan must include the following:

- HIV prevention must be integrated into campaigns against violence against women.
- Life-skills education, including sex-education, must be taught in every school. Condoms must also be available in every school.
- We can eliminate the paediatric HIV epidemic. The mother-to-child transmission prevention programme needs to be improved:
  (1) A proper monitoring and evaluation system must be implemented so we can know which parts of the programme work well and which need to be improved.
  (2) The single-dose nevirapine regimen must be improved. At a minimum provinces must implement the short-course AZT regimen used in the Western Cape in addition to single-dose nevirapine. Even better would be to give women the option of highly active antiretroviral treatment throughout their pregnancy.
  (3) Caesarian section births should be offered to HIV-positive women.
  (4) Where possible formula milk should be made available to HIV-positive mothers. Formula milk shortages are unacceptable.
  (5) If women cannot use formula milk or choose to breastfeed, they should be encouraged to take highly active antiretroviral treatment to reduce the risk of transmission.
- Post-exposure prophylaxis needs to be available at many more clinics. The list of clinics where it is available must be made available to the public in an easily accessible place and updated regularly.
- The Department of Health must implement a massive public information campaign that encourages:
  (1) everyone to get tested for HIV,
  (2) HIV-positive people to get regular CD4 and viral load counts,
  (3) people with CD4 counts below 350, TB or an AIDS-defining illness to begin highly active antiretroviral treatment,
  (4) everyone to use condoms,
  (5) more talk shows on radio and television to openly discuss and confront issues of sexuality.
- Tailor-made interventions need to be developed for vulnerable people, including men who have sex with men, sex-workers, transport workers, people living in informal settlements and migrant workers. Sex-work must be decriminalised.
- Active sexually transmitted infections put people at greater risk of contracting HIV. Government has a promising programme for the treatment of sexually transmitted infections (known as syndromic management). This programme must continuously be monitored, evaluated and improved.
- Mental health treatment and care programmes need to be developed and implemented at primary health care level.
- Social conditions are the drivers of HIV transmission. Improved public works programmes, social grant delivery, scaled up state supported microfinance programmes and the implementation of a basic income grant may contribute to reducing new HIV infections.
- There is a Tik (crystal meth) epidemic in the Western Cape. This is possibly a major driver of new HIV infections. More effective harm reduction and drug rehabilitation programmes must be implemented.

TAC appeal for funding

In South Africa we have over 5 million people living with HIV.
500,000 people will die if they don't get antiretroviral treatment soon.
TAC campaigns for access to treatment, a people's health service and community driven prevention strategies.

SUPPORT US TO SAVE LIVES

Donate at your nearest bank OR www.tac.org.za/donatenow

DONATE NOW

TAC
TREATMENT ACTION CAMPAIGN

treat
500 000
by 2008

TREATMENT ACTION CAMAPAIGN
NEDBANK, BRAAMFONTEIN BRANCH
ACCOUNT NO: 128 405 1870
BRANCH CODE: 195 005

Visit www.tac.org.za for more information on how you can help or volunteer at TAC.

Equal Treatment
November 2006

AKEKHO UMUNTU OKUFANELE AFE NGOBA ENEGCIWANE LENGCULAZA

U-Dudu Cwele uxoxele uNonhlanhla Ngema ngempilo yakhe.

Imiphakathi eminingi ibaphilisa kabuhlungu abantu abaphila negciwane le-HIV. Lokhu kwenza abantu bahluleke ukufuna usizo emitholampilo ezobasiza uku-qhubeka nezimpilo zabo.

Ngingu Dudu Cwele ngihlala Kwazulu Natal endaweni yase Gingindlovu esigodini sase Sabeka. Ngingowesifazane ophila negciwane le-HIV ngokungenankinga. Umphakathi engihlala kuwo usendaweni yasemakhaya ngaphansi kwamakhosi. Ungumphakathi othola izeluleko kanye nokuqwashisa ngezifo ezahlukene njenge sifo sikashukela, isifo sofuba, umdlavuza kanye negciwane le-HIV.

Ngaphumela obala ngesimo sami ngenxa yokufundisa abantu emphakathini ngenxa yezinga elinyukayo labantu abafayo mihla namalanga. Bayafa ngoba bezitshela ukuthi bayathakathwa ngoba bezondwa. Ngokwazisa umphakathi ngathola izinhlamba ezithi, kufanele ngibe nalo igciwane. Ngakwazi ukwamukela ngoba ngiphuma kwiqembu lokwesekana, ngasengithole izeluleko kanye nokufundiseka. Ngaba nezinto ezingibuyelayo emuva kokuhlola ngizibuza ukuthi, ngizoba naso yini isikathi esanele sokukhulisa izingane zami. Ngenxa yokwamukela, ngisaphila namanje angiphelanga amandla ngezinhlamba. Ngisaqhubeka nokuqwashisa umphakathi wangakithi.

Ngonyaka ka-2004 ngashonelwa umyeni wami ngengozi yemonto. Ngahamba ngayohlola amasosha omzimba ukuthi mangakanani emzimbeni ami (CD4 cell count) ayengu 259. Ngathi emuva kwalokho ngaba umuntu ovakashela umtholampilo ukuzinakekela ngokungaphezu kwakuqala. Emuva kwezinyanga ezingaphezu kwesikhombisa ngaphinda ngahlola futhi kwatholokala ukuthi sewekhuphukile asengu-424. Indlela engiphila ngayo imnandi ngoba angikuvumeli ukulala phansi uma ngigula ngivakashela emtholampilo masinyane.

Photo by Nonhlanhla Ngema

WHY BOYS DON'T CRY

by Pholokgolo Ramothwala

There is a saying that "boys don't cry." In our culture, if a man cries, it must be on the inside, so that others do not see. I used to think this worked for me. I asked my sister, a psychologist, why boys don't cry. She said, "It is because you believe society does not allow you to."

This reminded me of the day I found out I had HIV. I had always thought I would not get HIV, so this was the worst time of my life. But that day I threw a big party with lots of people – most of whom I didn't know – and enough alcohol to start a brewery. I have spent the seven years I've lived with HIV using this method to deal with my emotions. I drink and keep my worries to myself. When my ex-girlfriend died last year from what I believe was an AIDS-related illness, I went to her funeral so drunk that I don't remember most of it.

Despite drinking to deal with my stress, my health has always been excellent apart from a few minor infections. However, last year my six-monthly routine check revealed that my CD4 count had dipped below 500 for the first time and that my viral load was just over 18,000. I was in shock. During my days of boozing and partying I had always wanted to confide in someone, but could never bring myself to do so.

Finally I decided to talk to the friend I first trusted when I tested HIV-positive. I was really feeling scared because I had started getting regular infections. I wanted to do all my crying alone where nobody could see me. Admitting my fear to another person made me feel I was being weak.

But my friend's response got me thinking about my health and life. He said, "Your HIV might be progressing, but you have a very strong immune system. There is a lot you can do to stay healthy." I knew he was right, but I continued in my old ways and avoided talking about my health and feelings.

Later, my friend, who is on antiretrovirals, told me about his own fear: "Now I think: what happens when my medicines fail? That is natural. But I have deep confidence that these and other medicines will keep me alive and healthy for another 20 years. You have a good few years before you will need ARVs. Take the steps that can keep you off medicines for as long as you can."

Soon after, reality knocked at my door again. While my CD4 count had increased, so had my viral load. My fear increased every minute I thought about my health. I started to regret neglecting my health and now I wish for a second chance. Many of us, especially men, do not want to talk about our health until it is almost too late.

Take Khabzela, for example. He waited until it was too late to get medical help. Now he is gone. It is time we learn to confront our fears and take responsibility for our health.

Many of us, especially men, do not want to talk about our health until it is almost too late.

Equal Treatment
November 2006

A JOURNEY OF DISCOVERY

by Keith Milne

Keith Milne lives openly with HIV. Here he describes how he tried to find many solutions to avoid progressing to AIDS.

Photo by Nathan Geffen

To my great shock, I was diagnosed HIV-positive in January 2004, and so began a journey of discovery at the age of 43. Earlier, I had watched two close friends deteriorate before my eyes and succumb to AIDS-related diseases. I had also done a lot of reading about HIV/AIDS, and so was reasonably well informed about its progression and possible treatment options.

In the months before and after my diagnosis, the press in our country was filled with scare stories, supported by the Minister of Health, about the alleged toxicity and side effects of antiretroviral medication. But I knew that antiretrovirals support one's immune system by acting against HIV, which causes AIDS.

My family and close friends rallied around me and all gave me incredible love and support. I received new insight into the love of God. I took every vitamin that was being recommended, improved my diet and exercise regimen, created mantras to get my head in line and tried massage and aromatherapy. However, my CD4 count continued to plunge downwards. I was constantly fighting off throat infections, chronic tiredness, nausea, diarrhea, colds and flu, mouth ulcers, stomach cramps and weight loss.

Finally, in May 2005, my CD4 count reached 220 and I was encouraged to start antiretroviral treatment immediately. I was devastated, but despite great fear and trepidation, received my first prescription of efavirenz, stavudine and lamivudine. Now, 14 months later, I cannot believe the difference treatment has made. My weight is back up to normal. I have no nausea and my energy is back. My mouth ulcers are gone and my appetite has improved. My CD4 count is 465.

I had some side effects from the treatment –numbness in my feet (peripheral neuropathy)– but this is a thing of the past.

In other words, if I could have the last two and a half years over again, I would have started with antiretroviral treatment earlier and saved myself much suffering. Now I am living with the desire to look beyond myself and my disease and find others that I can help to cope in their times of darkness.

MY OPENNESS SAVES LIVES

by Phumla Tokwe

It was the month of August when I disclosed my status at the factory where I was working. We were being educated about the presence of HIV/AIDS in our community. In this community, many people are dying of pneumonia, TB, or "witchcraft" but in fact of AIDS.

When I disclosed my status, nobody believed me, because they saw that I was physically active. People cried, questions were asked, and people were telling others incorrect things about me. Some were coming to my house for advice. I was like a celebrity to those who wanted the truth. As a result of my disclosure, my community has formed a health forum. When there are workshops in my community, they use the people living with HIV that I recruited, or me sometimes.

My children have accepted me, and when they hear jokes about me from other children they do not take it as a joke. My husband turned his back on me because I disclosed my status. He said, "I will hate you for the rest of my life." I am not turning my back on him because one day he will need my help.

In order to disclose to my family, I invited them all to lunch. When we had almost finished eating, I asked them, "what would you do if one of us here in the house was HIV-positive?" They looked at each other, and I said, "keep quiet?" My mother said, "No! I do not want HIV-positive people in my house." I then said to her, "I am HIV-positive." They all stood up and walked out of the house. I told them that it wasn't as though I went and bought HIV, or else I would have taken the cash slip and returned it to the store! For almost a year, they didn't talk to me or come to visit me at home. Only my father accepted me, and he gave me a hug.

Photo by Nathan Geffen

I am glad that I disclosed my status. I am able to do everything on my own. My community is now aware of HIV/AIDS, and most people are now open about their status because of the education I am doing. If I was not a TAC member, there would be no education in my community clinic, and no antiretroviral distribution.

I told them that it wasn't as though I went and bought HIV, or else I would have taken the cash slip and returned it to the store!

Equal Treatment
November 2006

BOTSWANA'S AIDS PROGRAMME: SUCCESSES AND CHALLENGES

by Oratile Kidd, Botswana Network on Ethics, Law, and HIV/AIDS (BONELA)

The Botswana Government was one of the first to start several HIV/AIDS programmes, including a public health programme to prevent mother-to-child HIV transmission.

In 2002, the Botswana government initiated the antiretroviral programme, MASA, aiming to provide free antiretrovirals to all citizens who need it. According to the UNAIDS 2006 Global Report, Botswana had reached the impressive ARV coverage of 85%. However, are the programmes succesful? Are people living healthy and productive lives due in part to their antiretroviral treatment?

The most prominent health-care concern at the community level is that people on treatment know very little about the medication they are receiving, the possible side-effects, why they need to continue protecting themselves and others against HIV infection and what alternative treatment and care may be available.

Hope, a community activist living with HIV in Botswana, spoke about her own experience with the antiretroviral programme. "My doctor does not listen when I explain my long term side-effects to him and has not referred me to a specialist. The government is satisfied that they are giving us pills, but the antiretroviral programme needs to be strengthened." There is not a comprehensive and on-going treatment literacy approach.

"I recently met with TAC and the Aids and Rights Alliance of Southern Africa and told them my story. They confirmed that my health problems were antiretroviral side-effects, and they also referred me to a visiting doctor from South Africa," says Hope. The doctor gave her a prescription and advised her to see a specialist. She is still struggling to be seen by a government hospital specialist and was told to return home, 800km away, to get a referral note. She continues to struggle, like others, not just to access treatment, as seems to be the main concern of government, but to deal with the implications of a lifetime on antiretrovirals.

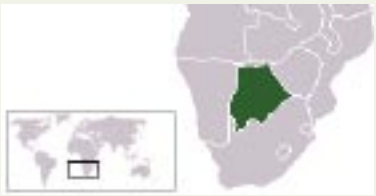
Botswana leads Africa in providing antiretroviral treatment but the programme needs better treatment literacy.

Most people living with HIV are enduring challenges with the antiretroviral programme. They are not learning about their treatment or teaching others. Individuals like Hope and groups such as BONELA are starting a new project to educate people about treatment, so that they can participate in caring for their health, without depending solely on doctors. They aim to work with the public health system to build community knowledge about the effective use of antiretroviral treatment.

KEY BOTSWANA STATISTICS

Population:	1.8 million
Life expectancy:	44
Per capita GDP:	$7,344 (South Africa: $8,506)
People with HIV:	+/-300,000
People on antiretroviral treatment who require it:	85%

Sources: World Health Organisation, UNAIDS. Flag and map are from Wikipedia.



OUR RIGHTS IN OUR COURTS: A VICTORY FOR PRISONERS' RIGHTS

On 22 June this year the Durban High Court affirmed the human rights and dignity of prisoners in a case brought by the AIDS Law Project on behalf of TAC and fifteen prisoners at Westville Prison. The Court ordered the state to provide antiretroviral treatment to eligible Westville Prisoners. The state was also ordered to report to the court on how it would make treatment available.

The judgment came after months of failed negotiation attempts with the Department of Correctional Services, during which time most prisoners remained without life-saving treatment. The Court then granted the government leave to appeal against the ruling, but made an interim execution order, which means that during the lengthy appeal process, the original order must be implemented.

Government then attempted to appeal against the interim execution order and did not implement it. The deadline of 14 August came and went without the government reporting to the court as ordered. During this time, one of the prisoners, known as MM, died of AIDS after having started ARVs much too late. When a few TAC members and healthcare workers went to the prison to give assistance to sick prisoners, they were threatened with guns and dogs and turned away.

On 28 August the Court found that government was in contempt of court for failing to implement the interim execution order. The judge expressed grave concern:
"If the refusal to comply does not result from instruction from [government], then the remaining respondents must be disciplined... for their delinquency. If [government] has given such an instruction then we face a grave constitutional crisis...".

Photo by Sylvia Flynn.

Sindi Blose of the TAC Treatment Project addresses demonstrators calling for treatment for Durban's Westville prisoners.

Government was again ordered to submit a treatment plan for inmates at Westville prison by 8 September. They finally did so, and while there are problems with it, a more systematic approach is now in place. Government's appeal against the original order must still be heard.

This case raises a number of important issues. First, the state's failure to properly implement its treatment plan is not restricted to prisons, but the facts in this case illustrate the administrative and managerial problems that are plaguing the programme as well as the lack of political leadership on HIV/AIDS. Second, the contempt shown for the rights to life, health and dignity of prisoners –a vulnerable group who depend on the state– does not reflect a culture of human rights rooted in the Constitution. Third, the state's attempts to avoid implementing the Court's decision constitute a challenge to the rule of law and the independence of the judiciary. Fourth, it is not clear if government intends to make treatment available for prisoners at other correctional facilities voluntarily or if litigation will be required to compel it to do so.

The legal victory has come too late for many prisoners and others. But if we build on it, it will be a victory for all in South Africa.

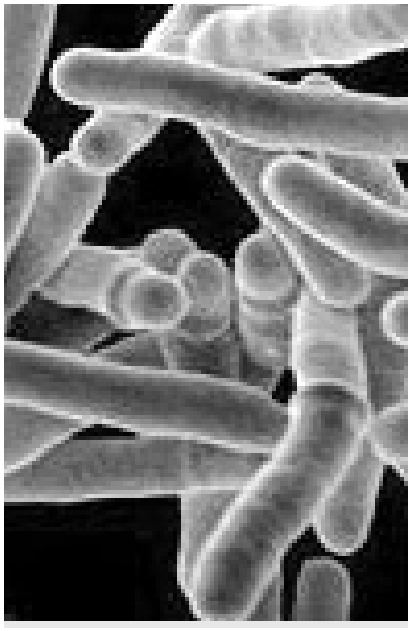
Equal Treatment
November 2006

BEATING DRUG RESISTANT TUBERCULOSIS

There is an outbreak of drug-resistant Tuberculosis (TB) in South Africa. This fact sheet explains what drug resistant TB is, the danger it poses and what can be done to prevent it spreading.

What is TB?

TB is an infectious disease that affects the lungs and other parts of the body. It is caused by a bacterium. If the body is weak it can lead to serious complications and even death. The World Health Organisation (WHO) statistics show that 115 million people across the world have the disease. 95% of TB sufferers come from low and middle-income countries like South Africa. Three million people die worldwide of TB every year.



Courtesy National Institutes of Health

How do you get TB?

TB is caught by breathing in droplets containing the TB bacteria. It is spread by coughing and sneezing.

If you have TB bacteria in your body, do you have TB disease?

Many people are infected with the TB bacteria, but remain healthy. Some people infected with TB bacteria get sick. They are said to have active TB.

Who is at risk from TB?

Although anyone can get TB, those at highest risk of catching the disease are people with weak immune systems. This includes people living with HIV/AIDS, people with drug and alcohol dependency and people that frequently come into contact with people with TB.

How is TB treated?

It is only necessary to treat active TB. i.e. it is unnecessary to treat people who are infected with TB but are not sick. There are four standard medicines that people with active TB take. Standard TB treatment lasts six months.

What is drug resistant TB

Two key standard drugs, Rifampicin and Isoniazid do not work on some strains of TB. This is called multi-drug resistant TB (MDR TB).

People with MDR TB have to take several second-line TB medicines. These are extremely expensive, have to be taken for a longer time (sometimes up to 24 months) and have worse side-effects than the first-line medicines. It is difficult to treat MDR TB; it requires individualised care, making it harder for public health workers.

Some people have strains of TB that even second-line medicines do not cure. TB that is resistant to three or more of the second-line drugs is called extremely or extensively drug resistant TB (XDR TB). XDR TB is very difficult to treat. Patients with XDR TB are very likely to die.

Symptoms of TB

- Persistent cough
- Lots of phlegm - sometimes bloodstained
- Swollen glands
- Weight loss
- Chest pains when inhaling
- Loss of appetite

What happened in Tugela Ferry?

The media has reported widely on an outbreak of XDR TB in Tugela Ferry's Church of Scotland Hospital. This is what happened:

- 53 people became infected with a strain of XDR TB.
- 52 died.
- The HIV status of 47 patients

was known. They were all HIV-positive. 15 were on antiretroviral treatment.

- TB usually takes many months to kill if left untreated. But half the XDR TB patients died within 25 days of being tested for HIV.
- Another disturbing finding is that 41% of a sample of patients who tested positive for TB at the hospital had MDR TB.

Is there just one form of MDR TB and XDR TB?

No. There are many types of TB bacteria that are resistant to different drugs. The XDR TB outbreak in Tugeal Ferry is just one example, a particularly fast-killing one. Drug-resistant TB strains have been documented since at least 1989 when a drug-resistant strain broke out in New York in the United States. XDR TB occurs worldwide but is probably a bigger problem in South Africa than most other countries.

Standard (first-line) TB medicines

- Rifampicin
- Isoniazid
- Pyrazinamide
- Ethambutol

Second-line TB medicines

- Cycloserine
- Kanamycin
- Amikacin
- Capreomycin
- Clarithromycin
- PAS
- Ofloxacin
- Levofloxacin
- Ciprofloxacin
- Thiacetazone
- Clofazamine

What led to MDR and XDR TB?

People with TB who did not take their medicines regularly developed strains of TB for which the medicines no longer work. Other people then caught these drug-resistant strains.

When drugs are poorly administered by clinics (e.g. drug shortages or poor patient education) patients are less likely to adhere to their medicines. This is when resistant strains of TB emerge.

How do we test for TB?

It is often difficult to make a quick accurate TB diagnosis. There are a number of methods used to test for TB. These include analysing the patient's full medical history, a physical examination, a tuberculin skin test, a sputum test and a chest X-ray.

What are the problems with TB tests?

The tuberculin skin test is almost useless in a population where many people are infected with TB because it tests positive if you are infected but do not have active TB.

The machines, available only in some hospitals and clinics, used to determine if you have TB from sputum often give negative results in people with HIV with low CD4 counts.

TB can be grown from a patient's sputum in a laboratory culture. This will tell almost with certainty if someone has TB. Unfortunately it often takes weeks to successfully grow TB in this way. Waiting for a sputum culture before treating people with TB is dangerous as they could die before the result is back. Therefore doctors need to use their judgment and treat people who they suspect have TB. Also, we urgently need better TB tests.

Side-effects of TB treatments

As with most other strong medical treatments there are often side effects from taking TB drugs.

Side effects of standard TB treatment:

- Dizziness
- Nausea
- Jaundice
- Fever
- Pins and needles

Side effects of drug resistant TB treatment:

- Seizures
- Depression
- Hypothyroidism
- Hypersensitivity
- Nausea and vomiting
- Gastritis
- Peripheral neuropathy
- Hearing loss
- Psychosis
- Hepatitis
- Renal failure
- Optic neuritis
- Arthralgia

If you feel these or other side effects remain on your drugs until you have seen a doctor and received alternative drugs. It is extremely important that your course of drugs is not stopped, otherwise you could develop a strain of TB that is drug-resistant.

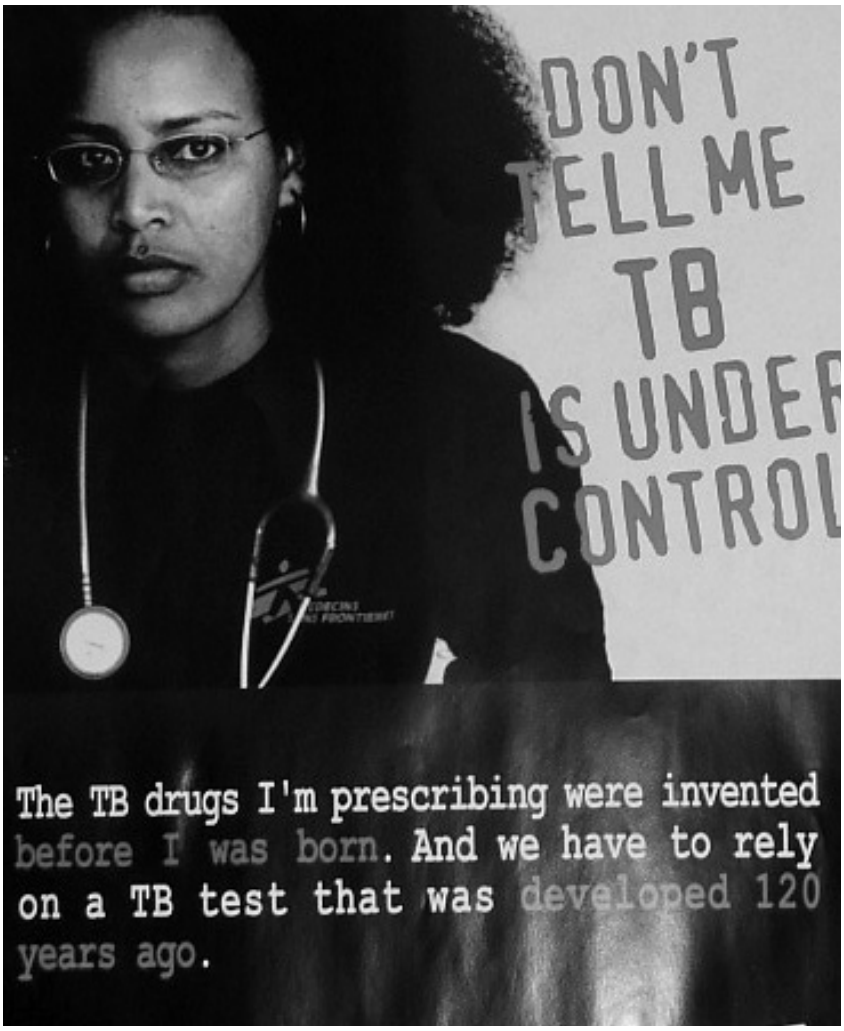
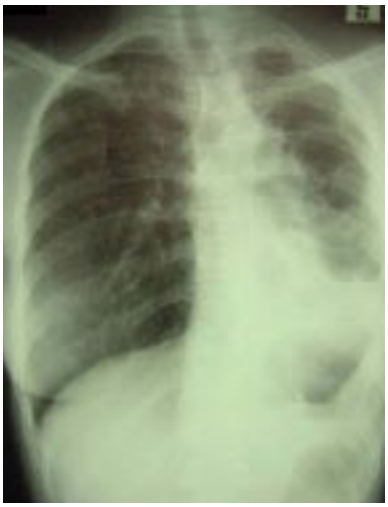


Photo of Médecins Sans Frontières poster taken by Saul Kowviser.

What about TB and HIV?

People with HIV are more likely to contract TB because they have a weak immune system. For example, eight in every ten new TB cases in Kwazulu-Natal occur in people with HIV. TB is the biggest cause of death among people with HIV in South Africa. The number of TB deaths more than doubled between 1997 and 2003. Worldwide one in ten TB cases are caused by HIV.

People with low CD4 counts are much more likely to contract TB. It is safe for antiretrovirals and most TB medicines to be administered to patients at the same time.



An x-ray showing a TB infected lung.

What is DOTS?

DOTS stands for Directly Observed Treatment Short-Course. It is the current system for treating TB patients. People with TB have to go to their clinic daily and take their TB pills in front of a health worker. This system is very different to antiretroviral treatment in which patients take responsibility for their own treatment, with the help of a treatment supporter, following counselling sessions and treatment literacy education.

We believe the DOTS model is a barrier to improved TB adherence. This can be seen by comparing the results of the DOTS model to the model for antiretroviral treatment. Even though people have to take antiretrovirals for life as opposed to TB treatment which is taken for months, the adherence rate for antiretrovirals is much higher.

How do we respond to drug-resistant TB?

A meeting of experts organised by the Medical Research Council has put forward a seven-point plan for dealing with the drug-resistant TB outbreak. Here are the seven points as well as other important suggestions:

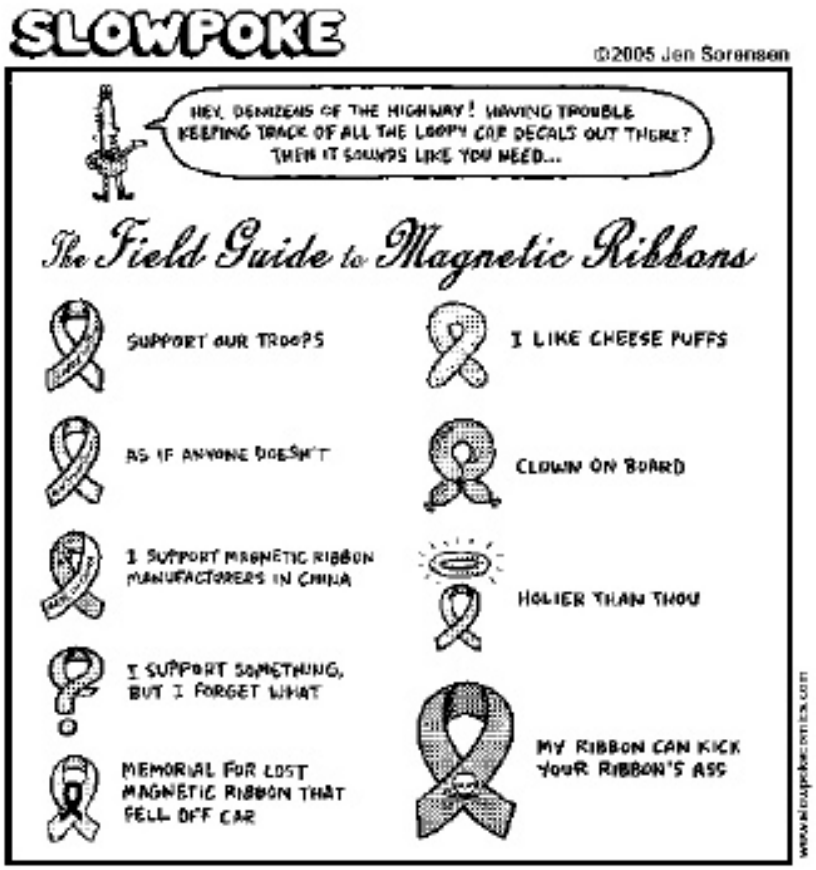
1. Conduct surveys to detect cases of XDR TB.
2. Equip laboratories to be able to detect drug-resistant strains of TB.
3. Provide training and resources to public health clinic managers and health workers so they can respond to XDR TB outbreaks.
4. Conduct public education to reduce the chances for TB to spread. This means:
   - Do not cough onto other people or in confined spaces.
   - Keep windows open and rooms ventilated.
   - Implement proper cleaning procedures in hospitals and clinics including the proper use of germicides (products that kill germs including TB).
   - Health workers should wear surgical masks.

5. Increase research for new anti-TB medicines.
6. Increase research for faster more accurate TB diagnostic tests.
7. Drug-resistant TB patients need to be isolated until they are no longer infectious. While this infringes on people's freedom, this is outweighed by the need to protect public health.
8. Antiretroviral treatment has been shown to reduce the risk of people contracting TB. Most people with AIDS are starting antiretroviral treatment far too late. If more people got tested before becoming sick with AIDS, they could be put on treatment earlier and often before getting TB.
9. There are a number of ways drug resistant strains of TB could be reduced. For example, many people cough and sneeze without knowing the dangers of spreading the disease. A public campaign on proper coughing etiquette this would be a simple but low-cost way of reducing and helping prevent the disease. There are many other similar measures that could be taken.

Sources: This article is primarily based on notes and diagrams provided to us by Professor Linda-Gail Bekker of the Desmond Tutu HIV Centre at the University of Cape Town's Medical School. Equal Treatment takes responsibility for any errors.

The Tugela Ferry notes are from Gandhi et al. High Prevalence and Mortality from Extensively-Drug Resistant (XDR) TB in TB/HIV Coinfected Patients in Rural South Africa, Abstract presented at Toronto International AIDS Conference, 2006.

MEANINGLESS RIBBONS



TAC supports equality for gays and lesbians and the right of people of the same sex to marry. Both cartoons reproduced with permission. Bottom cartoon is courtesy of Columbia Daily Tribune and John Darkow.

Equal Treatment
November 2006

WHY WE NEED A NEW HEALTH MINISTER

The Minister of Health again promoted unproven treatments for AIDS, this time at the International AIDS Conference in Toronto in August. At the same time, her Department was in contempt of court of the Westville prison judgment. This spurred a new TAC campaign for five demands, one of which calls for her dismissal.

Manto Tshabalala-Msimang's failure to manage the treatment of AIDS is well known. She has promoted pseudoscientific remedies and undermined the antiretroviral (ARV) rollout. South Africa is not even in the top ten in Africa for the proportion of people in need of ARVs who actually receive them – that is if we are to believe government's treatment statistics. The programme is poorly monitored so no one really knows how many people receive treatment.

Track record

However, the Minister has also failed on other critical aspects of her job, including AIDS prevention, TB management and adequately resourcing the health system. She has even failed at the one campaign she claims to champion: nutrition. She has undermined the independence of both the Medicines Control Council and the Medical Research Council (MRC) as well as shown contempt for the courts and the Constitution. During her term, many clinics and hospitals have got worse. Deaths among children and youth adults – especially women– have increased.

Photo by Nadine Hutton, courtesy of The Mail & Guardian

Prevention

The cabinet has emphasised the importance of prevention. Yet, the mother-to-child transmission prevention programme is implemented poorly. It has not been monitored and evaluated, so we have little understanding of how effective it is. Only the Western Cape has improved on the single-dose nevirapine regimen by using AZT as well. The paediatric HIV epidemic could be eliminated, but there is no political will to do so.

Accessing post-exposure prophylaxis after rape is challenging. Even health workers complain that accessing this programme is difficult following occupational injuries.

Few schools implement adequate sex-education programmes or make condoms available. Government-funded condom promotion campaigns are practically invisible. The Khomanani AIDS awareness campaign is in limbo. The health department's plan to deal with HIV prevention expired at the end of 2005.

Health care under pressure

As a consequence of HIV, the TB epidemic has exploded in the past decade. TB is the biggest recorded cause of death in South Africa. The minister spurned efforts years ago to form a coalition against TB. She also discouraged officials from attending a critical meeting to deal with the recent drug-resistant TB outbreak.

Many public health care workers in South Africa are doing a phenomenal job to give the best care they can to their patients. Yet the minister shows them contempt.

A Human Sciences Research Council survey showed the poor state of health worker morale. This is mainly because of the increased workload due to AIDS and high levels of HIV infections among nurses. The number of nurses per public sector users has declined during the minister's term. Many nurses and doctors have left the public sector either for the private sector or overseas. Many of our hospitals are in a dire mess. Patients have to queue in township clinics before sunrise and spend the whole day there. Yet the health department's framework human resources plan has no concrete measures to address this.

Nutrition

The minister has created the illusion that she is addressing nutrition. But telling people to eat garlic, lemons and African potatoes to ward off disease is pseudoscience, not nutrition.

Food insecurity is indeed a serious problem. Ensuring that unemployed people have access to healthy food, either through social grants or food parcels, is far more important than telling them what vegetables to eat.

A report from 2005 showed how poor the health department's nutrition interventions are. Further, not a single scientifically accurate fact sheet on nutrition and HIV for the public has been produced by the department.

President Thabo Mbeki has to take responsibility for Tshabalala-Msimang's failures. But it is not too late to address the crisis in our health system.

Firing the minister will not fix the problems, but it would be an important start. The president can show his commitment to resolving the decline in health care by firing Tshabalala-Msimang and replacing her with someone competent and less arrogant, who understands science and deals fairly with civil society.

SUPPORT TAC'S FIVE DEMANDS

1. Convene a national meeting and plan for the HIV/AIDS crisis now.
2. End deaths in prisons – provide nutrition, treatment and prevention.
3. Dismiss Health Minister Manto Tshabalala-Msimang.
4. Respect the rule of law and the Constitution.
5. Health for all – End health Apartheid, Build a People's Health Service.

Photo by Luckyboy Mkhondwane.

Photo by Joel Ntimbani

Global Day of Action - 24 August 2006: These photos are from the Gauteng and Limpopo demonstrations. Demonstrators held funerals in memory of their friends who have died of AIDS. They also mocked the Minister of Health's AIDS remedies by making props of vegetables.

Photo by Adam Malapa.

Learners at Mahlori Secondary School, Magoro Village, Limpopo Province, read TAC's CD4 pamphlet during a treatment and prevention literacy training session.

Ntombi Msiki conducts a treatment literacy workshop in the Western Cape. Every week, over 100 trained TAC treatment literacy practitioners conduct workshops in six provinces on HIV treatment and prevention in clinics, TAC branches, schools, businesses, trade unions and community meetings.

Photo by Adam Malapa.

A TAC member talks about HIV to a woman doing washing as part of a door-to-door campaign in Magoro Village, Limpopo.

LETTERS

WINNING LETTER

Dear editor

I am in prison at the moment. I would like to know what is the risk of being infected with HIV through oral sex. My partner complains that we must have oral sex but I am afraid because I don't know much about HIV/AIDS and sexually transmitted infections.

From Matthew Kanene (name changed, letter written from prison)

Our response

HIV transmission from oral sex is possible, but unlikely unless one of the participants has open cuts or sores on the genitals or mouth. For oral sex on a woman, you can use a dental dam. For oral sex on a man a condom will reduce the risk of transmission during oral sex even more. If you don't have a dental dam, you can cut up a condom to make a square piece of plastic and place it over your partner's genitals.

Dear editor

I have been HIV-positive since 1996, and I have not taken any kind of medicine. What I would like to know is what kind of immune booster should I take?

Linda Gantsho (name changed)

Our response

It is good that you have remained healthy for ten years since finding out your HIV status. This is not unusual. Healthy living, like eating well and exercising can help delay the time to when people with HIV develop AIDS. Chance (which many people call luck), your genes and the particular type of HIV with which you are infected also play a large role.

You should be careful about taking products that claim to be immune boosters. None of these products have been tested and they are often expensive. Rather go to your clinic, hospital or your private doctor and ask for CD4 and viral load counts. If your CD4 count is below 350 or you get a serious illness, like TB, you should talk to your health-care provider about starting antiretrovirals. These are medicines that help people with HIV to live normal lives, but they have to be taken everyday for life.

MORE MEANINGLESS RIBBONS

Write a letter

The writer of the best published letter will receive a R200 Pick 'n Pay gift voucher.

Keep your letters short and to the point. Indicate if you wish to have your name changed. Remember to include your contact details.

Write, fax or email to:

Equal Treatment,
34 Main Road
Muizenberg, 7945,
South Africa
Fax: 021 788 3726
Email: et@tac.org.za

EQUAL TREATMENT QUIZ

The first entry drawn from a box that answers 12 or more of the 15 questions below correctly will win a R200 Pick 'n Pay gift voucher. The winner of last issue's prize is Bheki Mokhabela of Nelspruit.

All the answers are in this month's *Equal Treatment*.

1. Approximately how many people are infected with HIV every day in South Africa?
2. True or false: Abstinence only programs are effective at preventing HIV transmission.
3. True or false: Alcohol consumption is a risk factor for having unsafe sex.
4. Name two ways men can contribute to women's empowerment.
5. Name one of the antiretrovirals that is usually used to prevent mother-to-child transmission of HIV.
6. Name two conditions in prisons that can be improved for those living with HIV.
7. Can HIV be transmitted by someone who is in the window period?
8. Paarl, Rietvlei and Umlazi are all mother-to-child transmission prevention sites. Which site had the best HIV transmission results?
9. True or false: Current evidence shows that circumcision has a protective effect against HIV transmission.
10. True or false: Current evidence shows that depression has no effect on HIV transmission.
11. What is the name of the organisation running a microfinance programme in Acornhoek?
12. Is tuberculosis a virus or bacterium?
13. Name two second-line TB medicines.
14. How many second-line TB medicines must you be resistant to before you are diagnosed with XDR TB?
15. Who is the judge living openly with HIV who rode the Argus cycle race in 2006?

How to enter

Send your answers, numbered 1 to 15, by post, email or fax. You must include your correct name and postal address. This competition is not open to TAC employees or current recipients of treatment literacy bursaries. Closing date for sending entries is 22 January 2007.

Post: Equal Treatment, 34 Main Road Muizenberg, 7945
Email: et@tac.org.za Fax: 021 788 3726

Photo by Adam Malapa

Over a million people watch *Siyayinqoba Beat It!* every week. Shouldn't you?

TREATMENT LITERACY SERIES

The new Siyayinqoba Beat It Treatment Literacy Series is now available. This comprehensive series provides detailed HIV/AIDS treatment literacy information. Ideal for people living with HIV, their support networks and organisations providing HIV/AIDS care, support, testing and treatment.

TOPICS COVERED IN THIS 21 PART SERIES

Introduction to HIV Part A • Introduction to HIV Part B • HIV and the Immune System • ARVs for Adults
TB and HIV • ARV Side Effects • Sex and the Positive Person • VCT • Kids With ARVs • Kids Without ARVs
Adherence • OIs of the Mouth • OIs of the Skin • OIs of the Respiratory System • OIs of the Nervous System
Rules for Better Living with HIV/AIDS • Nutritional Supplements • Women and HIV
PMTCT • Home-Based Care and Palliative Care • Human Rights

The treatment literacy series is a powerful training tool for treatment supporters and peer educators at work or in the community.

Now available: isiXhosa and English **Forthcoming:** isiZulu and Portuguese

The information is presented by TAC treatment literacy trainers in a simple and understandable style. Each programme has a facilitator's guide that can be accessd on the *Siyayinqoba Beat It!* website.

Order online at **www.beatit.co.za** or call **+27 (0) 21 788 9163** / Fax: **+27 (0) 21 788 3973**

SABC Education

Costs:

NGOs, Churches etc.	R150 per DVD or R2,350 per set
Business/Government:	R300 per DVD or R5,000 per set

(excluding VAT + packaging & posting)

CHMT Community Health Media Trust

TALK ABOUT nutrition & HIV

Nutrition and antiretrovirals are both important.

Good nutrition is very important if you are living with HIV. Antiretrovirals are the medicines that treat HIV. Most people with HIV only need to start taking them after a number of years, when they develop AIDS. Antiretrovirals help most people who take them live much longer, healthier lives. They have to be taken everyday for life. Nutrition is not a replacement for antiretroviral treatment. But good nutrition can help you stay healthy for longer so that you can start taking antiretrovirals later. Once you start taking antiretrovirals, good nutrition will improve their benefits.

Eat a balanced diet.

Foods fall into the following three groups:

Body-building foods (protein): *beans, soya, peanuts, eggs, meat, fish, chicken.*
Energy-giving foods (carbohydrates and fats): *maize, millet, rice, potatoes, sugar and oil.*
Foods with vitamins that protect against infections: *fruit and vegetables.*

Try to eat food from each of these groups every day. This ensures a balanced diet. Also try to eat at least three times a day.

Since your body has to fight HIV as well as other infections, it needs more energy. Foods that many people eat everyday like pap, bread, rice, potatoes and mngqusho contain lots of energy.

Eat lots of energy foods to prevent losing too much weight due to HIV.

Make eating an enjoyable event.

Many people living with HIV are badly informed about nutrition. We have been told, "do not eat this or don't eat too much of that". To wonder the whole time whether we are eating the right thing is not good. It makes us feel insecure and guilty. Eating should be an enjoyable, relaxed event.

What matters most is that you eat enough.

People with HIV often lose their appetites when they are sick. However, fighting HIV increases the energy needs of our bodies. Make sure you eat enough when you are ill even if you have lost your appetite.

If you cannot afford to buy enough food to eat, find out if you can apply for a social grant. Join the campaign for the Basic Income Grant so that everyone can have enough money to eat.

HIV causes poor nutrition. Poor nutrition makes HIV worse. A vicious circle.

HIV reduces absorption of food, which weakens the body's ability to resist all kinds of diseases. Poorly nourished people are much more likely to get severe diarrhoea, TB and other infections.

Vitamins

Public clinics give people with HIV vitamins pills. These are often useful for people with HIV. But they are NOT a substitute for antiretrovirals. You should eat lots of fruit and vegetables to ensure you get enough vitamins.

Reduce alcohol and smoking.

Large amounts of alcohol makes HIV worse. Alcohol can also interact very badly with antiretrovirals. Drink small amounts of alcohol or do not drink it at all.

Smoking causes many illnesses, especially chest infections. People often smoke instead of snacking. This is unhealthy if you have HIV. Try to give up smoking.

“Antiretrovirals keep me healthy.”

JUDGE EDWIN CAMERON

Edwin Cameron lives with HIV.
In 1997 he nearly died of AIDS.
In 2006 he rode the 110 km Argus cycle race.

GET TESTED. GET TREATED.

USE A CONDOM EVERY TIME YOU HAVE SEX.

treat 500 000 by 2008

TAC
TREATMENT ACTION CAMPAIGN