

Mujeres Adelante

Newsletter on women's rights and HIV • 6th SA AIDS Conference 2013 • Durban

In Focus...

Luisa Orza

Living with HIV is part of a continuum...

Among the many streams of dialogue that have contributed towards the post-2015 High Level Panel Report released a few days ago, one of the most prominent has been the focus on growing inequality within and between countries – an issue that the Millennium Development Goals (MDGs) failed to directly address.

And while an assessment of the achievements made under the MDG framework reveals that there is much to celebrate, there is growing consensus around the failure to reach 'the bottom fifth' – that is to say that for those most marginalised, most hard to reach, most affected by multiple layers of structural barriers



(including discrimination based on gender, age, disability, sexuality and gender identity, caste/class, race and ethnicity, among others) – it is entirely possible that not much has changed. The High Level Panel of eminent persons on the post-2015 development agenda concludes that

...to fulfill our vision of promoting sustainable development, we must go beyond the MDGs. They did not focus enough on reaching the very poorest and most excluded people.¹

Further, the focus on inequality as part of the new emerging framework (whatever that will eventually look like) seems to acknowledge the growing consensus that inequality is *bad* for everyone, not just for those 'at the bottom of the pile'. So it follows that addressing inequality is *good* for everyone.

Recently compiled research across a range of well-being indicators shows that countries and states with greater equality fare better on issues from crime, mental health, literacy, gender equality, and children's

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well-being to social mobility, maternal and infant survival rates and planned parenthood².



Within this dialogue, it has been said that

...Gender-based discrimination – including the denial of the rights of women and girls and their disempowerment to take control of their lives and bodies – remains the single most widespread driver of inequalities.³

Much has already been said and written about how gender inequality plays out within the realm of HIV. In generalised epidemics women are more affected than men – in terms of both susceptibility to HIV acquisition, and vulnerability to the impacts thereof – eg burden of care; stigma and discrimination; vulnerability to violence. Across a range of settings, young women are 3-4 times more susceptible to HIV acquisition, than male counterparts in the 15 – 24 year old age group; but in some areas – such as Rwanda – young women are 10 times more vulnerable among the narrower 18-19 year old cohort. Even in countries where incidence rates are leveling off, among young women they are rising. Young women constitute the fastest growing population newly acquiring HIV across the board.

Further, within key affected populations, gender dynamics are often ignored. But there is a growing body of evidence⁴ to show that among people who inject drugs, women face harsher disapprobation and stigma than men, due to the fact that drug use is seen as a more serious transgression for women, in addition to facing some gender-specific risks and vulnerabilities (such as having children taken

away from them, or lack of access to reproductive and maternal health options). Women who inject drugs also have more severely compromised health/life expectancy, than their male counterparts; women are more likely to acquire HIV, and die from drug overdose. And where this tragically happens, the length of time from inception of drug use to drug-related death for women is three years, in comparison to five years for men, and the average age of death is 17 for women; 25 for men. Also within the community of people who inject drugs we see similar patterns of gender power imbalance as among sex workers or the general population – lack of ability to negotiate harm reduction (clean needles) when injecting with intimate partners, whereas among a group of casual acquaintances not sharing needles is far more accepted. This echoes patterns of condom use, which tends to be easier for women – including sex workers – to negotiate with casual rather than regular partners.

Inequality was also a key thread among the sessions and discussions of last month's Women Deliver Conference in Kuala Lumpur. Almost every conversation I took part in highlighted the advances

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that have been made under the MDG framework, *and* noted that the poorest of the poor; those who among the most marginalised women – is achieved. But what struck me at Women



face multiple barriers to access; those who live in the most hard to reach areas; those who face stigma and discrimination as a result of their gender, sexuality, HIV status, caste/class or religion, disabilities, or legal status, are being failed in every area of MDGs 3, 4, 5 and 6 – not to mention the other four goals. Steps are already being taken to address this. The Family Planning Summit of 2012 aims to ensure that 120 million women – *among the hardest to reach* – are able to access and utilise hitherto inaccessible family planning products. The development of a human rights framework for the delivery of family planning products and services should help to ensure that the goal – not just of reaching new users, but of reaching new users Deliver, as well as at the Family Planning Summit in London last year – and in stark contrast to what has been one of the most successful characteristics of the HIV response to date – was the lack of involvement of the communities they aim to serve in the discussions of development practitioners, policy makers, donors and service providers. As a veteran of international, regional and country AIDS Conferences, I am used to a much greater degree of visibility (albeit hard-won and not always enough!) of the ‘*most affected*’ communities – those living with HIV and representing key affected communities. The GIPA principle has become both a signature and mainstay feature of the HIV response, and while the translation of the principle

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...continues to have its boundaries and terms negotiated, and contested...

...‘old fashioned’ sense of service provision and development intervention...

into practice continues to have its boundaries and terms negotiated, and contested, the principle itself is largely undisputed.

So it was interesting to me to hear the term ‘*investment*’ used not in terms of capacitating women to be part of the conversation, to be involved in the decision making that affects every aspect of their lives, but in the – to my mind – ‘*old fashioned*’ sense of service provision and development intervention. The steadily expanding HIV track of the conference was one of the only areas where an energetic community presence was felt, in particular from the dynamic and determined leaders of the *Unzip the Lips* campaign platform, comprised of a coalition of women living with HIV and women from key affected populations in the Asia Pacific region.⁵ This coming together of women in their diversity around a common set of sexual and reproductive health and rights issues has breathed a very special kind of life into the *Unzip the Lips* campaign, and it is a platform to watch and celebrate over the coming months as we move towards the Asia-Pacific regional conference (ICAAP) in November this year, and the International



AIDS Conference in Melbourne in 2014.

The need for coalitions, and the need to address women's issues where they are, was also brought home to me by another comment I heard from a long-term HIV activist during this conference week: that in the community in which she lives, women living with HIV are the *same women* as those not living with HIV. Regardless of status, these women all wait for the same buses, queue-up at the same supermarket check-outs, access the same clinics, and pick their children up from the same schools. Their communities face multiple challenges, including sexual and gender-based violence,

marginalisation of certain groups, drug and alcohol overuse, unemployment, and other harmful practices. And they also encompass support systems, networks and mechanisms that enable members of the community to survive, and sometimes thrive. They are the same women who face violence and rights abuses *as women*, potentially causing HIV acquisition, at the point of testing, diagnosis and treatment for HIV, or as a result of the same. Living with HIV is part of a continuum, not an isolated condition.

What these thoughts bring home to me is first, that the need for women living with HIV and their

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communities to be meaningfully involved in planning, implementing, monitoring and evaluating change interventions at the community level, remains an imperative for the HIV response, and the wider women's development agenda; and, second, that addressing the needs, rights and aspirations of women living with HIV, amounts to addressing the needs, rights and aspirations of women in all our diversity.

FOOTNOTES

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3. Global Thematic Consultation on the Post-2015 Development Agenda: Addressing Inequalities. Report. [www.worldwewant2015.org/inequalities]
4. See for example www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf.
5. For more information about the campaign, see <http://unzipthelips.org/>.

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Conference expectations...:

Transgender people, especially those who do not have access to basic resources, experience severe stigma, discrimination, difficult access to medical care, and a general lack of hope. This naturally results in low self-esteem and self-worth; and creates a compromised position when negotiating safer sex, leaving transgender people very vulnerable to HIV exposure and transmission.

Current HIV programming tends to ignore gender identity, and includes transgender people in same-sex HIV programming and research by making assumptions concerning their sexual anatomy. The lack of specific and adequate programmes responding to the realities and needs of transgender people leads to, among others, a reluctance to undergo voluntary HIV testing and thus often results in late diagnosis and access to treatment.

While there is a basic knowledge of HIV transmission and risks, one cannot generalise about transgender sexuality and gender identity in terms of sexual practices, as there is a wide continuum and diversity in practices and behaviours. Male condoms are the most commonly available prevention method, along with lubrication. While some transgender persons do practice safer sex, unsafe sex is common. Trans men and lesbian women need more understanding and

information regarding the risk of vagina to vagina sex, and how to protect oneself. Dental dams, female condoms and finger clothes are not well-known or available, and are not generally used, given the limited understanding of vagina to vagina vulnerability.

It is our hope that the Durban AIDS Conference will address these issues, and focus on ending the abuse and unprofessional behaviour transgender people are often

We need to move
beyond commitments...

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exposed to in health services, whilst ensuring that health services adequately address the particular needs of the transgender population in this country. Stigma and abusive behaviour are serious barriers to transgender people accessing care, including HIV testing and ART treatment. Health professionals need sensitisation, to enable services to be provided in an affirming way, which welcomes transgender clients. Similarly, forms and processes need to be updated so that gender identity is not a barrier hampering access to services, including ART, through for instance using the incorrect pronouns.

[Liesl Theron, Gender Dynamix]

Women's Realities...

Jordin Albers

Change at an individual level...

The Constitution of South Africa¹ is one of the most progressive documents in the world in terms of the human rights protections that it affords. The Constitution provides that all persons have the right to be treated equally regardless of status², the right to have his or her dignity respected³, and the right to a dignified life⁴.

However, despite these guaranteed protections, women living with HIV in South Africa are continually confronted with the negative stigma that is associated with HIV. As a result, the existing constitutional protections prove ineffective in protecting human rights, and women living with HIV are left without redress as and when their rights are violated. Thus, to more effectively protect the basic human rights of women living with HIV, it is necessary to ensure that women

are protected at an individual level through assuring that all women are not only aware of their rights, but also possess the skills and education necessary to advocate on behalf of those rights.

Women's rights

There are numerous protections expressly asserted in the Constitution, such as the right of freedom and security of person.⁵ For women living with HIV, this means that not only do all women have the right to be free from all forms of violence, but also the right to make their own reproductive decisions and to have control over their body, including determining whether or not and which medical tests she will be subjected to. The Constitution also guarantees the right to privacy, which means that all individuals have the right to either disclose or to keep secret their HIV status.⁶ Furthermore, no one may be denied work or discriminated against, in any manner, based on their HIV status.⁷ Finally, the Constitution asserts the right of access to healthcare, irrespective of HIV status.⁸



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In addition to these domestic constitutional protections, South Africa has signed several international documents providing further protection to women. For example, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Protocol on the Rights of Women in Africa provide that women and men are to be equal in laws and policies.⁹ These documents state that all women are

to have equal protection in the field of healthcare¹⁰ and have the right to a dignified life.¹¹

Women's realities

Despite these formal protections, women living with HIV in South Africa continue to be discriminated against at an individual level as a result of the stigma that is associated with HIV.¹² As a result of this negative connotation, the available legal resources prove ineffective, and women are consequently subjected to various forms of rights violations. For example, many women unlawfully have their HIV status disclosed and are then isolated from their families, or are regularly beaten, because of the virus that they carry.

HIV status may also influence the treatment that a woman is receiving in terms of healthcare. As a result of the widespread belief that a woman living with HIV should not have a child, many women are subjected to forced sterilisation.¹³ Women find themselves in a position where they must comply with the sterilisation either for their own health and the health of the child, or as a result of being pressured into compliance.

Many women living with HIV are actually denied access to healthcare either because healthcare providers

do not act in the same manner in treating a patient with HIV as they would in treating a patient without HIV; or because the women are fearful to obtain medical care, because their HIV status will not be kept confidential by medical personnel.¹⁴ A woman's positive HIV status may be disclosed, as women living with HIV are shouted at and commonly treated in a degrading manner by clinic healthcare workers.¹⁵ In addition to this, many medical facilities have infrastructural shortcomings for ensuring confidentiality – not only physically separating patients based on HIV status, but also marking patients' folders with stickers that denote this status, allowing everyone in the clinic to readily observe the HIV status of a patient.

Women's access to redress and justice

Notwithstanding these obvious violations and the existing constitutional protections, many women living with HIV continue to fail to obtain redress for the violation of their rights. Women in South Africa are mindful of the fact that they may take legal actions when their rights are infringed upon, in the sense that they are aware that there are legal mechanisms in place

to protect their rights.¹⁶ However, when rights specifically based on and in the context of HIV are violated, the vast majority of women do not actually take legal action. Instead, they simply choose to continue as if no violation occurred, opting to allow their rights to be violated, because they are fearful of the consequences of taking such action.¹⁷

One potential cause of this is the fact that although women living with HIV formally have access to the police when their rights are violated, many women do not take legal action

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because of the failure of the police to act when claims are actually made. Due to the stigma associated with HIV, many feel that the police do not take any action to protect the rights of people living with HIV, and instead treat these individuals with disrespect.¹⁸ Furthermore, if the police do involve themselves in protecting these rights, it nonetheless proves difficult to determine who actually violated the rights of the individual, as it may be unclear who actually disclosed the HIV status of a woman when everyone in the community has been discussing the matter. Thus, with many people involved, there is little confidence in the police to effectively manage the case.

In addition to these issues with law enforcement, the courts themselves do not provide compensation for women when claims are in fact made. Despite the fact that the Constitution guarantees people with HIV the same rights as those of all citizens, it is believed that since the courts share the same discriminatory attitude towards people living with HIV, women will find no redress in these venues.¹⁹ Instead, many women believe that the Courts will needlessly expose her to ridicule and further discrimination only to have the law interpreted

against her. If a woman brings a case for a violation of rights in terms of her HIV status forward, she must then discuss her status and the implications of it in a public proceeding – an experience that can be traumatic and can leave the woman feeling vulnerable and exposed. Despite this trauma, the court may then rule against her, holding that her rights were not in fact violated or finding that those living with HIV are not a special class under the law. Such a finding leaves the woman to have suffered emotional distress to no effect.

Moreover, further problems arise with the fact that when a woman makes an accusation, she does so knowing that her HIV status may be revealed by a number of sources. These sources include the police, the courts, or private individuals who are either directly faced with charges or who have indirect knowledge of the proceedings. These individuals may not appreciate the ramifications of disclosing the identity of someone living with HIV or may have personal motivations for disclosing the woman's status, because of the charges that she is bringing. Since many women choose not to disclose their HIV status for fear of the repercussions from family, friends, and the community as a

whole, it seems easier to remain quiet, since doing so ensures that her HIV status remains confidential, and protects the woman from any potential harm that she will be exposed to, if her status is revealed.²⁰ Not taking legal actions thus is valued in order to protect the woman's dignity.

Finally, women are not obtaining redress, because they are fearful in making complaints against those who violate their rights. In many instances, someone close to the woman violates these rights, and the woman does not wish to press charges against someone with whom she has a relationship.²¹ In other situations, the woman is faced with domestic violence, leaving her fearful of taking any legal actions in order to prevent the situation from worsening should the legal mechanisms prove ineffective in protecting her as someone with HIV. Therefore, the woman is more likely to accept the ill-treatment she is receiving, and not take any legal actions, out of fear that such actions will anger her partner and worsen the abuse after legal redress fails.



Way forward...

Each of these issues can only be rectified through ending the stigma that exists around HIV. Through educating communities about the circumstances that women are facing, and openly discussing the virus, society will begin to accept women living with HIV and will progress towards ultimately reducing the impact of the disease, as people will be more likely to access HIV-related services, and to receive treatment. As this occurs, women will be less fearful of taking legal actions and of disclosing their own HIV status.

As society progresses, women will be inspired with the realisation that their rights are significant, and that HIV does not define those rights. All women will come to appreciate their inalienable worth as human beings, and will be in a position to better defend themselves from discrimination and violations against their dignity. As society is educated, the negative connotation against women with HIV will dissipate, as women will be empowered and thus, in the position to pursue legal actions.

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In addition to this, the courts and the police will no longer be influenced by discriminatory attitudes. Consequently, there will be more confidence in the fact that the law will be interpreted fairly, and that the rights of people with HIV will be protected to the same extent that any other group is protected. With this confidence, claims based on HIV-related violation of rights will increase, and more women will be able to obtain redress for the abuse and rights violations they are subjected to. Furthermore, the police will view claims of this type more seriously and will pursue every action necessary to ensure that the rights of all citizens are fully protected. As rights violations concerning women living with HIV are treated as being equally important to those violations concerning other groups, the police will be incentivised to provide such cases with full protection, and will

no longer discriminate against cases involving women with HIV.

Concluding remarks

It is true that even if the stigma surrounding HIV is eliminated, women will still fear domestic abuse and harm from people who they have close relationships with. However, women will also be in a position to have more confidence in the legal systems. If women are not discriminated against, they will be more likely to bring cases to the fore, because of the belief that these cases would be successful and that redress will be obtained.

In conclusion, it is only through promoting change at an individual level that the formal legal mechanisms can effectively provide protection for the rights of women living with HIV. Without societal acceptance and supportive attitudes towards women living with HIV women will continue to be in an

oppressive state and will have no means for protecting their inherent human rights. Consequently, it is crucial that women living with HIV are empowered through education about their individual rights and through gaining the skills and capacity to advocate on their own behalf in securing these rights through the existing legal protections.

FOOTNOTES:

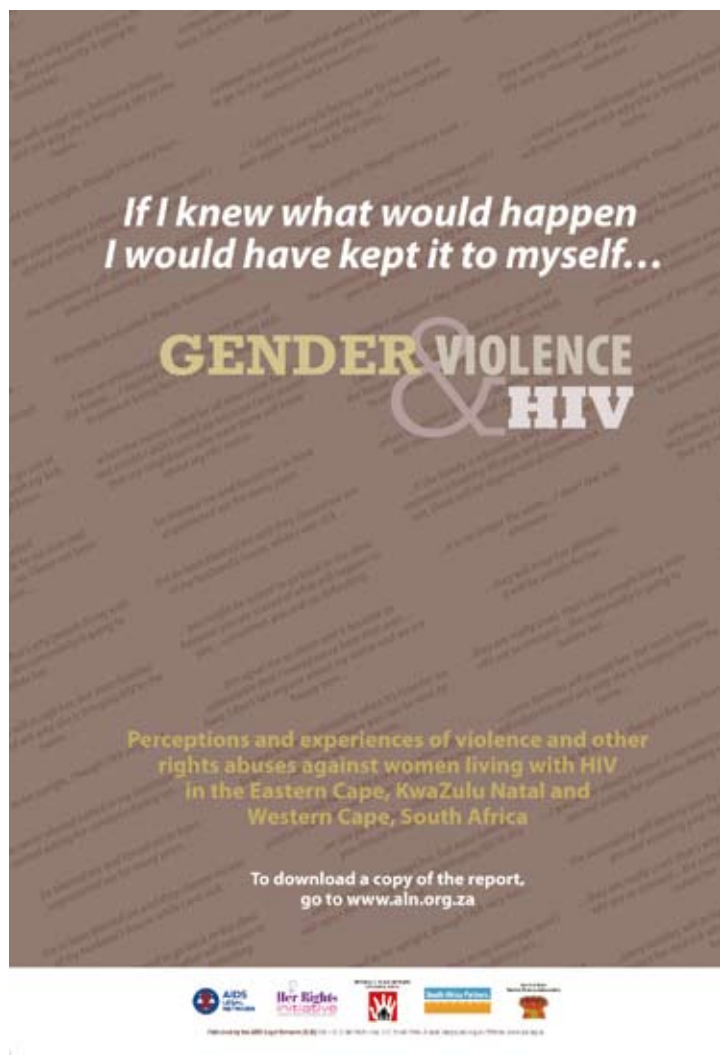
1. The Constitution of South Africa, Act 108 of 1996.
2. Constitution of the Republic of South Africa, Section 9.
3. *Ibid*, Section 10.
4. *Ibid*, Section 11.
5. *Ibid*, Section 12.
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8. *Ibid*, Section 27.
9. Convention on the Elimination of All Forms of Discrimination Against Women, Article 2; and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 8.
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11. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 3. See also Convention on the Elimination of All Forms of Discrimination Against Women.
12. Kehler, J. et al. 2012. *Gender Violence & HIV: Perceptions and experiences of violence and other rights abuses against women living with HIV in the Eastern Cape, KwaZulu Natal and Western Cape, South Africa*. AIDS Legal Network, Cape Town. [www.aln.org.za/downloads/Gender%20Violence%20&%20HIV2.pdf]
13. FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health. 2006. 'Ethical issues in obstetrics and gynecology.
14. *Ibid*, Note 11, pp33-35.
15. *Ibid*.
16. *Ibid*, Note 11, pp36-39.
17. *Ibid*, Note 11, pp22-24.
18. *Ibid*, Note 11; AIDS Legal Network. 2012. *Fact Sheet: Perceptions and Experiences of Violence Against Women Living with HIV in Tafelsig and Beacon Valley, Western Cape*, pp2-3.
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Women's voices...

...on HIV positive status disclosure...¹



...if I knew what would happen I would have kept it to myself...
[Western Cape]

...I remember it was in July when one of my neighbours shouted at me saying that

I'm spreading HIV, that's why people don't buy from me anymore. I was so shocked, because I didn't tell anyone about my HIV status. I was so embarrassed; I couldn't even go out of the house. I decided

to stay indoors with my kids to prevent being hurt by our neighbours... [KZN]

...it is risky...you need to think carefully about disclosing and that's why I keep mine a secret...
[Western Cape]

...I was never abused before in my marriage, until I started asking for condoms during sex...when I gave my husband my test results, he said 'I am so sorry my wife, I didn't tell you before that I am HIV positive'... it was a week after I tested positive that the husband wanted sex without a condom and that same week the beating started. I was afraid to have sex with him, because of my HIV status. He told me 'you are not going to tell me you're not going to have sex with me. I'm your husband and we are supposed to have sex, because we have done it before'. I told him if I had known he was HIV positive, I would not have taken the risk of sex without a condom...the social worker put me into an outreach centre for abused women and children and I divorced my husband...
[Eastern Cape]

...it broke our family apart and ended my relationship, it messed up everything, because of the blame...it's tough to deal with it... [Western Cape]

...in the community, you can't tell someone you're HIV positive, not even your neighbour...it's not safe, they will always reject you...you can laugh, talk and sing with them, but keep it quiet, because they always will point fingers...
[Eastern Cape]

...although I was ready to disclose my status, the community was not ready to accept me... [KZN]

...my friends were not informed by me that I am HIV positive, they just knew that I was sickly...this didn't stop them preventing me from using their cups that they use for themselves when I visited them. They had no shame in telling me that I can't use their toilets either and they started telling their children that they can't play with my children...I had problems with my husband too...this upset me so much and it became so unbearable that I moved away from that area to

...it's not safe, they will always reject you...

...I was never abused before in my marriage...

...they started telling their children that they can't play with my children...

...it became so unbearable that I moved away...

...you will be called names and you will be told that you're useless...

where I am staying now...here I don't tell anyone about my status and we are happy here... [Western Cape]

...we are tired of people looking down on us and discriminating against us...we are part of the community, you should accept us... [Eastern Cape]

...you will be called names and you will be told that you're useless...you lose friends that you were close with, and when you lose friends you become lonely... and the rest of the community start pointing fingers... they discriminate you, because of your status...people will define her as HIV positive and forget the person behind the status... [KZN]

...it's difficult, because if you don't disclose you are going to suffer and when you disclose you will be stigmatised... [Eastern Cape]

...I must not be seen as a woman who is HIV positive, but as a woman who is a human being... [KZN]

FOOTNOTE:

1. See Kehler, J. et.al. 2012. *Gender Violence & HIV: Perceptions and experiences of violence and other rights abuses against women living with HIV in the Eastern Cape, KwaZulu Natal and Western Cape, South Africa*. AIDS Legal Network, Cape Town. [www.aln.org.za/downloads/Gender%20Violence%20&%20HIV2.pdf]

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Tian Johnson

Special report:

Side-lined, left-off the agendas and underfunded...

At the Barcelona AIDS Conference in 2002, the world largely started talking about 'AIDS having a woman's face'. It leaves me bewildered, when we run this statement off, almost like a mantra, at conferences, workshops and campaigns, treating it as some gold nugget of breaking news. It's actually not!

Women and girls across Africa, and indeed the world, have always known what it feels like to *carry the burden* – the burden of disease and the burden of violence in all of its ugly forms – in and outside of marriage, including marital rape, female genital mutilation, maternal mortality and the list goes on. I wonder what kind of world we would be living in if that list was flipped on its side, and we had a

'paternal mortality crisis' on our hands?

In 2008, a rural women's empowerment organisation, the Thohoyandou Victim Empowerment Programme (TVEP), with support from Oxfam Novib, hosted South Africa's first National Dialogue on Universal Access to Female Condoms. This organisation has seen thousands of women, and men, go through its doors and accessing a wide range of services – from ground-breaking children's ARV adherence workshops to comprehensive one-stop centres of service and support to survivors of sexual assault – in one of South Africa's most rural areas. In retrospect there could have been no better suited organisation to take up the cause for female condoms in South Africa.

At the frontlines of the impact of sexual violence and HIV, especially on women and girls, TVEP for many years fought an uphill battle to get provincial government to fund NGO provided essential services, which



in reality was (and still is) the responsibility of government to implement. A case in point is the funding of *'care packs'* consisting of a toothbrush, face towel and underwear for a woman who has just survived the trauma of rape. That *'luxury'* has been funded over the years by the international donor community, despite several appeals to the provincial government – a telling sign indeed.

Universal access to female condoms: A human rights concern

In 2008, TVEP convened a gathering focused on universal access to female condoms as a *'human rights issue'*. Nearly five



years later, the landscape of HIV prevention, especially for women and girls, has changed dramatically; and not always in ways that bode well for gender equality.

South Africa is a country where the sexual and reproductive health and rights of women and girls are too frequently side-lined, perpetually underfunded, and the accountability of government agencies tasked with advancing these rights remains elusive and seldom goes beyond lip service. What other reason would there be – more than a decade into the female condom programme – for women to still struggle to access female condoms from public health facilities?

So what has changed since 2008,

when the following declaration was signed by some of the country's leading women's rights, faith-based and legal advocacy groups, including South Africa's largest trade union COSATU?

We the undersigned declare:

1. *Lack of adequate access to female condoms constitutes a human rights violation*
2. *An expanded definition of human rights inclusive of such issues as choice, accessibility and gender should be supported*
3. *Access to free and easily accessible quality female condoms restores women's self-esteem and dignity*
4. *The female condom is the only*

female-initiated and -controlled prevention and protection method, and as such, full participation of all stakeholders and the private sector must be incorporated into any strategy relating to access to female condoms

5. *The inequitable distribution of female and male condoms in the current National Strategic Plan is unacceptable and should be challenged immediately*
6. *Social norms are the major drivers of discrimination and inequalities and they contribute towards the feminisation of HIV*
7. *The use of any condom further empowers people to reduce the rate of reinfection, and to increase the total number of protected sex acts*

We further acknowledge that Universal Access to Female Condoms can only be achieved through enhanced:

1. *Resource allocation*
2. *Education and training*
3. *Infrastructure development and*
4. *Ensuring adequate policy implementation.*
5. *The roll-out of medical male circumcision (MMC) as an HIV prevention method need to be further investigated as to the impact on women's risks and vulnerabilities to HIV. In the context of potential decreased male condom use, as a result*

...responses have historically been narrated through masculine voices and articulated through patriarchal systems...

of MMC programmes, we strongly believe that universal access to female condoms is thus understood as a pre-requisite.

Two years after the dialogue, and in response to the 2010 mid-term review of the National Strategic Plan (which, among other, found that the national AIDS body was not user-friendly, failed to coordinate provincial HIV responses, and faced shortcomings in provincial monitoring and evaluation), an 18 months restructuring took place and a 'fit for purpose' National AIDS Council was launched. With a 2012/2016 vision that commits to a country with Zero new HIV infections, Zero HIV-related death, and Zero discrimination, and goals that include the reduction of new HIV infections by at least 50% (through a combination of available and new prevention methods and ensuring an enabling and accessible legal framework that protects and promotes human rights), the positioning of a woman's right to the only available female-initiated tool to protect herself from HIV; the way

forward should, be clear. At least in theory...

Access to female condoms: The national response

The objectives of the NSP, essentially our response roadmap to the epidemic, include 'to prevent new HIV, STI and TB infections, as well as to sustain health and wellness'. The grand mission boldly states that while progress has been made – and will continue to be improved – in the treatment of AIDS, TB and STIs, the ultimate mission of the NSP in the next three years is for prevention to take centre stage in the country's response to HIV. So, with a track record in commendable policy

speak, what does all of this mean for women's access to female condoms?

One of the emerging champions of the 'struggle' for female condom access and support is the SANAC Women's Sector. The fact that this sector exists beyond an obligatory mention in a policy document is a

reason to celebrate in and of itself!

As one of the 19 civil society sectors represented on the plenary of the National AIDS Council, this sector appears to be a logical partner in driving the female condom agenda. As in any effort to advance the rights of women and girls, this task will not be without its challenges. Intended to be a platform from which women's voices can be raised and represented, the sector is

...ensure that female condoms are never introduced as a stand-alone product...



positioned in an epidemic, whose responses have historically been narrated through masculine voices and articulated through patriarchal systems. It is in such an environment that female condom advocates need to approach the issue of universal access to female condoms. As the Women's Sector continues to work within the National AIDS Council, as well as with the Department of Health, our discussions and long overdue actions need to focus on what universal access to female condoms means in a tangible and accountable manner.

The newly launched multimedia, nationwide ZAZI campaign, within which the FC2 female condom forms an integral part, reminds women to use their inner strength and to look inside themselves; to know their strength, their value and what it means to be really true to themselves, so that they can overcome adversity. This campaign presents yet another opportunity to mobilise communities in all of their diversity to promote self-confidence amongst women, so that they can draw upon their own strength to make positive choices for their future. It encourages young women to resist peer pressure and to define their own values, so that they can prevent unwanted pregnancies, HIV, and have a safe pregnancy and healthy baby as and when they choose to become pregnant. The campaign calls upon young women to know their rights and what they are capable of; to stand up for themselves, and to have the strength to define what they think is right.

The very basic issue of the lack

of access to a female condom, and all of the support that needs to go with it, sadly, epitomises all of these elements, and thus positions the campaign as another key vehicle to drive the HIV prevention agenda for women and girls.

Female condom access opportunities

The FC2 female condom is the female condom that is available

in South Africa's public healthcare system, and through a national network of civil society partners¹.

The FC2 is manufactured by the Female Health Company, the only condom manufacturer to attend a major 2012 Family planning Summit in London, and one of

four private companies that made a commitment to the summit's goals by pledging an estimated \$23 million over an eight year period.

The company pledged to:

1. Invest up to \$14 million over the next six years in reproductive health and HIV/AIDS prevention education and training, in

collaboration with global agencies;

2. Aggregate annual public sector purchases from all large buyers to set prospectively volume-based discounts on unit pricing; and
3. Award major purchasers with free products, equal to 5 percent of their total annual units purchased.

...requiring an honest, accountable look at the status of health, sexuality and fundamental rights of women and girls in all their diversity...



On 28 May 2013, the Global Poverty Project and Women Deliver announced a new family planning campaign, *It Takes Two*, to raise awareness of, increase demand for, and improve access to family planning information and services around the world. The Female Health Company has become one of the product partners of the campaign, joining IPPF, The Bill and Melinda Gates Foundation, UNFPA, DANIDA, Marie Stopes, and several other campaign partners in this essential work.

Over the last decade a team of health professionals that I am proud to be part of specialise in FC2 female condom programming and training, SUPPORT Worldwide², has invested an estimated R300 million to assist organisations, professionals and governments, who want to increase the use of FC2 female condoms; with a significant amount of this investment being dedicated to supporting the South African female condom programming environment. Activists need to ensure that female condoms are never introduced as a stand-alone product, but are provided with high quality training and support.

Advocacy responses moving forward...

In June 2013, civil society organisations from around the globe will write to the Bill and Melinda Gates Foundation, to not only applaud the Foundation for prioritising the development of the ‘next generation condom’, but also urge the Foundation to build on, and further support programming of female condom products that exist today.

Despite being in existence for decades, the female condom still needs to be highlighted on the HIV prevention radar. We need to encourage more investment into HIV prevention overall within the country Global Fund proposals, as there seems to be consensus among activists that the current focus is too heavily biased towards treatment. Under the prevention umbrella there also needs to be targeted advocacy that equally speaks to an increase in female condom procurement and promotion.

Effective female condom programming can be used as a catalyst for so many issues that we face today; the daily reality of violence against women, unplanned pregnancies, poverty and blatant misogyny – all drivers of the pandemic and all requiring an honest, accountable look at the status of health, sexuality and fundamental rights of women and girls in all their diversity in South Africa.

Let this be a year to look forward to continuing our collective support for a women’s sector that shakes

ALL patriarchal structures to their very core when the most pressing issues central to the lives of women and girls are side-lined, left-off agendas and underfunded. Comfort and the maintenance of the status quo have never resulted in any change.

The female condom represents many things, including an opportunity to further dialogue and communications in relationships, and an opportunity to measure our progress as a people towards realising equality and dignity for all. And, on the rapidly changing landscape of HIV prevention, the female condom perhaps best represents an opportunity to lay the groundwork for potential microbicide introduction, an introduction that will be in peril from the start, if we fail to tackle head-on the patriarchy that festers within and has characterised our health systems for far too long.

Access to commodities is important, but they are only as effective as the power that women and girls have to use them. This is perhaps the new ‘freedom struggle’ in South Africa in 2013.

FOOTNOTES:

1. See also www.femalecondom.org.
2. A division of the Female Health Company, manufacturers of the FC2 Female Condom.

Tian is an HIV prevention advocate and the founder of the African Alliance for HIV Prevention.

For more information: partnerships@inbox.com.

...the patriarchy that festers within and has characterised our health systems for far too long...

Upcoming events...Poster Presentations

Tuesday & Wednesday

Commercial sex workers' experiences of sexually transmitted diseases and perceived susceptibility to HIV/AIDS in Ogbomoso, Oyo State, Nigeria PS 1-114 2208111

People living with HIV are more likely to use a condom, but not all! PS 1-138 2287880

Perceptions about the acceptability and prevalence of HIV testing and factors influencing them in different communities in South Africa PS 1-140 2287985

The 'victim victors'. Analysing the role women play in HIV/AIDS care and prevention PS 1-155 2276786

Strengthening and expanding HIV-related legal services and rights to promote access to HIV prevention, care and treatment services PS 1-159 2285590

Masculinity, livelihoods and HIV risk in urban informal settlements in South Africa PS 1-166 2287895

Gender violence and HIV: Perceptions and experiences of violence and other rights abuses against women living with HIV in the Eastern Cape, KwaZulu-Natal and Western Cape PS 1-168 2287927

Perceptions and experiences of HIV-related stigma and discrimination in the Northern Cape and North West PS 1-172 2288039

Perceptions and implications of stigma among HIV-positive SRH clients in Kenya PS 1-176 2289262

Male involvement in the prevention of mother-to-child transmission of HIV programme in Mthatha, South Africa: Women's perspective PS 1-182 2288143

HIV-related stigma as a barrier to PMTCT: The case of Kiboga District, Uganda PS 1-187 2287236

Thursday & Friday

School-based responses to sexuality education and HIV prevention: Learner engagement in the Life Orientation subject in 16 South African secondary schools PS 2-1 2288303

HIV infection among most at-risk populations of South Africa: Results from a population-based survey PS 2-9 2288530

Factors associated with self-reported HIV infection among South African women of reproductive age PS 2-11 2288698

The influence of multiple sex partners, condom use at first sex, beliefs, and the local context on condom use in South Africa PS 2-12 2288844

HIV risk and media consumption patterns: Identifying a wide-reach medium to reach young women with behaviour-change communication PS 2-15 2287888

'I know about HIV and AIDS but my choices as a woman are limited': Implications of gender inequalities for HIV prevention and access to treatment PS 2-20 2288921

Reproductive and sexual rights in the context of gender: Youths' perspective in Northern KwaZulu-Natal PS 2-25 2289293

The EMPACT framework for building stigma-free faith communities PS 2-44 2283835

Making the case for SRH and HIV integration in Zambia PS 2-77 2287912

Reducing HIV transmission, harmful cultural practices and stigma and discrimination through meaningful PLHIV participation – The case of the STAR Circles in Malawi PS 2-79 2287928

Strengthening networks and building capacity to reduce the effects of HIV among men who have sex with men, sex workers and

people who inject drugs in South Africa PS 2-81 2287965

Are women at the centre? A critical review of the NSP response to women's sexual and reproductive rights PS 2-87 2288236

Removing barriers, increasing access: Operational guidelines for HIV programmes for key populations in South Africa PS 2-99 2288391

From practice to policy: A critical study of the perceptions and use of the female condom by women in Durban PS 2-109 2288574

We are not all the same! Using community information to design a sex worker programme in rural South Africa PS 2-130 2286828

Involvement of women living with HIV in the PMTCT programme in South Africa PS 2-136 2288661

An exploratory study towards disclosure of status and reduction of stigma for people living with HIV/AIDS in a low income community: The development of a community-based framework PS 2-153 2288298

Experiences of pregnant women living with HIV/AIDS in the Vhembe District in the Limpopo Province PS 2-162 2288137

Engaging men in South African HIV policy for gender equality and HIV prevention – Examples of best practice and recommendations for improvement PS 2-168 2288124

Advocacy: A tool to improve girls' and young women's access to information on sexual and reproductive health, and access to sexual and reproductive health and services in Zambia PS 2-188 2287913

Agnes Junga

Regional voices...

Rural women in Tanzania

Tanzania has an estimated 1.6 million people living with HIV, which is 6% of the total population¹. HIV prevalence rates vary greatly between the regions, ranging from 16% in the Iringa region to less than 2% in Arusha². Women in Tanzania are most infected with and affected by HIV, comprising 60% of all people living with HIV in the country³.

The reasons for women's greater vulnerability to HIV transmission and the impact of HIV are multi-fold, including women's difficulties in negotiating safer sex, because of gender-based violence⁴, early marriages, and 'inter-generational sex'⁵. Especially in rural areas, women face additional challenges of lack of access to information and healthcare services, further increasing women's risk to HIV.

Access to healthcare facilities in Tanzania, especially in rural areas, is worsened by the shortage of physicians, which often results in a situation in which only nurses are available in rural clinics to treat patients.⁶ In addition, the fact that qualified doctors and nurses are emigrating to other countries, because of better pay, conditions and

...difficulties in negotiating safer sex...

training opportunities, means that health sector shortages remain a critical problem to the scale-up of HIV treatment, counselling and prevention in Tanzania⁷; and hence the provision of treatment to women in rural areas is very difficult.

According to Article 19(1) of the Tanzania HIV/AIDS Prevention and Control Act, the government shall use the available resources to ensure that

every person living with HIV, vulnerable children and orphans are afforded with basic health services⁸. In reality, however, the government has failed to provide adequate healthcare and treatment in rural areas, which not only greatly impacts on the extent to which women are in the position to access health services, including HIV-related services, but also infringes on women's right to health.

The second National Multi Sectoral Strategy Framework on HIV and AIDS (2008-2012) analyses the factors hindering the continuum of care, treatment and support for people living with HIV, especially for women in rural areas, and provide strategies to overcome these barriers. One of

...health sector shortages remain a critical problem...

the main challenges for addressing these issues however is that Tanzania as a country largely depends on donor funds, with no internal sources of funds for the provision of treatment, leading to among other things the disproportionate provision of and access to treatment between the rural urban areas.

The limited provision of treatment for women in rural areas impacts not only

on the effectiveness of the country's response to women and HIV, but also on women's ability to claim and realise their constitutionally guaranteed right to dignity and life.⁹

FOOTNOTES:

- 1 See www.unaids.org/en/resources/campaigns/20121120_globalreport2012/results.
- 2 See www.tac aids.go.tz/hiv-and-aids-information/about-hiv-and-aids.html.
- 3 See www.avert.org/hiv-aids-tanzania.htm.
- 4 UNAIDS. 2008. The HIV epidemic in Tanzania Mainland: Where have we come from, where is it going, and how are we responding?.
- 5 See www.tanzania.go.tz/hiv_aids.html.

- 6 See www.avert.org/hiv-aids-tanzania.htm.
- 7 *Ibid.*
- 8 Tanzania HIV/AIDS Prevention and Control Act (No 28 of 2008). [www.ilo.org/aids/legislation/WCMS_125594/lang--en/index.htm]
- 9 www.judiciary.go.tz/downloads/constitution.pdf

Agnes is with the Southern Africa NGO Network – Tanzania Chapter. For more information: aggymike@yahoo.co.uk.

Conference expectations....:

It is important to recognise and appreciate the commitment to the AIDS response that South Africa has shown in the past years. While we had bumpy roads, we are getting it right now.

My expectation is that the conference premise should be to influence the impact of the AIDS response in South Africa, and to stimulate a better response to mitigate the impact of a feminised epidemic in the country – where women are still marginalised,

and women's realities need a robust response addressing intersecting issues. Thus, I am hoping that this conference will very vigorously focus on science, community involvement, community driven initiatives, leadership, accountability and monitoring interventions to advance gender equality.

**No turning tides
without changing minds...**

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Glenda Muzenda

In my opinion...

Progress and/or counter-productive effects...

The challenges of preventing and ending violence against women and girls, as well as providing access to quality healthcare, including ARTs, prevail the world over, as resonated by the resolutions of the 57th session of the Commission on the Status of Women (CSW) in March, 2013¹. Under the theme of the 2013 CSW (The elimination and prevention of all forms of violence against women and girls), discussions centred around the various causes, forms and effects of violence against women and girls, as well as the various approaches and strategies to bring violence against women and girls to an end, and to adequately address its intersections with HIV risks.

Notwithstanding the political will to protect women and girls from violence, and commitments to provide quality health services,

including HIV-related services to all women and girls, concrete and holistic responses to the prevention and end of violence against women and girls remain scarce.

According to the 2013 CSW agenda, 'risky behaviours' leading to violence, such as alcohol consumption, are persistently reported, despite the many awareness raising campaigns and information available. One of the reasons might be that the links between gender-based violence and women and HIV, poverty eradication, food security, prevention of crime, and education are still mostly lacking in the conceptualisation, design and implementation of programmes.

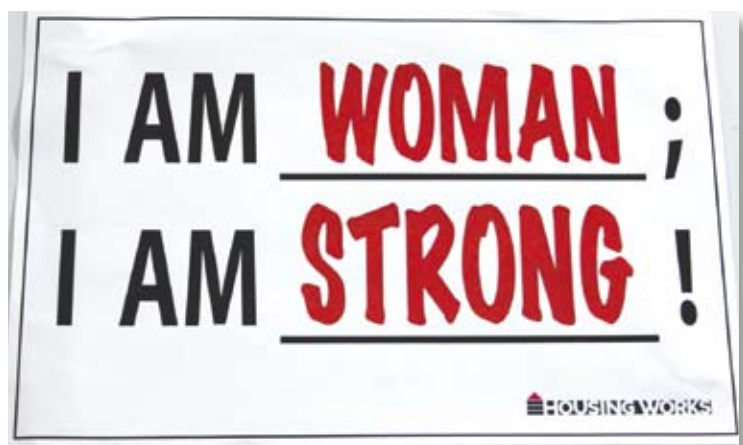
Very critical, as we come nearer to the end of the MDGs², is that acceleration efforts are made to ultimately prevent and end gender-based violence against women and girls, and to adequately respond to the intersections between gender-based violence and HIV.

...concrete and holistic responses to the prevention and end of violence against women and girls remain scarce...

...critical to ensure that responses to HIV are strengthened to prevent violence against women and girls...



Thus, it is critical to ensure that responses to HIV are strengthened to prevent violence against women and girls, whilst at the same time meeting women's and girls' specific needs for sexual and reproductive healthcare services. A holistic approach – ranging from diagnosis and affordable and accessible treatment to post-diagnosis care and assessment for all victims and survivors of all forms of violence against women and girls according to their specific needs – must be adequately resourced, and the processes in the judicial, policing and legal systems



must allow for justice for women and girls to prevail. In other words, responding ‘*holistically*’ to gender-based violence has to include ensuring that there are adequate and sufficient sexual and reproductive healthcare services, and that women are in the position to not only access women-centred prevention methods, such as female condoms, but to negotiate safer sex, without exposing themselves to the risk of violence from their intimate partners.

Similarly, while it is critical that all health needs, concerns and consequences in the context of gender-based violence are responded to, it is equally important to condemn actions in healthcare centres that demean, degrade, humiliate female patients, and/or force medical procedures, such as terminations of pregnancy

and sterilisation of women living with HIV. Limited and/or denial of access to services, as well as coerced and forced procedures need to be addressed as forms of gender-based violence, as these are to be seen as ‘*crimes against humanity*’, in which justice does not prevail, and the state often fails to take accountability, to intervene, and, so doing, fails to prevent (and end) such violence against women and girls.

It comes as no surprise that sexual violence, and many other forms of violence, were debated and discussed openly on a global level at CSW, given the events in the last six months concerning sexual violence against and rape of women and girls globally, and in South Africa especially. As the 2013 Durban AIDS Conference begins, it is a desire that key aspects of the deliberations include the dire need to

...meeting women’s and girls’ specific needs for sexual and reproductive healthcare services...

...responding ‘*holistically*’ to gender-based violence has to include ensuring that there are adequate and sufficient sexual and reproductive healthcare services...

prevent and end gender-based violence, and to adequately and holistically respond to the links between violence against women and girls and HIV risks and vulnerabilities – by highlighting how the same impacts negatively on the sexual and reproductive rights of women and girls.

What is needed, is that the ‘*beast of violence*’ be brought to its knees, as we consider the next steps towards achieving the goals of Zero new infections, zero discrimination and zero death going forward.

FOOTNOTES:

1. Commission on the Status of Women, 57th Session, March 2013 [www.un.org/ga/search/view_doc.asp?symbol=E/CN.6/2013/L.5]
2. Millennium Development Goals 2015.

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Conference expectations....:

The South African National AIDS Council Women's Sector Secretariat [SANACWSS] looks toward the upcoming 6th National AIDS Conference in Durban as a critical point of engagement and consultation among development partners, members of the broader women's sector and key government stakeholders engaged in the national HIV response.

Women in Sub-Saharan Africa carry a disproportionate burden of disease being infected and affected by HIV. Recent data speaks to condom use among youth decreasing, with a correlated increase in the number of young women contracting HIV and reporting of unwanted pregnancies. To bring down prevalence rates and turn the tide on the epidemic, the SANACWSS

hopes that the 2013 SA AIDS Conference will clearly respond to the need to place women at the centre of HIV prevention and treatment policies and programming. As such emerging programmes should speak to the inherent gender inequalities characterising women's access to, and uptake of, resources that seek to reduce and mitigate the impact of HIV.

Identifying mechanisms to address gender inequality at a social and institutional level cannot be seen as a 'nice to have'; it must to be an inherent part of HIV programme and policy formulation, monitoring

and evaluation mechanisms. We need to move from the development of interventions imposed on women to a national response that is characterised by meaningful participation, consultation and capacity building, to ensure that as women we move from being positioned as programme beneficiaries to a space where we are driving and owning the agenda that impacts on our lived realities. As such it is our hope that in the 2013 conference we move beyond a recognition of gender inequality as a driver of the epidemic, to one where all panellists respond to how they address (and/or



recognise as critical) addressing gender inequalities in their areas of focus.

The leadership of the SANACWS further looks forward to continued engagement and opportunities to work with all stakeholders to scale-up the national response to address the pervasive gender inequalities that continue to drive women's vulnerability to HIV.

[Greer Schoeman, SANAC Women's Sector Secretariat]

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I have the right to protect myself...
and be safe...

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Upcoming events...

TUESDAY, 18 JUNE 2013

16:00 – 18:00

Opening Session Hall 1

WEDNESDAY, 19 JUNE 2013

07:30 – 08:30

Gender-based violence against women living with HIV and Human Rights Count!: Implications for policy, legislation and programming Hall 4

11:30 – 13:00

Translating science into community practice Hall 2

Behavioural change communication Hall 3

Symposium: The use of contraception in the context of the HIV epidemic Hall 8

14:00-15:30

Satellite: South African national perspective on delivering comprehensive combination HIV prevention Hall 6

18:00-20:00

Symposium: Linking HIV prevention research in South Africa to the realities of women's lives Hall 8

THURSDAY, 20 JUNE 2013

07:30-08:30

Satellite: Structural issues and HIV & AIDS prevention: Alcohol, gender, culture and livelihoods Hall 2

Satellite: Cinderella's slipper: Forcing the shoe to fit, addressing social change challenges Hall 5

09:00-11:00

Plenary Hall 1

11:30-13:00

Stigma-reduction interventions Hall 2

Gender issues Hall 7

14:00-15:30

Symposium: Gender-based violence and HIV Hall 10

Symposium: Sexual and reproductive rights for HIV-positive people Hall 2

Symposium: Removing barriers, increasing access: Government-led initiatives to improve the HIV response for key populations in South Africa Hall 5

16:00-17:30

Particularly vulnerable populations Hall 1

Symposium: What does 'sex' mean and is our understanding of sex fit for the purpose of planning HIV prevention? Hall 8

19:00-21:00

Gala Entertainment Hall 1

FRIDAY, 21 JUNE 2013

09:00-11:00

Plenary Session Hall 1

11:30-13:00

Closing Session Hall 1

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