IMPACT OF APARTHEID ON HEALTH AND RESEARCH IN SOUTH AFRICA
Welcome to the newest edition of the HIV Vaccine Trials Network (HVTN) Community Compass.

HIV/AIDS continues to ravage families and communities, globally, more than 36 million people are estimated to be living with HIV as of 2017\(^1\). Also in 2017, around 1.8 million new HIV cases were seen, along with more than 900,000 deaths associated with HIV-related causes\(^1\). It is also estimated that only about 75% of persons living with HIV are aware of their status\(^1\), which exponentially complicates prevention and care/treatment efforts because persons who are living with HIV and unaware of their status are more likely to transmit the virus to others.

Though HIV is a major global public health issue, the continent of Africa bears the most burden of HIV disease, accounting for more than two-thirds of new HIV cases globally\(^1\). In 2017, nearly 59% of adults and 52% of children, living with HIV around the world were receiving antiretroviral therapy (ART)\(^1\), which is certainly progress but much more is needed.

Key populations such as transgender persons, people who inject/use drugs, prison populations, men who have sex with men, and sex workers and their clients, often represent smaller proportions of the larger population. They may be more vulnerable to HIV regardless of local HIV prevention and care/treatment efforts or the local HIV epidemiology due to social and
From the Editor

structural factors such as stigma/discrimination, heterosexism, poverty, intimate partner violence, economics, and cultural and social norms regarding gender and sex assigned at birth, sexuality, and ethnicity/race. These factors work like a cycle, reinforcing each other, ultimately resulting in decreased success at all points on the HIV care continuum and exponentially complicated prevention efforts. It is understood that HIV prevention tools do work, including one of the most recent, Treatment as Prevention, an HIV prevention strategy indicating that people who have an HIV viral load that is suppressed to undetectable levels are incapable of transmitting the virus to others. This message is gaining traction globally with campaigns like U=U (undetectable = untransmittable), particularly among advocates, activists, researchers and clinicians, as it is rooted in the science behind the results of many sources including a clinical research study, HIV Prevention Trials Network (HPTN) 052, which demonstrated that among serodiscordant couples (where one partner is living with HIV and the other is not), HIV transmission can be reduced by up to 96% when the partner living with HIV starts HIV treatment early, is adherent to treatment, and is virally suppressed (an undetectable viral load).²

None of these, or future advances to respond to HIV, will be effective without the community. Communities, particularly those most impacted by HIV, who serve as partners in the research enterprise and in local, national, and global responses to HIV, are critical. Moreover, communities that are well-informed about the science contribute effectively to better science. This is a core belief of the HVTN. It is demonstrated through our engagement of communities in all phases of the research process, which encourages trust, mutual respect, and understanding of the issues related to research. It also ensures that the processes and strategies that we use as a Network respect and honor the diverse values and differences of our study participants. The work of the HVTN is also informed by a model published by UNAIDS and AVAC entitled, “Good Participatory Practice: Guidelines for biomedical HIV prevention trials,” which provides a roadmap for researchers to best work and partner with communities as key stakeholders. These guidelines have been, and continue to be, a critical framework that informs our processes.

In this issue, we highlight some myths and facts about HIV vaccine research, describe important information relating to HIV testing considerations for HVTN study participants, and showcase some of the amazing people and research sites in the HVTN. We also have a special feature article on apartheid, the HVTN RAMP Scholars program, and a special award received by our very own Prof. Gita Ramjee, Director of the HIV Prevention Research Unit at the South African Medical Research Council.

Please help us ensure that this publication is representative of our entire global HVTN community! HVTN members (who have access to the HVTN member’s website) can use our newly developed submission page that offers the ability to submit content and articles for inclusion in future issues. More information about this follows on page 4 under the “Meet the Community Compass Team” section.

Thank you for your continued support of the HVTN wherever you are in the world, for the work that you do in whatever role you have in the HVTN community, and the impact we have been able to make in our collective history and communities, together. Though we have come very far in response to the HIV epidemic, we have so much further to go to achieve an effective global HIV vaccine. The HVTN Community Compass team wants to be everywhere you are, so please share with us what’s happening at your research sites, institutions, and in your communities, so that we can share it with the world. Please share HVTN Community Compass with your friends, family members, colleagues, and communities.

Be well,
Stephaun E. Wallace
Editor-in-Chief, HVTN Community Compass

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Our vision is an informed HVTN community that is aware of current events and activities relating to the HVTN network and its sites, advances in the field of HIV prevention and vaccination, as well as community priorities. We work to accomplish this by providing relevant information and updates to promote awareness, understanding, and support for HIV prevention and HIV vaccines, reaching global communities invested in the response to the HIV epidemic.

We welcome submissions of articles on any topic for publication that is relevant to the HVTN community. Submissions must be exclusive to us, and not appear in any other publication. Submissions must be 500 words or less to comply with our layout and design requirements. Due to space limitations, we may need to hold publishing your article for a future issue.

To submit articles for Community Compass, please go to the HVTN Members Site homepage, click on “About”, then click “Community Compass”, then click on “Submit to Community Compass”.

Meet the COMMUNITY COMPASS Team

Stephawn E. Wallace, Editor-in-Chief
Cody Shipman, Layout & Design

Gail Broder, Contributing Editor
Nina Ennis, Production & Distribution
Myth: HIV vaccines can give people HIV.
Fact: This statement is false: a person CANNOT get HIV from the study HIV vaccines because these study vaccines do not contain real HIV. Some vaccines, like those for typhoid or polio, may contain a weak form of the virus they are protecting against, but this is not the case for HIV vaccines. Scientists make HIV vaccines so that they look like the real virus, but they do not contain any HIV. Think of it like a photocopy: it might look similar, but it isn’t the original. In the past 25 years more than 30,000 volunteers have taken part in HIV vaccine studies worldwide, and no one has been infected with HIV by any of the study vaccines tested because they do not contain HIV.

Myth: An HIV vaccine already exists.
Fact: This is also false. There is no licensed vaccine against HIV or AIDS, but scientists are getting closer than ever before to developing an effective vaccine against HIV. In 2009, a large-scale vaccine study conducted in Thailand (called RV144) showed that a vaccine combination could prevent about 32 percent of new infections. The HVTN is leading the effort to build on these results, and planning for several studies is underway.

Myth: Joining an HIV vaccine study is like being a guinea pig.
Fact: Unlike guinea pigs, people can say yes or no about joining a study. All study volunteers must go through a process called informed consent that ensures they understand all of the risks and benefits of being in a study, and those volunteers are reminded that they may leave a study at any time without losing any of their rights or benefits. The HVTN takes great care in making sure people understand the study fully before they decide whether or not to join. All HVTN studies follow U.S. federal regulations on research, as well as international ethical standards and any country-specific requirements for the countries where our research is conducted. For more information, visit our Ethics page at: hvtn.org/en/science/hiv-vaccine-basics/ethics-hiv-vaccine-trials.html.

Myth: Western scientists are unfairly using people in developing countries to test HIV vaccines.
Fact: In order to find a vaccine that works in all kinds of people, it is necessary to test them in all kinds of people. This is especially true for groups of people that have been hardest hit by the HIV epidemic and who might benefit the most from a vaccine, such as those who live in sub-Saharan Africa. Protecting the well-being of study volunteers is the greatest responsibility in every study, and the HVTN works to make sure that studies follow the highest ethical standards and are done in collaboration with local scientists and researchers, and in consultation with local communities. Many studies are done in the US, Europe, and developing countries at the same time, and we follow the same procedures and international standards no matter where the study takes place.

Myth: A person must be HIV-positive (infected) to be in an HIV vaccine study.
Fact: This is false. The vaccines being tested by the HVTN are preventive vaccines. They must be tested on volunteers who are not infected with HIV, because our goal is to keep people that way. There are other research groups that are conducting studies of therapeutic vaccines that might be used in people who are already infected with HIV.

Myth: An HIV vaccine is unnecessary because AIDS is easily treated and controlled, just like diabetes.
Fact: While treatment for HIV infection and AIDS has dramatically improved over the last 30 years, it is no substitute for prevention. Current HIV medications are very expensive, and there are also many side effects. Sometimes people develop drug resistance and have to change the regimen of pills they take. Access to these drugs is not guaranteed, and some middle- and low-income countries do not have access to the same medicines that are available in the US and Europe. Additionally, the rate of new infections around the world is greater than our ability to get treatment to the people who need it.
Myth: Vaccine researchers want to study participants to practice unsafe behaviors so they can see whether the vaccine really works.

Fact: This is absolutely false! The safety of study participants is the top priority of HIV vaccine researchers and the staff at our study sites. Trained counselors work with study participants to help them develop an individual plan on how to reduce their risks for HIV infection. Participants also are given supplies such as condoms and lubricant as well as instructions on how to use them properly. We also provide information about new HIV prevention tools that are proven effective, such as PrEP and medical male circumcision, and how participants can access these tools. HIV efficacy trials enroll thousands of participants over several years, and even with the best risk reduction efforts some participants will still become infected. Changing human behavior is never easy; if it were, we would not have problems with obesity or lung disease due to smoking. One of the reasons a preventive HIV vaccine is so necessary is because its effectiveness is not so dependent on people's behavior.

Myth: Since pills can prevent HIV infection (known as pre-exposure prophylaxis or PrEP), an HIV vaccine is no longer necessary.

Fact: HIV-negative people who are at risk can take antiretroviral medication daily to lower their chances of becoming infected if they are exposed to the virus. The pill Truvada has been approved by the US Food and Drug Administration for use by people who are sexually active with multiple partners, for people who do not use condoms or do not use them all the time, and for people who have an HIV-positive partner or partners whose HIV status is unknown. PrEP is unlikely to be an option for everyone because the pills are expensive, may cause side effects, and may not be accessible. Remembering to take a pill every day is also challenging for some people. PrEP is an important new addition to the existing methods of HIV prevention, however, the most effective way to eliminate a disease is by using an effective vaccine. Vaccines are an effective, affordable and practical option. Until we have an effective vaccine, the HVTN supports the use of all available HIV prevention tools and encourages people to learn about their prevention options.

Myth: The search for an HIV vaccine has been going on for a long time and it just isn't possible to find one that works.

Fact: The science of HIV-vaccine development is challenging, but scientific understanding continues to improve all the time. In just the past few years there have been promising results from the RV144 study in Thailand as well as exciting laboratory work, such as the discovery of new broadly neutralizing antibodies against HIV. HIV is a powerful opponent, but scientists are constantly learning from one another and using advanced technology to fight it. Science has come a long way in the 30 years since AIDS was discovered. In comparing preventive HIV vaccine work to other vaccine development, the time it has taken is not so surprising; it took 47 years to develop the polio vaccine!

Myth: Vaccines cause autism and just aren't safe.

Fact: This is false. Many studies have found this claim to be false. The British doctor who originally published the finding about vaccines and autism has since been found to have falsified his data, and was stripped of his license to practice medicine. There is no link between childhood vaccination and autism. It is true that vaccines often have side effects, but those are typically temporary (like a sore arm, low fever, muscle aches and pains) and go away after a day or two. The value of protection to vaccinated individuals and to the public has made vaccines one of the top public health measures in history, second only to having a clean water supply.

Myth: People who aren't at risk don't need an HIV vaccine.

Fact: A person may not be at risk for HIV today, but life can change and so can disease risk. A preventive HIV vaccine may also be important for one’s children or other family members and friends. By being knowledgeable about preventive HIV vaccine research, a person can be part of the solution by educating their friends and family about the importance of research and debunking the myths that surround it. Even if a person is not at risk today, they can be part of the effort to find a vaccine that will hopefully save the lives of millions of people worldwide.
Getting the Right Test for HIV

Antibodies help to prevent infection. Most vaccines cause the body to make antibodies. If you get an HIV vaccine, your body may make antibodies to HIV. However, standard HIV tests search for HIV antibodies, a sign of HIV infection for people who have not previously received an HIV vaccine. If you get a standard HIV test after receiving an HIV vaccine, your HIV test results could come back positive even if you are not infected with HIV. This is called a VISP (Vaccine-Induced Seropositive) test result. To avoid this confusion, our study sites use different kinds of HIV tests that look for the virus itself, not antibodies.

FREQUENTLY ASKED QUESTIONS ABOUT VISP

Where can I get the right test for HIV?
You can get the right HIV test at the study site for free. After you leave the study you can continue to go to your study site to request HIV testing. If you are no longer located near your study site, the HVTN VISP Testing Service can help you get HIV testing in your area. The testing is free.

Getting the right test will prevent an incorrect diagnosis of HIV. Your study site or the VISP Testing Service can provide the right test.

What is “opt-out” testing for HIV?
“Opt-out” testing for HIV means that HIV tests may be done routinely unless a patient refuses to have the testing done. For more information on the Center for Disease Control's (CDC) recommendations for HIV testing in the U.S., please visit: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

For (U.S.) state-specific information, please visit: http://www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws/
For other information about HIV testing guidelines in your country, please visit: http://www.who.int/hiv/pub/national_guidelines/en/

How can I explain this situation to my healthcare provider?
No one can force you to have an HIV test for any reason.

• If anyone asks to test you for HIV or to draw your blood, tell them you are in (or have been in) an HIV vaccine study and that you need to get all your HIV tests at the study site.
• Explain that being tested outside of your study site or the HVTN VISP Testing Service could result in an incorrect diagnosis of HIV infection.
• Give the provider your study coordinator’s contact information. Ask the provider to call the study site or the HVTN VISP Testing Service directly (U.S. toll free: 1-800-327-2932).
• If you have to, simply say “no” to the HIV test, and then ask the study site or the HIV Vaccine Trials Network to help. We are happy to work with you to resolve your situation.

How long does VISP last?
If you have tested VISP, the antibodies may fade quickly or they may last for several years. In some cases, participants continue to test VISP for more than 20 years.
Can VISP be passed from one person to another?

- In most cases, no. If you have tested VISP you cannot pass the antibodies to another person by kissing or through sexual contact.
- If you are pregnant, we think there may be a chance that you could pass the vaccine antibodies to your baby. Although this has not been shown to happen with HIV study vaccines, we know that this happens with other vaccines, like the tetanus vaccine. Vaccine antibodies that mothers pass to their babies are temporary and go away over time, and they are not harmful to the baby. The HVTN can arrange for you and your baby to have accurate HIV testing for free for as long as it is needed.
- In order to donate blood or organs, the donation site will screen you using an HIV antibody test. If you test positive for HIV antibodies you may be unable to donate an organ. You may also be permanently banned from blood donation even though you are not infected with HIV.

How will a VISP test result affect me?

- If someone believes you are infected with HIV, you could face discrimination and/or other problems. For example, you could have problems with medical or dental care, employment, insurance, a visa for traveling, or entry into the military. You might not be allowed to donate blood or other organs. If you are pregnant, you may have to explain your situation to avoid receiving any HIV treatment during your pregnancy or labor/delivery.
- If you are planning to apply for insurance, employment, or the military, please inform your study site right away. The insurance company, employer, or military agency may not accept HIV test results from the HVTN. However, the HVTN can work with them to ensure the right test is done that will show your true HIV status.

What happens if I move far away from the study site where I participated in an HIV vaccine study?

For U.S. participants, call the HVTN VISP Testing Service at 1-800-327-2932 during business hours, Pacific Time. For participants outside the U.S., call your study site and they can assist you with testing for HIV. If you are unable to reach someone at your study site, send an email to vtn.core.vispcounselor@hvtn.org to request testing.

The HVTN VISP Testing Service provides HIV testing for participants who have received a study HIV vaccine in a National Institutes of Allergy and Infectious Diseases (NIAID) Division of AIDS (DAIDS)-funded HIV preventive vaccine trial and who are no longer able to be tested at their study site.

Will my information be confidential?

Yes. All of your information will be stored in a limited-access, password-protected, secure computer database. Access to your information will be limited to the HVTN VISP counselors. No identifying information concerning the testing will be released to any third party without your written approval, except when required by law.

How long does the HVTN VISP Testing Service take to provide test results?

Approximately 2 weeks.
What is a vaccine trial?

An AIDS vaccine trial is a study to find out how the vaccine reacts when administered to people. It is a carefully controlled test in which people receive an experimental vaccine to find out if it is safe and causes an immune response. The experimental vaccines have already been tested on animals and shown to be safe for clinical trials (testing in people). See How Vaccines are Developed for more details.

What is involved during an AIDS vaccine trial?

You will first be asked some basic eligibility questions to see if you qualify for a trial. If it is determined that you are eligible, you will then go to a screening visit where a clinician will explain the plan for the trial (known as the protocol) in full detail. A brief physical exam, some blood tests, and an HIV test will be done. Each study is different, but a typical trial lasts between 12 and 24 months, requiring an estimated 15-20 visits to the clinic. During the screening you will find out exactly what is involved with your trial. At clinic visits you will be asked questions about your health, any side effects you may have experienced, medications and drugs you are taking.

Can pregnant women volunteer in the AIDS vaccine trials?

No. Pregnant women will not be accepted as volunteers, and women who plan pregnancy should postpone it until after the trial. Pregnancy tests are done as part of the screening process and before each immunization. Women of childbearing age must agree to an adequate method of birth control prior to and during the immunization period.

How much blood will be taken from me over the course of the trial?

The total amount of blood drawn over the course of the trial will be less than you would give as a frequent donor through a blood bank.

Do all the volunteers receive an AIDS vaccine in the trial?

Some people don’t. To have a true, controlled comparison, some of the participants are given a placebo, an inactive substance or substitute, instead of the vaccine. You can’t choose which you are given. Neither you nor your clinician will know whether you receive a vaccine or a placebo. This is called a “double blind” study design and guarantees that all participants are studied and followed in exactly the same way. After the trial is over, you and your clinician will find out which you received—the vaccine or placebo.
Will the vaccine protect me from contracting HIV during the course of the trial?

No. It is not known whether any of the experimental vaccines will protect you against HIV. It is important for you to maintain a low risk of HIV infection. Your clinic will provide information and counseling on minimizing the risk of HIV infection.

What are the safeguards?

Safeguards have been built in so that you are told everything that is known about the procedures, including possible risks. No one can take part in a medical study without giving informed consent—learning about the study and signing a form to show that you understand the information. The FDA and other government agencies in each country must approve all vaccine trials before they are tested in people. The Institutional Review Board or Ethics Committee at each study site where vaccines are being tested monitor the participation and safety of volunteers. The safety and results of the trials are overseen by a Data and Safety Monitoring Board made up of independent experts, and they can stop a trial if any safety concerns are identified.

How will you know if the AIDS vaccine works?

In early stage vaccine trials (called Phase I or Phase II), we are not testing to see if the vaccines protect anyone against HIV and AIDS. We are testing the vaccines to see how the body responds. The clinics send blood tests to the lab to see if your blood can fight HIV after you are vaccinated. The only way to see if the vaccines actually protect against HIV and AIDS is through a Phase III trial.

How do I become a participant in a trial and whom can I contact for further information?


Will my participation in the trial be kept confidential?

Yes, your anonymity will be protected within the limits of the law. No medical information will be released to outside individuals without your written permission. No names are given when reports on trials are made to the scientific community, Food and Drug Administration (FDA) and pharmaceutical companies.

What are some of the possible side effects?

Possible side effects of the experimental vaccines could include fever, chills, rash, aches and pains, nausea, headache, dizziness, and fatigue. Injections can cause pain, soreness, redness, and swelling on the part of the body where you receive the vaccine shot. The side effects usually do not last long and participants usually do not need any form of treatment. However, if necessary, staff will advise you on treatment.
It Was Not Only a Racial Segregation System but the Birth of Violence and Transmission of HIV/AIDS

By: Busisiwe Nkala-Dlamini, Johannesburg, South Africa

Apartheid in South Africa

In 1948 a system aimed at racial discrimination came into effect after the White-only National Party government came into power. The policy served to formalize and legitimize the racial exploitation which was heralded by discovery of diamonds in Kimberly and gold in Johannesburg in the 1860s. History tells us that exploitation and slavery of Blacks had begun long before the diamonds and gold discovery, when South African indigenous people were dispossessed of their land.

Apartheid aimed at segregating both Blacks from Whites, and the different ethnic groups within the black population. The first such aspect involved the geographical displacement of millions of Black people from urban to rural areas, which were named ‘homelands’ and were segregated according to ethnic origin (Christopher, 1990) as per demographics and black population languages that were spoken (Figure 1) (Swati, Venda, SeSotho, SePedi, IsiZulu, IsiXhosa, SeTswana, Shangaan and Ndebele).

This process began with The Group Areas Act, which was enacted in June 1950 (Cameron, 2003; Seekings, 2000). Within the urban areas, the displacement pushed Blacks and other people of color to the borders of urban areas or outside of the cities, which were grossly disadvantaged in terms of services such as healthcare and educational facilities. In addition, the Separate Amenities Act of 1953 established a system of separate public facilities, such as buses and restaurants, for Whites and Non-Whites (Cameron, 2003). An example of these forced removals was that of the residents at the center of Johannesburg who were moved to Soweto (South Western Township). The result of this movement was that Black people had to travel long distances to work, were allocated poor housing facilities and experienced disruptions in their family lives (Sachs, 2002). Following this, millions of Black males were brought from the homelands in order to staff the mines and various industries, thus leading to the rise of migrant labor. These men could not bring their families with them and lived in overcrowded single-sex hostels with poor living conditions (Figure 2) (Pick & Obermeyer, 1996; Posel, 2003).

**Figure 1** Homelands in South Africa pre 1994, Source: [https://en.wikipedia.org/wiki/File:Indigenous_Homelands_of_South_Africa.jpg](https://en.wikipedia.org/wiki/File:Indigenous_Homelands_of_South_Africa.jpg)

**Figure 2** Men only Hostels, Source: [https://city-press.news24.com/Voices/the-indignity-of-the-back-yard-burial-20160520](https://city-press.news24.com/Voices/the-indignity-of-the-back-yard-burial-20160520)

Credit: Dr. Fatima Laher, CRS Leader, Soweto-Bara CRS and Director, PHRU Vaccines Research, Soweto, South Africa
Not all gold glitters

Lewin (1985) notes the destructive impact of apartheid on Black family life, where families were broken up as a result of migrant labor. He notes that most of the migrant laborers spent most of their lives away from their wives and children, which encouraged alcoholism, recklessness, and promiscuity. In addition to being separated from their families, Reid & Walker (2005) argue that South African men’s masculinities have been shaped in a profound way by closed institutions such as hostels and compounds. Gold and diamond mining, which has been the center of the South African economy, was developed as a result of the migrant system where men stayed in single-sex hostels in brutal and humiliating conditions. These men faced high levels of risk at work and often engaged in high-risk behaviors in social settings.

Breckenridge (1998) notes that the atmosphere in the mines was one of violence, where White shift leaders would beat Black miners on a regular basis, thus creating a culture of violence among mineworkers. In Black culture men were recognized as the head of the household, therefore the treatment men received at work had an impact on them attempting to reclaim their position when they got back home. Thus apartheid masculinities came to be mostly violent, authoritarian and patriarchal. The complex interplay of social processes during apartheid, as well as economic and political factors, served to fuel violence against women as African men tried to reassert their authority, which took the form of patriarchal domination (Marks, 2002). For these men, sexual violence was an outlet for their anger and an expression of their power, as well as a form of control when they had no control over other aspects of their lives. Reclaiming their power and control manifested in domestic violence where men beat their wives and children.

The pass laws enacted in 1952 forced Black people to carry ‘passbooks’, which regulated their travel and were often used to force people from the urban areas to the rural homelands, creating an enormous population of unemployed people in the rural areas with no hope of finding work (Figure 3) (Lewin, 1985; Möller, 1998). Employment in the urban areas was created only for men, including domestic services. Black women were meant to remain in the rural areas to look after the children and only have interaction with their husbands once a year. The passbooks also served to control the movement of these women to the urban areas. Men were stopped randomly to be asked for the passbook and were sometimes humiliated in front of their wives or partners. Bantu Authorities Act, No. 68 of 1951 and Native Coordinations of Documents Act, No. 67 of 1952 were among the two pieces of legislation used to enforce movement within the so-called ‘white areas’ and carrying of passbooks. This served as just another measure of separating families and keeping men from their spouses and children.

The destruction of a Black man’s family continues

Harries (1990) comments that Black men were also torn away from the traditions and beliefs of a structured tribal life, which left them vulnerable to certain ‘evils’ such as alcohol. The destruction of Black families during apartheid also had a profound effect on the children of migrant workers, especially young men, who were often left unsupervised and as a result became petty criminals and gangsters who engaged in violence against other gangs, against authority, and against women (Delius & Glaser, 2002; Morrell, 1998). Coovadia et al (2009) note that the abduction and rape of women were common among these young men from the 1940s, arguing that apartheid had made many traditional aspects of adult manhood, such as having a family and being a provider, unattainable. In addition, many children grew up without their fathers, which Coovadia et al (2009) argue undermined the socialization process in children, especially boys, into responsible and disciplined adults.

Violence: the only way to solve issues

People’s opposition to apartheid profoundly shaped male identities. Soldiers that fought against the apartheid government in the African National Congress’ and Pan Africanist Congress’ armed wings, Umkhonto we Sizwe and

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1 Passbook: an official document that Black people had to carry with them to prove their identity and where they could live or work, commonly known as dompas (Oxford Advanced Learner’s Dictionary, 2018).
Azanian People's Liberation Army, were seen as heroes, which was also true of the young men involved in anti-apartheid battles in townships (Reid & Walker, 2005). This has been referred to as the 'struggle masculinity' which was characterized by high levels of violence and militancy, justified as an essential response to the apartheid government (Xaba, 2001). The transition from apartheid to democracy in the early 1990's served to unsettle these masculinities, which had become entrenched over the period of the struggle. Thus, changes in the law and political system did not necessarily end violence against women. This is still especially evident in South Africa where rape and physical abuse are considered to be a cultural norm (Marks, 2002). Apartheid served to fuel violence on the occasions when peaceful marches against the system were turned into bloody battles by the apartheid government, leaving a number of Blacks dead. Two examples are the 1961 Sharpeville massacre when a non-violent protest by unarmed group marching against pass laws left 69 people dead (Figure 4). Again in 1976, a peaceful march by students protesting against Afrikaans as the language of instruction is estimated to have resulted in 575 people losing their lives (Figure 5) (Glaser, 1994). It must also be appreciated that these laws did not deter the resistance of Black people in their movements to the cities.

What will it take to return to the normal state?

After the abolishment of apartheid and the infamous pass laws in the 1990s, many people moved from the then homelands into urban areas where they mainly settled in informal settlements, which often had no water, electricity, or sanitation, and minimal, if any, health and educational services. This intensified poverty and furthered the spread of disease, including HIV. Coovadia (2009) argues that the overcrowding, malnutrition and lack of sanitation in many Black communities are strongly linked to their high burden of disease. The high mobility of large portions of the population also allowed for the rapid movement of the virus into new communities (Gilbert & Walker, 2002; Lurie, et al., 2003). Ogura (1996) and Cameron (2003) note the rapid urbanization that occurred in the 1980’s, where South African Black people were moving into urban areas at a rate of 3.5% per year. However, despite the rapid rates of urbanization, migration continued, with temporary labor migration within the democratic South Africa having increased, driven mostly by the rise in female labor migration (Posel, 2003). In their study, Lurie, et al. (2003) found that men who were migrants and had lived in four or more places had a significantly increased risk for HIV-1 infection compared to non-migrant men.

Migrant laborers also came, and continue to come, from other African countries, often as refugees from countries where HIV/AIDS is rampant, which has greatly influenced the spread of HIV/AIDS in South Africa (Sachs, 2002). Migrant laborers were often involved in casual and extramarital sexual encounters, often with

Figure 4: Sharpeville Massacre 1961
Source: City of Joburg@cityofjoburg.za, https://pbs.twimg.com/media/DYydh8HV4AEdRou.jpg

Figure 5: June 16 1976 Soweto Uprising
Source: https://upload.wikimedia.org/wikipedia/en/1/13/Hector_pieterson.jpg
Photo by Sam Nzima
sex workers, which significantly impacted the spread of HIV/AIDS (Abdool-Karrim & Abdool-Karrim, 2002; Williams, Gilgen, Campbell, Taljaard, & MacPhail, 2000; Zwi & Cabral, 1991). In addition, many of the workers engaged in homosexual relationships, often due to the complete lack of contact with women for long periods of time (Harries, 1990). Coovadia, et al. (2009) note that the women left behind in the rural areas often had other sexual partners while their husbands were away, while Zwi & Cabral (1991) argue that some of these women resorted to commercial sex in order to supplement their incomes.

In addition, the extramarital sexual encounters that many migrant laborers engaged in during apartheid continued even after its abolishment, and are now frequent among such men and widely tolerated by women (Gilbert & Walker, 2002; Susser & Stein, 2000). Interestingly, Gilbert and Walker (2002) argue that social inequality is the greatest transmitter of HIV/AIDS. They note the strong link between low income, high unemployment, and poor education (as represented by the Human Development Index) and HIV infection rates. This is echoed by Zwi & Cabral (1991), who refer to South Africa as a high-risk situation as a result of factors such as impoverishment, disenfranchisement, rapid urbanization, labor migration, widespread population displacements, and social disruption. In addition, both Mitton (2000) and Coovadia et al. (2009) note that great health inequities continue to exist within South Africa, despite the equal rights of all its citizens under the new democracy.

The apartheid government claimed that the apartheid segregation was equal, although the White community had attained a standard of living that was equal to those living in a first-world country, and the Black community’s standard of living was comparable to some of the least developed countries in the world (Sachs, 2002). The effects of apartheid can still be seen today, almost 25 years into democracy. Two of the most obvious areas of concern include healthcare and education (Sachs, 2002). Aspects of these inequalities have facilitated the spread of HIV/AIDS in South Africa, a country with one of the highest infection rates in the world. The poor or non-existent health and educational facilities within these areas meant that people living there were not informed about HIV/AIDS and its prevention (Sachs, 2002). Cameron (2003) notes that the government health expenditure was five times greater for White people than for Black people during apartheid.

Within democratic South Africa, sex and sexuality has taken center stage in the media and government as a result of a number of factors, namely the high prevalence of HIV/AIDS, as well as high rates of gender-based violence, rape, and child sexual abuse. Thus, it becomes clear that the transition to democracy brought changes to the existing gender order at the same time. These changes can be seen in the South African Constitution, where changes in legislation led to the perception that women are better off in the new South Africa (Reid & Walker, 2005). Posel (2005) further notes that sex and sexuality have become intensely politicized in South Africa since 1994, often a source of heated public argument, mobilization, and conflict.

Along with these changes and the public focus on sex came significant consequences for men and masculinities. Men have been a driving force behind the HIV/AIDS epidemic and have also been blamed for the high rates of rape, gender-based violence, and child sexual abuse. Walker, Reid, & Cornell (2004) argue that during apartheid, sexual violence was masked by various factors such as a very narrow legal definition of rape, economically dependent family members who relied on the perpetrator within their families, as well as the disinterest of the racist state in the growing problem of gender-based violence in Black communities. However, in the new South Africa, sexual violence has become a matter of public concern due to the prominence of sex and sexuality in public life (Posel, 2005). Cases of rape, especially those involving babies and children, are highly publicized and the blame is mostly placed on men, thus indicating a shift in expectations of men in the new social order, as well as a sense of role confusion (Reid & Walker, 2005).

It can be concluded that apartheid was indeed a system that demonstrated unjust laws, policies, and inequality according to race in terms of resources, treatment, and high levels of unjustified violence. Violence was by White men on Black men in the workplace, and by the state to any person or group opposing the system, which then generated Black men who translated that violence to their families, vulnerable women and children. The migrant labor system played a significant role in breaking families and family structures, leading to many unemployed landless adults. Unequal distribution

Continued on Next Page...
of resources in education and health fuelled inequality politically, economically, and socially. On the other hand, HIV has led to a number of families headed by children or by a generation of older people. Zwi and Cabral (1991) argue that effective health interventions need to include behavioural, legal, social, information, and economic aspects, while Wight and Abraham (2000) emphasize that the key to building sustainable programs lies in acknowledging the socio-cultural context in which they will take place. This view is echoed by Campbell and Williams (1998), who emphasize the importance of the social, cultural, and economic factors in HIV transmission. South Africa is left with a wounded population that includes people who grew up feeling that they were ‘sub-human’ beings. Changes in policy emphasizing the respect of people’s human rights has not yet translated to implementation.

*Busisiwe Nkala-Dlamini is a lecturer in the School of Human and Community Development at the University of Witwatersrand and a researcher with the Perinatal HIV Research Unit at University of Witwatersrand.

References


Busi siwe Nkala-Dlamini, Johannesburg, South Africa
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www.uhambo.org.za
UPCOMING EVENTS/CONFERENCES/MEETINGS

17-20 JANUARY 2019
2019 National African American MSM Leadership Conference
Arlington, VA, USA
www.naesm.org

4-7 MARCH 2019
Conference on Retroviruses and Opportunistic Infections (CROI)
Seattle, WA, USA
http://www.croiconference.org/

18-21 MARCH 2019
U.S. Centers for Disease Control National HIV Prevention Conference
Atlanta, GA, USA
https://www.cdc.gov/nhpc/

20-21 MARCH 2019
2019 HVTN Sub-Saharan Africa Regional Meeting
Johannesburg, South Africa
www.hvtn.org

13-14 APRIL 2019
U.S. National Transgender Health Summit
Oakland, CA, USA
http://transhealth.ucsf.edu/trans?page=ev-00-00

18 MAY 2018
HIV Vaccine Awareness Day

23-31 MAY 2019
2019 HVTN Full Group Meeting
Washington, DC, USA
www.hvtn.org

29 MAY – 2 JUNE 2019
2019 Saving Ourselves Symposium
Charleston, SC, USA
http://www.trdfoundation.com/

1-5 JUNE 2019
2019 HPTN Annual Meeting
Washington, DC, USA
www.hptn.org

10-13 JUNE 2019
2019 South African AIDS Conference
Durban, South Africa
www.saaids.org

11-14 JUNE 2019
2019 IMPAACT Annual Meeting
Washington, DC, USA
https://impaactnetwork.org/

16-20 JUNE 2019
2019 ACTG Annual Meeting
Washington, DC, USA
https://actgnetwork.org/

14-17 JULY 2019
2019 STI and HIV World Congress
Vancouver, BC, Canada
https://stihiv2019vancouver.com/
AIDS2018 Global Village: (l to r) Dr. Hyman Scott (Bridge HIV CRS), Dr. Susan Buchbinder (PI of Bridge HIV CRS), Courtney Liebi, Wakefield (HVTN)

AIDS2018 Global Village: (l to r) Dr. Myron Cohen (PI of HPTN) and Dr. Larry Corey (PI of HVTN) in the HVTN booth in the Global Village

AIDS2018 Plenary: Professor Glenda Gray (President of SAMRC and PI of HVTN)

AIDS2018 Poster Session: Gail Broder (HVTN) presenting a poster on community engagement in the AMP Studies

AIDS2018: (l to r) Dr. Sheldon Fields (HPTN) and Gail Broder (HVTN) in between sessions during the conference

AIDS2018: (l to r) Rev. Edwin Sanders (Metropolitan Interdenominational Church) and Wakefield (HVTN)
HVTN CEU Staff at FGM May 2018: (l to r) Nandi Luthuli and Stephaun Wallace

Dr. Michele Andrasik (HVTN) and Dr. Beryl Koblin celebrate via dance during Retirement Celebration for Dr. Koblin during the HVTN Reception May 2018

Retirement Celebration for Dr. Beryl Koblin during the HVTN Reception May 2018: (l to r) Jerry Ockfen, Annet Davis (UPENN CRS), Dr. Michele Andrasik

Retirement Celebration for Dr. Beryl Koblin during the HVTN Reception May 2018: (l to r) Dr. Jim Kublin, Dr. Michele Andrasik, and Dr. Larry Corey (PI of HVTN)

Retirement Celebration for Dr. Beryl Koblin during the HVTN Reception May 2018: (l to r) Dr. Susan Buchbinder (PI of Bridge HIV CRS), Dr. Beryl Koblin (PI of NYBC CRS), Dr. Ken Mayer (PI of Fenway CRS), Dr. Jim Kublin (HVTN)
**Seen Around the HVTN**

* Retirement Celebration for Dr. Beryl Koblin during the HVTN Reception May 2018: (l to r) Dr. Susan Buchbinder (PI of Bridge HIV CRS), Dr. Michele Andrasik (HVTN), Dr. Beryl Koblin (PI of NYBC CRS), Dr. Jim Kublin (HVTN Executive Director), Dr. Ken Mayer (PI of Fenway CRS)

* HVTN Reception May 2018: (l to r) Monica Pule (HVTN GCAB Co-Chair), Nandi Luthuli (HVTN), Thoko Sifunda (PHRU CAB Member)

* HVTN Reception May 2018 with Debbie Lucy (NYBC CRS) dancing to the tunes

* HVTN Awards Session: (l to r) Rosario Leon (IMPACTA CRS), Erika Trejo (IMPACTA CAB Member- Award Recipient), and Dr. Larry Corey (PI of HVTN)

* HVTN RAMP Scholars: (l to r) Czestochowa Francois, University of Rochester Medical School; Jenna Udren, HVTN; Barinaepkee Banuna, Stony Brook University School of Medicine; Shay Behrens, Duke University School of Medicine; Angela Broad White, University of California - San Francisco; Andrew Braun, The University of Texas Health Science Center at San Antonio
HVTN Community Session with (l to r) Keith Richardson (Vanderbilt CRS) and Brian Marshall (Vanderbilt CRS CAB Member)

HVTN CAB Session being led by (l to r) Coco Alinsug (HVTN GCAB Co-Chair) and Monica Pule (HVTN GCAB Co-Chair)

HVTN Community Plenary May 2018: (l to r) Jonathan Lucas (HPTN), Gail Broder (HVTN), Dr. Michele Andrasik (HVTN)

HVTN May 2018 attendees (l to r) Rosario Leon (IMPACTA CRS) and Dr. Pedro Gonzales (IMPACTA CRS)

HVTN Community Plenary May 2018: (l to r) Dr. Michele Andrasik (HVTN), Gail Broder (HVTN), Jonathan Lucas (HPTN), Rafael Gonzalez (Bridge HIV CRS), Sehar Khalid (Fenway CRS), Rudy Lott (University of Rochester CRS), Linda Oseso (HVTN)
Ro Yoon (Seattle VTU CRS) co-facilitating a session on “Changing the Focus: Shifting recruitment venues to reach Phase I populations” during the U.S. CER Phase 1 Retreat September 2018

Rafael Gonzalez (Bridge HIV CRS) co-facilitating a session on “Changing the Focus: Shifting recruitment venues to reach Phase I populations” during the U.S. CER Phase 1 Retreat September 2018

“Materials Marketplace” during U.S. CER Phase 1 Retreat September 2018 where CERs were able to share outreach materials and items (l to r) Shadi Houshangi (Bridge HIV), Andy Yousef (UAB CRS), William Juarez (Bridge HIV CRS), Machel Hunt (Emory CRS) September 2018

“Materials Marketplace” during U.S. CER Phase 1 Retreat September 2018 where CERs were able to share outreach materials and items (l to r) Brianna Patterson (UAB CRS), Gail Broder (HVTN), Andy Yousef (UAB CRS)

U.S. CER Phase 1 Retreat September 2018 attendees pause for a picture (l to r) Major Nesby (NY Blood Center CRS), DaShawn Usher (NY Blood Center CRS), Annet Davis (UPENN CRS)
Dr. David Malebranche (Morehouse School of Medicine) delivers a talk on the “Wider HIV Prevention Context Around Us” during the U.S. CER Phase 1 Retreat September 2018

Attendees working on their health marketing research materials during the U.S. CER Phase 1 Retreat September 2018 (l to r) Janet Dargon-Hart (Fenway CRS), Kathleen Bailey (Fenway CRS), Lauren Sayah (Fenway CRS)

Linda Oseso (HVTN) pauses for a picture during the U.S. CER Phase 1 Retreat September 2018

HVTN Staff give attendees of the U.S. CER Phase 1 Retreat September 2018 a preview of upcoming materials and tools for phase 1 work (l to r) Cody Shipman and Nina Ennis

Attendees working on their health marketing research materials during the U.S. CER Phase 1 Retreat September 2018 (l to r) Dan Mangini (UPENN CRS), Aeryanah Bryant (UPENN CRS), Annet Davis (UPENN CRS)

Attendees of the U.S. CER Phase 1 Retreat September 2018
The conference venue is large, with a capacity of well over 500 people. It buzzes with discussion and laughter. On the stage, a group of young researchers feels both their excitement and nervous energy. They talk with each other, review their notes, and look out at the growing audience. Here, at the May 2018 HVTN Full Group Meeting, the Research and Mentorship Program (RAMP) Scholars are about to culminate months of work on their research projects, and give voice to perspectives for which the Network has been yearning.

RAMP is an HVTN-sponsored and run program for African American and Latinx medical students designed to increase participation of these populations in HIV prevention research. The program’s goal is to develop future physician-scientists from these communities who pursue careers in the search for a safe and effective HIV vaccine. To achieve this goal, HVTN created this program to provide outstanding mentorship, training and support for U.S. medical students in an introductory experience with HIV vaccine research. These students, under the mentorship of HVTN-affiliated investigators, conduct research projects in areas aligned with the HVTN scientific agenda. Scholars can conduct short-term projects of 2-4 months, or long-term projects of 9-12 months. The awards are currently funded by the NIAID/DAIDS, with past support from the National Institute of Mental Health and other funders as well.

RAMP started in 2010 in response to discussions by the Legacy Project. The Legacy Project aims to increase clinical trial enrollment among the U.S. populations most affected by HIV, particularly African Americans and Latinx people. At the same time, HVTN leaders saw the importance of increasing diversity in their own ranks. They also were increasingly concerned with ensuring future generations of researchers would continue the work of the Network.

The need was there, but how could the Network respond? To gain some concrete guidance, Legacy Project staff convened a panel of experts who discussed the greatest needs and how the HVTN could make a difference. The panel included leading researchers of color, including former U.S. Surgeon General Dr. David Satcher, leading HIV prevention research scientist Dr. Cynthia Gómez, and Dr. George Ayala, now the executive director of the MPact Global Action for Gay Men’s Health and Rights (formerly known as MSMGF). The panel concluded that HVTN needed a pipeline of investigators of color to assume leadership positions, but none existed into which the Network could tap. Several HIV-focused research programs existed at the time, but they were working with young professionals who had already made their key career decisions. If HVTN wanted a pipeline, it would have to create its own. The panel recommended working with medical students who were still exploring their career options. This inherently risky approach could take years to bear fruit.

“[HVTN leaders] agreed with the committee that the change we were looking for, it was not going to be quick, it was not going to be short-term, but...it would take a longer-term commitment to introduce people [to HIV vaccine research],” says Steven Wakefield, HVTN director of External Relations and RAMP Scholar Program leadership team member leader, who led Legacy Project efforts at that time.

“It was exciting to watch the enthusiasm of this group of Black and Latinx professionals regarding something that could happen that would change the pipeline.”
It was a natural fit for HVTN’s Training Program, which has expertise in developing and mentoring young researchers, and ran two programs focused on attracting, training and keeping young scientists in HIV vaccine work. It also followed that the newly engaged program staff used a deliberate, evidence-based approach to design RAMP.

“It was important to figure out how to do it the right way... to get a better understanding of the issues underlying the lack of diversity among clinical investigators, and the factors that have both contributed to, and detracted from career development of African Americans and Latinx investigators,” says Danna Flood, HVTN’s director for Training, Evaluation and IT, and RAMP Scholar Program leadership team member leader.

In 2010, HVTN worked with Dr. Neva Pemberton, then a graduate student, to conduct qualitative research with several African-American and Latinx HIV/AIDS researchers to determine the factors that led to their interest and success in the field. The results showed that mentors played a key role in keeping them engaged and progressing.

RAMP Scholar Program Leadership team members convened an Advisory Committee for RAMP program development consisting of leading African American and Latinx investigators, medical students, and community leaders. The Committee met over several days to review the formative research and provide guidance on designing a responsive program. As a result, mentorship became a primary focus of RAMP. RAMP leaders also wanted to ensure the program provided a reasonable wage for scholars along with full travel and supply costs so that they could fully devote time to their projects and not have to work other jobs. This is especially important in the U.S., where 77% of African American and 57% of Latinx medical students expect to graduate with more than $150,000 of education debt1.

To ensure high quality mentorship in areas relevant to HVTN science, existing HVTN investigators were invited to participate in the program. These mentors would help the Scholars develop their research projects in areas relevant to HIV vaccine science. They would also guide them through all parts of the research process while introducing them to their clinical sites and the life of a physician-scientist. Mentors were given an opportunity to attend training on cultural responsiveness and ongoing skill-building in mentorship. Program staff also organized additional professional development activities for Scholars throughout the year.

With a data-informed program model, mentors, and funding in hand, the Network solicited applications for and awarded its first group of Scholars in early 2011. The six selected Scholars came from medical schools all over the U.S. They worked with mentors at locations representing the global reach of the Network, from Boston and San Francisco in the US to Cape Town, South Africa and Lima, Peru. Likewise, their projects spanned a variety of topics, from highly technical laboratory projects to qualitative research to assessing recruitment strategies for transgender participants.

For the Scholars, the experience was nothing short of deeply affecting. All of the Scholars reported high levels of satisfaction with the program and their mentorship. After their RAMP experience, Scholars reported tremendous gains in their knowledge of responsible conduct of research, the role of social science in HIV vaccine trials, and career opportunities in the field. They also learned many necessary skills to conduct original research.

In a post-program survey, one Scholar wrote, “The mentorship I have received has been outstanding and has changed my career path completely2.”

Based on these and similar positive results in subsequent cohorts of Scholars, HVTN leaders continue to enthusiastically support RAMP. In fact, the ninth cohort of Scholars will be awarded in early 2019. With each new group of Scholars awarded, the benefits to a variety of stakeholders – HVTN leaders, Scholars, mentors, community members and clinic staff – are evident.

“I don’t think we fully realized the impact scholars’ research projects would have on the science and operations of the Network. Scholars, with help from mentors, are asking important research questions. Their results inform future research and the conduct of our trials. Scholars present and discuss their research findings with luminaries in the HIV prevention field. Clinical trial sites learn how to effectively reach specific populations in their communities, and as a result, they modify how they educate, recruit and retain study participants, which improves study outcomes.” says Danna Flood.

Mentors have had some of the most transformative experiences with Scholars, and now are among the biggest advocates for the program.
“[Mentors] thought they were going to bring in someone where they were providing added value to that individual, but the individual’s work provided added value and allowed the mentor to answer a question they didn’t anticipate at the beginning of the research,” says Wakefield.

Dr. Michele Andrasik, HVTN Director of Social Behavioral Sciences and Community Engagement and a RAMP mentor, remarked that her RAMP Scholar’s project laid the foundation for an ongoing process to analyze and publish social behavioral data coming from HVTN trials. This has a major impact in the field, and for Scholars’ professional success.

“These students who don’t know anything about our work come out with a huge knowledge base of HIV prevention and vaccine research. [Mentors are] contributing to Scholars’ success in their fields by getting them published, and teaching them the skills needed for data analysis and moving data into a publication. It’s just a win-win across the board for these young Scholars and for us as an organization because we’re getting our data out there,” says Dr. Andrasik.

As the program and its more than 50 alumni mature, RAMP leadership and staff are now turning their attention to measuring long-term effects of the program on the Scholars and their careers. For the last four years, alumni Scholars filled out a yearly survey to describe where they are in their careers, long-term goals, and opinions about the ongoing impact of the program. For these young professionals, many of whom are still in their medical training or early stages of their career, their ultimate path remains to be decided. Whether HIV vaccine research will be part of that path is uncertain, even though they are aware that opportunities are available to them. Despite this, the majority of Scholars report that they are involved in research and personal or professional efforts related to HIV. Even years after their RAMP experience, Scholars indicate that the experience solidified their career goals or changed their goals entirely to include research or work with highly affected populations. They indicate that RAMP affected their ability to be culturally responsive professionals, and that it was an important learning and life experience.

In a typical comment, a Cohort 6 scholar recently stated, “RAMP made me realize how exciting it can be to be part of ground breaking research and reinforced my desire to continue to be involved in research throughout my career as a physician.”

While the program has helped to identify several individuals who will likely take up the mantle of HVTN work, these results indicate its effects are, as predicted, an ongoing introduction of a community of professionals to HIV vaccine work. This introduction and dedicated mentorship then produces a web of positive effects, and can sow the seeds that could lead them to HIV prevention work over the course of their careers.

Dr. Stephen De Rosa, one of the directors of the HVTN Laboratory in Seattle and four-time RAMP mentor, sums it up: “We’ve always questioned whether mentees will go directly into HIV vaccine research, but RAMP positions them to be involved in HIV-related research. Students don’t always get that in medical school or in medical training, and it encourages increased involvement in research of all types.”

Dr. Andrasik indicates RAMP could have further benefits in communities. “To have just one more provider who isn’t coming in with preconceived notions about HIV, who now understands the impact of HIV on her community and the people that she’s working with, is huge. There’s no way we can ever measure that impact. If we can do that for little pockets of communities across the U.S...we’ve successfully increased our efforts to prevent HIV in the community, both in the Latinx and the African American community.”

Back at the Full Group Meeting Plenary, the plenary chairs bring the audience to quiet attention, and begin to introduce the talented Scholars on the stage. The Scholars step up to the microphone to present their projects. The audience, and an entire Network, stops to listen.

*Jenna Udren is the RAMP Scholar Project Manager in the Training Unit at HVTN Core, Seattle, WA, USA.

I started my medical training in San Francisco in 1982. Like many of my colleagues at that time, I found myself at the center of a terrifying public health crisis, in which a then-unknown virus was killing young men at an alarming rate. Although I was preparing to be an internist and oncologist, I also became an AIDS doctor. That work eventually took me to Uganda to help care for people with HIV/AIDS as the epidemic took hold there.

I am still fighting this scourge, only now on a larger scale, leading the Bill and Melinda Gates Foundation. Our latest Goalkeepers report, a look at the most consequential trends and data in global health and development, focuses on Zimbabwe as an example of the enormous progress that has been made against HIV/AIDS since those dark early days.

At the height of its epidemic in 1997, a shocking 1 in 4 adults in Zimbabwe — roughly 1.5 million people, about the size of the population of Philadelphia — were infected with HIV, the virus that causes AIDS. So the country made a dedicated push to say we’re not going to be victims of HIV; we’re going to invest in treatment and prevention. As a result, HIV infections are down 49 percent since 2010 and AIDS-related deaths are down by 45 percent. These achievements have done much to transform the country, despite political and economic turmoil.
The Goalkeepers report focused on Zimbabwe for another reason in addition to its success against HIV: more than half its population is aged 25 or younger, which means they’re entering the time of life when they are most at risk of infection with HIV.

Zimbabwe isn’t unique in this regard. Globally, the largest generation of young people in human history is approaching that vulnerable age — a trend that’s most prevalent in sub-Saharan Africa.

The good news is that this generation is the healthiest and most educated the continent has ever seen. No previous generation has been so well-equipped to build strong communities, drive economic growth in their countries, and expand the limits of human possibility.

With the right investments in health and education, these young people will lead a new wave of economic progress in sub-Saharan Africa that matches what we have witnessed in China starting in the 1990s and India in the 2000s.

The promise of progress is incredible, but it won’t happen if this generation is ravaged by HIV. And the stark reality is that we won’t prevent another crisis if we just keep doing what we’re already doing. It won’t even be enough to expand our efforts with the methods and medicines currently available to prevent and treat HIV/AIDS, although that’s also an urgent priority.

The truth is, we must find new and better ways to dramatically accelerate progress on HIV/AIDS and start to turn ideas into solutions more quickly.

That demands aggressive, sustained investment in global health research and development into new methods for preventing HIV by governments, private enterprise, and philanthropic foundations like ours. These can take many forms. One is more effective and longer-lasting drugs, known as long-acting pre-exposure prophylaxis (PrEP), that can stop HIV from taking hold and spreading throughout the body. Another is exploring advances in immunology and the possibility that they can be trained against HIV. And then there is the medics’ holy grail: a vaccine.

It will take time before anything truly revolutionary becomes available. But at the Bill and Melinda Gates Foundation, we are confident that a new and better PrEP can be available in about five years’ time. And there are two large-scale clinical trials (called Uhambo and Imbokodo) underway to test potential HIV vaccine candidates.

Making such preventive measures extensively available could avert up to 364,000 new cases of HIV among 15- to 29-year-olds in Zimbabwe by 2050, according to data modeling carried out by a team from Imperial College London for the Goalkeepers report. That’s 364,000 more young Zimbabweans who can become leaders, activists, entrepreneurs, and innovators to carry the country forward.

The case is clear. If we keep doing the same things, the same way, we run the serious risk of a resurgent HIV/AIDS epidemic that will rob people in the world’s poorest places of the chance for long, healthy, productive lives — that’s the peril. The potential is that discovering, developing, and delivering more effective treatments and prevention methods for HIV/AIDS will unleash healthy, thriving young populations that will build healthy, thriving economies.

*Sue Desmond-Hellmann, M.D., is the CEO of the Bill and Melinda Gates Foundation.
Can you tell us a little about your professional background?

I am a basic scientist by qualification and my degree was conferred at the University of Sunderland in the UK. After moving to South Africa, I completed a Master’s degree in the role of Aflatoxins in childhood malnutrition. My PhD focused on the role of Proteinuria in childhood kidney diseases. After my PhD, I was invited to lead a project on vaginal microbicides for the prevention of HIV among a group of sex workers working along the trucking route between the port city of Durban and the commercial capital in Johannesburg. That trial was my introduction to HIV prevention among high risk populations. It was a pivotal study which changed the direction of my profession. I learnt about the dire need for women-initiated HIV prevention options and the socio-behavioural and cultural factors that impact women’s lives. I dedicated my time to researching methods of HIV prevention, and continue to do so to date.

What inspired you to get into science? HIV?

I had always wanted to be in science and was interested in science subjects at school. The interest in HIV grew after I conducted the first vaginal microbicide study among sex workers. Having completed a study that had a negative impact (the spermicide product N9 increased risk of HIV among women who used it more frequently), I was more determined to continue the search for a biomedical intervention that would prevent HIV. Although the initial focus was on microbicides, the science of HIV prevention has evolved rapidly. I firmly believe that it is not about which product delivers the “home run” but whether we can collectively have an impact on reducing the burden of disease in high HIV endemic areas. For this reason, I have expanded my scope of work to vaccines, vaginal rings and long acting injectables, but at the same time educating about and promoting use of proven methods such as condoms, male circumcision and PrEP. More importantly, I have learnt the need to capacitate young investigators to lead and conduct studies, and have the community’s support of the research we undertake.

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What are some of the unique challenges you have had to face being a woman in medicine/science in Durban, South Africa? How have you met or overcome those challenges?

I think women’s lives are complex. While we want to excel in our chosen career, we have this strong desire to have a successful partnership, give the best to our children and to have this unique ability to transform daily from being a wife and mother to an executive director! Its hard work! Playing these multiple roles is extremely difficult especially when you want each role you play to be perfect. I personally think women have to constantly prove themselves to be recognized and that in itself is hard work!!

I gave up on trying to prove myself to others some time ago. Instead, I let my commitment to and delivery of high quality research speak for me! It has worked! I do not feel the need to be this loud voice crying for recognition, but rather have the recognition come to me from my peers in the field.

What have been some of your proudest moments or accomplishments in your career?

I have numerous moments where I feel a great sense of achievement.

1. Completion of my first ever clinical trial, which was a pivotal trial to close the lid on further research on Nonoxynol9- this trial put me on the global landscape as a scientist who has experience in conducting clinical trials in a developing country. I was a sought-after scientist for future studies on HIV prevention.

2. Competing successfully and independently as the PI for the NIH-funded Clinical Trials Unit. I have achieved this successfully despite competition in Africa and elsewhere.

3. Building a world class clinical trial infrastructure with massive integrated operational, clinical, and financial systems to manage 6 clinical research sites. The sites are led by well-trained staff who are able to conduct multiple trials.

4. Building partnerships with local communities spanning over a decade, through bi-directional support, respect and transparency.

5. Receiving the following awards and accolades:

   - 2018 • EDCTP/ European Union Outstanding African Female Scientist (Lisbon, September 2018)
   - 2017 • SAMRC Scientific Merit Awards: Gold Scientific Achievement Award (October 2017)
   - 2015 • Clinical Professor, Department of Global Health, School of Medicine, University of Washington • Fellowship of Royal College of Physicians (Edinburgh)
   - 2014 • KZN Department of Health Service Excellence Award, February 2014 • MTN Service Of Excellence Award For Contribution To NIH-Funded Microbicide Network Leadership Group, February 2014

What can you tell us about the EDCTP and the Prize?

The European & Developing Countries Clinical Trials Partnership (EDCTP) is a public-public partnership between countries in Europe and sub-Saharan Africa, and the European Union. The EDCTP programme is supported under Horizon 2020, the European Union’s Framework Programme for Research and Innovation. The mission of EDCTP is to support collaborative research that accelerates the clinical development of new or improved interventions to prevent or treat HIV/AIDS, tuberculosis, malaria and neglected infectious diseases in sub-Saharan Africa. You can see the details at: http://ec.europa.eu/programmes/horizon2020/.

The EDCTP prizes recognise outstanding individuals and research teams from Africa and Europe who have made significant contributions to health research. In addition to their scientific excellence, the awardees will have made major contributions to the EDCTP objectives of strengthening clinical research capacity in Africa and supporting South-South and North-South networking.

The Outstanding Female Scientist prize is awarded to excellent world-class female scientists in sub-Saharan Africa working in the scope of the second EDCTP programme. I received this award in 2018 with close competition from scientists in Africa and Europe. I was absolutely thrilled by this award, as it recognizes decades of my commitment to clinical research activities in HIV prevention. What makes it more rewarding is that I now stand among the female giants who received this award in the past. This award is dedicated to all female scientists who play multiple roles (wife, mother and scientist) daily and their unwavering commitments to a greater public good.
2012 • Lifetime Achievement Award in HIV Prevention Research, Microbicides2012 Conference, Sydney, Australia, 19th April 2012
2010 • Outstanding Scientific Contribution to Microbicides2010, 1st Place Award to HPRU CTU
• Honorary Professorship awarded by Department of Epidemiology and Population Health, London School of Hygiene & Tropical Medicine, London UK
2006 • Distinguished Visiting Professorship awarded at 5th International Conference on AIDS in India by Tamil Nadu Medical University, India
• Research Service Award presented by the National Institutes of Health, HIV Prevention Trials Network
• Finalist: Woman of the Year Award, Category Science and Technology
• Finalist: Dept. of Science and Technology Award for Distinguished Woman Scientist
• Selected Scientist to be visited by President Clinton and Bill and Melinda Gates
2005 • NIH HIV Prevention Trials Network Award for outstanding efforts for HPTN 035 study
1996 • Co-Applicant, Africa Centre, funded by the Welcome Trust-£5 million over 5 years
1994 • Astra Zeneca award for best scientific paper, University of KwaZulu-Natal
1990 • Medical Research Council Scholarship – PhD

Are there any things you would change or do differently if you could?

Actually my growth in my field of expertise is better than I ever expected! I did not dream that the love of my job, my passion and drive would get me this far! I have an excellent team that do some amazing work and I would not change that. More importantly, I have two highly successful boys who are excelling in their chosen professions and a successful husband. So, I have not done too badly on all fronts.

If I was much younger and not committed to my family life, I think I would like to have done a medical degree after my PhD. Although I am a clinical researcher, I would have liked to pursue a medical degree.

If I was a drug sponsor, I would listen more to research site teams when developing a product. I think site team’s knowledge and insights of their communities and population would make a huge difference in product selection and in identifying key attributes needed for acceptability and adherence to a particular intervention.

What would you say to young women who might be interested in science or research as a career?

Interest in science and an inquiring mind is critical. If you have these qualities and have the passion, tenacity and determination to pursue a career where you may not always get the desired answer but have the commitment to make a difference in the lives of people, albeit in a small way, then you should definitely pursue a science career. Once you have developed your niche of expertise, the world is your oyster and you can reach even greater heights of scientific excellence. Love of the job, passion, drive and tenacity are critical traits to have for scientific excellence.

Editors Note: Thank you for all that you do Prof. Ramjee and for giving us a bit of your time.
My work on HIV began in the mid-90s. It was a time when HIV had reached the gay/trans community of Peru in a devastating and cruel way, taking the lives of dozens of friends in horrible ways. The life expectancy for a person with HIV was a few years because there was no antiretroviral treatment, there was not much information, and there was a lot of discrimination. This, together with the violence existing in the country toward our community, made it a period of dark and sad years. In ’96 I decided that I wanted to learn more about HIV because I was sure there should be something to tell people that could give them hope and faith. That’s how I discovered the world of scientific research.

In 2015, Machel joined Callen-Lorde Community Health Centre in New York City as a Research Associate/ Counsellor for the SPARK study. SPARK tested the success of two behavioral interventions to improve decision-making around taking PrEP, and improve medication-taking behavior for those individuals that decided to use PrEP as part of their HIV prevention plan. This was Machel’s introduction to clinical research in the United States.

In 2017, Machel relocated to Atlanta, GA, to work with the Hope Clinic, a part of Emory University Vaccine Center, where he manages the Community Engagement and Recruitment Team as well as clinical research projects to facilitate local community involvement and engagement. Machel is passionate about working with Black Gay Men/MSM and is active in providing education and support to this community which he is a part of, often volunteering at Pride events around the city and facilitating workshops for gay men.

He says, “I love the HVTN because it represents the best of what clinical research is. The ethos and objectives of the HVTN has community at its core and that makes my job that much easier when educating and recruiting in the field”.

Hugo Sanchez Sarmiento
Lead Community Educator and Recruiter, San Marcos/UNIDEC CRS, Lima, Peru

My work on HIV began in the mid-90s. It was a time when HIV had reached the gay/trans community of Peru in a devastating and cruel way, taking the lives of dozens of friends in horrible ways. The life expectancy for a person with HIV was a few years because there was no antiretroviral treatment, there was not much information, and there was a lot of discrimination. This, together with the violence existing in the country toward our community, made it a period of dark and sad years. In ‘96 I decided that I wanted to learn more about HIV because I was sure there should be something to tell people that could give them hope and faith. That’s how I discovered the world of scientific research. When I finished my degree in psychology, I decided to look for ways to transmit wellbeing to people. I worked for many years as a coordinator of recruitment, retention and community development, as well as counseling in HIV prevention and giving support to people living with HIV.

I currently have my own organization called EPICENTRO, which is aimed at preventing HIV through culture, and I am a community educator at UNIDEC where we work in clinical trials. What moves and enthuses me to participate in the HVTN is the careful manner that its representatives have about what is related to the wellbeing of our community. From the use of a photo that makes everyone feel included, to the minute detail with which they review each clinical procedure, all this gives me hope that we can soon make a big change in the world.
Communicating ideas and motivating others are two of my passions. After completing a Masters of Arts in Education at Tennessee State University, I immersed myself in Nashville’s health and fitness network. Building on this experience, I then joined the HIV Vaccine Trials Network (HVTN) team at Vanderbilt University Medical Center, bringing my joy and devotion to wellness education with a service-oriented outlook to this new opportunity I enjoy.

Education and empowerment are more than just words. These are critical tools essential to ending the HIV epidemic. Community conversations around sexual health have led to progress; however, there is still so much more work that needs to be done to address health disparities, HIV stigma and health literacy in the general population. Seeing advances in HIV research, specifically through the HVTN, is why I love working with the Network! It’s the people behind the research I find most inspiring. Everyone makes the work done at the HVTN possible and gives hope to those affected by HIV/AIDS.

The community educator role encompasses a wide range of educational topics on HIV/AIDS. Instead of contributing to the stigma, we assist in being part of the solution. Jim Watkins once said, “A river cuts through rock, not because of power, but because of its persistence.” Continued research is critical because it helps to resolve global inconsistencies in the health care system. Leaving an imprint on humanity is the greatest gift of all, and it’s why I look forward to many more years with the HVTN.

My work in HIV started in college when I took a course on anthropological biology as a pre-requisite for my degree in Psychology, and I wrote a paper where I drew a comparison between the finches on the Galapagos Islands to HIV and human cells. HIV was like the finches who would evolve based on their unique environment: the island or the human cell. Later that year, I applied to an internship through San Francisco Department of Public Health (SFDPH) called SHARP (Summer HIV AIDS Research Program). I was 1 of 5 students selected from across the nation to go through a summer of intensive learning within the extremely intersectional field of HIV. I was placed at Bridge HIV within SFDPH, and my research project that summer was to analyze a survey we had sent out to Bay Area-based Primary Care Providers about their knowledge of PrEP (Pre Exposure Prophylaxis) and willingness to prescribe it, as it had just been approved by the FDA.

Midway through my internship experience, I identified an open part-time Clinical Studies Recruiter position at Bridge HIV. I applied, got it, and the rest is history. While at Bridge HIV, I have been an intern, a recruiter, an educator, a research associate, and now Community Programs Manager. I have worked on a variety of studies from many different angles.

Not only do I feel exhilarated and humbled by what I get to contribute to my community on a local scale, I get to make an impact on a global scale by being a part of the HVTN. Specifically, my favorite thing about being a part of the HVTN are all the mentors it has provided me. You are all so inspiring!!
Dr. Fatima Laher is a medical doctor, director of the Soweto-Bara Vaccines Research Centre, and co-chair of HVTN 100, 702, 120, the HVTN Protocol Committee, and the HVTN Training and Education Committee. Dr. Laher, the recipient of a Young Physician Leader award from the Inter Academy Medical Panel in 2012, recently spoke at a Young Women in Science event. With a focus on advising young people how to map their scientific careers, Dr. Laher asked attendees to consider how to address the current systemic imbalances in South African communities affecting women in the workplace. These disparities include leadership roles (more than two-thirds of leaders in South Africa are male), pay gaps (on average men earn more than women despite working fewer hours), and unpaid work (in which women bear the brunt of family/home duties and so-called office housework). Speaking out against the discrimination that young women experience in the health sector, she said, “The health sector needs men and also women: women as healers; women as advocates to speak for our own bodies; women to innovate solutions for health issues; women to lead. Science shows that gender roles are conditioned into us; they are not natural. Be strategic and infuse your life with action. Make your way in the scientific world; change the ground around you, and it will continue to change things for the next wave of women. We are the daughters of thunder.”

Dr. Kathy Mngadi is a medical practitioner at the Nelson Mandela School of Medicine in 1987. While working in a communicable diseases outpatient clinic in Durban, following a personal bout of Tuberculosis, she first encountered HIV and referred confirmed TB cases for HIV testing through an NGO, in the days when only venous samples were drawn and results took two weeks to get back. At that time no treatment was available for HIV, and the havoc wreaked by the disease in those co-infected with TB prompted her to take on the role of Medical Director at a local hospice where she was pivotal in opening admissions to HIV-infected patients for respite, end-of-life care, and treatment of opportunistic infections. She worked in the first ART programme in South Africa at the Anglogold Orkney Hospital clinic, where she was first exposed to HIV treatment research through the Aurum Institute. She later joined in their own PEPFAR-funded ART programme and eventually in HIV and TB prevention and treatment research at the Klerksdorp site, working on HVTN 503 among other protocols. She joined CAPRISA in Durban 7 years later, implementing HVTN 100, 107, 108, 702, and 703, and also serves as co-chair of HVTN 107 and HVTN 705/HPX2008. She sits on the Scientific Governance, Protocol Committee, and Efficacy Trials Working Group. She recently re-joined the Aurum team in May 2018 as a CRS leader and PI for HVTN 705/HPX2008 at the Tembisa-Clinic 4 site. She enjoys the sense of community in the HVTN, the effort to build capacity among local investigators, and the strong Community Engagement programme promoted within the HVTN. She is determined to contribute to the collaborative efforts to find a safe and effective HIV vaccine.
Working with the organization’s community and site teams, Ntando ensures that communities are central to the efforts of the search for effective, affordable and accessible HIV vaccines, as well as research for other tools for HIV prevention. Ntando’s work of community engagement is guided by principles of informing, consulting, involving, collaborating, and mutual empowerment, to ensure meaningful roles of communities in the research process. In his role as a lead, he ensures the use of standard development and implementation of community education programmes, advisory mechanisms, partnerships with health service providers, and other community-based stakeholders. Ntando’s work is motivated by an interest in effectively engaging and involving communities, working and being attentive to interests and needs, such that they take ownership in the efforts that seek to achieve control of the AIDS epidemic, especially in sub-Saharan Africa.

As Co-Chair of the HPTN Community Working Group, Ntando has been involved in the establishment of a South African framework for stakeholder engagement which came about as a result of his AVAC fellowship work in 2013. This work bridges the gap between civil society groups that are within the country’s National AIDS Council (SANAC) through to the provincial and local levels where communities are involved in HIV vaccine research and other ARV-based prevention trials of microbicides and pre-exposure prophylaxis.

Ntando feels honoured and excited to have been part of HVTN’s journey as early as the days of Phambili (HVTN 503) through to the current era of Uhambo (HVTN 702) and Imbokodo (HVTN 705/HPX2008). One of the most exciting aspects about this journey is having experienced and knowing what it means to be very hopeful yet humbled by an era of disappointing outcomes of large scale trials in the late 2000s. Those experiences have taught us to appreciate the contribution of communities who, when the field was reeling from futility results, were the ones who reminded us what we had told them when introducing research to them, that it is only a trial. Therefore, the field, led by scientists, with all teams, communities and advocates, cannot stop but has to press on in unison until one of the ultimate hopes to defeat HIV is realized, finding an HIV vaccine.

Looking back and seeing the present, where two large scale vaccine trials are in the field with communities putting themselves forward to advance the discovery, brings cautious hope that whatever the outcome, one thing is for sure: the discovery of an HIV vaccine is more near than far. In fact, if for whatever reason vaccines are delayed, the world is not denied because of the growing body of knowledge about antibody mediated prevention. The future therefore continues to be one that is filled by hope, and the products we have currently in oral and possibly topical PrEP should be maximized. That way HIV has no option but to surrender in the near future!
Dr. Scott is the Medical Director for Clinical Research at Bridge HIV in the San Francisco Department of Public Health. He received his BA from Stanford University; MD from Yale School of Medicine; and MPH from the University of California, Berkeley. He completed his Internal Medicine residency, Chief Residency, Infectious Disease fellowship, and post-doctoral research training in the Traineeship for AIDS Prevention Studies at University of California, San Francisco (UCSF), where he is an Assistant Clinical Professor of Medicine.

His interest in HIV prevention research started during medical school after learning about the rising number of HIV infections in marginalized populations domestically and globally, and the need for new prevention options. He has a particular interest in the epidemiology of HIV-related racial and ethnic disparities among men who have sex with men (MSM), and interventions to reduce those disparities. He is currently the protocol co-chair of HVTN 119 and HVTN 129/ HPTN 088. He most appreciates the collaborative opportunities and support within the HVTN for early stage investigators. In addition to conducting HIV vaccine and Pre-Exposure Prophylaxis (PrEP) studies at Bridge HIV, he is developing and testing technology-based HIV prevention interventions for MSM, including mobile and web apps, focused on sexual behavior risk reduction and uptake of HIV prevention interventions such as HIV testing and PrEP. Dr. Scott currently has a K23 award from the National Institute of Mental Health to develop and test a mobile app-based combination HIV intervention that incorporates home HIV self-testing, self-collection of sample for STI testing, and PrEP uptake among young Black MSM in the San Francisco Bay Area.

I was introduced to HIV and the surrounding prevention work at an early age as a peer youth advocate for the MOCHA center, an organization focused on supporting LGBT youth of color in Rochester, NY. I learned about the devastating impact the disease was having on my community, and how community engagement activities are critical to providing education and tools to those who need it most.

When I first learned of my own HIV diagnosis in 2015, it lit a fire within me. I wanted to turn my diagnosis into something positive. In 2016, I joined the Community Education & Recruitment team, where it has been my mission to not only recruit new study volunteers but also educate people from all backgrounds about HIV prevention research.

Recently, I played an integral role in the University of Rochester Artist in Residence Project. This project aims to break the cycle of stigma surrounding HIV and to foster awareness through a series of watercolor portraits (of folks within our local HIV community), painted by our Artist in Residence. As part of the project, a short documentary was created about the process entitled, “Don’t Define Me”, where I shared my story of being an African American Trans woman living with HIV.

Being a part of the HVTN feels like belonging to a big family of superheroes from different walks of life all around the world. From Africa to South America to cities all over the USA, we are all doing the hard work of engaging our communities toward a common goal. I’m proud to be a part of that.
In 1980, when I was 10, living in East New York, Brooklyn, the streets were riddled with heroin injection drug users and soon followed by the crack epidemic. My neighbors also included gay men. Some owned it, however many more preferred to keep their sexuality private. Now it's 2018 and we still struggle with breaking down the systemic stigmas of being an LGBTQI & Same Gender Loving person. At that time, I witnessed the deterioration of people's physiques, having fallen ill at the hands of what scientists discovered to be HIV years later. My neighbors were dropping like flies. No one knew why and few cared. There wasn't much empathy toward drug users and "gays."

Fast forward 20 years. I made a transition from corporate design to concentrating my studies in biology, phlebotomy, and medical assisting. A friend pointed me to an open position with a research project that was right up my alley, in that it focused on testing a risk-reduction tool among non-injection drug users and their sexual and drug-using networks whose sexual orientations were diverse. In summary, we learned that risk-behavior is challenging to decrease, especially over time and that the MSM in the study were at higher risk than their heterosexual counterparts.

HIV vaccine research, to me, was a chance to contribute to my communities who were most at risk of getting HIV by exposing them to an intervention that could potentially prevent new infections with an injection (or 4). This is my driving force. The fact that the first drug, Truvada, used for PrEP to prevent HIV was discovered along with HPV vaccines gives me much hope that we will one day find an effective vaccine against HIV.

I would be remiss not to acknowledge that together, my family at the Columbia Research Unit, from the PI to me, all bust our butts to do the best we can while keeping ourselves in good spirits. This makes going to work a pleasure as we push forward with our scientific agenda.

As a child, Jemal Shelton held preconceived notions about the healthcare profession as being only a place for nurses and doctors; however, he was later enlightened to the varied opportunities in the healthcare field. Jemal remembers enrolling in a health course where he had to investigate his family medical history. He discovered that in his family were persons who had suffered from HIV, diabetes, asthma, strokes, seizures, cancer, and heart attack, and during this time his curiosity peaked.

HIV research became an area of interest to him in 2012, during matriculation of his Master of Science in Human Services. Jemal's research was based on HIV among youth living in the United States. However, in 2016, his focus transitioned toward the LGBT community, and primarily MSM, in Atlanta, GA. In 2017, Jemal started his journey with the HVTN as a volunteer with Emory School of Medicine Hope Clinic as a CAB member, where he later became the CAB Chair. The HVTN has enhanced his knowledge about prevention, education, and awareness surrounding his local community. Jamel notes he has had a superb experience working with HVTN. The diverse backgrounds among the staff and CAB members help to bring about social change throughout Atlanta.

Jemal has earned a Bachelor of Science degree in Administration Information Management and Master of Science in Human Services. He is currently pursuing a Ph.D. in Public Health with a specialization in Epidemiology, where he can continue to focus his HIV research on the LGBT community.
The process of building an identity is very complex and occurs over time. People do not usually accept us so easily, but when it happens, nobody can stop us. This is how Rassiel Ivanof lived it; she accepted it, she learned, she loved herself, and now she feels proud to be who she is.

The LGBT community in Peru is very vulnerable due to the lack of external and internal acceptance, and the daily struggle is constant and tenacious. Last year Lima repealed a law that protected its members from family violence, however, in Loreto the issue is reversed.

The Loreto region in Peru has been a pioneer of inclusion through regional and municipal ordinances in favor of the LGBT community, maintaining empowerment and support from schools, monitoring the issues of violence hand in hand with the Ombudsman’s Office, and the region is involved in research topics through the Amazon Rainforest Civil Association.

Part of this process is a special day called Pride Day that is celebrated every June 27 to stop and say here we are, we exist, and we will go for more.

This year in Iquitos the Regia Marcha brought together locals and strangers. The Amazon Rainforest Civil Association participated with an allegorical train that brought together members of the community, their family, and friends who showed the joy of living as a family with the diversity of our world. This was a message that was felt so deeply that it caused everyone, literally, to get on the train.

Feeling pride in oneself should not be a matter of 24 hours, but a constant part of life. How can we love ourselves without loving each other? How can we accept ourselves without accepting others? Every day we learn something new, and the goal of this day is to learn to respect.

Welcome to our Pride Train and the journey to be who we are.

*Carlos Vela is a Community Educator and Lucia Ruiz is the CER Manager of the ACSA Iquitos CRS.*
Background

In November 2017, the South African Medical Research Council (SAMRC) held a summit to discuss the standard of care in prevention and treatment trials in Southern Africa. The summit concluded that the SAMRC and the Fred Hutchinson Cancer Research Center (FHCRC, home of the HIV Vaccine Trials Network (HVTN)) will establish a fund to cover the cost of Truvada for oral Pre-Exposure Prophylaxis (oral PrEP) and HIV testing for HIV prevention trial participants for the duration of the HVTN 702 and HVTN 705 trials [Gray G, Executive Summary of the Summit on the Standard of Care in Clinical Trials in Low-Middle Income Settings, 06 November 2017]. Trial sites and their communities will decide how to provide oral PrEP at each site, and this will likely look different at different sites.

Prof. Gita Ramjee, Director, and Clinical Trials Unit (CTU) Principal Investigator (PI) of the HIV Prevention Research Unit (HPRU) of the SAMRC, held an Imbizo (Zulu term for a gathering or forum) on 08 December 2017 with stakeholders, community working group members (CWGs), peer educators and research team members of HPRU. The event guest speaker included the Deputy Director of HIV/AIDS, STIs and TB (HAST) from the Provincial Department of Health (PDOH). Prof. Ramjee highlighted the HIV epidemic in Sub-Saharan Africa and explained the need for additional HIV prevention methods. There were 7.1 million people living with HIV in South Africa (SA) in 2016. There were 240,000 new HIV infections and 110,000 people died from AIDS-related causes that year [http://www.unaids.org/en/regionscountries/countries/southafrica]. Young women are most affected by HIV. Data on men are still being collected in terms of new infection rates. SA has the highest number of people on ARVs, over 3,000,000 people where 56% are female. 54% of HIV infected children are on treatment. The problem is not getting people on treatment but to keep them on treatment. More HIV-positive people need to be retained in care so that they can achieve suppression of their viral load. Treating and looking after people living with HIV is critical, but it is also important that those who are negative must stay negative. Many people do not like using condoms. Medical Male Circumcision (MMC) is available for men, but few options are available for women. Licensure for a vaginal ring containing ARVs to use for prevention is pending. Additional options for HIV prevention continue to be important.

Objective

The objective of the Imbizo was to discuss the potential access to oral PrEP by trial participants, and gather the opinions of key stakeholders. There was interactive discussion regarding PrEP as an additional tool for HIV prevention among trial participants and the community.

Participants

49 people were invited including partners from the provincial hospitals [where HPRU has a Memorandum of Agreement (MOA)], Community Working Group (CWG) members, stakeholders and peer educators. 25 partners attended as follows:

<table>
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<th>Representation</th>
<th>No. Invited</th>
<th>No. Attended</th>
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<tr>
<td>MOA partners</td>
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<td>1</td>
</tr>
<tr>
<td>CWG Members</td>
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<td>18</td>
</tr>
<tr>
<td>Stakeholders</td>
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</tr>
<tr>
<td>Peer Educators</td>
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<td>3</td>
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<tr>
<td>Researchers</td>
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<td>21</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
<td><strong>46</strong></td>
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Discussion

The Director of HPRU gave an overview of all the HIV Prevention research conducted by HPRU and gave an update about Truvada as Oral PrEP. Oral PrEP is not for everyone, since it must be taken orally daily. It must be used consistently daily for 20 days to achieve adequate tissue protection levels for vaginal protection, and 7 days for anal protection, prior to sexual exposure. Oral PrEP does not prevent sexually transmitted infections (STIs) nor does it have any contraceptive properties. Dr. Simone Hendricks, a clinical doctor from HPRU, explained the clinical considerations, the eligibility criteria, indications, contraindications and side effects of using Truvada as oral PrEP. There were concerns about drug resistance. Prof. Ramjee explained that the risk of drug resistance is very low in HIV negative people using oral PrEP. Drug resistance is more likely to occur in a person who is already HIV-positive and is on ARV treatment. It is therefore important for a person who is on oral PrEP to have regular HIV tests. If a person becomes HIV positive, oral PrEP is immediately stopped and ARV treatment is initiated. To date there have been no issues with resistance post-seroconversion. The DoH is monitoring the issue of drug resistance.

Stakeholders agreed that oral PrEP should be available for clinical trial participants while they are in the trial. However, after the trial, participants will need to access oral PrEP via demonstration projects or at private healthcare providers and SAMRC will assist with referrals as necessary. There is no visit reimbursement for participants who attend the clinic only to access oral PrEP. They must be made aware of this and that it is a service HPRU, SAMRC will provide based on their individual requests.

Mukelisiwe Mlotshwa, Deputy Director from HIV/AIDS, STIs and TB (HAST) Unit of the Kwa-Zulu Natal Department of Health shared the plan to rollout oral PrEP to the public in a stepwise process. They have started oral PrEP access with men who have sex with men (MSM), commercial sex workers (CSW), and recently university students. One of the stakeholders expressed their excitement about the government’s decision to make oral PrEP available for young people as they are at high risk of HIV acquisition. The Minister of Health, Dr Aaron Motsoaledi is committed to making oral PrEP available to everyone eventually. The community stakeholders understood that this is a slow process, and they were made aware of the costs and resources needed to roll out oral PrEP.

All stakeholders at the meeting appreciated the opportunity they had to discuss oral PrEP and valued the new information they received. Many expressed their eagerness to share oral PrEP information with their families, communities and organizations.

“I will say I am very happy that the Universities were considered as one of the first people to access PrEP. As communities, we must be able to reiterate the message of HIV to the community. Coming together is the beginning, working together is a progress.” - Imbizo Attendee

“The steps in prioritizing PrEP access was also discussed with the group. It was clarified that access to specific populations was based on the high HIV incidence and prevalence rates among high risk groups. Service providers are also exploring options of where oral PrEP may be offered and overtime access to oral PrEP may be available in the health clinics within the public sector. The process of monitoring and evaluating oral PrEP access, use and adherence is key to its effectiveness, as a person may get infected with HIV while on oral PrEP is he/she is not adherent.

Recommendations from Community Stakeholders and Partners

The community stakeholders agreed that clinical trial participants should be provided with oral PrEP for the duration of the trial, thereby affording them the highest standard of care available. However, they emphasized that the trial participants need to be adequately educated about oral PrEP so that they can make an informed decision about whether they wish to access oral PrEP. Most community stakeholders believed
the packaging of oral PrEP (bottle) is not user friendly as people may think it is ARVs for treatment, thus, contributing to stigma against those who are living with HIV. They proposed that pill boxes may be a more user-friendly alternative to bottles. The attendees gained very useful information from the workshop. They recommended that HPRU train the CWGs on oral PrEP as they need to be educated since they are the heart and soul of the community. They need training to assist in educating communities and addressing myths and misconceptions about oral PrEP.

**Way Forward**

The community stakeholders valued the information and knowledge they gained from the workshop on oral PrEP. However, they urged the Department of Health to increase efforts to educate the community about oral PrEP as this may improve acceptability and use of the HIV prevention option. While oral PrEP was accepted as a potential HIV prevention method, community stakeholders supported the researcher’s efforts to explore new interventions such as infusions of antibodies. For current and new HIV prevention methods to be used, there is a need to have support of the community which is also important to achieve research outcomes.

*Neetha Morar is the Research and Community Manager, Ishina is the Research Assistant, Nokulunga Bhengu is the Community Liaison Officer, and Professor Gita Ramjee is the CTU Principal Investigator of the HPRU in Durban, South Africa.*

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The HIV Vaccine Trials Network (HVTN) is the world’s largest publicly-funded international collaboration focused on the development of vaccines to prevent HIV/AIDS.

**In 2019, the HVTN will continue:**

Several early phase studies to assess the safety and immune responses to vaccine and broadly neutralizing antibody candidates.

**HVTN 703/HPTN 081 and HVTN 704/HPTN 085 (The AMP Studies)**

Evaluating the use of a broadly neutralizing antibody (bnAb), VRC01, to reduce HIV infection in HIV-uninfected men and transgender people who have sex with men, and among women.

**HVTN 702 (Uhambo)**

Evaluating the use of a clade-specific combination vaccine regimen to reduce HIV infection in HIV-uninfected persons in South Africa.

**HVTN 705/HPX2008 (Imbokodo)**

Evaluating the use of a combination vaccine regimen containing a mosaic vaccine targeting global HIV strains to reduce HIV infection in HIV-uninfected women in 5 African nations.

Find out more at:

www.hvtn.org/participants
The Department of Social Science and Community Engagement at the National Institute for Medical Research-Mbeya Medical Research Center (NIMR-MMRC) works in collaboration with Principal Investigators, CAB members, local health authorities and community leaders to conduct community education meetings, provide annual CAB refresher courses, as well as participate to develop and implement activities for the World AIDS day and HIV Vaccine Awareness day celebrations. During the 2017 World AIDS Day, CAB members, CERs, study teams and District health authorities celebrated with community members by providing education on HIV infection and HIV vaccine research at MMRC.

The 2018 CAB refresher course took place on 27 January 2018 and involved Principal investigators, our Community Engagement Coordinator, and the site’s Director. Together they provided presentations on CAB roles and responsibilities, a review of informed consent forms, an overview of HIV vaccine trials, as well as other ongoing studies at the site related to TB, cervical cancer and HIV observational research.

* Doreen Pamba, Jane Ambindwile, Jerry Kapungu, Simeon Mwanyonga, Tausi Sade, and Lucas Lazaro are Community Engagement Officers with the Mbeya CRS in Mbeya, Tanzania.
Have you ever wondered how that flu shot works? We did!

The Seattle HVTU Community Advisory Board took a special field trip to the Pacific Science Center (PSC) to learn more about how vaccines work. The CAB met with PSC exhibit staff to learn about their experience with the public in creating this educational display. As it turns out, they talked to naysayers, heard about conspiracies, and spoke to folks who are uninformed of the science behind vaccines. The similarities of their interactions and ours in our work are uncanny. Have you ever been told the _____ (fill in the blank) vaccine causes _____ (fill in the blank)? That childhood vaccines cause autism? They have heard it and so have we!

After sharing common experiences between the PSC staff and our CAB, we visited the interactive exhibit about vaccines. We learned about herd immunity, HPV vaccines, why vaccines are important and who made some important discoveries. We played a Chickenpox video game and even learned more about vaccine innovators in Seattle—and yes, HVTN was listed! In fact, it was great to see our site’s own Principal Investigator Julie McElrath, MD highlighted, as well as the HVTN Principal Investigator Larry Corey, who was also an advisor on the exhibit.

After having some great conversations on how our research relates to other existing vaccines, we furthered our education with a special talk from Gail Broder from the HVTN Community Engagement Unit. Gail spoke about specific strategies we are trying in our HIV vaccine work in her usual engaging style. We then wrapped up our time with an update on the specific protocols the Seattle site is conducting and matched them up to the strategies we had just reviewed.

It was a fun day with members new and old as well as our new friends at the Pacific Science Center.

*Kim Louis is the Community Outreach Manager at the Seattle HIV Vaccine Trials Unit CRS, Seattle, WA, USA.
ACROSS
3 A substance that may be included in a vaccine to improve the body’s ability to fight disease or infection.
4 A research study or experiment in humans (as opposed to animals) that is designed to answer specific questions.
6 A subtype or strain of HIV.
8 The body’s system of many organs and cells that defends the body against infection, disease, and foreign substances.
11 The process of deciding whether or not to join a clinical trial, after learning enough information to make a responsible decision about participating.
12 A test-of-concept trial that is not designed to establish the efficacy of a particular candidate but rather to help researchers decide if a candidate is worth testing in larger Phase III trials.
13 An HIV vaccine created by a computer program to optimally reflect the known circulating strains of HIV from around the world.
14 A common virus that causes colds and sore throats. A defective version that cannot cause infections in humans is sometimes used as a vector in HIV vaccines.

16 An early clinical trial designed to study an experimental vaccine in humans. Generally small (less than 100 participants) and designed to see if the product is safe.
17 An independent group that reviews data during a study and can recommend the study be stopped if it appears the volunteers are being placed at risk.

DOWN
1 The effectiveness of a vaccine, or how well it works.
2 Assigned to a group by chance, like the toss of a coin.
5 One of the groups that monitors HVTN trials. Each research institution has one. Some sites may know them as Ethics Committees.
7 The process clinicians use to see if a volunteer is eligible to participate in a clinical trial.
9 An inactive substance designed to resemble the vaccine (or treatment) being studied.
10 Infection-fighting proteins that tag, destroy, or neutralize bacteria, viruses, or other harmful toxins.
15 An intermediate clinical trial to learn more about vaccine safety and to see if the vaccine generates an immune response.
ACROSS

2 Describes a particular group based on specific characteristics (e.g., race, ethnicity, gender)
6 A process for experimentation that is used to explore observations and answer questions.
8 Teaches the body’s immune system to prevent a particular infection or fight a specific disease.
9 The body’s system of many organs and cells that defends the body against infection, disease, and foreign substances.
10 Total number of people living with a disease in a given population during a specific time period
12 The process of deciding whether or not to join a clinical trial, after learning enough information to make a responsible decision about participating.
13 An inactive substance designed to resemble the vaccine being studied.
14 An international collaboration of scientists, educators, and community members searching for an effective and safe HIV vaccine.

DOWN

1 An area of healthcare that involves testing the safety and effectiveness of interventions for disease prevention, treatment, diagnosis, or symptom relief.
3 A substance that may be included in or added to a vaccine to improve the body’s ability to fight disease or infection.
4 Measure of new infections during a specific time period
5 An early clinical trial designed to study an experimental vaccine in humans. These trials are generally small (less than 100 participants) and designed to see if the product is safe.
7 A white blood cell present in the blood, lymph and lymphoid tissue that is essential in immune defense.
9 The process of deciding whether or not to join a clinical trial, after learning enough information to make a responsible decision about participating.
11 Natural substances that help build and maintain your body, and do the same for viruses such as HIV.
14 The human immunodeficiency virus.
The HIV Vaccine Trials Network is an international multi-disciplinary collaboration. Support for the HVTN comes from the National Institute of Allergy and Infectious Diseases (NIAID) of the U.S. National Institutes of Health, an agency of the U.S. Department of Health and Human Services. The Network and NIAID have a close, cooperative working relationship, with shared attention to intellectual and scientific issues.

ABOUT COMMUNITY COMPASS
The Community Compass aims to keep the HVTN community informed about the Network’s research, site activities, and advances in the field of HIV prevention and vaccination. We encourage community members to submit news and event reports to this magazine and make this a true community sharing platform.

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Editor-in-Chief:
Stephaun E. Wallace

Layout & Design:
Cody Shipman

Production & Distribution:
Nina Ennis

Contributing Editor:
Gail Broder

SEND INQUIRIES ABOUT THIS ISSUE OF COMMUNITY COMPASS TO:
Stephaun E. Wallace, sewallac@fredhutch.org

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hvtn.org/en/community/community-compass.html

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