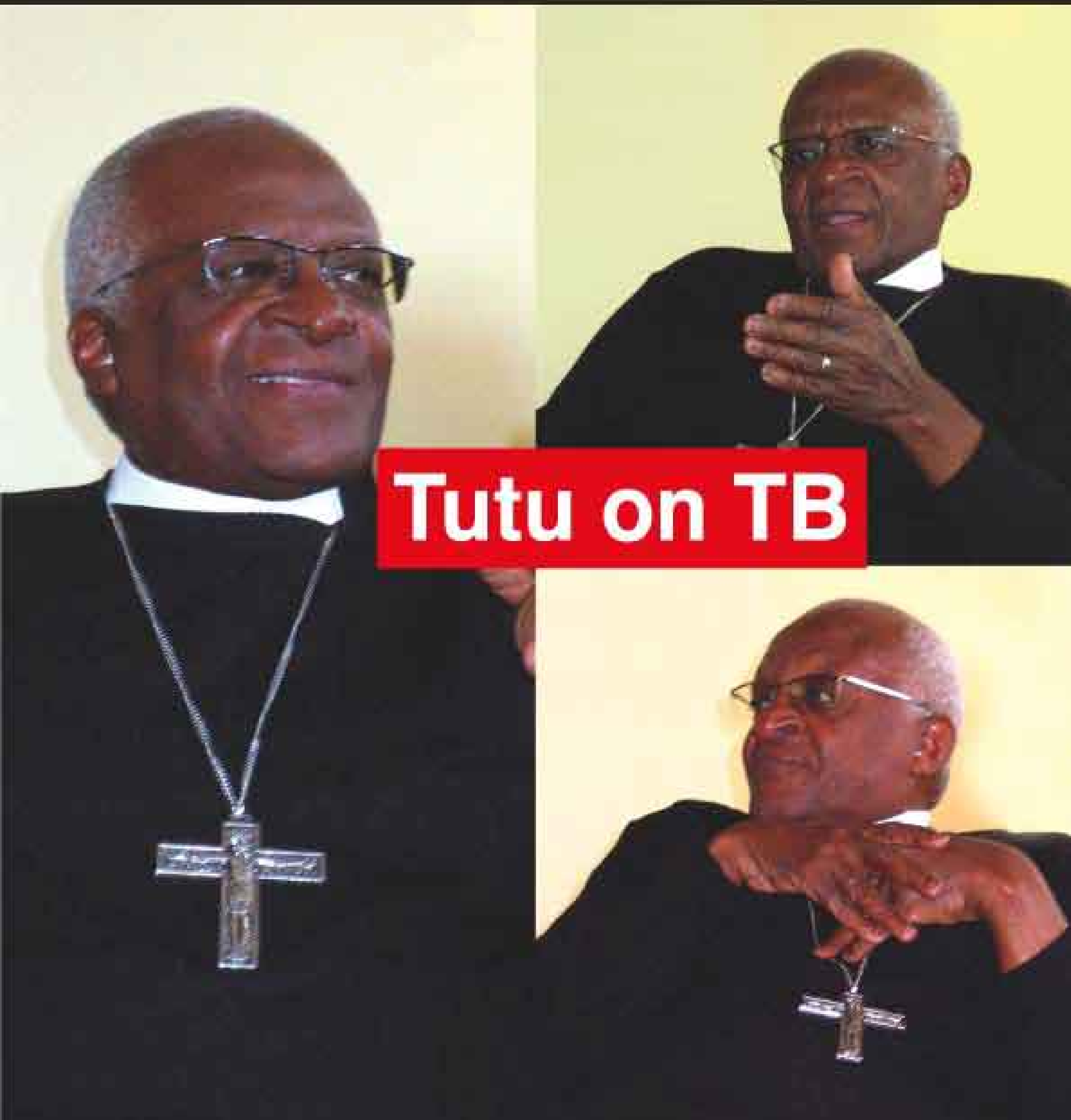
EQUAL TREATMENT

NEWSLETTER OF THE TREATMENT ACTION CAMPAIGN OCTOBER 2005



EQUAL TREATMENT

October 2005
Issue 17

CONTENTS

Editorial: Stop TB 1

Focus on TB 2-9

Interview with Archbishop Desmond Tutu 10-11

It's my life: Living with HIV..................12-18

TAC events 19-23

International news................................24-27

Human rights.......................................28-29

Poetry 30

Quiz...31

Letters..32

Police fire rubber bullets at fleeing TAC members outside Frontier Hospital in Queenstown on 12 July 2005. The police actions were condemned by numerous organisations including UNAIDS. See TAC Events for the full story. Photo courtesy of Community Health Media Trust.

A young TAC supporter. Phambili means forward. Photo by Saul Konviser.

The Congress of South African Trade Unions and the South African Communist Party lead a march in Khayelitsha to pharmaceutical salesman Matthias Rath's illegal medical clinic. The marchers demanded an end to his activities. Photo by Saul Konviser.

TAC members in Uitenhage inform the community about the rollout of treatment. Photo by Skhumbuzo Hambani.

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

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

Distribution: 35,000 copies

*Editors: Nokhwezi Hoboyi and Nathan Geffen
Administration: Faniswa Filani
Layout: Darryl Cotton
Layout consultant: Doret Ferreira
Proofreading (English and Afrikaans): Daphne Barends
Proofreading (Xhosa, Sotho, Xitsonga, Zulu): Nokhwezi Hoboyi
Front cover photos by Devon Manz
Additional contributors: Zackie Achmat, Sydney Masinga, Petunia Nkolele, Joel Ntimbani, Rodrick Clarens, Sibongile Mashele, Mazizole Gonyela, Zukiswa Nqiwa, Skhumbuzo Hambani, Reid Roberts, Jonathan Berger, Fatima Hassan, James Francis, Nomfundo Eland, Saul Konviser, Lerato Maloka, Devon Manz, Zanele Mncube.*

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*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.*

STOP TB

TB kills if it is not treated. But it can be cured with treatment.
We must work together to stop TB.

Ronald Louw, my friend and comrade, is dead. This is a terrible loss, both personally and politically. An edited obituary for Ronald that appeared in the *Mail & Guardian* is reprinted in this issue of *Equal Treatment* in Zulu, which is appropriate because Ronald lived in Durban and many of his friends were Zulu-speakers.

On 5 August a memorial service was held for Ronald at the University of Kwazulu-Natal where he was a professor of law. At the service, TAC, the AIDS Foundation of South Africa and the Durban Gay and Lesbian Community Centre (which Ronald co-founded) launched the "Ronald Louw Get Tested, Get Treated Campaign." You can do your share for this campaign by going to your local clinic and having an HIV-test, as well as convincing your friends and work colleagues to do the same.

In the last issue of Equal Treatment I mentioned that Ronald had *pneumocystis carinii* pneumonia (PCP) and was therefore being treated with a medicine called cotrimoxazole. But three days before Ronald died, he was diagnosed with tuberculosis (TB). So, all along, his main HIV-related infection had been TB. But he was treated for TB much too late. And it is not clear that he had PCP at all.

Recorded death certificates suggest that more people with HIV die of TB in South Africa than any other infection. In fact, except for HIV, more people die of TB than any other cause of death. Yet Ronald's late TB diagnosis is an example of one of the main problems with managing this disease: the current TB tests were discovered over 100 years ago. It takes weeks to get a test result which, in any case, is often unreliable for people with HIV.

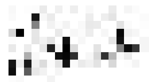
Many doctors in the private sector, where Ronald was treated, have not had sufficient training and experience to treat HIV and TB.

It is not only the TB test that is old. No new TB medicines have reached the market in 35 years. The reason for this is that drug companies are not developing medicines that affect poor people unless they also affect rich people. But TB is a disease that kills over 2 million people a year worldwide. It is unacceptable that so few resources are invested in eradicating it. The HIV epidemic has worsened the TB epidemic, and people with TB who are HIV-positive are much less likely to recover than people who are HIV-negative.

Yet the fact that most people with HIV in South Africa will eventually get TB presents an opportunity. It means that TB and HIV services should be integrated. People with TB should be offered HIV tests automatically. If they test positive, they should be considered eligible for antiretroviral treatment.

This issue of *Equal Treatment* focuses on TB. We look at the science and politics of TB. We also examine ways to improve the management of TB. We can roll back TB but as with HIV, it needs the will of our political leaders. See the TAC policy discussion document on TB at www.tac.org.za.

The tragedy of the aftermath of Hurricane Katrina unfolds as *Equal Treatment* goes to press. We express solidarity with the people affected and all our American comrades during this difficult time.



Zackie Achmat, TAC Chairperson

FOCUS ON TUBERCULOSIS (TB)

Compiled by Devon Manz and Zackie Achmat

Main source: Steering the Storm: TB and HIV in South Africa. A policy paper of the Treatment Action Campaign, by Zackie Achmat and Reid Roberts, http://www.tac.org.za/Documents/TBPaperForConference-1.pdf
Other sources: Stop TB, WHO, CDC, Avert

TB can be cured or prevented in people with HIV.

According to StatsSA (the government statistical agency) more than 50,000 people died of TB in 2001 alone. Twenty years ago, progressive ANC health activist Cedric de Beer wrote: "TB kills between ten and twenty people every day in South Africa. A conservative estimate is that 23,000 people have died from the disease in the last ten years. TB is South Africa's most common serious disease."

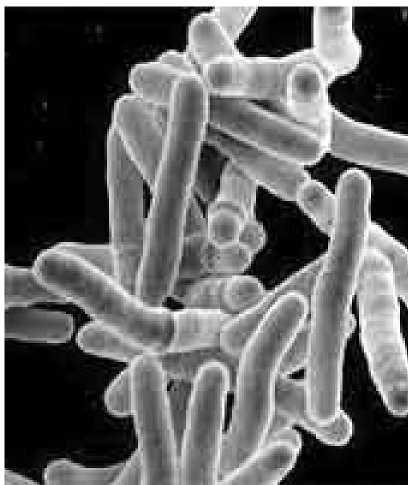


Photo (electron micrograph) of TB bacteria. Courtesy National Institutes of Health.

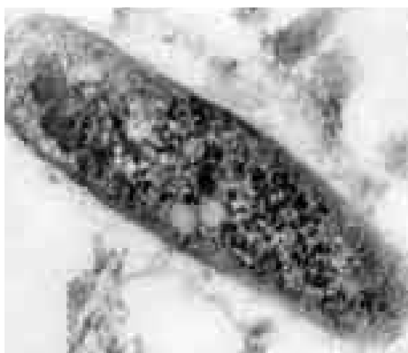


Photo (using electron microscope) of a single TB bacterium. Courtesy Dr. Kathleen McDonough, Wadsworth Center/NYS Dept of Health, and Dr. Yvonne Kress, Albert Einstein College of Medicine.

TB FACTS

- TB kills about **2 million** people globally each year.
- More than **8 million** people living with HIV in Africa are also infected with TB.
- **50%** of people with HIV in Africa will develop TB.
- South Africa has one of the highest rates of new TB cases in the world (**558 per 100,000**).
- TB associated with HIV is the **leading cause of death** in South Africa.
- If someone infected with HIV contracts TB their average survival time without treatment is **five to six weeks**.
- People with HIV are **5 to 10 times** more likely to develop TB than those without HIV.

"We cannot win the battle against AIDS if we do not also fight TB."
Nelson Mandela

St Peter's TB Clinic, Addis Ababa, Ethiopia: Technicians examine patients' sputum samples. Photo by Andy Crump, courtesy of WHO, TDR and Andy Crump.

WHAT IS TB?

TB is a bacterial disease that has existed for thousands of years. Once a person becomes infected with the bacteria, it often remains in their body for many years without making them sick. This is called latent TB. A properly working immune system is capable of fighting the infection and preventing the bacteria from multiplying. Poor nutrition or HIV weakens the immune system. When this happens, the bacteria begin to multiply. This makes the infected person sick. This is called active TB

HOW IS TB SPREAD?

The most common form of TB is TB of the lungs. This is known as pulmonary TB. A person with pulmonary TB will cough up very small particles which can remain in the air for a long time. These particles can then infect other people.

Direct sunlight can kill TB. TB thrives in damp and dark environments where there is little fresh air. So TB is most commonly transmitted to people in over-crowded and poor-housing conditions. Anyone who lives in the same home as a person with untreated active TB is at great risk of contracting TB, especially if they share the same room or bed. TB can occur in areas other than the lungs, such as in the lymph nodes, central nervous system, and the gastrointestinal tract. This is called extrapulmonary TB and is most common in HIV-positive people and children.

> TB is most commonly transmitted to people in over-crowded and poor-housing conditions.

HOW IS TB TESTED?

As HIV/AIDS became a health crisis in Europe and America, a lot of money was given to researchers who worked to develop reliable, affordable and rapid HIV-tests. In only 20 years since the first HIV antibody test, there are already tests that tell your HIV status within 20 minutes. No laboratories or skilled technicians are required. In one test, no blood is even needed. These tests are more than 99% accurate and inexpensive.

This improvement in HIV-testing was because HIV/AIDS was made a global health priority. Drug companies also invested in HIV tests because of the market for them in rich countries.

TB diagnostics or testing kits are inadequate because it is a disease of poor countries and communities.

The main way of testing TB is by taking sputum (a gob of mucus from the throat) from the patient. This sputum test technology was developed nearly 125 years ago. It has not improved much in this time. Ideally, a patient with active TB tests positive. This is called sputum-smear-positive (TB-positive). Also ideally, patients who do not have active TB test negative. This is called sputum smear-negative (TB-negative). But many people with HIV will test TB-negative, even though they have active TB.

Also, the test cannot diagnose extrapulmonary TB. The number of false TB-negatives is increasing in South Africa.

This means that diagnosis of TB-negative people has to be based on chest X-rays or the doctor's judgment based on the patient's symptoms. However, chest X-rays are often inconclusive in children and HIV-positive patients because

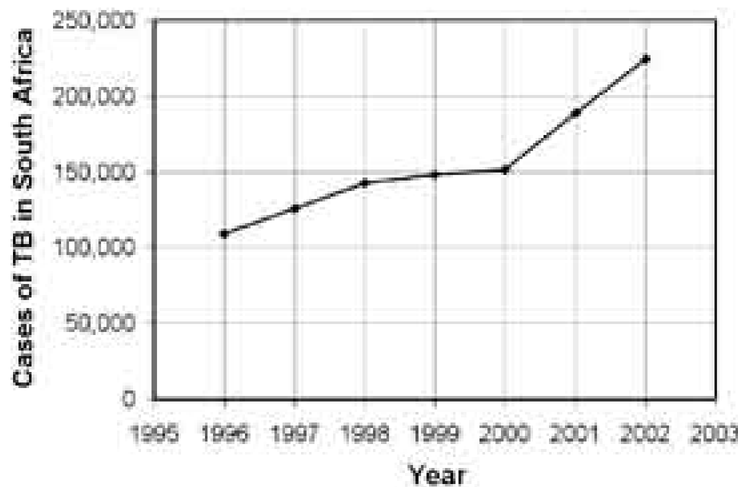
of their weakened immune systems. Other lung infections, like bronchitis or pneumonia, often co-exist as opportunistic infections, which makes X-ray diagnosis difficult.

Perhaps the biggest problem with the standard TB test is that it can take up to six weeks to get a result. This is partly because the test itself is time-consuming and because most clinics do not have the test facilities.

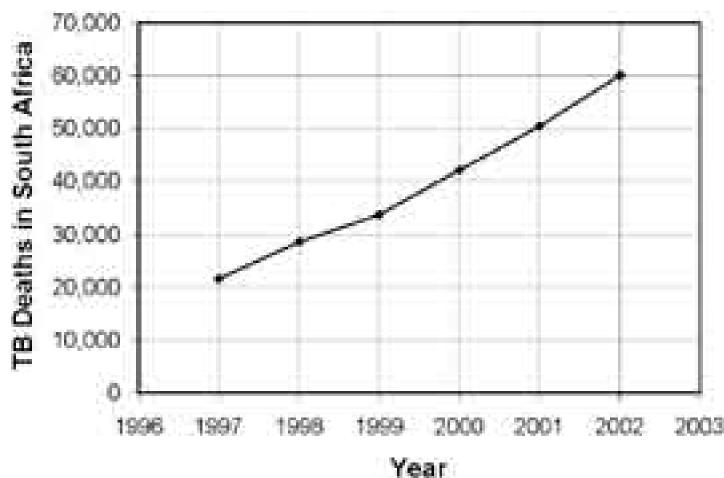
An additional TB test is the tuberculin skin test. But in countries like South Africa with a high TB prevalence, the test is of little use as it cannot distinguish between latent and active TB.

New TB tests are being devised but are not widely available in poor countries because of price. These tests reduce the number of false negatives and give results much quicker than the sputum test. For example, tests known as phage-based systems can give a result in as little as two days. The new tests can also be used to diagnose multi-drug resistant TB (which we explain later).

These diagnostic improvements will be a big step towards treating TB and reducing transmission. But it requires activism. Current anti-TB drugs also need improvements to make a long-term reduction in the TB epidemic. More funding and research into TB diagnostics is vital. Improving TB treatment protocols is necessary to ensure that those infected with TB do not go untreated because of a smear negative sputum sample.



Source: Dept. of Health's Nat'l TB Control Program 2003 Fact Sheet and HST



Source: Stats SA (18 February 2005)

The graphs above show how TB in South Africa has become much worse in recent years. TB cases doubled from just over 100,000 in 1996 to over 200,000 in 2002. Deaths from TB increased from approximately 20,000 in 1997 to about 60,000 in 2002. Only the HIV epidemic can explain this massive increase.

WHAT IS THE CONNECTION BETWEEN TB AND HIV?

TB and HIV are two different infections, but together they are the leading cause of death in South Africa. No matter how politicians try to disguise the facts, the number of TB deaths almost tripled between 1997 and 2002 even though the government is committed to stopping TB. This is because of the worsening HIV epidemic.

The immune system uses CD4 cells to defend the body against illnesses such as TB. A drop in CD4 cells (due to HIV) weakens the immune system and activates TB. A weakened immune system also causes TB to spread in the body. This increases the chances of extrapulmonary TB among HIV-positive individuals.

TB further worsens the already weak immune systems of people with HIV. If someone has active TB, they must take medicine to cure the

disease. If left untreated TB is very likely to cause death.

HOW IS TB TREATED?

The drugs used to treat TB are more than 40 years old and have unpleasant side effects. They are described on page seven of this issue of *Equal Treatment*.

TB drug treatment is divided into two phases. In the first phase, lasting two months, patients take a pill containing four medicines. The brand-name for this medicine is Rifafour. The second phase uses fewer medicines and lasts four to six months.

People with advanced HIV do not respond well to TB treatment. Furthermore, there are drug interactions between the two most powerful anti-TB drugs and antiretrovirals. Many people do not finish their TB treatment course because of a number of reasons: (1) they soon begin to feel better, (2) they cannot tolerate the side-effects and (3) the treatment period is a long time. People who do not finish their treatment are in danger of becoming ill with TB again, but this time they might not respond to standard treatment at all. This is because they have developed TB that is resistant to treatment. This is known as multi-drug resistant TB (MDR).

The standard test to see if someone has active TB involves using sputum (mucus from the throat) to grow TB in a culture. It can take weeks to get a result. Also, the TB test is unreliable for people with HIV, often showing no TB when the patient does in fact have TB. Photo by Brian Till.

No matter how politicians try to disguise the facts, the number of TB deaths almost tripled between 1997 and 2002 even though the government is committed to stopping TB. This is because of the worsening HIV epidemic.

Therefore, newer TB drugs are aimed at reducing the length of time patients have to be treated. Much of the new TB drug development is being done by public research groups and universities as opposed to pharmaceutical companies. This is because pharmaceutical companies do not see profit in TB. Pharmaceutical companies have developed new and promising TB drugs, but they are expensive and out of the reach of developing countries. Unless activists and governments compel the pharmaceutical industry to make anti-TB drugs available, improved treatments will not become available.

CAN TB BE PREVENTED?

TB can be prevented by improving living conditions, and also through medical interventions. People with HIV and latent TB can take a TB drug called

isoniazid (INH) to reduce the risk of getting active TB. Also, a study by South African scientists found that people with advanced HIV disease taking antiretrovirals were much less likely to get sick with TB than people with advanced HIV disease not taking antiretrovirals.

Another way to prevent TB would be the development of more effective vaccinations.

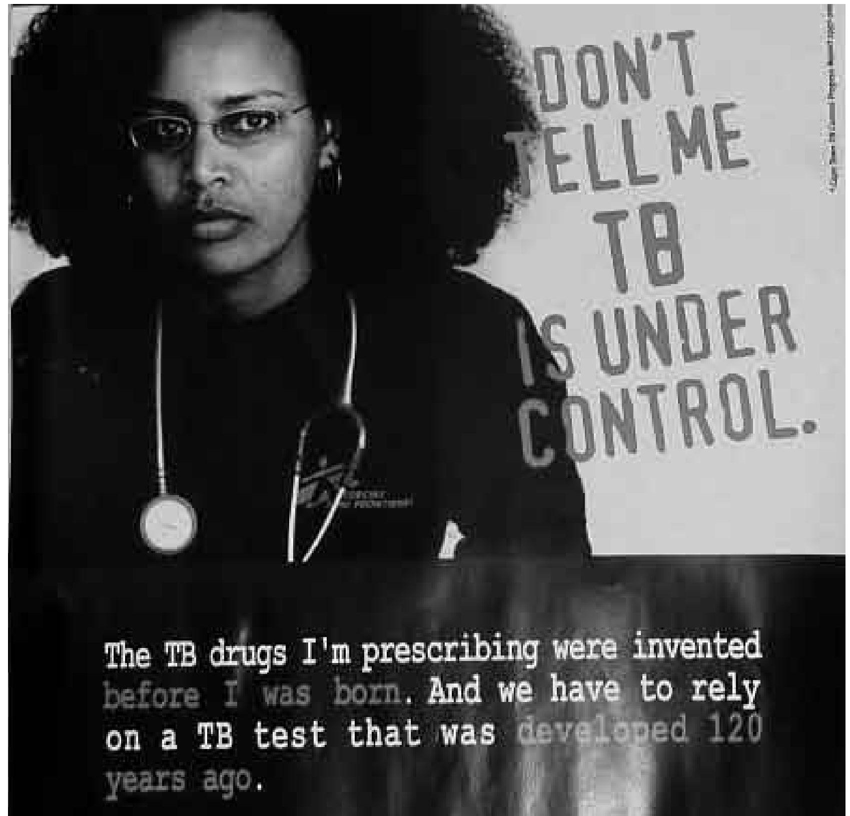
WHAT ABOUT TB VACCINES?

In areas where TB is common, such as South Africa, newborn children are often given the BCG vaccination. It is the only existing TB vaccine and was first used in 1921. It does reduce TB amongst children, but it is of little benefit to adults. In addition, HIV positive babies can get what is known as vaccine-induced BCG disease. Despite these problems, BCG is the standard by which all new vaccines are measured because of its low cost, safety and history. Since TB is most common in adults this will be the real test for a new vaccine and it will take time to be developed. A safer and more effective TB vaccine is needed, especially for HIV-positive infants and adults who no longer are protected by a childhood BCG shot.

MULTI-DRUG RESISTANT TB

Multi-drug resistant (MDR) TB is a growing problem worldwide. Patients whose TB does not respond to at least two of the main TB medicines have MDR TB. The treatment for MDR TB is less effective, much longer and has more side effects. People with MDR TB have a higher risk of dying than people with standard active TB.

The increase in MDR TB is higher in South Africa than the global average. But Eastern Europe is the hardest hit.



A Médecins Sans Frontières poster highlighting the sorry state of TB tests and drugs. Photo by Saul Konviser.

WHAT IS DOTS?

"DOTS has demonstrated serious limitations in its nearly decade-long existence – particularly since the HIV/AIDS pandemic has completely transformed the landscape of TB care." **Médecins Sans Frontières**

Directly Observed Treatment, Short-course (DOTS) was launched in 1994 by the World Health Organisation (WHO) to treat TB. People on DOTS are observed every weekday for six months. This is obviously very inconvenient and difficult for patients to adhere to, especially if they have to be observed at a clinic. Many people co-infected with HIV who take antiretrovirals find it difficult to accept that their treatment must be supervised. This is because there is a different model for antiretroviral treatment, which is life-long.

Also, DOTS was intended only to be used with patients who have tested TB-positive using the sputum test. This ignores the many HIV-positive patients with active TB who nevertheless test TB-negative. However, DOTS has been effective in rich countries with low HIV-prevalence rates.

DOTS VERSUS THE ANTIRETROVIRAL TREATMENT MODEL

Like TB treatments, antiretrovirals have side-effects. It also makes people who are sick feel better in a short period of time. Antiretrovirals have to be taken for life, as opposed to just six months.

Yet people are much more likely to take their antiretroviral treatment properly than take their TB treatment properly. Why?

The reason is that a different approach has been used for antiretroviral treatment. For example, people on antiretroviral treatment at the Médecins Sans Frontières (MSF) site in Khayelitsha choose their own treatment supporter; they are not observed on a daily basis by a health professional at the clinic. This means they can continue living a normal life. Furthermore, they are encouraged to learn about the science and treatment of HIV, as well as to join support groups. Contrast this patient-centered approach with DOTS where TB patients are given far less responsibility.

TB IN SOUTH AFRICA

TB is out of control in South Africa. According to the South African Health Review (2004) a "lack of management capacity, poor management systems and inadequately trained and motivated staff at district levels" were key reasons why the TB response has failed. This is made worse by the shortage of health-care workers trained to handle TB or HIV.

Despite promises over the past five years, the Department of Health has failed to integrate TB and HIV services. Community activism is needed to achieve this.

The South African TB Control Programme is hindered by inadequate TB facilities in the country. Eleven percent of public health facilities do not even stock TB medicines. This means that many TB patients go untreated.

Fixing this requires political will. Government must acknowledge the seriousness of the HIV epidemic if it is to make progress against TB.

Access to all essential drugs including TB drugs and tests at all primary care facilities remains a top priority for activists, health professionals, health managers, health departments and communities. For one thing, a comprehensive health human resource plan for the country is overdue. Also, traditional healers and community health workers need to be trained to support the management of HIV and TB.

Despite old tests and medicines, TB can be prevented, treated and cured.

KNOW YOUR TB MEDICINES

Medicines used to treat TB

The medicines used to treat active TB the first time you get it are:

- **isoniazid (better known as INH)**
- **rifampicin**
- **pyrazinamide**
- **ethambutol**

These are available in one pill at public clinics.

After two months you would normally continue only with rifampicin and INH.

People infected for the second time might also be given streptomycin injections for 40 days.

The first time you are treated for TB, treatment lasts six months. The second time, you could be treated for much longer depending on how your infection responds.

Side-effects

Typical side-effects are dark-yellow or orange urine, stools, tears and sweat. Other common side-effects are diarrhea, numbness and tingling in the hands and feet, skin rashes, nausea and vomiting, joint pains, loss of appetite, difficulty hearing, buzzing in the ears, urinating more than usual, unusual tiredness and dizziness.

Rare side-effects are unusual bruising, muscle twitching, difficulty seeing, seizures, depression, fever and chills.

You should tell your nurse or doctor about side-effects you experience. Continue taking your pills until your doctor or nurse advises otherwise.

TB medicines and antiretrovirals

TB drugs interact poorly with many antiretrovirals. Therefore, if a person with TB requires antiretroviral treatment and TB treatment at the same time, he or she would normally be put on stavudine, lamivudine and efavirenz. INH might increase the risk of peripheral neuropathy (tingling or numbness in the hands and feet) with stavudine.

Sources: Medline, HIV Insite's Database of Antiretroviral interactions

TREATING TB AND HIV TOGETHER IN KHAYELITSHA

The Ubuntu Clinic in Site B Khayelitsha is an example of the success of integrating TB and HIV. Located just outside Cape Town, Khayelitsha is the largest township in the Western Cape. The Health Departments of both the City of Cape Town and the provincial government have assisted Médecins Sans Frontiéres and the University of Cape Town as they develop and implement a combined response to the TB and HIV epidemics. Here are examples of what is happening at the Khayelitsha clinic:

- Staff are trained to deal with both TB and HIV.
- The clinic is a "one-stop" TB and/or HIV treatment centre.
- Voluntary counselling and testing (VCT) increased the number of TB patients who know their HIV status from 22% to 54%.
- The patient-centred approach to treatment (pioneered with antiretrovirals) as opposed to DOTS is used.

The success of the Ubuntu clinic has also revealed problems in the public health system. There is an increasing number of TB and/or HIV patients each month – more than any other clinic in the province. As a result, there are staff shortages which limit the quality of service. For example, there are not enough nurses and counsellors to offer VCT to every patient.

Nurses pose shyly for the camera at the TB clinic in Site B, Khayelitsha. The site integrates TB and HIV treatment. Photo by Devon Manz.

You should visit your local clinic if you have any of the symptoms of TB described in this poster. The poster is from Navrongo Hospital in Ghana. Photo by Andy Crump, courtesy of WHO, TDR and Andy Crump.

TB SYMPTOMS

- Coughing for three weeks or more
- Coughing up blood
- Pains in the chest
- Unexplained weight loss
- Loss of appetite
- Night sweats

MY BATTLE WITH TUBERCULOSIS (TB)

by William Tsolele as told to Sydney Masinga

My name is William Tsolele and I have been living with HIV since 1991. I was born in 1964 in a town called Matatiele in the Eastern Cape province. I came to Evander to work at the Harmony Gold Mines.

Before I knew about my HIV status, I was always sick and felt weak. I then went to Evander Hospital to check what was wrong with me. They did an X-ray but could not find out what was wrong. I told them that I was losing weight, always thirsty and coughing at night. They eventually diagnosed me with TB using a sputum test.

I started TB treatment in 1991 for about six months. There were complications because I was drinking a lot. I was on Rifafour [This is actually four medicines in one pill - Editor] for six months. After successfully completing treatment, I went for an X-ray again and the TB was gone. A second sputum test confirmed that I was

"My advice to people who are taking TB treatment is avoid smoking and too much alcohol. Try to eat as much healthy food as you can."

"I am healthy and I have just started taking antiretrovirals."

cured of TB. I went back to work, but because I am HIV-positive and working underground there was a chance that the TB might come back.

I went on leave at the beginning of 2004. One of my company's policies is that when you come back from leave you have to undergo certain tests if you work underground, as I do. After the routine X-ray tests, they found out that I had pulmonary TB. They also took my sputum to confirm the results. The lab results confirmed that I had TB again.

I started treatment again in April 2004. I continued until November. I had to take treatment for eight months because it was the second time I was treated for TB. The treatment cured me. The company has also improved working conditions underground and I try by all means to avoid re-infection.

It was easy for me to adhere to treatment the second time because I was not drinking and I was taking the treatment at the company's hospital with the help of a personal monitor.

I have seen some people defaulting on TB treatment when they go on leave from work and take traditional medicine.

My word of advice to people who are taking TB treatment is avoid smoking and drinking too much alcohol. Try to eat as much healthy food as you can.

I hope my TB is gone for good. At present I am healthy. I started taking antiretrovirals on 16 June 2005. I am positive antiretrovirals are going to be good to me.

William Tsolele battled with TB twice. He is now taking antiretrovirals. Photo taken by a friend of William's.

INTERVIEW WITH ARCHBISHOP DESMOND TUTU

Interview conducted by Nokhwezi Hoboyi, Nathan Geffen and Nomfundo Eland. Photos by Devon Manz.

Archbishop Desmond Tutu explained to *Equal Treatment* how he beat TB and prostate cancer. He also shared his views on HIV.

Archbishop Desmond Tutu was one of the most prominent anti-apartheid activists. He was the first black archbishop of the Anglican Church and in 1984 he won the Nobel Peace Prize.

Some people are difficult to interview. They do not say much and you have to ask specific questions to get clear answers. Tutu is not one of those people: after we started our meeting at his offices in Milnerton with a prayer at his request, he began describing in great detail how he survived TB as a 15-year old boy.

In 1947 Tutu lived in a Sophiatown hostel run by Father Trevor Huddleston, who later became a prominent anti-apartheid activist. One Saturday morning when Huddleston returned from a trip, Tutu could not join the other youths to greet him because he had a terrible headache and a high temperature. He was taken to Coronation Hospital in Johannesburg, where he was diagnosed with pulmonary TB. He was shaken by the diagnosis, especially when he was told that he was going to be transferred to Rietfontein Hospital, an isolation campus for people with TB and other infectious diseases. He recalled that there were no white patients and most of the staff were white. But despite these racial divisions, Tutu spoke affectionately about his doctor and nurses.

Back then there were no drugs available to treat TB. The only treatment people received was hospitalization where they were told to rest and eat as much as they could. The death-rate was high and people who survived had to spend a long time in hospital, often in isolation. Because Tutu had lost weight, his daily diet included lots of mutton and mash potatoes with a slab of butter to fatten him up.

"I was in hospital for 20 months, and during my stay there, I also had a procedure where they pumped air into my chest cavity," he explained. "There was no one in my family that had had TB before but there was a TB epidemic at the time. There was a lot of stigmatisation towards people with TB. Nobody wanted to come out and say that they had the disease.

"We have come a long way. For example, now we have DOTS so people are monitored till they finish their treatment. TB can be cured. We can also prevent it by strengthening the health service and providing treatment. We need to educate people by letting them know the signs of the disease and talking about good nutrition so that TB shouldn't be the scourge that it has been, especially in the Western Cape where the infection rate is so high."

> "There was a lot of stigmatisation towards people with TB."

Tutu is active in the campaign

against TB. He is part of an awareness campaign for lung infections and a TB centre named after him has just been opened in Stellenbosch. By telling of his personal TB struggle, he helps destigmatise the disease and encourage people to get diagnosed and treated.

A few years ago Tutu and his wife Leah faced another struggle: he was diagnosed with prostate cancer. The archbishop explained "I have always had a fairly elevated prostate specific antigen [this means he was at risk of prostate cancer]. After a high reading, I had a biopsy under anaesthetic. A piece of my prostate was taken for analysis." Tutu's doctor told him he did not think it was malignant. He and Leah were therefore very happy. But the following day the results of the analysis came back from the pathology lab. He had cancer.

Tutu talks with his hands and facial expressions as much as with his voice. Most of the time he is almost bouncing in his chair with joy. But now his voice was serious, softer and sadder. He explained that when he faced his own possible death, he thought about what he would lose: his beloved wife, the laughter of his grandchildren and the sight of a beautiful sunset.

"Being diagnosed with cancer was very difficult. It made me realise that I was mortal and that I could have a terminal illness and I have been blessed to have made it through. It also made me realise that I had taken a lot of things for granted," he explained.

But the sadness was soon replaced with a funny story. He told how he had cancer at the time when he was chairing the Truth and Reconciliation Commission. There would be difficult meetings. He used his illness as a tension breaker

by saying to conflicting parties, "Gentleman give me a break. You know I am sick!" He continued, "Life is too short for nastiness. One needs to be gentle and take it easy."

> "Instead of speculating about the cause [of AIDS] we should have provided antiretrovirals and had a campaign for prevention."

We also asked Tutu for his views on the HIV epidemic. He was thrilled by the commitment and caring shown by civil society. But he regretted the lives lost because of time wasted by politicians debating the cause of AIDS. "Instead of speculating about the cause, we should have had a campaign for prevention and provided antiretrovirals."

Tutu views the churches as having an important role in destigmatising the disease. HIV/AIDS is not God's punishment he explains, "what God would want a new-born child to be infected? I would not worship that God."

Tutu also shared his views on sex and HIV. He explained that most transmission is through sex and the best prevention is an oral contraceptive. For a moment we were perplexed. Then he clarified with animated facial expressions: "[Just say] no."

But he recognises that many people have sex outside marriage and urges people to practice safer sex.

He concluded, "Life is precious. We should treat one another with respect."

NGINETHEMBA INGANE YAMI IZOKHULA

ngu Zanele Mncube

Igama lami ngingu-Nozipho Shezi ngihlala e-Pietermaritzburg. Ngiphila negciwane lengculaza iminyaka eyishumi elinanye. Ngakwazi lokhu ngonyaka ka-1995.

UNozipho Shezi nengane yakhe. Isithombe sithathwe ngu Zanele Mncube.

Ngaqhubeka nempilo ngoba ngangingakholwa yilokhu. Ngo-1997 ngakhulelwa kodwa ngazihlalela nje ngangalandela imigomo eyayikhona. Ngangingazihluphi ngokunakekela ingane yami ngesikhathi ngikhulelwe.

Ngamthola ngo-1998 Februwari 26. Impilo yakhe yabayinhle isikhashana esincane. Uthe enezinyanga eziyisithupha waqala wagula. Ngangiphuma ngingena ezibhedlela ngaze ngabona kungcono ukuba ngixoxe nodokotela. Ngamtshela ngakho konke ngempilo yami. Yilapho angiququzela ukuba ngimhlole igazi. Ngempela naye wayethelelekile. Kumanje uphila nesifo sikagawulayo.

Yilapho ngaqala khona ukubona ukuthi kubaluleke kangakanani ukunakekela izimpilo zezingane zethu. Kumele sizinakekele ngoba azinacala futhi ithina esiziletha lapha emhlabeni.

Yingakho ngithanda ukuququzela omama ukuba basukume bahlole igazi uma bekhulelwe noma bengakhulelwe.

Ngamzama ngazo zonke izindlela waze wabancono. Uqale ukudla i-*cotrimoxazole*.

Wabanenkinga ye TB wabuye wadla imithi yokuyelapha izinyanga iziyisithupha. Ungenwe i-*pneumonia* izikhathi ezimbili, kodwa ngoba ngangizimisele ukumbona ekhula ngenza konke okwakushiwo udokotela. Wayehlushwa amadlebe kodwa bakwazi ukuwelapha.

Uqale ama-antiretrovaral drugs ngo-Februwari 2005. Akazange abe nankinga, udla i-d4t,3tc kanye ne-nevaripine. Uphila kahle, uya kahle esikoleni. Amaphilisi akhe uwathatha ekuseni ngo 6:30 kuya ku 18:30 ntambama. Mina nobaba wakhe siyamsiza ukumkhumbuza kodwa inkinga ukuthi akazi ukuthi kungani edla lamaphilisi. Ngoba nami akukho lula ukuthi ngimtshele. Ngidinga umuntu ongakwazi ukukhuluma naye ngoba usemcane uneminyaka eyisithupha (6-years).

Kodwa ngiyohlezi nginethemba lokuthi uzokhula abe ummeli. Ingakho ngithanda ukuququzela omama ukuba basukume banakekele abantwana babo.

VCT I YA NKOKA

yi Joel Ntimbani

Ngovhela clinic yi kumeka Nzhelele, eVenda. Murhangeri wa yona i-Frieda Skwivilu. Yi nyika vutsunguri eka matiko ya nkombo ku nga Ngovela, Ngwenani, Malungani, Mbilu, Manini na Tshivulani. Ayi na va ongori vo ringanela. Loko u nwana wa vona a kuma masiku ya ku ya wisa, swi nyika ntsakelo eka lavanga sala. Ku fana na hi suku ra 8 Mhawuri 2005 kuri va ongori va mbirhi ntsena.

Loyi a tekaka ngati kuyi kambela ku lavisisa xitsongatsongani xa HIV angari kona. Swi ti komba ingaku ndzawulo ya rihanyu a yi langutsi kahle mhaka leyi. Ku sukela hi Ndzati 2004 kufikela khotavuxika, akuri hava mu ongori loyi a kambelaka ngati kulavisisa xitsongwatsongwani xa HIV. I fanelo ya munhu ku kuma vutsunguri lebyi betisekeke. Hi fanele ku tiva xi yimo xa mavabyi ya hina. Le swi endliwa hiku I munhu unwe tsena a kambelaka ngati. Hi nawu u fanele kuva kona masiku hi nkwawo.

> Loyi a tekaka ngati kuyi kambela ku lavisisa xitsongatsongani xa HIV angari kona.

Vutsunguri bya HIV/AIDS bya kumeka yi kliniki yaNgovhela.

Ndawulo ya ri hanyo yi fanele ku yi langutisa mhaka leyi, yi antwisa swi yenge hikwaso swa vutsunguri. Va ongori lava hanga kona ka kliniki ya Ngovhela ava tivi ntshumu hi vutsunguri bya HIV/AIDS na leswi ndawulo ya rihanyo swikunguhataku. Swe endla leswaku vanhu lava xanisekaka hi ma vabyi lawa a va kumi kupfuneka. Kufana naswilonda swo huma emikolweni na ntswa vusiku namanwana lawa ava fanele ku pfuneka ekliniki.

Swi lava mina na nw`ina hi yima milenge kuva yi kombisa ndawulo ya rihanyo ku tikeriwa loku hi hlanganaku na kona. Ndawulo ya rihanyu yi fanele ku ta kuma Madokodela na va ongori lavanga na ntokoto eka ma vabyi na vutsunguri bya wona.

NOT ENOUGH BEDS!

by Petunia Nkolele

Tinyiko (not her real name) was a married, middle aged woman from Hlanganani location in Limpopo. One day as I was going to the hospital, I spotted someone sitting outside the TB ward. When I asked her why she was sitting outside, she told me that nurses told her to sit there because she didn't belong to that ward.

It was a cold morning. She had been waiting there since the previous day. Apparently the nurses said she should go back home because there were not enough beds. The nurses had asked her if she did not know where people like her are supposed to go.

I went to the matron of the ward and asked her why Tinyiko was sitting outside in the cold. The matron said that she didn't belong to that ward. I therefore asked the matron to take Tiniyiko to where she belonged and she arranged for someone to take her to Giyani ward.

Tinyiko's family then assisted with taking the matter forward. Later on I went to Giyani ward to see if she was admitted. She had been.

Three days later she was discharged. She went home and passed away.

GETTING INFECTED AS A TRUCK DRIVER

by Sam (not his real name) as told to Sibongile Mashele

Transport workers are at high risk of HIV. Yet their voices are seldom heard. Sam's story describes the difficulties with HIV experienced by transport workers. *Equal Treatment* points out that it was fortunate that Sam's wife remained HIV-negative after they had unprotected sex. If a male partner is HIV-positive, a process called sperm-washing can be used to safely impregnate his HIV-negative female partner.

Transport workers are at high risk of HIV, but their voices are seldom heard. Photo by Devon Manz.

I was born in 1946 in Lydenburg. My parents got divorced when I was young. My father then had to go to Mozambique. So my sister and I lived with my grandmother.

I spent my teenage years in Lydenburg where I attended school. I never completed matric because my girlfriend got pregnant and I had to go and work to provide for my family. In 1965 I started working as a switchboard operator at a hotel. I then moved to work in another company as a clerk in 1973. In 1978 I started driving at Ngodwana and then resigned in 1987. Just after that I got a job as a truck driver doing deliveries for a spice factory. I had to resign in 1990 because the company moved to Johannesburg. In 1991 I worked as a bus driver until 1999 when I retired as a driver.

In my younger days I loved sex too much. I slept with many women and wasn't using condoms for protection. Even though I slept around, I had a wife at home. I think it was because I was doing a lot of travelling.

I first found out that I was HIV-positive in 1985. I had trouble peeing. It was as if my pipes were blocked.

The doctor advised me to take an HIV test and I tested positive. At that time I didn't know about HIV. The only thing that I knew was that HIV kills. The doctor advised me to take care of myself and to make sure I used a condom every time I had sex. At that time condoms were only available at the pharmacy.

I once had TB in 1977. I took TB medicines but couldn't finish my treatment because there was no access to treatment where I lived and I had to travel to Nelspruit for treatment.

Years later TB re-occurred. I had to stay in hospital for a month and then continue my treatment at home. Since then I have not had TB again. I have experienced Drop and it re-occurred several times.

Because I was having unprotected sex with many people I got infected with HIV. After I knew about my status I always used condoms, even though I couldn't disclose to my sexual partners. If they didn't want to use condoms I would break up with them. At home with my wife I was using condoms till it came to a point whereby my wife desperately wanted a baby. So we didn't use condoms. She became pregnant but the baby died. We then tried later on and she gave birth to a baby boy who is now eleven years old. My wife tested HIV-negative years later.

One thing that I took from my doctor was that I must make sure that every time I have sex I should use a condom. If you are HIV-positive you must seek information about HIV. This will help you understand how to deal with HIV. Also make sure that you join a support group in your area.

ACCEPTING MY STATUS AND REGAINING MY HEALTH

by Sibongile Mashele

Violet Ntlatlela is an ex-teacher who was born in 1976 in Bronkhorstspruit.

In 2000 Violet's boyfriend died of an HIV-related illness. "After his death his doctor and I discussed my chances of having contracted HIV. But I was too scared to take a test because I knew I may be positive," Violet admits.

Violet's CD4 count has gone from 17 to 173, proving to her that antiretrovirals are effective.

Violet later got back together with the father of the baby she had while still at college. "He was supportive and knew about my ex's situation. We took precautions and talked about testing but couldn't face going."

After being diagnosed with pneumonia in 2002 Violet was found to be HIV-positive and started antiretroviral treatment. But then in 2003 Violet's aunt, a nurse, died of HIV-related illnesses. Violet remembers "when my aunt died I asked myself how someone who is a nurse can die of HIV. I was not sure if antiretrovirals were going to save me so I stopped taking them."

"I have realized that my problem was accepting my status."

During the next twelve months Violet became more and more ill, suffering from shortness of breath, dizziness and cryptococcal meningitis. She took *"timbita"* (traditional remedies) and lied to the doctors about taking her medication. She even started training as a sangoma.

She took 30 days leave to recover but after only a few days back at work collapsed and had to go to hospital where she admitted to not taking her treatment and was put onto a second regimen.

"I was declared medically unfit for work and had to go back home to Bronkhorstspruit." On the way home she had a deep, dreamy sleep. When she woke up her brother was crying and had covered her with a blanket because he thought she had died.

Now, with much support from her family Violet takes her pills regularly. Her CD4 count has gone from 17 to 173, proving to her that antiretrovirals are effective. She has joined a support group in Sizanani and is an active member of TAC.

"I have realized that my problem was accepting my status. People must know that life goes on after being diagnosed with HIV. We need support from our families and we need to support each other as people living with the virus," says Violet.

Violet Ntlalela in 2002, living positively with HIV. Photo by Violet's friend.

Equal Treatment
October 2005

Zackie Achmat (TAC), Jonathan Berger (ALP), Ronald Louw and Nathan Geffen (TAC)

RONALD, AWUHLOLELWANGA NGANI IGCIWANE LENGCULAZI

ngu Zackie Achmat

Omunye wabangane bami abakhulu no-comrade wami wesikhathi eside, uRonald Louw, akasekho emhlabeni. Kubili okukhulu okuhambisana nengculazi okuholele ekufeni kwakhe: ukungabuvumi ubukhona begciwane lengculazi kanye nesifo sofuba esingahlahlwanga. Ukuphika ubukhona begciwane lengculazi kusho ukuthi akahlolelwanga igciwane lengculazi kusenesikhathi. Kanti, ukuhlahlwa kwesifo sofuba okungethembekile okwasungulwa eminyakeni engaphezu kweyikhulu kwasho ukuthi njengoba amasosha akhe omzimba ayeseqediwe yigciwane lengculazi, isifo sofuba sasingenakubonwa emzimbeni wakhe kusenesikhathi. Wayebuyisa, ezikhulula ezingutsheni zokulala, kanti impilo yakhe ayizange ibe ngcono.

WONKE UMUNTU KUFANELE AHLOLELWE IGCIWANE LENGCULAZI

Ngeshwa akalashelwanga isifo sofuba kwaze kwaba amasonto amane emva kokulaliswa esibhedlela. Ukuthola ukuthi wayenesifo sofuba kwaqiniswa ukuhlolwa kwamaphaphu akhe (lung biopsy) ezinsukwini ezintathu ngaphambi kokushona kwakhe.Ngaphandle kokungabaza, uRonald wazisa abangane, umndeni, ozakwabo nezihambi ngokushesha ukuthi unengculazi, wacela usizo lokwelashwa.Yize wayehlakaniphile, efundile futhi ephila nabangane abayiqondayo ingculazi kanye negciwane layo, uRonald wehluleka ukuhlolelwa igciwane lengculazi kusenesikhathi.

Ukuba nengculazi ebisiqhubeke isikhathi eside ne-CD4 count engaphansi kwekhulu, sonke sasethemba ukuthi uzosinda. Mhlawumbe amakhambi adambisa igciwane lengculazi (ARVs) ayengasebenza. Kodwa awasebenzanga ngoba welashelwa isifo sofuba isikhathi singasekho. URonald wayeyisibonelo cishe kuyo yonke impilo yakhe ngaphandle kokungahlolelwa igciwane lengculazi. Sonke sasethemba ukuthi uma eba ngcono, wayezosichazela ngalokhu yena ngokwakhe. Impilo yakhe iyabonisa ukuthi akekho phakathi kwethu ongathi akathintekile ngokusuleleka ngegciwane lengculazi nokuliphika.

U-Ronald wayengumethuli wezifundo zomthetho futhi waba ngu-Associate Professor kwezomthetho enyuvesi yaKwaZulu Natal, kodwa akaluthandanga uphawu olwaluthi ungusolwazi olwalusegunjini lakhe esibhedlela.

Ngo-1981 wayeqashwe njengothisha eLivingstone Senior Secondary School eKapa. URonald wajoyina i-Factreton Youth Movement (FaYM) ngaphansi kukaTrevor Manuel noLionel October futhi wayezibandakanye emzabalazweni wokuncishiswa kwerenti, amanani okudla nasezinkulumweni zokuphikisana ngempilo emva kwenqubo yobandlululo kuleli. Wayeyi-"workerist" kanti mina ngangiyisisebenzi se-ANC.

Ngo-1994, ngesikhathi kusungulwa i-National Coalition for Gay and Lesbian Equality (NCGLE), uRonald Louw wayemele isigcawu esibizwa nge-Sexual Orientation Forum enyuvesi yaseNatal eThekwini. URonald wayebambe iqhaza elikhulu ekwenziweni kwemigomo namaqhinga alesi sigcawu. URonald Louw kanye noNonhlanhla Mkhize, Vasu Reddy, nomufi uMcDivitt Hove kanye namanye amashoshozela yibona abasungula i-KwaZulu-Natal Coalition for Gay and Lesbian Equality. Namuhla, basebenza esikhungweni i-Durban Lesbian and Gay Community and Health Centre.Ngikhumbula ngesikhathi efundisa esikoleni sabangezwa i-Wittebome School for the Deaf, watshela abangane bakhe ukuthi indlela ayekuthokozela ngayo ukuba namakhono okufundisa izingane ezingezwa kahle ezindlebeni, kwaze kwaba yilapho ethola khona ukuthi njalo nje uma engena ekilasini abafundi babecisha izinsizakuzwa zabo.

Wayenguthisha omangalisayo. Wayethandwa yiningi labafundi bakhe njengomphathi obhekele ezokuqondiswa kwezigwegwe enyuvesi yakwaKwaZulu Natal, iningi labafundi ayebashushisa babeya kuye kuyokucela izeluleko ngoba wayengakhethi futhi eqhuba ngokobulungiswa.

> Yize wayehlakaniphile, efundile futhi ephila nabangane abayiqondayo ingculazi kanye negciwane layo, uRonald wehluleka ukuhlolelwa igciwane lengculazi kusenesikhathi.

INGXENYE YAKHE KU-TAC

Phezu kwenkolelo yokuthi uyancishana, umusa wakhe umenze waba umngane omkhulu nocomrade eminyakeni eyisikhombisa edlule. Kusukela ezinsukwini zokuqala ze-TAC, ngangihlala endlini kaRonald eseQueensborough njalo nje uma ngiye kosebenza eThekwini (ozakwabo abanobunothongwana babekuzonda ukuya endaweni yomlungu owayengowekilasi labesebenzi). I-TAC ayizange ikhokhe ngisho isenti ngezindleko zokuhlala nokulala futhi kwakungavamisile ukukhokhela izindleko zokuhamba zomsebenzi wami KwaZulu-Natal. URonald wayethwala njalo izindleko nomthwalo wezinkomishi zetiye, ama-Marie biscuits, izingcingo eziphazamisayo, ikamelo lokulala elingcolile, ukungaphili kahle kwami nokunye okuningi. URonald wabuye waba ngumgcinimafa wokuqala we-TAC KwaZulu-Natal kodwa ingcindezi yomsebenzi nokuzibophezela esikhungweni i-Durban Lesbian and Gay Community and Health Centre, kwamenza umesekeli we-TAC ongayenzeli lutho.

Ngiqale ukubhala le athikhili (ngemvume kaRonald) ngimcela ukuthi aqhubeke nokuphila isikhashana. Akasekho manje. Wafa ngoba engahlolelwanga igciwane lengculazi kusenesikhathi. Kanti, emva kokuthola isimo sakhe ngegciwane lengculazi, amaphaphu akhe namasosha omzimba wakhe kwase kulimele. Ngibhalela nokucela wonke umuntu ukuba ahlolelwe igciwane lengculazi. Uma kuwukuthi awunalo igciwane lengculazi, yana ocansini oluphephile ukuze uhlale unjalo. Uma kuwukuthi unalo igciwane lengculazi, phila ngokuzethemba uziveze – dlana kahle, unciphise ukukhandleka komqondo (stress), zivocavoce, yana ocansini oluphephile, welashwe ngokushesha uma kwenzeka wesuleleka yizifo. Uma ukudinga, qala ukwelashwa ngama-ARVs.

Ngesikhathi elele egulela ukufa, uRonald wayengungwe ngabangane, ozakwabo nomndeni, ababemthanda – oVasu Reddy, Nonhlanhla Mkhize, Alan Rycroft, Judy Parker, Libby Morris, Jonathan Berger, Nathan Geffen, Jack Lewis kanye nabanye abaningi engingebabale. Udadewabo uPatricia Leaver, nabafowabo o-Alan noDeon Louw babonisa uthando nokumeseka.

Isikhumbuzo sikaRonald sidinga ukuba siwuqinise umzabalazo wokuthola ukuhlahlwa okusha nokunembayo kwesifo sofuba. Kudinga ukuba sihlangane ukuqinisekisa ukuthi wonke umuntu uhlolelwa igciwane lengculazi ukunqanda nokwelapha lesi sifo. Ukufa kwakhe kanye nokwabanye abangamakhulukhulu ezinkulungwane kuleli, kudinga ukuqeda ukuliphika leli gciwane okuhambisana nomuntu siqu sakhe, nokuhambisana namasiko, nezesayensi nezepolitiki. Ngaphezu kwakho konke, kudinga ukuqinisa futhi umzabalazo wenkululeko, wokulingana, wesithunzi somuntu nowobulungiswa kwezenhlalakahle.

It's my life

WAITING FOR THE SOCIAL WORKER

by Petunia Nkolele

Mavis Maphahle is 42 years old. She stays in Elim, Limpopo with her four children and her mother. She is HIV-positive and very sick. Three months ago she went for a CD4 count. It was 22. She was then sent to the social worker who told her to go home and wait for her to come and assess her for treatment.

Mavis cannot get treatment until the social worker visits her home to assess her living conditions.

Mavis has been waiting for the social worker since March and is very unhappy about her situation. She cannot get treatment unless the social worker visits her home to assess her living conditions. "I wish I could know my dying day so that I could write a letter to the social worker and tell her to take my children and stay with them. She mustn't take them to social services," said Mavis, crying.

The main problem at the hospital is that they have one social worker that sees patients at the hospital and within the community. Most people have the same problem waiting for the social worker. They end up dying without getting treatment while waiting for social workers to assess their homes.

Mavis with her mom and the food donated to them by Japanese tourists. Photo by Petunia Nkolele.

A media frenzy took place as to whether Stats SA or the Department of Health had the more accurate HIV statistics. This is cartoonist James Francis's depiction of the debate. See James Francis's cartoons on his website, www.jamesfrancis.net.

INTLEKELE KWISIBHEDLELE SASE-FRONTIER

ngu Zukiswa Nqiwa

Amalungu ka TAC egxadazela, ebaleka ukubethwa ngamapolisa kwisibhedlela sase-Frontier, e-Queenstown. Babehambise uluhlu lwezikhalazo malunga nokukhutshwa kwezithomalalisi zikagawulayo. Ifoto ithatyathwe ngu Masizole Gonyela.

Isibhedlela i-Frontier sanikezelwa imvume yokukhupha amchiza kagawulayo ngonyaka ka2004. Lwahamba kancinane unikezelo lwamachiza kuba wonke umntu wayefunda. Okwangoku esisibhedlela sinabasebenzi abangamashumi amabini ananye abasisigxina.

Abantu abasebenzisa izithomalalisi zikagawulayo bangama 192, abantwana bona bangama-42. Kuluhlu lokulinda lamayeza kukho abantu abangama-92 baseNomzamo kliniki nabangama-50 kwikliniki yase-Linge. Aba bantu bathe basweleka ngenxa yokulinda kuba izicwangciso zaseFrontier zithi kufakwe umntu abemnye ngenyanga kwizithomalalisi zikagawulayo.

Ngomhla wamashumi anambini kuJulayi 2005, umbutho ka-TAC wenza uqhankqalazo oluya kwesi sibhedlela uye kudlulisa isicelo sokuba kwandiswe inani labantu abafakwa kolu luhlu ngenyanga. Phambi kokuba kuyiwe esibhedlela amalungu kaTAC amisa kwindawo ekuthiwa sisangqa, edolophini apho ebesazisa abantu ngoluqhankqalazo. La amalungu ayephethe iibhodi ezazibhalwe ukuba "Phuma Zepe esihlalweni sakho xa ungawenzi umsebenzi wakho". Kwakuxongxwe neebhokisi zomgcwabo, ukubonakalisa ukusweleka kwabantu belinde lamachiza.

Utata uMatiti wavula ngomthandazo, waze uPhillip wachaza isizathu sokubakhona kwabo apho. UNozuko Smile okolu luhlu wathi " Ndaqala ukuzazi ukuba ndiphila nentsholongwane kagawulayo ngo 2003 ngenyanga yoMnga.Ndandikhulelwe, ndenza ubalo lwamajoni ngeyoMdumba 2004, iingxelo zabuya zisithi amajoni am angama-143. Ndahlaselwa sisifo sephepha esanyangwa kukuba nditye iipilisi zam ndizigqibe isithuba seenyanga ezintandathu. Okoko ndanditsalise igazi ekuqaleni kwalo nyaka ukuqonda ubungakanani bentsholongwane, andikafumani ngxelo unanamhla."

Endaweni yokufumana impendulo, kumphathiswa wesibhedlela. Amalungu kaTAC asuke abona sele ebhaxabulwa ngamapolisa. Bathi nokuba sebephandle badutyulwa ngeembumbulu nangezintywizisi apho konzakala abantu abaninzi.

BULLETS AND MEDICINES IN QUEENSTOWN

compiled by Sipho Mthathi, Linda Mafu, Nathan Geffen and Masizole Gonyela

The campaign for greater access to antiretroviral treatment in Queenstown received worldwide media coverage when police dispersed TAC demonstrators with gas, batons and rubber bullets. The police actions were condemned by many organisations including UNAIDS. But there are signs that despite police brutality antiretroviral treatment will be scaled up in Queenstown.

On 26 July 2005, TAC held a demonstration at Frontier Hospital in Queenstown. This followed months of efforts to increase access to treatment in Queenstown. It was also in response to the excessive use of force by police at a TAC march on 12 July.

At the 26 July event and meetings surrounding this event, TAC met with officials from the Eastern Cape Department of Health and Frontier Hospital, as well as the police. We are pleased to report that there has been progress:

- Four hospitals have been accredited for antiretroviral treatment in the Chris Hani District (which includes Queenstown). These are Glen Grey, Cala, All Saints and Cradock.
- The provincial officals explained that Frontier Hospital's limited uptake of patients was due to a lack of staff. TAC understands this problem and believes it must be solved by implementing a comprehensive human resources plan, as promised by the National Department of Health.
- TAC treatment literacy practitioners will be able to resume providing information to patients in the hospital about HIV.
- A community forum will be established at Frontier Hospital and TAC will have representation on this forum.
- Addressing the demonstration, police officer Pam McKenzie apologised to TAC for the events of 12 July. The Independent Complaints Directorate (ICD), South Africa's police oversight institution, is investigating the incidents of that day. TAC has also received a letter from the National Commissioner of the South African Police Service stating that they too are investigating the incidents of 12 July. We welcome such an investigation, but TAC also insists that the ICD investigation must be carried out independently of an internal police investigation.

Quotations from demonstrators as told to Masizole Gonyela:

"I joined the march because I was sick of being on a waiting list. So I wanted treatment and to stand up for my rights. We did nothing wrong at Frontier. Instead of committing to treating more people, the CEO called in the police." **Nozuko Smile**

"I am 31, living openly with HIV for 8 years and on treatment for a year. My CD4 count was 4 before treatment. Now it is 521. I joined the march because I access treatment through the TAC Treatment Project. However there are many people that do not and are dying because the rollout is slow." **Nompumelelo Khweza**

"I was shot in both legs. While inside the building I was beaten several times especially when I tried to help those who fell running away. People lost property. I lost my cellphone. The beating was out of proportion. Instead, the police could have arrested us."
Pakamisa Joloza

"Why did the police shoot at us with rubber bullets when we were running away outside the hospital?"
Mario Claasen

QUEENSTOWN: 12 JULY

A policeman aims at a marcher. Photo courtesy of CHMT.

A rubber bullet wound. Photo courtesy of CHMT.

TAC members fleeing. Photo by Masizole Gonyela.

QUEENSTOWN: 26 JULY

A large police presence. Photo by Masizola Gonyela.

Sipho Mthathi addresses marchers. Photo by Saul Konviser.

A cross-section of the march. Photo by Saul Konviser

THIRD TAC NATIONAL CONGRESS

CAPE TOWN, 23 TO 25 SEPTEMBER 2005

BUILD WOMEN AND PEOPLE WITH HIV/AIDS LEADERSHIP

Every two years TAC holds its National Congress. This is the organisation's highest decision making body. It is where the TAC National Executive Committee is elected and resolutions are made for the next two years.

TAC's third congress will be held on 23 to 25 September in Cape Town. The theme is *Women and people with HIV/AIDS leadership for a people's health service*. A report on the Congress will appear in the next issue of *Equal Treatment*.

Provincial congresses were held in August and September. At these congresses, provincial executive committees were elected and delegations to travel to the National Congress were determined. Provincial congresses also put forward resolutions for the National Congress.

Here are photos from some of the provincial congresses.

Delegates sing at the beginning of the Mpumalanga Provincial Congress that took place at Sizanani Village, Bronkhorstspruit, 6-7 August 2005. Photo by Sydney Masinga.

The TAC Gauteng choir gets into the groove at the Gauteng Provincial Congress held in Tshwane (Pretoria), 12 to 13 August 2005.

A treatment literacy workshop in Saldhana Bay, Western Cape. Photo by Rodrick Clarence.

Condom distribution in Kraaifontein near Cape Town. Photo by Vuyokazi Majali.

A member of the Independent Electoral Commission looks for the name of a TAC member on the voter's roll for the provincial elections of TAC Limpopo. Photo by Joel Ntimbani.

TAC members inform an Eastern Cape community about the rollout of antiretroviral treatment in their area. Photo by Skhumbule Hambani.

STATE TERROR IN ZIMBABWE

Here is a letter by a Zimbabwean AIDS activist. We have withheld his name to protect him from being harassed by the Zimbabwean state.

Since May, the Zimbabwean government has carried out *Operation Murambatsvina*, which means drive away rubbish.

Throughout Zimbabwe, homes and businesses have been destroyed. Police have bulldozed and burnt possessions. In Harare, people dependent on their informal businesses have been told by government to move to rural areas. But rural Zimbabwe cannot feed a huge influx of people from cities. Many people have also been forcibly removed in trucks to transit camps. *(source: Amnesty International)*

Zimbabwean President Robert Mugabe's gross human rights violations have resulted in massive displacement of ordinary Zimbabweans. Drawing by Masizole Gonyela.

Dear Friends

The situation in our country is currently worse than anything I could write here. Lives have been lost as a result of the clean-up campaign. What worries me most though is the timing: While we are struggling to access treatment for AIDS, we are faced with a famine.

The abuse is so gross. Medical doctors have increased consultation fees which means the sick will not go to hospitals, but die silently in their homes. If they are lucky and an NGO remembers them, they will get a bit of help before they die.

I have been involved recently in the turnaround of the network of people with HIV/AIDS in Zimbabwe but the process has been extremely stressful, as it has not been funded. So one is expected to walk to attend meetings. Not only transport is a nightmare. There is no electricity at home. And the lady where I normally order basic healthy food near the corner of the street is no longer there.

I visited a widow who is running a widows and orphanage trust. It took me four hours to travel nine kilometres to get there. Displaced people have gathered at her house for shelter and food. I can't describe the desperation of the people with HIV there. I have been for counselling and have told myself I will never cry but the situation is unbearable. We are just dying one by one. No-one seems to have the courage to tell people in authority that they need to think humanely.

Another form of discrimination we are facing is the voice of people with HIV which has gone. This is a result of some NGOs and people with HIV rubber-stamping decisions at workshops that far from fulfil our basic needs like food and shelter. Unfortunately it's not just the government of the day that has let us down; it is also the NGOs. They have missions and visions and state they are working on HIV/AIDS issues. I ask where? With whom? How? We don't get answers.

Things are just not normal here. But one thing can be said for Zimbabweans: we have learnt to endure extremely painful experiences.

It's more than just prayers that we need. We need assistance. We have been made to suffer on behalf of our government. When it comes to resource allocation, the few privileged are enjoying life in Zimbabwe at the expense of the poor and the dying. There is a sharp contrast in Zimbabwe between rich people and the poor (both with and without HIV).

I am coming from a Church service as I write this letter and the church was half-empty. Where is everyone ? Displaced? The situation in Zimbabwe has drawn world attention in the media. But what is needed now is practical assistance.

I thought I would die after a long time because someone had taught me positive living. Little did I know I would die sooner because with HIV in one's system and hunger your chances of going down quicker are higher.

I am proud to be Zimbabwean, but ...

MY TOER NA NAMIBIA

deur Rodrick Clarence

My toer na Namibia waar ek 'n MIV/VIGS werksessie bygewoon het was heel vrugbaar dog versteurend. Die werksessie het plaasgevind in Mariental. Die eerste ding wat my getref het, is dat daar baie min gedoen word vir mense wat leef met MIV/VIGS.

Die regering bied aan antiretrovirale behandeling (ARB) in die publieke sektor. Maar in Mariental is dit nog nie beskikbaar nie. Hier, is ARB slegs bekombaar in die privaat sektor en is glo taamlik duur. Die situasie is anders in groter stedelike gebiede soos Windhoek, waar daar 'n sterk aktiviste organisasie teenwoordigheid is.

Tot my verbasing, in Mariental, was werksessiedeelnemers nie eers opgelei om met mense te praat oor ARB nie. Daar bestaan geen voorkomingsprogram vir moeder-tot-kind oordraagbarheid van MIV nie. Hulle het ook nog nooit regtig iemand ontmoet wat openlik leef met die MIV/VIGS virus nie . Mense wat leef met MIV/VIGS word kwaai gestigmatiseer in hierdie plek en hulle het dus baie hulp nodig met opleiding en verspreiding van inligting. Ek het hulle toegespreek en hulle vertel van my eie ervaring met MIV/VIGS en ARB. Dit was vir hulle baie uitdagend en regtig aangenaam om my storie to hoor en om met my kennis te maak.

Op die laaste dag van my verblyf het ek die voorreg gehad om die Mariental Gemeenskapshospitaal te gaan besoek. Ek het verneem dat daar so pas 'n bejaarde dokter by die ARB program aangesluit het en hy wil baie graag die minder bevooregte gemeenskap help, maar die regering het nog nie enige ARB program goedgekeur in Mariental nie. Dit was uiters versteurend om die MIV/VIGS babas te sien op respirators wat na aan die dood was. Hulle het na hul laaste asempies gesnak terwyl ek hulpeloos moes aankyk, wetend dat daar geen behandeling vir hulle beskikbaar was nie.

Die probleme in Mariental is nie so verskillend van die probleme in baie plekke in Suid Afrika nie. Net soos TAC, het die Namibiese MIV/VIGS aktiviste groepe groot struikelblokke om te oorkom.

Die gemeenskap van Namibia was betrokke deur 'n optog vir antiretrovirale behandeling.
Foto verskaf deur Delme Cupido.

Rodrick Clarence en 'n vriend in Windhoek, Namibia.
Foto verskaf deur Rodrick Clarence.

> Mense wat leef met MIV/VIGS word kwaai gestigmatiseer in Mariental en hulle het dus baie hulp nodig met opleiding en verspreiding van inligting.

UGANDA'S CONDOM CRISIS

compiled from reports by Human Rights Watch and Health-GAP with added reporting from Equal Treatment

The United States government's ideological opposition to condoms has been embraced by Uganda's President Yoweri Museveni. This has resulted in a shortage of condoms in Uganda.

"There is no doubt in my mind that the condom crisis in Uganda is being driven by [US policies] ...To impose a dogma-driven policy that is fundamentally flawed is doing damage to Africa."

Stephen Lewis, Kofi Annan's special envoy for HIV/AIDS in Africa.

Source: The Guardian

The Ugandan government is obstructing access to condoms. Uganda's President Yoweri Museveni has spoken out against condoms saying that "this condomisation…is a recipe for disaster."

The First Lady, Janet Museveni, a vocal proponent of abstinence and opponent of other methods of preventing HIV, has criticized those who distribute condoms to young people, saying that the distribution of condoms is "pushing them to go into sex" and that "it is not the law that our children must have sex."

The Ugandan government has supported organizations that spread false information about the effectiveness of condoms as a method of preventing the transmission of HIV. Government adverts also promote abstinence in a judgmental way.

Today many non-government organisations that promote condoms say they fear that the recent policy shift to abstinence is reversing their success in gaining acceptance of condoms among young people. Many organizations believe that the recent shift in policy is due in part to the presence of U.S. funding for abstinence-only programmes. If action is not taken immediately, the situation in Uganda may spread to other African countries.

In October 2004, the Ugandan government issued a recall on all government-funded condoms. Allegedly the recall was in response to failed quality control tests on Engabu (Shield) - the only free condom available in Uganda. Within months Uganda's HIV experts were forecasting a condom shortage emergency.

The government-distributed condoms constituted 80% of the estimated 100 million condoms in the country each year. Today the condoms are in warehouses and the government refuses to state when they will release the condoms.

US Government's ideological approach to prevention

In 2003, President Bush announced a $15 billion emergency plan for AIDS relief (known as PEPFAR), but recipient countries must emphasize abstinence over condoms. A recent amendment to the act calls for recipient countries to condemn prostitution. Brazil announced that it will refuse to accept $40 million in aid rather than stigmatize prostitutes who Brazilian health workers said were essential to their anti-Aids strategy.

Source: The Guardian.

President George W. Bush is putting religious ideology before science. Photo from US Government.

What you can do to help

Please write to the Ugandan Minister of Health, Brigadier General Jim Muhwezi. Ask him, politely, to make sure that Uganda distributes more condoms. Also ask him to promote the use of condoms in Uganda's HIV prevention campaign.

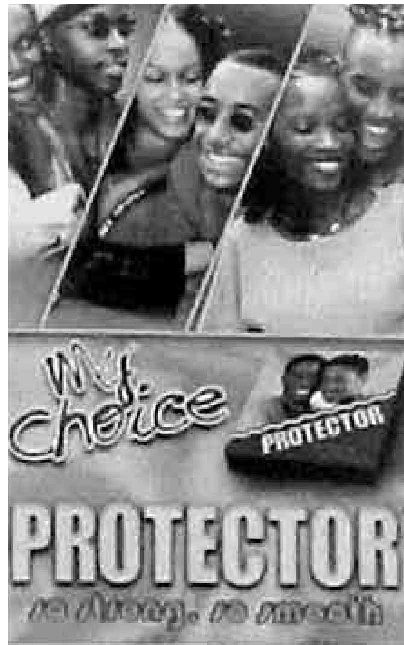
Please write or email him at:
Brigadier General Jim Muhwezi
P.O. Box 2780,
Kampala, Uganda
jkmuhwezi@parliament.go.ug

Uganda's Health Minister, Jim Muhwezi. Photo from Ugandan Government.

You can also send a message to Brigadier General Muhwezi through the following website: *www.advocatesforyouth.org/takeaction.htm*

Also write to US President George W. Bush and ask him, politely, to please stop imposing his religious views on US foreign policy. Ask him to encourage recipients of PEPFAR money to include condom promotion in their prevention campaigns.

Please write to him at:
President George W. Bush
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500, USA



Two HIV prevention adverts from Uganda. The left one promotes condoms. The right one promotes abstinence to transport workers. Photos from Bob Jones and the BBC. Copied for fair use.

A Brazilian Government condom promotion advert. Translation: Making love makes you relax…, gives you inspiration, replenishes your energy, is good for the heart, heightens your senses, stimulates your mind, brightens your soul and is good, really good. Safeguard your pleasure. Use a condom. Prevention is an act of love.

OUR RIGHTS IN OUR COURTS

No justice yet in Lorna Mlofana case

TAC protesters outside the Cape High Court at the trial of the alleged killers of Lorna Mlofana. Photo by Devon Manz.

TAC member Lorna Mlofana was murdered on 13 December 2003 at a shebeen in Khayelitsha after disclosing her HIV status to her attackers. It is alleged that Lorna was also raped by her attackers. Consequently, Khayelitsha residents, with the assistance of TAC, mobilised against rape and crime. After numerous postponements at the Magistrates' Court in Khayelitsha, the case was finally set down for trial in the Cape High Court on 22 August 2005. There it was delayed again because one of the two accused, who was out on bail, could not be located. The trial has been postponed again until 28 November 2005.

When the trial resumes, it will be nearly two years since Lorna was murdered. One of the accused has been in custody since January 2004. Not only does this call into question the accused's right to a speedy trial, but it is also an unjust delay for Lorna's family, friends and the residents of Khayelitsha who have mobilised for justice.

Sadly, the Mlofana case demonstrates how under-resourced the criminal justice system is.

Repeal of Black Administration Act

One of the last pieces of overtly racist legislation is being repealed (overturned) by Parliament. The Black Administration Act of 1927 deals with, among other things, the inheritance of estates owned by black people.

In 2000, the Constitutional Court described the Act as "a piece of obnoxious legislation not befitting a democratic society based on human dignity, equality and freedom" and "an egregious apartheid law which anachronistically has survived our transition to a non-racial democracy."

In a recent case dealing with the customary law of inheritance, Chief Justice Langa described the law as "a cornerstone of racial oppression, division and conflict in South Africa, the legacy of which will still take years to completely eradicate." While long overdue, the repeal of the Act is welcomed.

Stopping Matthias Rath's dangerous activities

Matthias Rath is a vitamin salesman and owner of a pharmaceutical company. He has committed the following illegal activities: making false claims about the products he promotes; conducting unauthorised medical trials and distributing unregistered medicines. An investigation by *Health-e* has found that patients on Rath's trials have died.

The Medicines Control Council (MCC) and Department of Health failed to take action against Rath despite TAC lodging a complaint with the MCC in March 2005.

Since *Equal Treatment 16*, the Advertising Standards Authority of South Africa (ASASA) has implemented sanctions against Rath:

- All Rath's adverts must be sent to ASASA's advisory committee before they can be published.
- A summary of ASASA's findings against Rath will be published, at his expense, in three newspapers.

TAC is taking legal action to stop Rath's illegal activities. We are also preparing to take action to hold the Minister of Health and the MCC to account for failing to stop Rath.

ALP/TAC Submission on the draft Health Charter

On 11 July 2005, the Minister of Health released the draft Health Charter for public comment. TAC and other civil society organisations were hoping that the draft charter would propose an agreement between all key stakeholders aimed at improving public health care. Such an agreement would include the investment of more money in the public health system and getting private health practitioners and companies to do more for poor people.

But the only concrete proposals in the draft are for the transfer of ownership of private health companies as part of black economic empowerment (BEE). TAC supports broad-based BEE but believes that on its own, changing ownership of private health care will not improve access to quality health-care for poor people.

On 15 August, the ALP and TAC handed a submission (endorsed by the Southern African Catholic Bishops Conference and NACTU) to the Department of Health. The joint submission raises our concern that the draft charter will not be able to transform the health sector into a people's health care service.

Progress on treatment in Limpopo and Eastern Cape

TAC has campaigned for more people to be put on antiretroviral treatment in Queenstown, Eastern Cape and throughout Limpopo.

Following a number of demonstrations and threats of litigation, we are pleased that some progress has been made.

A number of health facilities in Limpopo have been given the go-ahead to rollout treatment, including Tintswalo Hospital in Acornhoek. TAC has been campaigning with the Acornhoek community for antiretroviral treatment since late 2004.

As reported in the TAC events section, the Eastern Cape government has committed to improving access to antiretroviral treatment in the Queenstown area.

NAPWA's non-profit status

To receive funding from government, an organisation must be registered as a non-profit organisation (NPO). Following a complaint from TAC, an auditor-general's report released in 2004 found that the National Association of People Living with HIV/AIDS (NAPWA) had failed to account properly for the funds it received from the Department of Health.

Therefore, it appears that the Department of Social Development de-registered NAPWA as an NPO in early 2005. Since then, however, it appears that NAPWA was later re-registered, but we cannot confirm this.

Acting on TAC's behalf, the AIDS Law Project (ALP) therefore wrote to the Department of Social Development to establish the facts. The department failed to respond, so we have threatened to make use of the Promotion of Access to Information and the Promotion of Administrative Justice acts to force government to respond.

Poetry

CREATED FOR A PURPOSE

by Lerato Maloka

We are in this world to meet
others, be with others and
enjoy ourselves

We are in this world to
create opportunities, love
and hate others

We are in this world to
laugh, cry and regret

We are in this world to
encourage, discourage
and support

We are in this world to
challenge, build and destroy

We are in this world *and*
cheat, lie and
betray others

We are in this world to
experiment, learn and
face each day as it comes

We are in this world to
make mistakes and be corrected

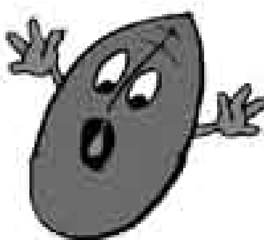
Mostly we are in this world to
live life to the fullest
and die

That is why it is so important
to take care of ourselves and
condomise!

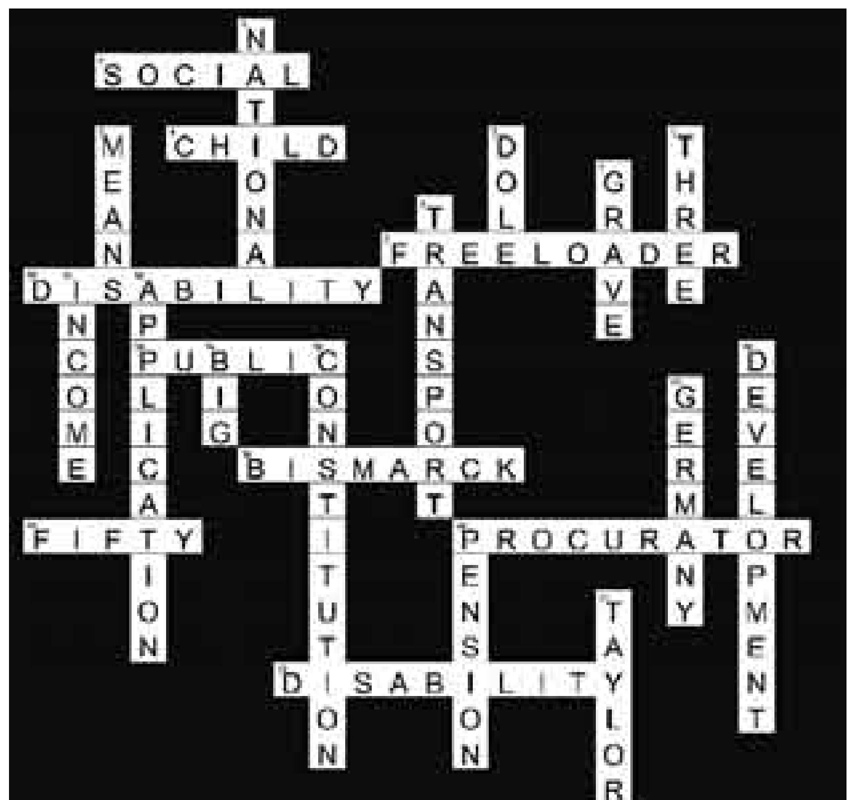
OOPS! WE MESSED UP

Error in the JULY issue of *Equal Treatment*

In the July issue, we referred to IDASA as the Institute for Democratic Alternatives in South Africa. IDASA changed its name many years ago to Institute for Democracy in South Africa.



SOLUTION TO LAST ISSUE'S CROSSWORD



WIN A PRIZE IN THE FIRST 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 Exclusive Books gift voucher.

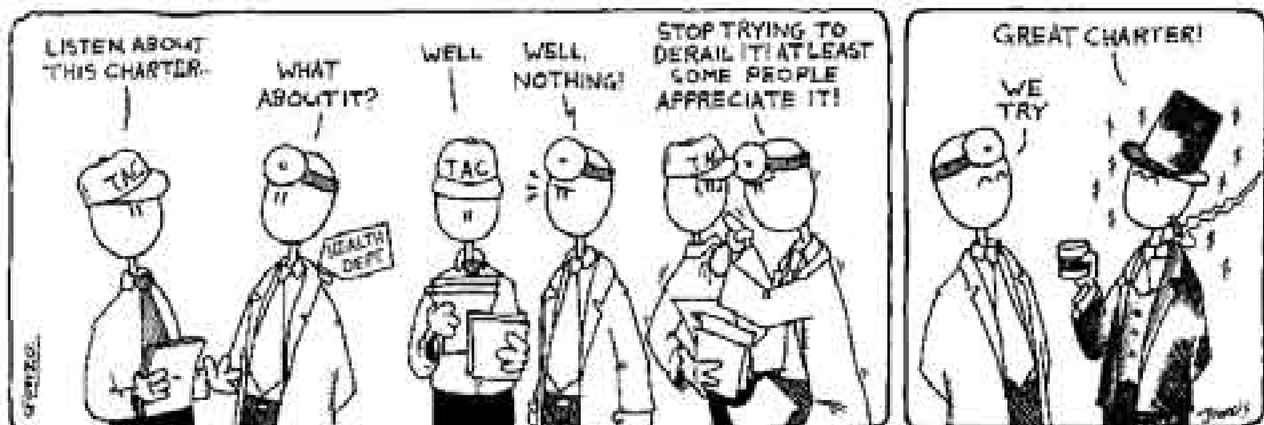
All the answers are in this month's *Equal Treatment*

1. List one symptom of TB. (Clue: I've been coughing for ...)
2. What is the abbreviation for the name of the current vaccine for TB?
3. When was the TB vaccine first used?
4. True or false: The TB vaccine is nearly 100% effective.
5. True of false: The tuberculin skin test cannot tell the difference between active and passive TB.
6. Name the four standard medicines used to treat TB.
7. Does MSF encourage the DOTS model for people taking antiretrovirals?
8. Is TB a bacterium or a virus?
9. What type of cancer did Archbishop Tutu recently recover from?
10. What is the name of the organisation that monitors police abuse and is investigating the incidents in Queenstown of 12 July?
11. What does Operation Murambatsvina mean?
12. What date was Lorna Mlofana murdered?
13. True or false: The draft Health Charter of 11 July 2005 contains no proposals for black economic empowerment.
14. Which organisation will print summaries of its rulings against Matthias Rath in three newspapers?
15. What is the scientific name for dandruff?

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 recipients of treatment literacy bursaries. Closing date for sending entries is 31 October 2005.

Post: Equal Treatment, 34 Main Road Muizenberg, 7945
Email: et@tac.org.za
Fax: 021 788 3726 - please phone 021 788 3507 to confirm receipt.



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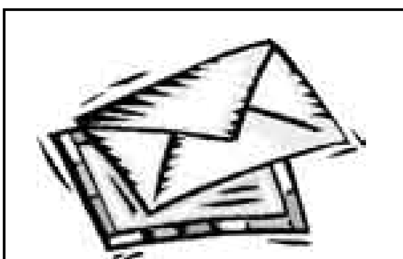
LETTERS FROM EQUAL TREATMENT READERS AND *BEAT-IT!* VIEWERS



Write a letter

The writer of the best published letter will receive a R200 Exclusive Books 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

Watch SABC 1 on Thursdays at 10h30 and on Sundays at 13h30. NEW SERIES BEGINS ON Sunday 16 October at 13h30.

SIYAYINQOBA

BEAT IT!

HIV

The TV programme for everyone living with HIV and AIDS, our partners, families, and friends.

SABC Education SABC 1 CHMT

Dry scalp

QUESTION: I am HIV-positive. My scalp is very dry and peels off. I have tried expensive shampoos and treatments but nothing works. What can I do?
Louise Mkhanya (name changed)

ANSWER: Firstly, you must see a doctor, preferably one with some HIV experience. We can only guess at what the problem is. It is possible you have a condition called seborrheic dermatitis (more commonly known as dandruff). This condition is much more frequent and intense in people with HIV. Antiretroviral treatment might assist with reducing the severity of seborrheic dermatitis.

What can I do to help?

QUESTION I live in North-West Province. I want to help people with HIV, but the clinics in my area do not yet provide antiretrovirals. What can I do?
Bridgette Sisulu (name changed)

ANSWER: There are many things you can do. For example, distribute TAC pamphlets on getting tested, nutrition and antiretrovirals to people in your community. Sit down with friends and explain the pamphlets to them. Make sure you and your friends get tested. That's a good start. Then perhaps join or try to start an activist group in your area to advocate for treatment in the clinics where you live.

Letters are edited for grammar and length.

FOKOFPOLISIEKAR MXO KAREN ZOID LOYISO MAFIKIZOLO KOBUS!
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SPRINGBOK NUDE GIRLS MALAIKA GODESSA 340 ML

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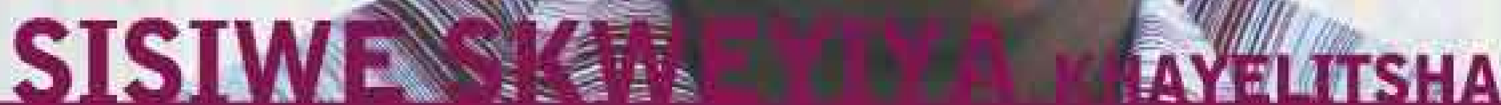

"Ndaqalisa ukutya i-ARVs ukususela ngonyaka ka-2002. Ndisempilweni, ndondlekile."

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