



# iTHEMBA!



October 2006 Volume 1, Number 2

## In this Issue

**Editors' Note**  
Pg 1

**Features**  
**Soldiers in the battle against HIV -**  
HPRU trains research participants as  
Peer Educators  
Pg 1

**An Inspirational Leader – Justice**  
Edwin Cameron talks about hope, life  
and being HIV positive  
Pg 6

**HIV Prevention goes beyond "ABC"**  
– Highlights from Gita Ramjee's plenary  
at AIDS 2006  
Pg 7

**A Day in the Life...**  
**Thabo Cele – HIV Counsellor and Tower**  
of Strength  
Pg 8

**Upcoming Events**  
Pg 3

**Recent Events**  
Pg 9

**Friends of HPRU**  
Pg 9

**Staff Corner**  
Pg 8

## EDITORS' NOTE

25 years, 16 International Conferences and 40 million HIV infections later, now more than ever, it is "time to deliver". Such was the theme of the XVI International AIDS Conference held recently in Toronto, Canada. The promise of a "magic bullet" in the form of an HIV vaccine remains elusive, pushing prevention technologies into the limelight. *iThemba* captured some of the highlights of the excellent plenary by Gita Ramjee on microbicides and other HIV prevention technologies.

Moving closer to home, we offer an insightful glimpse into a *Day in the Life* of an HPRU HIV counsellor. We go with him into the counselling room and talk about stigma, disclosure and confidentiality. We also talk to some research participants who have been trained by the HPRU to become Peer Educators in their communities. We find out what motivates them and the impact their work is having on the community.



Edwin Cameron, South African Supreme Court of Appeal Judge and author of the book "Witness to AIDS", tells us his story and offers an inspirational account of his experience of living with HIV and his renewed hope after treatment saved his life.

In the spirit of *iThemba*, we leave you with a notable quote: "If we are organised, persistent and passionate, we can break the back of AIDS and lift the hopes of billions of people" – Former US President Bill Clinton to delegates at the XVI International AIDS Conference.

- *Melanie Mills and Zakir Gaffoor*  
*Your Editing Team*

## FEATURE

### HPRU TRAINS 36 PARTICIPANTS AS PEER EDUCATORS

The HPRU recently ran a 5-day training course to equip research participants with the necessary skills and tools to become Peer Educators in their communities.

Read more about the HPRU Peer Education Programme and the impact on communities on page 4.

*Right: Celebrations as 36 research participants complete a training course to become Peer Educators*



## A DAY IN THE LIFE...

### TOWER OF STRENGTH

#### Thabo Cele offers *iThemba* an in-depth look at a day in the life of an HPRU HIV Counsellor

During the 20-minute drive to the clinic, Thabo is keen to talk about the study – a trial assessing short-course antiretroviral therapy at acute HIV infection, known as the SPARTAC trial. He is formal and talks knowledgeably about the study procedures. He is very thorough, making sure I write everything down and that nothing is left out. Even amongst his fellow counsellors, he is very business-like – ensuring that everyone is clear about the day's activities. Today, the team of 3 counsellors will see 7 participants before 1:00pm, with each session taking 45 minutes to 1 hour.

Since learning of his HIV positive status in 1998, Thabo has developed a true passion for helping others to come to terms with their HIV status. "I like to help a person to change his or her own life" he says. Thabo's passion for counselling began when he joined NAPWA (National Association of People with AIDS) in 1998. He later joined the Treatment Action Campaign (TAC) as Provincial Organizer in 2001 where, aside from counselling, he was responsible for co-ordinating a number of advocacy and education events. His desire to concentrate on counselling and education brought him to the MRC in November 2005.

Thabo publicly disclosed his HIV status in 1998. "Back then, people were very ignorant about HIV". "After disclosure, people would come and ask me when does this thing (HIV) kill – when are you going to die?" Disclosure helped Thabo to get the support he needed to come to terms with his status. "Disclosure is a process" he explains, and it is important for him that "people see (him) as an ordinary person, not as a person dying of AIDS."

I am lucky today, as one of the participants has agreed that I sit in on her counselling session with Thabo. Confidentiality is foremost, so the tape recorder and camera are left outside the counselling room. "Confidentiality is very important," explains Thabo. "If I break that confidentiality, a lot of harm can be caused, especially if she [the participant] hasn't disclosed."

The counselling room Thabo takes me to is simple. A small table in the corner is used to display a variety of education materials including condoms. The walls are covered in colourful posters telling me to "Get tested", "Live positively", "Abstain, be faithful and condomise". The participant Thabo will counsel is HIV positive. She is not the typical face of AIDS that we see splashed across television screens and billboards. This woman is well-dressed, her hair elegantly braided. She wears make-up.



*HPRU HIV Counsellor, Thabo Cele in a counselling session*

The counselling is conducted in the participant's local language, which, in this case is isiZulu. Much of the exchange between counsellor and participant is beyond my understanding, but I catch a few words and phrases interspersed with English. The participant's eyes are downcast and she laughs nervously, clutching her handbag to her chest. I get the feeling they are talking about very private and personal things. When I ask Thabo about it later, he tells me that he was asking her about her sexual relationships. Thabo asks if she used condoms with her previous partners. She says sometimes. She says she will use condoms with her next partner.

Thabo began anti-retroviral treatment in 2004, after being admitted to hospital with a CD4 count of 96. He firmly believes that living positively with HIV allows him to better understand the concerns and challenges his participants face, especially in terms of disclosure and treatment. Sometimes the emotional burden of counselling up to 5 participants a day takes its toll. MRC counselling mentors are on hand to assist the counsellors to overcome this stress. Thabo also facilitates support groups and conducts HIV and AIDS education. "When I do education, all the stress and emotion from the counselling session goes away," he says smiling.

Thabo hands the participant a copy of the trial information sheet which is in isiZulu. It is six pages long and very detailed. They go through it together, pausing to clarify sections and to allow the participant to ask questions. She is invited to take the information home with her to discuss with a confidant before she makes the decision to join the trial. Thabo tells me we are lucky as this participant is literate and well-informed.

She has been in a Phase III trial in the past- and is familiar with research language and concepts like CD4 count and viral loads. Many of the women cannot read or write, so the information has to be carefully explained which means the session can take as long as an hour and a half.

The participant has decided to join the study. She laughs – she is tired and is happy to hear that blood tests will be done on another day. She suppresses a yawn. We are nearing the end of the counselling session. It has taken 50 minutes.

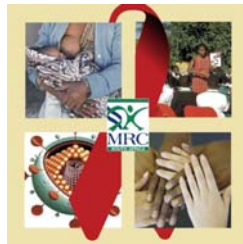
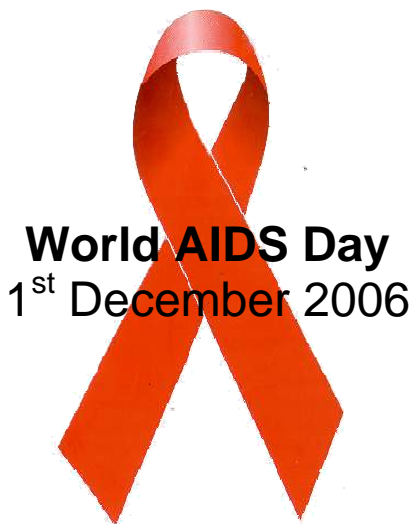
Once all the paperwork has been completed for this participant, Thabo will counsel another two women today. It is exhausting and emotionally draining, but dedicated people like Thabo work tirelessly to offer some comfort to these women. It is important for Thabo that the participants accept

their HIV status and begin the process of disclosure, all the time receiving counselling and support from the study counsellors.

Thabo would like to study further to become a psychologist and to continue helping people work through their own personal challenges. "I like counselling, I love it" he says, smiling. Thabo and his fellow counsellors are doing a wonderful job. Working in communities where the HIV prevalence among women ranges between 38% and 50%, Thabo will keep on helping people to live positively. "There are many people out there who need us," he says.

- *Melanie Mills*

## UPCOMING EVENTS



### HIV Prevention Research Unit: Research Day 2006

13<sup>th</sup> November 2006, HPRU, Durban  
The annual research day is a multidisciplinary forum for sharing of knowledge and best practices across the various HPRU studies and research sites. Highlights from the meeting will be included in the January 2007 issue of *iThemba*.



### The 14<sup>th</sup> Conference on Retroviruses and Opportunistic Infections (CROI)

24-28 February 2007, Los Angeles, California, USA.  
The conference provides a forum for basic scientists and clinicians to present, discuss and critique their investigations into the biology and epidemiology of human retroviruses and the diseases they produce with the ultimate goal of translating laboratory and clinical research into progress against the AIDS epidemic.  
[www.retroconference.org/2007/](http://www.retroconference.org/2007/)



**The KwaZulu-Natal AIDS Forum** is hosted in partnership by the MRC HIV Prevention Research Unit (HPRU) and the Centre for HIV/AIDS Networking (HIVAN). This monthly forum held in both Durban and Mtunzini (KwaZulu-Natal) is aimed at providing community and stakeholders updated information on HIV prevention, treatment and care using a multidisciplinary approach.

The main aim of the forum is to bridge the gap between science and community and provide a platform for the various stakeholders involved in HIV/AIDS to discuss issues pertinent and relevant to the way in which we respond to the epidemic.

For more information about the AIDS Forum, or to join the mailing list, please contact Thabile Zimu via email: [tzimu@mrc.ac.za](mailto:tzimu@mrc.ac.za)

## FEATURE

### SOLDIERS IN THE BATTLE AGAINST HIV

#### Training research participants to become Peer Educators

Sounds of singing and jubilation flow from the training room at the HPRU offices in Westville, Durban. Here, 36 research participants from communities in the greater Durban area are nearing the end of a 5 day training course to become peer educators.

Peer education is a critical approach to HIV and STI education within communities, and is a powerful tool used to effect changes in knowledge, attitudes, beliefs and behaviours at an individual level.

The HPRU has embarked on a programme to identify and train research participants to become peer educators within their communities. The 5-day training programme is designed to be interactive and to encourage dialogue. Through demonstrations, role-play and presentations, trainees are educated on transmission and prevention of HIV and STIs, TB, pregnancy and HIV, safe sex practices, male and female condom use, HIV counselling, disclosure, nutrition and health seeking behaviour.

On completion of the training, each peer educator is provided with education materials, community awareness flyers, posters, health education pamphlets and condoms to distribute, as well as a notebook to record their daily contacts and experiences.

Zakir Gaffoor spoke to four recently trained peer educators about what this programme means to them and their communities.

---

Set in the idyllic surrounds of the Valley of a Thousand Hills is one of the HPRU research sites. This picturesque setting makes it difficult to imagine the severe impact that HIV and AIDS is having on this community. The four peer educators, Doris Zondi, Dilili Ngcobo, Thafi Khanyile and Thembeke Nkala, all share a common passion: to make a difference in their communities. The following interview reflects their spirit of commitment to stemming the tide of the epidemic.

#### Did you like the training programme?

Yes we did. It went very well. We were extremely happy to be given training on counselling as well, since so many of our people come to us with their problems, health-related or otherwise. We also learnt about HIV and TB and how they are often related. This topic we think is important, since we see this a lot in the community. Also, people need to be educated so that they do not seek help too late.



*A Peer Educator receives her certificate from HPRU Director, Prof Gita Ramjee*

#### As peer educators, what have you identified as problems in your community with regard to HIV?

The main problem is fear. People are afraid to know their status, and those who do know, fear stigmatisation. People are scared to disclose if they are HIV positive. The women we talk to especially, lack the power to negotiate condom use. We go in and speak to people about these concerns.

#### Before you went into the community as peer educators, were programmes already in place? If so, were they working?

People were supposed to be able to get counselling and education from local structures like churches, etc. Unfortunately, this wasn't happening. People were scared to go to the clinics because they might be identified by people from the community who worked there. We see now the role that we are playing, and the community, even the youth, are very appreciative. The youth are even coming up to us and asking for condoms.

#### Why did you all decide to become peer educators?

Even before we became peer educators, we were active in the community. Before the HPRU came along, before we were educated, we were working to improve people's lives. We love our community. As past study participants, we knew first hand about the positive impact the trial made in our lives. We are the best people to communicate safe sex education at grass roots level.

*- Continued on Pg 5*

**How has your role as a peer educator changed your lives?**

Thembeke Nkala: Before I found it difficult to speak and would often be aggressive towards friends and family. Now I can say I speak easily. I talk all the time about HIV and AIDS issues to everyone, including family and friends.

Thafi Khanyile: I now have the confidence to stop people anywhere and chat to them about protecting themselves and others from this disease. I speak easily to family and friends now.

Doris Zondi and Dilili Ngcobo: As housewives, we now have the confidence to tell our husbands that we are going out to do important work for the community. We are no longer afraid to do what we feel is important and right.

---

Sister Bongickile Nxumalo runs the Mpumalanga Clinic near Botha's Hill where the community has access to a comprehensive care plan that includes VCT and PMTCT. She has first hand experience with the work of these peer educators.

**What do you feel about the peer educator training programme?**

It's good. These women will be able to provide an additional resource in taking the message out to where it's needed the most. I do feel however that the youth need to be targeted more, since they are most vulnerable to infection.

**What are your experiences with HIV in your community? What impact has the disease had?**

My experience is that the community is not educated enough when it comes to stigmatisation, disclosure, etc. It is sometimes surprising to see people who play a role in HIV awareness campaigns, who themselves do not practice what they preach. HIV and AIDS is widely prevalent in the community.



From left to right: Peer Educators: Doris Zondi, Dilili Ngcobo, Thafi Khanyile and Thembeke Nkala with HPRU CLO, Nomsa Ngwane

**In your view, what needs to be done to stem the tide of the epidemic at community level?**

One can never be really sure what's going to work. The media, education outreach efforts and such have all done a lot to spread the right message. People know what safe sex is. They are not ignorant when it comes to that. But I think that people simply refuse to change their sexual behaviour. I think it's all about behaviour. Hopefully the peer educators can try and make a difference here and get people to change.

**What impact has the HPRU and peer educators had in your community?**

Quite a significant impact. In terms of the clinic, the peer educators help out a lot, just by talking openly to people who may be waiting in line to be seen by a nurse or doctor. They are very hardworking, and come to the clinic very early, so that they may talk to all the people waiting outside. In this way, they are able to give health education to everybody.

Another thing is that the VCT counsellors at Mpumalanga clinic are all male. The peer educators are providing an invaluable service to the female patients who are more comfortable talking to them, rather than the men. They are also personally interested in the well-being of those they counsel, and follow up as much as possible with them.

**What would you like to see happening in your community with regard to HIV and AIDS?**

We are not accredited to provide ARVs, so I would like to see that and more roll-out efforts. At our clinic, we see people with TB who default on their medication. With ARVs, clearly that situation cannot happen. People need to adhere strictly to regimens. I see a role for peer educators in this, for the simple fact that they care and are willing to follow up on patients. If patients are intensively followed up, they are less likely to default. In terms of this country, I hope for an effective cure for AIDS one day. It will be a long way away, but that is my ultimate hope.

*- Zakir Gaffoor*



Above: HPRU CLO, Nomsa Ngwane speaks to Sister Bongickile Nxumalo from the Mpumalanga Clinic near Botha's Hill

FEATURE



**AN INSPIRATIONAL LEADER**

**Judge Edwin Cameron talks about hope, life and being HIV positive**

South African Supreme Court of Appeal Judge Edwin Cameron is no stranger to the issues of HIV and AIDS in South Africa, having been one of the earliest high profile figures to go public and disclose his HIV positive status. His current standing as a moral and intellectual leader in the fight against the epidemic led him to write his book, *Witness to AIDS*, and takes him on lecture tours to various institutions, where he seeks to inform government, the business world, civil society and the public at large about the HIV and AIDS epidemic. His thoughts on stigmatisation and treatment have been described as particularly frank and insightful, and Judge Cameron remains a creative contributor to the civil discourse surrounding HIV and AIDS in South Africa and abroad.

The *iThemba* editing team managed to track him down for a feature article, and we are proud to present in this issue an edited version of a lecture given by Judge Cameron in August this year entitled “*Leadership Lessons from Surviving an Epidemic*”.

I was diagnosed with HIV in December 1986 – that’s very nearly twenty years ago. For many long and dreadful years I kept my diagnosis a secret from nearly everyone. In doing so, I hoped against hope that I would never fall ill from AIDS. But eventually I did. In October 1997, just about nine years ago, I fell very severely ill. I was a judge in the high court in Johannesburg at the time and it was very difficult to continue working, but I managed to do so. What is very important is that by the time I fell ill, there was medical treatment for AIDS. AIDS had for many years been an incurable and unavoidably fatal condition. Now it had become medically manageable. I started on the new medications and began what seemed to me – and still seems – a miraculous recovery. The fact that I had fallen ill with a deadly illness, but that I had been allowed to recover, made a very profound impact on me. It seemed astonishing, extraordinary. I had expected to die: and yet now I would live.

**“I had expected to die:  
And yet now I would live.”**

me access to doctors and medication. This was while many millions of poor people in Africa and elsewhere were dying because they did not have the same privileges.

At the same time, there was the problem of stigma. AIDS is perhaps the most reviled and stigmatised epidemic the world has ever experienced. This is for two reasons: because AIDS is associated with debilitation and death, and because HIV is sexually transmitted.

The first reason is no longer valid, and the good news that AIDS can be successfully treated is spreading, with new medications increasingly reaching even poor people.

But the second reason remains. It is an intractably difficult issue, but the truth is that to carry a sexually transmitted infection bears a stigma. I thought when I discovered that I had HIV that it was because I was a gay man. I was proudly and openly gay, a young practising human rights lawyer: and

I realised that I had recovered for only one reason: Because my privileged position gave

I thought the shame I felt was because of my sexual orientation. But as the epidemic deepened in Southern Africa into a predominantly heterosexual problem, it became clear to me that the feelings of shame and contamination I felt had nothing to do with being gay. They stemmed from sexual transmission, for heterosexual people, even those infected by their sole sexual partner, report the same feelings of shame and contamination.

So people living with AIDS remain scared to speak out because of stigma and discrimination and ignorance and fear. And because no one with HIV/AIDS speaks out, there is more stigma and discrimination and fear – a malevolent circle. So I decided to speak out. A few years ago I made a public announcement –

- That I was living with HIV
- That I had recovered from AIDS
- That my recovery was entirely due to my privileged access to medical care and expensive medications, and that I wanted to help secure conditions where everyone with HIV could have access to the same medications that had saved me from suffering a terrible death from AIDS.

- *Continued on Pg 8*

## FEATURE

### HIV PREVENTION GOES BEYOND “ABC”

#### Highlights from Gita Ramjee’s plenary “Microbicides and other prevention technologies”

Prof Ramjee, as Director of the South African Medical Research Council HIV/AIDS Lead Programme presented a plenary entitled “Microbicides and other HIV prevention technologies”. Her talk emphasized the importance of finding options for women to protect themselves against HIV, especially since the strategy of ‘ABC’ (Abstinence, Be faithful, Condomize) are often not viable options for those who are vulnerable to abuse and exploitation. Prof Ramjee’s assessment encompassed the full spectrum of current and future HIV prevention methods; among them progress with regard to the current batch of microbicide clinical trials, the first results of which are expected towards the end of 2007. Advances towards developing and testing 2<sup>nd</sup> generation microbicides like Tenofovir, as well as novel delivery strategies such as vaginal rings were presented. These innovative approaches hold significant promise for the future, in terms of overcoming current microbicide challenges like male acceptability.

The potential for HIV prevention through cervical barrier technologies such as vaginal diaphragms added another option to the armoury of prevention. An update on the status of cervical barrier trials was presented. The Methods for Improving Reproductive Health in Africa (MIRA) trial, which is testing a latex diaphragm with Replens gel, is nearing completion in South Africa and Zimbabwe with results expected by June 2007.

One of the more recently debated aspects of prevention is male circumcision. From a biological and epidemiological point of view, male circumcision is shown to significantly reduce the risk of HIV acquisition and transmission. The Orange Farm study conducted in South Africa revealed an effective protection rate of 60% among circumcised men, in comparison to those not circumcised. Three trials are currently being conducted to determine whether or not circumcision should be included in public health policy as a prevention tool. Prof Ramjee stressed the challenges that accompanied this kind of intervention, including cultural, religious, safety and ethical factors.

Another novel aspect of prevention is pre-exposure prophylaxis (PrEP). PrEP derives proof of concept from malaria and PMTCT, and researchers in the field believe that it may be effective in preventing HIV transmission and acquisition among high risk populations. The current candidates, Tenofovir and Truvada, have shown good safety profiles. However, the concern of drug resistance and breakthrough infections, as well as the ethical implications of

providing healthy people with potentially toxic drugs remain a challenge.

The plenary profiled studies that reported HSV-2 infection to increase the risk of HIV transmission, infection, as well as increase viral load in people who are already HIV positive. HSV-2 suppressive therapy has been identified as yet another intervention to be explored in HIV prevention. Clinical trials are underway, and challenges include possible HSV-2 resistance and concerns with adherence.

Delegates at the plenary were reminded about the likely impact of diverse and increasing HIV prevention options on public health. A 60% effective microbicide for example, could avert 2.5 million new infections in middle to low income countries [1], and widespread implementation of male circumcision in Sub-Saharan Africa could avert 2 million new infections over the next 10 years [2].

Prof Ramjee’s plenary in many ways echoed a major theme of the conference. Adopting an integrated approach to tackling HIV prevention received heightened awareness from the likes of Bill and Melinda Gates. In her concluding remarks, Ramjee noted that the current alphabet of

#### “Treatment without prevention is simply unsustainable” – Bill Gates

prevention *viz.* abstinence, being faithful and using condoms (ABC) was no longer enough. She presented an innovative model for HIV prevention, which, in addition to 4 proven HIV prevention technologies - behavioural change, voluntary HIV testing and counselling (VCT), prevention of mother-to-child transmission (PMTCT) and male and female condoms – now included emerging technologies. “HIV prevention is more than just ABC.” said Ramjee. “We may soon be adding another C for circumcision, D for diaphragm, E for exposure prophylaxis pre- and post, F for female initiated microbicides, G for genital tract infection control, H for HSV-2 suppressive therapy, and I for immunity (vaccines)”.

I close with the words of Helene Gayle, conference co-chair: “Our commitment has to be to make options available, develop options that are safe and effective, so they can be used by people who need them the most, and at the same time make sure we have policies so that they are used in the safest way possible from a public health perspective”.

- Zakir Gaffoor

#### References

- 1 Public Health Working Group: model projects, 2002
- 2 B. Williams *et al.* The potential impact of male circumcision on HIV in Sub-Saharan Africa. PLoS Med 2006;3:e262



For Prof Ramjee’s and other presentations from AIDS Toronto, go to [www.aids2006.org](http://www.aids2006.org)

- Continued from Pg 6

The result of my decision was for me an intensely moving experience.

When I made my public statement I was deeply fearful of how my friends and colleagues and the public and the media would react. As it was, I was overwhelmed with the extent of the positive reaction – I received only love and support and affirmation from almost every side. Nearly nine years after facing death from AIDS I am still living – in joy and hope and surrounded with activity and commitments and friends and involvement. It is a wonder and a miracle and a joy to be privileged to survive an epidemic in which so many have died, in which so many will die today, in which so many still face unnecessary death.

So I want to share with you the things that I have learnt in surviving AIDS:

First, and most basically: *Work with what you have*. I didn't want to have AIDS. For years I found it impossible to accept, to acknowledge that I had AIDS. Now I am reasonably sure that not all of you have AIDS. Yet life has perhaps given you things that you struggle against, fight against, refuse to accept. *Work with them*. You may not have all you want or desire. But you have been given so much else. You have been given life and friendship and hope and love and family in a world in which each of these is a very precious commodity. I was given AIDS in a world in which to have AIDS is not recommended. The hardest task I faced in my life was to accept that I had the virus, that I faced death from its effects, and that I had to integrate that

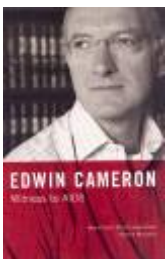
fact into every aspect of my existence. And when you accept and integrate what you do have, your life becomes more powerful, more open, fuller, more joyful.

Second, *never give up*. You may think everything is stacked against you. But the world is full of surprises. When I discovered in 1986 that I was infected with HIV, I knew with dread certainty that my life was at an end. I planned for an early death. But events surprised me. AIDS, instead of remaining an inevitable death sentence, became a medically treatable condition. One of the impelling missions of my life is to expand the benefits of that surprise to other people, people who face avoidable death and unnecessary suffering in a world that has the capacity to treat their condition.

Third, and most importantly: take a look around you. *Take a risk*. You are surrounded by people. Each of them is a potential friend and ally. So take a risk sometimes. Trust people, even where you may risk disappointment. There is more love and warmth in this world than any of us expect or can hope to exhaust in our lifetimes. Take a risk occasionally and claim it. I did, when I spoke out, and people's responses still dumbfound me in their generosity.

So - three simple lessons: *Acceptance* in self-knowledge, *perseverance* in the expectation of surprise, and *risk-taking* in faith. They are the building blocks of human enterprise, joy, connection and achievement. The world is a perilous and sometimes dangerous place, but through self-acceptance, perseverance and faith we can truly make it better.

- Edwin Cameron  
(Edited by Zakir Gaffoor)



Judge Cameron's recently published biography entitled '*Witness to AIDS*' has been acclaimed as a work of achingly beautiful prose, a devastatingly personal account that in many ways mirrors the wider tragedy-and hope-that is the AIDS pandemic in Africa.

Nobel Laureate for Literature Nadine Gordimer has spoken thus of his book: "If truth is beauty, this relentlessly brilliant and hopeful book is beautiful. It is a text to live by, if we aspire to the possibility of a better life for all.... in a world widely threatened by HIV/AIDS"

## STAFF CORNER

### FIGURING IT ALL OUT



The HPRU would like to introduce our new Finance Manager, Kumeshini Haripersad. With over 10 years experience in finance and accounts, Kumeshini has a degree in Commerce, a diploma in cost management accounting and is currently completing an MBA.

On behalf of *iThemba* and HPRU, we would like to welcome Kumeshini to the team!

### STORK SOON TO VISIT HPRU

HPRU staff members, Cecilia Milford and Dennis Makhubela, are soon to be proud parents of baby girls.



## FRIENDS OF HPRU



Left: Zeda Rosenberg, CEO of International Partnership for Microbicides (IPM) visits the MRC site where IPM funded studies will be conducted



Right: Sandra Lehrman, Director of the Therapeutics Research Program, Division of AIDS, National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health (NIH), recently visited the HPRU. Dr Lehrman spoke to senior scientists and clinicians about the advances in ARV development and research

## RECENT EVENTS



### MICROBICIDES DEVELOPMENT PROGRAMME (MDP) INVESTIGATORS' MEETING Durban, September 2006

Members of the MDP team let their hair down following a week of intensive meetings and workshops at their International Investigators' Meeting. The meeting brought together investigators from the MDP microbicide trial sites in Durban, Johannesburg, Tanzania, Zambia and Uganda, as well as programme leaders. The culprits in the photos below prefer to remain anonymous



### COMMUNITY MEETING HELD IN HLABISA 13<sup>th</sup> October 2006

As part of the HPRU community mobilisation strategy, large community meetings are held by the HPRU Director at each research site twice annually. These meetings provide an opportunity to present updates on the research to the community stakeholders as well as facilitating on-going dialogue between researchers and the community. Recently, such a meeting was held in Hlabisa where HPRU is conducting the HPTN 035 microbicide trial. The audience included trial participants, traditional leaders, community advisory board members and other stakeholders. In addition, the FHI study manager and data manager from Seattle were present.

From left to right: Members of the community attending the meeting; CWG Chairperson, Mrs. Miriam Hlabisa; Prof Ramjee speaking to the attendees with CLO Sibusiso Nhleko translating into isiZulu



The Editing Team would like to thank Edwin Cameron and Thabo Cele for inspirational and honest accounts of their HIV/AIDS stories. To everyone who contributed to this issue of *iThemba* through your suggestions and comments, we thank you.

For further information or questions regarding the stories in this publication, please contact the editing team Melanie Mills and Zakir Gaffoor at [ithemba@mrc.ac.za](mailto:ithemba@mrc.ac.za)