The MRC KwaZulu-Natal AIDS Forum

KZN e News

Volume 1, Number 1 **HIV vaccines and community issues** **July 2002**

Ed's Say:

Welcome to the first edition of KZN E-News, a bi-monthly electronic newsletter that forms an integral part of the MRC KZN AIDS Forum, a community platform which aims to bridge the gap between science and community through informed discussion. Each issue will contain among others, articles on current and topical issues, reviews of past/ future forums, community players and scientific updates which are not too scientific. This is *your* newsletter & as such, we welcome Forum Topic suggestions, questions and article submissions (See Community role players making Waves) . Send contributions to: Marlijn v Berne, AIDS Forum Co-ordinator, MRC AIDS Forum, PO Box 70380, Overport 4067, DURBAN.

e-mail: marlijn.vanberne@mrc.ac.za
Fax: +27 (0)31-2034707

A South African AIDS vaccine initiative: An update

By Dr Andrew Robinson, MRC Site Director HIV Vaccine Research

Reviewing the South African preventative AIDS vaccine development timelines.

Much has been said or 'quoted' in the media over the last few years as to *when* the first South African AIDS vaccine trial will start and *when* will the vaccine be registered for general use. Let me update you.

The vaccine development team are acutely aware of the extreme urgency of their task to deliver a safe, affordable, effective and locally relevant preventative vaccine to the southern African region. All possible networks, agreements, planning, budgeting and lobbying are geared to deliver a vaccine in the shortest possible time. All clinical trials are by law subject to review and approval by statutory regulatory bodies such as the Medicines Control Council (MCC) in South Africa and the Food and Drug Administration (FDA) of the United States of America.

In addition Ethics Committees or their US counterparts, Independent Review Boards (IRBS), are also required to review and approve clinical trials. This review process must be thorough and therefore does take time for very good reason.

(cont. p.2)

Inside this issue

A South African AIDS vaccine cont. from p.1

The VEE vaccine trial still awaits final approval from the MCC and the FDA.

Vaccines, unlike medicines that are made from inert substances or chemicals, are made from *living* organisms, i.e. they are grown. That is why each vaccine, such as the measles, polio, flu and clinical trial vaccines are made in batches to enable quality control of the highest possible standards. One of the VEE clinical trial vaccine batches did not meet the stringent quality control checks. This has delayed the trial starting as all batches were withdrawn so that new batches of VEE vaccine can be grown which will meet the required standards. With 'cutting edge' science, using novel and complicated processes, it is not surprising that difficulties are encountered during the manufacturing process. It is fortunate that the quality control issue was detected *before* the trial started. So with the above in mind we will only start the vaccine clinical trial once all the pre- trial requirements are met. Similarly, the preventative vaccine licensing for general use will only happen once all three trial phases are complete and the vaccine has shown itself to be safe and effective on review by the MCC and FDA. If one likens the process to that of a tree growing; the best time to plant a tree is 20 years ago, so one would have immediate benefits of the shade, fruit, beauty or timber. Likewise with the HIV preventative vaccine, we would like to have begun 20 years ago, but failing that, the best time is to start now. So, for timelines on the highly complex and exciting path of HIV vaccine discovery, I will hazard a guess: HIV vaccine trials will get under way in South Africa within months, while registration and licensing will take years, possibly ten or so. In the history of vaccine development such as that for smallpox, polio, measles and the like, this timescale is quick, very quick. As this is a highly dynamic process with issues and obstacles coming and going on a daily basis, the best way to find out about the *when* of HIV vaccines, will be to open and maintain effective channels of communication such as the MRC KZN AIDS Forum, so researchers can act in a transparent fashion, informing South Africans of all aspects of HIV preventative vaccine development so that reasonable expectations can be set.

All possible networks, agreements, planning, budgeting and lobbying are geared to deliver a vaccine in the shortest possible time.

Community mobilisation - Durban vaccine trial

By

Laurentia Ogle

SA HIVAC vaccine educator

Since the beginning of 2002, HIV vaccine issues have been introduced by the vaccine educators to various sectors of society in the KZN province. Provincial structures were targeted, where introductory presentations were done, and this process facilitated general community education

Cont. p.9

Points of interest

- Vaccines are made from living organisms.
- Stringent quality control checks have delayed the VEE vaccine trial
- All clinical trials are by law subject to review and approval by statutory regulatory bodies such as the Medicines Control Council (MCC) in South Africa .

Barriers to HIV vaccine trials in South Africa: Perspectives of an American student

Stacey L. Hannah, MHS

Last November, as a student at the School of Public Health at Johns Hopkins University in Baltimore, Maryland, I crossed the Atlantic Ocean to spend five months working on site preparation for the first HIV vaccine trial in South Africa. The lessons I learned through this experience cannot be taught on American soil, and I now possess new and invaluable perspectives on international HIV research, particularly in the vaccine arena. Upon my return to Baltimore in April, I attempted to capture these lessons in a 50+-page report on my experience. Much of the report discussed my perceptions of the major barriers to HIV vaccine trials in South Africa. The content below is my valiant attempt to convey the essence of my report. If ever the world has experienced such a dreadful epidemic as HIV/Aids, comparisons as HIV/AIDS, comparisons may be made to the times of smallpox and influenza. For years, researchers have been seeking the same solution for HIV that was found to curb these epidemics - a vaccine. As education, awareness, and prevention practices reach new heights in South Africa, leading HIV researchers in the country look to a new approach. None too soon, the effort to find a global HIV vaccine has now hit South Africa.

The first HIV vaccine trial in South Africa will be undertaken in trial sites in Johannesburg and Durban, according to HIV Vaccine Trials Network (HVTN) Protocol 040. As plans for HIV vaccine research begin between the US and South Africa, we must realistically embrace the challenges this effort will entail. Especially in South Africa, where a uniquely personal hope for a vaccine exists, considerable risk exists in thinking that an orderly and timely answer can be found through implementation of a series of trials starting with HVTN 040.

The long road to finding an HIV vaccine must begin with the first, small-scaled Phase I trial: Prior to this event, however, efforts must begin at an individual level to educate and prepare community members.

A large number of barriers stand in the way even of the first volunteer signing his or her name on the consent form and enrolling in HVTN 040.

The following list offers a glimpse of the challenges facing the commencement of the first HIV vaccine trial in South Africa.

Cont. p.13

Upcoming Forums:

DURBAN

August 27. "A general overview of MTCT, focusing on infant feeding issues." By Dr Nigel Rollins, Dept. of Paediatrics, University of Natal

September 24. Holiday

October 29. "A personal & scientifically-based perspective on indigenous herbal medicines in the treatment of HIV/AIDS— a clinic experience." By Ann Hutchins, Ethno Botanist, University of Zululand

November 26. "HIV Vaccines - An Update." By Dr A. Robinson , Director MRC Vaccine Research Unit.

December. Holiday

MTUNZINI

August 28. "A general overview of MTCT, focusing on infant feeding issues." By Dr Nigel Rollins, Dept of Paediatrics, University of Natal

October 30. "HIV Vaccines - An Update." By Dr A. Robinson, Director MRC Vaccine Research Unit.

PIETERMARITZBURG

September 25. "HIV Vaccines - An Update." By Dr A. Robinson, Director MRC Vaccine Research Unit.

November 27. A talk by Cathy Slack, HIV Vaccine Ethics Group (HAVEG).

Infant feeding and child health

A report produced by the Health Systems Trust (HST) for the National Department of Health. It is part of HSTs commissioned role to help develop and co-ordinate a research and evaluation programme for the national Prevention on Mother To Child Transmission (PMTCT) learning sites .

By D.McCoy

With all the publicity surrounding government's position on Nevirapine, the more important and serious issue of its policy on infant feeding and providing free formula has been neglected.

The current policy needs to be reconsidered, as there is a danger that it may do more harm than good in many communities. When one looks at overall child health as an outcome, instead of just HIV transmission, the benefits and advantages of promoting free formula become questionable. The downside of promoting formula feeding, and government subsidizing it are explained and discussed in section 6.2 of this report.

Although the long-term aim should be to enable all HIV positive women to provide safe and affordable *exclusive* formula feeding, under the current circumstances, the policy may lead to higher rates of mortality and morbidity due to other diseases, as well as higher rates of mixed feeding.

A national commission of experts should be urgently set up to review the current policy and guidelines on infant feeding and mother-to-child transmission. One option that must receive serious and urgent attention is the post-natal administration of short-course antiretroviral treatment to mothers and/or babies as a strategy for making breastfeeding safe.

Finally, the imperative to save babies from HIV should provoke a broader and urgent response from government and civil society to address child poverty, the unacceptable levels of child care and child mortality from easy to prevent causes.

HIV Vaccine Training Workshop (Koinonia Conference Centre, Hillcrest). Delegates included members of NAPWA (National Association of People Living with AIDS).

Past Forums :

CINDI (Children in Distress) – Networking for Children Affected by AIDS

By: Yvonne Spain, Co-ordinator of the CINDI network and supported by the Department of Welfare & Population KZN.

Introduction: Yvonne Spain commenced her address by reading extracts from the CINDI Booklet "How AIDS Affects Me" - a compilation of essays and extracts from the High School's Essay Competition held in conjunction with *The Natal Witness* on 16 June 2001.

Yvonne read about the prejudice experienced by youth living with AIDS, fears of being raped and the indifference of teachers and health workers' (The booklet containing this information is available on request from Yvonne - Cell: 083 46 77124). A series of slides were used to illustrate the activities of the CINDI Network and are summarised below:

Background: CINDI was founded in July 1996 and currently consists of over fifty government and non-government agencies who collaborate around the issue of children affected or orphaned by AIDS in and around Pietermaritzburg (where it is estimated by practitioners in the field that the numbers of orphans in the municipal area range from between 8000 - 15 000. See attached comment by Rob Garner CINDI Chairperson). CINDI Partners look to each other for support, share information, mobilise resources, lobby on behalf of children affected by HIV/AIDS and unite for action.

Working Groups: **Child Intervention Panel:** (CHIP - leaflet available from Yvonne Spain), a monitoring and advocacy peer group panel that secures administrative justice for children caught up in bureaucracy. CHIP has assisted over 100 individual children, developed an Abandoned Children's Protocol for use at Edendale Hospital (see CINDI website), and is lobbying the KZN Dept. of Health for improvements to the service offered by the District Surgeons/Crisis Centres to child rape victims.

CINDI Research Reference Group: guides research conducted on behalf of the Network, e.g. "Wo! Zaphela Izingane/It Is Destroying The Children" by Prof. Tessa Marcus, and "CINDI : A Critical Analysis and Guideline for Networking.". These documents are available on our website

Home-based Care Consortium: that developed an isiZulu Home Based Care Tutor Training Curriculum aimed at Adult Basic Literacy Level Three - funded by the Nelson Mandela Children's Fund. The teaching material for this course was developed in conjunction with the Centre for *Adult Education, University of Natal*, Pietermaritzburg and has been included in the Adult Literacy Section of the local newspaper, *the Natal Witness*. (circ. 50 000). The Consortium has recently secured training contracts for the local Departments of Health and Welfare and, funding permitting, aims to offer the Course to disadvantaged communities at no charge.

The Medicines Access Working Group (Thapelo Project): accesses non-script palliative medicines (e.g. worm remedies, vitamin syrups, Bactroban ointment, etc.) on behalf of home-based carers, foster parents and institutions who are caring for dying children. (This project is named after an abandoned little girl who died of full-blown AIDS at one of the facilities run by a CINDI Partner. The staff named the child Thapelo, which means prayer in Sotho.) The Thapelo Project has just been given a converted shipping container by Coca Cola that will be placed at Msunduzi Hospice's office in Edendale from where we will begin our Pilot Dispensing Project on 22 April 2002. We are able to purchase an initial stock of materials thanks to the generosity of a Dutch surgeon who worked at Edendale Hospital in the 1970s and who, on his retirement, asked patients and colleagues to make monetary contributions to CINDI in lieu of (unwanted) gifts - this

Past Forums Cont, :

amounted to R28 000. Thapelo receives advice from the Chief Provincial Pharmacist who will hopefully facilitate our access to State Tender prices for the purchase of our supplies.

The Healing Plants Project:
Together with the National Botanic Society, CINDI and LifeLine/Rape Crisis are propagating and promoting the use of the common indigenous plants bulbine and carpobrotus (sour fig) in the treatment of skin diseases and thrush associated with HIV/AIDS .

These plants are available from LifeLine at no charge and complement the work of the Home-based Care Consortium and the Thapelo Project.

The Housing Access Working Group:
(Built Environment Support Group/BESG is the Lead Partner) is lobbying the Municipality and Provincial Housing Department to ensure that their policies make allowance for the reality of child-headed households, orphans and vulnerable children.

Children to Children Outreach:
A pilot programme involving approximately five local primary schools which will collect items for sick children (such as Super C's, lipIce, face cloths, toilet soaps, Dettol, etc.) which are then distributed to CINDI organisations who are caring for dying children via the Thapelo Project.

Local Government Working Group:
CINDI works closely with local government (especially our Deputy Mayor, Clr Zanele Hlatshwayo) to ensure that the needs of children in distress are included in the Integrated Development Plans of the Msunduzi and Umgungundlovu Municipal Councils.

We are currently developing the Msunduzi Care Referral Network with the MOH and LifeLine. LifeLine is creating a database for HIV+ patients discharged from the three state hospitals in Pietermaritzburg, so that they can access help (e.g. home-based caregivers, Dept. of Welfare, nutrition advice etc.).

The newly formed Nutrition Working Group:
Recognises that it is difficult for HIV+ people and other vulnerable groups to live healthy lives in the absence of adequate nutrition. Consequently, the Working Group will seek to enhance people's access to organisations in Pietermaritzburg which are providing emergency food aid, sharing information about nutrition and the preparation of food and offering training in order to encourage communities to become involved with food production.

The CINDI Funding Panel: The CINDI Network has recently been approached by several large donor agencies who have enquired about the possibility of giving money to CINDI Members through the Network.

In addition, they have asked CINDI to take on the role of selecting and monitoring the final funding applications.

Consequently in March 2002 CINDI drew up a Corporate Funding Protocol and agreed to become a conduit for funding proposals in excess of R500 000. In order to manage this process and in the interests of equity and transparency CINDI will create a Funding Panel consisting of neutral members of the Network and independent members of the community, who will be elected by the CINDI Members.

Conclusion

Yvonne concluded her address by emphasizing the benefits of networking and highlighted the following challenges: Poverty , community, Lack of action and problems in the education sector.

PLEASE NOTE:

This is a report back on a talk given by Yvonne Spain. Statements and references in this report are based on her personal expertise and research.

ARV adherence : Be prepared & informed

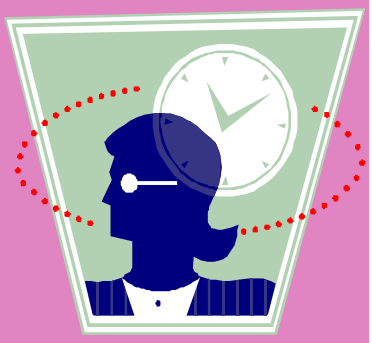
Most South Africans don't have the means to access antiretroviral (ARV) therapy, BUT, that situation is changing daily. If you chose to take this route in the future be 'prepared' and make an 'informed' choice.

Adherence or compliance with your ARV treatments basically means:

Taking your HIV treatments at the right times, at the right dose and with the appropriate nutrition.

Anti-HIV regimes need to be adhered to almost all of the time; because skipping doses will undermine the drugs' attempts to control the HIV virus in your blood from replicating. Thus, reduced levels of the drugs could allow the virus to make more copies of itself.

If the virus is successful in replicating there is also an increased chance that it will become resistant to the drugs you are taking. Additionally, try not to miss doses or 'take a break' as this could lead to your viral load rising .



Living where we do, it is very important to keep your medications away from extreme heat or damp and make sure they are stored properly, out of the reach of children.

Try taking your medication during a particular routine you feel most comfortable with, like brushing your teeth, having a bath, listening to a favourite radio programme , or preparing a meal .

Try keeping a spare supply at work , in the car, in your bag and/or at a friends house in case you forget to take them with you outside of your home.

Be prepared and renew prescriptions in advance - this way you can ensure a continuous supply. Set an alarm clock or programme your cell phone or watch to sound an alarm when it's time to take your next dose.

If you notice that you are experiencing side effects from the treatment you are taking, write down what you are feeling and take this with you to your local clinic or doctor. Discuss further treatment options with your doctor or healthcare worker if another combination might be easier to manage. Nausea, which appears to be one of the most common side effects, can be addressed with the help of either anti-nausea tablets from your doctor or traditional remedies such as herbal teas (chamomile, ginger and peppermint). Go with what works best for you.

For further information on Treatment Literacy contact the TACs Desmond Mpofu on 031-3043673 or 083 492 0845.

From Durban to Barcelona An excerpt from the Opening

Speech of the Barcelona Conference's Community Programme by Pumi Yeni

The Durban 2000 Conference BROKE THE SILENCE. A lot of private and public sector organizations in Durban pride themselves on having either HIV/AIDS Desks or programmes and policies. Sadly, all this has not done much to decrease the infection rate in this city. There is still a high prevalence rate among females and children. The stake still remains urgent and personal for those directly infected and affected by the pandemic. But what about the community level?

Community is the centre that holds a society together. It is the fabric, the beat and essence of a thriving society. For as long as we can recall, the relationship between Community and Science has always been that scientific breakthroughs advance community development. We have now come to a point where we acknowledge the wealth and richness of the knowledge, that is embedded in the heart of every society- the community. It therefore stems from this understanding that the gap that exists between Community and Science needs to be bridged as a matter of priority. But the challenge for us is to define for ourselves how the gap presents itself in our minds so that we are able to think it through carefully and thus address it meaningfully.

Gradually, the International AIDS Conferences have become very community aware and each year they master new approaches in getting the community involved by creating a platform for community across the world to share their experiences and learn new ways of responding to the HIV/AIDS pandemic. This was well captured in the Durban 2000 Conference, where the idea of a Community Project, AIDS 2000 Development Project (ADP), was conceived.

In its conception, the purpose of the ADP was to develop a community liaison project to ensure that the Durban 2000 was a conference for and about the community activists, advocates, people living with HIV/AIDS (PLWHA) and care givers, whose stakes in the pandemic are personal and urgent. The project commenced well in advance of the conference and continued throughout the duration of the conference. It was hoped that the momentum built by the conference, would have been strong enough to see the project sustained 12 months after the conference ended (3rd phase).

As a conference project, the ADP was aimed at bringing the Conference to the broader community and encouraging awareness as well as active participation in terms of focal issues in the conference and within the context of HIV/AIDS in the community. As the XIII International AIDS conference drew to a close, arrangements for the implementation of the 3rd phase were made with the Aids Foundation of South Africa (AFSA). This institution planned, managed and implemented this phase.

Lessons learnt, through different community interventions and experiences of community educators/advocates/activists and mobilisers, models of best practices and formulae, should be recorded or documented in order to inform future interventions and strategies towards building frameworks of channeling and informing future scientific breakthroughs. In order for this to happen community should be well placed to take on the amount of responsibility and accountability that will come with such a task. This would be as a result of community efforts being pulled together as a collective, to maximise and optimise the limited resources that community has at their disposal, in addressing the scourge of HIV/AIDS. The only way that community would be able to pull together is when we come to a realisation that every single organisation has an important role to contribute towards the greater good which we are all striving for.

From the science perspective, it is acknowledged with great appreciation that scientists as a result of their work in the laboratories, come up with new ideas that sometimes result in scientific breakthroughs. As much as science has acknowledged the importance of community in trying out their new ideas and implementing their breakthroughs, it should be noted

Cont. Durban to Barcelona from p.8.

that the time has come for science to move beyond rhetoric to meaningful action which will translate into community sharing in the conceptualising of those new ideas. Until such an understanding is arrived at, our efforts to bridge the gap will be constrained and meaningless.

One meaningful step towards bridging the gap, is making it possible for community to participate meaningfully at meetings such as the International AIDS conferences.

This will not happen just by allocating them the platform for doing that, but by also making it financially accessible/ affordable. We all know that scholarships are awarded to a number of community members to attend these conferences but have we ever taken the time to think about how many who would representing community never make it because of the monetary value attached to these conferences?

Maybe the right question to ask would be; are these conferences put together to generate profit or to make an impact so great, enabling us to be better equipped to address the HIV/AIDS pandemic?

If this is the beginning of a journey where community and science will walk together side by side, the one depending on the other, we would like to arrive at a place where our partnership will be equally meaningful and to the greater benefit of the human race.

Community mobilisation cont. from p.2.

and workshops on HIV vaccines to regional, local structures and eventually to the community at large. Amongst others, trade unions, non-governmental organisations (NGOs), faith-based organisations (FBOs), AIDS service organisations (ASOs), community based organisations (CBOs), and the private sector, etc. embraced this information positively as research information is enhancing their curriculum.

The aim is to build knowledge about research, build advocacy for community participation, public education and empowered community engagement.

A CAB (community advisory board) structure, consisting of community representatives has been in existence for several years in Hlabisa and one is in a process of being set up for the Durban Metro Region. The role of this structure, amongst others, would be; represent the communities' interests and their rights, give advice to the trial units on community concerns, etc. This structure will serve as the mouthpiece of the larger society and there are a series of workshops being run so as to give them a deeper understanding of the issue.

Vaccine information sessions have also been set up on a monthly basis at the Medical Research Council (MRC) offices in Ridge Road for those who wish to know more about HIV vaccines or would like to participate in trials.

Highly competent vaccine educators with a strong history of community experience employed by the Medical Research Council's (MRC) South African AIDS vaccine initiative (SAAVI) for the South African HIV Vaccine Action Campaign (SAHIVAC) project, are responsible for community mobilisation, education and encouraging community participation in research trials. The research staff of the Durban MRC HIV vaccine Research Unit supports these educators.

What next? For more information, contact the author, Laurentia Ogle, on:

Tel 031 – 203 4700 or, e-mail: logle@mrc.ac.za

Community Role Players Making Waves

The recent victory by the ***TREATMENT ACTION CAMPAIGN*** at the Constitutional Court on the MTCT case against government represents a significant victory for all poor people in South Africa.. Writes Sizwe Shezi.

When the Constitutional Court finally made a ruling in favour of the Treatment Action Campaign and others on Friday, 5 July 2002 on the Mother-to-Child HIV Transmission Prevention (MTCTP) Case against the National Minster of Health and seven other provincial Health MECs it brought to an end a drama which started last year at the Pretoria High Court when Judge Chris Botha ruled that the government is obliged to provide Nevirapine in all hospitals and clinics where a doctor and a superintendent has concluded that there is capacity and infrastructure to administer MTCTP services to HIV-positive pregnant women. Part of the requirements to accertain MTCT readiness was the availability of counselling and testing services in a particular hospital or clinic wanting to start providing Nevirapine.

The Constitutional Court judgement will bring joy to thousands of women throughout the country who can now have access to Nevirapine should they be pregnant and test HIV positive after counseling. TAC and all its partners including its co-applicants like the Children's Rights Centre and Save our Babies Campaign is overwhelmed with joy for all HIV-positive women. One woman who gave birth to an HIV-positive child and one who did not get the chance to use Nevirapine for MTCT Prevention purposes said that the court has given women hope.

For many people, especially women with HIV, TAC's victory on the MTCTP case represents an important step in treating HIV-positive people with respect, dignity and fairness. However, for many people living with HIV/AIDS the ultimate measure of fairness and government commitment in fighting the HIV/AIDS pandemic rests in childrens' lives being saved through a clear and sound MTCTP national programme and the ultimate availability of essential HIV/AIDS treatments including Highly Active Anti-retroviral Treatment (HAART) for all people living with HIV/AIDS.

Since 1998, TAC together with its partners and supporters, has worked hard trying to convince our government about the importance of starting a national MTCTP programme. This was after the results of a study in Thailand that examined the efficacy of AZT administered to HIV-positive pregnant women in reducing MTCT. The Thailand study was the first study of this kind to be conducted in a developing country like ours. The second study done in Uganda using Nevirapine showed that a short course of Nevirapine is as equally effective as AZT in reducing the chances of MTCT and most importantly its cheaper and easier to manage. The South African Interpartum Nevirapine Trial (SAINT Study) confirmed these findings and presented an ideal opportunity for the government to swiftly move and start a national MTCTP programme.

While the debate on whether to provide Nevirapine went on, government lost significant opportunities to save the lives of children and to mitigate the impact of HIV on the lives of women.

The court case was based on the fact that by not implementing a national MTCTP programme government was failing to recognise women's rights to dignity, reproductive

Community Role Players Making Waves

choices, health care and children's right to life. The court papers included testimonies on the impact of HIV on children's health from women and men living with HIV. One of the touching testimonies is the one about a young Sibongile Mazeka who was five years old when she died of AIDS-related illness in September 2001. Sibongile's aunt submitted an affidavit in support of TAC and its court case. Her affidavit states that during her lifetime, Sibongile was hospitalised more than 14 times. These hospitalizations included intensive care and altogether costs the state about R50 000. It cost her family years of trauma and impoverishment. Her aunt, who looked after her when her mother died, had to take days off from work to take her to hospital and eventually lost her job because of absenteeism. Now the family is without an income and will depend on support grants from the state. Although people's lives cannot be measured in monetary terms, a national MTCTP programme would cost about R600 per child including all aspects of the programme.

The success of TAC in the Constitutional Court therefore, was the ultimate measure of our success in advocating for children's and women's rights.

In conclusion, TAC's success symbolises an important victory, not only for people living with HIV/AIDS or HIV-positive pregnant women, but for all poor people in our country because it empowers the poor to challenge the state on matters of service delivery on its constitutional obligations like basic health care, education and the provision of shelter. This can only be good for our young democracy because the Constitutional Court decision also confirmed the independence of our judiciary from the Executive.

TAC's victory also proves once and for all, that socio-economic rights of the poor are human rights and the state must use its limited resources in the interest of the poor and marginalised. The poor have spoken. The debate on MTCTP must stop and now is the time for the real implementation.

Mr Sizwe Shezi is the Provincial Co-ordinator for the Treatment Action Campaign in KwaZulu Natal and a former student activist. He writes in his personal capacity.

Tel: (031) 304 3673/304 9007. Fax: (031) 304 9743

E-mail:

dlabas2000@yahoo.com

Lesbians Are Women and Yes they are at risk of being infected with HIV

By Nonhlanhla Mkize

Durban Lesbian & Gay Community & Health Centre

I've often wondered about the despair, the desperation and the enormous courage I would need to have to summon the words that would pronounce my death sentence. "I'm lesbian", a friend said to me not so long ago. I could not argue with her, nor could I be able to convince her that no one would find out about her being lesbian now that she is dating me.

Community role players making waves

Working with the Durban Lesbian & Gay Community & Health Centre has made it less difficult for me to live openly as a gay person. Like the Community Centre though, I don't encourage 'coming out' simply because the environment to come out to is still a sea of hungry lions. Progressive as the South African community might seem, it still does not fully accept nor is it appreciative of human diversity irrespective of race, sex, **gender**, **sexual orientation**, religion, marital status and even **health status**.

'Lesbians' is a term used to describe women who are attracted to other women. Who we are attracted to, want to date or want to fall in love with – the person of the same sex - is what we are unfairly discriminated for. The majority of the South African community still denies the fact that lesbians are females - women. They do not want to believe that like all women lesbians are sensitive and vulnerable to all forms of violence, sexism, abuse and rape.

Lesbians are *survivors of domestic violence*. They are *survivors of stereotype-based violence and discrimination*. Society gives itself 'cultural norms' and gives us a gender identity (woman) and a role. Should this role not be fulfilled, society again gives itself the right to unfairly discriminate against us and rob us of our power. Gender roles therefore, still make it hard for women to protect themselves. As *survivors of myth related discrimination*, many lesbians are still unwilling to share their experience of being raped by men who argue that the act would make us straight.

A large number of young lesbian women still find it difficult to understand how they got raped by men who thought of them as still being virgins. What these women do not understand is that it is still a myth in our society that a pure person like a virgin can cure one from the HI virus. Which, in this case, implies that sleeping with a lesbian - a virgin - is a cure.

Fact is women do lose their virginity from sleeping with other women. Fact is since the mid 1980s cases have been reported indicating that lesbians are also at risk of contracting HIV from each other. Fact is, it may now be widely accepted that AIDS is no longer an automatic death sentence but for many of us and our friends this still remains very true. When I think of lesbians from Zimbabwe, Namibia and Egypt, my heart sinks. Presidents in these countries spearhead movements against lesbian, gay, bisexual and transgender people. In these countries there is a continued rise in homophobia, sexism and xenophobia. The rights of HIV-positive lesbian and gay people are not respected or protected in these countries as yet. It was even more shocking when last year I read a comment made by a woman from Pretoria (South Africa) who argued 'Stop the Spread of AIDS by banning Homosexuals' (*The Daily News*, July *5, 2001, p. 5*).

She obviously did not take a moment to think

Making Waves Cont. from P12

how detrimental her words were to the innocent lives of other women – lesbians – outside her family. The Community Centre has experienced a rise in calls for counselling from lesbians (and gay men) surviving assault and rape as a result of expressions like these.

I wonder what would happen were this woman to discover that her own niece is lesbian. Would she then kill her; get a priest to pray for her so that she can be cured; would she give her to the boys or men in the neighbourhood to rape and make her straight, or would she give her to an HIV-positive uncle or husband to sleep with so that his HIV can be cured?

301 Protea House,

Mark Lane, Durban, 4001,.

Tel: 031 - 301-2145

Fax: 031- 301-2147

e-mail:

gaycentre@freemail.absa.co.za

Website: www.gaycentre.org.za

Barriers to HIV vaccines cont. from p.3.

*Consistent education efforts should be in place well in advance of the commencement of a trial, due to the integral part played by community members and the need to clarify many complex aspects of HIV vaccine trials.

*Ethical issues must be addressed to the highest standards; in-country review processes should be enhanced, and trial staff must be well trained in good clinical practice skills.

*A large number of domestic and international co-ordinating bodies oversee the trial; solid partnerships must be made so as not to cause confusion or distrust among the general public, as well as among study staff.

*Persisting stigma surrounding HIV requires high regard for participant confidentiality and support; procedural aspects of participation, recruitment, and even community education must be well thought out by trial staff and partnering organisations or institutions.

*The rapidly changing social situation in South Africa creates barriers between different age, gender, and cultural populations of its society. These barriers affect community outreach, counselling of potential participants, and even working relationships among staff members.

Correspondence regarding this article should be directed to:

Stacey Hannah, shannah@jhsph.edu