EQUAL treatment

Magazine of the Treatment Action Campaign June 2008

Welcome to South Africa?

A special report on the systematic abuse of immigrants

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Front Cover Photo: Jodi Bieber. Undocumented immigrants in Lindela waiting to be deported. www.jodibieber.com.

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A SOUTH AFRICAN WELCOME?

The rights to life and dignity are the basis of the South African Constitution. The Constitution guarantees the right of everyone to access health care.

In South Africa, people who have migrated here from other countries are being denied their human rights. They live in permanent insecurity and endure violence and illegal detention. They do not have adequate access to health care or social support. In our communities they experience xenophobia and discrimination.

The political and economic crisis in Zimbabwe continues to worsen. While people in Zimbabwe starve and are subject to abuse and intimidation, President Mbeki has chosen to remain silent. He has failed to speak out against the tyranny of Robert Mugabe. As *Equal Treatment* goes to press, the outcome of the unfree and unfair Zimbabwean elections still remain unclear.

Every day people flee Zimbabwe for neighbouring countries like South Africa. At least a million Zimbabweans are trying to survive here. Our government is failing to protect the rights of immigrants, whether they be from Zimbabwe, Congo, Somalia, Mozambique or other African countries.

We have created this special issue on immigrants, mainly from Zimbabwe, because we cannot remain silent while atrocities continue in Zimbabwe and while foreign nationals in South Africa are denied their basic human rights.

Regis Mtutu

TAC International Co-ordinator and Zimbabwean Citizen

ARRIVING

By Adam Malapa and Jessica Kiddle

Thousands of foreign nationals arrive in South Africa each month. Those who have a passport and the correct paperwork enter legally through designated border posts. Without these documents many choose to cross illegally. This can involve squeezing through border fences, dodging border guards, bribing border officials or surviving violent border gangs.

The majority of immigrants now entering South Africa are from Zimbabwe. This is because of the political crisis there. Significant numbers also arrive from the DRC, Somalia, Mozambique, Kenya and other African countries.

WHY DO SO MANY TAKE THE RISK TO CROSS ILLEGALLY?

Getting the right paperwork in Zimbabwe is difficult. Zimbabweans looking to live and work in South Africa need a passport. These are now very difficult to get in Zimbabwe. The registry office has largely stopped issuing new ones. For those with a passport, gaining a visitor or work visa is an expensive and long process. It also requires immigrants to meet certain standards like a specific skill set or having a job offer. For many people, getting a job in South Africa before they arrive is unrealistic.

It is possible to enter the border legally as a refugee. A refugee is someone who is, or fears being, persecuted in his or her home country. Under international refugees can arrive in South Africa and apply for refugee status.

Upon arrival at the border a foreign national can inform the border official that he or she is a refugee. According to the 1998 Refugee Act, the border official should then grant the person a 'Section 23' permit that allows him or her 14 days to get to a Refugee Reception Office. As it stands now, many border officials are not aware that people have the right to enter legally if they are refugees. People who obtain this permit successfully arrive at the border with a good knowledge of the refugee application process. Importantly, the Refugee Act states that people who have entered the country illegally may still apply for refugee status at inland Refugee Reception Offices.

Many Zimbabweans report fear of crossing the border through formal processes. They are concerned about the presence of Zimbabwean security agents at the border who could try to prevent them from crossing. On the South African side officials often refuse access or demand bribes.

These obstacles increase the likelihood that people will cross illegally. Crossing the border this way exposes them to the risk of physical and sexual violence, exploitation and illegal detention.

The Beit Bridge border between South Africa and Zimbabwe. Here, people can legally declare their intention to apply for refugee status in South Africa. Photo by Jakob Karte

A young Zimbabwean, Phillip*, talks about crossing the border into South Africa

"I just felt bored at home doing nothing, I had no income and nowhere to go after finishing high school. A friend of mine had the idea of crossing the border and getting a better life in South Africa. This is when I began to think of coming too."

Phillip crossed in 2006. "I only had 10 000 Zimbabwean Dollars on me," he recalls. "That only took me to the border at Beit Bridge. I was stuck there at the gate not knowing how to get through." Without a passport he decided to cross illegally. He and his friend walked along the border fence until they found somewhere to cross. They were then attacked and beaten by four men who were part of a border gang. "They thought we had money but we had nothing. They were disappointed and stabbed me in the hand."

Maguma-Gumas are the nickname given to these border gangs who travel along the border stealing from migrants as they come through illegally. Migrants report that these groups are often violent. They have also reported violence against them from police, immigration officials and the military.

Phillip says he will never forget this border gang. He continues to cross the border illegally. He goes back to Zimbabwe as often as he can to give food and money to his family. Is he afraid of being stabbed and beaten again at the border? "Yes," he says, "but I have learnt to be smart when I cross."

*Not his real name.

Using the right words to describe people from other countries

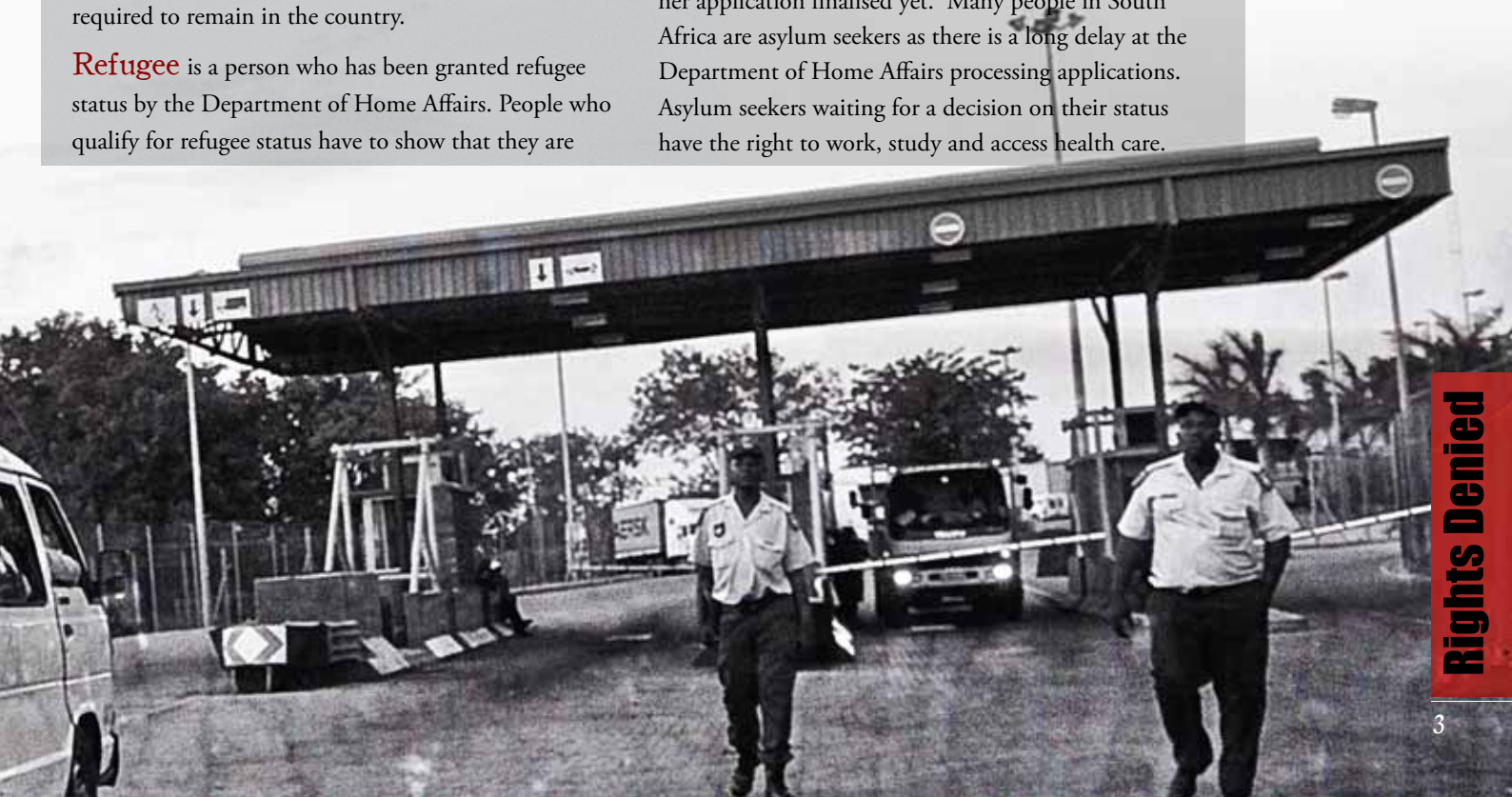
For this issue, we spent hours trying to decide the best way to describe people from other countries who live in South Africa in an unprejudiced, respectful way. There are so many ugly ways of describing foreign nationals. We hope we have managed to avoid these.

Immigrant or foreign national is someone who lives outside his or her home country.

Undocumented immigrant is a person in South Africa who does not have the legal documentation required to remain in the country.

Refugee is a person who has been granted refugee status by the Department of Home Affairs. People who qualify for refugee status have to show that they are unable to return home because they are being persecuted because of their race, religion or political beliefs.

Asylum Seeker is a person who has applied for refugee status in South Africa but has not had his or her application finalised yet. Many people in South Africa are asylum seekers as there is a long delay at the Department of Home Affairs processing applications. Asylum seekers waiting for a decision on their status have the right to work, study and access health care.



Immigrants are taken to Migrant Detention Centres if they are caught by police or immigration officers without proper documentation. There are two such centres in South Africa. The larger one is Lindela. It is run by a private company called Bosasa and is under the authority of the Department of Home Affairs. There have been allegations in the media that Bosasa is owned by the ANC Women's League. The other is located near the Zimbabwean border in Musina. It is estimated that 20,000 Zimbabweans are deported each month from these centres.

Many violations of human rights have been recorded at these centres. Migrant Detention Centres in South Africa fail to conform to international human rights standards or the protections guaranteed by our Constitution including the rights to dignity, privacy and access to legal services.

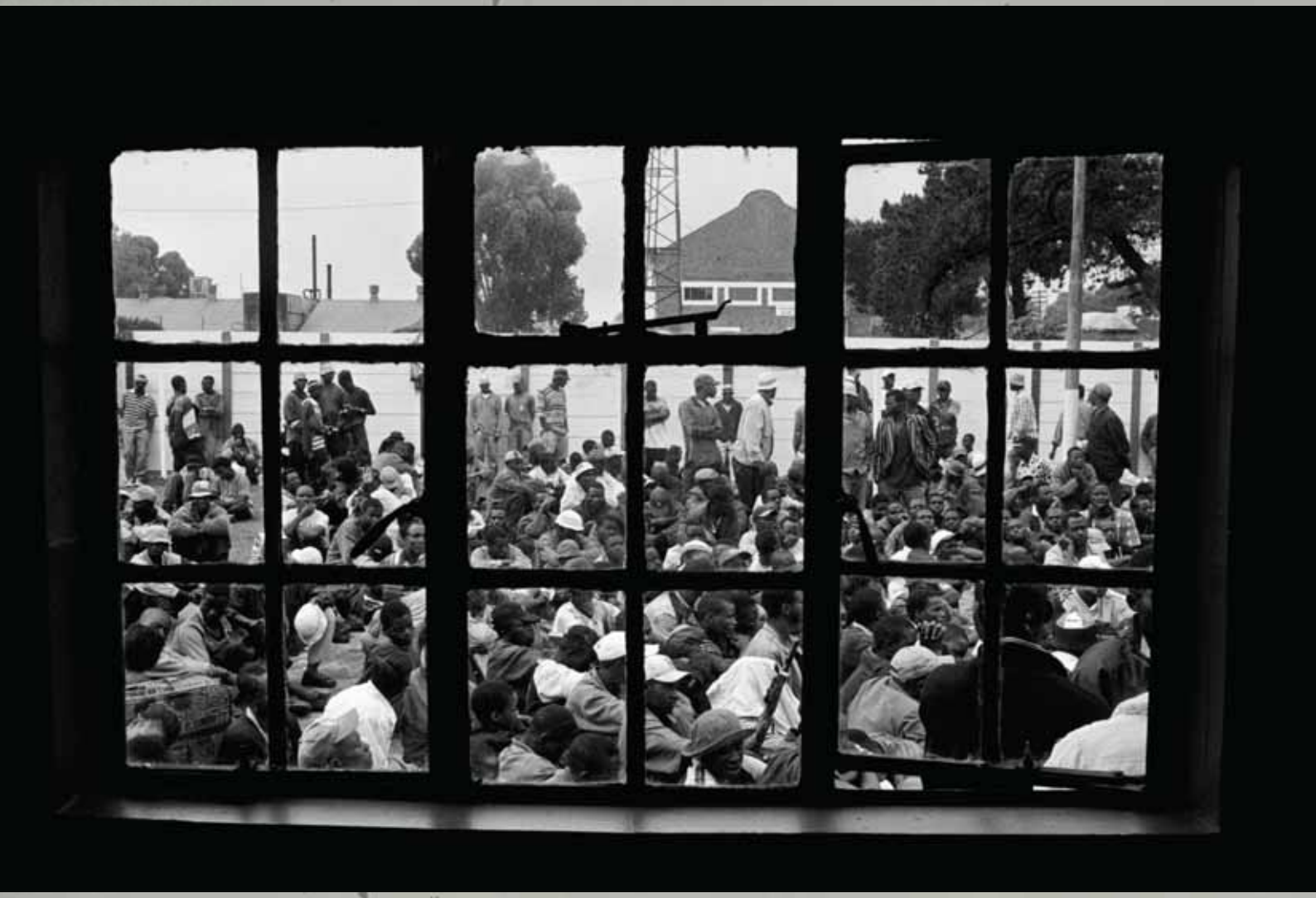
Detained illegally

Lindela is the largest immigration detention centre in the country. It is located just outside Johannesburg and has the capacity to hold up to 4,000 detainees. The picture below was taken in 2001. Since then there are far less detentions than in previous years and the deaths in custody have decreased. Nevertheless, much remains to be done to improve the centre.

Detention centres pose health risks for immigrants. Detainees report that they are subject to physical abuse and intimidation from prison wardens, private security guards and government officials. Over-crowding and lack of adequate ventilation puts detainees at risk of contracting TB. The food is poor and the living conditions are filthy. Regular access to health care for chronic conditions such as HIV is virtually non-existent.

Detainees report that they are dissatisfied with the level of care in Lindela's medical clinic. Their requests for treatment are almost always denied. If detainees brings in their own supply of antiretrovirals (ARVs) the clinic will store them. Otherwise there is no access to ARVs or TB treatment. Migrants have been held for up to one year in Lindela in these conditions. The Department of Home Affairs and Bosasa have an obligation to ensure that conditions of the centre meet standards that uphold basic human rights.

Both photos taken at Lindela Detention Centre. Right: There are no longer children being detained in Lindela. This photo was taken in 2001. Photos by Jodi Bieber.



A photo taken from inside Lindela. Photo by Jodi Bieber.

In keeping with the Constitution, the Immigration Act provides that people need to be informed of their rights while detained, including their right to legal services in a language they understand if possible. By law, detainees should only be held for a maximum of 120 days, the last 90 of which must be confirmed by a warrant from a magistrate's court.

It is difficult for detainees to access the legal representation they need. In Lindela, if they have money for a phone call or a friend or family member that is willing, they can contact Lawyers for Human Rights. This organisation works with people who have been detained. Otherwise, no legal aid is provided. If the decision has been made to deport a detainee they are served papers in English. There are reports that people have been lied to about the contents of these deportation papers.

Inside Lindela, detainees do not know how long they will be detained for. This creates terrible stress for many. In some countries, courts have ruled that indefinite detention of immigrants is cruel and unusual punishment. While some detainees are deported soon after arriving others have been held for up to one year. This can be for a variety of reasons including decisions made by the South African Department of Home Affairs, or foreign embassies refusing to identify their own citizens.

Officials intimidate people in detention centres. There have also been complaints from these facilities of physical abuse. In Lindela, officials have used tear gas to control detainees. For example, sometimes officials will throw a tear gas canister into a room of 60 people and then close the door, opening it again only some minutes later.

The Musina detention centre is located near the Zimbabwean border. It is a small but busy centre with approximately 500 people being kept there at any given time. A TAC task team visited the centre in March 2008 to assess the health conditions of the people being deported. They were escorted to the centre, located on a South African National Defence Force base, by the Musina police.

The centre is a large warehouse that is separated into two sections by a metal fence. On the male side, detainees live and sleep on a concrete floor that was covered with garbage and insects. It smelled strongly of human shit. Outside there was one toilet in extremely poor condition. There was potential for overcrowding and a lack of adequate ventilation, creating a high risk environment for the spread of TB. The detainees claimed the food was inadequate. There was not an obvious source of clean water inside the centre. There is no medical equipment on site. Ambulances are called for emergencies but this takes 45 minutes. Children are detained at the centre.

"The place was dirty with flies all over as if something died. What the Department of Home Affairs, police and the military are doing is inhumane." – Eddy Marilele TAC Limpopo deputy Chairperson.

The women's side of Musina Detention Centre in March 2008.

Inside Lindela. These people are preparing for deportation back to their country of origin. Photo by Jodi Bieber.

PRETORIA, 0001
Republic of South Africa

LINING UP FO

There are four Refugee Reception Offices in South Africa located in Pretoria, Durban, Cape Town and Port Elizabeth. A fifth in Johannesburg has been closed for several years. Thousands of immigrants are now waiting outside these centres trying to apply for refugee status. Without papers, it is difficult to live, work and access health care in South Africa. It might take years for people to have their refugee application processed and accepted. In the interim, refugees are issued with Section 22 Asylum-Seeker permits which need to be renewed on a regular basis, usually every three months.

In Cape Town, only a small number out of the thousands waiting in line are seen each day. There is a big backlog of people waiting to make their application for refugee status. The situation has been made worse by officials demanding bribes for places further up the line.

"The law assumes that people will be able to lodge their application within 14 days after arriving in South Africa but some people have been in the queue for a month and a half," says Braam Hanekom, chairperson of PASSOP, an NGO that has been monitoring the refugee application queues. "They are not provided for by the Department of Home Affairs. They live in disgusting conditions and beg or raid garbage bins to feed themselves. All because they simply want to fill in a form for refugee status."

There are often over a thousand immigrants in the queue to get to the Refugee Reception Office in Cape Town. This queue includes pregnant women, children and the elderly. They have to sleep on the pavement. There is no security or shelter. Access to clean water and toilets is minimal. Despite a written waiting list being set up by the refugees in Cape Town and a system by which different nationalities are seen on different days, many fear losing their place in the queue if they leave.

Others are scared of being arrested if they leave because they do not yet have papers. Others simply have nowhere else to go. Exposed to the elements and left without adequate sanitation many are affected by ill health but are afraid to leave the queue to seek medical care. Those with chronic illnesses, including HIV, have little chance of accessing treatment.

David, a 54 year-old Zimbabwean waiting in the queue told *Equal Treatment* that he sold his car when he left Harare but now his money has run out. He wants to get an Asylum Seeker permit so he is legally able to work. He wants to find a job as quickly as possible in South Africa so that he can send money home for his children. "As a father, I've got to do something."

The Home Affairs parliamentary portfolio committee have acted on this matter in Cape Town. Now there are

OR RIGHTS

more toilets and water taps. They have also increased staffing levels and committed to seeing 300 people a day. Despite this commitment, PASSOP estimates that only 100 are getting served on a daily basis.

Once seen by the Department of Home Affairs, asylum seekers are usually granted 3-6 month permits which must be renewed. These allow them to work and live legally in South Africa. Getting refugee status can take many months and many get rejected. Of the estimated 200,000 refugee applications submitted between 2000 and 2006, only 30,200 applicants gained refugee status. Many people are still waiting for the outcome of their application. As government has not formally recognised Zimbabwe as a country in political crisis, refugee status is even more difficult to get for Zimbabweans than for people from other countries.

Photo by Jodi Bieber.

Photo by Braam Hanekom.

TREATMENT INTERRUPTED

Photo by Lucky Mkhondwane.

Equal Treatment *spoke to a Zimbabwean woman in Johannesburg who was denied access to antiretroviral treatment.*

34 year-old Edwick Nyamhungu, originally from Zimbabwe, has been living in South Africa for 16 years. She has learnt to speak Zulu fluently. After being diagnosed with TB Grace chose to get an HIV test. She tested positive in September 2007 with a CD4 count of 42. After her test she was referred to Johannesburg General Hospital. The hospital staff illegally refused to give her antiretroviral treatment because she was foreign and did not have citizenship papers.

Foreign nationals who cannot pay have the right to access free and comprehensive HIV treatment, care and support. You do not need asylum-seeker or refugee papers.

A woman sits inside a police van after being arrested as an illegal immigrant. Photo by Jodi Bieber.

Paula Chirundu is a 34 year old Zimbabwean refugee women living with HIV. Her husband passed away in 2007 so she stays with her sister in Johannesburg. She has three children who are still living in Zimbabwe. Paula was diagnosed with HIV in May 2005 and started taking antiretrovirals (ARVs) while in Zimbabwe.*

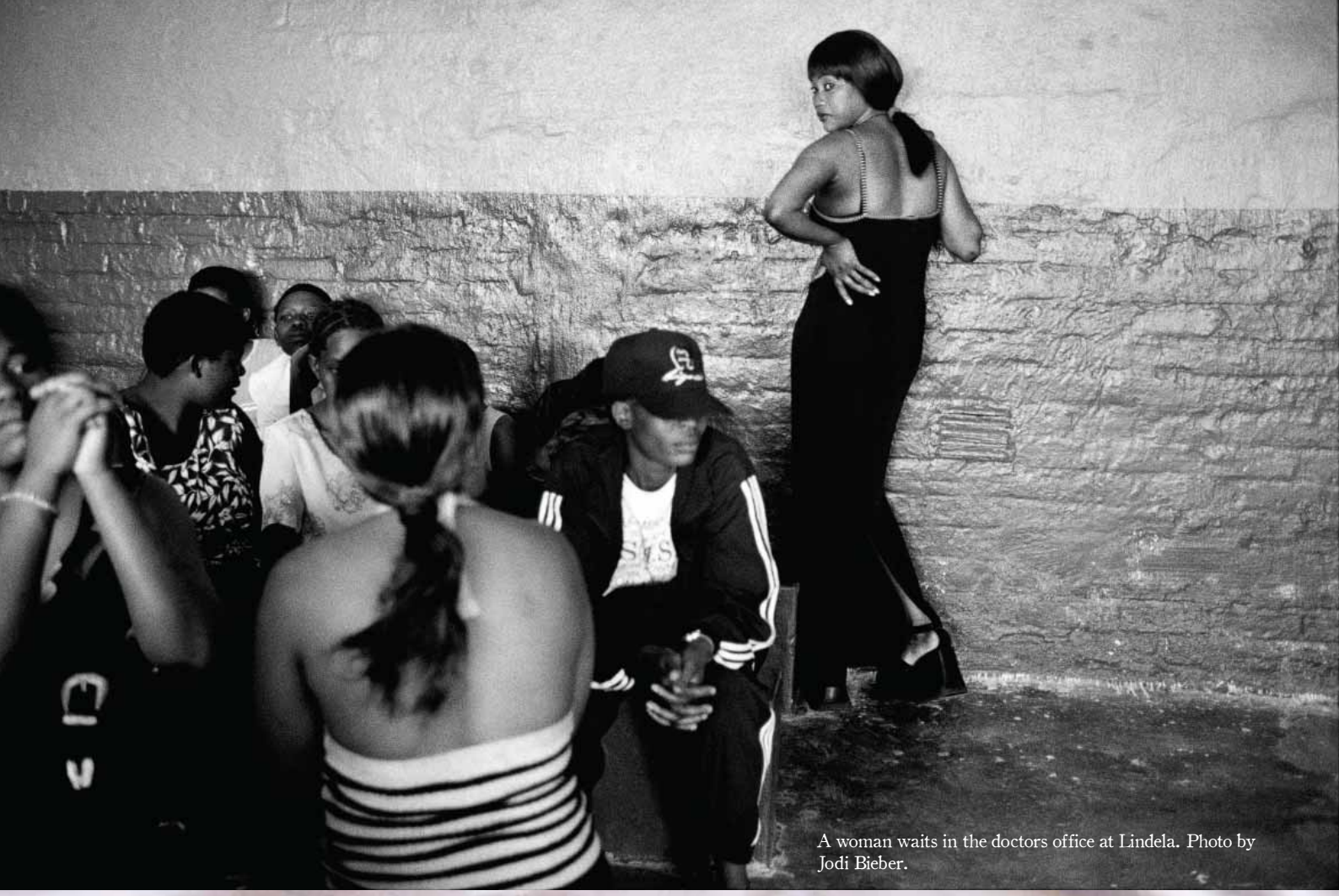
Paula does not have a passport. She came through the border illegally. She was detained a short while later and imprisoned at Motswedi Police station for 20 days. Her ARVs ran out and she was not able to access more in prison. After her release, she went to Hillbrow Hospital in Johannesburg to try and get more ARVs. They refused to give her any because she was not from South Africa. She spent another three months without ARVs until she began to get sick. She went to the Central Methodist Church and was referred by Bishop Paul Verein to Nazareth House for treatment. Here she was seen by a doctor. Her CD4 count was 136. She was restarted on ARVs and now her CD4 count is going up. She is healthier now. Her greatest challenge is to get enough food because she does not work full time. Paula would like to go back to Zimbabwe if the situation gets better.

**Not her real name.*

A treatment interruption is when someone on antiretrovirals stops taking them. This might be because the person chooses to stop treatment or for reasons out of their control like being detained in a Migrant Detention Centre. Some immigrants to South Africa arrive having had to stop treatment because supplies of antiretrovirals (ARVs) have run out in their home countries. Some immigrants have been denied treatment in the public sector.

Adhering to ARV treatment is very important. Once you have started treatment you should not stop. You should also try to take the drugs at about the same time everyday.

A treatment interruption can have serious health implications. A person could develop a strain of HIV that is resistant to their ARVs. Resistance occurs when the virus mutates when it reproduces so that one or more ARVs no longer work against it.



A woman waits in the doctors office at Lindela. Photo by Jodi Bieber.

Accessing Health Services

Refugees, asylum seekers or undocumented immigrants may access emergency and basic health services in South Africa's public health system.

The Constitution of South Africa guarantees everyone the right to access health care services. As an asylum seeker, refugee or undocumented immigrant you cannot be refused emergency medical treatment or basic health services.

Many immigrants face discrimination or outright denial of health services. This is illegal in South Africa. If you do not have any money to pay for private medical services you have the right to access health care free of charge in the public sector.

The International Federation of Human Rights reported an extreme case where a pregnant Somalian woman was refused care on the grounds that delivery, unless problematic, did not constitute an emergency. The hospital also expected her to pay the additional fee levied on foreigners, which as a refugee she was in fact not required to pay. As a result she gave birth to the child on a pavement outside the hospital.

In South Africa you have the right to deliver your baby at a public facility at no cost to you. Go to the nearest clinic for pre-natal treatment, HIV/AIDS services including voluntary HIV testing and counselling.

The National Department of Health has declared that foreign nationals with HIV, irrespective of their legal status and where medically appropriate, have the right to access antiretroviral medicines free of charge both for treatment and also to prevent the transmission of HIV from mother-to-child.

ART Management for Displaced Populations

Guidance for clinicians, non-governmental organisations and governments on the provision of antiretroviral therapy (ART) among displaced populations

This guide to antiretroviral therapy (ART) was designed by the HIV Clinicians Society as a guide for government, clinicians, nurses and organisations working with displaced populations like immigrants.

All people, including displaced persons, should be encouraged to regularly **test for HIV**.

As with all patients, proper **counselling** is key to ensuring the displaced person's understanding of ART. Counselling in an appropriate language and with regard for cultural differences is crucial.

Displaced patients may be anxious that disclosure of their HIV status will have implications for their residency or have other **legal consequences**. HIV status does not have an impact on the legal status of a displaced person in the southern African region.

Initiation of ART- biological criteria and choice of regimen. A full history, clinical, psychosocial and available laboratory evaluation should be done for all patients according to the national protocol.

Adhere to national country guidelines. Where these are not available, follow WHO guidelines. The absence of laboratory facilities should NOT be used to exclude HIV positive people from treatment.

Try to match the regimen to the one the individual is likely to be on over the next year. If return or displacement may soon occur, try to match the regimen to that available where the person is going to.

Choice of regimen if currently on ART. Currently, most patients in sub-Saharan Africa are initiated on d4T or AZT, 3TC and an NNRTI, either nevirapine or efavirenz.

- **If on same regimen** as national programme: continue same regimen.
- **If on different regimen** from national programme: if the national guideline supports the different regimen, continue with this regimen and initiate monitoring according to the local algorithm. Occasionally, national protocols may offer better treatment options, or new treatment options may become available; these options should be assessed.

If the national guideline does not support the regimen, consider the following: history of side-effects and co-morbidities; history of possible virological, immunological or clinical failure; use of concomitant medication.

In this case, select the best available regimen from available drugs.

Choice of regimen if ART was interrupted. Establish the cause of the interruption. Displaced persons often have treatment interruption due to factors beyond their control, e.g., conflict. If there were no adherence, resistance or toxicity issues, reinitiate ART as soon as possible.

Adherence support needs of displaced persons may be very different to those of the local community. In the absence of a 'treatment buddy', a friend, companion, family member, support group, local health worker, or local faith-based or non-governmental organisation may be able to fill this role.

Psychosocial and mental health. Displaced persons, particularly those coming from conflict areas, may have experienced trauma and violence, including sexual violence, and therefore may be in need of specific psychosocial support. Explore these issues sensitively and make efforts to refer to specialised services.

Contingency planning. Displaced persons can be affected by unforeseen events, causing them to move unexpectedly. Explore this at every visit. Discuss the provision of a personal ART stock if necessary (2 - 4 weeks will allow time to make alternative plans for ART access).

Referral letters. The health worker in the site being traveled to may not speak or read the referring site's language. In referral letters use generic names and terms such as stavudine, tuberculosis, cryptococcal meningitis and internationally agreed upon acronyms such as PMTCT or VCT.
Referral letters get lost. Make sure the patient can relay the information verbally.

Displaced populations include:

- **Refugee:** a person who flees his/her own country because of race, religion, nationality, membership of a particular social group, political opinion, or civil unrest/war, and who cannot return home for fear of persecution
- **Asylum seeker:** a person who has applied for asylum and is awaiting a decision on his/her case
- **Internally displaced person:** person who has been forced to flee his/her home suddenly or unexpectedly due to armed conflict, internal strife, systematic violations of human rights or natural disasters, and who is still within the territory of his/her country
- **Economic migrant:** person who moves to another country seeking economic opportunities
- **Undocumented migrant** (often negatively referred to as 'illegal immigrants'): person who has entered another country and remains without the required legal documentation

UNHCR The UN Refugee Agency

Southern African HIV Clinicians Society

For more information, see the UNHCR/ Southern African HIV Clinicians Society's Clinical Guidelines on Antiretroviral Therapy Management for Displaced Populations, 2007 (www.sahivsoc.org or www.unhcr.org/hiv-aids)

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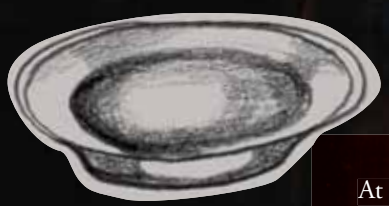
Tel: (27) 11 663 6300

UNHCR Regional Representation for Southern Africa
Tel: (27) 12 354 8303

Young boys near the Beit Bridge border. Photo By Jakob Karte.



At the border gate in Musina I interviewed 12 male children ranging from seven to eighteen years old. Most of them had come to South Africa in 2007. Some of them had come because their parents had died, others told me how the political situation in Zimbabwe had made it impossible to stay there. These boys survive by fetching water for people working in the market. They also carry petrol containers over the border to sell because there is a shortage of petrol in Zimbabwe. They try to save their money for food and to travel back to Zimbabwe to visit their families and bring supplies for them. They sleep outside, near the border. When I asked if they wanted to go to school they all said yes. For now, because they don't have the right documents, not one of them have access to a public school in Musina.

Reported by Adam Malapa, TAC Limpopo Provincial Organiser.

Children and Immigration

trying to make it on their own

Many children who cross the border from neighbouring countries into South Africa are unaccompanied by adults. Save the Children estimates that the average age of an unaccompanied immigrant child is 14. Equal Treatment *spoke to some as young as seven who are working and living in Musina. Many children come to South Africa in search of work. Their parents may have died or some are working to send money back to their families in Zimbabwe.*

Without documentation many cross illegally. This means wading through rivers or passing through holes in the border fences. Some pay for a guide or come in large groups to try to protect themselves. This does not always guarantee their safety. When crossing, children are vulnerable to extortion, theft of their property and violence.

Human Rights Watch has reported that children immigrants to South Africa have been arrested and detained. When detained they are sometimes kept with adults and/or criminals.

Often under the age of legal employment, young boys have been documented working as farm workers, bar or restaurant staff. Young girls often work in shops, do housework, sell sex or have sexual relationships with much older men for security. As with adults, immigrant children whose rights are violated at work or who are not paid for their services have little access to legal assistance and justice.

Many immigrant children do not go to school. They cannot afford school fees or the cost of uniforms and materials. Often they have no choice but to work instead of going to school.

Many children live in unacceptable conditions. They share very small shacks in informal settlements without access to adequate water or electricity. *Equal Treatment* spoke to three young refugees who reported that the police raided their homes searching for undocumented immigrants. They said they had been subjected to police violence and extortion. The police, however insisted to *Equal Treatment*, that foreign nationals in the area are treated fairly and non-violently.

Children who come into contact with the police should be taken to a social worker who can assess their situation. If they qualify for refugee status they should be supported though the asylum seeking process. If they are being deported, they need to be accompanied to ensure their rights are protected.

We need to advocate for laws that specifically deal with undocumented immigrant children. The Refugee Act must recognise and protect the rights of children.

Young women immigrants

Young women who migrate alone to South Africa are at high risk of being exploited and sexually abused.

Trying to cross the border or while living in South Africa, young women are at high risk of sexual exploitation and abuse. Some girls are raped while crossing the border or forced to exchange sex for a safe crossing. While living and working in South Africa many enter into relationships with much older men who offer housing and financial security. Some sell sex in order to survive.

Young girls who are exposed to sexual violence such as rape, in relationships with older men or engaged in sex work need to access adequate health services. This includes contraceptive options, HIV counselling and testing and emergency care.

Comprehensive care for victims of sexual violence is not adequately accessible in the country. Post Exposure Prophylaxis (PEP), if given within 72 hours, significantly reduces the risk of contracting HIV.

Rape survivors also need counselling and may need emergency contraceptives. Young women, by law, do not need a police report to get PEP or other heath services, although many clinics ask for it.

Many young immigrants are scared of accessing official services such as hospitals or clinics but they have the right to do so.

Finding girls to interview was difficult. They do not hang around the border like the boys. Instead, they mostly work informally in the townships or on farms. Girls are extremely vulnerable to sexual abuse when they live illegally in South Africa. This is because they are desperate for money and also because they don't have access to justice if a crime is committed against them. They are too scared of the police to report a crime like rape. The girls we interviewed shared a small shack for R200 a month with no electricity or running water. They told me how they worked as domestic workers around Musina. They get paid between R200 and R400 a month. Sometimes their employers do not want to pay them. Instead, they call the police so the girls have to run away instead of collecting their money. "It happens most of the times that you work and suddenly they call the police to come and arrest you," said one of the girls to me.

Reported by Adam Malapa, TAC Limpopo Provincial Organiser

For a list of PEP sites in South Africa, go to: http://www.tac.org.za/community/pep

Human trafficking is like modern-day slavery. It is when individuals are forced, defrauded or coerced into labour or sexual exploitation. A common method used by traffickers is to promise people exciting jobs, even paying for their travel costs, then forcing them into labour or sex work without pay when they arrive to a new country. Anyone can be a victim of trafficking but young women are particularly at risk.

Inside Lindela. Photo by Jodi Bieber.

Working in South Africa

Thandai worked a whole month without being paid. This is a familiar story for immigrants trying to find work in South Africa.

My name is Thandai.* My husband and I fled Zimbabwe last year because we could no longer survive there. The conditions were very difficult. We had no food and I could not find work. We arrived in Cape Town after a long and difficult journey. In Cape Town we managed to get refugee papers. After this I found work as a domestic worker for a woman in Milnerton. I worked for one month and at the end of the month she did not pay me my full salary. After six months she still owes me R700. At the moment I have no work. I need that money but I don't know how I can force this woman to pay me.

Thandai's story is very familiar. Foreign nationals are often exploited when they find work in South Africa. Employers take advantage of how desperate they are for money and employ them in jobs at very low wages, often much less than minimum wage. They are not paid overtime, often do not receive benefits and in some cases are not paid at all.

Labour exploitation is particularly common on farms in Limpopo. Farmers are granted 'corporate permits', which allow them to employ Zimbabweans for seasonal jobs such as tomato picking. By law they are expected to comply with the Basic Conditions of Employment Act, including paying a minimum wage of R5.07 per hour or R989 per month. Yet workers often get R14 for eight to ten hours of work. These farm workers do not have access to health care. A nurse in Musina explained to *Equal Treatment* that immigrant workers come to the clinic only when their employers are doing some business in town and they can come along.

Undocumented immigrants are particularly vulnerable to abuse. Despite a recent court ruling which states that migrants, with or without a permit, have the same labour rights as those afforded to South Africans under the Labour Relations Act many fear arrest or deportation if they try to report the crimes of their employers.

* Not her real name

An undocumented immigrant being deported back to Mozambique by train in 2001. These are the only possessions he has with him to take home. Photo by Jodi Bieber.

UNDERSTANDING THE POLITICAL CRISIS IN ZIMBABWE

Full Name: Republic of Zimbabwe

Population: 13 million

Life Expectancy at birth: +/- 35 years

Major Languages: Shona, English and Sindebele

Major Religions: Christianity, Traditional beliefs

Capital City: Harare

Photo by Jodi Bieber.

Zimbabwe gained independence from Britain in 1979. Robert Mugabe, a freedom fighter who fought against colonial rule, has been president of Zimbabwe since 1980. When Mugabe first came to power he represented the same dreams of those who struggled against apartheid here in South Africa: equal rights, majority rule, a new beginning and reconciliation with an unjust past.

Now things are very different. President Mugabe's rule has become a reign of corruption and terror mixed with grotesque incompetence. The country is in severe political and economic crisis. The health system has collapsed. Life expectancy is one of the lowest in the world. People with HIV or TB have no access to treatment.

Political Crisis

In Mugabe's five terms in office his government has become increasingly autocratic. He and the ruling Zanu PF have detained, abused and murdered political opponents. Elections are neither free nor fair. Mugabe is largely to blame for the economic and infrastructure collapse in the country. His crimes date back to at least 1982 to 1983 when his government massacred thousands of Ndebele people in Matabeleland.

Economic Collapse

Zimbabwe used to have a strong economy. Now unemployment is 80% and inflation is between 100,000% and 300,000%. The collapse had been caused by corruption, violent land reform which destroyed the agricultural industry, increasing international isolation and an expensive war in the DRC.

Food Shortages

Zimbabwe once had a vibrant agricultural industry. Now this has been destroyed and there is a shortage of food. There has also been a severe drought for the last two years. Seed and fertilizer are in short supply.

Environmental Degradation

Between 1990 and 2005 Zimbabwe lost 21% of its forest cover. Continued illegal tree cutting (which many Zimbabweans have turned to since the collapse of the agricultural industry) has resulted in erosion and has destroyed dams and streams. There are also concerns about the country's water supply.

Human Rights Abuses

The Zimbabwean government severely restricts its political opponents, the media and non-governmental organisations. In 2007 Human Rights Watch reported that many activists, journalists and political figures were physically abused and imprisoned. This included the leader of the opposition, Morgan Tsvangirai, who was seen on TV in hospital after being beaten and jailed by government officials. Since the 2008 elections systematic state violence has been used against opposition supporters.

Media

All broadcasters (TV and Radio) in the country are state-run and rarely oppose any actions or policies of the government. Journalists must register with the government or they can be arrested. In 2007 several journalists were jailed for covering events led by opposition political parties. It is difficult for Zimbabweans to get news that isn't heavily censored by the government.

A billboard near Musina highlights the unfree and unfair 2008 election in Zimbabwe. Despite Mugabe's tactics, the opposition MDC still won both the Parliamentary and the first round of the Presidential elections. Photo by Jacob Karte.

An empty grocery in Zimbabwe. Photo by Kathryn Chu.

A car returns to Zimbabwe from South Africa packed with basic goods no longer available in Zimbabwean shops. Photo by Jakob Karte.

Sources: Human Rights Watch, British Broadcasting Corporation, World Health Organisation, International Monetary Fund, Medecins Sans Frontieres, UNAIDS.

ACCESS TO HEALTH CARE IN ZIMBABWE

Photos by Kathryn Chu.

Zimbabwe has one of the highest HIV prevalence rates in the world. Between 1.1 and 2.2 million people are infected according to UNAIDS, though accurate statistics are impossible in the current situation. Hospitals are understaffed, there is a shortage of medicine and many clinics have difficulty accessing regular water and electricity supplies.

Over 300,000 people need antiretroviral (ARV) treatment. Under 30,000 people are currently receiving treatment. Over one million children have been orphaned in Zimbabwe.

Médecins Sans Frontières (MSF) surgeon Kathryn Chu visited Zimbabwe in early 2008. She spoke to *Equal Treatment* about the health crisis she saw.

You just came back from three weeks in Zimbabwe. What did you see?

HIV care is a major challenge. There is an enormous shortage of human resources and a need to scale-up and decentralise services. A big barrier to healthcare is the high cost of medical care. For example, fewer HIV-positive mothers are enrolling in prevention of mother-to-child transmission programmes because it is too expensive. ARVs are mostly free but people cannot afford other treatment for opportunistic infections or TB.

What are the clinics and hospitals like?

Zimbabwe once boasted one of the best health care systems in Africa. It is now collapsing. At one point, continued water and electricity cuts in one of the provincial hospitals resulted in laboratory closure until an organisation volunteered to truck in water. I saw sick patients check themselves out of hospitals because of the stench from dirty linen and unwashed bodies.

Are ARVs easily available?

In 2007, there was a national shortage of drugs so the number of people who could start on treatment was dramatically reduced. We do not know how many people have died because many clinics stopped keeping track. CD4 counts for many people were not ordered because health care workers thought it was unethical to know the CD4 results if treatment could not be provided.

Department of Home Affairs Answers our Questions

Equal Treatment (ET) interviewed the Department of Home Affairs (DHA) about the problems facing foreign nationals.

ET: How long are refugees and asylum seekers waiting to lodge their applications?

DHA: It takes asylum seekers a week to lodge their applications for asylum. This is attributable to the fact that applicants are serviced per nationality and not on "first come first serve" basis. Applications are then processed and asylum seekers are issued with a permit (Section 22 of the Refugee Act,1998). It takes about six months for the applications to be adjudicated.

ET: How many people are currently waiting in the queue at Refugee Reception Centres?

DHA: On a daily basis, the number of people waiting in queues to apply for asylum is estimated at 400 in "large" Refugee Reception Centres such as Cape Town, Pretoria and Johannesburg. The number of people seeking asylum in "small" centres in Port Elizabeth and Durban is estimated at 200.

ET: According to our research only about 100 people are being served a day. Is this correct? The Home Affairs Parliamentary Portfolio Committee recently pledged to serve 300 people a day. Is this happening?

DHA: Since February this year, precisely 300 people seeking asylum are being processed at the Cape Town Refugee Centre on a daily basis.

ET: At the Foreshore in Cape Town (where those in the line for the bus to take them to the Department of Home Affairs in Barrack street wait) people sleep on the pavement and have little shelter. Does the DHA think the provisions they have made for people waiting are adequate? If not, are there plans to improve the conditions in the near future?

DHA: The Foreshore is meant to be a transit point. However, asylum seekers who have nowhere else to go have turned the place into a shelter. The Department, through its Turnaround Initiatives, is determined to re-engineer its systems and revamp its infrastructures in order to effectively and efficiently achieve its mandate of determining people's status and giving them enabling documents under world class conditions.

ET: Do detainees have access to treatment inside Lindela?

DHA: Yes detainees have access to treatment inside Lindela.

ET: Does Home Affairs recognise Zimbabweans as people in need of asylum and with the right to seek refugee status due to the political and economic situation in this country?

DHA: In addition to the 1951 UN Convention on the status of refugees, the 1967 Protocol relating to status of refugees, the 1969 OAU Convention governing the specific aspects of refugee problems in Africa, the 1993 Basic Agreement between the Government of South Africa and the UNHCR to which South Africa is signatory, the Refugees Act No 130 of 1998 together with the 1996 South African Constitution provide the legislative framework on which to deal with people in "need of protection" whose removal to his home country would subject him personally to a danger of torture or to a risk to his life or a risk of cruel and unusual treatment or punishment. Zimbabweans are no exception.

STOPPING DISCRIMINATION IN OUR COMMUNITIES

Immigrants from Zimbabwe and other African countries face harassment and discrimination from South Africans. In some townships gangs terrorise foreign nationals, burning their homes and inciting violence. Fearing for their lives after a gang attack like this, 400 immigrants sought shelter in a school near a police station in Pretoria as Equal Treatment *went to print.*

Faniswa Filani. Photo by Roulé le Roux.

STOP XENOPHOBIA!

TAC member Faniswa Filani speaks about fighting for the rights of immigrants in her community.

On 23 February 2008, I, a Xhosa woman, went to Nyanga terminus to get a taxi from Nyanga to Cape Town. Fortunately I got the sprinter bus which is a 23 seater. On the bus there were two Zimbabwean men sitting in front of me. There was also a woman sitting next to me. I don't know how it all started but there was a conflict between these two men and this woman. She was shouting at them. The bus was full of South Africans. As soon as they heard that there was a conflict they didn't want to know who was right. They just started shouting at the Zimbabweans. I told them not to take sides or do favours. They must listen to each party and not start shouting. Then maybe they could solve the problem. I told them that everyone has a right to speak, they mustn't discriminate against a person. I said that we need to treat immigrants as our brothers and sisters. Somewhere somehow these people have helped us too. Some of us have jobs from them.

Maybe one day your sons or daughters will go to Zimbabwe. What if they get into a similar situation, what would they do? Think of it.

The Zimbabweans left the bus before we arrived in Cape Town. All of them were angry with me for saying what I said. They wanted to beat me and said that maybe I was working for them or I was married to them. I was wearing the t-shirt that I got from the march where we stood up for immigrant rights. I stood up in the bus and said that everyone must look at my t-shirt before they attack. You can imagine how everyone on the bus was shouting at me. I told them to do whatever they wanted to but I would not change my mind. I was fighting for human rights and I will always stand up for them.

We arrived in Cape Town. We descended from the bus and I saw that they wanted to harm me. They looked at me aggressively. I told them that if they want to strike me dead they must do so, as I wouldn't be intimidated. I ordered them again to look at my T-shirt. The slogan said "Stop Police brutality and xenophobia. Protest against the attacks on immigrants."

They eventually said "No, no, we won't do anything to you. Maybe that will get us into trouble." One by one they went their different ways.

TAC's 4th National Congress in March passed resolutions to address the situation in Zimbabwe. These included resolutions aimed at stopping President Mbeki's political denialism, ensuring all foreign nationals have access to adequate health services, addressing xenophobia, taking immediate legal action to halt the inhumane conditions of detention centres and mobilizing for days of action to stop the human rights violations occurring in the country. Since Congress, TAC has been busy fulfilling these commitments.

TAC and the AIDS Law Project submitted a joint submission on the Refugees Amendment Bill, including a report from the TAC task team that went to Musina. We are continuing to engage with the portfolio committee on this issue, especially in regards to Lindela and Musina detention centres.

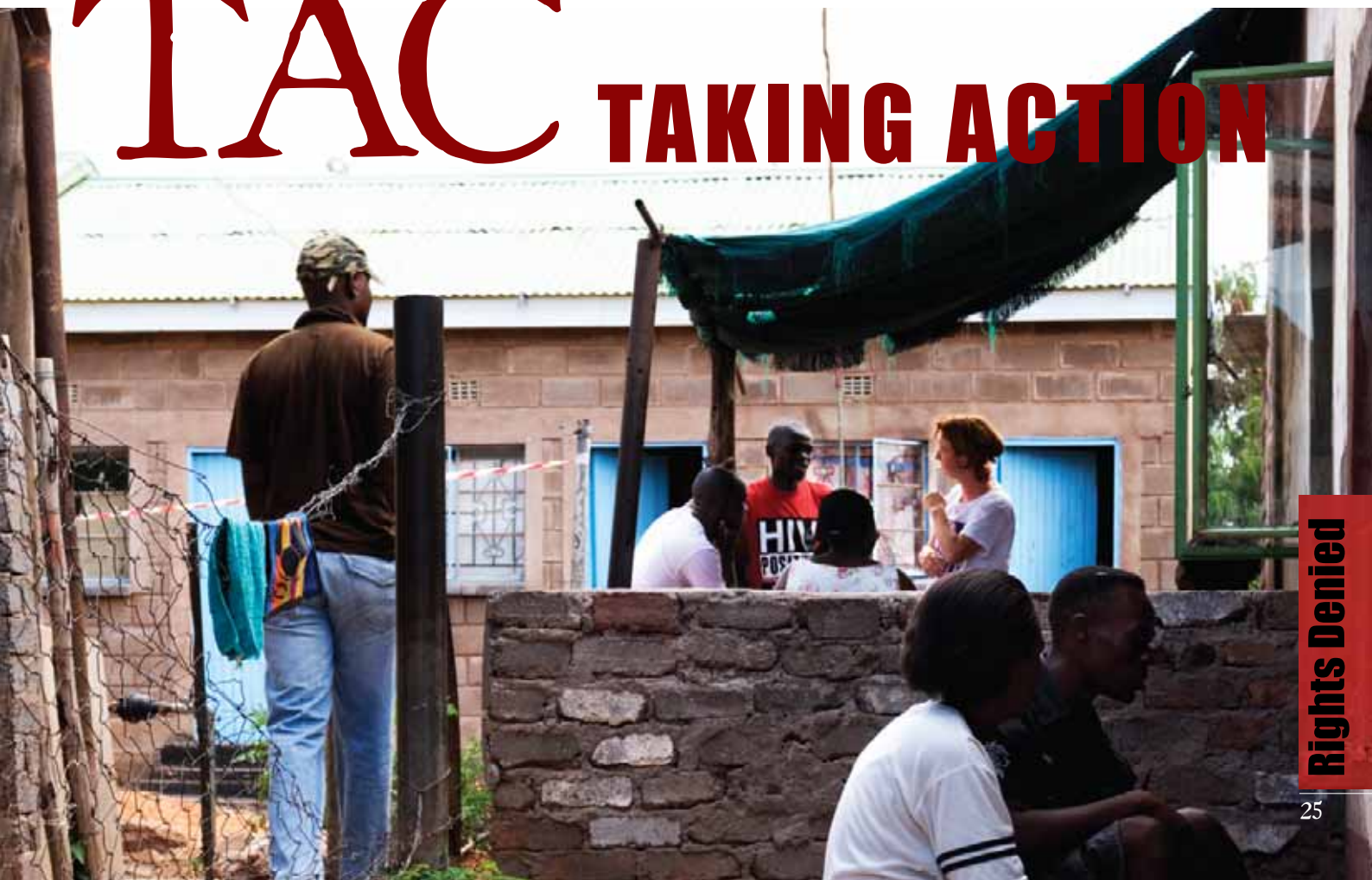
TAC Limpopo has been mobilising in the Vhembe district. There are plans to open a TAC branch in Musina to strengthen health services for the local population and Zimbabweans crossing the border in this area.

TAC is producing materials that will help refugees understand how to access health services. We will also send information pamphlets to Zimbabwean AIDS organisations.

The AIDS and Rights Alliance for Southern Africa has developed a pamphlet for immigrants for all SADC countries on health and human rights.

On 7 February about 300 people took part in a demonstration, organised by PASSOP and TAC, against police brutality and xenophobia. The protest took place outside the Caledon Square Police Station in Cape Town. A memorandum was handed over to the station commander. This followed the raid on the Central Methodist Church in Johannesburg on Wednesday 30 January 2008 in which the police arrested over 300 people. The police mostly targeted men, whom they shouted abuse at and labelled as criminals, but also arrested women and one juvenile.

TAC TAKING ACTION



TAC members talk to people in Musina about the work that TAC does and the importance of having a branch in the area. Photo by Jakob Karte.

During a police raid in Hillbrow in 2001, home to thousands of immigrants, police check the innoculation marks of this man to see if he is South African. Apparently, different countries have different markings, but this cannot be a reliable or Constitutional method for determining someone's country of origin. He was not South African but his wife was. The police took him away to Lindela. Photo by Jodi Bieber.

Sources for the focus on immigrants: Lawyers for Human Rights, Federation of International Human Rights, TAC Consortium for Refugees and Migrants in South Africa (CoRMSA), Aids Law Project, United Nations High Commissioner for Refugees (UNHCR) and Human Rights Watch.

Social and Legal
Assistance for Immigrants

The places below provide social assistance and can tell you about services available in your local area. Most are open 9 to 5 pm during the week. Some you need to make an appointment with. Some of these organisations can also provide assistance for children.

Johannesburg

Social Assistance:
Jesuit Refugee Service
130 Commissioner Street,
2nd Floor, Dynamo House,
Marshalltown
Tel: 011 331 0037

Ministry for Zimbabwean Immigrants
Corner of Simmonds Street and Wolmans Street, 1st Floor
Tel: 073 832 5362

Legal Assistance:
Lawyers for Human Rights
2nd Floor, Braamfontein Centre,
23 Jorissen Street, Braamfontein
Tel: 011 339 1960

Durban

Social Assistance:
Mennonite Central Committee
N242 Diakonia Centre,
20 St. Andrews Street, Durban
Tel: 031 310 3578

Port Elizabeth

Legal Assistance:
Black Sash
1st Floor, Dorsham House,
Cnr Elizabeth & 384 Govan Mbeki Ave, North End, Port Elizabeth
Tel: 041 4873288

Pretoria

Social Assistance:
Jesuit Refugee Service
4th Floor Provisas Building,
Cnr Beatrix and Church Streets,
Arcadia
Tel: 012 341 9185

Legal Assistance:
Lawyers for Human Rights
Kutlwanong Democracy Centre,
357 Visagie Street,
Pretoria
Tel: 012 320 2943

Cape Town

Social Assistance :
Cape Town Refugee Centre
F12 1st Floor Wynberg Centre,
123 Main Road, Wynberg
Tel: 021 762 9670

Also:
Scalabrini Centre
147 Commercial Street,
Cape Town
Tel: 021 465 6433

Legal Assistance:
UCT Law Clinic
Kramer Law School Building,
1 Stanley Road, UCT Middle Campus,
Rondebosch
Tel: 021 650 3775/3551

Musina

Social Assistance:
Musina Social Development Offices
Musina Hospital, Alderwood Avenue next to Nandos
Tel: 015 5343292

Legal assistance:
Musina Legal Advice Office
1224 Kwinda Street,
Extension 2, Nacefield, Musina
Tel: 015 533 1002

Thanks to Consortium for Refugees and Migrants in South Africa for helping us to compile these contacts.

Braam Hanekom runs PASSOP, a refugee rights organisation. His number is 076 101 1324.

Regis Mtutu is TAC's International Solidarity Co-ordinator. Contact him on 0861 END HIV.

TAC's Fourth National Congress

14 to 16 March 2008

Above: Victor Lackay, People with HIV Co-ordinator.
Bottom: Fredalene Booysen, Western Cape Co-ordinator.
Photos by Cecilia Melani.

We celebrate the End of Denial – Time for a Genuine Partnership against HIV and AIDS!

Mobilise all of South Africa behind implementation of the National Strategic Plan!

Campaign for dignity, equality, health and life!

From 14 to 16 March 2008, 550 delegates from TAC branches across South Africa participated in the TAC's 4th National Congress held at the Birchwood Hotel in Ekhuruleni. The majority of delegates were people living with HIV and women, in keeping with TAC's principles.

The Congress gave an award to former Deputy-Health Minister Nozizwe Madlala-Routledge for her courage in standing up to state-supported AIDS denialism. Deputy-President Phumzile Mlambo-Ngcuka and the chairperson of the ANC's Health and Education Committee, Zweli Mkhize, addressed the Congress. TAC delegates responded unanimously to their calls for a robust and honest partnership of common purpose by agreeing that TAC will work tirelessly with the ANC and the government on urgent prevention and treatment campaigns, particularly at district and local level. TAC does not seek conflict. However, TAC will maintain pressure on the government, while trying its best to avoid conflict. We will participate actively in the South African National AIDS Council and other structures. Advocacy, lobbying and mobilisation remain necessary.

Delegates called on the government to rebuild unity with health workers and scientists, many of whom have also been alienated by almost a decade of state-supported denialism. TAC called on government to urgently resolve current disputes over AIDS policy, stop the victimization of certain doctors, create mechanisms to quickly resolve disputes that may arise in future, and unlock key policy issues that are delaying and undermining implementation of the National Strategic Plan.

Congress elected a new TAC secretariat, the organisation's office bearers who are responsible for TAC's political and strategic direction on a day-to-day basis.

Nonkosi Khumalo, National Chairperson

Nonkosi started as a Kwazulu-Natal TAC volunteer in 2000. She became National Executive Secretary in 2001, Women's Health Programmes Coordinator in 2002 and coordinated TAC's Treatment Project in 2004. In 2006 Nonkosi began to work for the AIDS Law Project. She is the mother of two year old Owethu. For the next two years Nonkosi plans to fight for access to justice for women and build leadership of women in TAC, address the implementation of the National Strategic Plan and more.

Vuyiseka Dubula, General Secretary

Vuyiseka lives openly with HIV. She joined TAC in 2001 as a volunteer. She started as a receptionist for TAC in 2002. She became Western Cape Treatment Literacy Co-ordinator later that year and eventually Provincial Co-ordinator for the Western Cape in 2006. She started TAC's PWA programme in late 2007. Vuyiseka wants to strengthen our mass movement of people living with HIV.

Teboho Klaas, Deputy Chairperson

Teboho is a church minister in Soweto and has been involved with TAC since 2003 through his role in promoting HIV/AIDS issues in the South African Council Churches. Teboho hopes to bring about a swelling in the ranks of TAC over the next two years. Teboho sees himself providing leadership in communities and building good relations with other civil society organisations and Government.

Zackie Achmat, Deputy General Secretary

Zackie is a founding member of TAC. He has a long history of social activism since the student uprising of 1976 and has been a vocal gay rights activist. In the next two years Zackie plans to create an effective, efficient, ethical, accountable and open TAC management at local, provincial and national level. He also wants to assist the Community Health Advocacy programme to build leadership strength in TAC.

Nathan Geffen, Treasurer from July 2008

Nathan joined TAC in 2000. He became treasurer during that year. In 2002 he became a staff member, first as national manager (until end of January 2005) and then as director of Policy, Communications and Research (until June 2008). He will be taking over from Mark Heywood as TAC's treasurer in July 2008.

Details of the council can be found at http://www.tac.org.za/community/nec

National Council Members

The Fourth Congress elected a new National Council. The Council includes the above secretariat members and the following people: Fredalene Booysen, Ntombozuko Kraai, Portia Ngcaba, Anele Yawa, Gordon Mthembu, Bheki Khoza, Bongi Skhosana, Phillip Mokoena, Gugu Mpungose, Eddy Tinyiko Marilele, Solanga Solly Milambo, Sidumo Dlamini, Bukelwa Voko, Lihle Dlamini, Emma Baleka, Mashudu Mfomande and Thuli Manikela.

Our Rights in Our Courts

Stopping Charlatans

On 14 March 2008, TAC and the South African Medical Association (SAMA) gave their final arguments in the Cape High Court in their case against Matthias Rath and Government. TAC has argued for the court to force government to stop Rath's unauthorised experiments on humans, his distribution of unregistered medicines and his false claims that vitamin and micronutrient supplements can reverse the course of AIDS.

The legal battle to stop Rath began in November 2005. Then government responded by saying it had conducted an investigation and found no evidence of wrongdoing by Rath. The state has presented no evidence that an investigation was ever properly conducted.

The current court case is important because Rath with the support of South Africa's Minister of Health, Manto Tshabalala-Msimang, has sown confusion in South Africa about the treatment and prevention of HIV. Rath has run campaigns that have misled people into trying alternative unproven remedies instead of using scientifically proven treatments like antiretroviral therapy.

If TAC and SAMA win this case it will set an important precedent for the Department of Health to investigate and stop charlatans who sell untested medicines.

IMPLEMENTING THE NEW PREVENTION OF MOTHER-TO-CHILD TRANSMISSION PROGRAMME

Photo by Thandeka Vinjwa.

By Thandeka Vinjwa

In February 2008 the Department of Health finally released the new prevention of mother-to-child transmission (PMTCT) protocol. Now clinics across the country may begin providing two antiretrovirals (ARVs) to pregnant women: AZT from 28 weeks and nevirapine when she goes into labour. The newborn baby should get nevirapine syrup within 72 hours after birth and AZT syrup for seven days. This will prevent many new infections.

Nowethu Nokewula was born in 1975. She tested for HIV with her husband Ntsindiso in 2002 and her test came back positive. In 2003 her CD4 count was 146. She started a readiness programme and began taking antiretrovirals (ARVs). Six months later, she did a CD4 count again and it was 400. Her viral load was undetectable.

Ntsindiso and Nowethu joined TAC and learnt about treatment and other HIV issues. Their daughter, born in 1998, suffered from recurrent fever and persistent cough and her weight was unstable. So in 2004 they decided to test her. She was HIV-positive. They managed to put her on ARVs. But she had been diagnosed too late and her immune system was weak. She developed TB and died.

In November 2004 Nowethu's CD4 count was 600 and her viral load was still undetectable. So in August 2006 they spoke with a doctor from Médecins Sans Frontières at the Qaukeni clinic because they planned to have a child. They followed all the proper measures the doctor told them to and she became pregnant. She began the PMTCT programme at the clinic. In 2007 they had a baby girl who was named Zusiphe. She was born at St Elizabeth Hospital. The baby got nevirapine.

Six weeks after birth Zusiphe had a PCR test.* Zusiphe tested HIV-positive. They were surprised and the test was done three times to confirm the first results. In a dual therapy programme (i.e. AZT and nevirapine) their baby would have had a much smaller chance of contracting HIV. Zusiphe is in good health and is about to do a CD4 count this month. She is however currently not on antiretroviral treatment. [New research in South Africa shows that babies diagnosed with HIV should be put onto antiretroviral treatment immediately. – Editor]

Nowethu, told *Equal Treatment* that she "urges the government of the Eastern Cape to initiate dual therapy for HIV-positive pregnant women as it reduces the risk of transmitting HIV to new born children. The government must also provide tuberculosis skin tests** in all clinics."

* A PCR (Polymerase Chain Reaction) test is the most accurate way to test children less than 18 months for HIV. A PCR test is usually carried out at six weeks after birth. It is an expensive test that requires a well equipped laboratory.

** The TB skin test is also called the Mantoux test. It is most often used in children and detects if they have been exposed to TB.

LUSIKISIKI UPDATE

TAC's Lusikisiki office has helped mobilise people for HIV treatment in one of the poorest areas in the country.

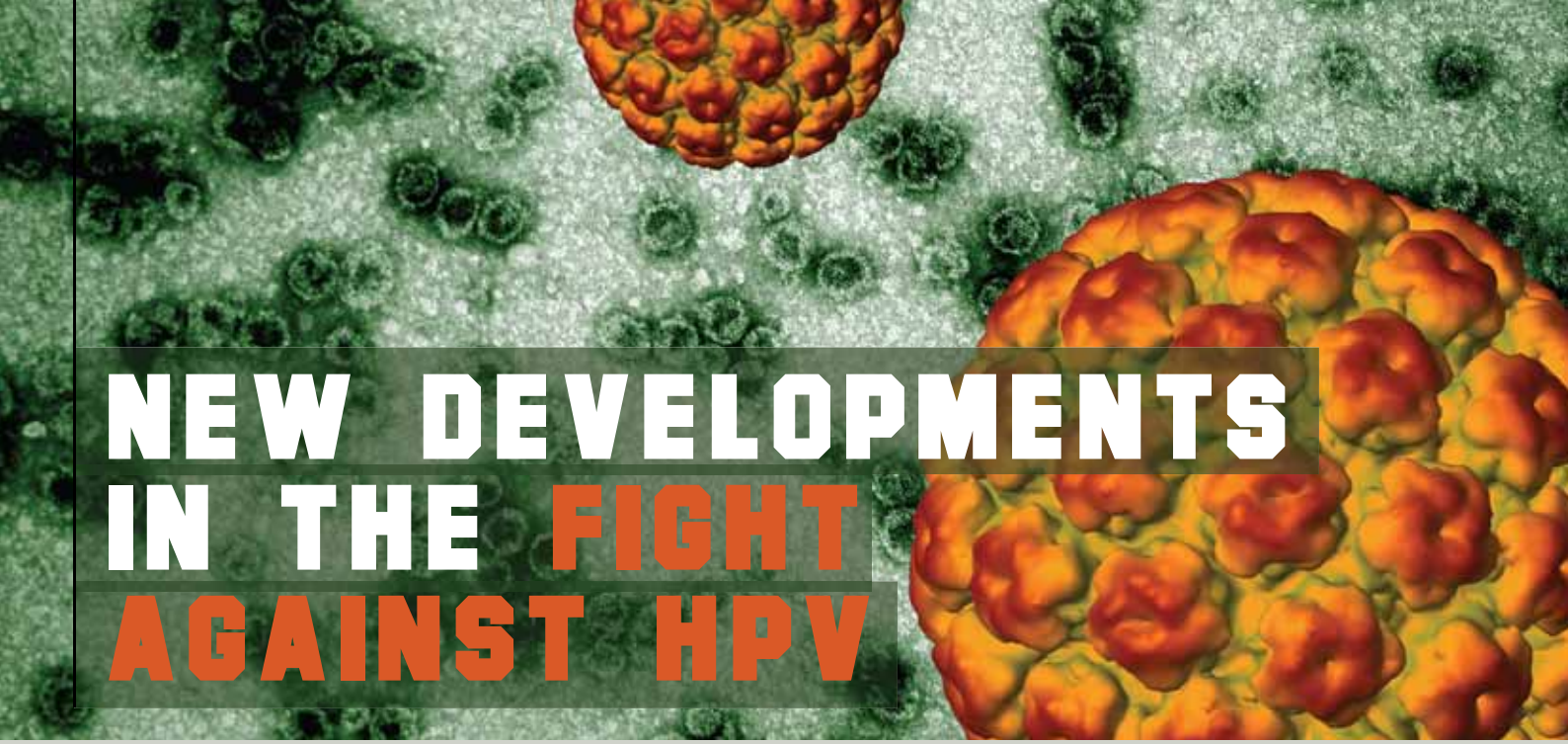
This year Canzibe Hospital and its feeder clinics are the focus area for TAC's OR Tambo (Lusikisiki) office. Located south of Mthatha in the rural Transkei region of the Eastern Cape, Canzibe serves the Nyandeni sub-district. It is one of the most deprived health-service districts in the country. Less than 30% of the population has access to piped water. Communities in the Nyandeni sub-district have been particularly hard hit by HIV. The district has one of the largest proportions of AIDS orphans in the country. Overall, the region's HIV prevalence rate among antenatal clinic attendees is estimated at 25%. There is also a very high incidence of TB. Canzibe's TB ward is often completely full.

The high burden of HIV and TB in the area has placed enormous pressure on the Canzibe hospital and its small staff. Yet, despite the hospital's limited resources, Canzibe has successfully rolled out an effective antiretroviral (ARV) programme. It started in 2006 with financial and logistical assistance from Transcape, a non-profit organisation managed locally by Arjan van der Sar, whose wife, Simone, is a physician at Canzibe. The hospital ARV programme now has over 300 patients enrolled. Transcape, working together with Siyakhula, a local community-based organisation which provides support for people with HIV, has organised many awareness campaigns that increased uptake of HIV prevention, treatment and care services. These organizations have done excellent work in the area.

In spite of the accomplishments made in rolling out the ARV programme, lots of work still needs to be done to scale-up access to HIV and TB services. In late 2007 representatives from Transcape and Siyakhula contacted TAC proposing a partnership to mobilise and educate communities in Nyandeni on HIV and TB. "We need TAC," says Arjan van der Sar, Director of Transcape. "It's time for more action. Working together with TAC we can make big steps forward in getting more people on treatment."

On 10 March 2008 a TAC delegation led by Noloyiso Ntamehlo, TAC's OR Tambo District Organiser, held a series of consultative meetings in Nyandeni. Representatives from Transcape, Siyakhula, Department of Social Welfare and the hospital's management team were present. The needs of the area and how TAC might be of best assistance were discussed.

It was resolved that TAC will begin organising treatment literacy training for members of Canzibe's ARV adherence support groups as well as training for Siyakhula's home-based care givers and the nurses and counsellors working at Canzibe's ARV unit. TAC will also work with Transcape and Siyakhula to educate local communities on the importance of HIV and TB testing. Unfortunately stigma and discrimination are a substantial barrier to the uptake of HIV services in many communities around Canzibe so TAC will also mobilize to increase awareness. Our campaign in Canzibe began in April 2008.



NEW DEVELOPMENTS IN THE FIGHT AGAINST HPV

Equal Treatment May 2007 (Issue 22) focused on human papilloma virus (HPV). A vaccine for certain strains of HPV is now available in South Africa. HPV causes cervical cancer which is a common cancer for women in South Africa, especially women with HIV.

The vaccine, called *Cervarix*, stops the harm done by strains 16 and 18 of HPV, the most common cancer causing strains of HPV in Europe and USA. The vaccine currently costs R2,100 per person. This is the most expensive vaccine in the world. Another vaccine called *Gardasil* will become available in South Africa shortly. Gardasil prevents infection from more strains of HPV than Cervarix. Gardasil prevents strains 6 and 11 of HPV, which cause genital warts as well as stopping strains 16 and 18. Gardasil is also expected to be expensive.

Price is not the only factor that will determine its use in South Africa. For now, it is not yet clear how effective the vaccines will be in South Africa because strains 16 and 18 might not be the main strains of HPV among South African women. The largest study on this so far was published in February 2008. It indicated that in a population of women in the Western Cape HPV strains 16 and 18 were common. This means the vaccines are expected to reduce the risk of cancer for a significant number of women. However future studies will also need to consider the importance of strain 35 which was found to be equally as common as strain 16.

Importantly, it is not yet clear how effective the vaccines will be in HIV-positive women.

The vaccines work best if administered before someone is sexually active and therefore they are recommended for young women under the age of 15. Women up to age 26 may be vaccinated. Prevention of HPV infection and cervical cancer can be achieved through the vaccine, but it is also important for women of all ages, and especially older women, to have regular cancer screening with a pap smear. Cervical cancer is treatable if found in its early stages.

TAC will have to campaign for the price of the vaccines to be brought down substantially and for them to be made available in public health facilities. TAC also encourages all women to have a pap smear test once a year. Pap smears can detect early signs of cervical cancer.

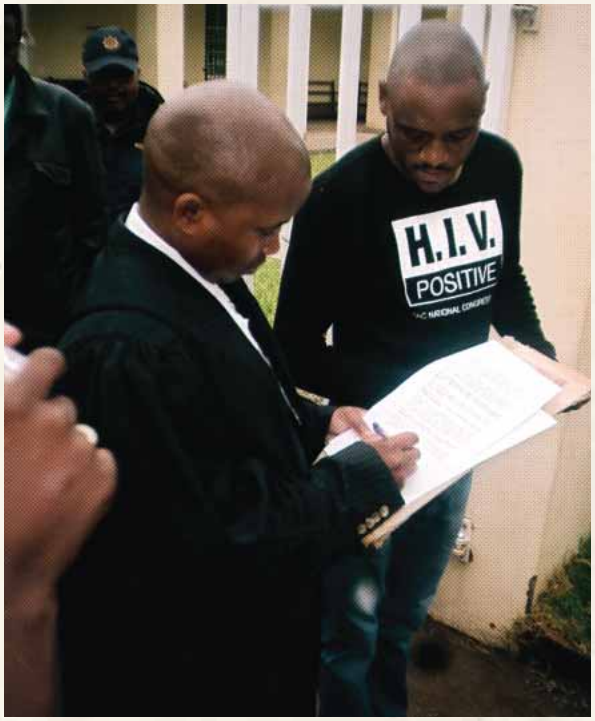
Sources: Dr. Lynn Denny Groote Schuur Hospital, Cape Town

Allan et al.. Cervical human papillomavirus (HPV) infection in South African women: implications for HPV screening and vaccine strategies Journal of Clinical Mircobiology 2008 February;46(2):740-2

Update from *Equal Treatment* Issue 24

In our last issue we discussed medication abortion for women who are 12 to 20 weeks pregnant. While this is available in the private sector, most public health facilities still use surgical abortion, a safe but usually less convenient procedure than medication. Medication abortion is being piloted in some public health facilities.

TAC News



Chris Hani District plans to demand justice for rape survivors

The TAC Chris Hani District in the Eastern Cape held a demonstration to demand justice for rape survivors on 12 May 2008 outside the Regional Court in Lady Frere. This followed the alleged rape of a nine year old girl by a 20 year old man. TAC has been campaigning around this case since it was identified by a TAC member last year. This case has been postponed more than nine times.

Justice for Nandipha Makeke

After more than two years since TAC member Nandipha Makeke was raped and murdered in Khayeitsha her killers were sentenced. On 7 April in the Khayelitsha Magistrates Court both of the accused were sentenced to 20 years imprisonment. The case was postponed over 20 times. TAC members were at the court every time to see that justice was done.

The case against two of the accused was dismissed for lack of evidence. One of them, Yanga Janet, is a gangster who threatened to kill some TAC members. Therefore TAC got a protection order against him on 8 April.

We answer your letters

Can I be infected through oral sex?

I am very worried that I am HIV-positive. I recently performed oral sex on a man and swallowed his semen. I am HIV-negative. I did not use a condom and I do not know his status.

Lwandile Dlabantu (Name has been changed)

The risk of HIV transmission from oral sex is lower than with vaginal or anal sex, but it still exists. The risk is higher if you are the person performing oral sex and you have cuts or sores in your mouth or a sexually transmitted infection. The risk is also increased if you swallow semen. Although evidence suggests that oral sex is an uncommon way to transmit HIV, we recommend that you get an HIV test about two months after an oral sex act in which you swallowed semen.

Preventing HIV in my baby

I recently visited a clinic after finding out I was five months pregnant. I am HIV-positive. Is my HIV dangerous to my baby? If so, what should I do?

Nomawethu Ganca (Name has been changed)

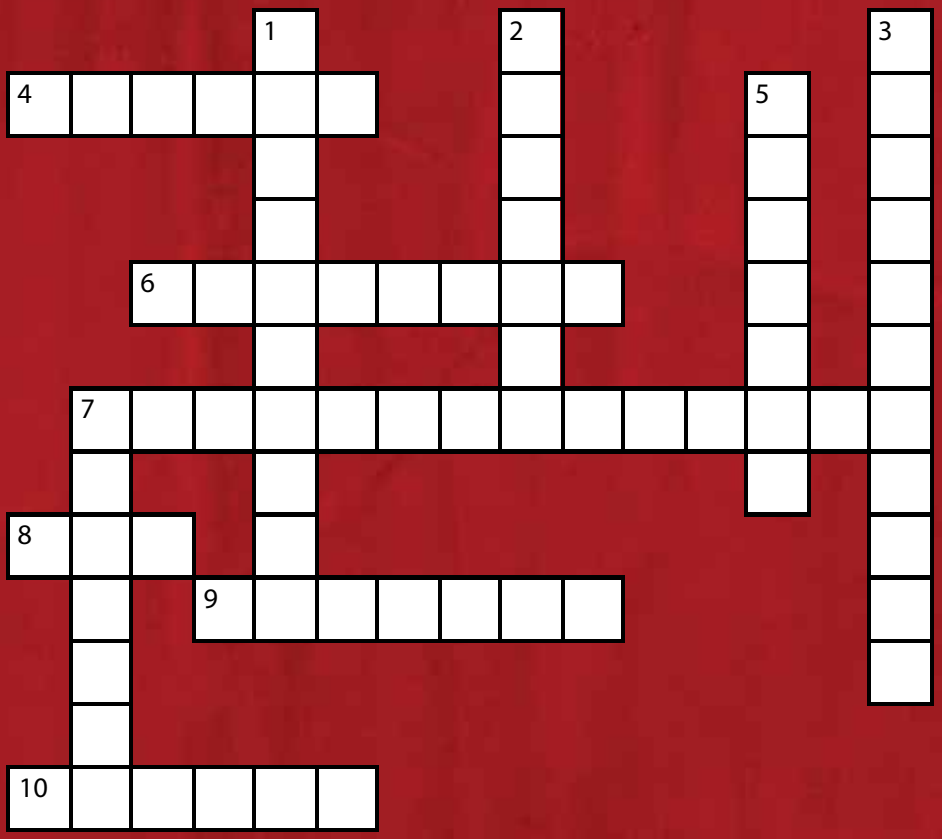
HIV can be transmitted from mother-to-child during pregnancy, delivery and through breastfeeding. However, since you know your status, you can look after your child's health by taking the antiretroviral medicines, AZT and nevirapine, which should be offered by your health facility. Taking these medicines will make it unlikely (but not impossible) for your baby to be infected with HIV. AZT should be taken from 28 weeks of your pregnancy and one dose of nevirapine should be taken when you go into labour. Your child should also be given a single dose of nevirapine shortly after birth and AZT for seven days.

Breastfeeding your baby also increases the chance of HIV transmission. You have two options: (1) Either give your child formula milk and do not breastfeed at all or (2) feed your child only breastmilk for six months.

Send your letter to:

Equal Treatment,
PO Box 2069, Cape Town, 8001
Fax: 021 422 1720
Email: et@tac.org.za

Equal Treatment's Crossword Puzzle



We will give a R200 Pick n' Pay gift voucher to the first crossword drawn from a hat with all the correct answers. The answers can be found in this issue of *Equal Treatment*.

Fax or post your completed crossword, with your name, address and contact number.

Address: Equal Treatment, PO Box 2069, Cape Town 8001

Fax: 021 422 1720

1. The leader of the opposition MDC in Zimbabwe is Morgan _____ .
2. What is the largest Migrant Detention Centre in the country?
3. Migrant Detention Centres are over-crowded. To reduce the risk of TB these centres need adequate _____ ?
4. What private company is contracted to run Lindela?
5. What is another name for the tuberculosis skin test that is most often used to test children for TB?
6. It is difficult for Zimbabweans to get news that isn't heavily _____ by the government.
7. The new general secretary of TAC is?
7. A _____ for certain strains of HPV is finally available in South Africa.
8. This test for HIV for children less than 18 months is called _____ .
9. The Constitution of South Africa was founded on the principle of human _____ .
10. All foreign nationals have the right to access these services in South Africa.

Decriminalise Sex Work

Sex workers cannot fight HIV without human rights and worker rights.

Calling all sex workers: join Sisonke and fight for your rights!

Sisonke
TOGETHERNESS
SEX WORKER MOVEMENT OF SOUTH AFRICA

SWEAT

TAC
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