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Have the NSP's objectives on gender-based violence been realised?

Strategies to address gender-based violence

The *HIV & AIDS and STI National Strategic Plan 2007 – 2011* (NSP), released in 2007, recognises that, if South Africa is to deal with the HIV epidemic, it is crucial to also focus attention on alleviating poverty, improving the status of women and addressing gender-based violence. This article focuses narrowly on the provisions in the NSP that address gender-based violence and comments on the extent to which progress has been made at the end of the first year of its operation.

The NSP primarily addresses gender-based violence through overlapping interventions in two priority areas, *prevention* and *human rights and access to justice*.

It must be noted that:

1. The prevalence of gender-based violence is influenced by a range of social and economic factors, and strategies to address gender-based violence should thus not be approached in isolation. For example, research has shown that -
   - Microfinance and gender education interventions (Objective 1.2 of the NSP) can lead to a reduction in intimate partner violence.[1]
   - Certain communication strategies which address the unacceptability of coercive sex, gender power stereotypes and sexual behaviour could reduce gender-based violence (Objective 1.3 of the NSP).[2]
2. The NSP is a five year plan which identifies certain key interventions in respect of gender-based violence. It is not intended to develop a comprehensive response to gender-based violence, and sectors should also develop other interventions to address violence against women.
3. In addition to the NSP, three other multi-sector framework documents to address gender-based violence were also launched in 2007. All these documents have their limitations but also create opportunities for action:
   - In March 2007, the *365 Days National Action Plan to End Gender Violence 2007-2009* was launched with its mission

     …to devise a comprehensive and concerted plan for ending gender violence with measurable targets and indicators to which South Africans

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Editorial…

> *…sexual violence is linked with a culture of violence involving negative attitudes and reduced capacity to make positive decisions or to respond appropriately to HIV prevention campaigns … in South Africa, the gender system fosters power imbalances that facilitate women's risks for sexual assault and sexually transmitted infections*… [NSP, pp31-32]

It is within the context of '*power imbalances*' defining and maintaining HIV risks and vulnerabilities that this edition of the ***ALQ*** is focusing on the National Strategic Plan (NSP) and gender-based violence. Examining both the policy document and the impact of gendered power on women's realities, the various articles raise the question as to whether or not strategies and programmes meant to address gender-based violence, as one of the underlying factors fuelling the HIV and AIDS pandemics, are indeed adequate and responsive to women's risks and vulnerabilities. The extent to which NSP objectives on gender-based violence have, thus far, been realised; the '*invisibility*' of lesbian women's risks and vulnerabilities in national HIV interventions and programmes; civil society's response to addressing the links between gender-based violence and HIV and AIDS; the extent to which sexual and reproductive health and rights are integrated in the national response to HIV and AIDS; and challenges faced by the healthcare system tasked with implementing the objectives, goals and targets outlined in the National Strategic Plan are some of the issues explored in this edition.

This issue also provides a '*provincial feedback*' highlighting some of the challenges impacting on the potential of the National Strategic Plan for civil society; introduces the *One In Nine Campaign*, as one of the advocacy strategies to address gender violence; and is '*making a point*' about '*power*', its meaning and impact on strategies and programmes pursuing social transformation.

In this edition, **Anneke Meerkotter** explores the National Strategic Plan (NSP) and its strategies aimed at addressing gender-based violence. Examining NSP objectives and interventions designed to prevent gender-based violence, and to provide access to health services, as well as access to justice, for survivors of gender-based violence, she raises questions as to their adequacy and levels of implementation; and argues, that – while energy and resources have been spent to develop strategies addressing gender-based violence – the extent to which these strategies are known and implemented at a service delivery level remains an area of great concern.

Based on the premise that lesbian women are overlooked in the response to HIV and AIDS, **Melanie Judge** provides an overview of the multiple strains of risks and vulnerabilities experienced by lesbian women. Highlighting the lack of adequate programmes and services responding to lesbian women's realities and needs, she argues that as long as HIV and AIDS programming is based within an heterosexual paradigm, lesbian women will continue to be *'invisible'* in the national response to HIV and AIDS.

Examining civil society's response to the link between violence against women and HIV and AIDS, **Ruth de Bruyn** discusses findings of a baseline study amongst various South African organisations. Introducing various initiatives and interventions, and exploring some of the successes and challenges in addressing the links between violence against women and HIV risks and vulnerabilities, she concludes that, while a lot has been done, there are a number of emerging challenges, which need to be addressed so as to be in the position to develop a more effective response.

The *One In Nine Campaign*, an advocacy response to the links of sexual violence and HIV and AIDS, is introduced by **Larissa Klazinga**, **Dawn Cavanagh** and **Carrie Shelver** – providing an insight into the history and development of the campaign, as well as an overview of some of the successes and challenges of the campaign, since its launch in February 2006 during the Zuma rape trial.

Gahsiena van der Schaff provides the '*provincial feedback*', exploring some of the opportunities, potentials and challenges of the NSP and its implementation as experienced by civil society. Analysing '*provincial views*' as to the challenges in adequately responding to the opportunities afforded in the National Strategic Plan, she argues that as long as there is a general lack of knowledge of, and critical engagement with, the policy document amongst civil society, the potential impact of the national response to HIV and AIDS, as well as civil society's meaningful involvement in implementing the NSP, will be severely limited.

Implications and requirements for the health sector, as the lead agency responsible for the implementation of many of the NSP goals and interventions, **Erica Kessie** and **Johanna Arendse** discuss some of the challenges, impacting on the extent to which the NSP can be implemented effectively. Exploring systemic challenges, such as shortage of human resources and adequate skills base, and highlighting the important role of healthcare

from all walks of life, in all spheres of government and at all levels of society can contribute.

- In May 2007, the 4th draft of the *Integrated Victim Empowerment Policy* was issued by the Department of Social Development. The policy seeks

  …to provide a framework to guide and inform the provision of integrated and multi-disciplinary services aimed at addressing the needs of victims of crime and violence. It also seeks to co-ordinate all activities and efforts by various government departments and civil society, to empower victims.

Provincial Victim Empowerment Forums were established to discuss and implement the policy.

- In December 2007, the National *Five Year Implementation Plan for the Service Charter for Victims of Crime 2007-2011* was launched by the Department of Justice, to document the plans by various government departments to implement the Service Charter for Victims of Crime (Victims' Charter) released three years earlier.

...one gets a distinct feeling that the documents were drafted in isolation of each other, often reinventing the wheel and establishing contradictory targets...

4. Various government departments have specific roles and responsibilities to address gender-based violence, but it remains difficult for civil society to monitor and evaluate the extent to which these departments are complying with their duties. Departments often talk openly about their achievements, but seldom provide insight into what is happening at service delivery level. More attention should be paid by civil society organisations to develop mechanisms to hold government accountable.

Preventing gender-based violence?

Objective 1.3

Develop and implement strategies to address gender-based violence

The *365 Days National Action Plan to End Gender Violence 2007-2009,* 4th draft of the *Integrated Victim Empowerment Policy,* and the National *Five Year Implementation Plan for the Service Charter for Victims of Crime 2007-2011* are strategy documents to address gender-based violence.

Although similar interventions are set out in all these documents, one gets a distinct feeling that the documents were drafted in isolation of each other, often reinventing the wheel and establishing contradictory targets. None of the documents are incorporated into the strategic plans of the individual government departments in a meaningful way. It is unfortunate that, when it comes to gender-based violence, much money is often spent on events, and insufficient time and resources are allocated to implementation and to the strengthening of service delivery.

Intervention: Develop communication strategies, including leadership messages, which address the unacceptability of coercive sex, gender power stereotypes and the stigmatisation of rape survivors

Lead agency: National Prosecuting Authority, with the Departments of Education, Social Development, Health and Justice, NGOs and the Presidency

Leadership messages, as a key strategy, leave much to be desired – government leaders are quick to pay lip-service to the need to address gender-based violence during the 16 Days of Activism to End Gender Violence Campaign but some leaders continue to treat women with disdain and stigmatise rape survivors.[3]

The SANAC Civil Society meeting held on 26 and 27 November 2007 to discuss the NSP, highlighted the fact that communication strategies regarding HIV and AIDS

providers in the national response to HIV and AIDS, the article argues that there are a number of challenges which are in urgent need of attention, so as to minimise its negative impact on the possibilities afforded by the NSP.

Rebecca Freeth is '*making a point*' about '*power*' and the potential of power to achieve greater gender justice in HIV programmes and initiatives. The article explores core concepts of power and rank; examines the '*power*' of changing limiting assumptions into liberating alternatives; and outlines how the concept of power can be both '*destructive*' and '*constructive*', she argues that enlisting power is a necessary step to further social transformation.

Recognising the importance of integrating sexual and reproductive health and rights into the national response to HIV and AIDS, **Marion Stevens** explores the NSP and raises the question as to whether or not the need for integration of SRHR and HIV and AIDS has been adequately responded to. She argues that, even though there are some developments, the adequate integration of sexual and reproductive health and rights into the national response to HIV and AIDS remains a crucial area of development and debate.

There have been many debates and discussion about the NSP and its possibilities, since its approval in April 2007. And while there are many opinions and viewpoints expressed over time, most of us would argue that the National Strategic Plan is a '*great*' policy document, as it is based on a situational analysis of HIV and AIDS realities, and includes clear objectives, interventions and targets. Yet, there are some, who would argue that the situational analysis falls short of addressing and responding to underlying factors, such as power, patriarchy and *'hetero-centrism'* – and thus, has its limitations. And some would also stress that there are real risks and '*tendencies*' of compromising human rights for the sake of pubic health interventions, especially people's right to informed consent and autonomy in the context of HIV testing. As for implementation challenges, many of us would argue that without adequate infrastructure, including human resource and skills base, resource allocation, multi-sectoral approaches and knowledge of the content of the policy document, the National Strategic Plan will not achieve its desired goals. Whatever the argument, it seems commonly agreed that the 'real proof' of whether or not the National Strategic Plan is an adequate response to HIV and AIDS lies in its implementation, and its '*real success*' is to be measured by improved '*quality*' of programmes and services, and not by enhanced '*quantity*' alone.

The question as to whether or not the NSP provides a '*real*' opportunity to address gender-based violence and to enhance access to services for survivors of gender-based violence seems, however, to raise more debates and questions than provide answers. One of the more contentious debates initiated by this question is whether or not the strategies are indeed responsive to the needs of survivors of gender-based violence, and whether or not the societal context in which gendered violence and abuse occurs and *'thrives'* is taken into account and adequately responded to. And in most cases, the answer seems to be '*no*', since underlying factors maintaining and, to an extent, '*condoning*', the occurrence of gender violence and abuse are often overlooked and neither addressed nor responded to. There is also the commonly raised issue as to whether or not there is sufficient '*ability*' and/or '*preparedness*' to translate an adequate policy response into practice, so that people meant to benefit are indeed in the position to access and realise the policy provisions, and truly benefit from available services.

Recognising that the adequacy of strategies addressing gender-based violence can only be measured by the extent to which strategies respond to both the needs and realities of survivors of gender violence and the underlying factors of gender violence – it seems essential to raise the question as to whether or not sufficient efforts and resources are spent in preventing gender violence and abuse. Taking into account that addressing gender-based violence is an integral part of the national response to HIV and AIDS, it could be argued that the National Strategic Plan is indeed adequately responding to HIV realities, needs and challenges – especially since gender violence is widely recognised as one of the underlying factors fuelling the pandemics. However, the NSP falls short of addressing the '*real*' underlying factors – gender, gendered power and heterosexim. And as long as the patriarchal, powered and heterosexual paradigm – in which HIV responses are designed, situational analyses are placed, and HIV risks and vulnerabilities are defined and maintained – remains unchallenged, the impact of the national response to HIV and AIDS will remain limited, as it fails to address the '*real*' underlying factors.

So, if we are to agree that there are '*new*' opportunities afforded by the National Strategic Plan, then we also have to agree that there limitations – as the '*real problem*' is yet, once again, overlooked, silenced and made invisible…

Johanna Kehler

are currently not actively coordinated within SANAC, especially with regard to Khomanani, and that there is a need for more coordination and collaboration among the different civil society media organisations such as *Soul City*, *Community Health Media Trust* and *Love Life.* The specific communication strategies envisaged by the NSP on gender-based violence have, however, not received much attention.

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Objective 1.5

Build and maintain leadership from all sectors of society to promote and support the NSP goals

Intervention: Ensure regular updates in sectors on priority activities and messages

Lead agency: SANAC

This objective is key to ensuring that the objectives and goals of the NSP are implemented. At the moment, key individuals from the various government departments and civil society sectors have been drawn into the SANAC processes. As leaders, they are expected to ensure that their respective government departments and sectors are fully aware of the NSP goals and objectives, and are working towards implementing these. This is where the greatest gap lies. Civil society sectors have to admit that their consultation within their respective sectors has not yet been optimal and many organisations and individuals remain unaware of the NSP. Similarly, the annual plans and strategic objectives of government departments clearly show that they have not integrated the NSP goals and objectives into their departmental plans. For example, the Department of Justice's *Medium-Term Strategic Framework 2005/06 – 2008/09* only mentions HIV/AIDS once in relation to prioritising '*child care and protection applications for children infected with and affected by HIV/AIDS*'. The Department of Justice's *National Five Year Implementation Plan for the Service Charter for Victims of Crime 2007-2011* is similarly out of sync with the NSP, which designated the Department of Justice as a lead agency on various interventions.

Access to health services for survivors of gender-based violence?

Objective 2.9

Increase accessibility and availability of comprehensive sexual assault[4] care including PEP and psychosocial support

Intervention: Increase the proportion of facilities offering the comprehensive package of sexual assault care in accordance with the *National Policy on Sexual Assault Care* of the National Department of Health

Lead agency: Department of Health with Departments of Justice, Correctional Services, Social Development and National Prosecuting Authority

Objective 19.2

Ensure implementation of existing laws and policies that protect women and children from gender-based violence

Intervention: Ensure that the National Sexual Assault Policy and Management Guidelines are implemented by health care workers in all districts

Lead agency: Department of Health

In January 2005, the Department of Health released

its *National Sexual Assault Policy* and *National Management Guidelines for Sexual Assault Care*. One of the objectives of this policy is

> *…to establish designated, specialised, accessible, 24-hour health care services for the holistic management of patients to improve health status after sexual assault.*[5]

The Policy and Guidelines have not been widely published and are not well-known among healthcare providers or civil society. The documents were not gazetted or placed on the Department's website. In the Department of Health's *Annual National Health Plan 2006-2007*, it committed itself to the development of an implementation plan for the *National Sexual Assault Policy* and conducting nine training workshops for professional nurses and medical practitioners on sexual assault care practice and the implementation of the Policy and Guidelines. Provinces were tasked with supporting the implementation of the Policy and Guidelines. The Department has not yet publicly reported on whether an implementation plan was developed and to what extent it has provided services to survivors of sexual assault.

...to date, there is no policy that guides the provision of healthcare, including PEP, to women in abusive relationships....

In March 2007, the *365 Days National Action Plan to End Gender Violence 2007-2009* noted the need to implement the Policy and Guidelines and recommended that an Oversight Committee be established by the Gender Focal Point Directorate of the Department of Health (including provincial representation and civil society organizations) by 2007. The Department of Health has since held quarterly oversight meetings in various provinces. The *National Action Plan* reiterated the commitments made in the Department of Health's *Annual National Health Plan 2006-2007* to develop a similar policy for victims/survivors of domestic violence by 2007, and for each province to develop and implement a comprehensive plan to establish psycho-social and mental health care for victims/survivors of gender-based violence starting by 2007. Little feedback has been given by the Department of Health on progress made on these commitments and to date, there is no policy that guides the provision of healthcare, including PEP, to women in abusive relationships.

...since the chapter provides for much less than what rape survivors are currently entitled to in terms of the National Sexual Assault Policy, *it is unclear what exactly the effect of this chapter will be...*

It is important to note that providing post-exposure prophylaxis for HIV (PEP) is only one aspect of a comprehensive service for survivors of sexual assault and that the provision of PEP should be integrated into a comprehensive package of care for adult and child survivors of sexual assault. This is recognised by the wording used throughout the NSP, and other multi-sector documents which emphasise the need for comprehensive sexual assault services. The *Criminal Law (Sexual Offences) Amendment Act* (No 32 of 2007), which was tabled by the Department of Justice, in its chapter on services for survivors of sexual assault, does not mention comprehensive care nor psycho-social support but only entitles rape survivors to PEP at designated facilities. Since the chapter provides for much less than what rape survivors are currently entitled to in terms of the *National Sexual Assault Policy*, it is unclear what exactly the effect of this chapter will be. At the moment, the provision of sexual assault services is budgeted for by the Department of Health, whilst it receives additional grants from the treasury for the provision of post-exposure prophylaxis (PEP) after sexual assault at hospitals.

Objective 19.3

Address the needs of women in abusive relationships

Interventions: Distribute Guidelines on SAPS and their

responsibilities in terms of the National Sexual Assault Policy; Train SAPS on Guidelines; Train VCT and adherence counsellors to identify barriers that prevent women from accessing HIV prevention, treatment and care services

Lead agency: Department of Justice, Department of Correctional Services, human rights sector

The *National Sexual Assault Policy* sets out the relationship between health services and the SAPS. In line with the Policy, the National *Five Year Implementation Plan for the Service Charter for Victims of Crime 2007-2011* commits the South African Police Service (SAPS) to ensure that rape kits are properly managed and victims are transported to doctors and hospitals and back home. At some police stations, victim empowerment programmes are in place where volunteers assist rape survivors and take them to hospital. Many civil society organisations report that some police officers continue to treat rape survivors badly and fail to offer them the required support specified in the Policy. It is not clear if this policy has been transferred into national instructions, standing orders or guidelines as specified in the NSP.

Rape survivors must access PEP as soon as possible after a rape. If they first report to the police station, the *National Sexual Assault Policy* requires police to take them to the nearest facility that provides sexual assault services. Yet, many rape survivors still wait for unacceptably long periods at police stations before they are assisted. The *Criminal Law (Sexual Offences) Amendment Act* (No 32 of 2007) now places a responsibility on a police official to whom rape has been reported to immediately inform the victim of the importance of obtaining PEP within 72 hours, the need to obtain medical advice regarding the possibility of other sexually transmitted infections, and to provide him or her with a list of accessible public health establishments designated to provide PEP (Section 28). The limited and ambiguous nature of this section is extremely unfortunate. It is crucial, in order to ensure that rape survivors access comprehensive services, including PEP, as soon as possible after the incident, that police officials are adequately trained on what to inform rape survivors and that they are properly instructed to ensure that rape survivors are able to access the facilities immediately. Although Section 28 does not mention the other services to which rape survivors are entitled to in terms of the *National Sexual Assault Policy*, it does not exclude them either. It is accordingly recommended that any training and instructions, developed in terms of Section 28 of the *Criminal Law (Sexual Offences) Amendment Act,* refer to this provision in the context of the services prescribed in the *National Sexual Assault Policy* to avoid the possibility of officials developing a narrow and dangerous perception of what health services rape survivors need.

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Under priority area two of the NSP (treatment, care and support), **Objective 6.5** suggests various interventions to strengthen the health system and remove barriers to access. The interventions anticipated, such as expanding human resource pool, streamlining drug procurement and supply management, will have a beneficial impact on all health services and would impact positively on the provision of sexual assault care.

Access to justice for survivors of gender-based violence?

Objective 19.2

Ensure implementation of existing laws and policies that protect women and children from gender-based violence

Women and children who experience gender-based violence are often denied access to justice and find that

their human rights to dignity and freedom from violence are ignored. The *Criminal Law (Sexual Offences) Amendment Act* will assist the prosecution of rape and sexual assault cases. The finalisation of the Act was a key recommendation by the NSP. The next phase in this law reform process is the development of a National Policy Framework by the Minister of Justice by December 2008 to ensure a uniform and coordinated approach by all government departments, and the development of National Instructions for police and National Directives for prosecutors, as well as directives, where necessary, for other departments, by June 2008. The Department of Justice in its *Medium Term Strategic Framework 2005/6-2008/9*, sets itself the target of ensuring that the *Criminal Law (Sexual Offences) Amendment Act* is implemented and that the policy framework is also in place by 2008/9.

A key concern in the development of the National Policy Framework is that it might, as with the *Criminal Law (Sexual Offences) Amendment Act*, again be out of sync with developments in other government departments to address gender-based violence.

A strategic goal of the Department of Justice in terms of the *Medium Term Strategic Framework 2005/6-2008/9* is the effective management of sexual offences and domestic violence cases, with the aim of 70% of cases finalised within nine months of formal charges and an improvement of 15% in the conviction rate by 2007/8. The *365 Days National Action Plan to End Gender Violence 2007-2009* aims for an increase in conviction rates by 10 percent per year, roll out of Sexual Offences Courts and the reduction of rape cases by 7-10 percent per year.

...positively, the Department of Safety and Security has incorporated various references to domestic violence in the Firearms Control Amendment Act...

The *Strategic Plan for SA Police Services 2005-2010* states that a key strategic priority is to address crime against women and children (rape, domestic violence, assault and child abuse). One mechanism is its *Anti-Rape Strategy* which seeks to reduce rape and improve the investigation of rape cases and services provided to rape survivors. Guidelines for the strategy was apparently issued in 2003 and further development and implementation of the *Anti-Rape Strategy* was supposed to take place during 2005/06. The National *5 year Implementation Plan for the Service Charter for Victims of Crime 2007-2011*, however, commits the South African Police Service to finalise the development of the *Anti-Rape Strategy* (guidelines, training, instructions) in 2006/2007, and to implement the *Anti-Rape Strategy* (anti-rape programme, national instructions and guidelines, national framework guidelines, training, better investigation) in 2007/2008. The content and impact of this strategy is not clear.

...it is argued by many civil society organisations that the continued criminalisation of sex workers violates their right to equality, dignity, freedom of person and privacy...

Objective 19.3

Address the needs of women in abusive relationships

There are a whole range of interventions that can be used to assist women in abusive relationships. One of the issues the NSP identifies as crucial to enable adequate implementation of the NSP objectives, is the allocation of adequate resources for the implementation of the *Domestic Violence Act* (No 116 of 1998). It does not appear that the Department of Justice is aware of this provision since the budgeting for implementation of the Act remains inadequate.

Positively, the Department of Safety and Security has incorporated various references to domestic violence in the *Firearms Control Amendment Act* (No 43 of 2003) and proposed Regulations published at the end of 2007.

The NSP recommended the finalisation of the

Domestic Partnerships Bill as a key law reform measure, which would assist the implementation of the NSP goals and objectives, since it would improve the status of many women in cohabitation relationships. The Department of Home Affairs published its first draft of the Bill for comment in January 2008.

...lead agencies are obliged to account on their efforts to achieve the goals and objectives in the NSP...

Objective 19.4

Ensure laws, policies and customs do not discriminate against women and children

It is argued by many civil society organisations that the continued criminalisation of sex workers violates their right to equality, dignity, freedom of person and privacy. The NSP recommended that sex work should be decriminalised. The South African Law Reform Commission is expected to table its report on adult sex work in April 2008.

The Department of Justice, however, included in the *Criminal Law (Sexual Offences) Amendment Act* a provision making it a criminal offence to engage the sexual services of a person 18 years or older (Section 11). The Department argued that it was obliged to effect this amendment after the Constitutional Court, in the case of *Jordan v the State* (CCT 31/01), stated that the criminalisation of sex workers and not their clients were discriminatory.

Conclusion

The government has spent some energy and resources on the development of strategies to address gender-based violence. A key concern remains the extent to which these strategies are known and implemented at service delivery level. The structures established to ensure the implementation of the NSP provide an opportunity for the gender-based violence sector to monitor and evaluate the extent to which government departments effectively implement strategies to address gender-based violence, since lead agencies are obliged to account on their efforts to achieve the goals and objectives in the NSP.

FOOTNOTES:

1. Pronyk, P. et.al. 2006. 'Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: results of a cluster randomized trial'. In: *The Lancet,* Vol 368, pp1973-1983; South African IMAGE Study on Violence and HIV. Available at [http://web.wits.ac.za/Academic/Health/PublicHealth/Radar/SocialInterventions/InterventionwithMicrofinanceforAIDSGenderEquity.htm]
2. Jewkes, R. et.al. 2007. *Evaluation of Stepping Stones: A gender transformative HIV prevention intervention.* Policy Brief, Gender & Health Research Unit, Medical Research Council. Available at [http://www.mrc.co.za/gender/reports.htm]
3. For example, the high profile cases of sexual harassment by the late Norman Mashabane and Mbulelo Goniwe.
4. Reference to the term '*sexual assault*' in the NSP and Department of Health documents refer to all sexual offences including rape, whilst the term '*sexual assault*' in the *Criminal Law (Sexual Offences) Amendment Act* replaces and goes beyond the previous definition of indecent assault, and is different from rape.
5. The *National Sexual Assault Policy* identifies the following strategies to achieve this objective: 1. Provision of health care immediately after sexual assault; 2. Sexual Assault examination kits should be available at facilities that provide sexual assault services; 3. Providing proper treatment of injuries; 4. Ensuring safety and avoiding re-victimisation; 5. Preventing unwanted pregnancy; 6. Providing post-exposure prophylaxis for HIV; 7. Preventing and treating sexually transmitted infections; 8. Preventing and treating psychological distress; 9. Providing access to psychological/psychiatric care; 10. Medical certificates for sick leave; 11. On discharging the patient ensure that proper follow-up arrangements are in place; 12. Ensuring the integrity of the evidence chain; 13. Clinical management guidelines for health care professionals; 14. Provision of information to the patient; 15. Documentation of evidence;16. Reporting of forensic evidence; 17. Giving evidence in court; 18. Accreditation of Providers of the service; 19. Provisions of support services for health providers to prevent vicarious trauma; 20. Services have to be supervised, monitored and evaluated on a regular basis; 21. Provision of adequate 24-hour facilities.

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Melanie Judge

'Invisibility in plain sight'[1]... Lesbian women and HIV

This paper aims to provide a broad overview of some of the key issues pertaining to HIV and AIDS in the context of lesbian sexualities and identities. Lesbian women are largely overlooked in mainstream responses to the epidemic. However, the particular vulnerabilities we encounter demand attention at the level of research and programming, as well as in informing how we understand the epidemic in the context of gendered power that is rendered invisible. Indeed, if we examine the interface between HIV and AIDS – as a social problem – and the lives of lesbian women, we get to see, in plain sight, the critical contextual factors that shape the course of the epidemic. And this course is inextricably linked to the social dimensions of gender, identity, sexuality, power and violence. The lethal combination of these elements results in multiple strands of vulnerability for women – and for lesbian women in particular.

I wish to frame my analysis within a sexual rights paradigm, which allows us to examine the lesbian experience to the extent to which one is able to do the following: exercise and express sexuality freely and safely; be protected from sexual violence and discrimination; be in charge of decisions about one's own body; have access to information and services necessary for sexual health; and experience sexual pleasure. Although fundamental to the person, these sexual rights cannot be divorced from the economic, social and cultural contexts that mould them. Neither can their realisation be interrogated outside of economic, social and political rights, to which they are deeply bound. In this sense, a violation of one set of rights negatively affects the other rights.

Sexuality and silence

Social representations of sex and sexuality, despite being the main vectors of HIV transmission, are mostly still shrouded in denial and/or disapproval. Sexuality is essential to individual and social well-being. However, lesbian sexuality remains largely silenced within our hetero-normative, patriarchal reality.

While the right to make informed decisions about reproduction, the right to security and control over one's body, and the right to be free from all forms of violence is constitutionally guaranteed to everyone[2], it is the societal context in which these rights and freedoms are accessed that define their limitations. This is the same context in which HIV stakes its claims.

Noting this mileu, it is exceedingly difficult for lesbian women to access adequate information about sexual health, including STIs and HIV. And the stigmatisation of lesbian sexuality silences much needed research, and targeted HIV and AIDS responses.

Systemic discriminations in the health care setting result in the denial of access to care, or inadequate or inferior care. HIV infected lesbian women carry the

burden of double stigmatisation, as a result of both their HIV status and their sexual orientation.

Often, health seeking behaviour is influenced by the homophobic and heterosexist attitudes of healthcare providers, either preventing access to healthcare or reducing openness and trust within healthcare settings. Research of lesbian women's experiences within the public healthcare sector points to institutionalised homophobia and heterosexism that render us at risk of decision-maker de-prioritisation and/or and service provider neglect.

...HIV infected lesbian women carry the burden of double stigmatisation, as a result of both their HIV status and their sexual orientation...

In studies conducted in both Gauteng and KwaZulu Natal, 6% and 4% of lesbian women, respectively, were refused healthcare, because of their sexual orientation.[3]

Of concern is the fact that about 11% of lesbian women had delayed seeking treatment for fear of discrimination. Some women had lived with certain medical conditions and had not sought help, because they were afraid of their sexual orientation being discovered. Not seeking healthcare appears to be more prevalent amongst lesbian women under 25 years. These statistics are concerning, as living with sexually transmitted infections (STIs) can accelerate the spread of HIV and AIDS.

Healthcare workers compromise trust and the ability to reveal complex life issues that may be of relevance to the person's health when they ask questions that assume a woman is heterosexual. The research indicated that almost half of the healthcare practitioners visited in the preceding two years, asked heterosexist questions (49%) or assumed respondents were heterosexual (41%). In all, 55 % reported that healthcare providers asked them questions which '*made it seem that being heterosexual is the only normal way to be*'.[4]

Discrimination experienced in the healthcare sector can have a serious impact on health seeking behaviour and, in turn, on the general and sexual health of lesbian women.

Traditionally, lesbian women are thought to be relatively risk free in relation to sexually transmitted infections (STIs) and HIV. However, research findings indicate that 8% (in KwaZulu Natal) and 9% (in Gauteng) of respondents self-reported as being HIV positive[5].

Research suggests that most lesbian women do not perceive themselves to be at risk of HIV. The de-prioritisation and exclusion of lesbian women within HIV programmes, as well as the invisibility of our sexualities, reinforce this erroneous sense of invulnerability. Because of these misperceptions of risk, lesbians are not '*targeted*' in HIV prevention campaigns. This perception impacts on HIV testing practices:

- '*I have never been in a situation where I could have contracted HIV*' reported 57% of the women who had not been tested
- '*I do not think I am at risk of being HIV positive*' reported 53% of the women who had not been tested

...in studies conducted in both Gauteng and KwaZulu Natal, 6% and 4% of lesbian women, respectively, were refused healthcare because of their sexual orientation...

Multiple strands of risk

We know that HIV follows the path of least resistance. Social power constellations in South Africa create the contour paths through which the virus navigates. Engaging with the issues affecting lesbian women in the context of the epidemic forces us to pay attention to the way in which

gendered power facilitates vulnerability and how different aspects of a person's identity (such as race and class) compound this vulnerability. The dominant discourses of HIV still tend to de-gender the epidemic, thus, over-emphasising the individual and under-examining the social and economic contexts in which people are able (or not) to make sexual choices.

Gendered inequalities, imbalances and injustices, in combination with social, cultural and religious values, norms and beliefs are but some of the indicators determining the extent to which a woman can make informed sexual choices. These indicators are further shaped by a person's sex, gender, sexual orientation, age and/or HIV status.[6]

Social power derives from the social context in which we live. The social and political realities of a given society impact on a person's dominant or subordinate status within that society. The prevailing hegemonic discourses around gender, heterosexuality, culture and religion impact on a lesbian woman's experience of power, and her lived reality is mediated by power of different kinds.

...research suggests that most lesbian women do not perceive themselves to be at risk of HIV...

Prejudice, based on gender identity and sexual orientation, makes lesbian women and other sexual minorities susceptible to varying forms of discrimination, including sexual abuse. HIV prevalence amongst lesbian women in South Africa can at least, in part, be attributed to sexual violence. Sexual violence capitalises on the vulnerability of already marginalized groups, and creates new forms of vulnerability. Socio-economic inequality, along with patriarchal gender and sex roles, subjects women to high rates of sexual violence. This in turn magnifies HIV risk. Sexual choices are often made in the context of violence, and freely made choices are often responded to with violence and abuse. This has particular relevance for lesbian women, whose sexuality is perceived to challenge and/or undermine the dominant hetero-normative order.

The rape epidemic in South Africa, and its role in the risk of HIV transmission, cannot be addressed without understanding how gender and sexual norms function in communities.

...we know that HIV follows the path of least resistance. Social power constellations in South Africa create the contour paths through which the virus navigates...

Sexual assault and rape, motivated by homophobic prejudice, is a particularly common problem for lesbian and bisexual women. According to research, 8% of respondents reported to have been sexually abused or raped in the preceding two years[7]. When looking at lifetime prevalence, figures are likely to be much higher. Lesbian women living in townships face almost double the risk. The Institute for Democracy in South Africa (IDASA) reported that lesbians are at increased risk of being raped or violently attacked.[8]

Rape is always an act of power. '*Corrective rape*' is when women are targeted for rape, because of their actual or presumed sexual orientation. The very notion of '*corrective rape*' is based on a prejudice that seeks to justify the rape of people, who are perceived to not conform – or who disrupt – expected gender roles, behaviour and/or presentation. Misogyny and homophobia underpin the prejudice associated with '*corrective rape*'.

In addition to this, lesbians often hesitate to report rape and sexual assault, which puts them at further risk of HIV infection. The bias that renders lesbians a frequent target of sexual violence also victimises them when they turn to service providers for assistance

after the violence, a phenomenon known as '*secondary victimisation*'. As such, many women do not report incidents of discrimination to the police.[9]

These barriers to services and justice have a knock-on effect for HIV prevention and care, as people are less likely to seek post-exposure prophylaxis (PEP), and other services related to physical well-being, in the case of rape.[10]

As a result of heterosexism and patriarchal gender inequalities, many lesbian women do have sex with men and this facilitates the risk of HIV transmission. The pressures to conform to heterosexuality – as a compulsory social prescription – are powerful, and may result in lesbian women finding difficulty in actively seeking relationships with other women, in refusing sexual engagements with men, and in coming out.

In South Africa, large numbers of women live in poverty and are locked out of the formal economy for structural reasons, so are likely to be unemployed. As such, they may engage in sexual relationships with men for transactional purposes. Lesbian women are no exception to this.

Other reasons for sex with men may include confusion about sexuality or family pressure to '*prove*' heterosexuality. For lesbian women, sex with men may frequently be unplanned, unexpected and/or transactional and therefore even more likely to be unprotected.

...the very notion of 'corrective rape' is based on a prejudice that seeks to justify the rape of people, who are perceived to not conform – or who disrupt – expected gender roles, behaviour and/or presentation...

Women under certain circumstances are also at risk, albeit low, through sex with same-sex partners.[11] It is thought that sexually transmitted infections significantly increase the risk of HIV transmission between lesbian women.

The experiences amongst lesbian women, and related HIV risk factors, are not the same, for lesbian women as a social group are not homogenous. Sexual and gender identities intersect with economic and racial inequities. This renders black lesbians particularly vulnerable. Self-reported HIV prevalence reflects these intersecting forms of discrimination.

...as a result of heterosexism and patriarchal gender inequalities, many lesbian women do have sex with men and this facilitates the risk of HIV transmission...

More research needs to be conducted on the prevalence and impact of HIV on lesbian women if we are to gain a more concise and accurate picture of the intersections of vulnerability and risk.

If a woman cannot choose whether, when and with whom to have children, both her rights and health are compromised. Conservative and mythological representations of the nuclear family – largely based on myth and used as a form of social control – negate other forms of family, including those of lesbian women. In this regard the particular experience of HIV positive lesbian mothers, and how this may shape impact, needs exploring.

Transforming our responses to HIV and AIDS

The vast majority of HIV and AIDS public education and information has at its foundation the assumption of heterosexuality. And this is confined to an often imagined notion of human sexuality, based on hetero-normative,

highly gendered assumptions of behaviour. As a result, national HIV messaging and service provision is presently not equipped to deal with a range of sexual and gender identities. HIV and AIDS programmes across the board do not address the intersecting factors that place lesbian women at particular risk, and that determine the impact of the epidemic on lesbian women. Concrete examples of this would include the absence of specific HIV messaging for lesbian women, as well as the inaccessibility of dental dams and adequate safer-sex information. Presently in South Africa, HIV and AIDS services that consider the realities facing lesbian women are solely provided by lesbian, gay, bisexual and transgender (LGBT) organisations.

...we need service provision that is underpinned by notions of human dignity and agency, and that is mindful of gender and sexuality appropriateness...

While the societal context already limits individual sexual choices, HIV and AIDS programming further limits the access to quality care. Discriminatory attitudes, beliefs and practices violate a service beneficiary's right to dignity, autonomy, confidentiality and non-discrimination.

Central to the right to health for all South Africans is assurance of equal access based on the principle of non-discrimination. South African health frameworks assert that no one may refuse a person a service or treatment, or provide them with inferior services, due to their sexual orientation and gender. But, as has been illustrated, this is not borne out in practice.

Safe and lesbian-affirming responses should include a guarantee of the right to privacy and confidentiality. In addition, we need service provision that is underpinned by notions of human dignity and agency, and that is mindful of gender and sexuality appropriateness.

The ideological approach that underpins a sexual rights response offers an important tool to inform our work with lesbian women in the context of sexual health and well-being. However, deepening poverty and unemployment – as rights issues – must be addressed if we are to get any closer to ensuring that our interventions enhance the sexual rights of all women, including lesbians.

FOOTNOTES:

1. This phrase, although not in direct reference to the experience of lesbian women, is attributed to Ida Susser, based on her input as a respondent at the 'Exploring HIV and AIDS care through a sexual and reproductive rights lens' Roundtable at the 3rd PHASA Conference on 02 June 2008, in Cape Town, South Africa.
2. The Constitution of South Africa, Act 108 of 1996; Section 12.
3. Polders, L. & Wells, H. 2004. Levels of Empowerment among Lesbian, Gay, Bisexual and Transgender People in Gauteng, South Africa. OUT LGBT Well-being; Wells, H. 2006. Levels of Empowerment among Lesbian, Gay, Bisexual and Transgender People in KwaZulu-Natal. OUT LGBT Well-being, 2006. These studies were commissioned by the Joint Working Group – a national network of lesbian, gay, bisexual and transgender organisations. The Gauteng study was conducted by OUT LGBT Well-being and the Unisa Centre for Applied Psychology. The Kwa-Zulu Natal study was conducted by OUT LGBT Well-being, Unisa Centre for Applied Psychology and the Durban Lesbian and Gay Community and Health Centre.
4. Ibid.
5. Ibid.
6. Drawn from the AIDS Legal Network & OUT LGBT Well-being Joint Submission on the Choice on Termination or Pregnancy Amendment Act to the Provincial Standing Committee on Social Development, 13 August 2007.
7. Op cit. (note 2).
8. Graham, T. & Kiguwa, S. 2004. *Experiences of Black LGBT Youth In Peri-Urban Communities in South Africa*. IDASA, p15.
9. 41% of incidents of rape and sexual abuse against lesbian and gay people in Gauteng and 53% of similar incidents in KwaZulu-Natal are reported to the police. Reasons given for nor reporting include: they expect their report not to be taken seriously; they fear abuse by the police; they do not want the police to know about their sexual orientation; the incident embarrassed them; and they feared that reporting it would make their sexual orientation public knowledge.
10. Ibid.
11. See *Fact sheet: HIV/AIDS & U.S. Women Who Have Sex With Women (WSW)*. National Center for HIV, STD and TB Prevention. Divisions of HIV/AIDS Prevention. Available at [http://www.cdc.gov/hiv/pubs/facts/wsw.htm]; Shisana, O. 2002. *Nelson Mandela/HSRC Study of HIV/AIDS*. Human Sciences Research Council Publishers. Available at [http://www.hscrpress.ac.za].

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Ruth de Bruyn

Twin pandemics:
Violence against women and HIV and AIDS

Baseline study on organisations in South Africa working on the interface between HIV and AIDS and violence against women

It has become urgent to build consensus amongst stakeholders on how deeply inter-related these two pandemics are and to decide on the most effective manner of addressing the interface between violence against women and HIV and AIDS, so that violence against women is ended and the spread of HIV is halted. One has only to see the proliferation of concern about the interface between violence against women (VAW) and HIV and AIDS globally to know that there is a powerful new focus in women's health and human rights. This includes the efforts of organisations, such as the Global AIDS Alliance, which recently added its voice to the growing list of those calling for more decisive action to address violence against women and children as a key risk factor for HIV infection.

> *…Women who have experienced violence may be up to three times more likely to acquire HIV, and women who are living with HIV have more lifetime experience of violence than those who are not…Unless a fully-funded comprehensive approach is taken, it will not be possible to address the twin epidemics of violence and HIV/AIDS.*[2]

The *Women Won't Wait* campaign Coalition, launched in March 2007 at the UN in New York, cited the failure of international agencies to address violence against women in HIV and AIDS programmes. An overview of the work of the various members of the Oxfam South Africa Country Group in the past couple of years likewise reveals a deepening concern with the interrelatedness of violence against women/gender-based violence (GBV) and the HIV and AIDS pandemics. Some practitioner organisations in South Africa have devoted a good deal of thought and expertise to the bi-directional impact of VAW/GBV and HIV and AIDS on each other. Knowing what the current state of correlation and understanding is between the stakeholders in both areas has the potential to provide a basis from which to jointly put time and energy into a mutually agreed direction.

Research Findings

Some quotable quotes from respondents

Donors should

> *…provide funding at grassroots level instead of funding these big organisations that are not even seen in the communities...I am sick and tired of these big organisations getting funding and instead of using it in communities to conduct capacity building, advocacy etc. they use the funds at five star hotels, five star meals, five star hire vehicles and are always preaching to the converted.*

> *The gap between research and activism is too big. Too many researchers write their papers to be presented at international conferences – they are not adding value on the ground.*

> *I have a very strong sense that we need to go deeper and recognize the complexities in the interface between HIV/AIDS and violence against women. We need to build the skills that enable people to do this, not have once-off campaigns.*

> *Women with many years of experience in the sector prevent the young, fresh voices from speaking.*

We don't think often enough about the vulnerability of women to HIV/AIDS and violence in access to housing and poverty generally. Women stay in a high risk situation because they don't have an alternative.

Some current campaigns, programmes and interventions focusing on the interface between VAW and HIV and AIDS in South Africa

NISAA Institute for Women's Development started mainstreaming HIV and AIDS into all its programmes from 2003. All staff were involved in the development of the organisational policy, as well as the Shelter Policy on HIV and AIDS. Nisaa includes HIV as an integrated topic in school or community-based presentations on gender-based violence prevention. Nisaa initiated the Red and White Ribbon Campaign in 2003, where it distributed ribbons and pamphlets and conducted talks on the link between HIV and AIDS and gender-based violence. Nisaa has consistently addressed issues of masculinity in its campaigns, ranging from the award winning '*You're only half a man if you rape a woman*', through the poster showing the smaller brain of the perpetrator of violence against women ('*Size matters*'); the 2005/2006 bus campaign describing abusive behaviour – '*Are You a Lover or an Abuser?*', and the recent '*Consent is Sexy*' poster series that reinforces gender equality and draws non-violent men into the response to gender-based violence – a watershed in South African VAW campaigns. Messages include *Real Men Respect Women; Abusive Speech is a Dangerous Weapon;* and *You Can't Beat a Woman.*

Gender Programme of the Community Law Centre (CLC), University of the Western Cape, has initiated a project designed to bring together a network of organisations in the Southern African region to exchange resources, including training materials on the interface between the two pandemics. The project arose out of awareness that various organisations were covering the same areas of the interface but staying in silos without the information being shared across the sector. The first step was starting a newsletter called *Imnyango* (meaning '*door*') with the first issue appearing in January 2007.

...the recent 'Consent is Sexy' poster series...reinforces gender equality and draws non-violent men into the response to gender-based violence...

KZN Intersect Coalition is an organisation linked to the International Intersect Coalition. The objective of the coalition is to '*link the GBV and HIV/AIDS sectors through common action with the aim of changing the social environment*.' It draws on the resources of established organisations in the sectors. Together with the AIDS Legal Network (ALN), the KZN Intersect Coalition facilitated eight four-day workshops on Gender Violence and HIV and AIDS in different regions of KZN – the *Gender Violence and HIV and AIDS resource and training manual*[3] was developed for use in the training. The publication has a holistic approach in response to the links between gender violence and HIV and AIDS, including a gendered look at prevention, treatment, support and care related to both pandemics.

Donor Network for Women (DNW), Gauteng, has focused on the interface through various roundtable meetings for some years, drawing role players together to discuss the links between the pandemics, including the 2003 Roundtable on HIV and the workplace; and the 2004 Roundtable on the OxfamGB model on the interface between HIV, poverty and violence against women.[4] There has been a consistent message of solidarity from the DNW in recent times conveying to all stakeholders in the GBV sector *'We are in this together'*.

Sonke Gender Justice (SGJ), including the **One Man**

Can campaign, has the mission to:

> *…build the capacity of the government, civil society organisations and citizens to achieve gender equality, prevent GBV and reduce the spread of HIV and the impact of AIDS.*

Following an evaluation SGJ adopted the '*write and do*' approach, where both research and activism are practiced and integrated with one another. SGJ emphasises that HIV and AIDS on farms are worsened by gender inequality and generally the two pandemics are integrated into its campaigns and its training workshops. Sonke Gender Justice has three programmes:

1. Next generation children and youth, including a youth learnership on gender and HIV and AIDS.
2. The One Man Can campaign, which targets faith communities, traditional/cultural groupings, and rural areas, tries to walk the tightrope of both holding government accountable and offering support to it, as and when its actions match the values of Sonke Gender Justice. It is grappling with defining – along with other organisations that focus on masculinity – what the shape should be of the most effective means of working with men on gender inequality issues.
3. Women's Health and Human Rights – SGJ believes that existing gender roles condone violence against women and give men the power to dictate the terms of sexual relationships. Dean Peacock argues that

   > *…this gender power imbalance makes it extremely difficult for women to protect themselves from either HIV or violence or to access critical health and education services.*

Gender Links (GL) – following the PEP campaign in 2003, and its support for the scaling-up of the integrated approach to Thuthuzela Centres for survivors of rape and abuse, and after an audit of commitments by civil society – took a decision to move from campaigns to concrete outputs that could be measured, and hence, the National Action Plan. Gender Links has been at the forefront, together with government and, in particular, the Sexual Offences and Community Affairs (SOCA) Unit of the National Prosecuting Authorities (NPA), in developing a detailed, measurable National Action Plan (NAP) to end gender violence. The 63 page NAP was launched on 8 March 2007 following the efforts of a task team that came into being after the 365 Days of Action to End Gender Violence Conference in May 2006 at which the Kopanong Declaration was adopted. Through a GL initiative, 218 media houses in the region have thus far adopted policies committing to being sensitive to the direct links between HIV and AIDS and violence against women.

Gender Links has been at the forefront, together with government ... in developing a detailed, measurable National Action Plan (NAP) to end gender violence.

As the HIV and AIDS pandemic grew, **Masimanyane Centre for Women's Leadership,** based in the Eastern Cape, broadened its services to respond to this, including prevention of both violence against women and HIV and AIDS through programmes on masculinity and work in communities and schools. It re-thought its strategy and decided to focus primarily on advocacy and strengthening its alliance partnerships. It works closely with the Gender Aids Forum, and the Reproductive Rights Alliance amongst others. Masimanyane extends its services deep into rural areas. Masimanyane's three current priority areas, within a knowledge-based approach, are gender-based violence; sexual and reproductive health rights; and the gendered nature of the HIV and AIDS epidemics.

Following a **Treatment Action Campaign (TAC)** workshop on re-evaluating the position of women in TAC, the Women's Reference Group was initiated at

a TAC national congress to give a gendered profile to HIV; to move away from a patriarchal way of running TAC; and to draw attention to the interface between HIV and violence against women. Women from outside TAC were drawn in to assist with training, such as the Gender Aids Forum, POWA, and the Western Cape Network on Violence against Women. Phase One of the effort to engender TAC comprised a political and personal focus on what was being faced by individual women. Phase Two looked more widely at women and HIV and violence against women, with TAC members interviewing women in different provinces – Limpopo, Mpumalanga, Gauteng, the Western Cape, Eastern Cape and KZN. Stories from women were listened to and recorded – some are featured on the TAC website. Phase Three was a campaign on access to justice and health services. TAC officials went back to the provinces and mobilised women, taking them to clinics, to the police stations and to courts. Inadequate conditions were highlighted and better services demanded to reduce women's vulnerability. Equally, demands were made to police to find '*disappeared*' documents and to arrest alleged rapists, who the police had been '*unable to locate*'. Court dates were set and women accompanied to court and referred for counselling. Women came forward to report rape and sexual abuses that they had previously been silent about.

...TAC officials went back to the provinces and mobilised women, taking them to clinics, to the police stations and to courts...

POWA has chosen to go in the direction of sector strengthening by not opening further offices, but by assisting women's groups and CBOs in local and rural areas to develop response services defined by the needs of the particular community. Emphasis is on women's rights and access to their rights. The principle underlying this is to create strong voices for women, who can articulate what the needs or issues are in their own area. A response is designed around these needs whether it is for training or for mentoring and in the process POWA is learning much about rural challenges and about advocacy. POWA sees itself as committed to activism that it can own and as a vehicle to hold government accountable. POWA has strongly articulated the need for activism to be combined with spaces for reflection and thinking.

...POWA sees itself as committed to activism that it can own and as a vehicle to hold government accountable...

POWA was one of the key organisations that initiated the One in Nine campaign during the Zuma Rape Trial, One in Nine depicting the number of women raped who actually report the rape. The campaign decided to focus first on violence against women and then on HIV, and at different times in the trial chose to focus on one or the other. Another outcome from the Zuma Trial was that POWA and the Women's Reference Group in TAC contributed to each other and moved in the same direction. POWA now operates with four foci: direct action; research; law reform; media work. The One in Nine campaign is fairly unique in that it is an advocacy campaign that harnesses people; no one is excluded; it is consciousness raising; it is explicitly feminist; it has school chapters; and women take ownership of the space afforded by the campaign.

Tshwaranang Legal Advocacy Centre (TLAC) together with the **Centre for the Study of Violence and Reconciliation (CSVR)** hosted a conference on the interface on HIV and gender violence in April 2006 for a wide spectrum of role players.[5]

TLAC runs a project with the Aids Consortium where care workers are trained on HIV and violence

against women, as well as having done legal work on the Sexual Offences Bill and the compulsory HIV testing of alleged rapists. The national working group on the Sexual Offences Bill, that has functioned over four years, is seen as a successful model of collaboration in the two sectors; as they draw in fairly wide participation, have a clear focus and a measurable set of tasks. This group will be monitoring the implementation of the Sexual Offences Act.

...any new campaign would need to address the issue of taking personal responsibility, rather than an attitude that 'the government must provide'...

The Gender Programme at the CSVR is planning to do training in the health sector with a focus on value systems, i.e. how women and men live their sexuality. Poor black women tend to have been the focus in HIV and AIDS campaigns, whereas a lot of the newly infected women are from the emerging middle class. There is a lot of denial around this, with a failure to take responsibility for the consequences of one's own behaviour. Any new campaign would need to address the issue of taking personal responsibility, rather than an attitude that '*the government must provide*'. Campaigns also need to target men in a way that engages them. With VAW/GBV too, it is important that there be an acceptance that this occurs across all classes and groups.

The **National VAW Helpline** operated by **Lifeline** was originally initiated by the National Network on Violence Against Women, with support from the Departments of Justice and Social Development. Currently, the salaries of the fourteen counsellors on this Helpline are supported by Telkom, Gauteng Department of Social Development, the Department of Public Enterprises and SASOL.

The **AIDS Helpline** is operated on behalf of the Department of Health. Counsellors on both helplines are trained in both HIV and violence against women, and refer to the other, when elements of either abuse or HIV are mentioned. Materials from Nisaa's red and white ribbon campaign are distributed to clients who phone in, and also to communities where awareness work on the interface between HIV and violence against women is done – this is decentralised through the 17 Lifeline offices around South Africa.

Lifeline ran a pilot project in 2006 in the Northern Cape and Mpumalanga on a three phased campaign combining GBV, suicide/depression and HIV. The first phase was counselling of people in any of the three categories; the second phase was peer education on all three issues; and the third was support groups encompassing the three. An evaluation was done on the pilot project resulting in a very positive report of how the three phase campaign had helped people and resulted in behaviour change. Lifeline aims to replicate the project in other areas as funds become available.

...a perhaps unexpected side-effect was that magistrates from Benoni and Ubombo (KZN) independently arranged education in their churches on the interface between HIV and GBV and the role that religion has played in subordinating women...

In 2004, the **Law, Race and Gender Unit (LRG),** University of Cape Town, developed a two-pronged programme on the intersectionality of HIV and AIDS and GBV, and how this impacted on the decisions magistrates made in dealing with people affected by HIV and AIDS in the context of gender-based violence, bail and sentencing. Magistrates came to understand the links between GBV and HIV and AIDS when violations of protection orders

occur, for example, and kept records to identify this. A perhaps unexpected side-effect was that magistrates from Benoni and Ubombo (KZN) independently arranged education in their churches on the interface between HIV and GBV and the role that religion has played in subordinating women.

Thohoyandou Victim Empowerment Project (TVEP), Limpopo, integrated HIV and AIDS into its gender programme two years ago – it offers a 24-hour service to rape survivors at two hospitals and arranges voluntary testing for HIV and access to PEP, in addition to the rape counselling and support to the survivor, through all the stages of the police investigation. TVEP monitors the ARV medication where indicated. The empowerment side of its activities includes workshops and awareness on the interface between the two pandemics.

...because of its involvement with the workplace, COSATU Gender Desk's major focus is on sexual harassment...

Congress of South African Trade Unions (COSATU) has a national desk for gender and a national desk for HIV and AIDS. Because of its involvement with the workplace, COSATU Gender Desk's major focus is on sexual harassment – during the 16 Days of Activism however, COSATU devotes a day to the interface between HIV and violence against women.

In June 2007, **Actionaid South Africa** called a meeting of a few stakeholders to discuss whether to introduce the *Women Won't Wait* campaign into South Africa. Actionaid's stance is that '*men's violence against women is one of the critical stumbling blocks in developing effective prevention strategies for HIV/AIDS*'. Unequal peer relations are seen as the structural hub of the problem with one of the objectives of the campaign being:

…To reduce women's vulnerability to HIV/AIDS by promoting their right to information, protection from violence, power to negotiate safe sex, freedom from stigma and discrimination, and decrease in the burden of care.

...Oxfam Australia in South Africa has produced a well regarded series of booklets on HIV and AIDS and gender-based violence...

The campaign has a multi-level approach focusing on one level on the social, political, and community norms, state policy, media and public discourse; on another level on the interpersonal relations in the family, amongst peers and at work; on a third level the focus is on the individual – personal knowledge, attitudes, perception of risks, and motivation to change.

Oxfam Australia in South Africa has produced a well regarded series of booklets on HIV and AIDS and gender-based violence. These publications are in case study form and beautifully presented. It has, like other parties in the Oxfam family in South Africa, been active in supporting JOHAP.

Oxfam NOVIB has provided valuable support to practitioner organisations in the GBV field in South Africa over a good number of years. It has also initiated thorough research into gender-based violence in South Africa and Southern Africa in recent years. Oxfam NOVIB has consciously moved towards a stance of supporting advocacy and transformation approaches to the issue and has strongly encouraged beneficiaries to integrate the two pandemics into their programmes.

Oxfam Canada has provided breakaway opportunities for South African partners to reflect on the interface between the two pandemics and to plan strategically in response to the challenges identified. They have also funded work on the interface, such as Nisaa's Red and White Ribbon Campaign.

Over and above its investment in the current research, **Oxfam GB** has for several years provided leadership and support in facilitating awareness amongst its stakeholders of the interface between the two pandemics.

Themes emerging from interviews with stakeholders

This section seeks to bring together the reflections of seasoned practitioners in the violence against women and HIV and AIDS fields, and to group the ideas and opinions they have raised into themes, which will lead to further reflection by a larger group of stakeholders. This section is separate from the brief descriptions of organisations above and is drawn from the content of interviews conducted by the researcher.

...without exception collaboration takes place, either formally or informally, both within and across the two pandemics...

Theme 1 – Take the work to the local level

There is a growing belief that the most effective approach to making an impact on the interface between the two pandemics is to work at the local or community level, with whoever is there, be it on farms, small enterprise empowerment schemes, rural areas where tradition holds sway, township courts or clinics. Thusanang Women's Centre in QwaQwa, Limpopo, was cited by a number of respondents as being an inspirational model of this. Work with groups of people over a period of time is favoured.

Theme 2 – Work through partnerships and networks

Respondents emphasised that more can be achieved together than alone. Without exception collaboration takes place, either formally or informally, both within and across the two pandemics. This is a dramatic development after the territorialism evident in the past. Either existing networks are utilised or new ones created.

Theme 3 – Doubt amongst respondents that campaigns and programmes in the sectors have had the intended impact in the past

The lack of intended impact is in part attributed to a lack of understanding of how to reach the consciousness of individuals and communities at grassroots levels. There is concern for example that much research in South Africa appears to be designed for presentation at international conferences, with no ongoing link between the researchers and the communities, or even a deep understanding of the communities by the researchers. In addition – because there are so many different campaigns and programmes – mixed messages are going out to communities at all levels. The sectors are not working coherently together to give one simple message that takes into account the very complex behaviours of human beings – e.g. the 'ABC' message is viewed as unrelated to the reality of many people living in South Africa. In addition, an issue was raised that there is sometimes an idealisation of the victim/survivor with not enough emphasis on her own responsibility for her behaviour.

...there is concern for example that much research in South Africa appears to be designed for presentation at international conferences, with no ongoing link between the researchers and the communities...

Comments on the 16 Days of Activism campaign varied with some respondents viewing it as having been '*hijacked*' by government, which does not embed its tenets into every day values, budgets and practices, for instance within the courts and health system. The 16 Days campaign is seen

by some as little more than a list of high profile events (sometimes outsourced to expensive agencies) to tick off on a planning schedule as they happen. Some thought the 16 Days had lost the sharpness of its impact by becoming a 365 Days campaign. Others were more enthusiastic about the campaign and use the 16 Days to focus on particular activities, such as launches of programmes or publications.

In the focus group, the point was made strongly that civil society should be thinking ahead and be proactive in leading government in the right directions, while simultaneously holding government accountable.

Theme Four – In depth solutions are needed rather than once-off mass campaigns

A significant number of interviewees argued that what was needed to be effective in stemming the tide of both violence against women and HIV and AIDS was intense long-term attention to process, not events. Building women's self confidence and economic skills for example, would enable women to make changes in their own situations. Organisations in the two sectors needed to be working with small groups of people over a longer period of time, so that people experiencing violence, and infected or affected by HIV and AIDS, could make their own internal changes.

...Masimanyane brought a group of twenty women living with AIDS together from all over South Africa and simply asked 'What is it like to live with AIDS?'...

It was also felt that awareness campaigns do not address the individual change that needs to take place. This individual change in itself is very complex, in that so many South Africans come from dysfunctional families and communities. This has to be addressed on a deep, individual level – e.g. Masimanyane brought a group of twenty women living with AIDS together from all over South Africa and simply asked 'What is it like to live with AIDS?' This simple approach resulted in a wealth of information and also revealed what enormous problems there are with disclosure, for example, and how little accurate information there is around HIV and AIDS. One woman, who had been an AIDS activist for eleven years, did not know that she needed an annual PAP smear. Respondents generally report limited knowledge about PEP (post exposure prophylaxis) as well.

...the support for Zuma ... as well as the introduction of the role of tradition in the trial brought home what a long way there is still to go in changing attitudes and beliefs ... in South Africa...

Theme Five – The Zuma Rape Trial in 2006 was a catalyst for a number of organisations to re-think what impact they were having

Some organisations changed direction during or after the Zuma rape trial, moving to a greater emphasis on advocacy and/or on networking with other bodies. This trial brought the interface between violence against women and HIV and AIDS to the fore – it proved to be a watershed event for both the gender and HIV and AIDS sectors of civil society in that it gave them a common agenda and the challenge to work together was presented in the face of harassment of, and threats to, the complainant to the extent that she has had to go into exile outside of South Africa. The support for Zuma by many women that was captured on television outside the court, as well as the introduction of the role of tradition in the trial brought home what a long way there is still to go in changing attitudes and

beliefs in gender power relations in South Africa. Gender activists too were endangered and openly threatened in public during the course of the trial.

Theme Six – The sector needs complementarity, rather than competition

A number of respondents spoke of the antagonism between various role players within the sector and the lack of generosity of spirit towards one another's achievements. This Jungian '*shadow*' of repressed envy and abuse of one another in the human rights sector is distressing and destructive, leading to burnout on the individual level and loss of valuable people from the sector, and the collapse of unified coherent planning in the bigger picture. Space for different niches and priorities needs to be accepted and time committed to surfacing issues and/or debriefing staff and activists who work in the two pandemics.

Theme Seven – Ways need to be found for faith-based communities to play a far greater role in the twin pandemics than they currently do

Colin Collett van Rooyen (Oxfam Australia) sees the role that faith-based organisations (FBOs) can play in the twin pandemics as hugely underutilized. Sonke Gender Justice is one organisation that directs itself specifically to religious leaders, giving practical guidelines on what religious leaders can do to be more active in ending violence against women and children. It also gives explicit *'Do's'* and *'Dont's'* to religious leaders on how to respond to domestic violence both with the survivor and the abusive partner, both of whom may of course be in the same congregation.

Theme Eight – The role of men in addressing the pandemics and their interface

There is virtually no one in the sectors, who believes men can be excluded from addressing the interface between the pandemics. As stated by one of the players, who has been deeply involved in the combined Oxfam's JOHAP project conducting workshops and mentoring CBOs in KZN over a six month period:

> *…There needed to be men at the centre in these rural areas, men who fostered overt communication about gender and about sex. It is blindingly obvious that any work around HIV has to reach and involve men. We have to draw men in and appeal to their needs.*

However, at least one respondent pointed out some of the dangers inherent in involving men, including the destructive messages about violence against women given by some men in the men's movement, and the way some men could overtake women by becoming the '*experts*' on violence against women in rural areas – thus perpetuating oppression of women. Sonke Gender Justice has developed extensive tools to assist men in countering violence against women and in stemming HIV. These include specialised approaches to sports coaches and to '*traditional*' men.

...there is virtually no one... who believes men can be excluded from addressing the interface between the pandemics...

Well regarded and comprehensive perpetrator programmes are run by Childline (for youth and adult perpetrators) and by Masisukumeni Women's Crisis Centre in Gauteng. The Childline treatment programme is team-based, and multi modal in that it includes a combination of individual, family and group therapy, and integrates a number of theoretical approaches including psycho-dynamic, behavioural, rational-emotive and family theories and methods of intervention. The core approach is a humanistic client-centred one. The programme is long term, usually a minimum period of two years, which may be extended. NICRO, which has functioned in South Africa since 1908, has developed a programme aimed at reducing the incidence and breaking the cycle of intimate partner

violence. The programme aims to

> *…hold perpetrators systematically accountable as well as to optimise intervention and support for women and children and to understand the structural causes of violence rooted deeply in the fabric of South Africa society.*

NICRO strives to ensure better access for people seeking help and to reach those target groups of women and children, who up to now have not been reached by any support programme.

The alternative to involving men is that the denial continues – this manifests in not testing, not treating, not supporting, and in blaming women. As things stand, men on the whole seem not able to use the considerable resources that exist – how to place this access to information and treatment within their reach, so that it is seen as a benefit and not a loss, appears to be the key '*breakthrough*' that is needed.

...a number of respondents suggested that Oxfam GB could play a very positive role by bringing government and civil society organisations ... together to listen to one another non-defensively in an independent forum...

Theme Nine – The relationship between government and civil society needs to be examined

One of the biggest challenges currently being experienced by civil society is how to work with government, and how to share existing resources, taking into account the complexities related to a collegial versus adversarial role. The response of the state is often on the level of criminal justice, believing that if the law is fixed, the problem will be solved. Thinking in parts of civil society has shifted to the role of housing and economic empowerment of women in ending violence against women. An unequal, uncritical partnership between government and civil society is unacceptable to many organisations, and yet, there is so much overlapping territory between government and civil society that needs to be navigated in an attitude of respect for, and acceptance of, each other's roles and contributions. Frustration is high in organisations that receive funding from government – e.g. funding that should have been made available early in the financial year (from April on) is only paid towards the end of the calendar year and yet, the NGO is expected to have provided the services for the whole financial year and to report on the year's activities by March of the current year. Experiences like these result in civil society doubting government's technical abilities in a donor role. A number of respondents suggested that Oxfam GB could play a very positive role by bringing government and civil society organisations in the HIV and AIDS and violence against women sector together to listen to one another non-defensively in an independent forum. Apart from increased understanding of one another's motives and roles, there might be an outcome of smoother interaction and more effective delivery/impact in the communities both are seeking to serve.

Gaps in the Interface between the two pandemics as expressed by respondents

The following gaps were identified by persons interviewed:

1. The gap between policy setting and activism on the ground is too big – it was pointed out for example that the recent appointments to the South African National AIDS Council show virtually no grassroots representation.
2. There is a gap between available information and its implementation in communities – reflected in researchers being on the whole detached from communities; reflected also in a lack of analysis through monitoring and evaluation more especially in the HIV and AIDS sector.

3. There is a perceived gap between what the government says and what it does – interpreted as a lack of political will to respond seriously to the two pandemics. The point was made by two major organisations for example that if government meant what it said, it would long since have implemented the Shelter Policy it developed. Instead NGOs are left to '*carry the can*' with negligible and/or erratic funding, often late in arriving. The three years that it took to get the Rape Law Reform through parliament was also quoted as evidence of the lack of political will to speedily address issues affecting vulnerable women in South Africa.

...there is a perceived gap between what the government says and what it does – interpreted as a lack of political will to respond seriously to the two pandemics...

4. A further massive gap is the inconsistency in Health Care Units' approach to policy and delivery around HIV and AIDS in different provinces, as well as access to their services. This confuses the public and creates very different standards of service in different areas.
5. It was mentioned that far higher quality standards in the training offered in communities and workshops is required, with both government and civil society being at fault here. Content is lacking; training is often too brief with no testing of the trainee's competence some period after the training or any ongoing monitoring of their work provided; a lot of training is a-contextual and not taking into account the environment that the trainees work in.
6. Women's health has been reduced to HIV and AIDS – civil society needs to build a strong movement on women's access to health care in a wider sense.
7. The NGO sector is often not critical enough of itself. This is evidenced by how few NGOs have independent evaluations of their work against established benchmarks. It is noteworthy that marked changes in direction for a number of NGOs were the consequence either of external evaluations or time set aside by the organisation to reflect internally on the impact of its activities. A further challenge made to NGOs was to assess the degree to which the internal workings of the organisation are engendered and empowering towards its own staff and volunteers.

The full report includes further findings on the role of donors, reflective questions, a media scan and a bibliography.[6]

FOOTNOTES:

1. This article is an abbreviated version of a baseline study conducted under the auspices of NISAA Institute for Women's Development for Oxfam GB in 2007.
2. Imnyango, Vol.1, No.2, p1.
3. To obtain a copy of the publication, please contact the AIDS Legal Network on admin@aln.org.za.
4. Reports on the meetings are available on the Women'snet website [www.womensnet.org.za].
5. A comprehensive 53 page report on the papers presented and of the discussion that took place called *Developing Strategies around HIV/AIDS and GBV* is available on the CSVR website [www.csvr.org.za]
6. To obtain a copy of the report, please contact the Oxfam GB office in Johannesburg on +27 11 642 9283. – Disclaimer: The contents of the report are intended as a contribution to the debate and should not be taken as representing the official positions of the organisations involved (Oxfam GB and NISAA), nor do they necessarily reflect the views of either organisation. The contents may be used for non-profit purposes provided the source is acknowledged.

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ALQ | March 2008

Larissa Klazinga, Dawn Cavanagh, Carrie Shelver

Kae kapa kae (survivor) rona renale wena…

We are with the survivor – The One in Nine Campaign

The situation of women and girls in Southern Africa is such that every single aspect of our lives is powerfully impacted on by patriarchy so that our well-being – emotional, social and economic – is now extended to the physical, where women's bodies are becoming the *'site of struggle'*.

Women's Bodies as a 'Site of Struggle'

Both HIV and AIDS and violence against women impact on all of these aspects of women's lives, and both of these epidemics are leading to physical illness, disablement and death.

The roots of these impacts lie in the social fabric of society and within patriarchy, in particular. Both HIV and AIDS and violence against women are clearly sites of power and struggle that provide us with spaces to organise ourselves to resist the way that women and girls are kept in situations and contexts, which are undignified, unequal and fundamentally oppressed. The absence of women's autonomy is central to this situation.

The Medical Research Council (MRC) study on sexual violence[1] indicated that only one out of every nine rape survivors report the attack to the police. This statistic prompted the name: '*One In Nine*'. Furthermore, statistics indicate that of the cases that do reach the courts, less than 5 % of the rapists are convicted. This highlights the serious need for reform of the legal system and for transforming the institutional framework for responding to women, who speak out.

Rape survivors have described their experiences of the criminal justice system as being like a '*second rape*'. At every stage in the system, rape survivors are forced to confront long delays, administrative problems, negative and stereotyped attitudes, under-resourced, and shortages in skills, government departments and ultimately low conviction rates in rape cases.

The experiences inside the court continue to mirror rape survivors' experiences outside the court, where survivors confront '*victim-blaming*', '*secondary victimisation*' and social stigma when they speak out about the violence they have experienced. Supporting survivors is essential to ensure that they are able to speak out in safety, and

to decrease the impact of '*secondary victimisation*' and '*victim-blaming*' they are likely to experience when they do speak out.

One in Nine Campaign – Solidarity with Women Who Speak Out

It was in response to the problems experienced by rape survivors when reporting rape that the *One in Nine* Campaign was formed. The Campaign was first launched by five organisations, in February 2006 during the Zuma rape trial, in order to demonstrate public support for Khwezi (the complainant in the case), and has since grown to a coalition of more than 26 organisations. The Campaign has a diverse membership, consisting of organisations and institutions involved in HIV and AIDS, violence against women, women's rights, human rights, lesbian, gay and bisexual activism, and even academic institutions and legal research groups.

...the Medical Research Council (MRC) study on sexual violence indicated that only one out of every nine rape survivors report the attack to the police...

The *One in Nine Campaign*, through the various partner organisations, seeks to ensure that women can live autonomous lives. This involves strengthening women's ability to access, and have control over, resources, wealth and to exercise freely the right to have control over our own bodies. Decision-making is a central part of the process of building autonomy. Women's lack of autonomy leads to vulnerability to infection with HIV and STIs and also to violence against women. The relationship between violence against women and HIV and AIDS is now well established. The systems and mechanisms in society that sustain the lack of autonomy of women include religion, culture, the law and other institutions, such as the family and marriage.

The Campaign membership is bound by the following principles:

The campaign shall be driven and sustained by women's leadership

Women's leadership aims to create equal power relations within the campaign, through good and democratic governance practices, based on feminist principles of shared leadership and joint decision-making. The *One in Nine* Campaign is part of the global women's movement and as such, a vehicle for building women's leadership by providing a platform for women's voices to be heard and for women activists to gain leadership experience.

The ideological premise for all campaign actions and governance shall be feminism

The *One in Nine* Campaign's ideological stance reflects the basic tenet of feminism that the personal is political. Recognising this fundamental truth, the campaign acknowledges that in order to eradicate sexual violence against women, it must actively act against all forms of oppression, including, but not limited to, racism and classism, as all of these impact on women's access to equality and justice.

Campaign actions will be informed by recognition of the intersectionality of various forms of oppression

The Campaign recognises that manifold forms of oppression, including, but not limited to, sexism, racism, classism and homophobia, converge to deny women access to equality and justice. The campaign will incorporate this consciousness into its policy and practice, such that it will shape the manner in which we understand and respond to sexual violence against women.

Rape is gendered

The Campaign asserts that rape is a fundamentally

gendered act and disproportionately affects women and girl children.

Men can be campaign allies, but not campaign leaders

The Campaign can be assisted by men and men's organisations, but MUST be lead by the intentions of women and must reflect our plans and objectives.

Transparency and accountability are key values of the campaign

The Campaign is committed to maximising transparency, through sound communication and good governance based on consultation. The campaign will be accountable to all campaign partners; and to survivors of rape and sexual violence.

Survivors are our priority and will shape all campaign responses

The voices of survivors of sexual violence must inform all campaign activities and must be the central concern of all campaign actions. The Campaign must create an environment, where true agency is possible, and which acknowledges that the needs of individual survivors must be paramount.

Campaign Mission

The Campaign has defined its mission as working to ensure that the issue of women's sexual rights is addressed through building solidarity, research, engagement with the media, legal transformation and direct action.

Since its inception, the Campaign has engaged in intensive monitoring, advocacy and direct action on rape cases, including:

Khwezi

The complainant is an HIV infected woman, who reported that she had been raped by Jacob Zuma at his Johannesburg home in 2005. The '*not guilty*' judgment was handed down in May 2006.

Buyisiwe

The survivor reported that she was gang-raped by eight men in Thembisa, Gauteng, in October 2005. The Campaign became aware of Buyisiwe's case when she approached POWA for assistance, at the time when her case was struck off the court roll. We successfully lobbied to have her case reinstated on the court roll and we are currently monitoring court proceedings, which are on-going.

Christina and Hola

Two women, aged 38 and 76 respectively were brutally gang raped, tortured and murdered in Egazini, near Grahamstown. Three youths were arrested but were never charged with the murder, despite Hola identifying one of them before she died from burns sustained during the attack.

Successes

By focussing on these five key areas of activism, the Campaign has, over the course of the past two years, achieved the following:

- Provided media commentary and engaged in advocacy around Mike Tyson's visit to South Africa in 2008, contributed to Zuma not sharing the stage with Tyson
- Held protests, national days of solidarity and marches during 16 Days of Activism, National and International Women's Day
- Developed the 16 Demands, a set of demands for an improved criminal justice system for women rape survivors
- Developed a sexual rights activists package
- Developed a guide to organising for women's rights in South Africa
- Developed, in conjunction with member organisations, a drama production for the National Arts Festival

The initial impact of the Campaign's activism and advocacy has been:

- Successful mobilisation of individuals and organisations in civil society around the women and the three cases themselves
- Informed an increasingly sensitive mass media able to engage with the issues of speaking out; reflecting the positions and perspectives of the Campaign and women who speak out against rape and sexual violence
- Deepening the level of debate on the issue of rape and sexual violence
- Bringing together the women's movement, the gender-based violence/violence against women sector and the AIDS sector. This has been difficult in the past and there have been many '*false starts*'
- Deepened the level of analysis and understanding of the links between violence against women and HIV/AIDS
- Deepened democracy, particularly in relation to the role of civil society in holding leaders accountable, and articulating this in the face of blind loyalty by followers and supporters of charismatic leaders in particular

The *One in Nine* Campaign is, by definition, a feminist movement, subject to ongoing opposition from patriarchal hegemony, much like all other national and international feminist organisations. Building solidarity, while working to act against the manifestations of patriarchy inherent in institutions, like the South African legal system and traditional religion, poses an ongoing challenge. This challenge can only be overcome by continuing to build partnerships based on the recognition of the intersectionality of oppression.

FOOTNOTES:

1. Medical Research Council. [www.mrc.ac.za]
2. For more information please contact *intern@powa.co.za.*

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Stand Up Against Sexual Violence – Join the One in Nine Campaign

Individuals and organisations can show support for rape survivors and the campaign by:

- Joining the Campaign – find out about membership criteria and how to join[2]
- Starting a local chapter of the ***One in Nine*** Campaign and engage in direct action and advocacy around rape cases in your area
- Finding out about ***One in Nine*** Campaign rape cases in your province and support actions organised around them
- Discussing and sharing information on cases and sexual violence generally
- Getting informed and inform others about sexual rights and our responsibility in confronting the crisis of sexual violence in this country
- Adding your voice to call for the implementation of the 16 Demands

Gahsiena van der Schaff

Prevention is not a one party thing...

Provincial strategies for exploring the opprtunities and challenges of the NSP

The second round of provincial networking meetings facilitated by the AIDS Legal Network (ALN) in 2007, focused on the HIV and AIDS & STI National Strategic Plan, 2007 – 2011, (NSP), explored opportunities and challenges of the NSP, critically engaged with the analytical framework of the NSP, as well as assessed the potential of the NSP as an *'advocacy tool'.*

The purpose of the meetings was to collectively identify possible advocacy strategies to further the adequate and effective implementation of the national strategic plan for HIV and AIDS.

Meetings were conducted in the Northwest Province (01 November 2007), Northern Cape (08 November 2007), Mpumalanga (15 November 2007), KwaZulu Natal (16 November 2007), Eastern Cape (20 November 2007), Limpopo (21 November 2007), Western Cape (22 November 2007) and Free State (05 December 2007).

The NSP recognises the need for everyone's involvement in the implementation process of the identified interventions, programmes and targets. However, one of the common challenges raised in all the meetings was the lack of knowledge of what is contained in the NSP, as well as lack of access to the NSP. Another common challenge highlighted in the meetings was a lack of knowledge and involvement in discussions around the NSP on a provincial and local level. In addition, concerns were raised about the level of civil society's involvement in local AIDS councils – with several participants unaware of the existence of this structure. In summary, partners felt largely excluded from the various processes surrounding the new national strategic plan.

For anyone to benefit from interventions and programmes, to participate in the implementation, and thus, to contribute to achieving the goals, it is essential to be knowledgeable of the contents of the NSP. Enhanced levels of awareness/knowledge of the NSP would, arguably, result in civil society organisations, based in communities, participating, benefiting, and taking ownership – and more importantly taking responsibility for reaching the aims of the National Strategic Plan. In turn, civil society could inform the community about the benefits of participating in the implementation processes of the NSP.

Constitutional imperatives versus reality

The NSP is as much an ambitious, as it is an impressive plan[1]. Like the Constitution[2], the National Strategic Plan is grounded in human rights principles, and

> *...the principles guiding the implementation of the envisaged interventions, programmes and targets based on the imperatives of the Constitution.* [NSP, p59]

The referred to constitutional '*imperatives*' include guarantees of the right to equality, enjoyment of all rights and freedoms, non-discrimination, freedom and security of the person, including the right to be free from all forms of violence and to bodily integrity; access to information, and to healthcare services – irrespective of a person's sex, gender, age, pregnancy, sexual orientation and/or HIV status.

However, the reality mostly seems to indicate, dictate and promote '*coercion*', rather than freedom of choice, respect for dignity, and bodily autonomy – as societal norms, beliefs, and values, and not individual rights and

freedoms, largely inform HIV and AIDS programmes, services and interventions. Similar to constitutional provisions, as well as the legal and policy framework, many who stand to benefit from these programmes and interventions, are either excluded from, or '*targeted*' and/or '*coerced*' to participate in HIV programmes and interventions. While the constitutional and legal framework is intended to protect users from violations, and provide avenues for recourse, its impact remains limited amongst '*users*' and civil society at large, due to a general lack of knowledge and understanding of laws, as well as how to access available legislative provisions.

...the NSP is as much an ambitious, as it is an impressive plan. Like the Constitution, the National Strategic Plan is grounded in human rights principles...

In reality, societal value, beliefs and norms inform decisions as to who is in the position to enjoy rights and freedoms, as well as when and for how long it is enjoyed. Many women, for example, because of pregnancy, have their right to make reproductive decisions and/or decisions about HIV testing limited and violated, or both. In some instances, people are '*coerced*' into testing for HIV in order to access other healthcare and treatment services.

Condoms

The lack of available femidoms remains a bone of contention, particularly in rural areas. If female condoms are available, they are often inaccessible to women. Whilst, for example, male condoms are available at the front desk at clinics, female condoms are only accessible from a dedicated person, after a '*lecture*' from this person.

Yet another issue centred on the issuing of male condoms to women who test positive for HIV. Besides the inappropriateness of issuing male, as opposed to female condoms, participants felt that the burden is placed on women to initiate condom use – an issue many women feel uncomfortable with.

Discussions around issuing condoms to young people and challenges around this followed. After heated debates, the common agreement was that in the end it is the right to have access to these and other prevention tools, which needs prioritising, irrespective of a person's beliefs, culture and religious and societal persuasion.

Men's involvement

Discussions around the gender bias of the pandemic resulted in heated and at times controversial debates. Men are notoriously absent from programmes, participation in prevention and HIV testing, and like one participant said: '*Prevention is not a one party thing*'. However, the challenge remains as to how to get men involved and not to remain the person, who makes decisions around sex – compromising women's bodily integrity – and at the same time getting women, who are informed '*not to listen to their men*'.

...whilst, for example, male condoms are available at the front desk at clinics, female condoms are only accessible from a dedicated person, after a 'lecture' *from this person...*

Groups felt that chiefs and community leaders must be included in the plans of how to get communities, women and men, to equally participate, benefit and take responsibility for HIV prevention, treatment, care and support. Equally, healthcare providers should be approached to increase efforts to include men into programmes and awareness, instead of '*just making women their target*'.

A concerted effort must be made to make services more '*men-friendly*'.

...healthcare providers should be approached to increase efforts to include men into programmes and awareness, instead of 'just making women their target'

Young people

Discussions also highlighted that programmes focussing on young people should include increasing access to condoms, to reduce unprotected sex and teenage pregnancy. A challenge raised was the lack of '*sex talk*' amongst parents and children. Youth organisations, for example, pointed out that raising awareness amongst young people does not work, if parents do not support and/or respect the choices that children make. Much family conferencing should be encouraged, so as to facilitate open '*sex talks*' between parents and children.

HIV Prevention

Like the Constitution, the implementation of the NSP happens in a gendered societal context, which is acknowledged in the policy document, yet for the bigger part ignored. For example, the 'ABC' message that remains the key prevention message is known to fail in a gendered society, which is very much prevalent in all sectors of society. Participation in this message is gender biased, since women, due to societal perception of lower status, are the ones more likely to participate in the 'ABC', whilst men are more likely not to participate. Needless to say, the potential benefit of this prevention message is minimal, as long as only one partner participates and the other not.

Secondly, the prescriptive and value-based nature of this message is contrary to the fundamental right to make informed choices for one's body.

Thirdly, women are blamed for not being faithful or for not abstaining, whilst more often than not the male partners are the ones, who are involved in concurrent sexual relationships.

And lastly, expecting people to abstain and be faithful also results in minimal provision of prevention tools, such as female and male condoms, necessary to minimise the risk of HIV transmission.

Challenges of partners

Partners raised numerous challenges during the provincial meeting. Some of the recurring challenges across provinces include:

- Home-based carers complained about lack of trust in NGOs and carers, due to fear of unlawful HIV disclosure, even to the extent that treatment services are refused.

...women are blamed for not being faithful or for not abstaining, whilst more often than not the male partners are the ones, who are involved in concurrent sexual relationships...

- Conduct of many healthcare providers is contrary to constitutional imperatives and Batho Pele principles – yet these attitudes prevail largely unchallenged, and attitudes of healthcare providers remain discriminatory, judgemental and prejudicial
- Lack of involvement of men's forums in reducing stigma and discrimination, promoting gender equality and reducing gender violence
- Lack of condoms for males/young people and almost

non-existence of female condoms – and if condoms are available, the lack of accessibility of condoms for particularly young people and women

...response will be severely limited if communities and civil society are not informed that everyone has to participate...

- Lack of quality/appropriate services
- A common challenge among partners is the lack of knowledge of the NSP – resulting in non-involvement, and exclusion from NSP implementation processes
- Lack of funding and or support from the local aids council, local municipalities and government in general, and lack of sponsorships

Identified strategies

Part of the meeting was spent on identifying potential strategies of how to address and respond to the challenges facing various stakeholders at a provincial level. These strategies include:

- Working through chiefs, community leaders and councillors – as men are more likely to show an interest and/or listen, if the leaders/chiefs speak about sex and HIV
- Invite members from municipalities/government, chiefs to join the governing structure of NGOs
- Invite healthcare providers and members of AIDS councils to workshops, particularly HIV and the Law workshops – so healthcare providers have a better understanding about the laws that govern everyone, as well as to hear community members' complaints and challenges
- NGOs to build trust in the communities and give correct, as well as rights information – so that communities are better equipped to report and respond to rights violations
- Build, support and engage support groups to find out and respond to challenges people living with HIV and/or AIDS are facing
- Increasing availability and access to both female and male condoms in communities
- And finally, keep the media informed about happenings in the community, to inform the community, to emphasise, criticise and highlight challenges that are commonly experienced in the community and health facilities

Conclusion

The National Strategic Plan, the policy document meant to guide the national response to HIV and AIDS, has been lauded for its ambitious aims. However, the adequacy of the national response will be severely limited if communities and civil society are not informed that everyone has to participate, benefit and work towards the desired aims – if we are to reach half new HIV infection and assure treatment, care and support to 80% of people living with HIV and/or AIDS 2011.

FOOTNOTES:

1. Kehler, J. 2007. A Responsibility of All: The NSP & HIV Prevention. Cape Town: AIDS Legal Network.
2. The Constitution of South Africa, Act 108 of 1996.

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ALQ | March 2008

Erica Kessie, Johanna Arendse

An enormous challenge...

Requirements of the NSP for the public health sector

The two main aims of the HIV & AIDS and STI National Strategic Plan, 2007 – 2011, (NSP), is to half the number of new HIV infections, and to ensure that at least eight out of ten people (80%) living with HIV and/or AIDS have access to treatment, care and support services and programmes by 2011.

The Department of Health is the identified lead agency responsible for the implementation of many of the goals and interventions outlined in the NSP. While the adequate implementation of the NSP goals and targets seems like an enormous challenge in and of itself, the Department of Health faces additional challenges of a more structural nature, such as the shortage of human resources and adequate skills base, demoralised staff, and an ever-increasing workload.

The shortage of skilled human resources in the public health sector has undoubtedly direct impact on, especially, disadvantaged communities, such as informal settlements and rural and remote areas. As a result, access to treatment, care and support may be inaccessible, limited or insufficient. As and when services are available, they are often not of the required quality, and patients may have to spend hours at a health facility to receive the required healthcare services.

The systemic challenges in the public health sector also impacts greatly on the adequacy of ARV services and programmes.

> *…Access to drugs is a necessary condition, but will not be enough to save millions of lives at risk unless priority is also given to ensure the necessary personnel to provide treatment.*[1]

Statistics indicate that an estimated 5.54 million people in South Africa are living with HIV and/or AIDS. Furthermore, it is estimated that 18.8% of the adult population, between the ages of 15-49 years old are living with HIV and/or AIDS; that 55% of people infected with HIV are women; that 40% of people living with HIV are women between the ages of 25-29 years; and that 75% of people caring for people living with HIV and/or AIDS are women and children. Finally, it is estimated that 1800 people are newly infected everyday.[2]

The national response to HIV and AIDS

The NSP, the policy document guiding the national response to HIV and AIDS in South Africa, outlines the two main aims as:

- To reduce the national HIV incidence rate by 50 % by 2011; stating that identifying and keeping HIV negative people negative is the most effective and sustainable intervention in the AIDS response.[3]
- To provide an appropriate package of treatment, care and support services to 80% of people living with HIV and their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV.[4]

Identified key requirements for meeting the goal of providing access to treatment, care and support to 80% of people living with HIV are to:

- encourage VCT and promote regular VCT
- enable people living with HIV to lead healthy and productive lives
- address the special needs of pregnant women and children

- mitigate the impacts of HIV and AIDS and create an enabling environment for treatment, care and support.[5]

...it could be argued that the 'option' of VCT should be 'user-initiated', rather than service provider initiated... the user will only 'initiate' VCT, if the environment is perceived to be safe, supportive, and that confidentiality is assured...

HIV testing

It is commonly recognised that in order to achieve these goals, we have to take into account the human rights of all people. Respecting everyone's human rights also entails that in order to encourage the uptake in voluntary counselling and testing for HIV (VCT), we need to create an enabling environment for people to do voluntary counselling and testing. People should feel free from being pressurised and/or coerced to test for HIV – for instance as a means to access other healthcare services, such as STI treatment. It is within this context that it could be argued that the '*option*' of VCT should be '*user-initiated*', rather than service provider initiated. This argument is primarily based on the assumption that the user will only '*initiate*' VCT, if the environment is perceived to be safe, supportive, and if confidentiality is assured. Considering basic rights of consent, confidentiality and counselling, the NSP goal to increase the uptake in HIV testing, might become questionable, especially if the means to achieve this goal is a '*provider-initiated*' approach to HIV testing.

In the context of antenatal healthcare, and prevention of mother-to-child transmission of HIV (PMTCT) programmes, it is also crucial to acknowledge that women, and especially pregnant women, are seemingly the '*target*' for HIV testing, as well as its increased uptake. Within antenatal care a common scenario is that HIV information sessions are provided to groups of women, that an '*offer*' to test for HIV is made – and if the client '*refuses*' to test for HIV, the test will be offered to her at every follow-up visit to the clinic. Looking at this particular scenario, an argument could be made that this form of HIV testing is closer to a '*mandatory*', than a '*voluntary*' HIV testing approach.

Moreover, it is important to recognise that a positive HIV diagnosis does not necessarily translate into adequate access to treatment, care and support. Many areas characterised by not only a lack of

> *...specialised paediatric healthcare facilities and services, but a lack of specialised skills to diagnose/ or treat children.*[6]

In addition,

> *…The shortage of skills in managing ARV treatment for children amongst healthcare providers also create a situation in which healthcare providers often lack the confidence to treat children; are reluctant to draw blood from young children, and experience difficulties in calculating the dosage of ARVs for children.*[7]

...it is important to recognise that a positive HIV diagnosis does not necessarily translate into adequate access to treatment, care and support...

In addition, it has to be acknowledged that

> *…access to voluntary counselling and testing (VCT) and prevention-from-mother-to-child-transmission (PMTCT) programmes have also been constrained by poor infrastructure, an absolute shortage of human resources and insufficiency of skilled management capacity, stigmatization and inadequate integration with other healthcare services.*[8]

...it is important to make sure that pregnant women living with HIV get correct and factual information ... so that they can make an informed choice as to their health, as well as their child's health...

Women may have to travel long distances to access PMTCT programmes and services, with often unaffordable costs involved. The lack of correct and factual information can hinder access to, or the choices that needs to be made for, PMTCT programmes. It is important to make sure that pregnant women living with HIV get correct and factual information and support, medication, medical care and feeding advice so that they can make an informed choice as to their health, as well as their child's health – and not information as to what is perceived to be in the best interest of the mother and/or the child.[9]

Taking these factors into consideration, the question arises as to why are women '*coerced*' to test for HIV, especially taking into account all the major challenges associated with the provision of adequate access to treatment, care and support as and when women test positive for HIV.

HIV treatment

According to the NSP, '*South Africa has the largest number of people enrolled in antiretroviral therapy in the world*'. The policy does, however, also admit that there are '*many more people that are in need of ARVs and other intervention programmes*'.[10] As many more people are in need of ARV treatment, and accessing care and support services remains a challenge for many, especially poor people in rural and remote areas – compounded by increasing costs of public transport, overcrowding and poverty levels – it is essential that the '*success*' of the NSP implementation be measured not only against the numbers of people who are newly enrolled in treatment programmes, but also the enhanced quality of services and adherence of people who are already enrolled in ARV programmes. Thus, it is important to not only ensure enhanced levels of patients' adherence to treatment programmes, but also that there are sufficient processes in place to '*follow-up*' on clients, and to adequately facilitate that people enrolled in ARV programmes are '*retained*' in the programmes.[11]

Healthcare Providers

Service providers play a vital role relating to the quality of services and are expected to address the needs of their clients in a non-judgmental manner. As such, service providers are expected to provide correct and factual information, so as to ensure free informed choices of clients/users of healthcare services.

...it is well recognised that stigma and discrimination in healthcare settings... is a gross violation of fundamental human rights and freedoms...

It is well recognised that stigma and discrimination in healthcare settings, based on a person's age, sex, gender, sexual orientation and/or HIV status is a gross violation of fundamental human rights and freedoms. In addition, discriminatory attitudes can also prevent, and/or limit access to available basic, as well as specialised, health services. To enhance quality of care, the healthcare environment must become user-friendly, supportive, non-discriminatory, and afford all people the same quality care.

The important role of healthcare providers in affording clients quality care is also discussed in Bharat and Mahendra (2006)

> *…Health care providers, some of whom may themselves be HIV positive, can make an important*

difference, especially if they are supported in their working conditions, are knowledgeable about HIV and sexual and reproductive health and have the skills to provide good quality care.[12]

...there has to be enhanced education and training on human rights, including women's rights, to facilitate women's participation in society at a more equalised level....

Research also suggests that the well-being of people living with HIV and/or AIDS

…depend as much on curing the ills of prejudice and discrimination, including among health professionals, as on medical intervention.[13]

Concluding remarks

In order to have effective HIV prevention, testing, treatment, care and support programmes, stigma and discrimination need to be addressed; existing programmes intended to empower women need to be accelerated and strengthened, especially since women are more vulnerable to HIV infection and are mostly infected with HIV. At the same time, there has to be enhanced education and training on human rights, including women's rights, to facilitate women's participation in society at a more equalised level. We need to also move away from prevailing social norms and beliefs that '*reinforce*' the imbalance of power between women and men – as this attitude only increases women's risks.

Recognising the crucial role of healthcare providers, it seems equally important to ensure that healthcare providers are adequately trained in adhering to human rights provisions, especially in the context of HIV testing, as well as '*sensitised*' to the impact of discriminatory and judgemental attitudes within healthcare settings. Subsequently, it is essential to enhance healthcare providers' skills base, both scientific and social, to facilitate quality care to all clients, irrespective of age, sex, gender, sexual orientation and/or HIV status.

And finally, the successful implementation of the NSP needs adequate funding for the identified goals and targets to be achieved – as the lack of funding not only impacts on the extent to which interventions are implemented, but also on the quality of service provision. Attention also needs to be given to improved monitoring and evaluation processes throughout the implementation phase of the NSP.

FOOTNOTES:

1. Du Plessis, J. 2007. 'Government has biggest ARV programme in the world.' Business News, 31 August 2007 [www.health-e.org.za/news/article/php]
2. UNAIDS. 2007. Report on the Global AIDS Pandemic. Geneva: UNAIDS.
3. Priority Area 1 of the National Strategic Plan, p.64.
4. Priority Area 2 of the National Strategic Plan, p.64.
5. See also Kehler, J. 2007. National Strategic Plan & HIV Treatment, Care and Support: Mitigating the impact. AIDS Legal Network: Cape Town, p26.
6. Kehler, J. 2007. National Strategic Plan & HIV Treatment, Care and Support: Mitigating the impact: Mitigating the Impact. AIDS Legal Network: Cape Town, p.29.
7. Kehler, J. 2007. National Strategic Plan & HIV Treatment, Care and Support: Mitigating the impact: Mitigating the Impact. AIDS Legal Network: Cape Town, p.29.
8. Ntulu, A. et al. 2007. 'HIV/AIDS and health sector responses in South Africa: Treatment access and equity – Balancing the Act'. In: *Reproductive Health Matters*, 2007:15 (29 Supplement).
9. See also Health Systems Trust [www.hst.org.za]
10. National Strategic Plan, p45.
11. See also Kehler, J. 2007. National Strategic Plan & HIV Treatment, Care and Support: Mitigating the impact: Mitigating the Impact. AIDS Legal Network: Cape Town.
12. Bharat & Mahendra, as cited in Lusti-Narasimhan, M. et al. 2007. 'Ensuring the sexual and reproductive health of people living with HIV: Policies, programmes and health services'. In: *Reproductive Health Matters*, 2007:15 (29 Supplement), p1.
13. Segurado and Paiva, as cited in Lusti-Narasimhan, M. et al. 2007. 'Ensuring the sexual and reproductive health of people living with HIV: Policies, programmes and health services'. In: *Reproductive Health Matters*, 2007:15 (29 Supplement, p3).

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ALQ March 2008

Rebecca Freeth

Gender, HIV and Advocacy: Enlisting power

Introduction

If we claim to work towards social transformation, then we are working with power. In fact, we are not only summoning up our own power to generate change, but challenging the power locked up in systems resistant to change. Yet, power can be an uncomfortable issue in NGOs and CBOs. This *comment* argues that there are at least three risks of denying power and the way it flows between us and all the individuals, groups and formal structures we engage with in the pursuit of social change.

If we fail to acknowledge our own power, we may be unable to access it in the interests of change. Whether the advocacy strategy is to facilitate change gently or to demand immediate change, power is a sensitive and finely tuned instrument at our disposal. To be effective agents of change, we need to be skillful in our use of that instrument.

If we remain unaware of the power we hold *and are perceived to hold*, we run the risk of unwittingly disempowering the people we want to empower. Co-workers, service users, partners and others may find themselves feeling less able and less in control, because of the way we manage the power in those relationships.

Lastly, if we – as individuals or organisations – wield too much power, then we become unassailable. And so do the assumptions we carry into our work. Some of our assumptions are limiting and distort our strategies for change. But they remain unchallenged because of the power invested in them. In particular, our HIV work may be compromised by powerful but limiting assumptions about gender, sex and sexuality.

This article explores core concepts wrapped up in the meaning of power, and attempts to provoke deeper exploration of how power works, so that we can enlist it towards greater gender justice in our HIV work.

Definitions

Some of the terms used in this article – such as power and advocacy – are used in so many different ways, that the way I'm choosing to use them deserves some explanation.

Mindell, in his ground-breaking work on groups, enlisted the concept of **rank** which refers to the power we hold *and the privilege it gives us*. Rank operates in all interactions, sorting people into higher and lower rank. As contexts change, so does our location on each ranking continuum. There are obvious forms of rank, such as job title in a hierarchy as well, and more subtle forms, such as who speaks their mother tongue in a linguistically diverse group. Rank splits group into majority (with higher rank, not necessarily the majority in *number*) and minority subgroups. What is most useful for the purpose of this article is that those in the majority subgroup make decisions that affect the minority, but often deny their high rank. Ignorance about power is part of the privilege of the majority. Meanwhile, those in the minority are often acutely conscious of the power differential, resent it and may make moves to defy and destabilise it. I use the terms power and rank interchangeably in this article.

Forms of rank include:

- physical rank – e.g. height, beauty, strength
- social rank – e.g. race, gender, age, class, faith, sexual orientation
- educational rank
- skills rank
- psychological rank – e.g. public displays of self confidence
- spiritual rank – e.g. a perception that one can draw on the power of prayer, or divine intervention. Archbishop Emeritus Desmond Tutu has high spiritual rank.

I understand **advocacy**, at its most basic, to be about ***influencing people with power to take action in the interests of your constituency***. This definition encapsulates lobbying and campaigning. The act of exerting influence involves the use of power.

Questions and issues raised by the concept of rank

Bringing conversations about power and privilege home to the NGO or CBO environment can touch some exposed nerves. It is easier to talk about the inequality and abuse of power out there. In here, it raises some uncomfortable questions, such as:

> *...We, in civil society, strive for equality. If we focus on high and low rank among us, aren't we reinforcing inequality?*
>
> *...Apartheid legalised race as rank and did so much damage in the process. If we talk about how power and privilege work between us today, won't we just be opening a can of worms?*
>
> *...Doesn't power always corrupt? If we talk about owning our power, aren't we at risk of being corrupted too?*

This *comment* argues that power cannot be wished away. Awareness of our rank does not imply abuse of the power and privilege we hold. If we truly aspire to a more equal society, our heightened awareness of power can enable us to use power constructively. We can draw on high social rank for positive ends, and notice when our work unintentionally disempowers others, or maintains the status quo.

Four characteristics of power

Source: *Structural and personal*

At a structural level, society clearly distributes power and privilege according to one's social identity. Historically, white heterosexual men have had access to more structural rank than any other social group. Personal power is sourced in one's own sense of agency. Do I, as a result of the way I was raised and my experiences in the world, believe I can be effective? While structural rank can determine one's sense of personal agency, you probably know a white heterosexual man, who feels deeply unable to make an impression on his world. And you might know a black lesbian, who believes the world is her oyster. Any one of us may have a complex combination of structural and personal power.

Manifestation: *Visible / invisible*

Some forms of power are tangible and others are not. Rank that manifests at an invisible level may be easier to abuse.

Distribution: *Power is not finite, it can multiply*

One of the things we assume about power is that it is finite, which implies that we have to compete for power. But this is a limiting assumption and leads us to power grabbing. But if I have power and you claim some for yourself, it doesn't automatically mean that

I've lost my power. It's my choice whether I retain power, whether or not you have some too. Or we can choose to share it.

Use: Power over versus power with[1]

Following from the above, I can use my power to make you feel powerless. Or I can use my power consciously and skilfully to work alongside you, and to be accountable.

Limiting assumptions and liberating alternatives[2]

A *limiting assumption* sits like an obstacle in one's thought process, blocking the path to new ideas, or to new strategies and projects. We treat limiting assumptions as if they were true, allowing them to direct us away from alternative ways of thinking or doing things. In order to release the potential trapped inside limiting assumptions, we need to test them and, if they prove not to be true, to identify what is true for us. This is what Kline calls a liberating alternative.

Accessing power locked up in limiting assumptions...

Kline (2007) discusses bedrock limiting assumptions. I imagine these to be the ones that have sunk to the depths of our unconscious streams of thought, weighing heavily but invisibly on our perceptions of ourselves, our organisations and our beliefs about change. Finding and rolling away these bedrock assumptions can release incredible amounts of energy to think differently.

Gender and limiting assumptions

As women and men, we are all affected by limiting *gender* assumptions. Unless we're conscious of them, we are at risk of internalising and passing them on. Delegates at a recent workshop easily generated three assumptions about men and about women, that they thought limited their potential:

Although many assumptions relating to men are predicated on men's access to power, they can impact negatively on men. The assumption that men are decision-makers can be experienced by some men as burdensome and stressful.

Assumptions about women	Assumptions about men
All women bear children	Men cannot show emotions that reveal vulnerability
Women don't take risks / are scared to take risks	Men are leaders
Women don't have power to make decisions	Men make decisions

These assumptions not only curtail us, but also the way we design HIV interventions. The act of articulating a liberating alternative is an act of power; believing that another version of truth is available to us and that we can realise it.

An example of a limiting assumption is that a woman cannot advocate for gender change in a room full of male leaders; especially in rural areas. This may be '*true*' for some men, but is it necessarily true for the woman? A liberating alternative for her could be: I have a different life experience to these men, *precisely because of my gender*. So I have something to teach them and something to learn from them.

In this way, we can shift personal power. And by wearing that power confidently but lightly – not wielding it in ways that threaten others – we can start to challenge structural patterns of power.

Gender, HIV and Power

Subjecting our HIV work to gender scrutiny exposes limiting assumptions that constrain its potential for deep change. But in order to turn these limiting assumptions around, we need to know that we

have the power to identify liberating alternatives, the power to use these new ideas to re-think our strategies, and ultimately, the power to be more effective in generating the kind of change we want to see in our constituencies and communities.

In a five minute session, a group of HIV activists identified the following three limiting assumptions about gender in their work:

Limiting assumption: *Men do not want to change.*

Liberating alternative: Masculinity is not static, it is dynamic. We can work with masculinity as something where change is possible.

Limiting assumption: *Sex is sterile and causes death.*

Liberating alternative: Sex is fun. Sex is about life. We can inform people about safer sex in ways that encourage creativity.

Limiting assumption: *Black men are not gay or have sex with other men. Homosexuality is not African.*

Liberating alternative: There are other forms of sexuality beside heterosexuality. We want to reach everyone through our HIV messages and interventions.

FOOTNOTES:

1. See 'Right Use of Power: Ethics for the Helping Profession'. [www.rightuseofpower.com]
2. See Kline, N. (1999). *Time to Think: Listening to ignite the human mind*. Cassell Illustrated: London.

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Try these exercises

If you want to take the concepts explored in this paper into your organisation, try these two exercises.

Exercise 1

Interview each other in pairs, running through all four questions before swapping:

1. *What limiting assumptions does the world make about you as a man or woman?*
2. *Of these assumptions, which is the MOST limiting?*
3. *Do you think this assumption is in fact true? What are your reasons?*
4. *What, in your own words, is a true and liberating alternative to that assumption?*

Exercise 2

Discuss as a group:

1. *What is a limiting assumption about gender in our HIV work?*
2. *What is a liberating alternative to that assumption?*
3. *If we knew that [insert your liberating alternative] was true, how would this change our approach?*

ALQ March 2008

Marion Stevens

A crucial area for debate...

Integrating sexual and reproductive health and rights into the national response to HIV and AIDS

In 2001, at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), South Africa signed the Declaration of Commitment – a document listing 72 goals to be reached by 2010 in a global response to mitigate the impact of the HIV and AIDS pandemics. Twelve of these goals relate to crucial aspects of women's health and, in particular, to sexual and reproductive health and rights (SRHR).

Monitoring UNGASS

While South Africa has an impressive legal and policy framework, lauded internationally, health system challenges, integration of HIV and AIDS and sexual and reproductive health and rights (SRHR), and implementation of services have made it difficult to overcome challenges that persist in addressing the pandemics effectively.

During the past few months, a study was conducted aimed at examining the progress made in South Africa pertaining to the 12 indicators in relation to sexual and reproductive health and rights. The purpose of the study was to identify gaps and progress in the implementation of activities addressing sexual and reproductive health and rights of women and girl children in the response to HIV and AIDS. This study formed part of a broader international initiative, through which NGOs from sixteen countries reviewed the relevant indicators for their respective countries.[1]

In South Africa, some twenty NGOs representing various sectors have spent time and resources collating research and finalising the country report. The process began in July 2007, when the participating organisations first met to familiarise themselves with the indicators, and to refine some of the indicators to be more applicable for the South African context. Three drafts were developed and the final report was launched in May 2008.

While material has been submitted to the South African National AIDS Council (SANAC) on several occasions, for inclusion in the country report, sexual and reproductive health and rights are not addressed sufficiently in the South African country report, which was prepared and presented at the UNGASS meeting at the United Nations in June 2008.[2]

At the launch of the final report, a joint press statement was released, calling on government to meet international obligations regarding HIV and sexual and reproductive health.[3] A further call was made

> *...to consider the findings of this research and to explore the integration of SRHR issues in relation to HIV and AIDS through the continuum of care. This would strengthen the gains that have been made in relation to sexual and reproductive health policies and services.*

...during the past few months, a study was conducted aimed at examining the progress made in South Africa pertaining to the 12 indicators in relation to sexual and reproductive health and rights....

Recommendations to a more effective response to the sexual and reproductive health and rights imperatives of the UNGASS Declaration, highlighted in the report, include:

- The need to integrate sexual and reproductive health and rights services in relation to HIV and AIDS in addressing the epidemics – for example, STI services need to deal with violence against women, and HIV infected women need to be afforded the choice to continue their pregnancy or to terminate their pregnancy
- Issues of sexual and reproductive health and rights for women living with disabilities need to be addressed and further research needs to be done to document experiences
- The need to strengthen the voices of HIV positive women within SANAC
- Strengthen adult women's treatment guidelines that include a focus on women, particularly dealing with the continuum of care; and that respect women's choices to parenthood in treatment regimes
- Leaders must denounce the homophobic violence against black lesbian women and take active steps to ensure the swift investigation and prosecution of offenders
- Health facilities to offer unlimited access to sexual and reproductive health services for migrant and refugee women
- A review of the National Cervical Cancer Screening Policy with specific reference to new vaccines registered and also the need to increase coverage to HIV positive women
- We support voluntary testing of pregnant women, however, attention needs to be given to the barrier that *'mandatory/provider initiated'* HIV testing imposes on women in shying away from services
- Increased research to explore the impact of male circumcision on women, noting that currently research only notes benefits for men

...leaders must denounce the homophobic violence against black lesbian women and take active steps to ensure the swift investigation and prosecution of offenders...

Exploring the NSP

In 2007, government, in collaboration with many stakeholders, launched the HIV and AIDS and STI National Strategic Plan 2007 – 2011 (NSP). The process of developing this policy was led by the Deputy President Phumzile Mlambo Ngcuka, as chair of the South African National AIDS Council (SANAC). The National Strategic Plan has been lauded as a first in getting stakeholders to work collaboratively, and set out an ambitious plan for addressing the HIV and AIDS pandemics.

While the policy document includes substantive discussion noting key areas of gender and gender-based violence, cultural attitudes and practices, sexual concurrency, and sex workers, there is no overall conceptual lens unpacking sexual and reproductive health and rights. This, arguably, sets a muddied conceptual framework for exploring this feminised pandemic, and addressing HIV

and AIDS realities comprehensively within this policy document.

...within the Department of Health, reproductive health is not on the essential health research priority list....

The language of sexual and reproductive health and rights is used as part of priority area one of the NSP, focussing on HIV prevention, under goal two:

> *…Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services.*[4]

Yet, this focus on sexual and reproductive health and rights is not continued into the priority area two of the NSP, focussing on HIV treatment, care and support, and priority area three of the NSP, dealing with research, monitoring and surveillance.

Within the Department of Health, reproductive health is not on the essential health research priority list. This leaves gaps in terms of the continuum of care, and there is a general lack of integration – resulting in a situation in which, for example, HIV infected women's sexual and reproductive intentions are not provided for; abortion services are not regulated within HIV care; and sexual violence is not part of the STI syndromic approach.

Monitoring UNGASS and exploring the NSP as to the extent to which SRHR are adequately addressed as part of the national response to HIV and AIDS clearly indicates that integrating HIV and AIDS into ongoing sexual and reproductive health and rights programmes, and conversely SRHR issues into HIV and AIDS programmes, remains a crucial area of development and debate for South Africa.

The e-list, called 60percent, is one of the forums for debate and discussion exploring the intersectionality of sexual and reproductive health and rights and HIV. The list acknowledges by its name that we have a feminised HIV and AIDS pandemic; and is intended to create a safe and respectful space to dialogue on HIV and AIDS within a gender, women's rights, and sexual and reproductive health and rights lens through the continuum of HIV prevention, treatment and care.[6]

FOOTNOTES:

1. The process was initiated by GESTOS Soropositividade, Comunicação e Gênero, an NGO in Brazil, and was funded by the Ford Foundation
2. The complete report can be found at: [http://www.hst.org.za/generic/94#ungass]
3. The following organisations undersigned the press release: AIDS Legal Network; Centre for the AIDS Programme of Research in SA; Centre for the Study of AIDS; Health Systems Trust; Ipas SA; Mosaic Training, Service and Healing Centre for Women; OUT LGBT Well-being; Treatment Action Campaign; Women'snet; Women's Legal Centre; Women's Health Research Unit, UCT; SANAC Women's Sector Secretariat; SANASO; Action AID; and NACOSA.
4. National Strategic Plan, Goal 2, Objective 2.6.
5. For more information and/or to subscribe to the list, please contact lyris@hst.org.za.

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