TAC Electronic Newsletter

By *moderator*
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(1 of 2 Newsletters for 16 February 2006)

Contents

In Brief

- TAC expresses its condolences to the Khoza family on the passing of Zodwa Khoza. We welcome Irwin Khoza's courage and openness in declaring that Zodwa dies of AIDS. This will contribute to the destigmatisation of the HIV epidemic.
- Joint Seminar on the Right to Food: Hosted by COSATU, NALEDI, the AIDS Law Project & the Chris Hani Institute.
  Venue: Elijah Barayi Training Centre
  Date: 21st February 2006
  Time: 9am to 3pm
- Schedule for South Africa's television series guide to living with HIV/AIDS - *Siyayinqoba Beat-it* (1:30pm every Sunday on SABC 1, repeated on Mondays at 8:00am):
    - 26 Feb Disabilities
    - 5 March: Mental health
    - 12 March: HIV and media
    - 19 March: Handling death and loss
    - 26 March: VCT vs routine testing
    - 2 April: Vaccines and prophylaxis
    - 9 April: Nutritional supplements

TAC launches manifesto for health and accountable local government

Today, TAC launched its manifesto for health and accountable local government. The whole manifesto can be read here . Below is an extract of the manifesto.

TAC's Position on the Local Government Elections

TAC encourages everyone to vote in the local elections on 1 March 2006. We have fought and shed blood for democracy in South Africa. The vote is our right and we should exercise it. Many of our communities are disillusioned with our local government and ward councillors. Many councillors are corrupt and do little for our communities. But the vote and activism can change that. It is our opportunity to make local government accountable. TAC is not endorsing any political parties in this election. Who you vote for is your choice.

In key districts TAC will challenge local government candidates to explain how they will be held accountable for health services. We will ask candidates to affirm that HIV causes AIDS and that people with AIDS should have access to antiretroviral treatment.

We will actively campaign against candidates who are AIDS denialists.

We need People's Health Services: This means having access to healthy living conditions including food, running water, flush toilets, electricity, decent housing, social security, decent education, freedom from violence and proper medical care.

Continue reading the manifesto here.

Example activities

Here are examples of what our members will be doing up till local elections.

Umtata, Eastern Cape

Many areas around Umtata have no proper sanitation and no electricity. Some communities still rely on mobile clinics that come once a week (despite Umtata being a major Eastern Cape city). A team of 25 TAC members will spend eight days in Umatata meeting with community leaders and ward councilors, key stake holders, presenting the TAC manifesto and distributing the manifesto from door-to-door. On 24 February, TAC will have a mass rally in Umtata challenging all the political parties to to answer our questions and demands for accountable service.

Gauteng

TAC's Gauteng members are conducting door-to-door campaigns explaining the manifesto. Two public meetings are planned, one in Seibeng on 18 February and another in Katlehong on 28 February. Election candidates have been invited to present their plans for their communities.

Khayelitsha, Western Cape

TAC Western Cape members have already held meetings throughout Cape Town presenting the manifesto to communities. TAC members also attended the Cape Town mayoral debate at the Centre for the Book last night. In Khayelitsha, TAC has organised with taxi drivers to distribute pamphlets and condoms. Meetings are being held throughout the township. A key them of TAC Khayelitsha's activities is campaigning against violence against women. TAC is participating in a public meeting on this issue on 25 February against gender violence.

Delmas, Mpumalanga

TAC Limpopo will work with the Delmas community to put pressure on local government for better services. This will culminate in a mass rally on 27 February in Delmas. Last year TAC members exposed government's underestimation

of the death toll due to a diarrhoea and typhoid outbreak. Service provision in Delmas is very, particularly sanitation, refuse removal and clean water. The quality of the hospitals and clinics in Delmas also needs to be improved.

Vhembe and Bohlabela, Limpopo

TAC will focus on greater delivery of HIV services in Limpopo, which has one of the poorest antiretroviral rollouts in the country. Meetings and door-to-door campaigns are taking place in a number of areas. On 28 February, public meetings will be held which local election candidates will attend. A number of AIDS service organisations will also attend and question candidates on their plans for improving delivery of HIV services.

[END OF MANIFESTO EXTRACT]

Jacob Zuma's supporters must show respect for women's rights

The Treatment Action Campaign is dismayed at the conduct of the Friends of Jacob Zuma Trust, the ANC Youth League and the Young Communist League during the demonstrations outside the trial of Zuma for rape that started this week.

TAC agrees that all people, even those accused of violent crimes like rape, have a right to be presumed innocent and to a fair trail. However, the large demonstration was not about this. The demonstrators instead attempted to intimidate the woman alleging rape by heckling, insulting and even throwing objects at her. Women in South Africa face the threat of violence on a daily basis. To subject a complainant in a rape case to threats and intimidation demonstrates callous contempt for all women and for the constitutionally protected human rights that form the cornerstone of our hard won democracy.

By suggesting that the accusation of rape is made up, the demonstrators launch an attack on a person who alleges she has already suffered violence, has had to go through the trauma faced by many women of deciding whether to seek support from the legal system and to trust in a judiciary that often fails women and has conviction rates of less than 10% for both rape and domestic violence.

In South Africa rape and sexual violence against women and girls are significant drivers of the HIV epidemic. Violence against women is a daily attack on the dignity and equality of women, and our social values. A demonstration that belittles this reality, and further reinforces women's exposure to violence, is a tragedy that demands immediate intervention from the police to ensure safety and to hold accountable those breaking the law .

The Treatment Action Campaign has a firm commitment to promoting gender equality, to ending domestic and sexual violence and to mobilizing men and women for gender justice.

We call on Jacob Zuma to insist that his supporters respect the rights of the complainant. We also call on the Friends of Jacob Zuma, and all organizations committed to his defence to respect the rights and dignity of the complainant in the case and of the judicial system in general. Given the extremely low conviction rates for violence against women, TAC also calls for the criminal justice system to be given the resources needed to address rape and other forms of violence against women. Lastly TAC urges all South Africans-men and women alike-to take a stand against domestic and sexual violence in our homes and in our communities.

[END OF STATEMENT ON ZUMA TRIAL]

MSF statement

MSF remains as committed as ever to HIV/AIDS care in Khayelitsha

There have been a couple of recent news reports recently stating that Médecins Sans Frontières (MSF) is leaving Khayelitsha. One report claimed that MSF will pull out by April. These reports are incorrect. Specific activities are being gradually handed over to the relevant authorities, but MSF has no plans to leave Khayelitsha.

In early 2000, MSF together with the health department of the Provincial Government of Western Cape started to offer comprehensive services for people with HIV/AIDS. In May 2001 this site became the first public sector antiretroviral treatment programme in South Africa. At that time we committed to a five-year plan to treat 180 patients. With approval of national HIV treatment and prevention plan in 2003 enrolment increased dramatically. Today over 3,000 patients are benefiting from the ARV services in Khayelitsha.

Initially MSF provided the medicines and medical staff, but over time, the resources and commitment coming from the provincial ministry of health has scaled-up significantly, and MSF has been able to withdraw from certain activities. In late 2004 we handed over the supply of antiretroviral medicines. The number of MSF doctors working in Khayelitsha has been reduced from four in 2003 to two today. Nursing staff for the antiretroviral programme, previously coming from MSF, are today all employed by the province. Administrative staff are still largely provided by MSF and the University of Cape Town.

At the same time, other activities have been started up. A programme to provide integrated services for HIV and TB (the Ubuntu clinic) was started in late 2003; in September 2004, a youth centre promoting awareness and prevention of HIV among this high-risk group was launched; the Similela centre, which provides comprehensive services for rape survivors, was established in August 2005. Each of these projects will need considerable support from MSF for some time to come. In addition, the number of people on antiretrovirals in Khayelitsha is projected to double in the next 12 months, reaching 6,000 by the end of the year. MSF is ready to assist in the development of models of care to cope with the increasingly large numbers.

Research to improve clinical practice will also remain an important focus for MSF. By closely monitoring all patients as they are put on antiretrovirals we have been able, together with our collaborating colleagues at the University of Cape Town, to document and share a number of important lessons for providing effective care for people with HIV/AIDS. These activities will continue over the coming years.

By handing over of certain aspects of the programme, MSF is able to free up resources that allow us to provide services elsewhere. Last month we opened a new HIV care programme in Lesotho that aims to treat around 600 patients by the end of the year. It is an important part of our role as an international medical relief organisation to take the lessons learnt from the success of Khayelitsha and apply them elsewhere to prevent unnecessary illness and death.

So while we are in the process of handing over clinical and management responsibilities for the three community health centres, this does not mean we are leaving Khayelitsha. We maintain a strong commitment to HIV care in Khayelitsha. Our collaboration with the provincial health services, the University of Cape Town, the Treatment Action Campaign and other local NGO partners is as strong and necessary as ever. Scare stories about MSF leaving serve nobody, least of all the patients who are left confused about their future care.

Issued by Médecins Sans Frontières

[END OF MSF STATEMENT]

Memorandum to Minister of Health

The following memorandum addressed to the Minister of Health in Khayelitsha was handed over to her spokesperson Sibani Mngadi on 14 February.

Memorandum to Minister of Health

Khayelitsha
14 February 2006

Dear Minister Tshabalala-Msimang

END AIDS DENIALISM! HOSPITALS AND HEALTH-WORKERS FOR KHAYELITSHA!

Khayelitsha has become a model for the whole world on how to manage the HIV epidemic in a poor area. Here, government officials and NGOs like TAC and MSF have worked together to create what the United Nations calls a best practice. We have shown that a comprehensive response to HIV is possible in the developing world.

Here community organisations work together to campaign against violence against women. We distribute condoms and promote sex-education in schools. We help members of the community to access social grants so they can eat enough. Medicines are provided to people with HIV for their opportunistic infections. Mother-to-child transmission prevention of HIV is implemented using both AZT and nevirapine, resulting in greater reductions in transmission than the rest of the country.
We have shown that treatment using highly active antiretroviral treatment is possible in a resource-poor setting. We have over 3,000 people on treatment at three clinics and this is expected to rise to 5,500 by the end of 2006. Our results have been excellent with more than 80% of our patients still alive after four years. Nearly everyone of them would have been dead without treatment.

However, to continue succeeding the Khayelitsha HIV programmes need the support of the National Department of Health. To be frank, Minister, we have not received this support so far.

End Denialism

You have personally supported Matthias Rath who has tried unsuccessfully to destroy Khayelitsha's HIV programmes. Rath and his agents have been directly responsible for the deaths of members of our community.

We have always agreed with you that nutrition is important. That is why we campaign for social grants so that people can afford to eat. That is also why we distribute a fact sheet on nutrition. It is unfortunate that your department, which claims to be concerned about nutrition, has never done the same.

We call on you to

- condemn Rath and his agents and
- encourage people to get tested for HIV and, if necessary, get treated using highly active antiretroviral treatment.

Allow us to Stop Nevirapine Resistance

Many women who use nevirapine for mother-to-child transmission prevention develop resistance to this medicine, thereby limiting their future treatment options. This can be avoided in most cases by giving women with HIV AZT/lamivudine for seven days after they give birth.

We therefore call on you to allow Khayelitsha's treatment sites to give AZT/lamivudine to pregnant women for seven days after they give birth.

Khayelitsha Needs Resources

The Khayelitsha clinics are overburdened. Members of the community are using to the three clinics in ever larger numbers because they have know they can be helped. But our health workers are working under enormous pressure and patients have to endure long queues and sub-optimal service because the clinics are under-resourced. One clinic alone in Khayelitsha (Site B) saw more than over 2000 new TB patients last year. This is unmanageable.

We therefore call on you to

- extend HIV and TB services to other community health centres across Khayelisha,
- to address the chronic shortage of nursing staff and
- support the building of a new hospital in Khayelitsha.

As always, TAC is willing to work with you and the National Department of Health. We ask you to make the same commitment.

Forward to a People's Health Service!

Signed

Mandla Majola
TAC DISTRICT CO-ORDINATOR

and

Vathiswa Kam-Kam
TAC WC PEC CHAIRPERSON

[END OF MEMO TO MINISTER]

How we know antiretrovirals work: Evidence from Africa

Installment 3

Zambia's Ministry of Health has just announced results of its antiretroviral programme. Over 22,000 patients in the Lusaka area are now on treatment. The programme shows unequivocally the massive benefit of antiretroviral treatment in people with AIDS.

For patients with CD4 counts below 50 cells/mm3 at the time they started treatment, more than 90% are still alive after 15 months. In a historical control group from before antiretroviral treatment was available, all patients with CD4 counts below 50 who did not receive treatment and followed up over 15 months had died.

For more on this story see:
http://www.aidsmap.com/en/news/B67B5B29-EAFE-4563-A98E-539EA9086356.asp

Below is the abstract of a paper presented on the Zambian programme at the 13th Conference on Retroviruses and Opportunistic Infection recently held in the United States.

From: http://www.retroconference.org/2006/Abstracts/27048.HTM

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Background: Massive scale-up of HIV care and treatment services is currently underway in a number of developing countries. Whether these efforts will translate into favorable long-term outcomes is not fully known.

Methods: We report on programmatic outcomes from 18 public and private clinical sites across 3 provinces of Zambia. Clinical care has been standardized according to national guidelines. Initiation of ART is dependent upon World Health Organization (WHO) clinical staging and CD4 cell count. First-line drug regimens are zidovudine (ZDV) or stavudine (d4T), plus lamivudine (3TC), plus nevirapine (NVP) or efavirenz (EFV). Individual-level outcomes data are collected through a computerized record system and standardized chart review.

Results: From April 2004 to August 2005, we enrolled 18,075 adults into a government HIV care and treatment program, and started 11,074 (61%) on ART. Of those starting ART, 6806 (61%) were women. Among those commencing ART, mean CD4 was 131 (IQR 52 to182), mean body mass index was 21.3 (IQR 17.9 to 22.4), and 8009 patients (73%) were WHO stage III or IV. Over 81,248 patient-months, 1269 patients died (crude death rate 0.016 deaths/patient-month); 43% of deaths occurred in patients with entry CD4 £50 and 53% of deaths occurred within 60 days of enrollment. In a multivariable Cox regression, restricted to those on ART, risk of death was strongly associated with entry CD4+ count £50 (adjusted hazard ratio [AHR] = 2.1, 95%CI 1.8 to 2.4), WHO stage III or IV (AHR = 1.9, 95%CI 1.5 to 2.4), body mass index <16 (AHR = 2.2, 95%CI 1.8 to 2.5), hemoglobin <8 (AHR = 2.6, 95%CI 2.2 to 3.1), and male gender (AHR = 1.4, 95%CI 1.2 to 1.6). At least 6 months of follow-up was given 11,854 individuals to allow assessment of CD4 response. Those starting ART (n = 8284) had a greater mean increase in CD4 at 6 months (+61 vs +5 cells/mL; p <0.0001) and at 12 months (+85 vs ?23 cells/mL; p <0.0001) than those not on ART.

Conclusions: Rapid initiation of ART in a programmatic setting led to favorable clinical outcomes at 6 and 12 months in Zambia. Advanced HIV disease was a very strong predictor of mortality in this population, suggesting that every effort should be made to identify and treat infected patients earlier in their disease course.

[END OF INSTALLMENT]

- Jacob Zuma
- South African Government
- Treatment
- Treatment Literacy

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