MOBILISING COMMUNITIES

18 May was World HIV Vaccine Awareness day. It was an appropriate time to reflect on the community preparedness we are undertaking in at least four provinces in South Africa at present. In Soweto and Durban early-phase vaccine trials are already underway. But the big and exciting challenge will be the larger efficacy trials that will be needed to develop a successful vaccine. South Africa will be a significant role player when a candidate looks promising enough to test in thousands of volunteers to assess efficacy. Heartening for us all is the fact that the lists of potential candidates for testing are much longer than before, and we need to move these quickly into humans to see whether any of them show promising immunogenicity. It is proving tricky to understand exactly what type of immune responses will be protective against HIV. We do know that we will need to stir up both humoral and cellular immunity, and have yet to confirm whether viral subtype will be important or not.

In the meantime community education and mobilisation must go on – and this is a positive spin-off for communities while awaiting vaccine trials. Good preparation means more resources for education, risk reduction counselling and research around sociobehavioural issues related to infection risk, testing and participation in research trials. There is no doubt that a lot of community education is needed to ensure that volunteers are truly informed and that research trials are ethical. Some of the research underway involves how to be sure that participants actually are informed adequately before signing consent to participate, what motivates volunteers to participate, what motivates volunteers to participate, and what the sexual practices and risks in volunteering individuals are. Some of our local work has shown that fear of needles is a significant deterrant to voluntary counselling and testing – a good reason for doing finger prick rapid tests for HIV!

A large multicentre study to be carried out by all four SAAVI clinical trial sites, Soweto, Durban, Orkney and Cape Town, is currently being finalised. It will assess incidence in each of these sites and give each the opportunity to investigate retention rates. Other in-depth immunological and virological studies will be carried out in volunteers who seroconvert despite risk reduction counselling and support. These studies will give insight into the natural history of clade C infection. All very important information when designing vaccines and vaccine trials for South Africa.

One of the areas that SAAVI and its investigators are grappling with is the issue of participation of minors in vaccine trials. If a successful preventive vaccine is found we will want all vulnerable South Africans to be vaccinated. There is no doubt that our 12 - 19-year-olds are at particular risk, and we need to be sure that any vaccine developed will also be licensed for this group. Children at risk for HIV as a result of maternal transmission and rape also need to be included. So many legal and ethical concerns need to be considered and worked through so that we are not caught flat-footed should the wished for and hoped for breakthough of a successful vaccine occur.

As we have in this week considered the community preparedness that has gone on in the four SAAVI potential vaccine sites (and there are others), it has been great to note the level of preparation and education that we have been able to attain and that which is still planned in these communities for vaccine trials. The thought crossed my mind – how nice it would be if we could do the same amount of preparation before initiating our treatment programmes. Yet, with a life-saving therapy we cannot, must not, hold back until sufficient preparation is in place. Instead we must find the energy and resources to do the preparation in parallel with implementation.

We have this month had the joy of doing some ART training in the Northern Cape. Besides the cold mornings and long travel distances it has been terrific to see the eagerness of health care workers to get on with actually providing treatment to their needy patients, but at the same time there is also a real recognition of the size of the task ahead. When I think back to the start of our programme in Gugulethu, I realise that we could have done so much more community education and mobilisation. While we have engaged to some extent with the traditional healers in this community, we could be doing much more. We could have engaged more with the local private health network. We have had to discover other social resources and CBO networks in the community as needs have demanded, but could have been better prepared to deal with issues of food security, alcoholism, domestic violence and housing – just some of the other problems faced by people who need antiretroviral treatment. As we gear up in communities to begin to distribute these life-saving therapies to as many as possible, it is vital that all community-based resources step forward (even unasked) to ensure a national ARV programme that is equitable, successful and comprehensive.

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