Double Dividend: Keeping Mothers, Children Alive And Healthy

By Mercedes Sauagues and Shantha Bloemen

CAPE TOWN - Florence Ngobeni-Allen choked back tears when she recounted the death of her two children from AIDS more than 17 years ago. It was a time when few pregnant women knew their status, let alone had access to treatment to improve their health and protect their babies from being infected with the virus.

Her tears brought home the painful reality that, despite the success in scaling up prevention of mother-to-child transmission, each year 260,000 children are still being born infected with HIV.

Children are half as likely as adults to be on antiretroviral treatment (ART), with only 34 per cent getting the life-saving medication and only a third receiving it within the first two months of life.

The South African born Ngobeni-Allen was addressing Ministers of Health from seven high-burden countries in Africa – Lesotho, Malawi, Swaziland, Uganda, Zambia and Zimbabwe – at a panel during the 17th International Conference on AIDS and STIs in Africa [ICASA], held in Cape Town between 7-11 December.

The panel was hosted by the South African government and convened by the United Nations Children’s Fund (UNICEF), the World Health Organisation and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).

Entitled the Double Dividend, the panel sought to align efforts to scale up paediatric ART and link it to broader child survival efforts. UNICEF and EGPAF experts presented an Action Framework to better integrate services in the 20 sub-Saharan African countries considered priority due to their high HIV burden.

"As we know, HIV disease progresses much faster in children than adults – without HIV treatment, half of children born with HIV die by the age of two, and 80 percent die by age five," said Chip Lyons, President of EGPAF.

The Framework aims to take HIV out of isolation, so that greater efficiency can be derived from the wider child health systems, and to strengthen the networks of referral and support for mothers and children.

"In countries where child mortality and HIV is high, this alignment means we not only address the unmet needs of children born to women living with HIV, but make sure both child and mother are healthy and that children survive, especially in the first few years of life when the risk of mortality is greatest," explained Martin Mogwanja, UNICEF deputy executive director.

By the end of 2012, coverage of prevention of mother-to-child transmission services had reached 65 percent in the priority countries. However, projections estimate that 1.6 million children aged 0-14 will need ART by 2020 in the priority countries.

Dr Chewo Luo, head of paediatric HIV at UNICEF, explained that the majority of children living with HIV often come to health centres suffering from other diseases, their HIV status unknown to their caregivers.

“Children face multiple threats like pneumonia, diarrhea, tuberculosis, malaria and malnutrition,” she said. “Unless we link our efforts, we risk losing children from multiple illnesses that, with the added burden of HIV, put them at risk of death.”

Even with ART, mortality rates for HIV positive children are estimated to be 30 times higher than mortality among HIV-negative children, largely due to opportunistic infections and common childhood illnesses, said a briefing paper presented by UNICEF.

Challenges
The Ministers observed that a mix of overburdened health workers, loss of HIV positive mothers to … Continued on page 3
Des travailleuses du sexe veulent être engagées dans la lutte contre le SIDA

Por Nqabomzi Bikitsha

L’ÉCAP – Des travailleuses du sexe en réunion en marge de la 17ème Conférence internationale sur le SIDA et les IST en Afrique (ICASA) au Cap, en Afrique du Sud, se sont plaintes d’être écarter dans les programmes d’intervention contre le VIH et le SIDA.

“ Ils [les gouvernements] disent qu’ils cons- tituions la cause du VIH et du SIDA mais ils refusent de nous engager de façon significa- tive, ils laissent mieux de cibler d’autres parties de la population “

Namakula Nakato Daisy de l’Alliance des trava- billeuses du sexe d’Afrique (ASWA) a déclaré à ICASA-Terraviva: “ Nous sommes très impor- tantes pour la réussite des interventions contre le VIH parce que nous constituons souvent les cibles pour le viol “.

Daisy, qui est originaire de l’Ouganda, a af- firmé qu’à travers l’ASWA, les travailleuses du sexe font actuellement pression sur les gou- vernements africains pour la reconnaissance de leurs droits – y compris l’accès à des soins de santé gratuits, la distribution des préservatifs, l’autonomisation économique et la décri- minalisation du travail du sexe.

Beyonce Karungi, une travailleuse du sexe transgenre - qui se décrit comme une femme bloquée dans le corps d’un homme – affirme que la criminalisation du travail du sexe dans la plupart des pays fait qu’il est difficile pour les travailleuses du sexe de négocier avec les gou- vernements pour une autonomisation.

“Quand un client vous viole, vous avez peur de signaler cela à la police parce qu’ils vous demanderont d’abord ce que vous faisiez en vendant les rapports sexuels. Certains clients refusent d’utiliser de préservatifs et il y a très peu de choses que nous pouvons faire à ce sujet”, explique-t-elle.

Karungi a déclaré que les travailleuses du sexe sont souvent forcées de refuser l’aide des travailleurs sociaux et des agents de santé à l’hypothèse qu’ils pourraient être des policiers en civil. "En fait, les travailleuses du sexe transgenres sont marginalisées plus que d’autres travail- leuses du sexe. Nous sommes écarter et on nous dit que nous n’appartenons à rien", s’est- elle plainte.

“Quand nous allons au centre de santé pour demander des préservatifs ou pour des soins de santé, on nous dit [que] nous faisons la promo- tion de l’homosexualité, parfois nous sommes battues pour le fait d’être transgenres. J’aimerais voir les gens éduqués sur les questions des transgenres au lieu de les discriminer “.

Tough Laws Against Sexual Minorities Slowing Down HIV/AIDS Fight – Mogae

By Ignatius Banda

CAPE TOWN – Former Botswana presi- dent Festus Mogae has advised African governments to soften their stance against homosexuality and protect the rights of sexual minorities if the continent is to win the battle against HIV and AIDS.

Mogae, who is chairman of the Champions of the HIV Free Generation – an association of ex- presidents – said tough anti-gay laws have only blocked the fight against the HIV and AIDS.

“Our African continent is becoming a hot-bed for punitive laws, discriminatory and marginalis- ing policies. We need to be reminded that these are citizens too and are entitled to human rights and dignity,” Mogae told delegates at the on- going International Conference on AIDS and STIs in Africa (ICASA) in Cape Town, South Africa. “The energy we devote to marginalise our very own [people] is an opportunity cost to advance our humanity.”

In several African countries, including Zimb- babwe, Zambia and Malawi, men having sex with men (MSM) have been branded crim- inals and in some cases slapped with lengthy prison terms on account of their sexual orienta- tion, while in other countries they have be- come targets of lynching mobs.

Mogae said criminalising minority popula- tions both violated human rights and affected how governments addressed HIV and AIDS on the continent.

Non-governmental organisations and gay rights activists have continued to lobby gov- ernments for laws that bar discrimination of lesbian, gay, bisexual, and transgender (LGBT) people.

The Council for Global Equality, which fights for the inclusion of sexual orientation and gen- der identity in the development agenda, says as many as 37 African countries are currently criminalising homosexual activity.
Making Young People The Centre of Reproductive Health

By Mantoe Phakathi

Mantoe Phakathi interviews Dr Julitta Onabanjo on UNFPA’s goal for young people post 2015 and whether enough has been done to address the obstacles they face today.

Q: Why is UNFPA Supporting a Sustainable Development Goal (SDG) for young people post-2015?

A: This is particularly relevant for Africa because the majority of the populations in Africa are young. There is a real moment in terms of the population size around young people. Young people should be at the centre of the agenda.

Our challenge is that they continuously face bottlenecks and barriers. They continue to be infected by HIV. Fifty percent of HIV in this continent is among young people.

Q: Part of the stumbling blocks that young girls in Africa face is the cultural and customary practices. Have we moved forward in addressing these barriers over the years?

A: I think we’ve moved forward but never enough. One girl who is being put up for marriage while she is a child, one girl that is exposed to gender-based violence, sexual violence by somebody who is close to her in her family, is one girl too many.

But we are seeing some progress and clearly partnerships, particularly partnerships and leadership from those who hold culture, custodians of culture, where they have changed and taken action.

Very recently in Malawi, we’ve had the leadership at cultural level in terms of chief-tancies making a change. In fact, in Malawi now what they have done is they have come up as traditional leaders and said no girl should be married before 20 or 21. That is the movement we want and I think that’s where we are seeing change.

Q: What are the interventions targeting the youth on HIV/AIDS?

A: Well, I think clearly we are saying that for the drive to zero new HIV infections, for the drive to zero discrimination, for the drive to zero deaths from HIV, young people are central. So in all the agendas that we will talk about, the conference, the scientific research, there is a lens that reads from a youth perspective.

Q: I have noticed the education around the new improved female condom at this conference, is it going to be accessible in terms of cost?

A: Interestingly enough, the cost of female condoms has really gone down and I think cost is very much driven by supply. The more we can ensure that women find this as a method which they can use, the more the supply increases and the cost goes down.

At the moment we are, as the UN system with donors, trying to subsidise that and to ensure that at least for the end-user it is not as expensive. Many times we help governments provide those commodities to facilities so [that] in countries where health service is free, and many are, they will have access to them. We are hoping that it will not be something that becomes exclusive to those who can afford.

Q: Hasn’t HIV/AIDS affected the supply of contraceptives in African countries, where governments have to cut their budgets on family planning to fund HIV/AIDS interventions?

A: One of the most important strategies that we’ll come to, maybe a little bit later, but we’ll take forward is the integration of HIV/AIDS with Sexual and Reproductive Health. It just makes sense. If that is done well, then there are sufficient gains that we can’t even begin to talk about.

We’ve made great strides. Because these are connected, whatever strides you make in HIV prevention, you make strides in sexual reproductive health and so there is a savings there.

We are really now doing much more to integrate family planning with HIV work, with antenatal with PMTCT [Prevention of Mother-to-Child Transmission] work. I think it will be the model to go forward.

Dr Julitta Onabanjo is the United Nations Population Fund (UNFPA) Regional Director for Eastern and Southern Africa.

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Continued from page 1... follow up, and a shortage of early infant diagnostic tests were barriers to identifying and treating more HIV positive children. Also in the wish list are palatable and affordable ARVs for children.

To bypass staff shortages, several countries are using community health workers to get sickly young children tested and started on treatment earlier to prevent high mortality rates.

Some countries plan to use the opportunities presented by immunisation, nutrition and health services as entry points to test and treat more children.

Today, Ngobeni-Allen has two young children born without the virus, thanks to ARVs and works as an adviser for EGPAF. She wiped her tears, looked at the audience, and said, “I don’t want any woman to go through what I did.”
Budding Recognition of Health Needs for Sexual Minorities In Uganda

By Wambi Michael

KAMPALA – At an unremarkable office on Bukoto Street in the Ugandan capital, Kampala, health workers and civil society activists attend a regular meeting to offer information and advice on living with HIV and AIDS. What is unusual is that these information sessions cater to a group of around 50 transgender women.

The "Come Out Post-Test Club", as the group calls itself, was established early this year as a safe space and advocacy group for trans women sex workers living with HIV. The club’s executive secretary, Bad Black, says it comes as a great relief to the members.

"It is one step in the right direction," says Black. "We hold online discussions. We also have regular physical meetings in a safe space. We are about 50 members, as of June 2013, although the numbers are growing."

According to her, many trans women have died in Uganda because of discrimination in the public health service. "We have lost seven of our colleagues this year alone," she recounts. "The biggest problem was negligence by the doctors. They never wanted to treat us because of our sexual orientation. We thought many more of us would die if we remained in hiding."

The turning point for the group was in April this year when a colleague, Abbey Mukasa Love, died.

"Abby wouldn't have died if the nurses and doctors had not stigmatised her," says Black. "They wrote the word 'gay' on her file. We decided to come out and form a support group and 20 of us began holding meetings every Sunday. We would invite some people to talk to us about treatment and prevention. It was not easy for many of us to come out."

The club's interaction with health workers at the Bukoto Street office – has brought about some change. According to Black, some health workers are opening up to offer better treatment and support to members of sexual minorities.

"To us that is a milestone, because very few would even associate with us once the Anti-homosexuality Bill was tabled in Parliament in 2009," Black adds.

The bill, which is still before the Ugandan Parliament, would impose strict penalties against sexual minorities. It proposes the death penalty for the offence of "aggravated homosexuality".

A survey by Makerere University’s School of Public Health into HIV infection in men who have sex with men (MSM) in Kampala in 2008-2009, found infection rates among this group were, almost twice as high as the national average. Whereas the national infection rate on average is 7.5, according to the Uganda AIDS Commission, the Makerere University survey puts the rate at around 13 percent for MSM.

Beyonce Karungi Tushabe, the executive director of Transgender Equality Uganda, an NGO working for the rights of transgender people, says it is difficult for transgender people to live with HIV in an environment where they have to keep their identities hidden.

"The restrictions are still the same (since the study). The stigma is still higher (for transgender) in hospitals. So, the few of us that are on (antiretroviral) treatment are just the tip of the iceberg," Tushabe says.

However, there has been some progress for this minority group. According to Flavía Kyomukama, a member of the Global Coalition of Women against AIDS, Uganda’s new strategic plan on HIV/AIDS control mentions MSM among high risk groups whose HIV prevalence is above the national average.

"This is the first time that our plan is mentioning MSM in HIV/AIDS control. And that is good for MSM and other most-at-risk populations like sex workers," says Kyomukama, who has lived with HIV/AIDS for 25 years.

In their World AIDS Day message, a coalition of 14 civil society organisations said that they were seeing some positive developments toward mainstreaming MSM and other at-risk populations in HIV and AIDS policy, and treatment by the health ministry and other actors.

Moses Kimbugwe, an activist with Spectrum, an NGO providing HIV and AIDS education and prevention for MSM in and around Kampala, says, "We are happy the Ministry of Health is committed to establishing clinics for MSM and sex workers in Kampala."

The ministry is also carrying out an epidemiological survey of key at-risk populations in order to determine their estimated size and better define their unmet public health needs.

The secretary for most at-risk populations – in whose Bukoto Street office the "Come Out Post-Test Club" meets – is now partly funded by the Ministry of Health and the Uganda AIDS Commission.

Understanding the terminologies...

The terminology used to describe different gender identities can sometimes be confusing. ICASA-Terraviva asked John Marnell, communications and outreach officer at the Gay and Lesbian Memory in Action Centre, to explain some of the terms being used at ICASA:

Transgender: Someone whose gender identity – that is, the person’s sense of himself or herself as either male or female – does not match their biological sex. This person may or may not have undertaken gender re-assignment through hormones or surgery.

Transwoman: A male-to-female transgender person who has a female gender identity.

Transman: A female-to-male transgender person who has a male gender identity.

Marnell explains that while gender is usually distinctly defined as either male or female, it is better understood as a spectrum. He also notes that gender identity has nothing to do with sexual orientation, but rather refers to our personal sense of who we are as a man or woman, without considering physical attributes.

Gay and Lesbian Memory in Action (GALA) is a centre for LGBTI [Lesbians, Gays, Bisexuals, Transgenders and Intersex] culture and education. Their mission is to act as a catalyst for the production, preservation and dissemination of knowledge on the history, culture and contemporary experiences of LGBTI people in Africa. You can find out more about them at their website www.gala.co.za
No Sign Of Care: HIV Testing For The Hearing Impaired

CAPE TOWN – John Maletsi, a hearing impaired South African, has been living with HIV for the past 12 years but his experience with HIV testing, shows just how much the rights of persons with disability are often violated in the HIV and AIDS discourse.

Maletsi, who is attending the ongoing 17th International Conference on AIDS and STIs in Africa (ICASA) in Cape Town, South Africa, recounted his experiences through an interpreter to ICASA-Terraviva:

I started to feel some changes in my body; I would be active in the mornings and become extremely tired in the afternoons.

I decided to go to the clinic, a small clinic close to my home. When I arrived, there was a sign language poster so I thought the counsellor or the nurse or the Doctor would be able to use sign language.

I just assumed there would be someone there who can sign. So, I thought I’d go in and give it a try. I went in and signed to the nurse and she said to me, sounding very shocked “Ooh he’s deaf”. I was offended because I felt he was patronising me.

The nurse later apologised and asked if I could lip-read. I said I could and the nurse took me to a counsellor who asked what I had come in for. I told them I had come in for an HIV test. The counsellor also could not communicate with me and kept me waiting for a long time. People kept passing, I felt angry not knowing what was happening.

Eventually, the counsellor fetched me and the whole time he was talking to the doctor. I thought maybe I could jot down notes. So, the doctor and I started writing notes but the terminology he used was so difficult for me to understand. The doctor had a terrible handwriting.

I knew I was supposed to get counselling but I never received it. The doctor told me to wait 15 minutes for the test. I was very anxious.

I sat there, no one came to comfort me and no one gave me any pre- or post-counselling. When my results were ready, the doctor wrote “YOU ARE HIV-POSITIVE” and splashed it in front of my face.

No explanation was given and I kept asking if they were sure. They became very irritated with me and just told me, “bye bye, now go!” I was devastated. Looking back now, I can see that deaf people do not get access and there are many disabled and deaf people out there and they are dying.

I will never forget what I went through. My poor education has made it difficult for me to understand HIV and AIDS terminologies. What about Braille? Why don’t condoms and ARV packaging have Braille? We have many challenges and there are no sign language interpreters for us in the clinics.

When I found out about my status [in 2001], I thought I was going to die instantly because I thought HIV means you are on the verge of dying.

When I started [taking] ARVs [Antiretroviral] drugs two years ago, I experienced the same problem. No one told me how to use the treatment. No one told me what they are for. No one explained CD4 count to me. They just gave me my pills and told me to go home.

I would like the government to give people living with disabilities information, use terminolgy we can understand.

Reporting by Nqabomzi Bikitsha
Intolérance aux ARV – un problème croissant pour le traitement du SIDA

Por Ignatius Banda

Le CAP – De nouvelles recherches suggèrent que certains malades du SIDA développent une intolérance médicamenteuse et des effets secondaires graves. Ces malades devront désormais passer à de nouveaux régimes anti-rétroviraux plus coûteux.

Des chercheurs au Zimbabwe, en Ouganda, au Nigeria et au Malawi déclarent que certains malades mis sous névirapine et l'Éfavirenz (EFZ), des médicaments anti-rétroviraux (ARV) de première ligne, mon- trent des signes d'intolérance à ces deux médicaments.

Daniel Sibanda, un chercheur de l'Université du Zimbabwe, a indiqué que bien que peu d'études aient été effectuées sur l'intolérance aux médicaments et les effets secondaires de la thérapie anti-rétrovirale (TAR), de nouvelles recherches ont révélé qu'il y a des inquiétudes par rapport à la toxicité pour certains malades.

"Notre recherche a montré que les femmes malades ayant des comptes de CD4 élevés avaient développé une toxicité à la névirapine", a expliqué Sibanda à la 17ème Conférence internationale sur le SIDA et les IST en Afrique (ICASA), qui se déroule actuel- lement au Cap, en Afrique du Sud. "Cela signifie qu'elles doivent passer à d'autres régimes de médicaments mais ceux-ci pourraient être des alternatives coûteuses".

Ces nouvelles inquiétudes apparaissent juste au moment où le Zimbabwe adopte de nouvelles directives de l'Organisation mondiale de la santé (OMS) qui a revu le seuil recommandé pour l'inscription des ma- lades sous la TAR, passant d'un compte de CD4 de 350 à 500. Les nouvelles directives ont augmenté le nombre de Zimbabwéens qui ont besoin de la TAR de 800.000 à plus de 1,2 million, selon le ministère de la Santé et de la Protection de l'Enfance.

La difficulté à payer pour l'élargissement de cette couverture du traitement est compli- quée par la possibilité que certains malades auront besoin de médicaments différents.

"Ceux-ci (névirapine) sont des médica- ments de première ligne et lorsque les ma- lades sont ensuite mis sous d'autres médi- caments à cause de la toxicité, cela pourrait poser des problèmes pour un pays tel que le Zimbabwe parce que ces médicaments sont coûteux et ne sont pas disponibles comme les ARV qui sont gratuits", a déclaré Sibanda à ICASA-Terraviva.

Au Malawi, l'un des pays ayant le plus grand nombre de personnes vivant avec le VIH selon le Programme conjoint des Na- tions Unies sur le VIH/SIDA (ONUSIDA), cer- tains malades développent des effets sec- ondaire de l'EFZ.

Dr Colin Speight, de l'Hôpital central de Kamuzu à Lilongwe, a déclaré à la conférence, Dr Daniel Sibanda, un chercheur de l'Université du Zimbabwe, a indiqué que les effets secondaires observés incluent l'étoile, l'insomnie et des rêves intenses, la psychose, la confusion, des éruptions et une démarche anormale.

"L'EFZ a été promu comme le nouveau médicament miracle au Malawi, et bien que la plupart des malades n'aient pas d'effets secondaires, des effets secondaires bénins étaient fréquents", a expliqué Speight.

Alors que le nombre de malades souffrant de problèmes reste faible, selon Speight, il n'existe pas beaucoup d'alternatives possi- ble pour les soigner.

"Ce que nous [visons] désormais au Malawi, c'est d'essayer de trouver un régime qui marchera le mieux pour autant de person- nes que possible. Nous n'allez jamais avoir un seul médicament que tout le monde sup- porterait", a-t-il souligné.

Au début de l’année, il y avait un tollé parmi les malades et les activistes du SIDA au Malawi qui pressaient le gouvernement à chercher de nouveaux médicaments après que plusieurs se soient plaints de différents ef- fets secondaires.

Une option pour faire face aux effets sec- ondaire et réduire la toxicité de la TAR pour- rait être la réduction de la dose que les ma- lades prennent, a déclaré à la conférence, Dr Jackson Mukonzo, un chercheur ougandais à l’Université Makerere, à Kampala, la capitale.

Mais le professeur Tandakha Dieye du département de l’immunologie de l’Université de Dakar a prévenu que les agents de santé et les malades avaient besoin de peser les in- quiétudes par rapport à la toxicité contre la capacité des médicaments à prolonger la vie.

"La toxicité ne se produit pas toujours dès que le malade prend le médicament; elle peut prendre beaucoup de temps avant de se développer ou même d’apparaître 20 ans plus tard", a expliqué Dieye. "Les avantages sont plus élevés que le problème des ris- ques... nous devons trouver un équilibre entre la toxicité et l’avantage des médicaments".

Sur un continent où beaucoup de personne- nes vivant avec le VIH sont déjà incapables d’accéder aux médicaments anti-rétroviraux qui prolongent la vie, le défi de l’intolérance aux médicaments menace des mesures effi- caces pour maîtriser l’épidémie du SIDA.

Des recherches plus approfondies pour dé- terminer les causes et le degré de l’intolérance aux médicaments sont demandées. Les chercheurs, praticiens de soins de santé et les responsables gouvernementaux peuvent ensuite élaborer des plans pour résoudre le problème.