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Mujeres Adelante

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In Focus...

Creating new pathways of change...

Ebony Johnson

Sam Cooke may have said it best, *'It's been a long time coming, but I know; Change Gonna Come. Oh yes it will'.*

Since the spring of 2011 in the lead up to the High Level Meeting on HIV (HLM); there has been a renewed spirit of tenacity, advocacy and determination to ensure that all women have universal access to HIV prevention, treatment and care; sexual and reproductive health and rights, and moreover a robust call for all women to have ownership, voice and choice in the decisions that impact our lives. Leading up to the HLM, the Global Coalition of Women and AIDS (GCWA) and the ATHENA Network cast a broad net across the globe through a virtual consultation on universal access. This virtual consultation was the only avenue that captured the voices of young women, sex workers, women living through chemical dependency, women living with HIV, migrant women – women from across the spectrum – bringing together voices of nearly 1000 women to ensure that the concerns and needs of all women were incorporated in the 2011 UNGASS Political Declaration.

In Women's Words

What started as a process to inform the Declaration has now become a global campaign, *In Women's Words*, being utilised by women in every corner of the world, from grassroots advocacy to global policy platforms, ensuring that the priorities deemed by women are integrated in policy and planning in National AIDS Strategies (NAS); monitoring and evaluation processes, funding allocations, and across multi-stakeholder collaborations.

Change does not happen by accident, it happens by collective action. In different languages, women across the globe came together for the common good of women and girls. We spoke collectively… passionately... and deliberately.

What's inside:

Together, we spoke in one voice. Our voices echoed 5 key priority areas:

- Services that address the visions, life-long needs, and rights of women and girls in all our diversity
- Eliminate stigma and discrimination, and ensure full protection of the human rights of all women and girls, including our sexual and reproductive rights
- Strengthen, invest in, and champion our leadership and equality to ensure the full and meaningful participation of women and girls, in particular those of us living with and affected by HIV, in the HIV response
- Empower us to be catalysts of social justice and positive change, and eliminate all forms of violence against us
- Ensure full access to information and education, including comprehensive sexuality education for all women and girls

Responding to these calls from *In Women's Words* to '*invest in and champion leadership*', to '*ensure full protection of the human rights of all women and girls*', and to 'empower us to be catalysts of social justice'; the GCWA launched the *Young Women's Leadership Initiative* at the IAS Pathogenesis Conference in Rome in July 2011. This empowering initiative brought together a diverse cadre of amazing young women leaders to develop a vast knowledge base on HIV research, sexual and reproductive health and rights, gender equity, human rights and effective advocacy. This bold group of visionaries has been taking young women's health and HIV out of isolation and demystifying the notion that young people are voiceless, sexless and needless. We demonstrated that young women have vivid voice and vision, need tailored SRHR services, and are ripe to speak up and speak out!

With this, we as young women changed the discourse in Rome demanding, '*Where the Hell is the Gel?*', leading off to a press conference highlighting the importance of female-initiated prevention tools, like microbicides, PrEP and treatment as prevention. Our compelling voices of change, impassioned by lived realities of the inadequacy of the current prevention tools for women, called HIV researchers to stop and take heed.

In Women's Words: Africa

The GCWA will be continuing this legacy of leadership at ICASA in December 2011. Through the *Young Women's Leadership Initiative*, the GCWA, in collaboration with the ATHENA Network and the Network of Positive Women Ethiopia, will bring 10 young women from across Africa to expand their skills, broaden their advocacy networks, and to make compelling conference presentations. The young women leader will lead as panellists in the Community Village, as Critical Dialogue moderators in the Women's Networking Zone, as featured plenary speakers in the main conference, and through a number of Athena satellite sessions. The young women will be key in the development of '*Africa: In Women's Words*'; giving voice to the particular challenges and calls to action for young women and HIV across Africa.

…change does not happen by accident, it happens by collective action…

…we spoke collectively… passionately… and deliberately…

With the torrential volume of new HIV infections for young women in Africa; this is the moment to build new messages, push for new policy and programming, and make way for a new generation of unapologetic women's leadership. As I, alongside the young women, tackle the battles of today, we create fertile ground to win the victories of tomorrow, as we head towards the 2012 International AIDS Conference (IAC) in Washington, D.C.

Make Women Count!

As we move toward IAC 2012; ATHENA, Positive Women's Network (North America) and ICW Global have united along with nearly 100 women-centred networks and organisations, carrying the torch to give voice and vision to the priorities of women in their full diversity through '*Make Women Count*'. The campaign, brings together

representatives of women and HIV communities, including women living with HIV who account for over half of all people living with HIV globally, to urge the leadership of the 2012 IAC to ensure that there is a central platform throughout the conference that *comprehensively addresses and engages women, girls, and gender equality* through the formal conference programme, and all related initiatives, including the Global Village.

Since its inception in Spring 2011, the *Make Women Count Campaign* has been an effective and strategic advocacy tool to highlight the imperative nature of research, interventions, expertise and community response lead by and specific to women in the overall success and utility of the IAC 2012. As, IAC 2012 promises to be a historical moment for people living with HIV, while commemorating the repeal of punitive laws in the U.S. that in previous decades denied entry to people living with HIV into the United States, *Make Women Count* strives to make IAC 2012 a historical moment for women globally, as we push for greater representation, visibility and priority of the alarming rates of HIV infections among women, fuelling social drivers, and ways forward to keep women healthy. Through the *Make Women Count Campaign*, we have begun to see major success, as we secured key wins for women, including 50% dedicated scholarships for women, close to 40% of plenary presentations by women, and a focus on '*Turning the Tide for Women*' on day three of the conference.

Towards IAC 2012

As we continue to move closer toward IAC 2012; we continue robust advocacy for the inclusion of gender parity; scientific *data and analyses relevant to and specific to women*, community-led sessions throughout Track D (Social Science, Human Rights and Political Science); equitable presence of presentations specific to women *across all Scientific tracks*; and dedicated space in the Global Village for the continued presence of the Women's Networking Zone (WNZ).

…demystifying the notion that young people are voiceless, sexless and needless…

…make way for a new generation of unapologetic women's leadership…

As the Buddhist says, '*we can turn poison into medicine*!'. Through addressing HIV, we, as women, are lifting up a lifetime of cultural, social and political practices and thoughts that reinforced gender inequity, disparity, vulnerability and human rights infringement for women; and creating new pathways of change that span far beyond HIV and delve into the core of living well as women. As we reflect on the past year, it has not been through one action or a single voice; it has been through a united voice, collaborative advocacy and investment, and through a shared will and belief that '*It Gets Better*!'.

Incrementally from the virtual consultation to beyond IAC 2012, we swing the pendulum a little bit further and we move us leaps and bounds closer to a better way and a better world for women.

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Women's Voices:

We need women who are living with HIV to be the drivers of the services, because they are the people who are facing the situation and they can be able to identify with people in the same situation…

[South Africa]

There is also the weight of traditions, religions, husbands, and socio-cultural burdens that affect women… *[Cameroon]*

I think there can be a serious change, if we change mindsets… *[Swaziland]*

Women's Realities...

AIDS Legal Network

We have to have the means to protect *ourselves*...

HIV Prevention for Women

The need to scale-up HIV prevention efforts, and to focus specifically on women and HIV prevention, has been widely recognised, and has also been the centre of debate and renewed commitment for quite some time.

HIV prevention for women

Given the commitment to place HIV prevention at the core of all interventions and to address women's realities, national responses to HIV and AIDS should arguably have been marked with a rapid increase in women-centred and women-controlled HIV prevention strategies; should have seen a drastic increase in resource allocations for HIV prevention options for women; and thus could potentially have led to a decrease in women's risks and vulnerabilities.

In reality, however, women's greater risks and vulnerabilities to HIV transmission prevail, as prevention strategies focusing specifically on the realities, risks and needs of women remain rather scarce, and prevention options available continue to be

> *…neither centred around women's realities, rights and needs, nor are women placed in the position to have control over decisions regarding their own HIV risks*[1].

In addition to ongoing debates focusing on women's realities, rights and needs in the context of HIV prevention, recently emerging issues of discourse also focus on potential negative impacts on women, and women's HIV prevention realities and risks, associated with the introduction of medical male circumcision (MMC) for HIV prevention. A potential decrease in the extent to which women are in the position to negotiate condom use, due to beliefs that MMC affords full protection from the risk of HIV transmission; further stigmatisation of positive women; as well as an increase in gender violence and abuse are but some of the examples of the emerging discourse. Concerns have also been raised that the introduction and roll-out of MMC for HIV prevention diverts funds from existing HIV prevention interventions focussing on women's needs, such as female condom promotion and distribution.[2]

The Study

The AIDS Legal Network (ALN) engaged in a study intended to document and analyse women's HIV prevention realities and needs in light of the renewed focus on, and commitment to, HIV prevention efforts, including women's realities and needs in the context of the introduction and roll-out of new HIV prevention technologies, such as medical male circumcision – so as to enhance women's access to, participation in, and benefit from available and newly emerging HIV prevention strategies and methods.[3]

…women are, however, concerned about their lesser power to negotiate and to have control over their own HIV risks and prevention needs…

The study was conducted between April and July 2011 in three areas of KwaZulu Natal, namely KwaMakhuta, Umlazi and Mandeni. While KwaMakhuta and Umlazi can be described as urban and semi-urban areas south of Durban (approximately 30km from Durban), Mandeni is a rural area, approximately 100 kilometres west of Durban.

A total of 559 questionnaires were administered to women (192 in KwaMakhuta, 177 in Mandeni, and 190 in Umlazi), and 3 focus group discussions were facilitated in the respective communities.

The study design was based on the principled understanding that since

newly emerging HIV prevention technologies do not exist in isolation from available HIV prevention realities, challenges, needs and options, women's HIV prevention realities and needs have to be documented and assessed in its entirety, encompassing both available and newly emerging HIV prevention strategies and methods.

Main Findings

Perceptions of HIV risks and needs for prevention

> *…we have to have the means to protect ourselves…* [Woman, 40s]

The study clearly highlights women's levels of awareness and understanding about the need for women-centred and women-controlled HIV prevention options. Women are, however, concerned about their lesser power to negotiate and to have control over their own HIV risks and prevention needs, which is partly due to the lack of access to and availability of HIV prevention options for women.

More than half of the women participating in the study perceived themselves to be at risk of HIV, most qualifying their responses with reference to '*inconsistent condom use*', '*unsure about partner's faithfulness*', and the '*risk of being raped*'.

The impact of high levels of sexual violence in communities on women's perceptions of HIV risks was most evident in the Mandeni sample, with more than a third of respondents linking their individual risk of HIV transmission with the 'risk of being raped'.

The need for HIV prevention options for women to be available and accessible was stressed by participants throughout the study, as women need '*to be protected and be able to protect themselves*', be '*in control of their lives*', and '*be safe*'.

> *…if we can't talk about HIV… rather we protect ourselves because the men then blame us for this…* [Woman, 50s]

Women perceive access to female-controlled prevention options as key to their own protection and raised concerns about current HIV prevention strategies and the continuing lack of female condom availability and access, as well as the failure to adequately respond to women's realities.

> *…the only thing that's missing are the female condoms, but treatment is available…* [Woman, 40s]

> *…we need posters that talk about the reality of women, not what women should be behaving like…* [Woman, 30s]

Although recognising the importance of talking with their partners about their fears of being infected with HIV and their individual prevention needs, only about a quarter of women participating were in a position to do so. Reasons most frequently mentioned for not talking to their partners included fear of partner's reaction and '*fear of being rejected*', the fact that '*such things are not open for discussion with my partner*' and '*have never been part of our conversation*', and that '*it's against our culture*'.

> *…it's not easy to talk to a man about this, because they get aggressive, make accusations that you are seeing somebody else…so rather be quiet…I don't even know how I would approach him…* [Woman, 40s]

Awareness of new HIV prevention methods

Levels of knowledge and awareness in relation to HIV prevention methods and technologies were extremely low amongst the study participants, greatly impacting on the extent to which especially women are in the position to make informed decisions and to take control of their own HIV prevention needs. Recognising the key role of access to information in effective HIV prevention strategies, it is of grave concern that the vast majority of women in the sample (95%) indicated that they did not receive any HIV prevention information in the last six months. Moreover, only 7% of women participating in the study knew about PEP, as compared to 30% of women who heard about MMC for HIV prevention.

...more than half of the women participating in the study perceived themselves to be at risk of HIV...

Women are much more aware about newer HIV prevention options, than existing prevention methods. However, this does not necessarily translate into being knowledgeable about the impact and limitations of newly introduced methods. The relatively high number of respondents who believe that men who have undergone medical male circumcision are safe from HIV transmission is a clear indication of misconceptions

and inadequate information disseminated about the introduction of medical male circumcision for HIV prevention.

> *…if they remove the foreskin men should be protected from HIV, even if they don't use condoms…* [Woman, 50s]

Notwithstanding women's perception that men may feel protected from HIV after being circumcised, women also have concerns about the potential negative impact of MMC on women and women's risks, as men will be even less inclined to use condoms.

> *…already men are having sex without a condom, because they say they can't get HIV…things were bad enough without this MMC and now it's worse…* [Woman, 30s]

While women do perceive medical male circumcision to be part of HIV prevention efforts, women question the continued lack of access to HIV prevention options for women, at a time where resources and attention seem to be given to medical male circumcision as an HIV prevention option for men. The data also seems to suggest a need to focus as much on existing and proven HIV prevention technologies as on new prevention technologies, such as MMC – so as to ensure that women's HIV prevention options are indeed increasing, as compared to new HIV prevention technologies replacing both in emphasis and budget existing and proven technologies, such as female condoms and post-exposure prophylaxis.

Awareness of underlying factors

> *…it reduces the capacity for women to make their own decisions…* [Woman, 20s]

The study shows that women have far greater levels of awareness and understanding of the links between gender violence and HIV risks, than the correlations between gender inequality and women's risks of HIV. The data also suggests a strong influence of socio-cultural values and norms used to 'justify' inequalities and violence against women.

Affirming that gender inequalities impact on women's risks to HIV, women's explanations mostly referred to an environment in which '*men are controlling women*' and '*women are then treated as minors*', as well as the fact that '*culture plays a role in this because it teaches us to treat each other differently*'.

> *…we have been taught to submit to our partners, so that's why men will always feel superior…* [Woman, 20s]

Women feel strongly that gender violence increases the risks of HIV, as '*women are raped*' and '*violence and abuse has become a norm*'. Lack of control and power over decisions affecting women's lives, including women's HIV prevention choices, are further exacerbated by women '*living their lives in fear and in abuse*', and being '*forced to agree on things they don't like*', because '*if you are beaten up all the time you can't make your own decisions'*.

Recommendations

Women's responses highlight the perceived lack of adequate and effective responses to women's HIV prevention realities and needs, as women perceive access to female-controlled prevention options as key to their own protection.

What do women recommend?

Women participating in the study clearly expressed their understanding of how to further prevention efforts and better respond to women's HIV prevention realities and needs.

- ***Education and information on HIV prevention***

  …people need more information and there needs to be programmes that address the real challenges in communities… [Woman, 30s]

- ***HIV Prevention options for women***

  …women should have their own prevention tool, so that they can be able to protect themselves instead of depending on men for their protection… [Woman, 40s]

- ***Greater involvement of women***

  …government should not assume what we want…in fact, we should be asked and participate to avoid going back and forth where women's prevention is concerned… [Woman, 30s]

- ***Greater focus on women***

  …we need new strategies and the focus to be on women… [Woman, 20s]

- ***Better communication between partners***

  …women need to talk to their partners about their fears of getting infected and to condomise all the time… [Woman, 20s]

Advocacy responses

To ensure that a) HIV prevention efforts are adequately responding to women's realities and needs; b) HIV prevention for women is prioritised in programme design and implementation; and c) *new* HIV prevention technologies, such as medical male circumcision, have no adverse effect on women and women's risks, it is essential to advocate for and create sustained change in the following areas:

Societal and community

- Address gender and power imbalances so as to ensure that women are in the position to freely access and benefit from available HIV prevention methods
- Enhance levels of awareness and understanding of women's HIV prevention realities and needs, as well as women's rights in the context of HIV prevention

Policy and programme design and implementation

- Guarantee women's central participation in policy and programme design and implementation, including new HIV prevention strategies, such as medical male circumcision for HIV prevention
- Ensure that women and women's needs are prioritised in HIV prevention strategies in a sustained way

Women-centred and -controlled HIV prevention options

- Ensure adequate and sustained access to and availability of HIV prevention options for women, particularly female condoms
- Re-intensify and sustain information and education on available HIV prevention options, such as PEP

New HIV prevention technologies

- Assess and evaluate the impact of new HIV prevention technologies, such as medical male circumcision for HIV prevention, on women, so as to ensure that women are not adversely impacted by the introduction of new prevention technologies
- Ensure women's involvement and participation in the design and implementation of strategies promoting new prevention technologies

FOOTNOTES:

1. Kehler, J. & Radebe, B. 2010. 'Moving beyond the commitments and rhetoric: HIV prevention interventions for women'. In: *ALQ/Mujeres Adelante*, March 2010 Edition, p24.
2. The Clearinghouse on Male Circumcision for HIV Prevention. 2011. *Male circumcision and women*. [www.malecircumcision.org/advocacy/male_circumcision_advocacy_women.html]
3. Kehler, J. & Massawe, D. 2011. *We have to have the means to protect ourselves: HIV Prevention for Women*. Cape Town, AIDS Legal Network. [www.aln.org.za]

The report is available at www.aln.org.za.

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Luisa Orza and Ebony Johnson

In Women's Words:
'Where the hell….are the young women?'

The HIV epidemic remains a major global public health and human rights challenge, being the leading cause of death among women of reproductive age (15-49 years)[1].

State of the epidemic

Of the total estimated 33.4 million people living with HIV worldwide, women account for over half (15.9 million) of adults living with HIV. The vulnerability of women and girls to HIV remains particularly high in sub-Saharan Africa; 80% of all women in the world living with HIV live in this region.[2] In addition, in the majority of countries the epidemic shows the most growth among young women between the ages of 15 and 24; in sub-Saharan Africa young women of this age group are up to 8 times more likely to acquire HIV than their male peers. In Asia overall, women account for a growing proportion of HIV infections: from 21% in 1990 to 35% in 2009; however among young people aged 15-24, this percentage rises to 45% in East Asia and the Pacific, 47% in South Asia, and up to 64% in Central and Eastern Europe and the Commonwealth of Independent States.[3]

In every region of the world, incidence rates of infection among young women are increasing. Gender inequality, including violence, continues to be both a cause and a consequence of HIV. At least one in three women will be beaten, coerced into sex or abused in her lifetime. Women subjected to violence are at higher risk of acquiring HIV, and women who are living with HIV are more likely to experience violence.[4] Further, women, especially young women living with HIV, continue to experience violence and human rights violations that relate to their sexual and reproductive health within health services, including breaches of privacy or confidentiality by health workers; stigma and discrimination, as well as judgmental attitudes regarding the rights of women living with HIV to start sexual relationships, get married, or have children; lack of information about and access to sexual and reproductive health and rights services; and mandatory or coerced HIV testing, and coerced or forced abortion and sterilisation.

While young women living with and affected by HIV are affected by many of the same issues as older women or men, they also face particular, nuanced, or exacerbated issues, including:

- Exclusion from fora where decisions that affect their lives are made, including at the level of the family, community, health institutions, and in local, national and international policy.

- Sexual and reproductive health violations, including lack of access to information and services; negative or judgmental attitudes of healthcare staff, compromising the ability of young women living with HIV in particular to realise their sexual and reproductive health and rights, even to the point of coercion or force around sexual and reproductive decision making; stigma and discrimination at the family, community and health service level; fear of disclosure, breaches of confidentiality and violence; and the criminalisation of sexual transmission or exposure, and/or vertical transmission.

- Violence against young women and other human rights violations, including rape and sexual violence, forced/coerced sex and marital rape, early marriage, female genital cutting, and lack of property and inheritance rights. Violence against young women is also a consequence of HIV transmission, creating a barrier to treatment and care

services, vertical transmission, and secondary prevention, and increasing the vulnerability of young women living with HIV to abandonment, destitution and '*survival sex*'.

- Lack of economic empowerment opportunities.

- Pervasive cultural and social norms that reinforce abstinence and associate guilt and/or penalty with sexual debut outside marriage, which serves to reinforce internal stigma and isolate sexually active young women from needed sexual and reproductive health rights, care, treatment and open inclusive processes with their medical providers.

> *…I want for us, the developing communities, to have a say and a choice in what Africa wants and I want to change how Africa is defined by the international community… I want to see a change in people's attitudes towards vulnerability…I don't want people to be categorised into vulnerable groups, I want all of us to be seen as one people…*
>
> [Young Woman, July 2011]

Furthermore, the HIV epidemic is entering a new phase whereby young people who have acquired HIV perinatal are now entering adolescence and young adulthood[5]. Young women who have grown up with HIV again face a nuanced and particular set of challenges, as they transition from paediatric to adult services and navigate not only the uncharted waters of early sexual encounters, changing bodies, and increasing independence, but also have to deal with issues around disclosure, treatment adherence and often conflicting messages from policy- and programme makers, service providers and family members regarding their sexuality. This group of young people constitute a '*hidden*' – and silent – epidemic, and are in need of supportive environments, including psycho-social support and tailored information on their sexual and reproductive health and rights and living healthy with HIV.

…face particular, nuanced, or exacerbated issues…

Political Declaration 2011

The Political Declaration of 2011[6], which came out of the High Level Meeting on HIV and AIDS in June 2011, recognises with concern '*that globally women and girls are still the most affected by the epidemic*' (para 21), and '*that young people aged 15 to 24 account for more than one third of all new HIV infections, with some 3000 young people becoming infected with HIV each day*' (para 25). The Declaration further acknowledges that underpinning the vulnerabilities both among women and young people are '*insufficient access to … sexual and reproductive health*' (para 21), as well as '*limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves*' (para 25).

The Declaration also recognises that '*close co-operation with people living with HIV and populations at higher risk of HIV infection will facilitate the achievement of a more effective HIV and AIDS response*' (para 40), and makes a strong commitment to '*encouraging and supporting the active involvement and leadership of young people, including those living with HIV, in the fight against the epidemic at local, national and global levels*' (para 56).

Further, the Declaration pledges to ensure that young people are spear-heading HIV prevention efforts, by

- harnessing the energy of young people in helping to lead global HIV awareness (para 59b) and,
- ensuring that all people, particularly young people,

have the means to exploit the potential of new modes of connection and communication (para 59e).

These commitments underpin the need to ensure that young people – and young women in particular – living with and affected by HIV, are meaningfully engaged at all levels of the HIV response; that safe spaces are available for young women in all their diversity to meet, share and learn from one another towards developing and agreeing on advocacy priorities and action agendas; and, that their leadership is supported and an enabling environment is created in which young women in all their diversity can safely give voice to these priorities and be heard.

Bold New Commitments

In addition to the recognitions and pledges made above, the Political Declaration of 2011, also articulated three bold new numerical targets in relation to redoubling efforts around HIV prevention, with the aims of ***Reducing sexual transmission of HIV by 50 per cent by 2015*** (para 62); ***Reducing transmission of HIV among people who inject drugs by 50 per cent by 2015*** (para 63); and ***Eliminating mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths*** (para 64). In addition, and in relation to these targets, the Declaration re-iterates the commitment made in the 2006 Declaration to bring an end to gender inequality.

In order to meet these targets and realise these ambitions, the meaningful involvement of young women and men is a pressing imperative. As seen above, young women account for up to 75% of new HIV infections in some areas of sub-Saharan Africa, and in concentrated epidemics, while drug use remains higher among men than women overall, there is evidence to show that among women who inject drugs, the proportion of women affected by drug-related harms – including acquisition of HIV – can be vastly greater than among their male counterparts, with some countries reporting the incidence of HIV amongst female drug users to be as high as 85%.[7]

…young women in all their diversity can safely give voice to these priorities and be heard…

Finally, while support and involvement from men as partners and fathers in vertical prevention programmes is desirable, these programmes clearly '*target*' women. For this target to be achieved, women living with HIV – and young women in particular – need to feel fully supported in their decision to have children. Currently, many young women living with HIV are treated judgmentally when they decide to have children, on the grounds of both their youth, and their HIV status. For others, fear of disclosure may act as a barrier to service use; which needs to be urgently addressed. Yet

Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence.

[Political Declaration 2011, para 53]

others lack the information, access to services, and economic and social empowerment to make informed or voluntary reproductive choices, and need to be supported to do so, in order for this target to be met.

For young women living with or affected by HIV – especially for those with additional long term health issues or disabilities; in hard-to-reach or rural areas; in poverty; in asylum or displacement; for those affected by migration, imprisonment or detainment, or homelessness; for those expressing diverse sexual orientation or gender identities, or engage in transactional sex or sex work – the enjoyment of the basic rights, needs and aspirations necessary to meet these goals may seem an elusive dream. It is, therefore, the more imperative that young women living in contexts of vulnerability are drawn into the centre of these discussions, and that their meaningful participation is promoted and supported at every level.

> *…I wish to have the power to change everything…I would love to see all the young women empowered and to see women in the highest decision-making positions, sitting right there on top, not only men on top of everything…women are just being ignored, we are not being cared for, people are not listening to us and they think because some of us are not educated, we have nothing to say…and so, I would really love to see women, young girls, HIV positive women to be empowered…women generally to be empowered…and to have the power to make decisions…*
>
> [Young Woman, July 2011]

Participation at international and regional conferences

The biennial International AIDS Conferences, the HIV Pathogenesis, Prevention and Treatment Conferences, and the regional HIV Conferences, such as ICASA, constitute important fixtures in the international HIV calendar, and remain a central pillar to the HIV response, supporting knowledge sharing and -generation around every aspect of the HIV response. These conferences also provide important and varied fora and platforms for advocacy and leadership at different levels, and the priority events, themes and outcomes of the conferences act as important markers for tracking the trajectory of both the HIV epidemic and the global HIV response.

…in need of supportive environments…

As such, the participation of women and men living with HIV has been an integral – if hard-won – aspect of such conference spaces over the last two decades. Indeed, the lack of representation of women living with HIV at the International AIDS Conference in Amsterdam in 1992 led to the storming of the stage by 53 women living with HIV, an event that marked the foundation of the International Community of Women Living with HIV and AIDS (ICW) – which remains today the only global network of women living with HIV. The ATHENA Network also owes its genesis to the lack of space for local participation in the International AIDS Conference at Durban, and the spontaneous parallel organising – led by women's civil society organisations and networks – that took place there, and on which the tradition of the Women's Networking Zone has been built.

Women's international organising and leadership in the AIDS response is an on-going process with long-term goals and outcomes, which requires a coherent and cohesive momentum. Since the 2010 International AIDS Conference that took place in Vienna, a growing movement of youth activists, and a growing attention to young women and men living with and

affected by HIV has been finding its place within the conference environment.

A delegation of young women emerging activists, who attended the International AIDS Society Pathogenesis, Prevention and Treatment conference in Rome in July 2011, articulated what the opportunity to participate in such a forum meant to them:

> *…I'm expecting to hear different life experiences from the young women; expect myself to grow stronger – I went for different conferences, but I've never experienced a big conference where I see a white person or an Asian person telling me she is HIV positive – HIV has a woman's face, but those speaking about it are from Africa…*[8]

> *…I want to meet new people; establish new contacts; feel the spirit of different networks and orgs – forge close relationships…feel empowerment and energy from our community to continue working in our country…*[9]

> *…I think it's about taking this experience and translating it into best practice – sustainable beyond the conference – stay connected, continue to build other young women, and increase our knowledge together…*[10]

…the enjoyment of the basic rights, needs and aspirations… may seem an elusive dream…

These comments speak not only to the opportunities to learn, network, and to define and give voice to priority issues for the sake of moving the collective goals of the epidemic forward; to hold policy and programme makers to account; to claim leadership; and to link local and national efforts to region-wide and global responses. They also speak to the challenge of being a leader and activist in a competitive and ever-changing environment; to the need for not only financial, but emotional and spiritual support to do this work.

Because regional and international conferences of this size are among the few occasions to meet and interact with other activists, they provide important opportunities for mentoring, learning and skills-building in addition to the building and consolidating of global networks and friendships. Paradoxically, despite the incredibly hard physical and mental work that goes into engaging at large conferences, they can also be an opportunity to refuel, reflect and re-engage on a spiritual and emotional level for the next stage of the journey.

FOOTNOTES:

1. World Health Organisation. 2010. *Women and health: Today's evidence tomorrow's agenda*. Geneva, WHO.
2. UNAIDS. 2010. The Global Report. UNAIDS Report on the Global AIDS Epidemic. Geneva, UNAIDS.
3. UNAIDS. 2011. *Opportunity in Crisis: Preventing HIV from Early Adolescence to Young Adulthood*. p4.
4. The Global Coalition on Women and AIDS. Preventing HIV infection in girls and young women. [http://data.unaids.org/GCWA/GCWA_BG_preventation_en.pdf]
5. There are an estimated 2 million people aged 10-19 living with HIV globally of whom some will have acquired HIV vertically, and others horizontally, primarily through unprotected sex, sharing on injecting drug paraphernalia. See also UNAIDS. 2011. *Opportunity in Crisis: Preventing HIV from Early Adolescence to Young Adulthood*. p24.
6. Political Declaration on HIV/AIDS. 2011. [www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf]
7. Pinkham, S. & Malinowska-Sempruch, K. 2007, *Women, Harm Reduction and HIV*. New York, Open Society Institute.
8. Authors' personal conversations with young women in July 2011.
9. *Ibid*.
10. *Ibid*.

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Women's Voices:

…on prevention of vertical transmission programmes…

It does not cater for the health of the mother, but addresses relatively well the needs of the child…women have to fend for themselves and as a result, they sometimes die leaving their infant child…

[Swaziland]

Not all women have access to or know about the services…there is often a shortage of ARVs because of poor distribution and many women are forced to breastfeed because of the stigma attached to not breastfeeding…

[Tanzania]

After so many years of projects and programmes, lives of women have not changed and neither has the attitudes towards women…

[Malawi]

Have women's rights experts as part of the process, so it is not only about the baby…

[Ethiopia]

Women's realities are never addressed, thus the poor results in the programmes… women are tested at the antenatal clinics and if infected with HIV, the discrimination begins immediately…this makes women turn to traditional birth attendants…

[Kenya]

Our local clinics and hospitals are so unfriendly and this propel women to shy away from seeking medical attention and thus results in grievous harm to both women and baby…if only government could stress the necessity of commitment and treatment…more women, young or old, will frequent the clinics and hospitals…

[South Africa]

We need consultation with women at all levels and areas on their challenges in accessing services and how these can be alleviated…women should be involved in all planning, design, implementation, monitoring and evaluation of interventions for women…

[Zimbabwe]

Though efforts are there, women are still neglected when it comes to their SRH&H…efforts are geared towards preventing transmission to the child, but the mother's needs are not taken care of…

[Botswana]

The programme is accessible to women in the urban areas, but very difficult or inaccessible to women in some rural areas, due to poor road and communication networks… **[Cameroon]**

Due to cultural practices and lack of health infrastructure in rural areas, many women do not benefit from the pregnancy assistance and this reason they aren't reached by the programmes…

[Mozambique]

It is the fear of being stigmatised that stops women from going to clinics…

[Cote d'Ivoire]

Special report:

Making (women's) human rights central to the AIDS response in Africa[1]

Meaka Biggs and Johanna Kehler

Violations of civil, political, economic, social and cultural rights increase vulnerabilities to HIV and related rights abuses. HIV-related stigma, discrimination and other violations of rights impede effective responses to HIV and AIDS at a national and regional level.

In order to effectively respond to the AIDS pandemic globally we need to ensure that human rights are at the centre of our response to AIDS. Recognising especially women's HIV risks and vulnerabilities in Africa, it is essential that in the African response women's human rights are at the centre of our response, so as to ensure that the laws, policies and protections in place actually do what they are intended to do – protect the rights of women in Africa.

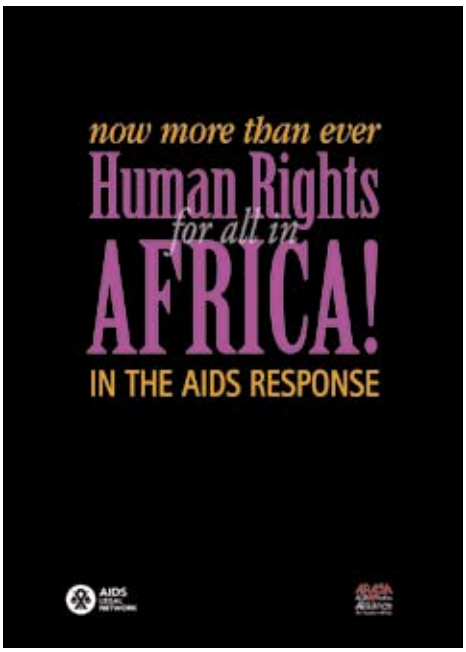
HIV risks and vulnerabilities

It is widely recognised that risks and vulnerabilities to both HIV transmission and related rights abuses in the region are based within, and largely determined by, the gendered, unequal and powered societal contexts, which place women and girl children at greater risk.[2] Furthermore, women's HIV risks and vulnerabilities in the region are further exacerbated by high levels of sexual and gender violence.[3] Moreover,

> *…persistent gender inequality and human rights violations that put women and girls at greater risk and vulnerability to HIV, continue to hamper progress and threaten the gains that have been made in preventing HIV transmission and increasing access to anti-retroviral treatment.*[4]

Some of the specific risks and vulnerabilities in the context of women and HIV in Africa include:

- *Limited control over life and body*. Women are not in the position to equally participate in decision-making regarding their lives. This includes decisions about their sexual and reproductive choices, which are often linked to limited



access to women-initiated and -controlled HIV prevention options, high levels of violence and abuse, and prevailing socio-cultural gendered expectations for women to bear children. This impacts on the extent to which women are in the position to access, claim and realise their rights, and to access and benefit from available HIV prevention options[5]. Without adequate responses to women and HIV, these realities will continue to

> *…not only limit women's and girls' autonomy and skills to protect themselves from HIV, but also hinder access to services and ultimately women's and girls' ability to exercise their human rights.*[6]

- *More likely to access services which often results in increased risks of abuse.* Women are more likely to access health services. This means that HIV testing initiatives that appear neutral often target women in implementation and

practice. Subsequently, women are more likely to be subjected to mandatory and/or coercive HIV testing practices, severely limiting women's rights to equality and security of the person, and increasing women's risks to rights abuses in the context of HIV testing and sexual and reproductive health services[7].

- *First to know HIV status – first to face negative consequences.* The promotion of HIV disclosure in its implementation is often discriminatory and biased against women, as women are often the ones first to know of a positive HIV diagnosis – as such, negative consequences of HIV disclosure, such as stigma, discrimination, violence, destitution and even death is, in reality, mostly experienced by women. As such women living with HIV '*may also avoid HIV-related services to prevent such disclosure*'[8].

- *Inadequate access to services and secondary victimisation.* High levels of violence and abuse, including sexual violence and rape, impact greatly on especially women's risks to HIV transmission. *Violence against women is both a cause and a consequence of HIV infection*'.[9] Given the limited and often inadequate access to socio-medical and legal services for victims and survivors of sexual violence, women's rights are violated not only by the sexual offence itself, but also by the subsequent inadequate access to, and secondary victimisation by, health, psycho-social and legal services.[10]

- *Limited access to integrated health services.* Although the need to incorporate sexual and reproductive health into the AIDS response is well recognised, '*present HIV services do not comprehensively include the promotion and protection of the right to sexual and reproductive health of all women and girls*'[11], and subsequently, many women continue to have severely limited access to integrated health services.[12] Women living with HIV experience additional barriers to accessing sexual and reproductive health services, as their rights are

  …compromised by discriminatory legal frameworks, rigid health care systems, misinformed medical practices, and stigmatising attitudes of healthcare workers…[and women] *continue to experience serious violations, including poor standards of medical care, coerced abortion, forced sterilisation and lack of confidentiality.*[13]

HIV risks and vulnerabilities in Africa have to be effectively addressed as a matter of urgency by all relevant State and non-State actors, as well as regional human rights bodies and mechanisms. The newly established African Commission on Human and People's Rights (ACHPR) Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV is one of the actors who should, by its mandate, take an active role in promoting and protecting human rights in the context of HIV, and in addressing HIV risks and vulnerabilities in Africa.

Human rights and HIV

Globally, as well as in Africa, it is widely recognised that human rights are to be at the centre of the AIDS response, and particularly in the response to women and HIV, so as to ensure both an adequate response to public health needs and concerns and the protection of human rights in the response to HIV and AIDS.[14] Acknowledging that human rights and gender equality are effective responses to HIV further implies that realities and needs of women and other key populations at higher risk are to be a central component of programme design, implementation and monitoring of the AIDS response at a global, regional and national level.[15]

…implementation is often discriminatory and biased against women…

> A *rights-based approach to HIV requires: realisation and protection of the rights people need to avoid exposure to HIV; enabling and protecting people living with HIV so that they can live and thrive with dignity; attention to the most marginalised within societies; and empowerment of key populations through encouraging social participation, promoting inclusion and raising rights awareness*.[16]

However, human rights, and especially women's human rights, seem to be continuously compromised, threatened and violated in the response to HIV and AIDS, despite the commitment globally, and in the African context, to promote and protect women's human rights.[17] Responses to HIV and AIDS globally, and in the African context, for example, often seem to place public health needs and concerns for increased HIV testing over the need to protect individual human rights of consent, confidentiality and counselling in the context of HIV testing, in that the shift from a 'voluntary' approach to a 'provider-initiated' approach to HIV testing potentially threatens and compromises human rights protections in the context of HIV testing both in policy and practice.[18] In addition, '*services to prevent vertical transmission of HIV fail to take into consideration the rights and needs of women living with HIV*'[19].

As many of the human rights threats and violations occur within the context of programme implementation and service delivery, and women are the ones mostly accessing HIV-related programmes, interventions and health services, including sexual and reproductive health services, it is women who are most vulnerable to, and at risk of, rights abuses in the context of HIV and AIDS.[20]

> …*HIV services equally neglect the empowerment of women and girls to exercise their rights, access services, and make autonomous choices about their bodies and lives*.[21]

It is also widely acknowledged that women living with HIV experience gross violations of their rights, particularly in relation to their sexual and reproductive health and rights within service provision, since '*women living with HIV are frequently unable to exercise reproductive self-determination*'[22] – which both '*severely undermine utilisation of health services and information*', and is counterproductive to effective HIV and health responses.[23] There is growing evidence of coercive sterilisation of positive women in the region (e.g., Namibia[24]), as well as 'forced' termination of pregnancy[25]; coercive practices of HIV testing during pregnancy and subsequent rights violations, including denial of services (e.g., South Africa[26]); and lack of access to safe, legal termination of pregnancy and impact of unsafe abortions on women's health, well-being and rights[27].

…to be effectively addressed as a matter of urgency…

These realities not only constitute a violation of the rights to dignity and security of a person, but also impact negatively on the overall progress made towards the promotion and advancement of gender equality, as well as the promotion and protection of people living with, and affected by, HIV and AIDS. Furthermore, the persistent violations of women's human rights in the context of HIV and AIDS as much perpetuate women's risks and vulnerabilities to HIV transmission and related rights abuses, as it continues to impede on the effectiveness of responses to HIV and AIDS at a national and regional level.[28]

To end the violation of human rights in the context of HIV in Africa and to improve access to services especially for women, it is argued that the ACHPR and its Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV should:

- Urge State Parties to remove discriminatory laws and policies that hinder just and equitable access to health services for women and other key populations at higher risk
- Engage State Parties and relevant non-state actors to scale-up comprehensive programmes that build capacities of HIV-related service providers and address stigma and discrimination in laws, institutions and communities
- Recommend to State Parties to ensure the promotion and protection of human rights within health services, by means

of rights-based education and training as an integral part of the curriculum of health professionals, as well as by means of measurable outcomes in national strategic plans outlining the response to HIV and AIDS

- Urge State Parties to ensure sufficient budgetary allocations for the implementation and monitoring of national responses to HIV and AIDS, with a particular focus on resources allocated toward women-centred HIV prevention, testing, treatment, care and support services

- Advise State Parties and relevant non-state actors to include clear and measurable indicators for the education and training of law enforcement agencies and the judiciary to ensure quality, timely and just access to services for victims and survivors of sexual violence and rape

- Strongly recommend the removal of legal barriers to accessing quality and timely health, psycho-social and other related services in the context of sexual violence and rape, including access to post-exposure prophylaxis and emergency contraceptives, such as laying a charge at the police station as a pre-requisite for rape survivors' access to available and much-needed services

- Urge State Parties to ensure the provision of quality integrated services so as to facilitate that women, and especially women living with HIV, and other key populations at higher risk are treated with dignity and respect, are free of violence, coercion, stigma and discrimination, whilst ensuring access to services based on counselling, informed consent and confidentiality

- Support the development and implementation of stigma indicators within health services to ascertain country specific data on levels, as well as impact, of stigma and discrimination and to ensure evidence-based stigma mitigation programme development at a national and regional level

Criminalisation laws and policies

Given the above context of the HIV and AIDS pandemics, especially in light of women's HIV risks and vulnerabilities in the African context, recent legislative trends towards the criminalisation of HIV exposure and/or transmission have been responded to with concern and opposition. The fact that criminalisation laws are unjust and a threat to human rights; and will have an adverse impact on women and women's risks to both HIV and related rights abuses, are but some of the concerns raised.[29] According to the UN Secretary General,

> *…these laws stigmatise people living with HIV and key populations at higher risk without promoting public health goals*.[30].

…human rights and gender equality are effective responses to HIV…

In addition, as highlighted by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the criminalisation of HIV exposure or transmission has no impact on behaviour change or the spread of HIV[31]. It undermines existing public health efforts[32], disproportionately impacts on vulnerable communities[33], increases prevailing stigma, discrimination and violence[34], and constitutes an infringement of the right to health[35]. Laws criminalising HIV exposure, transmission and/or failure to disclose one's HIV positive status also contradict the commitment made by governments in the Political Declaration on HIV/AIDS in 2006[36]

> *…to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status*.[37]

The call to apply criminal law to HIV exposure and transmission is often driven by a well-intentioned wish to protect women and women's rights, as well as to serious concerns about the rapid spread of HIV in many countries. Criminalisation laws are not in the position to prevent new HIV transmissions or to respond to women's HIV risks and vulnerabilities. Laws criminalising HIV exposure or transmission

> *…unjustifiably penalise women, who, in many settings, are unable to prevent HIV transmission, because they have no power to negotiate conditions of sex or to make the*

decisions whether or not to have children…[and women may] *face prosecution as a result of their failure to disclose, despite having valid reasons for non-disclosure*.[38]

In addition, the responses to HIV risks and vulnerabilities in the African context are severely impacted in their adequacy and effectiveness through the growing and renewed calls to criminalise homosexuality (e.g., Uganda[39]); the continuing criminalisation of sex work across the continent; and the failure to adequately address risks and vulnerabilities of people who inject drugs in national and regional responses to the pandemics. The continuing failure to adequately address key populations at higher risk is especially alarming given statistics that clearly indicate that

…unprotected paid sex, sex between men, and the use of contaminated drug-injecting equipment by two or more people on the same occasion are significant factors in the HIV epidemics of several countries with generalised epidemics.[40]

These legislative and policy trends are not only a clear reflection of the persistent human rights abuses of already marginalised people and key populations at higher risk, but also a clear indication that national and regional responses to HIV and AIDS are limited accordingly. It is also widely recognised that criminalising the already 'marginalised' will perpetuate and manifest existing risks and vulnerabilities to HIV transmission and related rights abuses (instead of addressing these realities), as well as justify both continuing limited access to (and even denial of) available HIV prevention, testing, treatment, care and support services, and gross human rights violations based on the criminalised status of key populations at higher risk.[41]

Legislative and policy provisions are crucial elements in the response to HIV and AIDS and are key in creating enabling and supportive environments for the advancement and protection of human rights in the context of HIV, as well as in ensuring that AIDS responses at a national, regional and global level are in the position to adequately and effectively respond to people's HIV risks, vulnerabilities, realities and challenges.[42]

It is within this context, the ACHPR and its Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV is called to:

- Urge all African Commission member states to reaffirm their commitment to human rights and HIV in general, and to women's human rights in the context of HIV in particular, by ensuring that all countries are not only signatories to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, but also ascend and domesticate the provisions of the Protocol at a national level; and to take necessary measures to ensure the timely implementation of the Maputo Plan of Action on Sexual and Reproductive Health and Rights and the Abuja Declaration

- Urge State Parties to take measurable actions to translate the political commitment to women's human rights and HIV into effective programmes and interventions, including sufficient budgetary allocations, that adequately address women and HIV in Africa[43]

- Engage State Parties at a national and regional level to repeal all laws that facilitate gross human rights violations in the context of HIV and AIDS

- Recommend the removal of punitive laws and discriminatory legislative and policy provisions that promote human rights abuses at a national and regional level, including in relation to
  - Criminalisation of HIV exposure and transmission
  - Mandatory and/or forced HIV testing
  - Mandatory and/or forced HIV disclosure

…continuously compromised, threatened and violated in the response to HIV and AIDS…

- Strongly support law review and reform, where necessary, with respect to restrictive abortion laws, in order to create enabling legal environments for safe, legal and choice-based terminations of pregnancy, especially for women living with HIV

- Recommend to State Parties and relevant non-state actors to establish effective enforcement mechanisms of protective laws and policies for women, especially women living with HIV, and other key populations at higher risk, so as to ensure access to justice and redress through HIV-related legal services and legal literacy programmes[44]

- Conduct fact finding missions to ensure an enhanced evidence base on the adverse impacts of laws criminalising HIV exposure and transmission on women and women's risks to HIV transmission, and other related rights abuses adversely impacting on women, especially women living with HIV

- Recommend documenting best practices at a national and regional level, with a specific focus on the promotion and advancement of human rights in the context of HIV and AIDS, with a specific focus on promoting and advancing women's rights in the response to women and HIV

- Urge State Parties to take appropriate measures to ensure that the right to freedom of association can be effectively enjoyed without discrimination on grounds of sexual orientation or gender identity

- Urge State Parties to take necessary measures to prevent and remove discriminatory administrative procedures, including excessive formalities for the registration and practical functioning of associations

- Strongly recommend to State Parties to take all necessary measures to prevent the abuse of legal and administrative provisions and to discriminate against, and violate the rights of, sex workers, people in same-sex relationships and other key populations at higher risk

- Engage State Parties and relevant non-state actors to promote and protect the rights and well-being of sex workers, same-sex practicing people and other key populations at higher risk so as to ensure adequate access to and benefit from available HIV prevention, testing, treatment, care and support services

- Strongly recommend to State Parties and relevant non-state actors to take actions to decriminalise sex workers, same-sex practicing people, people who inject drugs and other populations at higher risk

…impede on the effectiveness of responses to HIV and AIDS at a national and regional level…

FOOTNOTES:

1. This contribution is based on a Position Paper prepared by a Regional Civil Society Consortium of human and women's rights organisations and submitted to the ACHPR Committee on the Protection of the Rights of People Living with HIV, Those at Risk, and Vulnerable to and Affected by HIV in April 2011.
2. UNAIDS. 2010c. *Agenda for Accelerated Country Actions for Women, Girls, Gender Equality and HIV: Operational Plan for UNAIDS Action Framework: Addressing women, girls, gender equality and HIV*. Geneva, UNAIDS; Report of UN Secretary General on the Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS. 31 March 2011; UNAIDS, 2010a, *Global Report.*
3. UNAIDS, 2010a:134-136.
4. UNAIDS, 2010c:1.
5. *Ibid*, pp6-9; UNAIDS, 2010a, Chapter 5; Report of UN Secretary General, 31 March 2011, paras 55-57.
6. UNAIDS, 2010c:p6.
7. See also Jürgens, R. 2007. *Increasing access to HIV testing and counselling while respecting human rights: Background paper*. New York: Public Health Program of the Open Society Institute; *Women and HIV Testing: Policies, practices and the impact on health and human rights*. Public Health Fact Sheet. OSI Public Health Program; Gruskin, S. 2006. 'It is time to deliver right! HIV testing in the era of treatment scale up: Concerns and considerations'. In: ALQ, September 2006 Edition.
8. Gerntholtz, L. & Grant, C. 2010. *International, African and country legal obligations on women's equality in relation to sexual and reproductive health, including HIV and AIDS*. HEARD and ARASA. Durban, South Africa, p20.
9. UNAIDS, 2010c:10.
10. See also WHO/UNAIDS. 2010. *Addressing violence against women and HIV/AIDS: What works?* Geneva, World Health Organisation.
11. UNAIDS, 2010c:11.
12. See also Report of UN Secretary General, 31 March 2011, paras 77-78.
13. High Level Consultation of Influential Leaders and Women's Advocates. One day consultation on the sexual and reproductive health and rights of women and girls living with HIV. 24 February 2011. Meeting Report, p5.
14. UNAIDS, 2010a:122; OSI. 2007. *Human Rights and HIV/AIDS: Now More Than Ever. 10 Reasons Why Human Rights Should Occupy the Centre of the Global AIDS Struggle*. New York: Open Society Institute.
15. See also UNAIDS, 2010c:pp6-21.
16. *Ibid,* p122.
17. *Ibid*, pp121-137.
18. Jürgens, 2007; UNAIDS/WHO. 2007. *Guidance on Provider-Initiated HIV Testing and Counselling*. Geneva, World Health

Organisation; *Women and HIV Testing: Policies, practices and the impact on health and human rights.* Public Health Fact Sheet. OSI Public Health Program.
19. UNAIDS, 2010c:11.
20. UNAIDS, 2010a:121-137; UNAIDS, 2010:1-3.
21. UNAIDS, 2010c:11.
22. Gerntholtz & Grant, 2010:19.
23. High Level Consultation of Influential Leaders and Women's Advocates, 2011:3.
24. CW. 2009. *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*. [www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf]; Anand, N., Erdman, J., Kelly, L. & Robonson, C. 2009. *Policy Brief: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion*. Bridging the Gap. Athena Network. [www.athenanetwork.org/assets/files/Bridging%20the%20Gap%20Policy%20Brief.pdf.]; Gatsi, J., Kehler, J. & Crone, T. 2010. *Make it everybody's business: Lessons learned from addressing the coerced sterilisation of positive women in Namibia. A best practice model*. Namibia Women's Health Network, Namibia.
25. Anecdotal evidence from Namibia and South Africa suggests that positive women are coerced to terminate their pregnancies.
26. Kehler, J., Howard Cornelius, A., Blosse, S. & Mthembu, P. 2010. *Where are the Human Rights for Pregnant Women? Scale-up provider-initiated HIV testing and counselling of pregnant women: The South African experience*. Cape Town: AIDS Legal Network.
27. Grimes,D. A. et al. 2006. *Unsafe abortion: the preventable pandemic*. The Lancet Sexual and Reproductive Health Series, October 2006.
28. See also Gerntholtz & Grant, 2010; High Level Consultation of Influential Leaders and Women's Advocates, 2011; UNAIDS, 2010c:1-3.
29. Eba, P. 2008. 'One size punishes all: A critical appraisal of the criminalisation of HIV transmission'. In: *ALQ*, September/November 2008 Special Edition, pp1-10; OSI. 2008. *Ten Reasons to Oppose the Criminalisation of HIV Exposure or Transmission*. New York, Open Society Institute; Athena Network. 2009. *10 Reasons Why Criminalisation of HIV Exposure or Transmission Harms Women*. Athena Network & AIDS Legal Network, South Africa.
30. Report of UN Secretary General, 31 March 2011, para 37.
31. Grover A. 2010. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Geneva, Office of the United Nations High Commissioner for Human Rights, para 62.
32. *Ibid*, para 63.
33. *Ibid*, paras 64-65.
34. *Ibid*, paras 68-71.
35. *Ibid*, para 61.
36. UNAIDS, 2010a:128.
37. *Ibid*, p128.
38. *Ibid*.
39. Anti-Homosexuality Bill introduced as a Private Member's Bill in 2009 in Uganda.
40. UNAIDS, 2010a:30.
41. See also Grover 2010, paras 6-26 (criminalisation of Same-sex conduct, sexual orientation and gender identity), and paras 27-50 (criminalisation of sex work).
42. See also Gerntholtz & Grant 2010; High Level Consultation of Influential Leaders and Women's Advocates, 2011; UNAIDS, 2010c.
43. UNAIDS, 2010c, Recommendation 2.
44. See also Global Report Action Points Human Rights, UNAIDS, 2010a:137.

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In Women's Voices:

The hierarchy within the family is never addressed in any forum…it is accepted as the cultural norm to be subservient and humble because you are a woman… *[India]*

Due to cultural barriers, a woman doesn't have a chance to get information and services without her husband's involvement, and most of the husbands or male partners are not willing to go to the clinics…and a woman doesn't have money for transport and health services, unless she got it from her husband… *[Ethiopia]*

If in an abusive relationship, the women will be scared to access the services because she is scared of her partner… *[South Africa]*

Educate and inform women living with HIV, their partners and mother in-laws to better understand the treatment literacy programmes… *[Mozambique]*

Cultural affliction, religious afflictions are most of the barriers…for example certain cultural practices make women more vulnerable to HIV and AIDS…therefore, they should provide training, capacity development and support to existing women associations to empower them to challenge social and cultural practices… *[Nigeria]*

The programme is not accessible to all women in our country in an equitable manner because of lack of infrastructure and information on HIV… *[Democratic Republic of Congo]*

Nonandi Diko

The Women's Protocol...

A tool for advancing women's sexual and reproductive rights?

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[1], better known as the Maputo Protocol, guarantees comprehensive rights to women, including the right to take part in the political process, to social and political equality, to control of their reproductive health, and an end to female genital mutilation.

The Maputo Protocol (the Protocol) was adopted by the African Union in the form of a Protocol to the African Charter on Human and Peoples' Rights[2] on 11 July 2003, at its second summit in Maputo, Mozambique. The protocol entered into force on 25 November 2005, after being ratified by the required 15 member nations of the African Union, South Africa included[3][4].

The Protocol contains very useful information concerning the protection, promotion and advancement of women's sexual and reproductive rights, including women living with and affected by HIV. Moreover, the Protocol goes beyond other binding treaties, such as CEDAW, in recognising women's reproductive rights.[5]

Article 14 of the Protocol: Health and reproductive rights

Article 14 of the Protocol affords women, including women living with HIV, with insurmountable protection of their human rights, and states that State parties shall ensure that the right to the health of women, including sexual and reproductive health is respected and promoted, including

- the right to control their fertility,
- the right to decide whether to have children and the number and spacing of the children,
- the right to choose any method of contraception, and
- the right to have family planning education.[6]

In addition, the Protocol affords women

- the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS, and
- the right to be informed on one's health status and on the health status of one's partner, particularly if affected with STIs, including HIV/AIDS, in accordance with internationally recognised standards and best practices.[7]

However, it is up to State Parties who have ratified the Protocol to ensure that these rights, to which it has bound itself to, become a living reality for all women, including women living with HIV.

Once a state has ratified the Protocol, that state is bound under international law to refrain from any acts that would defy the object or purpose of the Protocol. This means that women living in South Africa, or any other country which has ratified the Protocol, are entitled to the protection afforded by the Protocol and that State parties are obligated to take active measures to refrain from any acts that would defy the object or purpose of the Protocol, including active measures to ensure that the right to sexual and reproductive health for all women is respected, promoted and protected.

Conflict of rights in the South African context?

In South Africa, everyone has the constitutionally guaranteed right to privacy and autonomy.[8] The question to be raised here is how this relates to the Protocol which affords women the right to protection, including *the right to be informed on one's health status and on the health status of one's partner, particularly if the person is affected with sexually transmitted infections, including HIV/AIDS*? Reconciling these two provisions could

become challenging. Since nobody can and should be tested for HIV without their informed consent, forcing someone to go for an HIV test against their will and without their informed consent would be a gross violation of their constitutional rights to human dignity, privacy and autonomy, to name but a few.

Article 14(2) of the Protocol further requires State Parties

- to provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas,
- to establish and strengthen existing pre-natal, delivery and post-natal and nutritional services for women during pregnancy and while they are breast feeding,
- to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother and the foetus.[9]

The Protocol further prohibits all medical or scientific experimentation on women without their informed consent[10], which would include cases where women are sterilised without their consent when they attend hospitals to give birth, merely on the basis of their HIV positive status.[11]

…prevails over any harmful cultural and traditional practice…

South Africa ratified the International Covenant on Civil and Political Rights (ICCPR), which amongst other things states that *'no one shall be subjected to arbitrary or unlawful interference with his privacy'* and such a right to privacy[12]. It would, therefore, be unconstitutional and contrary to the spirit of the Constitution of South Africa and the ICCPR to allow someone to know another person's health status against their will, as this would be an unreasonable infringement on a person's right to privacy, as well as the right not to be subjected to medical and scientific experiments.

It remains to be seen how State Parties to the Protocol will make Article 14 relating to the right to know one's HIV status succeed without a gross violation of human rights and without conflicting with the ICCPR. In reality, women are mostly the first ones to find out about their HIV status, particularly when accessing sexual and reproductive health services, and are also the ones mostly subjected to HIV-related stigma and discrimination. A woman is hence less likely to disclose her HIV status to her partner, and if she does reveal her status, she is likely to be discriminated against and violated by her partner and/or by the community.

…concerns about the cost of reviewing legislation and implementing reproductive rights…

Customary and traditional practices

It has been argued that the Protocol's provisions on harmful cultural practices lay to rest arguments that customary and traditional practices can prevail over the rights of women under the African Charter[13]. This is all good and well. However, until State Parties take active measures to ensure that the Women's Protocol prevails over any harmful cultural and traditional practice, this will merely be just a dream for many, and women will continue to experience abuse in the name of tradition and custom, increasing their risks to STIs and HIV transmission, particularly in countries, like South Africa, where polygamous relationships form part of some traditions. In these kinds of situations, State Parties should be obligated to take active measures to ensure that the rights of women in polygamous relationships, including women's sexual and reproductive rights, are protected. Can the Protocol adequately ensure the right to self protection and the right to be protected from sexually transmitted infections, including HIV, for women in these relationships?

So far, studies have shown that women continue to be exposed to HIV infection in the name of tradition, despite the protection afforded in the Protocol.[14] More often than not, women are 'submissive' and feel inferior in these relationships, and are thus less likely to be in a position to insist on condom

use, let alone requiring the partner to go for an HIV test, so that the woman can know the health status of her partner, as envisaged in Article 14 of the Protocol. Given this reality, women continue to be more susceptible to and at risk of STIs and HIV transmission, despite the provisions in the Protocol.

Women's experiences and recommendations

At a Sexual, Reproductive and Maternal Health and Rights Regional Advocacy and Policy Forum held in Johannesburg from 22 to 25 November 2010, a woman from Botswana shared her experiences with public healthcare workers who asked her 'why she was pregnant' when she was 'sick', and since she was informed and knowledgeable, she told the doctor that she had a right to choose whether or not to be pregnant.[15] This is but one of many examples of discrimination and denial of access to healthcare services, including reproductive health services, often encountered by positive women. It is not only greatly concerning that these kinds of attitudes are still prevalent in healthcare, despite the Protocol affording women the right to reproductive and sexual decision making, but also raising the question as to the extent to which the Protocol can impact on women's realities.

Recommendations made by women who participated at the meeting included the following:[16]

Recommendations to policy-makers

- Our governments need to urgently and effectively respond to the sexual and reproductive rights and needs of women and young women living with HIV, in accordance with The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. All African member states must ratify the aforementioned Protocol and report on its implementation.
- Policies and laws, such as those criminalising the transmission of HIV, only increase violence and abuses against women living with HIV while legalising their discrimination. These legislative issues need to be urgently addressed by our governments.
- Recognising that the voices of young women and women living with HIV are critically lacking in policy-making, consequently their issues are not addressed effectively, with dramatic consequences on attaining the gender equality and health Millennium Development Goals.
- Women living with HIV are calling on African Heads of States to live up to their commitments to women and girls, by allocating much needed resources and capitalising on women living with HIV, in terms of their expertise of sexual and reproductive health and rights.

Challenges and conclusions

Countries that ratified the Protocol frequently raise concerns about the cost of reviewing legislation and implementing reproductive rights.[17] With this kind of an attitude, and apparent lack of government's commitment to prioritise women's rights and to domesticate such a potentially useful instrument, women's sexual and reproductive rights will continue to be compromised and violated.

…continued tensions between human rights and customary laws…

A further barrier seems to be the continued tensions between human rights and customary laws, polygamy being but just one example of how women will continue to be oppressed and not be in the position to negotiate for safer sex, for fear of losing shelter and food[18].

In addition, women's right to sexual and reproductive healthcare remains but a dream for many women, with women in abusive relationships least in the position to access ARVs or female condoms. Female condoms remain inaccessible in many areas, especially in small towns and rural areas in South Africa, while there is a huge roll-out of male condoms – demonstrating once again the reality of gender inequalities and imbalances despite the guarantees of equality in the Constitution, and the commitments to achieving gender equality, which is central to many other instruments South Africa has ratified.

Recognising the Protocol on the Rights

of Women as a tool to claim sexual and reproductive rights, Murrithi[19] raises the question as to whether or not the Protocol adequately caters for all women, including women living with HIV. Examining women's realities and challenges pertaining to their sexual and reproductive health, and looking at the opportunities within the Protocol to address these, she argues that the Protocol, despite its progressiveness fails to adequately address the needs and realities of women living with HIV and thus, calls for further advocacy and lobbying so as to ensure that the sexual and reproductive health rights of all women are equally protected by the Protocol.

…rights can be readily invoked in the local courts…

One way of achieving the Protocol's stated goal of protecting the rights of all women would be for State parties to domesticate these rights by making them part of national legislation, so that these rights can be readily invoked in the local courts. Civil society should play an active role in advocating for the domestication of the rights afforded to women in the Protocol, be involved in processes of policy-making, and be in the position to make submissions concerning areas where State parties are failing to meet the needs of women, as outlined by the Protocol.

Adequate reporting by State Parties is crucial in monitoring the effectiveness of the Protocol in the realisation of the rights of women living with and affected by HIV. Without reporting and monitoring, this potentially useful instrument will not serve any purpose. Learning from CEDAW, civil society has a crucial role to play in ensuring accountability and implementation, including production of shadow reports and active lobbying of governments to encourage further implementation. Civil society may, however, remain constrained without significant resources being allocated to this specific role[20].

FOOTNOTES:

1. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. [www.achpr.org/english/_info/women_en.html]
2. African Charter on Human and Peoples' Rights. [www.achpr.org]
3. South Africa ratified the Protocol in November 2005.
4. UNICEF. 2006. Toward ending female genital mutilation: Press Release, 7 February 2006.
5. Gerntholtz, L., Gibbs, A. & Willian, S. 2011. 'The African Women's Protocol: Bringing Attention to Reproductive Rights and the MDGs' In: PLos Medicine, 8(4). [www.plosmedicine.org]
6. Section 14(1) of the Protocol.
7. Section 14(1) of the Protocol.
8. The Constitution of the Republic of South Africa, Act 108 of 1996, Section 12 and 14.
9. Section 14(2) of the Protocol.
10. Article 4(k) of the Protocol.
11. ICW. 2009. *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*. [www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf]; Anand, N., Erdman, J., Kelly, L. & Robonson, C. 2009. *Policy Brief: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion*. Bridging the Gap. Athena Network. [www.athenanetwork.org/assets/files/Bridging%20the%20Gap%20Policy%20Brief.pdf.]; Gatsi, J., Kehler, J. & Crone, T. 2010. *Make it everybody's business: Lessons learned from addressing the coerced sterilisation of positive women in Namibia. A best practice model*. Namibia Women's Health Network, Namibia.
12. Article 17(1) of the International Covenant on Civil and Political Rights (ICCPR). [www.who.int/hhr/civil_political_rights.pdf]
13. Centre for Reproductive Rights. 2006. Justice Briefing Paper: *The Protocol on the Rights of Women in Africa: An Instrument for Advancing Reproductive and Sexual Rights*. [www.reprorights.org]
14. See also Tfwala, N. 'Women's control over sexual matters in traditional marriages: A development perspective'. [www.unisa.ac.za/bistream/handle/…/dissertation-tfwaala-n.pdf]
15. ICW Southern Africa & ICW Eastern Africa. 2011. Sexual, Reproductive and Maternal Health and Rights Regional Advocacy and Policy Forum: Meeting report. [www.icwea.org/admin/files/SRMHR%20Region]
16. *Ibid*.
17. Gernholtz et al, 2011.
18. *Ibid*.
19. Murrithi, C. 2007. 'A tool for claiming sexual and reproductive rights: The AU Protocol on the Rights of Women'. In**:** *ALQ*, March 2007 Edition, pp9-13.
20. Gerntholz et al, 2011.

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In my opinion…

Luisa Orza

HIV prevention methods and 'barriers' for women…

One of the highlights of the Rome Pathogenesis Conference in July 2011 was* In my opinion*, a presentation given by Zena Stein during a Satellite convened by the Global Coalition on Women and AIDS, in partnership with Salamander Trust, ATHENA Network, WECARe+, and the Italian Network of People Living with HIV (NPS+).

Stein, now in her late 80s, may have the look of a kindly grandmother, but she still packs a punch. As a feminist activist, Stein has been involved in the discourse around HIV prevention and research since AIDS entered the world stage in the 1980s, and was one of the earliest proponents of the microbicide (at the time dubbed the '*viruicide*') as a means of female-centred controlled prevention. It had not taken Stein, among other feminist activists, long to realise that for women – especially married women or women in established relationships – to attempt to introduce condoms into their relationships during the heyday of the Pill, was to give voice to, or invite, mistrust, fear and suspicion.

> *…The advice given to women that they could protect themselves from acquiring HIV by using a male condom was absurd … they couldn't or wouldn't…*[1]

However, Stein (also called 'the mother of the microbicide') recalls that around the time of the first discussions on a potential virucide/microbicide, another conversation was taking place – the proposal for a female condom, a barrier method for women. And despite limited support and enthusiasm for the project, the first female condom was approved by the FDA in 1993. Few women had access to them, and those who did, didn't always know what to do with them. (*I remember the bemusement and hilarity they caused while I was still at university – they were so long! Where exactly was all that slippery latex supposed to go?*) Other women complained about the smell, the noise …. Yet, it wasn't until sixteen years later in 2009 that the FC2 – a more use-friendly, less expensive model was approved. There are now seven other models available and four under development, but they have been a long time coming … and there are other women-centred barrier methods that, to date, remain uncharted as potential HIV prevention methods. Already, as Stein points out

> *…we know no microbicide will promise above 50% of protection … why have these obviously useful and important physical barriers never attracted the same interest among advocates for women, funders, national and private? And now, when realistically we know they have to be further developed, tested, funded, distributed, we have lost 2 decades of potential prevention?...*

Stein points to the lack of political will and investment in

…the lack of political will and investment in social-science intervention…

…be undermined by the onset of loudly hailed bio-medical advances…

social science intervention vis-à-vis bio-medical research and development. While there is a growing evidence base of good practice in the field of social interventions, there is a risk that these will be undermined by the onset of loudly hailed bio-medical advances. (For example, there has been great concern among women's rights advocates that the discovery that medical male circumcision reduces the risk of HIV infection in men by up to 60% threatens to undo the gradual increase – albeit limited – in both male and female condom use that has been seen over the last three decades). At the same time, bio-medical advances are nothing without community-based interventions to roll them out, create awareness, adherence literacy and demand, and to explore and address any gendered implications of new technologies. We live in a gendered world; nothing is without its gender implications, no matter how '*scientific*' the prevention tool.

Yet, investment in the social marketing and roll-out of the female condom has been limited. Zimbabwe is one of a handful of countries, which has taken advantage of the female condom and made major inroads into promoting its use. From 2005, when the strategy was launched, to 2008 female condom distribution by the public sector increased from 400 000 to more than 2 million.[2] But to put this into perspective, the per capita distribution of female condoms in 2008 equated to 1.48 female condoms per woman (aged 15-64) per year, compared to 28.5 male condoms per man per year; and on average, across 14 sub-Saharan African countries, the availability of female condoms was 142 times less than male condoms.[3]

...male condoms come up as the source of tension, impasse, control and violence in relationships, especially within marriage...

...much greater investment in making the female condom a viable alternative to the male condom is needed than mere distribution...

However, the doubts remain: are female condoms '*doing*' anything different from male condoms? Do they in any way address the issues that cause such resistance to male condom use? Do they address issues of lack of skin-to-skin contact; implied mistrust or infidelity; diminishment of (male) sexual pleasure; contraceptive? Again and again among young women in high prevalence areas male condoms come up as the source of tension, impasse, control and violence in relationships, especially within marriage, and more especially in marriages between adolescent women and older men, where an age differential exacerbates the gender power imbalances within the relationship. Both the suggestion of male condom use and use of other contraceptives are cited as precursors to intimate partner violence.

For women in these or similar circumstances, does the female condom offer a viable alternative? As I pondered this (and not for the first time), I met two young women

from Tajikistan, where condom use is similarly difficult to negotiate, especially within marriage, and where women at highest risk of HIV acquisition are those married to men who inject drugs, or who are forced into economic migration to find work. Is the female condom available and accessible to these women? *No; it is very expensive and there is no public sector distribution, although there is some demand for it among women, particularly from sex workers*. Would women be able to use it if it were more available? *Palpable pause*. Neither of the two women I was speaking with had ever tried it; women would probably need practice. And practice would certainly require not only provider support, but also intimate partner support… Much greater investment in making the female condom a viable alternative to the male condom is needed than mere distribution.

> …*Extending the protection afforded by female condoms does not rest on more technical studies: it needs active support by governments and agencies, funding for manufacturing and marketing, education and training of public health workers* [and] *appreciation of these devices by men and women and communities*…[4]

The microbicides gel has been welcomed as a prevention technology that women can use to protect themselves '*secretly*', without needing partner knowledge, affirmation or support (although in reality, how practicable would this be?). In contrast, the female condom is visible, it has an external ring, through which the penis '*has to be rooted*' (Stein); a man would necessarily be aware of its presence. Stein challenges this problematic, *('why the hell shouldn't he know?')*, and in doing so reminds us that practical solutions alone will not bring about sustainable structural change; that there needs to be a much more radical shift away from the discourse of prevention, protection and negotiation, towards a discourse of equitable female and male sexuality, pleasure, and care.

And while we applaud the advances in the science of HIV prevention for women, we are also reminded of the need to balance our efforts, energies and resources to ensure that existing and proven women-centred prevention options (such as the female condom) receive as much attention as '*new*' technologies, including microbicides. As long as we fail to reach this balance and women-centred HIV prevention options remain but a dream for most women, we will continue to hear chants of '*Where are the female condoms?*' and '*Where the hell is the gel?*', and will continue to raise questions as to when advances in science will become advances in reality for women.[5]

…nothing is without its gender implications, no matter how 'scientific'…

…practical solutions alone will not bring about sustainable structural change…

FOOTNOTES:

1. Stein, Z. 2011. 'HIV Prevention: Gender and MIPA: Complement or Collission?' Satellite Meeting at the IAS Pathogenesis Conference, 17 July 2011, Rome.
2. Zimbabwe Country Report. 2008 – 2009. United Nations General Assembly Special Session Report on HIV/AIDS follow up to the Declaration on the Commitment to HIV/AIDS.
3. USAID. 2010. *Is There A Condom Gap in 2010? A Review of Condom Availability, Accessibility and Acceptability in Sub-Saharan Africa*, pp 13-14.
4. Stein, 2011.
5. See also Stein, S. & Susser, I. 2011. 'In Focus: Science advances become real advances for women'. In: *Mujeres Adelante*, July 2011 Edition, pp1-3.

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Women's Voices:

…on prevention of vertical transmission programmes…

We have a PMTCT policy and most healthcare providers have not engaged with this document…in as much as the programme is declaring availability of services in many healthcare centre, women do not even access the services due to stigma and hostility by healthcare providers at the facilities…

[Kenya]

The programme doesn't address the needs and realities of women, because there are no adequate information to all the communities and women who should access the services; thus leading to stigma and discrimination from the communities…

[Uganda]

Firstly, a lot of women in rural areas have no access to PMTCT and as such are at risk of transmitting the virus to their unborn babies…secondly, gender barriers are also causing a lot of harm, as some women are not given the opportunity by their husbands to participate, owing to cultural beliefs…thirdly, a lot of facilities don't carry out PMTCT programmes…and fourthly, fear of stigma prevents many from accessing PMTC…

[Nigeria]

First, they should ensure that there are women living with HIV in the development planning groups…and secondly, that there is support for those women to participate and that their recommendations are actually listened to and acted upon…

[India]

Women in rural areas still face challenges in accessing services…for starters, PMTCT is institution-based, which brings into play issues of transport and shelter costs, particular for rural women…an assessment of what is happening on the ground has shown that the quality and level of prevention of vertical transmission services offered at rural and urban health centres differs…most of the services are found in urban areas, even though 70% of the population is rural-based…

[Zimbabwe]

The health workers in rural areas cannot meet the large number of women who need the services…there is a shortage of personnel and the existing few are not well conversant with the programme, due to lack of in-service training… the most affected women are from the society of women living with HIV…we have good guidelines on vertical transmission, but they are kept on the shelf…

[Tanzania]

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