EQUAL TREATMENT

NEWSLETTER OF THE TREATMENT ACTION CAMPAIGN JUNE 2006

Women and HIV

School students in Alice, Eastern Cape, show their issues of Equal Treatment. Photo: Thulani Nqambi.

Judge Edwin Cameron completed the 108km 2006 Argus Cycle Race. Cameron was sick with AIDS in 1997. In 2006 he is in superb health and alive because of antiretroviral treatment.

Photo: Donated by ActionPhoto.

Equal Treatment's newly trained community journalists pose at a workshop in Athlone, Cape Town. The workshop taught writing skills, photography, film and much more.

Photo: Nathan Geffen.

TAC members gathered in Cape Town to discuss gender and HIV. Here, TAC's general secretary, Sipho Mthathi, addresses the meeting.

Photo courtesy of Jean-Marc Moorghen, Conrad Hilton Foundation.

TAC

TREATMENT ACTION CAMPAIGN

EQUAL TREATMENT

June 2006
Issue 20

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Equal Treatment is published by the Treatment Action Campaign
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Distribution: 40,000 copies

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Thanks to David Goldblatt for taking and donating the front cover photo to Equal Treatment.
Cover photo is of TAC member Busisiwe Naqungo, who lives openly with HIV.
Thanks to Marlise Richter, Adila Hassim, Michelle Govender, Jonathan Berger and Fatima Hassan of the AIDS Law Project for supplying legal information.
Thanks to John Curtis for allowing us to use his cartoons at no charge.
Thanks to Zanele Muholi for allowing us to use the photo on page one at no charge.

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

Equal Treatment is sponsored by the Swedish International Development Agency.

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

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

A photo titled Ekaya *from* Only half the picture*, a photographic collection by rising South African photographer, Zanele Muholi.*

editorial

A WOMEN'S MOVEMENT TO END WOMEN'S OPPRESSION

It is 50 years since the women's march, but the women of South Africa battle with HIV, poverty and patriarchy. Yet we live in a country with a Constitution which guarantees equality of all citizens.

It is great that we have constitutional rights, but their application remains problematic. The justice system has not become less patriarchal with the advent of democracy. Oppressive practices underpin all spheres of our sexual, social, economic and political lives.

Jacob Zuma trial

The Jacob Zuma rape trial is over. A few weeks after Judge Van Der Merwe delivered his verdict, the nation moves on. The ANC has given Zuma his job back. The Friends of Jacob Zuma are crafting a strategy for the 2009 presidential contest.

The court found Zuma innocent. None of us were there so we must accept the verdict: no one wants Zuma or anyone convicted of a crime which they did not commit. But, it remains unacceptable that the judge allowed Zuma's lawyer to bring up the victim's "dubious sexual history" as the response to her rape charge.

Yet no questions were raised about Zuma's sexual history.

Those who have been raped will tell you this is typical. As Linda Mafu's story in this month's issue shows, the complainant has to establish guilt beyond a reasonable doubt. And who determines reasonable doubt? The police, lawyers and judges - all professions dominated by men?

> South Africa needs a powerful social movement to end oppression of women.

By justifying why he allowed Kemp's line of defence, the judge revealed his own deep patriarchal prejudices, culminating in his stigmatisation of women who bring charges of rape.

The Friends of Jacob Zuma called anti-Zuma those who criticised their sexist conduct and stood for the complainant's right to a fair hearing. Some of us who have had Zuma's audience, and even received warm hugs from him will attest to his accessibility (particularly compared to President Mbeki's cold aloofness). But the issue is bigger than the personalities of ANC leaders.

Pro-poor, pro-women leadership

At issue is the kind of leadership our country needs: leadership which puts the interests of the poor first; directs state resources and institutions to the upliftment of women and provides leadership in the struggle against HIV. Some support Zuma because they believe that under Zuma's presidency the voices of the poor and marginalised will be heard.

But it is contested whether Zuma is pro-poor and whether the ANC will enable a re-orientation to pro-poor policies.

Zuma's statements about what "culture" says about women, sexual relationships and men's entitlements, and how HIV is transmitted shocked all of us. With 1,500 new infections each day, our country battles to control the spread of HIV. We battle a crisis of illness and death, with 900 people dying of AIDS every day.

While we must accept his unconditional apology, Zuma must accept that his utterances have caused damage to the rights of women and the country's anti-HIV efforts. Considering his position as

Photo: Luckyboy Mkhondwane

Demonstrators support the rights of the complainant (known as Khwezi) at the Jacob Zuma trial in Johannesburg. Some Zuma supporters incited violence against Khwezi with the slogan, "Burn the Bitch". Zuma did not speak out against his supporters for doing this.

the former head of the South African National AIDS Council, we believed him to understand the science of HIV. The damage caused by his statements cannot be reversed by his apology.

Burden of HIV on women

The continued subjugation of women's rights, as epitomised by the Zuma case, obscures the burden of HIV on women. Women do not only shield society from the burden of caring for the sick, they take on the failures of the health system as unpaid AIDS workers, provide much needed relief and give support to families burdened by the disease. The extent to which HIV impoverishes women and undermines their development is not acknowledged in the national AIDS responses.

Material conditions and social attitudes towards women must change. The rights enshrined in the Constitution belong to us. But rights are always subject to interpretation. They can be taken away as easily as they are granted. A movement to end the social and institutional acceptance of a system which allows the continued denigration and violation of women must emerge.

We have won the war against apartheid, but we do not yet have equality for all. While we have a Bill of Rights proclaiming to protect the rights of women, we clearly have not won the war against patriarchy.

The health of a nation is dependent on equitable rights and access to healthcare, welfare and education, the respect and bodily autonomy of all, and equal access to justice. Without activism to achieve this, freedom will remain the privilege of men and only a few women who have "pulled themselves up by their bootstraps" to escape poverty and other forms of oppression. And women will remain marginalised non citizens.

Khwezi's words best capture where we have to start:

**"The role of those organizations who campaign and struggle for changes in the laws, policies ... is critical. But these alone and on their own cannot and will not bring the change. Unfortunately, it is going to take ordinary women, individual women to stand up ...We cannot wait for the Minister of Justice to make the change. We have got to make the change ourselves."*

Sipho Mthathi
TAC General Secretary

**Quotation from Khwezi, the woman who brought the rape charge against Zuma, in an interview with Dawn Cavanagh and Prudence Mabele, Wednesday 10 May 2006.*

THE BURDEN OF HIV ON WOMEN

HIV affects men and women. But HIV creates a greater burden for women. In this issue of *Equal Treatment*, we focus on the specific concerns women have about HIV.

There are a number of factors that increase the burden of HIV for women:

- More women are infected with HIV than men.
- For biological reasons, an HIV-negative woman is more likely to contract HIV from an HIV-positive man than vice-versa.
- Women usually have less power in sexual relationships. This means that the decision to use or not use a condom for sex is often taken by the man.
- Women can pass HIV onto their babies either through birth or breastfeeding. It is therefore usually women who take most of the responsibility for avoiding transmission to their babies.
- Women usually have to care for sick family members who have HIV.
- Women with HIV have health needs particular to their gender.
- Studies show that many women have sex with much older men. This often happens because older men can offer economic security to younger women, but it also means women are more likely to get HIV at a younger age than men. A 2003 study in Soweto found that 21% of women reported having sex in exchange for money or goods.
- In the same study in Soweto more than 50% of woman reported being sexually assaulted.
- The Soweto study found that violence and lack of power in their relationships were associated with a higher risk of HIV infection for women.

Facts about women and HIV

- A large survey conducted by the Human Sciences Research Council across South Africa in 2005 found that 13% of women over two years old are HIV-positive, as opposed to 8% of men.
- A study has found that many HIV-positive rural women whose partners work on mines are not infected by their partners but by other men living in their rural areas. There are important lessons from this study:
  - South Africa's migrant labour system separates families for long periods of time. This has contributed to the large HIV epidemic.
  - HIV is not spread only by men having sex with multiple partners. Many women have multiple partners too.

Sources: Human Sciences Research Council, ASSA, Lurie et al. The Impact of Migration on HIV-1 Transmission in South Africa: A Study of Migrant and Nonmigrant Men and Their Partners. Sexually Transmitted Diseases. 30(2):149-156, February 2003, Dunkle et al. Gender-based violence and HIV-1 infection among pregnant women in Soweto, June 2003.

BREAKING THE SILENCE

As told to Sylvia Jacobs by Nkhensani Mavasa

Nkhensani Mavasa is the TAC's deputy-chairperson. She told Sylvia Jacobs why she is speaking out about abuse and her HIV status.

My name is Nkhensani Mavasa from a village in Limpopo Province. I am HIV-positive and open about my status.

I was tested on 7 April 2005. At the time I had been giving education about HIV/AIDS, but I never saw the need to get tested. Eventually I did get tested because I was always telling people to get tested yet I didn't even know my own status. My boyfriend accompanied me to hospital where I tested HIV-positive. I could not believe it.

A week later I went to another clinic for a second test and the results were the same. I was still in denial. After two days I went to a third clinic and got tested again. The results were still positive. It was hard for me to accept I had HIV. My boyfriend supported me a lot and after a few weeks he also went for a test.

> Ten years ago I was raped by a pastor from my church.

Then I told my parents. It was terrible because my father told me to leave the house and that I was no longer part of the family. My mother was heartbroken but she and my sisters continued to support me. I was devastated when I left my home. I moved in with my boyfriend and it took me a few months to accept my status. When I educate at the clinic now I do so with confidence because I know my status.

Photo: Vuyiseka Dubula

I then went public about my HIV status. People in my community started calling me names but I didn't give up. After two months, I met a woman TAC activist who convinced me to join TAC. I started volunteering for TAC and things improved for me because I did a lot of things for my community. I spoke about how TAC works and informed people about human rights. Many people came out about their status. I am grateful that antiretroviral treatment is available now in our clinic.

Ten years ago I was raped by a pastor from my church. But I couldn't tell anyone because nobody would have believed me, as the pastor was a role model to a lot of people and very powerful in the community. I was also abused at school when I was 13 years old and I have kept quiet about this for a long time. Now the time has come for me to break the silence.

I call on women to break the silence and talk about abuse. I want people who are HIV-positive to stop being in denial and be open about their status so that they can help other HIV-positive people. My life has changed for the better since I got tested and talked about my experiences. Women can and must stand up for their rights.

> My life has changed for the better since I got tested and talked about my experiences.

WOMEN'S REPRODUCTIVE RIGHTS

The Constitution of South Africa gives everyone the right to access health care services. It also recognises the reproductive health-care rights of women. We all have the rights to non-discrimination, privacy, bodily and psychological integrity. In addition to the Constitution, there are various laws and policies that describe the rights of people in South Africa to health care, and how health care workers have to treat clients. This article explains the reproductive rights of women.

TAC members talk about their rights.

Reproductive health care includes prevention services, management of sexually transmitted infections and HIV/AIDS, infertility, termination of pregnancy (abortion), cancers of the reproductive system, contraceptive services, antenatal care, safe delivery of babies and post-natal care.

HIV/AIDS

Reproductive health rights means that no health worker may tell people with HIV/AIDS that they may not have children. It is advisable that a woman with HIV talks to a health care worker about the options available to her before she plans a pregnancy.

Sex

In addition to reproductive rights, women and men are also entitled to sexual rights. All men and women are entitled to

- control their own bodies and not be forced to have sex through the use of violence or coercion;
- only have sex when, with whom and how they want to;
- live out their sexual orientation (whether a person is heterosexual, gay, lesbian, bisexual or transgendered);
- be protected from HIV and other sexually transmitted infections.

Besides rights, we also have to exercise the responsibilities that go with sexual rights, such as respecting the sexual rights of other people.

Cervical cancer

The cervix is a part of a woman's womb. The Department of Health National Guideline on Cervical Cancer Screening Programme says that all women without symptoms of cancer should have at least three free pap smears (test for cancer) in their lifetime, starting when they are 30.

This is far too few. Many organisations and guidelines recommend that women with HIV should have a pap smear every six months. Without HIV, a woman should have a pap smear every year from the age of 30.

Breast Cancer

Breast cancer can develop quite quickly, but the earlier it is found, the earlier it can be treated. All women should be informed how to examine their breasts to detect any lumps and be aware of the dangers of breast cancer.

When breast cancer is suspected, a woman should get medical attention immediately and discuss treatment options with her health care worker. Unfortunately, there is no government policy on breast cancer screening.

Termination of Pregnancy

The Choice on Termination of Pregnancy Act makes it possible for women to choose to have an abortion. Abortion is now a possibility for most women or girls who have an unwanted pregnancy and want to abort the foetus.

Abortions can be done for free at a public clinic or hospital by a doctor or registered midwife, who has completed a training course in abortion.

Women should be able to receive counselling on abortion and the procedure, but may choose not to have counselling. Girls under 18 may obtain an abortion without their parents' consent or permission. The law advises that a young girl should discuss abortion with someone she trusts before having one, but does not make this discussion a requirement for an abortion.

Contraception and family planning

By contraception and family planning, we mean

- the methods of birth control that allow women and men to decide whether they want children;
- how many children they want to have; and
- when they wish to have children.

Contraceptive and family planning services fall under primary health care services that are free of charge to all public health system users. Women thus have a right to receive contraception free of charge.

Pregnancy and health

Women who are pregnant and those who have just given birth have special health needs. Good medical care in hygienic conditions can reduce the risk of complications and infections in both the mother and baby, and should be available to all women. This includes access to a good prevention of mother-to-child transmission of HIV programme.

All mothers with HIV/AIDS now have a right to receive a comprehensive package of services within the government HIV programme, including antiretrovirals.

The National Health Act instructs state clinics and community health centres to provide free health care services to pregnant and lactating women (women who are breastfeeding) who do not have medical aid.

All women and men are entitled to control their own bodies and not be forced to have sex through the use of violence or coercion.

Infant feeding

The Department of Health policy guidelines for feeding of infants of HIV positive mothers makes it clear that there is a risk of HIV transmission through breastfeeding by mothers with HIV/AIDS. It also points out the dangers of diseases posed by unclean water when formula-feeding is used.

The guidelines recommend that

- women should be counselled about the risks of breastfeeding and the risks of formula-feeding;
- women should make the best decision for their particular circumstances; and
- mothers must be provided with ongoing support, whatever their decision.

Women over 30 should have a regular pap smear to check for cervical cancer.

Equal Treatment
June 2006

THE UNFAIR BURDEN OF PROOF FOR ABUSED WOMEN

Linda Mafu, TAC's National Organiser, tells her story of childhood abuse and how she fought it.

Linda Mafu (right) hands out Equal Treatment *in Alice, Eastern Cape.*

I grew up in Gugulethu township in Cape Town. My parents valued education and everything else that is suppose to come with it.

But I learnt a lot about growing up from a different school: at the age of eight an adult in my home started to touch my vagina. I told my parents. According to my young mind they would be able to protect me. There were many challenges in reporting this at home.

First this was a trusted member of my family and he was 24 years at the time. He had access to all the beautiful women he wanted. So why would he touch me in a sexual way? That was the first question that I was supposed to answer beyond reasonable doubt.

The second question was what did he do exactly? The challenge was to find anatomically correct names of my and the perpetrator's body parts - a huge challenge for any eight year old. So I lost my case at home and could move no further. That gave the perpetrator a license to rape me at least twice a week. There were threats and physical assaults. There were times I would go to school with blue and black marks on my legs and face - beaten because I dared to say "No"!

So how many of us associate "No" with pain and torture and therefore freeze before they could say this powerful word? I knew what was happening to me was abnormal but I had to survive and find a way of normalizing my life. To survive I started reading books to escape my reality. Becoming a sexual partner before I could even enjoy my childhood was not easy. My body was owned by someone else. It was painful when some of the young girls at High School started to talk about their virginity, when and how they choose to break it. We had a teacher that spoke to girls everyday about loving your bodies and keeping your virginity as part of your dignity and pride.

By the age of 14 I had given up on life, my rights to my body and my right to be treated with dignity. So it made sense that I should die. I tried to take my life and landed in Conradie hospital. When I woke up and realized that I was still alive, I cried tears of anger for failing to save myself. The social workers referred me to another social worker based in the township. She decided that I knew too much and was just a silly little girl who wanted attention. The system failed me.

I went back home to the same situation. Reporting this to teachers with the hope that I will be protected was met with "we do not know what to do so just finish your education and leave your home." I was in standard seven (grade 9)!

Rape continued. Physical assaults became severe until I was 17 . My neighbours and community realized that there was something wrong but

they did not want to intervene in domestic issues. I was supposed to act as if all was normal and not talk about it. When I realized again that the community was not going to help me I tried to take my life again. Damn! That did not work either.

The system failed me again. After this episode I tried to find an emotional home. I found that in the struggle for the freedom of African people. I participated enthusiastically and took leadership positions, articulating issues affecting youth. I had many personalities. I was an outspoken young woman who would stand her ground. I found a space to vent my anger and personal frustration. Within the movement, I 'd found a home. But I could not stand my ground at my own home.

I never saw myself as a sexual being but comrades did. Twice I was almost raped by my trusted comrades.

I found my voice in the movement and fought for my rights. I was sent to lead the gender desk. But rape was not addressed in the movement at the time. We were fighting for freedom and women' s rights were not a priority. At 17 fighting back was my priority and I knew that fighting back was the only way I could save myself.

When I started working I began going to counselling. This was a very painful journey that I walked alone. It took me four years of counselling to learn to cope with what had happened in my life but I would recommend counselling to anyone.

I had strong support from other women and men. When in doubt, I relied on them heavily.

Rape survivors are stigmatized which means many cases are not reported. We need space for women to talk about their painful experiences without being judged. We need space for the silent voices to come out and find a home in TAC. We must fight for access to justice starting from the police, the social workers and the doctors that do not want to sign the J88 form (police form for rape and domestic assault survivors) because they do not want to go to court.

We must change the courts and make it more enabling for women to access justice. We must also fight for more resources to provide continuous psycho-social support.

Sexual abuse and rape: what are my rights?

I am being abused at home. What legal options do I have?

- Lay a criminal charge against the abuser, assault for example.
- Get a protection order against the abuser under the Domestic Violence Act. This will prevent the abuser from contacting or coming near you.
- If the abuser has used a gun to threaten you, get a court order to have the abuser's gun removed.
- Make a civil claim against the abuser to claim financial compensation for pain and suffering and any medical costs.

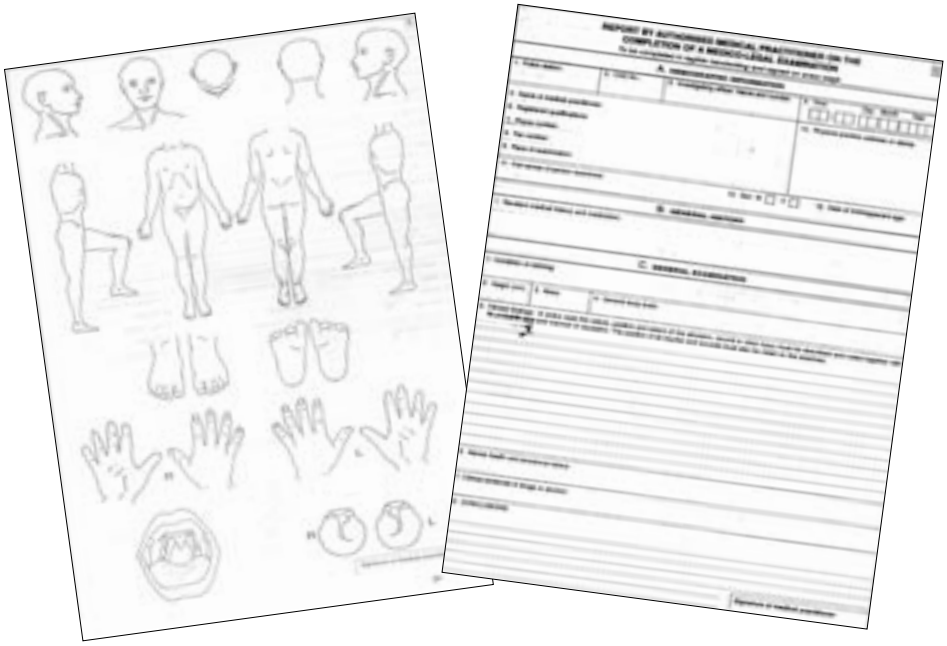
I was raped. What are my rights? How do I report it?

If you make a complaint to the police, the police must investigate the matter. They must arrest the accused and may arrange identity parades for you to identify the criminal. They must collect evidence that will help the court properly try the person accused of the crime. They must get statements from any witnesses.

You also have the right to:

- Call the police and have them come to you.
- Have a friend or a family member with you to support you when you make a statement to the police.
- Make your statement in privacy.
- Make your statement to a female officer.

Adapted from Family Violence and Violence against Women.
Available: http://www.paralegaladvice.org.za/docs/07_full.html



This is the J88 form that must be filled out when women report sexual abuse.

UBOMI NGAMAHLA NDENYUKA

ngu Thandeka Vinjwa

UBukiwe Diko ubalisele u-Thandeka Vinjwa ibali lakhe lokukhula ngaphandle kothando lukanina.

Ifoto: Tandeka Vinjwa

U-Bukiwe Diko ukhule exhatshazwa ngunina nezalamane zakhe.

NdinguBukiwe Diko oneminyaka engama-18 ubudala. Ndizalwa nabafowethu ababini kwilali yaseJambeni eLusikisiki. Ndikhule ndihlala nabazali bam, de utata wasutywa kukufa ngomnyaka ka-1998 kweyoMdumbi. Kuthe nje emva kwenyanga ezimbalwa umama wagoduka waya eGoli kubazali bakhe. Ubuyile wazokusithatha saya kuhlala naye kunye nabazali bakhe. Sahlala kamnandi ngethuba umama ekhona de kwafika ixesha lokuba asishiye abuyele eLusikisiki. Ndandinezinto ekwakunzima ukuzifumana kuba umakhulu wayesithi umama akayithumelanga imali yokusithengela izinto esingenazo. Ndandibethwa esikolweni kuba ndingenazo izinto ezifunwayo.

Kuthe ngoDisemba, umama weza kusithatha sayokuchitha iholide zehlobo ekhaya. Besihlala nomakazi kunye nosisi kuba umama ubesishiya engasixelelanga nokuba uyaphi na. Kwakumnandi ukuhlala nabo ngaphandle kwaxa kufike umama. Abahlobo bakamama babemxelela izinto ezingezizo ngam, njengokuba ndinetshiki kwaye andimameli. Ubesithi akuva ezi zithyolo andibethe. Wade wandinika isohlwayo sokuba kunyaka olandelayo andihambi naye ukuya kuhlala e-Mthatha. Ndandingaphathekanga kakuhle ekhaya, imeko yayimaxongo kakhulu.

Ngomnyaka ka-2002 ndade ndaya kuhlala nomama e-Mthatha ndafunda kwisikolo sase-Fairfield Junior Secondary School. Umama wayendibetha xa ethe wandibona ndihamba namakhwenkwe endandifunda nawo. Wayede andithuke athi ndakufa ndiyinja atsho andibethe ngesitya nokuba sinokutya kuba esithi ndithanda amakhwenkwe. Wandibetha ngenye imini wade wandijula esitovini esasivutha, ndatsha iinwele kobo buthuba. Ngenxa yokusoloko ndibethelwa izinto endingazenzanga ndacinga ukuba kungcono ndizibulale. Ndasela amanzi ebhetri lemoto, ndasindiswa kukuba ndakhawuleza ndabonwa ndasiwa esibhedlele.

Ngenxa yemeko ebendiphila phantsi kwayo, ndabaleka e-Mthatha ndeza ekhaya (eLusikisiki). Umama wafuna umkhondo wafumanisa ukuba ndisekhaya, waya koonontlalontle waluchaza lonke udaba olundibangele ukuba ndimshiye. Kwathiwa masixolelane ndiphethwe sisiteyiji (ukufikisa). Ndahlala kunye nomakhulu. Nalapho kwakubakho iimini zengxabano naye endithuka ngokuthanda amakhwenkwe ade athi mandihambe ndiye kumama. Ibali lam ndalibalisela amalungu axhatshaziweyo njengam apho ndithe ndafumana uncedo kusisi ekuthiwa nguNontembiso Mzinyo othe wangumama wam omtsha.

Ngoku ndinekhaya elitsha elifudumeleyo, ndinikwa inkxaso kuyo yonke into endingenayo. Ndiqhubekela phambili ngezifundo zam, ndenza ibanga leshumi kwisikolo sase-Mqikela Senior Secondary School. Ukuthetha phandle ngobume bentlalo yakho kusenokuba luncedo komnye umntu.

POST EXPOSURE PROPHYLAXIS (PEP) AFTER SEXUAL ASSAULT

What is PEP?

The theory behind PEP is that there may be an opportunity to prevent HIV by stopping the virus replicating by using a course of antiretrovirals following HIV exposure.

Once HIV has crossed the *mucosal barrier* (our first line of defence against infection), research suggests that it takes about 48 to 72 hours before HIV can be found in our lymph nodes and up to five days before it can be detected in our blood.

PEP is offered to healthcare workers after what's called *occupational exposure* to HIV. Typically, this happens after a nurse or doctor has a needle stick injury. PEP is also offered to women in South Africa following sexual assault. PEP might also work for intravenous drug users.

Why do we think that PEP works after sexual assault?

There has been limited research into the effectiveness of PEP used in this setting.

In a Brazilian study of men who have sex with men (MSM) there were significantly fewer seroconversions among those who used PEP immediately after sexual exposure than those who did not (0.6 % vs 4.2%).

A second Brazilian study found that no one who received PEP within 72 hours following sexual assault serconverted versus 2.7% of people who did not.

What should I do after rape?

A person who has been raped is referred to the nearest district surgeon. He or she conducts an examination and, if the person is not HIV-positive, prescribes AZT and lamivudine for 28 days. If the rape has caused trauma to the vagina then lopinavir/ritonavir (known as *Kaletra*) is also prescribed. It is important for an HIV-negative rape survivor to start PEP within 72 hours of being raped.

The district surgeon must also fill out a J88 form which the rape survivor then takes to the police station to be part of the police docket.

Women who have been raped are also offered emergency contraception known as *the morning after pill*. This is like the contraceptive pill but in higher doses and must be taken within 72 hours to be effective.

HIV, WOMEN AND SEXUAL HEALTH

Women need to be aware of their gynaecological conditions. HIV-positive women need to be particularly aware of the following conditions which are easily treated if caught early. However, sometimes they may be symptomatic of more serious HIV related problems.

Changes in menstruation

Some HIV-positive women find that they have changes in their menstrual cycle or periods. These changes can be due to different things and not always HIV. For example, a missed period could mean that you are pregnant, but it can also be a symptom of AIDS wasting. Heavy bleeding can be a sign that you have an infection of the genital tract or it can be associated with some HIV drugs including AZT.

It is important that HIV-positive women pay attention to any changes in their periods and talk to their nurse or doctor about them

Genital herpes

A large number (about 75%) of women with HIV have genital herpes and HIV-positive women are far more likely to experience herpes outbreaks than HIV-negative women. This is often because of a low CD4 count which means the immune system is weak.

Treatment with acyclovir, which you will need to get on prescription from the clinic, is very effective. People with frequent herpes outbreaks may need to take acyclovir everyday to control the herpes (called prophylaxis).

One thing to be aware of is that herpes is very easily transmitted from mother to child. Herpes sores contain high levels of HIV even if the viral load in your blood is very low.

The herpes virus can also be released from the sores during labour. This will put the baby at increased risk of contracting HIV.

Prophylaxis and treatment with acyclovir is safe to use during pregnancy.

If you are a woman with HIV:

- Pay attention to changes in your periods.
- Treat herpes as soon as you have an outbreak.
- Have a regular pap smear examination (once every year or every two years).
- Treat vaginal thrush with an antifungal.
- HPV is usually treated by burning the warts e.g. using liquid nitrogen (a simple and not too painful procedure).

Vaginal thrush

In HIV positive women persistent vaginal thrush is often also a result of a weakened immune system. Thrush is caused by an over activity of a fungus called candida, which is normally present in small amounts in our bodies when we are healthy.

Vaginal thrush will need treatment with antifungals. Some creams are available over the counter at the chemist. For more effective treatment, which is often necessary for HIV-positive women, you will need to obtain a stronger strength cream prescribed through a doctor or an antifungal drug such as fluconazole.

HPV

HPV (human papilloma virus), the virus that causes warts on our skin has many different strains most of which are harmless. But it can cause genital warts and abnormalities in the cells of the cervix, which can sometimes lead to cancer. These abnormal cells are called precancerous or dysplasia.

HIV-positive women are more likely to be infected with HPV than HIV-negative women, and again a weakened immune system will make someone more vulnerable. At lower CD4 counts and higher viral loads women are more at risk of developing dysplasia.

RESTORING MEN'S DIGNITY

Equal Treatment's Vathiswa Kamkam and Nathan Geffen interviewed TAC's Khayelitsha District Co-ordinator Mandla Majola about his district's campaigns to reduce violence against women.

ET: Many people know you as TAC's Khayelitsha District co-ordinator. Can you tell us about your background?
Mandla: I was born in Gugulethu, Cape Town. I am the third child of seven but now we are five left. A brother and sister have passed away.

I was an active member of the Pan African Congress (PAC) and also of the South African Mobile Library Association (SAMLA).

I joined TAC in 1999 because people close to me were dying of AIDS. I wanted to know about HIV medicines and what TAC was fighting for. Through TAC I developed an understanding of the Constitution and realised the power of social mobilisation.

ET: What are the key problems TAC Khayelistsha District faces?
Mandla: HIV, unemployment, poor housing and gender-based violence. The Simelela rape survivors' centre releases statistics on the number of rapes reported to them in Khayelitsha every month. We have a crisis. One of our key concerns is to remedy this.

The community has mobilised against violence against women by creating a forum composed of the police, Simelela, Nonceba, Rape Crisis, Social Services, MSF, TAC and other groups. We are also mobilising men to fight against the abuse of women and children.

Mandla Majola, TAC's Khayelitsha District Co-ordinator.

ET: What is the district doing to reduce violence against women?
Mandla: TAC Khayelitsha member Lorna Mlofana was murdered in December 2003. She was raped at a shebeen. She told the man who raped her that she was HIV-positive, so he, his girlfriend and possibly others beat her to death. We mobilised the community by marching to the shebeen. We demonstrated at every court hearing and we put pressure on the police and prosecutor to do their jobs. Eventually the perpetrators were found guilty. This case highlighted the problem of violence against women in Khayelitsha.

We also march regularly to inform people about the Simelela rape survivors' centre.

We work with Positive Menu United (POMU) to run door- to-door campaigns against violence against women.
TAC members speak on the local community station, Radio Zibonele, every monday.

Men must be involved in the campaign against violence. We must condemn the violence that men do. We have to go to men's forums, football clubs and sheebens to educate each other. We also have to go to big football matches like Kaizer Chiefs and Sundowns because they are dominated by men. We should also involve the youth. For example, during the circumcision period young men should be taught why abuse of women is wrong.

ET: What is causing the high levels of violence against women?
Mandla: Men struggle to find their dignity in Khayelitsha. We have high unemployment. So many men feel useless. They use alcohol and drugs to try to cure their frustrations. Then they vent their anger on women because they think women won't fight back. We need to give men their dignity back.

FINDING OUT YOUR HIV STATUS IN PREGNANCY

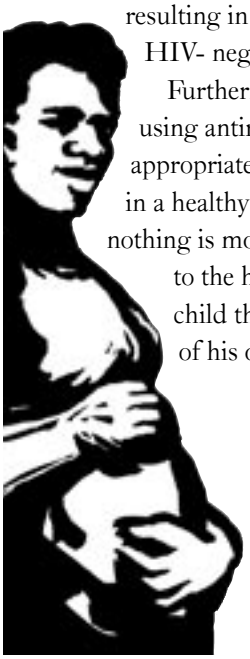
Receiving an HIV diagnosis in pregnancy can be very confusing and difficult. Finding out either that you are pregnant or that you are HIV-positive can be overwhelming on its own. It can be even harder if you find out both at the same time.

The advice that you receive when you are HIV-positive and pregnant may be different to advice given to pregnant women generally. This includes information on medication and breast-feeding.

Like all aspects of HIV, the better you are informed the more you will be able to understand and own your health decisions. Whatever you decide to do, make sure that you understand the advice you receive. Having as much information as possible will help you make informed choices.

Can HIV-positive women become mothers safely?

Yes! With HIV medicines. Women around the world have safely used antiretroviral drugs in pregnancy now for over 10 years, resulting in many HIV- negative babies. Furthermore using antiretrovirals appropriately will result in a healthy mother. And nothing is more important to the health of a child than the health of his or her mother.



Also see "Reducing mother-to-child transmission to zero" on page 14 in the March 2006 issue of Equal Treatment.

Are pregnant women automatically offered HIV testing?

In most parts of the world, no. But in South Africa healthcare providers and clinics generally offer pregnant women an HIV test. This is usually part of routine prenatal care.

It is important for a woman, who does not know her status, to have an HIV test when she is pregnant. Her ability to look after her own treatment, health and well-being is vastly improved when she knows if she has HIV or not.

This knowledge also means that she is aware of why and how she can protect her baby from HIV, if she tests positive.

HIV diagnosis in early pregnancy

If a woman's CD4 count is less than 200 she needs treatment for her own health. She is entitled to antiretrovirals like any person with HIV. Using triple combination therapy has shown the greatest reduction in mother-to-child transmission of HIV to date (almost down to zero).

What if a women does not yet require treatment for her own health?

She will still need to take antiretrovirals in her pregnancy to reduce the risk of her baby being born HIV positive. In South Africa she will most likely be offered nevirapine, either as single dose in labour or single dose in addition to a short course of AZT.

These strategies are effective in reducing transmission but not as effective as a short course of triple therapy. In South Africa we need to move on to better strategies both to protect the baby from HIV and the mother from the risk of nevirapine resistance

HIV diagnosis in late pregnancy

If a woman only finds out that she is HIV-positive very late into pregnancy or in labour she is again most likely to be offered nevirapine. This drug is absorbed very rapidly and is the most effective drug for reducing mother-to-child transmission in this situation.

As resistance to nevirapine develops easily, it is better with two other drugs (if these are available). These are often AZT and lamivudine. This will reduce the risk of resistance.

In all of these situations the baby will need to take a short course of antiretrovirals after it is born.

MY PARTNER IS HIV POSITIVE. HOW DO WE HAVE A CHILD?

This article explains what to do if one partner in a relationship is HIV-positive and the other is HIV-negative (known as a *serodiscordant* couple) and they want to conceive a child.

It is unwise for a serodiscordant couple to have sex without a condom. Even when trying to conceive a child there is always a risk to the negative partner of contracting HIV.

In one study of HIV-negative women and HIV-positive men for example, 4% of women became HIV-positive. Most would consider this an unacceptable risk. If one of you has stayed HIV-negative until now, you don't want to change this over a decision to have a baby.

For those who wish to conceive though, there are other options that involve almost no risk to the negative partner.

When the man is HIV-positive and the woman HIV-negative

When the man is HIV-positive and the women is HIV-negative you can use a process called *sperm washing*.

This involves the man giving a semen sample to the clinic. A special machine then spins this sample to separate the sperm cells from the seminal fluid.

Only the seminal fluid contains HIV-infected white blood cells. And these cells carry the risk of passing on HIV. Sperm cells themselves do not contain infectious HIV.

The washed sperm is then tested for HIV. Finally, a catheter is used to inject the sperm into the woman's uterus. In vitro fertilisation (IVF) may also be used. IVF is important if the man has a low sperm count.

Illustration: Beth Higgins

There have been no cases of HIV transmission to women from sperm washing.

This is therefore the safest way for an HIV-negative woman to become pregnant from an HIV-positive man.

Sperm washing is available in the private sector. It costs approximately R2,000 and much more if one of the partners is infertile.

In some countries, such as Britain, it is sometimes available in the public sector.

TAC must campaign for cheaper sperm washing.

When the woman is HIV-positive and the man is HIV-negative

The options are usually much simpler in this situation.

Do-it-yourself artificial insemination or "self insemination" using a plastic syringe carries no risk to the man. This is the safest way to protect the man from HIV.

Around the time of ovulation, you need to put the sperm of your partner as high as possible into your vagina. Ovulation takes place in the middle of your cycle, about 14 days before your period.

Different clinics may recommend different methods. One way is to have protected intercourse with a spermicide-free condom. Another is for your partner to ejaculate into a container. In both cases, you then insert the sperm into your vagina with a syringe.

Your clinic can provide the container and syringe. They can also give detailed instructions on how to do this, including advice on timing the process to coincide with your ovulation.

Source: from the i-Base guide HIV, pregnancy & women's health. *http://www.i-base.info/guides/pregnancy/index.html*

CONTRACEPTIVE CHOICE

In South Africa the most widely used methods of contraception are condoms, injectables and oral contraceptives.

Condoms and femidoms

As is very obvious to anyone reading *Equal Treatment*, seeing our posters, reading our booklets or meeting our members, TAC strongly supports the use of condoms!

Condoms and femidoms (female condom) are very good at protecting HIV-positive people from infecting their partners. They also protect us from other sexually transmitted infections such as gonorrehea, chlamydia and trichomoniasis. Additionally they are very good at preventing unwanted pregnancy.

In one year, only 3% of women will become pregnant if they and their partners use a male condom correctly every time they have sexual intercourse, the efficacy rate for female condoms is 79% with "typical use". With "perfect use", it is 95%.

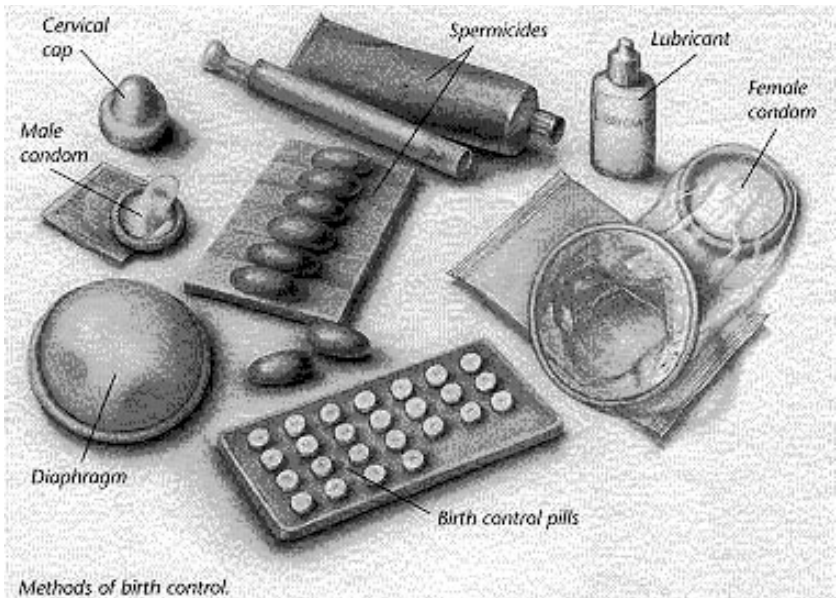
Condoms are available free in public clinics and are for sale at pharmacies.

In the March 2006 issue of Equal Treatment *we explained how we know that condoms work on page 15.*

Injectables

Injectable contraception prevents pregnancy by preventing ovulation. They are long lasting; *Depo-Provera*, the most commonly used injectable in South Africa, lasts for 12 weeks.

Injectables are a very effective form of contraception (over 99%) but they do not protect us from HIV or other sexually transmitted infections.



Methods of birth control.

From http://sitemaker.umich.edu/kwshwin.356/my_personal_sex_ed_experience

Only a doctor or nurse can give the injections, which are available free at clinics. Some clinics will only prescribe the HIV drug efavirenz to a woman if she is using an injectable contraception. This is because of the possible risks to the developing baby if the woman were to get pregnant while taking efavirenz.

Oral contraceptives (The Pill)

Several types of pills exist and most also work by preventing ovulation. Oral contraceptives must be taken regularly each day to be effective and with "perfect use" are over 99% effective.

Oral contraceptives are only available from clinics.

For women using antiretrovirals however, there are interactions between some protease inhibitors and nevirapine with one of the ingredients of most oral contraceptives (called ethinyl-estradiol, which is a synthetic version of the naturally occuring hormone called oestrogen). Antiretrovirals can lower the levels of ethinyl-estradiol and thereby leave a woman at risk of an unwanted pregnancy.

As a result the manufacturers of these antiretroviral drugs do not recommend using them with oral contraceptives, or confusingly recommend a barrier method "in addition".

Other methods

Other methods less commonly used in South Africa are the IUD, diaphragm and surgical sterilsation.

On page 11 we also look at emergency contraception: the morning after pill.

On 23 April, several civil society organisations co-hosted a meeting and march for HIV prevention. Here is a selection of photos from the event.

WOMEN, HIV TREATMENT AND SIDE EFFECTS

Differences between women and men in response to HIV

There are some important differences between the treatment of men and women with HIV. Studies have shown a difference between women and men in viral load: at the same CD4 count, women can have a slightly lower viral load than men. Some studies also show that women have a slightly higher risk of becoming ill than men at the same CD4 count. One study found that viral load levels vary slightly during the different stages of the menstrual cycle.

None of these factors have led to differences in recommendations for starting antiretroviral treatment in women and men. Most studies show that women and men respond equally well to treatment.

Differences between men and women with side effects

Side effects of HIV treatments are where women and men are most likely to experience differences.

Liver toxicity and nevirapine

An important difference is with the drug nevirapine. In 2004 it was found that the risk of liver toxicity was different between men and women. Women had a higher risk of nevirapine-associated liver toxicity than men.

The higher risk is for women starting treatment for the first time with a CD4 count over 250. This is unusual in South Africa and most other countries where guidelines recommend starting treatment at a CD4 count of 200. However, women receiving a short course of triple drug antiretroviral treatment to prevent mother-to-child transmission and who do not yet need treatment for their own health could potentially fit into this category.

The risk for men is when they start nevirapine with a CD4 count over 400, which is rare in South Africa.

These CD4 levels do not affect people already using nevirapine and have CD4 counts above these levels, or people switching one of their current drugs to nevirapine.

They do not relate to pregnant women who are using a single dose of nevirapine alone or with other drugs to reduce the risk of transmitting HIV to their baby.

The risk of nevirapine-associated rash is also higher in women than men.

Everyone starting treatment with a nevirapine-containing regimen must start with a lower dose and be carefully monitored for liver toxicity.

> The benefits of antiretrovirals far outweigh the risks. But antiretrovirals do have side effects. It is important for people taking antiretrovirals to recognise side effects.

> Women had a higher risk of nevirapine-associated liver toxicity than men.
>
> The highest risk is for women starting treatment for the first time with a CD4 count over 250.

Lactic acidosis

Lactic acidosis is a rare but life-threatening side-effect of antiretrovirals. It means too much acid in our bodies, which happens when cells make lactic acid (from glucose) faster than we can metabolise it. Symptoms of lactic acidosis include difficulty breathing, nausea, vomiting and abdominal pain.

Lactic acidosis can sometimes be caused by the class of antiretrovirals

known as NRTIs (better known as nukes), particularly d4T and ddI. Research shows that it may be more common in women than men and that it may be more common in people who weigh more and people with more advanced HIV.

Lactic acidosis does not occur immediately but (if it is going to happen) happens about six to nine months after beginning treatment.

Recent research from Khayelitsha, showed higher risk of lactic acidosis for women weighing over 75kg and using d4T for more than 6 months (70% of patients in Khayelitsha are women).

As d4T is one of the drugs in our national treatment protocol for first line treatment, this raises some concerns. The researchers from the Khayelitsha study proposed some suggestions for starting treatment in new patients. One important possibility is to replace d4T with a new drug called tenofovir, at least for some patients. Tenofovir has relatively few side effects. But tenofovir is not yet registered in South Africa and its price is much higher than d4T.

Lipodystropy

Lipodysrophy refers to changes in the composition of our bodies including changes in our body shape and changes in our metabolism. It occurs in both women and men, but research suggests that women may be more at risk than men.

Women appear to be more likely to get fat accumulation, particularly in the breasts and abdomen, than men. Men are more likely than women to experience fat loss (called lipoatrophy). A recent study found that women had the most fat loss in their legs.

Scientists are still unclear as to the exact cause of lipodystrophy but it is thought that antiretrovirals in the class of drugs known as protease inhibitors are more likely to cause fat gain. Nukes are more likely to cause fat loss. Again d4T has been particularly shown to contribute to fat loss.

Recent research from Khayelitsha showed a higher risk of lactic acidosis for women weighing over 75kg and using d4T for more than six months.

Equal Treatment
June 2006

HIV AND SEX WORK

by Nicolé Fick

Nicolé Fick of the Sex Workers Education and Advocacy Taskforce (SWEAT) explains why the criminalisation of sex workers harms HIV prevention and treatment.

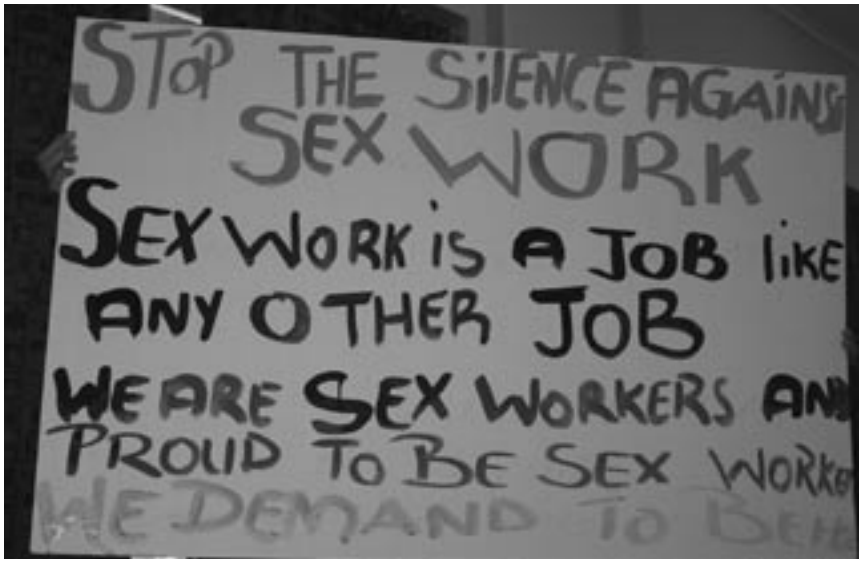


Photo: Courtesy of SWEAT

When I first met Natalie she was vibrant and alive, with a lot to say for herself. And as I interviewed her for my research she seemed to enjoy the opportunity to talk freely about her life. I was privileged enough to hear her talk about herself as a mother and as a daughter. She shared some of her strengths and the way she coped with the difficulties she experienced working in the sex work industry.

Some time passed before I would see Natalie again and I was shocked by the change in her circumstances. She was subdued and painfully thin, so ill she could no longer work to support herself. Initially she spoke about having TB, but as she talked some more she disclosed to us that she was HIV-positive and that a homeless shelter had refused to admit her.

When we took Natalie to the nearest clinic, we had to put pressure on the nurses there to assist her. They implied that it was useless to provide her with treatment as she had not complied with her TB treatment in the past. They had effectively given up on her. She had told us previously that the reason she was not able to take her treatment was that she had no food to eat. Before we could get her to an appointment with the doctor at the clinic she was hospitalised. She died three days later.

> The criminalisation of sex work is a violation of human rights.

SWEAT wants to remember Natalie's spirit and mourn her sad and lonely passing. Her lack of access to proper care and support is an example of the lack of services overall for people living with HIV/AIDS. Natalie's death also highlights the severe stigma and isolation that sex workers face.

The continued criminalisation of sex work in South Africa has contributed to the stigma, isolation and violation of human rights of sex workers. Sex workers are forced to work in isolated and remote areas. These working conditions not only make them vulnerable to violence and abuse, but also make it very difficult for projects to locate them to do prevention work. More importantly, criminalisation forces sex work underground hampering sex workers' ability to organise themselves in any significant way to address their human rights needs.

It is for these reasons that SWEAT advocates for the decriminalisation of sex work in South Africa. In a decriminalised system sex workers would be able to access human rights as well as health, safety and legal services.

INTERVIEW WITH A SEX WORKER

conducted by Luckyboy Mkhondwane

Sex work is illegal in South Africa. Sex workers are harrassed by police and made to feel ashamed by society. Even the Constitutional Court has let down sex workers by refusing to decriminalise sex work. Therefore few sex workers are prepared to talk publicly about their life and work. But thousands of people across South Africa sell sex for a living and are forced to live at the margins of society.

It was almost noon when I got to the hotel in Brakpan where I was told I could find someone to talk to. The place had a number of people drinking and playing pool - on a Thursday, before noon! I introduced myself to the barman and told him what I came to do. He pointed out a group of women sitting in a corner and suggested I talk to them.

Only one of the eight women at the table was willing to talk provided I did not mention her name.

Dineo (name changed) is 24 and from Daveyton. She has been selling sex for almost three years now. She started sex-work because she could not find a job and she has just lost her mother who was the sole bread winner at home. For her there was no other alternative way to make a living, so she stood on roads and sold her body to passing motorists in order to survive.

"I think that the work I am doing should be made legal because for most of the women who do this it is the only means of income. I would not be ashamed of it if it was a recognised way of life," she said.

She moved from the roads because she had been arrested a number of times. Even at the hotel she experiences harassment from the police who regularly raid the place.

When asked if she ever experienced abuse from her clients she said, "Sometimes a client can beat you up, refuse to pay or force you to do things you don't want like anal sex."

> I would not be ashamed if sex-work was a recognised way of life.

It is very difficult for her to get help from the police, so she and her colleagues never report any form of violence they experience. Only if what she was doing was legal would her voice be heard.

Since it is not easy to get clients she charges extra for sex without a condom. Her regular fee is R50 but R80 without a condom. "I know I am risking my life because I have seen people die of AIDS. I just hope it does not happen to me."

She has experienced sexually transmitted infections and goes to different clinics for treament so that she does not get recognised by the nurses. Sometimes she uses different names. The reason she goes for medical help is because when she is sick she can't work. She has never had an HIV test and thinks it woud be hard for her if she found out she was positive.

"Maybe one day someone will give me a job because I don't do this because I like it`"

Photo: Luckyboy Mkhondwane

Dineo moved from the roads to the hotel because she was arrested a number of times.

WHAT MUST BE DONE?

WHAT YOU CAN DO

- **HELP BUILD A MUCH MORE ACTIVE AND EFFECTIVE WOMEN'S RIGHTS SOCIAL MOVEMENT IN SOUTH AFRICA** that campaigns vigorously against violence against women. Both men and women have a role to play in this movement.
  Start building it by organising the women you work with, live with in your street and worship with. Start in your street and link up with other organisations.
- **KNOW YOUR RIGHTS AS A WOMAN** – and **stand up** for them.
- Go for **regular PAP SMEAR TESTS**.
- **GET TESTED FOR HIV**. If you are HIV-positive, monitor your CD4 and viral load counts regularly. If you have AIDS or a CD4 count below 350, you need to consider going onto antiretroviral treatment.

Campaign goals for improving women's health

- Government policy must be changed to allow a free pap smear test every year (or two years) in the public sector for women over 30 and women with HIV.
- The mother-to-child transmission prevention programme should be part of a package of care that appropriately treats women. Women have the right to this and, furthermore, the health of its mother is crucial to a child.
- The new Sexual Offences bill needs to be improved significantly and come into law. The bill needs to address the inadequacies of the justice system in cases of abuse of women.
- Post-exposure prophylaxis needs to be widely advertised and more widely offered.
- The price of sperm washing needs to come down. This will enable HIV-negative woman to choose to be able to have children safely with their HIV-positive partners.
- The price of the female condom needs to be brought down. It needs to be distributed by government in much larger numbers.
- There needs to be sufficient investment in microbicide development (see pages 30-31 of the March 2006 issue of *Equal Treatment*).

LIST OF CONTACTS FOR HELP

National AIDS Help Line: **0800 012 322**
SWEAT: **021 448 7875**

Numbers to call for assistance if you have been raped or sexually abused

Bloemfontein:	051 447 6678
Cape Town:	021 447 9762
Durban:	031 312 2323
East London:	043 743 7266
Johannesburg:	011 728 1347
Kimberley:	053 831 1715
Mafekeng:	018 384 4870
Nelspruit:	013 755 3606
Polokwane:	015 297 7538
Port Elizabeth:	041 484 3804
Pretoria:	012 342 2222

TAC Offices

National:	021 788 3507
Western Cape Province:	021 447 2593
Khayelitsha District:	021 364 5489
Gauteng Province:	011 339 8421
Ekurhuleni District:	011 873 4130
Limpopo Province:	015 291 5448
Mpumalanga Province:	013 755 2298
Eastern Cape Province:	043 722 1966
Lusikisiki District:	039 253 1951
Queenstown District:	045 838 1364
Kwazulu-Natal Province:	031 304 3673
Pietermaritzburg District:	033 394 0845
Ilembe District:	032 552 5160

Where to get post-exposure prophylaxis

When you report a rape, you should be assisted with finding a site or doctor that provides post-exposure prophylaxis. All public antiretroviral sites should stock medicines for post-exposure prophylaxis (see a full list of antiretroviral sites on the TAC website, www.tac.org.za). The following private pharmacies sell antiretrovirals for post-exposure prophylaxis (but they must be prescribed by a doctor):

Johannesburg:	Morningside Dispensary	011 804 6901
Pretoria:	Hyperpharm	012 333 0233
Durban:	Atlas Pharmacy	031 202 9122
Cape Town:	Glengariff Pharmacy	021 434 8622
	Victoria Pharmacy	021 447 2850
Bloemfontein:	Willow Pharmacy	051 444 0978

IKHONA IMPILO NOMA UNELIGCIWANE LESANDVULELA NGCULAZA

ngu Nelsiwe Sithole

Sitfombe: Nelsiwe Sithole

UZandile Mahlangu uphila neligciwane lesandvulela ngculaza.

Ligama lami ngingu Zandile Mahlangu, ngineminyaka lengamashumi lamabili nemfica (29) ngihlala eNkangala, eSiyabuswa e-Mpumalanga. Ngiphuma emndenini lonakekelako nalonelutsandvo, lonebantfwana lababili. Futsi ngingumake wemntfwana munye futsi ngilindzele lomunye masinya. Ngemnyaka wa-1998 ngacala kukhwehlela kakhulu ngaze ngacabanga kutsi ngine TB ngaya emtfolampilo. Ngaya emtfolampilo ngayohlola kutsi anginaso isifo se TB na? Kwatfolakala kutsi anginaso. Kwatsi ngo 2002 ngavelwa libhande (shingles) ngendansi kwemabele ngaya emtfolampilo. Laphindze labuya futsi kuwowona lowomnyaka ngaphansi kwemabele futsi ngaphindzela emtfolampilo. Udokotela wangiluleka ngekutsi angihlolele ligciwane lesandvulela-ngculaza. Ngabona kukuhle, ngavuma kwenta luhlolo. Umphumela wabuya utsi nginalo leligciwane. Kepha abazange bangiluleke ngaleligciwane ngalesosikhatsi, batsi ngiphindze ngibuye ngemuva kwemalanga lasihlanu batongiluleka. Ngabuyela emuva kwalawomalanga lasihlanu bafike bangiluleka bangitshela nekutsi leligciwane alilapheki,ngavele ngakwamukela loko ngobevele bekute lebengingakwenta.

Ngabuyela ekhaya ngafike ngashayela sesi lucingo ngamtshela ngesimo sami wamangala kakhulu. Ngaphindze ngatshela make wami watfuka wafuna nekufa. Ngabatshela kutsi bangangikhaleli kepha babe nami kulesimo lengikuso. Bagcina sebakwamukela loko nami sebangamukela ngesimo sami ngekuhamba kwesikhatsi. Ngicale kutsatsa ma- *antiretrovirals* ngo March 2006 ngobe masotsha ami emtimba bekehlile angu (153) ngenca yekukhulelwa kwami. Ngahamba ngayojoyina inhlangano yekululekana emtfolampilo. Ngatfola umngani wangitshela ngenhlangano i-Treatment Action Campaign ngabona kukuhle kutsi ngiyijoyine. Ngayijoyina ngemnyaka lophelile ngoJune. Nyalo sengikhululeke kakhulu kunakucala ngenca yebangani lengibatfole kulenhlangano futsi sengitiva ngisekhaya. Umlayeto wami kubantfu utsi: "Bantfu abahambe bayohlolela ligciwane lesandvulela ngculaza. Kulaba labanalo ngitsi, ungajabula empilweni noma unalo ligciwane lesandvulela ngculaza."

"Ngabuyela emuva kwalawomalanga lasihlanu bafike bangiluleka bangitshela nekutsi leligciwane alilapheki,ngavele ngakwamukela loko ngobevele bekute lebengingakwenta."

"Bantfu abahambe bayohlolela ligciwane lesandvulela ngculaza. Kulaba labanalo ngitsi, ungajabula empilweni noma unalo ligciwane lesandvulela ngculaza."

HIV NEARLY DESTROYED MY FAMILY

as told by Bongi Skhosana to Lindiwe Ntuli

My name is Bongi Skhosana from Kwaggafontein. I am a member of TAC and I live with HIV. I am a 29 year old mother of three young children, one girl and two sons.

I knew about my HIV status after I lost my two sisters to AIDS. The first one died in 2002 because there were no antiretrovirals in the public hospitals. My second sister died in July 2005 due to Immune Reconstitution Syndrome (IRS).

My sister's CD4 count was only 2 when she started treatment and that was too low. The IRS activated pneumonia and cryptoccocal meningitis that eventually killed her.

I became scared that HIV was destroying my family so I went for voluntary counseling and testing. The main reason I decided to go for a test is that I did not want to see my mother go through the same pain again because this virus is tearing families apart. This virus is leaving orphans behind and is worsening poverty. The second reason is that I don't want to leave my children behind.

I tested at KwaMhlanga Hospital in September 2005. The test came back positive. I was angry and scared. But my CD4 count was high: 700. It came as no suprise to me that my results came back positive because my boyfriend was living openly with the virus. He was always encouraging me to go for a test even after the birth of our son.

Bongi got tested after two of her sisters died of AIDS.

I would like to thank the staff at KwaMhlanga wellness clinical staff for their support and encouragement throughout my ordeal. I disclosed to my boyfriend when I came back from the clinic and he comforted me. He then encouraged me to disclose to my family.

> Bongi went for an HIV test because she did not want her mother to lose another child.

I knew it was going to be hard for my mother because she had already lost two daughters to HIV but I had no choice, I had to tell her. She was so emotional when I told her though. I assured her that I will take care of myself and that I was not going to die.

I am determined to beat the virus that my sisters succumbed to. At first it was difficult for me to accept my status but I had to and I have moved on.

I attended a TAC Kwagga branch treatment literacy workshop and I started to understand the science of HIV and its treatment. The workshop became an eye opener for me about ways of living with the virus because now I had enough knowledge to deal with this illness.

I became a full member of TAC and this has helped me accept my status. I am now the chairperson of the People with HIV/AIDS sector in KwaMhlanga sub-district.

COMING TO TERMS WITH RAPE

by Georgina Booysen

My name is Georgina Booysen. I was born in Paarl in Klein Drakenstein in October 1967. I have been married twice - with the same man. I've got three children. I like to sing, dance and model.

On my 21st birthday in 1988 I was going with a friend of mine to Bellville South. It was the first time I went there. That night my friend, a male friend of her and I went to celebrate my birthday. I got drunk and told her that I wanted to go home. She told me she was going home then but instead sent her friend to go home wth me. I agreed because I didn't know the place.

We walked through the bush and then all of a sudden he pushed me down on the ground and he raped me. At that time I could not believe this was happening to me. I was crying and the pain between my legs was very heavy. When he was finished he said that if I told anybody he would kill me.

After that night my life was not the same anymore. When I got home I did not know how to look at my grandma's face. It was as if she knew what happened to me.

After a month I didn't get my period. Two months went by. Then after three months I went to the doctor. He examined me and told me I was pregnant. I thought I would kill myself. I started to cry and he asked me what was wrong. Then I started to talk with tears in my eyes. When I had finished the doctor said I should tell someone, but at the time I could not talk to anyone.

The day after I went to the doctor

I went looking for the man who raped me. I found him. I told him that I was pregnant and he replied that it was not his child.

I was sick with worry. What would my grandma say? I was so tired so I went to a place called Aberdeen for six weeks where I stayed with a female friend.

For the nine months while my child was growing in me it was like a death sentence. When she was born I looked at her and decided not to give her away.

Two years later, in 1991, I got married. In the same year I gave birth to a baby boy. Four years later I gave birth to another baby girl. After over five years of marriage I divorced my husband and worked alone for my kids without any support from their father.

Then I started to do modelling work again while I was still working. In 2002 I remarried my husband and a year later I realised I had made the biggest mistake in my life.

Later I opened a shop in my house. That's how I live. In 2002 I started working as a volunteer at our local radio station. There I got involved with a lot of organisations and I got introduced to a TAC volunteer. He told me all about TAC and I decided to join.

I have been a TAC member for two years and it has changed my life. Here we are a family. We don't discriminate and people understand our situations.

After a year in TAC I decided to tell my story. TAC members did not discriminate against me or gossip about me.

Today I have a beautiful 17-year-old daughter, a son and a baby daughter. I told my daughter about the rape last year in November and we talked about it the whole night. Now we are very close friends. I'm glad that I kept her. I have forgiven the man who raped me because through all my pain and suffering I have grown strong.

My plans for the future are to help more people in my community and achieve the goals I had before I was raped. Life goes on.

TAC appeal for funding

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

SUPPORT US TO SAVE LIVES

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

DONATE NOW

TAC
TREATMENT ACTION CAMPAIGN

treat 200 000 by 2006

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

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

Equal Treatment
June 2006

HIV/AIDS TREATMENT IN UGANDA

by Milly Katana, Health Rights Action Group-Uganda

On the face of it, Uganda has an excellent antiretroviral treatment programme. But there are actually many problems that threaten patient welfare and create inequalities.

"I started treatment in May 2005. I was very ill; by June, my condition worsened," recounts a woman receiving free antiretrovirals from the Infectious Diseases Institute (IDI) in Mulago. She adds, "in July, my relatives were waiting upon my last breath". She says that all through that ordeal, she insisted on taking her antiretrovirals. She had been cautioned by her caregivers that she had to take her drugs always. Telling her story on 1st January 2006, this woman was back on her feet, looking after herself and had hope for the future. She was also now able to look for work.

There are so many similar stories all over Uganda by people whose hope had vanished because they could not afford the cost of antiretrovirals. Hope was restored when they received free treatment in the past year. Uganda is estimated to have one million people living with HIV/AIDS. This is about 7% of the adult population. It was estimated that about 120,000 Ugandans needed antiretrovirals by end of 2005. With the advent of the 3x5 goal in 2003, this estimate was revised downwards to 60,000.

Uganda is one of the few countries to not only meet but also surpass its 3x5 target. By May 2005, official statistics indicated that 64,000 people were on treatment, from under 10,000 before the 3x5 goal.

Whatever the magic, Uganda remains in the limelight like a poster child on the HIV/AIDS front. There is so much publicity over antiretrovirals that their increased availability has enhanced uptake of voluntary counselling and testing services. Laboratory capacity to monitor patients on treatment has improved over the years. The cost of laboratory tests has also come down from Ugshs 150,000/= (R500) in September 2004 to Ugshs 30,000/= (R100) now.

However, equity in HIV/AIDS treatment remains far from being a reality. Whereas only 12% of the population lives in urban areas, the majority of those receiving treatment are in urban areas.

Government abolished user fees in public health facilities except hospitals with private wings. But HIV/AIDS treatment continues to be provided largely by private not-for-profit (PNFP) facilities and their satellite centers situated in government facilities. However, the number of patients is overwhelming the private sector capacity to deliver quality care.

Government and the local administrations, which govern health facilities in districts, have minimal influence over what happen in these facilities. Private-for-profit (PFP) facilities are also becoming major providers of antiretrovirals and private facilities set their own fees. Many of these facilities are supported by international organizations including PEPFAR. Therefore, the fees charged are highly subsidized. However, given that HIV/AIDS hits the lower income bracket mercilessly, any form of payment for HIV/AIDS care stands in the way of adherence. Some patients have to go from one facility to another in order to seek the least costly care. This contributes to double and multiple counting in

the reported numbers of individuals receiving treatment. The number also includes "defaulters" who are unable to continue treatment because they cannot meet the costs of care.

One can comfortably say that health sector reforms in Uganda have failed. HIV/AIDS treatment is being provided in a system that is marred by corruption, lack of accountability, ongoing drug stock-outs including TB drugs, and sit-down strikes by health care workers in public facilities.

Health care workers have trouble following treatment guidelines. For example, whereas the 2003 guidelines recommend a once daily dosage of ddI 400mg, some patients indicate that they are taking 200mg twice a day. Given that the drug is best absorbed on an empty stomach, dosage that is more frequent can result in poor adherence or malabsorption when taken shortly after the evening meal.

Whereas it is relatively easy to have an HIV test, being screened for eligibility and consequently accessing affordable treatment remains a struggle for many. The Minisry of Health goal is universal access to treatment. However, it encourages tiered eligibility criteria which excludes some from free treatment. Free treatment is still very limited. Independent donors, as expected, have allocated limited supplies to different PNFP facilities. For example, TASO Mulago centre, the oldest and biggest provider of HIV care in the country, received enough drugs for only 1,000 patients from PEPFAR. It looks after more than 40,000 patients. The centre now has to make choices over which patients to treat.

This situation has left many patients without access to treatment even though they meet the medical criteria. Patients are forced to move between facilities trying to find one that will treat them.

Other facilities maintain that those patients who were on antiretrovirals before the 3x5 inspired rollout of free treatment must continue to pay for them. This is irrespective of the fact that many of these patients started treatment in anticipation of free treatment and as a panic act to stay alive. Many such patients have sold their properties in order to maintain the treatment. Some of them have had to stop treatment because they could not pay for second line regimens whose prices are way beyond ordinary Ugandans' income. Many PNFP and PFP facilities continue to demand consultation fees from such patients, in addition to paying for the drugs.

"There is no mechanism in many facilities to follow-up on paying patients. They work like grocery stores; waiting for buyers of their merchandise," commented a patient who has been paying for her treatment since 2000. "If I do not pick my drugs up, that is fine for my care givers."

For facilities receiving donated drugs, some patients who fail on first-line regimens are left with limited second-line regimens. Health care workers are forced to keep patients on ineffective regimens because of a lack of options.

Whereas challenges for accessing HIV/AIDS treatment persist, for those who have "hanged-in" there, there is reason to smile. "Having been on treatment for four years, I have now gone back to study in high school," brags a 32 year old who works at one of the care providing centres in Kampala. "Many of my friends are now doing developmental projects including building houses".

In conclusion, one can say that until financial and structural barriers are removed, equity in universal access to treatment will remain a dream.

Sources: Ugandan Ministry of Health Documents: STD/HIV/AIDS Surveillance Report 2005 and Preliminary Results of the Uganda HIV/AIDS Sero- Behavioral Survey 2005.

Uganda Bureau of Statistics and ORC Macro. Uganda Demographic and Health Survey, 2000-2001. Kampala, 2001.

Katana M. Utilization of Formal Health Care Services and Associated Factors in Uganda: A case study of Luweero District. MUCHS, Dar es Salaam, 2005.

US Presidential Emergency Plan for AIDS Relief

MOH, Republic of Uganda. National Antiretroviral Treatment and Care Guidelines for Adults and Children. Kampala, November 2003

The AIDS Support Organization (TASO)

Photos courtesy of Milly Katana

Equal Treatment
June 2006

TREATMENT LITERACY: TAC MEETING LINKS INTERNATIONAL ACTIVISTS

by Simon Collins

Treatment activists from India, Malawi, Russia and South Africa disscuss how we can support our health care systems with a South African nurse at the TAC/i-Base Global Treatment Literacy meeting.

On 1-2 April, 45 treatment advocates from 23 countries, met in Cape Town to learn from each other and to become stronger in our demands for better support for treatment literacy in antiretroviral programmes. The meeting was organised by TAC and i-Base – a treatment information project based in London, UK.

Treatment literacy starts every time you ask your doctor a question, or when you discuss HIV with your friends. It can be simple questions like 'what is a virus?' or 'why is my CD4 count so important?' Without treatment literacy, antiretroviral programmes only do half the job.

> Treatment educators have experience and time to help in under resourced and overburdened health care systems.

When antiretrovirals have been given without information, people develop resistance because adherence support is low, or continue with side effects instead of managing them or changing drugs.

One delegate from Zambia described a person who came to a conference, ran out of medicine, came home, counted the days missed then took it all at once. He died.

Many organisations, including TAC, address treatment literacy in

Treatment literacy starts every time you ask your doctor a question, or when you discuss HIV with your friends.

It can be simple questions like"what is a virus" or "why is my CD4 count so important".

workshops, publications and other non-technical resources. However, many countries have little printed information, and when it is produced it is not in every local language. What is available, often cannot be understood by rural communities.

The urgent need for community educators in many countries is directly related to the strain on doctors and nurses in countries with high HIV incidence. Treatment educators have experience and time to help in these under resourced and overburdened health care systems.

These issues are important in South Africa. They are important in Namibia, Ghana, Swaziland, Kenya, Mozambique, and Zambia – countries we know well – but also Nepal, Ukraine, Russia, Portugal and India – that most of us only know from a map. But we share similar problems and can help each other.

It was clear that resources have to be very specific for the communities that use the information. Material produced in Zambia will need to be adapted for use in India – though the subjects may be very similar. Specific resources may be needed for children or deaf people. Some subjects need to be tackled directly – like how to balance benefits of antiretrovirals as something that does not have to be in opposition to some traditional medicines.

But some information is constant and easy to adapt. There is no need to reinvent the wheel – but you have to make sure that it fits your car!

Above: Treatment literacy materials from the Plus and Minus *Foundation in Bulgaria.*

Literature from Nava Kiran Plus *in Nepal.*

From HIV i-Base *in the UK. For further treatment literacy material go to: http://www.i-base.info/guides*

Photos: Polly Clayden

OUR RIGHTS IN OUR COURTS

Westville prisoners fight for treatment

Prisoners at Westville Correctional Centre in Durban are fighting for their lives as their campaign for access to antiretroviral treatment enters its seventh month.

The AIDS Law Project (ALP), acting for the prisoners, brought the matter to the attention of the Department of Correctional Services (DCS) in October 2005.

At meetings with the DCS and Department of Health (DoH) in December, government promised to accelerate access to treatment. This did not happen. Therefore, the prisoners took the DCS to court to compel it to provide antiretrovirals.

If the DCS does not give prisoners access to treatment, the case will be argued on 30 May.

TAC wins case against Rath

The Cape High Court recently ruled in favour of the TAC by stopping vitamin salesman Matthias Rath and his foundation from claiming that TAC is a drug company front and/or in the pay of drug companies. The interdict – the order preventing Rath from making such claims – will remain in force until TAC's main case against Rath is concluded. That case, in which TAC is suing Rath for defamation (spreading malicious lies about the organisation that damage its reputation), is not expected to go to trial until later this year or even in 2007.

TAC takes more action against Rath

Together with the South African Medical Association (SAMA), TAC has taken further legal action against Rath, his foundation and his agents. In this third case, which is also directed at the South African government and various of its officials and bodies (such as the Minister of Health and the Medicines Control Council), TAC and SAMA have asked the Cape High Court to stop Rath and his agents from carrying out unlawful experiments on people, distributing his unregistered medicines and making false claims about his medicines. TAC and SAMA have also asked the court to find that the government has acted unconstitutionally by failing to stop Rath's illegal activities.

De Lille and Smith case reaches the Constitutional Court

Independent Democrats Leader, Patrica De Lille, and journalist, Charlene Smith, disclosed the names and HIV status of three poor women without consent. But even as the case was argued before the Constitutional Court they denied that they had acted unlawfully.

At issue is whether the Constitution requires that the law of privacy be developed so that it imposes a duty on those who publish the private medical facts of another to act reasonably.

The AIDS Law Project, which acted on behalf of the three women living with HIV, argued that Smith should not have used the women's real names in the biography she wrote about de Lille. If she was unable to establish whether the women had in fact consented to their private medical facts being disclosed, she should have used pseudonyms instead. As a result of the disclosure, the three women suffered irreparable harm.

Smith and De Lille's lawyers argued against the development of the law, saying that all it should require of people like their clients is that they do not intentionally disclose private medical facts. But even if the law were to be developed, they argued, Smith and de Lille should not be held legally liable for the harm suffered by the women, as it was reasonable for them to assume – incorrectly it turns out – that consent had been granted.

The court is expected to rule in a few months.

LETTERS FROM OUR READERS

WINNING LETTER

WHAT TO DO ABOUT PAINFUL LUMPS?

I am a person living with HIV for the past five years with no problems at all. Now I have developed lumps under my arms and in my private parts. They are very painful. My skin is itching but there are no rashes.

From Thandi (name changed)

TAC RESPONDS:

It could be many things including eczema or scabies. The itching and lumps are not necessarily related. You must see a doctor.

PEPFAR AND SEX WORKER RIGHTS

The March issue of Equal Treatment apologised for stating in the December issue that PEPFAR funds are not subject to the US Global Gag policy. The apology was unnecessary because the December issue was correct.

The former US health attaché confirmed in a public meeting of the 6th Joint Civil Society Monitoring Forum in November 2005 that recipients of PEPFAR money must sign the sex worker declaration.

Three projects that receive PEPFAR money also reported that they had to sign this declaration.

While PEPFAR funds can be used to treat sex workers, they may not be used to promote the decriminalisation of sex work.

From Fatima Hassan, AIDS Law Project

PEOPLE WITH HIV RESPOND WELL TO TB TREATNMENT

The October 2005 issue of Equal Treatment focussed on TB. It states (page 5) that people with HIV do not respond well to TB treatment. This is inaccurate.

Although there is higher mortality amongst persons with TB who are co-infected with HIV, cure rates are no different. The cure rate is the percentage of people who successfully complete their TB course and no longer have TB.

The most important reason for knowing the HIV status of persons with TB is so that they access antiretrovirals. 36% of our patients in Stage 3 and 4 get TB each year. Antiretrovirals can reduce this by 60%.

From Dr. David Coetzee, UCT School of Public Health

Write a letter

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

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

Write, fax or email to:

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

Photo: Adam Malapa

The March issue of Equal Treatment *was tremendously popular. We printed 40,000 but ran out of stock and had to print an additional 3,000.*

EQUAL TREATMENT QUIZ

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

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

1. What percentage of women over two years old are infected with HIV in South Africa?
2. What percentage of women living in Soweto had transactional sex according to a 2003 survey?
3. True or false: Women under 18 must obtain permission from their parents before having an abortion.
4. What type of cancer is a pap smear used to diagnose?
5. What is the name of the form that must be completed when a woman reports being raped?
6. Within how many hours of being raped must a HIV-negative woman access post-exposure prophylaxis?
7. What are the two usual antiretroviral medicines prescribed for post-exposure prophylaxis?
8. For how many days must post-exposure prophylaxis medcines be taken?
9. What is the usual treatment for genital herpes?
10. What chemical is sometimes used to burn off HPV warts?
11. Name an antifungal used to treat vaginal thrush.
12. What was the name of the TAC activist murdered at a shebeen in Khayelitsha in December 2003?
13. Name the process that makes it possible for an HIV-positive man to impregnate an HIV-negative woman safely?
14. Name three contraceptives.
15. What are the two antiretrovirals used in the public health system that are most likely to cause lactic acidosis?

How to enter

Send your answers, numbered 1 to 15, by post, email or fax. You must include your correct name and postal address. This competition is not open to TAC employees or current recipients of treatment literacy bursaries. Closing date for sending entries is 30 June 2006.

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

Participants in a treatment literacy workshop in the rural town of Giyani, Limpopo. Photo: Adam Malapa

TAC Gauteng Provincial Executive Chairperson, Isaac Skhosana, outside the Johannesburg High Court during the Zuma rape trial.

IT'S ME AND YOU

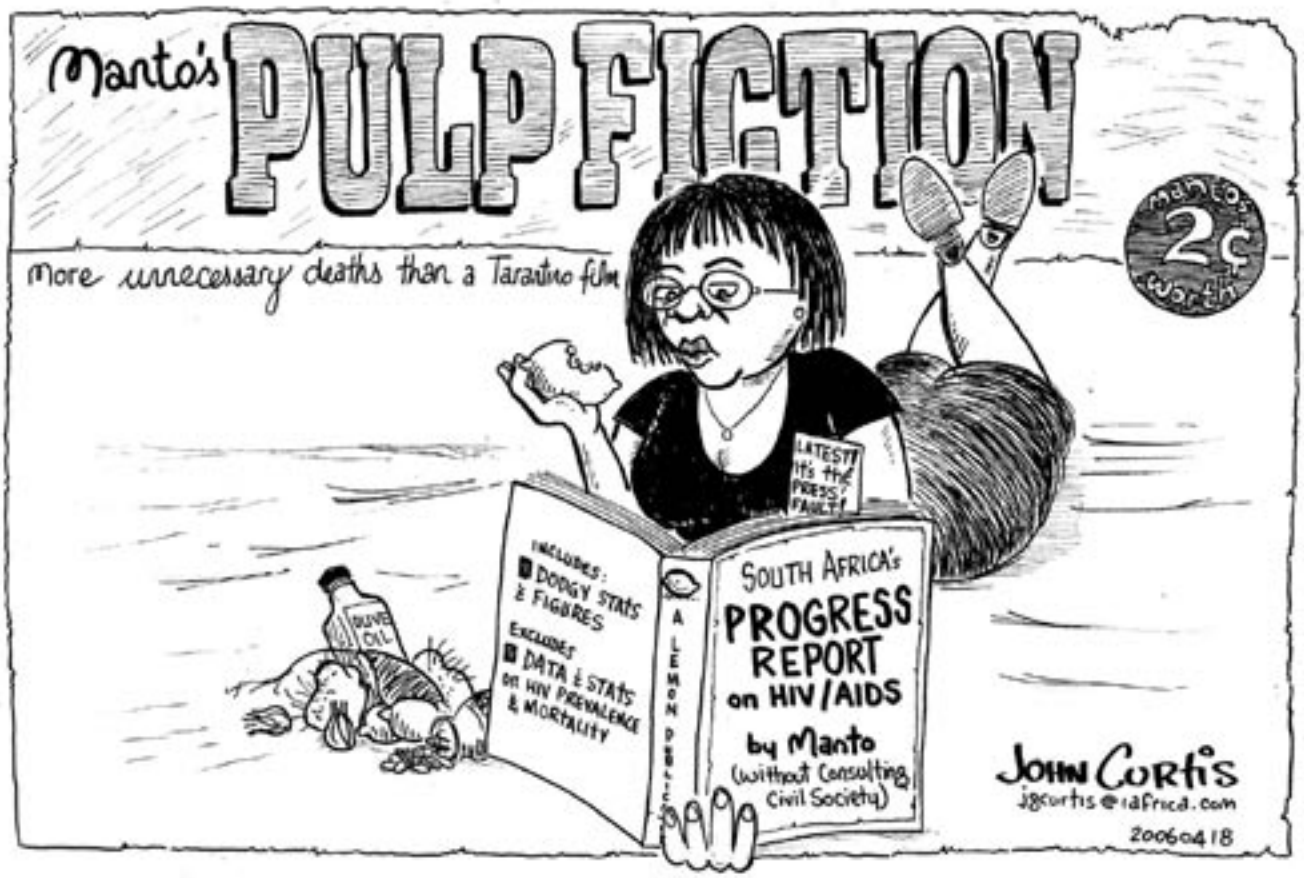
By Sylvia Fynn

Ok you gave me no choice.
Like a thief you creeped into my life. Like a vulture you fly around, hunting. Always on the lookout. For the bodies you can prey on. You are clever and you are quick I can give you that. For you don't wait for a minute or a day.

Well this is another century.
You shall rule our world no more
There is a force out there stronger than you can ever be. There is a unity that you can never break. A unity of TAC. A force that's a lookout for every corner of the body you attack. A force that knows where you attack and the damage you create.

You are a visitor in my body.
But you cannot overtake your host.

If I go down, you go down with me. But I choose to stick around. I have dreams and ambitions to fulfil. I know you'll never go down completely. But I sure will weaken your powers. And slowly with time, you'll be so weak. That you'll wish you never messed with me.



Production schedule for June/July 2006:

4	*June*	*Living with PLWHA*
11	*June*	*Food Gardens*
18	*June*	*Condoms in Schools*
25	*June*	*Tertiary Institutions*
2	*July*	*Best of Beat It*
9	*July*	*Lesotho*
16	*July*	*Children on ARVs*
23	*July*	*Water and Sanitation*
30	*July*	*Faith Based Communities*

This cartoon, by Argus cartoonist John Curtis, was part of the portfolio that earned him a place amongst South Africa's five top emerging cartoonists in 2004, and was part of the resultant international exhibition in London and Johannesburg during 2005. It is published for the first time here in Equal Treatment.

The South African Democratic Teacher's Union, Chris Hani Institute, Gender AIDS Forum, Rural AIDS and Development Action Research Programme, Triangle Project, AIDS Law Project, TAC and Masimanyane held a prevention summit and march on 23 April 2006 to coincide with the opening of the International Microbicides Conference. The next issue of Equal Treatment will focus on HIV prevention.

OWAMI & PHINDILE MADONSELA

"Antiretrovirals prevented my child from getting HIV."

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TAC TREATMENT ACTION CAMPAIGN