MONITORING FOR THE UNITED NATIONS SPECIAL SESSION ON HIV AND AIDS (UNGASS)

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INDICATORS

A CASE STUDY FROM SOUTH AFRICA

2008

FACILITATED AND COLLATED BY MOSAIC AND THE HEALTH SYSTEMS TRUST
A workshop was held in July 2007 hosted by MOSAIC at which the participating organisations discussed the identified indicators, refined these and shared research and findings. In collaboration with GESTOS (GESTOS - Soropositividade, Comunicação e Gênero www.gestos.org) this forms part of a 16 country process. The process of collation was a dynamic iterative process with a first draft circulated, a further second draft was circulated for further comments and this is the third draft, collated by Marion Stevens (HST).

The document was circulated in November 2007 to additional organisations invited and distributed to for comments including:
Sonke Gender Justice
SWEAT
Children’s Rights Centre
Children’s Institute
Treatment Action Campaign
AIDS Law Project
Soul City
Human Science Research Council

This draft was finalised in February 2008 for final comment and is to be launched by the Reproductive Rights Alliance in April 2008
COUNTRY PROFILE AND INDICATORS

Population: 47.4 million
Water access: 85% of households have access to piped water. There is great variation in access to water across districts with 90% of metro (Cities) having access to piped water yet some rural areas particularly in the Eastern Cape only having 28% access to piped water.
Gini Coefficient: 0.722
Human Development Index: 0.653
Gender-related Development Index: 0.646
Unemployment: 26%
Life expectancy: 47 years
Energy supply: 40% experienced at least periodic shortages of fuel for cooking or home heating. 61.3% used electricity for cooking.
Mortality: HIV (51%) is the leading cause of death of women aged 15-54 years.
Connectivity: 28 million out of 47 million people have cell phones. Over 90% of public health clinics have a cell phone.

Women’s Health and Sexual and Reproductive Health and Rights

Rapes reported: 55,111 reported from April 2004 – March 2005.
Incidence: 143 per 100,000
PPTCT: 51% of HIV positive pregnant women accessed neviripine. Use of combination ARV treatment in the Western Cape by HIV positive pregnant women was shown to decrease perinatal transmission to below 2%.
Total Fertility rate: 2.7
Contraception rate: Use of contraception: 65% -generally the injectable
Male Condom Distribution Rate – 8.8 per man per year in 2005 Female condoms thus far have only been available at pilot sites. Research is underway to determine the effectiveness of microbicides as a female controlled HIV prevention method.
Delivery Rate in Facility. The average delivery rate in a facility was 81.1% in 2006.
Antenatal care attendance: 95%
Abortion: There have been 529,410 safe and legal pregnancy terminations during the ten year period (1997 to 2006) since the introduction of the Choice on

Termination of Pregnancy (CTOP) Act in February, 1997. This has led to a 90% reduction in maternal mortality and morbidity in relation to abortion.

**Abortion Facilities:** 51% of designated facilities functioning

**Maternal death:** 150/100 000. The main reasons for primary obstetric death are non-direct causes of non-pregnancy related infections. Maternal deaths (deaths during pregnancy and the puerperium) was made notifiable condition in 1997. The National Committee for Confidential Enquiries into Maternal Death (NCCEMD) secretariat is responsible for coordinating the process or notification and reporting and making recommendations.

**Caesarean Rate:** 18.4%

### HIV/AIDS and other STIs

**Estimated number of people living with HIV:** 5.5 million

**Antenatal HIV prevalence:** 29%

**Overall adult prevalence rate:** 18.8%

**Average STI incidence:** 4.8% (This indicator measures the percentage of people 15 years and older who have been treated for a new episode of a sexually transmitted STI)

**Incidence in terms of gender and age:** Women are disproportionately affected: accounting for approximately 55%-60% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 39.5%

**HAART treatment:** January 2007 250 000 on treatment in government public sector and 100 000 on treatment in private sector

**Treatment by Gender**

Within the private sector 60% of those on treatment are women and in the public sector 65%.

**AIDS Defining Illnesses:** The incidence of cervical cancer is 30:100 000. There is presently an increase in pre-cancerous lesions in HIV positive women. Cervical Cancer is the leading cause of cancer mortality in South African women.

**Mortality.** 51% of deaths of women between the ages of 15 and 54 are HIV related.

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8 Xundu, N. ‘Unveiling the NSP’ by Thabane in Mail and Guardian April 13 pg 11 2007
9 Leigh Johnson, UCT Actuarial Science, Personal Communication, September 2007
10 Dr Jennifer Moodley, Director of the Women’s Health Research Unit. Personal Communication. 9 May 2006.
OVERVIEW OF SOUTH AFRICAN HEALTH SYSTEM AND SEXUAL AND REPRODUCTIVE HEALTH AND HIV/AIDS POLICY.

South African is a country in transition, some 14 years after the first democratic elections. Part of this transition has been the reorientation of the health system. Previously most expenditure took place in the private sector with a minority using it. The public sector was also oriented towards tertiary care. A vertical family planning programme was implemented in 1974 framed to reduce black population numbers.

Following the change of government in 1994 rapid strides were taken to prioritize women’s health. In the first 100 days of President Mandela’s presidency, an announcement was made that primary health care was to be free to pregnant women and children under six. This was to ensure that poor women and their children had access to care. These broad strides were welcomed and heralded a period of significant policy and legal change orientated to the poorest of the poor. This took place when the health care system itself was transforming towards developing an integrated and decentralized health care system based on primary health care. Subsequently primary health care was made freely available to all citizens in the public sector. Health workers were not prepared for this and in retrospect have become overwhelmed with what is commonly termed ‘change fatigue’. Efforts continued to increase access to health broadly and are clearly defined in the South African Constitution in section 27 in the clause ‘Health care, food, water and social security’. It states: ‘(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water: and (c) social security, including, if they are unable to support themselves and their dependents appropriate social assistance. (2) The state must take reasonable legislative and other measures within its available resources, to achieve progressive realization of these rights, (3) No one may be refused emergency care treatment.”

While efforts have been made to implement this with over 4000 public health facilities employing some 235 000 personnel, care is sometimes sub-optimal, public facilities have long waiting times and primary care facilities have too few doctors. In relation to broader determinants of public health many people do not have access to clean water, sanitation, nutrition, electricity and safety which facilitates poor health. Poor people face the high costs of transport, buying medicines, and follow up visits to a doctor. Language barriers between patients and health workers mean that many people many not be able too fully understand their treatment. Many women experience domestic violence, sexual offences and other forms of violence against women. There are discriminatory attitudes amongst health care workers against people because of their race and gender. Because of the HIV/AIDS crisis,

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many hospitals and clinics face a huge increase in patients, but there has not been an increase in the doctors and nurses available to care for all the new patients. The health care system is better equipped and provides better services in provinces like Gauteng and the Western Cape, than in others such as the Eastern Cape and Limpopo.

It is perhaps important to underline the period of ‘transformational flow’ or ‘soft boundaries’ during the period of about 1994-1998. This period was characterized by a flow and political ease in which policy change at addressing the apartheid past was welcomed. It was enabled by relationships which spun a network into various institutions including parliament, political parties, the media, government departments and NGOs. There was an element of trust and the need to work collaboratively to address the past imbalances that characterized South Africa. As Black women were known to have borne the brunt of apartheid evils, women’s rights were acknowledged as human rights and there was an understanding that laws and policies were needed to put in place to correct this.

LAWS AND POLICIES ADDRESSING WOMEN’S HEALTH

While there were broad reforms addressing issues of equity and women’s health, there have also been very specific changes. These include:
- The Choice on Termination of Pregnancy Act 1996
- The Choice on Termination of Pregnancy Amendment Act, 2004,
- The Notification of and Confidential Enquiry into Maternal Deaths (NCCEMD)
- The Sterilization Act, 2000,
- Contraception policy guidelines
- The HIV and AIDS and STI National Strategic Plan for South Africa, 2007-2011
- 365 Day National Action Plan to end Gender Violence
- Signing of the Maputo Plan of Action aimed at universal access to comprehensive sexual and reproductive health services in Africa by 2015

In highlighting a few of these areas:

16 The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No 21 of 2007
17 365 Day National Action Plan to end Gender Violence, 8 March 2007
1. While South Africa has liberal abortion law which has successfully reduced abortion related maternal mortality and morbidity, demand for services exceeds supply and health workers have not easily accepted the provision of this service. The law is constantly under attack from anti-choice activists. The media is not helpful and in 2006, services were suspended for two weeks in the Northern Cape as service providers thought the legislation had been repealed.

2. The NCCEMD is a process designed to evaluated, indirectly, the quality of care that women receive during pregnancy and childbirth. It is evident that AIDS is proving to be the largest challenge to addressing maternal mortality in South Africa. HIV infection has reversed prior gains in maternal mortality and it is estimated that at least 29% of maternal mortality was due to AIDS in the years 2002–2004.

3. As part of the HIV/AIDS continuum of care, the programme for the prevention of mother to child transmission PMTCT was the first step in improving the health care of pregnancy women infected with HIV in that it helped to identify those pregnant women who were HIV positive. The South African PMTCT programme was largely introduced as a vertical programme to allow for central control and faster implementation; however the result is that it does not function integrally with broader maternal and child health services. The indicators suggest that many opportunities to prevent mother to child transmission are being missed and uptake is variable between the provinces. The orientation of the programme has tended to emphasise child’s health and not the mothers’ health which has been problematic. However, increasingly this is being acknowledged and is beginning to be addressed. Women testing positive for HIV in PMTCT programs in some provinces continue on ARV treatment where appropriate after the birth and there are suggestions to decrease the CD4 count necessary to qualify for ARV treatment to 350 for HIV positive pregnant women.

The period of policy has changed and is not as open and easy as in the late nineties. The Sexual Offences Bill was passed in Parliament in 2007 and has been in the making for some ten years. While it has been welcomed as a positive change by activists, it still falls short in including clear regulations concerning integration of health, justice and safety and security which would make the law implementable. Furthermore, a national team (comprising of SOCA and NPS prosecutors) has drafted all the annexure (charge sheets) to finalise the Directives as prescribed by the legislation without involving any civil society in the process.

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HEALTH SYSTEMS CHALLENGES
As noted all of these developments have taken place in a transforming health system. There has been increased expenditure in primary health for capita from R168 in 2001 to R232 in 2005. The average clinical workload of a nurse was 31.6 patients a day in 2005. And the primary health care utilization rate is the average number of visits a person per year to a public PHC facility which in 2005 was 2.1. The challenges of South Africa are complex as it is a profoundly inequitable country as noted by the gini coefficient. Prior to 1994, the greatest proportion of health resources were allocated to the delivery of health care through provision of curative, high technology, hospital-based services to urban centres. There are consistent efforts to spread the resources and transform the health system through developing systems to increase the supply of health workers in rural areas. Health graduates from South African public funded tertiary institutions have a compulsory community service year in underserved areas and there is a rural allowance for certain categories of health workers to encourage them working in rural areas.

LAWS AND POLICY SPECIFICALLY DEALING WITH HIV/AIDS and SRHR

In 2004, the country began to provide HAART as part of the continuum of HIV care within the public sector. Currently some 350 000 are on treatment and an estimated 500 000 needing to be on treatment. In 2007 Government in collaboration with many stakeholders (civil society, the private sector) 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 Ms Phumzile Mlambo Ngcuka as head of the South African National AIDS Council (SANAC). While there is 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. The language of sexual and reproductive health and rights is used as part of priority area one: prevention under goal two ‘Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services, yet this is not continued into Priority area 2 of Treatment care and Support and Priority area three of Research monitoring and Surveillance. Currently reproductive health is not on the essential health priority list.. This leaves gaps in terms of the continuum of care and there is a lack of integration, for example, HIV positive women’s sexual and reproductive intentions are not provided for, abortion services are not regulated within HIV care, sexual violence is not part of the STI syndromic approach.

Within SANAC there are 17 sectors, one of which is the Women’s sector. The group has met twice in 2007 and areas of discussion and action have included election of representatives, advocacy issues and terms of references which still

Before 1994, there were no comprehensive sexual and reproductive health policies in South Africa. The apartheid government had largely ignored the emerging issue of HIV/AIDS. However, it is important to note that in the previous ten years South Africa’s HIV/AIDS policy has been characterized by a lack of leadership and mistrust of politicians. One of the most encouraging occurrences has been the significant role played by civil society in affecting legislative and policy change.

The influence of civil society has been particularly important in three areas of reproductive health legislation and policy:

1. Abortion;
2. Gender-based violence and
3. PMTCT and ARV treatment for HIV.

Nevertheless, as the country matures in finding its identity, a period of ‘hard boundaries’ could occur, where a tiredness and a sense of poor morale begins to prevail. Recent developments in government consultations with civil society over the NSP for HIV/AIDS 2006-2011 and the re-election of SANAC are to be welcomed.

While the HIV/AIDS sector has embraced the concern of general equity issues, women’s sexual and reproductive health and rights in relation to HIV/AIDS are not being explored and addressed with the same vigour and passion.

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23 Personal Communication Judi Merkel – SANAC Women’s Sector Secretariat 26 November 2007
## SECTION II – UNGASS goals and proposed indicators:

### Goal 37 – Government leadership in facing the HIV/AIDS epidemic

By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector, and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, Vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;”

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<th>Proposed Indicators:</th>
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<td>• Effective participation and meaningful (quality) of representative of women and youth living with HIV in the HIV/AIDS Programs, including the decision making spaces and in the UNGASS monitoring actions.</td>
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• Participation of groups of women in assisting by the design, implementation, and evaluation of the programs directed towards them.

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<th>Issues concerning this indicator:</th>
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<td>• Do the women and girls participate in the decision making processes in the HIV/AIDS National Program? Describe and analyse;</td>
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• Do the representatives of the women’s movement and of women living with HIV/AIDS participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
ANALYSIS OF GOAL 37
Following the release of the 9th draft of the NSP in October 2006, there was concern from women’s groups that women did not feature significantly in the plan. As a result a number of actors in this sector, worked to try and remedy this. In March 2007 a women’s consultative meeting was held funded by Government as part of the process of revitalizing the South African National AIDS Council (SANAC). The meeting was attended by over a hundred women’s organisations from across South Africa who deliberated on a revised version of the NSP and elected three representatives to the high-level SANAC structure. A reference group has met subsequently twice. Three sector leaders were elected to serve on the high-level SANAC structure. None of the sector leaders have disclosed that they are HIV positive. Two are leading researchers and one is a former General Secretary of the Treatment Action Campaign (TAC). There is a youth sector but not specifically a girls sector and girls are not very active in the women’s sector. SANAC is being revitalized but has thus far not had a dedicated and funded secretariat. This has lead to difficulties in getting timeous notice out for meetings and ensuring adequate representation. While much work remains recent developments indicate a positive trend. In addition to the high level SANAC body several there is women’s sector representation on the SANAC monitoring structures such as the Program Implementation Committee (PIC), and the Sector Coordinating Committees. The women’s sector representative on the PIC is from the Progressive Women’s Movement. Women sector representatives on the SANAC Sector Coordinating Committees include two representative of Women in Partnership Against AIDS (WIPAA), The mandate of the women sector representatives is to identify issues that advance women’s interest in SANAC and broaden their involvement in the NSP. The means by which they intend to do this is by support, coordination and communication within the sector. The women’s sector is committed to ensuring transparency, mobilization and accountability. Mechanisms to enable these processes still have to be developed.

It has been difficult engaging the SANAC women’s sector representatives in this process as they have been preoccupied with their work and as such they have not been able to attend requested meetings with them.

The 365 Day National Action Plan to end Gender Violence17 is a national guiding framework resulting from the Kopanong Conference in South Africa in May 2006. The Action Plan is a definite confirmation of the partnership between Government and Civil Society to address the high levels of violence against women in South Africa. A key issue stated in the Plan is the fact that the relationship between gender violence and HIV/AIDS is not adequately understood or addressed. However, a lack of leadership in co-ordinating implementation, monitoring and evaluation has resulted in no action since the launch of the Plan in March 2007. Important stated actions in the Plan with regard to mobilisation of resources, integration of GBV strategies into
development plans and developing a policy framework for substantively supporting civil society organisations as strategic partners need urgent attention.

In December 2007 the Institute for Security Studies and Transparency International-Zimbabwe launched a groundbreaking study into corruption and accountability in HIV/AIDS prevention and treatment efforts in South Africa. The main findings are quoted below:

2. In addition, the lack of tracking of donor funding poses the risk of duplication of resource and efforts between government and civil society.
3. The lack of accountability for financial mismanagement is also cited as a source of concern. Furthermore, the lack of transparency (including openness to engage with civil society and the media) has been a key feature impacting on delivery.
4. Under spending in provinces due to lack of capacity and internal management problems is a compounding impediment to delivery. In this regard, the Auditor General is reported to have submitted qualified audit reports on health for several provinces over the past few years.
5. Key concerns relate to the lack of institutionalisation of processes for the spending of HIV/AIDS funding. The more loose and unregulated the system for the provision of funds and services, the greater chance of corruption. Where services are rolled out for the first time, resource distribution is often characterised by ad hoc solutions and improvisation. Few associated institutional structures and oversight mechanisms are in place. Where they exist, they are poorly conceptualised and undeveloped.

In terms of corruption the following was stated:

In the South African context, corruption in the HIV/AIDS sector does not only pertain to abuses in funding and other conventional corrupt activities. Other factors play a role. First, high levels of poverty appear to encourage the abuse of resources by HIV-infected people in particular. Secondly, the politicisation of the disease has created channels for abuse and consequently undermined HIV/AIDS policy and its active implementation, patient care and certain health regulatory bodies. Finally, as mentioned above, where systems are weak, it becomes difficult to disentangle corruption from mismanagement and system failure as the root causes of poor HIV/AIDS responses.

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**Goal 52 – Prevention**

By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections.

**Proposed Indicators:**
- Reach, adequateness and effectiveness of prevention educational programs for women and girls;
- Female and male condoms availability in the health services, schools and associations- range of places;
- Condom easiness to obtain and proper orientation to use it, even by young people.
- Issues of male circumcision, dry sex and virginity testing, psychological support services
- Raise issue of Tik

**Issues related to this indicator:**
- What are the main elements that compose the prevention policy of the HIV/AIDS National Program related to sexual and reproductive health?
- What are the strategies implemented to reduce HIV prevalence among young girls of 15 to 18 and 18 to 24 years old? Is the implementation effective? Does it have a good coverage? How is it evaluated?
- What are the strategies that guarantee that women of 15 to 18 and 18 to 24 years old have access to information and education about HIV? Are there specific campaigns with the use of distinct media? Analyze their methodology, the education messages to different groups; quality, type, and duration of the campaign; and content adequateness.
- How do you evaluate the effectiveness of such initiatives? Does it have good coverage?
- Is it easy for women, including girls, to obtain, in sufficient quantity and for free, condoms (male and female) and lubricants?
- Are there formal or informal barriers to provide services and/or HIV prevention tools for women/girls? Describe and comment.
- Are the STD diagnosis and treatment available and accessible in the basic levels of attention to health? Are there statistical data and national campaign related to STD?
• Is there regular monitoring of S&R health, HIV/AIDS, and control of STD by the government? If yes, is the data trustworthy and available?
ANALYSIS OF GOAL 52
Government adopted a curriculum called ‘Life orientation’ in early 2002. Within this curriculum there is vast scope for prevention educational programmes. The curriculum deals with personal, physical and social development. A number of NGOs have developed materials in partnership with government, for example, Soul City, Planned Parenthood, LoveLife and WPF. These materials contain information on a range of areas in relation to sexual and reproductive health and rights. However, it is up to the teacher to facilitate the educational programme and this is likely to be uneven across schools and regions.

High teenage pregnancy rates and high numbers of pregnant girls in schools spurned a big debate about the influence of the R200 support grant that mothers may access from Government. Although the Department of Social Development provided HSRC research results that “child farming” is not in practice to access grants, many teachers and principals don’t agree and say that it certainly plays a role. A policy stating measures for the prevention and management of learner pregnancy was sent to all public schools in 2007. The policy states that a pregnant learner may not be expelled from school but also that no learner should be re-admitted in the same year that she left school due to a pregnancy to ensure that learners (girls) take responsibility for parenting. Measures encourage children to abstain from risky sexual behaviour and highlight the importance of positive values, sex education, and HIV/AIDS education programmes. The Social and School Enrichment Branch of the Department of Education has put into place specific objectives in their 2007-2011 strategic plan to manage learner pregnancy in schools. The Plan for Gender Equity also includes objectives to address gender-based violence and sexual harassment in schools. The Department of Education and 13 Higher Education institutions recently launched a two month “Each One Reach Five” campaign through which university leaders initiates a mass testing campaign benefitting large numbers of students. The campaign is aimed at tackling the stigma that testing still seems to carry and will hopefully be implemented by other universities.

While equality and non discrimination in relation to sexual orientation is guaranteed constitutionally, there is limited appropriate and targeted messaging and information on HIV prevention for lesbian women, men who have sex with men (MSM) and gay men. Moreover, barrier methods such as dental dams for

26 http://curriculum.wcape.school.za/
28 Today’s Choices
lesbian women and lubricant for MSM, are not available in the public sector. Messaging that is sensitive and appropriate to a diverse range of sexual behaviours and orientations is severely lacking across all public health sector HIV/AIDS programming. There is limited ability to assess the quality and content of the programme actually delivered. Similarly issues of HIV/AIDS and abortion are stigmatized.

As noted in the indicator section, there are some 8.8 male condoms distributed per man in 2005 for that year. Femidoms are not widely available and are generally limited to research sites and programmes. The Department of Health has now issued directive for these to be made available at all public sector sites. The average STI incidence is also measured and is noted in the indicator section. At the end of 2007 evidence emerged that staff at the South African Bureau of Standards had accepted inferior quality condoms and that these had been distributed and were not of acceptable standard. These were recalled, however, left those dependent on these public sector condoms mistrustful.

Cultural issues have been debated recently including dry sex, virginity testing and male circumcision. There are also concerns regarding the ‘magic bullet’ approach which might instil a sense of false confidence in men. Men may feel protected and this may decrease the practice safer sex and diminish women’s ability to assert their need for this. The impact of male circumcision on women also needs to be addressed as thus far no studies have been completed to assess the protective effect of surgical male circumcision on HIV acquisition for women. The number of research related questions from attendees at the WHO/UNAIDS technical meeting on circumcision based on studies in three African countries including SA also indicated that communication strategies with regard to circumcision will have to take human rights and gender issues into account.

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35 Centre for the Study of AIDS (CSA) Revised indicators of Stigma. Meeting the needs of People Living with HIV or AIDS. 2005 Siyam ‘Kela Stigma Project, Rohleder, P. and Gibson, K. 2005. ‘We are not fresh’: HIV-positive women talk of their experience of living with their spoilt identity. ASRU UCT.

36 www.rhru.co.za, Female Health Foundation – www.femalehealth.com

37 www.rhru.co.za


Virginity testing has also become more prevalent and exposes young girls and women to be preyed upon. This annual celebration of virginity amongst Zulu people celebrates young girls virgin status. Older women inspect the young girls and supply them with certificates. It has been argued that by exposing these young girls they become vulnerable to sexual violence by men believing that having sex with a virgin will cure them of HIV/AIDS.\footnote{Le Roux, L. 2006 ‘Harmful traditional practices, (male circumcision and virginity testing of girls) and the legal rights of children’.LLM Thesis. University of the Western Cape .} \footnote{Le Roux, L. 2006 ‘Harmful traditional practices, (male circumcision and virginity testing of girls) and the legal rights of children’.LLM Thesis. University of the Western Cape .} King Goodwill Zwelithini criticised the Children’s Act during the annual royal reed dance ceremony in September 2007 saying that regardless of the legislation outlawing the practice, virginity testing will not be stopped and that the Zulu nation cannot be told what to do about their culture.\footnote{“Zulu culture wears the pants”, Sunday Times September 9 2007, p7.} \footnote{http://forum.southafrica-direct.com/tik-crystal-meth-t283-1.html}

Government has been a signatory to the Maputo Plan of Action which highlights a sexual and reproductive rights and integration lens on HIV/AIDS prevention; however this has not been matched with adequate services. The National Strategic Plan (NSP) developed in 2007, notes in Goal 2 ‘reduce sexual transmission; and Objective 2.6 ‘develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services’. The target for 2007 for this objective is to reach 40% of services and 90% of services by 2011. This objective also notes increase access to quality STI services using updated syndromic management guidelines. It is worth noting that the syndromic approach does not deal with violence against women. Objective 2.2 notes the need to target HIV infection in young people focusing on young women. The interventions suggested include dealings with schools, keeping young girls in school and to strengthen life education in all primary and secondary schools.

There is a large issue of drug abuse with a drug called ‘Tik’ (crystal meth) that is very prevalent, particularly in the Western Cape. Many young girls are manipulated into starting to use it as they attempt to loose weight\footnote{http://forum.southafrica-direct.com/tik-crystal-meth-t283-1.html}. Interventions for dealing with reducing recreational drug use for young people is noted in the NSP under objective 2.8.
Goal 53 – Prevention

“By 2005, guarantee that at least 90% of youth of both genders, 15 to 24 years old, and by 2010, that at least 95% of them, have access to information, education, including peer education and specific education for youth about HIV, as well as the necessary services to develop the required abilities to reduce their vulnerability to the HIV infection; all of this in collaboration with young people, mothers and fathers, families, educators and health care professionals;”

Proposed Indicators

- Reach, adequateness and efficacy of sexual health programs for youth – content and quality, integration of services, access friendly.
- Access to unsafe sex post-exposure prophylaxis – non-occupational – public and private

Issues related to this indicator:

- Are there special services for young women (for example, with special time or facilities) that offer information and instruments for preventing against HIV?
- Are there formal or informal barriers to offer services and/or instruments for preventing against HIV for youth bellow the legal age? Describe and comment.
- Are there trained health care professionals to provide prevention counselling specific for women? Are there governmental initiatives trying to train its teams to perform such task? Describe and comment.
- Is emergency contraceptive and anti-HIV prophylaxis for unsafe sexual exposure available and accessible?
ANALYSIS OF GOAL 53
Organisations such as Soul City, LoveLife and PPASA have been leading in providing prevention messaging and some services. The public sector does have some youth clinic specific services, aimed to provide services that are private and friendlier and welcoming to young people. Minors can access services without their parental consent, but there are anecdotal reports of judgemental and hostile health workers. The Children's Bill passed in November 2007, makes provision for young girls from age 12 to obtain contraception. Similarly the Choice on Termination of Pregnancy Act No 92 of 1996, does not place an age restriction on abortion access.

An exciting initiative is the Drama for Life programme developed by Wits School of Arts and sponsored by GTZ. The programme aims to use drama and theatre as powerful intervention against the HIV & AIDS pandemic. GTZ is sponsoring the development of short courses and 28 scholarships in Applied Drama and Theatre Postgraduate Studies at in an effort to develop capacity in HIV & AIDS education.

Counselling is often not widely available due to lack of capacity. There have been a cadre of community health workers that have been part of the treatment movement, who have provided this service, but they have not been incorporated as yet into the public sector and much of the work is voluntary.\(^{44}\)

Post Exposure Prophylaxis (non-occupational) is not consistently available in all public sector facilities. It is available in private facilities. Many women do not know about this service. Policy recommendations on PEP have not been finalised as part of the National Working Group on sexual offences\(^{45}\) (See Tshawarang Legal Advocacy Centre website for helpful updates). Across the country treatment of rape survivors by police and healthcare workers is sub-standard. A rapidly evolving policy environment has yet to be met by a systematic approach to post rape management at local or national levels. An innovative study aimed to address the following questions: What are the various program components that need to be strengthened as part of an integrated post-rape service? How can such a program be integrated into existing health services within a rural setting? How effectively can the service be delivered? And finally, what is the cost of such an intervention?\(^{46}\)

\(^{44}\) MSF 2006. Confronting the health care worker crisis to explain access to HIV/AIDS treatment. Johannesburg
\(^{45}\) www.tlac.org.za
**Goal 54 – Prevention (perinatal transmission)**

"By 2005, reduce the amount of HIV infected breast fed babies in about 20%, and by 2010 in about 50%, offering to 80% of all pregnant women prenatal services with information, psychological support, and other HIV prevention services, growing the availability of efficient treatment to reduce the transmission of the virus from mother to child and giving access to treatment for HIV infected women and babies, and offering access to treatment for HIV infected women that are breast feeding, as well as efficient interventions for HIV infected women that should include psychological support and the voluntary and confidential testing services, access to treatment, particularly the antiretroviral therapy and, when appropriate, to the substitute of breast milk, and a continuous series of attention services;"

**Proposed Indicators**

- Reach, quality and care of services for HIV infected pregnant women.
- Access to adequate treatment to pregnant women. Is HAART available to all women who need it?
- Availability of appropriate detection HIV testing.
- Quality of counselling for HIV detection testing in pre-natal services.
- Access to detection of syphilis in the maternity attention services.
- Access to treatment of identified syphilis cases during pregnancy.
- Nutritional support for HIV infected pregnant; anti-HIV prophylaxis during delivery.
- Reach, adequateness and efficacy of programs that guarantee breast milk substitutes
- Integration into other sexual and reproductive health services – including voluntary abortion or supported pregnancy

**Issues related to this indicator**

- Do the services (public and private) that attend pregnant women offer information, counselling, and HIV testing?
- In the case of HIV positive pregnant women, are there efficient services available to reduce the transmission of the virus from mother to child, nutritional orientation for the newborns, and psychological and social support for the mothers?
- Is there free breast milk substitutes for newborns of HIV positive women? If yes, is the quantity enough? Describe and comment.
- What contraceptive are provided for the HIV positive women? Is there a way that induces them to ‘sterilize’ themselves?
- What is your country’s policy on abortion? How does public opinion consider the right of a HIV positive woman to interrupt her pregnancy/choose to have an abortion?
ANALYSIS OF GOAL 54

There has been considerable work done in the area of prevention of perinatal transmission. Government initially did not adopt the WHO guidelines in providing dual therapy of Nivirapine and AZT and currently this is only provided in the Western Cape. As indicated in the indicator section only 51% of HIV positive pregnant women nationally accessed PMTCT. Goal number 3 in the NSP directly deals with ‘reduce mother to child transmission of HIV and suggests the need to scale up coverage through increased testing. Use of combination ARV treatment in the Western Cape by HIV positive pregnant women was shown to decrease perinatal transmission to below 2% \(^{14}\). In addition, infant mortality in the Western Cape and Gauteng have begun to decline. This is thought to be due to successful PPTCT programs in these two provinces\(^{47}\). These findings are extremely encouraging and combination therapy needs to be introduced nationally.

One of the key barriers to prevention of transmission has been shown to be after birth when mixed feeding practice takes place.\(^{48}\) There are currently projects engaging peer counsellors to support women in being able to exclusively feed. It has been concluded that much of this dilemma relates to devastating socio-economic conditions where women live in absolute poverty. There is free formula milk available to women; however there are problems with a sustainable supply and women fear stigma in being identified as HIV positive. Some women in severe poverty also sell the formula to make ends meet. Adequate counselling services remain a challenge. In line with WHO policy for low resource areas and in line with the findings of recent research, exclusive breastfeeding is being encouraged where formula feeding is not feasible. These nuanced strategies need to be vigorously pursued.

An important barrier concerns the focus of these programmes on the baby and services that are integrated and are able to provide services to the mother or pregnant women are limited. HAART treatment for pregnant women if indicated is not accessible to all women. Currently only 25% of all those who should be on treatment are on treatment currently and there are backlogs.

There has not been adequate provision of contraceptives for HIV positive women. In many settings injectable contraceptives are provided to women as part of the first line regimens as the drugs of Tenovir and Evafirenz are contraindicated in pregnancy and breast feeding. The male condom barrier method is generally suggested to women. Female controlled barrier methods as in femidoms, are not widely available. There has not been adequate space created for women to assist them in providing them with adequate skills to negotiate safer sex\(^{49}\).

\(^{47}\) (Personal Communication, David Bourne, 14 July, 2007)
\(^{48}\) Tanya Doherty http://www.hst.org.za/publications/708
Syphilis testing and treatment is routinely done in pregnant women, however this is not an equitable service\textsuperscript{50} with vast differences in access through South Africa. The national figure for 2006 was 1.6% for pregnant women attending public antenatal services.\textsuperscript{51}

While Health workers have adopted the public sector principle of “Batho Pele” People First and the Patients Rights Charter – there are prevalent attitudes and frustrations expressed by health workers that HIV positive women should not be sexually active and have children. This may lead to abuses of suggesting that they have a sterilization or an abortion. There are anecdotal reports of women having to have injectable contraceptives as part of their treatment as some first line HAART regimens are contra-indicated in pregnancy and breast-feeding.\textsuperscript{52}5354

Abortion is legal in South Africa, however only 60% of designated facilities are functional. Currently the amendment to the Choice on Termination of Pregnancy Act of 2004 which seeks to remove some of the barriers to service access for women seeking abortion is being challenged by ‘Doctors for Life’ and has been sent back to parliament to ensure greater public participation. Currently the law provides for surgical and not medical abortions. The NSP in Objective 3.1 notes the need of to ‘implementation programmes to reduce the percentage of unwanted pregnancies through scaling up contraceptive services in public sector facilities increasing access to TOP services in public sector facilities and develop policy on medical abortion.’ There have been anecdotal reports of HIV positive women being coerced to be sterilized to obtain a legal abortion. There is being remedied through reproductive rights advocacy, possible research and litigation processes\textsuperscript{55}. In addition, knowledge of Emergency contraception is inadequate especially among HIV positive women\textsuperscript{56}.

\textsuperscript{50} Nkonki, L., Doherty, T., Hill, Z., Chopra, M., Schaay, N. and Kendall, C. Missed opportunities for participation in prevention of mother to child transmission programmes: simplicity of nevirapine does not necessarily lead to optimal uptake, a qualitative study AIDs Research and Therapy 2007, 4:27 doi:10.1186/1742-6405-4-27
\textsuperscript{52} GAF 2005. ‘Things are so wrong out there; The experiences of of women living with HIV and AIDS in accessing sexual and reproductive health and rights in KwaZulu Natal, South Africa: A study with women living with HIV and AIDS.
\textsuperscript{53} Cooper, D. et al 2005 ‘Reproductive Intentions and choices among HIV-infected individuals in Cape Town, South Africa: Lessons for reproductive policy and service provision from a qualitative study. Women’s Health Research Unit UCT. Population Council
\textsuperscript{54} Personal Communication. Nokuthula Mabele ICW January 2008
\textsuperscript{55} Personal Communication, Tyler Crone, ATHENA NETWORK, December 2007
Goal 59 – Human Rights

“By 2005, taking in consideration the epidemic context and specificity, and that women and girls are disproportionately affected by HIV/AIDS, elaborate and accelerate the application of national strategies that promote women’s progress and the respect for their human rights; promote the shared responsibility of men and women to secure safe sexual relations; train women to freely and responsibly control and decide the issues related to their sexuality with the objective of increasing their capability to protect themselves against the HIV.”

Proposed Indicators

- Reach, adequateness, and effectiveness of government’s policies and programs directed towards the promotion, security, and reparation of women’s rights;
- Interrelated policies directed towards women’s rights with the HIV/AIDS National Programs;
- Reach, adequateness, and effectiveness of government’s policies and programs directed towards men’s responsibility in sexual and reproductive health issues;
- Reach, adequateness, and effectiveness of the policies and programs of protection for vulnerable women’s sexual and reproductive rights;
- Access to assisted client friendly sexual and reproductive services.
- Has your government developed policies and programs destined to promote women’s rights? If yes, is there a specific organism to coordinate the actions? What is your evaluation on the developed actions effectiveness? What are the main barrier and debilities for the implementation of these policies and programs?
- Are there strengthening actions developed with the HIV/AIDS program or with the SR health program? What are the main challenges and facilitators to establish a common work?
- Are there strategies to promote shared responsibility of men and women regarding safe sex? If yes, how do you evaluate its coverage, effectiveness, and adequateness in the context of gender relations in your country?
- Are there specific governmental strategies to strengthen the decision making ability of women in relation to their sexuality and prevention against the HIV and other STD? If yes, how do you evaluate its effectiveness? What are the strong and the weak points? Please, describe and comment.
- Are there specific governmental strategies to protect the women worker rights? And how about for women living with HIV? Is there data that shows labour agreements for women living with HIV?
ANALYSIS OF GOAL 59

A number of government policies (Reconstruction and Development Programme, Choice on Termination of Pregnancy Act) have an excellent articulation of women’s sexual and reproductive health and rights. Government has also led international processes and were clear advocates for the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (FWCW). The Maputo Plan of Action (Plan of Action on Sexual and Reproductive Health and Rights) is a document of the African Union which has had excellent support from government.

However, these excellent policies have not been matched by the allocation of resources and implementation of integrated services\(^57\). Service providers whether health care workers, educators and facilitators may not all subscribe to these rights articulated in these policies and this affects service provision\(^58\). There have been some shortcomings in the past in the treatment sector within the AIDS movement not adequately engaging the sexual and reproductive health and rights movement, and women’s rights issues are often not prioritised to the extent that other rights are. This is beginning to be addressed. For example the Treatment Action Campaign has recently supported the Reproductive Rights in supporting the Health Systems Trusts submission in support of the CTOP Amendment Act of 2004. There are gaps in certain service provision area. For example, findings on a study on HIV and cancer of the cervix in South Africa, underscore the importance of developing locally relevant screening and management guidelines for HIV positive women in South Africa\(^59\).

Health and Reproductive Rights form one of the articles of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the African Protocol) that was ratified by South Africa in January 2005. It was recently rightly stated that the African Protocol is not yet used as a human rights instrument in South Africa. Limited reference is made to the provisions of the Protocol in court judgements. Advocacy campaigns focusing on benefits of the Protocol by either government or civil society are non-existent and rights education does not include reference to the African Protocol. Only 2 of 8 organisations with observer status actively participate in the deliberations of the African Commission. Government should make budgetary considerations for the domestication of the protocol and should ensure that the judicial framework is aware of the commitments and state responsibilities that exist within the Protocol.


Promoting the Protocol however is also the responsibility of civil society and mobilisation through joint ventures of interest groups to campaign and advocate for the accountability of government is an untapped priority.60

In November 2006 SA become the first African country to legalise same-sex unions when Parliament approved the Civil Union Bill61. However, there is evidence that prejudice by marriage officers of the Department of Home Affairs cause delay and long waiting lists for performing of marriages62.

There have been increased reports of attacks, prejudice-motivated rapes and murders of lesbian women. Women’s sexual rights and ability to express these are not given. None of the reported crimes have had any people arrested following an investigation of the crimes.

There have been activities many initiated by NGOs in dealing with men. Sonke Gender Justice is an example of this63. Sonke Gender Justice has recently initiated a meeting of all stakeholders to develop policy and services for men’s reproductive health based on the premise of gender equity and justice64. Some of these activities are in partnership with government. Another example has been the MRC Stepping Stones initiative which has conducted a randomised control trial showing how effective that particular intervention programme has been65.

Women are disproportionately infected and affected by the epidemic and the focus on men should not deter on prevention and treatment efforts to enable women to mitigate the effects of the epidemic.

The area of HIV/AIDS and the workplace doesn’t generally deal with women as a category for labour rights. There has been little work in this area. David Dickinson in reviewing the area of peer educators notes generally the over-representation of women, and African women in particular, within the ranks of peer educators when compared with the overall profile of the companies’ workforce66. This points to the care taking role that women and in particular African women have taken in mitigating the impact of the epidemic. In addition women in South Africa are

61 The Civil Union Act, 2006 (Act No. 17 of 2006)
64 Policy approaches to working with men to improve men’s health and achieve greater gender equality: A national consultative meeting. September 17th and 18th, 2007. Gauteng.
disproportionately employed in the informal economy where there is a lack of formal protection of rights.

Military HIV prevalence levels are cited between 15-20% for South Africa\(^{67}\) indicating that the Department of Defence needs to develop special SRHR programmes for its soldiers and peacekeeper staff that are deployed within and outside of South Africa.

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\(^{67}\) Prof Lindy Heinecken, University of Stellenbosch (paper at 4-day Institute of Security Studies Dec 2007)
Goal 60 – Human Rights

“By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, mainly through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework.”

Proposed Indicators

- Reach, adequateness, and effectiveness of prevention programs actions for young women.
- Reach, adequateness, and effectiveness of non-formal sexual and reproductive health and rights education programs that promote gender equality, considering aspects of maleness, heterophobia, homophobia, and misogyny - note role of culture

Issues related to this indicator

- Are there government directives for education that promotes gender equality? If yes, how do you evaluate its coverage and effectiveness?
- How are gender inequalities treated in the government backed educational programs for HIV prevention?
- Are there legal or traditional barriers (informal, socio-cultural) that limit the young women to obtain ARV treatment, sexual, and reproductive health care when needed?
ANALYSIS OF GOAL 60

Government adopted a curriculum called ‘Life orientation’ in early 2002. Within this curriculum there is vast scope for prevention educational programmes. The curriculum deals with personal, physical and social development. A number of NGOs have developed materials in partnership with government, for example, Soul City, Planned Parenthood and LoveLife. These materials contain information on a range of areas in relation to sexual and reproductive health and rights. However, it is up to the teacher to facilitate the educational programme and there is limited ability to assess the quality and content of the programme actually delivered. As such the information regarding sexuality and gender may not all be adequate.

Goal 2 of the NSP in referring to ‘reduce sexual transmission of HIV includes in its objectives 2.1 ‘strengthen behaviours change programmes, interventions and curricula for the prevention of sexual transmission of HIV, customised for different target groups with a focus on those more vulnerable to and at higher risk of HIV infection’ and objective 2.2 ‘implement interventions targeted at reducing HIV infection on young people, focusing young women. Interventions to achieve these objectives include ‘identify and prioritise interventions in schools reporting high rates of teenage pregnancy per year through a gender sensitive package that addresses sexual and reproductive health and rights, HIV, alcohol and substance abuse’. By 2008 the target of 50% of schools has been set in achieving this intervention.

Cultural issues have been debated recently including dry sex, virginity testing and male circumcision. The impact of male circumcision on women also needs to be addressed as men feel protected and might not practice safer sex and women may not be able to assert their need for this. There are also concerns regarding the ‘magic bullet’ approach which might instil a sense of false confidence in men. Virginity testing has also become more prevalent and exposes young girls and women to be preyed upon. The Children’s Act which prohibits virginity testing is a step that has been taken to protect young girls.

As noted above the legal and policy environment makes provision for young girls to access services. However, this is not often the reality on the ground with health services not welcoming young girls and accepting their sexual and reproductive health needs. Attitudes and prejudice among service providers often creates a barrier.

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69 Personal Communication, Johanna Kehler, AIDS Legal Network, January 2008
70 Personal Communication, Johanna Kehler, AIDS Legal Network, January 2008
Goal 61 – Human Rights

“By 2005, ensure development and accelerated implementation of national strategies for women’s empowerment, the promotion and protection of women’s full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls.”

Proposed Indicators

- Reach, adequateness, and effectiveness of specific laws to prevent, prosecute, and repair (restitution and compensation) the damage caused by violence against women.
- Reach, adequateness, protection and effectiveness of specific actions against the sexual exploitation of girls.
- Coverage, quality, and care of emergency services for women and girls victims of violence or sexual violence, with anti-HIV and anti-STD prophylaxis, emergency contraceptives, and abortion.
- Existence of a public system for collecting and dissemination of data about violence against women and girls.

Working with Offenders

Lesbian violence
Traditional cultural practices
Circumcision
Commercial sex work

- How do you analyze the coverage and effectiveness of the governmental initiatives to stop violence against women and girls?
- Is there an effective government monitoring system for such actions? And how about by civil society, is there such a monitoring system as well?
- Are there antiretroviral, STD prophylaxis, emergency contraceptives, and counselling available for sexually violated women? Are there national statistics about violence and sexual violence against women and girls?
- Are there regularly organized national campaigns to fight violence against women and sexual exploitation of girls? If yes, how do you evaluate the effectiveness of these initiatives and the relevance of the message’s content?
- What are the government initiatives to stop sexual exploitation of girls? How do you evaluate its coverage and effectiveness? Is there an effective monitoring system by the government for these actions? How about by civil society?
ANALYSIS OF GOAL 61

There have been a number of initiatives in dealing with Violence against Women. The Domestic Violence Act No 16 of 1998 was developed with the consultation of a number of civil society stakeholders and addresses violence against women and articulates the mechanism for obtaining a protection order. The effectiveness of this Act is dependent on the correct implementation of all relevant role players including the police, the domestic violence courts, the sheriff’s office, the Department of Social Development, the Department of Health, etc. Numerous studies have shown that there are challenges with the implementation of the Act due to a number of factors including police dereliction of duty, different interpretations of the DVA by magistrates, and a lack of minimum standards and co-ordination efforts for and between the relevant role players. A civil society initiative was started in 2006 by the Gender Advocacy Project (GAP), Mosaic and Tshwaranang to compile a minimum standards document collating all existing and addressing gaps for minimum standards for service delivery agents. The Department of Justice and Constitutional Development supports the process but its participation at national level to this point was limited and protracted.

The Sexual Offences Act that has been passed in Parliament in November 2007 has been the subject of intense negotiation for the past three years. The Act makes provision for the following activities:

To comprehensively and extensively review and amend all aspects of the laws and the implementation of the laws relating to sexual offences, and to deal with all legal aspects of or relating to sexual offences in a single statute, by—

* repealing the common law offence of rape and replacing it with a new expanded statutory offence of rape, applicable to all forms of sexual penetration without consent, irrespective of gender;
* repealing the common law offence of indecent assault and replacing it with a new statutory offence of sexual assault, applicable to all forms of sexual violation without consent;
* creating new statutory offences relating to certain compelled acts of penetration or violation;
* creating new statutory offences, for adults, by criminalising the compelling or causing the witnessing of certain sexual conduct and certain parts of the human anatomy, the exposure or display of child pornography and the engaging of sexual services of an adult;
* repealing the common law offences of incest, bestiality and a sexual act with a corpse and enacting corresponding new statutory offences;
* enacting comprehensive provisions dealing with the creation of certain new, expanded or amended sexual offences against children and persons who are mentally disabled, including offences relating to sexual exploitation or grooming, exposure to or display of pornography and the creation of child pornography, despite some of the offences being similar to offences created in respect of adults as the creation of these offences aims to address the particular vulnerability of children and persons who are mentally disabled in respect of sexual abuse or exploitation;
* eliminating the differentiation drawn between the age of consent for different consensual sexual acts and providing for special provisions relating to the prosecution and adjudication of consensual sexual acts between children older than 12 years but younger than 16 years;
* criminalising any attempt, conspiracy or incitement to commit a sexual offence;
* creating a duty to report sexual offences committed with or against children or persons who are mentally disabled;
* providing the South African Police Service with new investigative tools when investigating sexual offences or other offences involving the HIV status of the perpetrator;

* providing our courts with extra-territorial jurisdiction when hearing matters relating to sexual offences;
* providing certain services to certain victims of sexual offences, inter alia, to minimise or, as far as possible, eliminate secondary traumatisation, including affording a victim of certain sexual offences the right to require that the alleged perpetrator be tested for his or her HIV status and the right to receive Post Exposure Prophylaxis in certain circumstances;
* establishing and regulating a National Register for Sex Offenders;
* further regulating procedures, defences and other evidentiary matters in the prosecution and adjudication of sexual offences;
* making provision for the adoption of a national policy framework regulating all matters in this Act, including the manner in which sexual offences and related matters must be dealt with uniformly, in a co-ordinated and sensitive manner, by all Government departments and institutions and the issuing of national instructions and directives to be followed by the law enforcement agencies, the national prosecuting authority and health care practitioners to guide the implementation, enforcement and administration of this Act in order to achieve the objects of the Act;
* making interim provision relating to the trafficking in persons for sexual purposes; and to provide for matters connected therewith.  

Besides the need to implement the provisions of this Act, there a numerous challenges. These include adequate information systems to monitor the incidence of violence against women. The collaborative working together of policing, safety and justice and health is an enormous challenge and is not viewed as a priority. Sexual Violence is not part of the syndromic management of STDs in South Africa. Emergency Contraception and Post Exposure Prophylaxis is a challenge within the public sector. Health information systems and Crime information systems are a challenge, despite this there are statistics collected and these are released annually.

The South African Law Society and the National Working Group on Sexual Offences has monitored and commented on the sexual offences legislation reform but has generally found an unwillingness from the Department of Justice and Constitutional Development to consider recommended changes to the Bill. There have been guidelines developed for the media on the reporting of Domestic Violence. While these are good and worthy initiatives it is difficult to evaluated their success and efficacy. Government has set up special courts to deal with sexual offences and in particular to assist young girls in not having to confront their offender. These are not widespread and state financial support for these is erratic.

Women’s empowerment and gender equality still has a long way to go when we look at the results of the South African leg of the World Values Survey that was done in 2006:
- half of all South Africans (and 37% of women) still believed that men make better political leaders than women do
- 23% of men and 17% of women still believed that a university education is more important for a boy than for a girl.

http://www.tiac.org.za/images/documents/sobill10nov06sobpc06.doc
- Nearly 10% of South African believed that it is in some way justifiable for a man to beat his wife.

There are a number of excellent NGOs working in this field which do significant work to further the ability of women to deal with the impact of violence against women. Government has endorsed the annual international campaign of 16 days of activism to end violence against women and it has been widely advertised in the media. During a conference in May 2006 it was decided that the 16 days of Activism campaign needed to be sustained all year around resulting in a 365 Day National Action Plan to End Gender Violence\textsuperscript{17} launched on 8 March 2007 (International Women’s Day). Issues of concern however are that:

- Since the launch of the Plan there has been no further movements from the Programme Management Unit to coordinate and monitor the implementation of the Plan
- The National Network on Violence Against Women and most of the provincial affiliated networks have dissolved due to a lack of funding and related management problems
- The Plan should use stronger language such as in the Maputo Plan of Action to address VAW and sexual and reproductive health and rights, and HIV/AIDS in the prevention, treatment and co-ordination sections.

Oxfam recently commissioned a baseline study\textsuperscript{74} in South Africa on organisations and campaigns currently addressing VAW and HIV/AIDS and studying the focus of the work and its impact. Important observations which were made included:

- To have an impact on both epidemics (HIV & VAW) works needs to be done at community level
- Networking and collaboration is essential to make an impact
- Impact of campaigns and programmes in the sectors is doubted, especially with the view of many different messages at all levels
- In-depth solutions with intense long-term attention to the individual circumstances of women are much more important than once-off mass campaigns
- The Zuma Rape Trial brought the interface between VAW and HIV to the fore and served as a catalyst for many organisations to rethink their strategies
- The sectors need complementarity rather than competition referring to antagonism between players in the sector over the past years
- Faith-based organisations should play a bigger role in the twin epidemics
- Men must be included to address the interface between the epidemics
- The relationship between government and civil society needs to be examined to smoothen interaction and increase effectivity.

\textsuperscript{74} De Bruyn, R. 2007. Report to Oxfam on baseline study of organisations and campaigns in the context of HIV and AIDS in SA to end violence against women.
The most important gaps in the interface between the two pandemics were identified as:
- Gap between policy and ground level is too large
- Researchers are detached from communities – gap between available information and its implementation in communities
- Gap between what government says and does – implementation lags far behind
- Different standards of services and access to services in different areas confusing the public who hears about policies but who don't see it on the ground
- Quality of training (on intersection) at government and civil society level is too low, no testing, no monitoring
- Women's health has been reduced to HIV/AIDS and needs to be extended to include access in a wider sense
- NGOs need to do more review and self reflection.

A recent Save the Children report documents the experience of young SADC migrant children and in particular young girl’s vulnerability to rape and sexual violence by border guards, police, and truckers. It reports that many resort to sex work to enable them to survive.

In support of the recommendation paper coming out of the Gender Civil Society side event at Replenishment, South African civil society should take a much stronger and more co-ordinated stance in lobbying the Country Co-ordinating Mechanism to strengthen integrated gender responsive programming and to include women's human rights groups, especially groups with expertise in women's and girls' SRHR, GBV and its intersection with HIV and groups of women living with HIV. Participation in the Global Fund Replenishment debate needs to be focussed, especially with a view to lobby for more GBV and SRH-related funds when the mid-term meeting in 2009 to review the performance of the Global Fund would be taking place.

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Goal 62 – Reduction of Vulnerability

“By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behavior and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement.”

Proposed Indicators

• Reach, adequateness, and effectiveness of support programs for vulnerable women;
• Reach, adequateness, and effectiveness of productive programs or projects (small business) for vulnerable women – basic social security and socio-economic rights;
• Reach, adequateness, and effectiveness of human rights defence policies and programs for vulnerable women;
• Reach, adequateness, and effectiveness of programs that attend the causes and structural problems of women and girls human traffic, without getting into individual criminalizing and discrimination – commercial sex workers.
• Reach, adequateness, and effectiveness of the international agreements, conventions, and treaties application in the country, as well as the effort of federal laws to punish women trafficking;
• Reach, adequateness, and effectiveness of government backed monitoring actions, with clear and available indicators and with the participation of civil society.

Working with offenders

Issues related to this indicator

• Are there specific actions or programs to repress women trafficking? If yes, how do you evaluate its effectiveness?
• Are the government actions related to the inclusion of vulnerable women transparently monitored?
• Are there representatives of women’s groups in the planning/evaluation of such initiatives?
ANALYSIS OF GOAL 62

The South African Law Reform Commission (SALRC) released an Issue Paper on Sexual Offences which calls for the decriminalization of sex work in 2002.\(^78\)

The SALRC has also drafted legislation on Trafficking which has yet to be introduced into the national parliament. No law exists currently dealing specifically with trafficking. However traffickers may be dealt with in terms of other laws, such as the Prevention of Organized Crime Act, the Sexual Offences Act, the Child Care Act, the Immigration Act, the Films and Publications Act and the common law, which prohibits abduction, kidnapping, rape, indecent assault and assault.

A necessarily underground activity, such as trafficking, is assisted by an environment that makes all sex work illegal. Persons trafficked into the sex work industry face a complex context in which they themselves are perceived as criminals and treated as such. Threats by their traffickers that going to the police will simply get them arrested and deported are real. Decriminalization will therefore assist in addressing trafficking issues by making it easier for the authorities, victims of trafficking, sex workers and others to seek assistance.

A Trafficking Hotline exists which was initiated by the International Organisation for Migration (IOM). The Western Cape Provincial Task Team Against Human Trafficking (WCTTT) launched in Cape Town in December 2007 is the first provincial coordinated civil society structure to address trafficking.\(^79\)

There have been a number of initiatives to enable women in poverty to obtain grants. There are disability grants, pension grants and child support grants for caregivers of children under the age of 18. While commendable, these are viewed as inadequate and there are campaigns in place for a basic income grant. There has been concern expressed by PWA’s on grants where a CD count that rises after being on HAART might cause them to be at risk for losing this grant. There are calls for a Chronic Disease Grant, to deal with this complexity.\(^80\)

Roughly half of South Africa’s people live in poverty. And nearly half of all poor people live in households that have no access to social security. The Basic Income Grant Coalition was formed in mid-2001 to develop a common platform among advocates of a universal income support grant and to mobilise popular support for the introduction of the grant. The Basic Income Grant Coalition calls for the introduction of a Basic Income Grant which would

- provide everyone with a minimum level of income,
- enable the nation’s poorest households to better meet their basic needs,
- stimulate equitable economic development,

\(^78\) N Fick SWEAT. Personal Communication, November 2007.
\(^80\) Nonkhosi Khumalo ALP. SANAC Human Rights and Stigma presentation. November 2006
• promote family and community stability, and
• Affirm and support the inherent dignity of all.\textsuperscript{81}

There are a number of initiatives that work with sexual and domestic violence offenders such as NICRO, Sonke Gender Justice and Mosaic Training, Service and Healing Centre. Mosaic and its partners are currently in the process of developing a best practice model for counselling and group work with male abusers.\textsuperscript{82}

Given the instability in the SADC region, South Africa hosts a number of refugees. A Refugee Act governing the admission of asylum seekers was passed in 1998, and became effective in 2000. A refugee can apply for permanent residence after five years of continuous residence since the date of asylum being granted. Only recognised refugees can apply for identity documents and an asylum application should be adjudicated within 180 days, including the appeal. For many, post-apartheid South Africa has become both an imagined Mecca of economic opportunity, or a haven from war-torn or troubled homelands. Most of South Africa’s refugees come from countries like the Democratic Republic of Congo, Burundi, Rwanda, Angola and Somalia. In the first five months of 2003, South Africa received 14 000 new arrivals, bringing the total number of persons of concern to 90 000, comprising 24 000 recognised refugees and 66 000 asylum-seekers. In some instances the increase in the number of refugees in the country has created tensions with South African citizens, many of whom have blamed escalating crime on illegal immigrants and refugees. Xenophobia has become a problem in some areas of the country.\textsuperscript{83} Living on the Fence is a compilation documenting women refugee’s voices in writing and poems and also covers difficulties in accessing health services and especially services for HIV/AIDS.\textsuperscript{84}

Recently the Joint Civil Society Monitoring Forum issued a press statement\textsuperscript{85} condemning the SA Police raid on the night of 30 January 2008 into the Central Methodist Church in Johannesburg during which they beat, harassed and used pepper spray against several hundred people from Zimbabwe who were seeking refuge in the Central Methodist Mission. Many were physically abused, manhandled and arrested. Many of those who were arrested were not in the process of committing any crime, and many were actually living in South Africa with the requisite documentation. The JCSMF called for government not to compromise services ordinarily provided to those seeking refuge at the church such as medical care for TB and HIV/AIDS. Mosaic and the Refugee Centre in

\begin{itemize}
  \item \textsuperscript{81}www.big.org.za
  \item \textsuperscript{82}M. De Vos. Personal Communication. January 2008.
  \item \textsuperscript{83}http://www.southafrica.info/public_services/foreigners/immigration/refugees_asylum.htm
  \item \textsuperscript{84}Yuin Tal and Schuster, 2008. Living on the Fence. Poems by women who are refugees from various countries in Africa. Women’s Writing workshops.
  \item \textsuperscript{85}JCSMF STATEMENT CONDEMNING SAPS ACTION AT CENTRAL METHODIST CHURCH. 1 February 2008.
\end{itemize}
Cape Town often receive complaints from legal refugees and migrants of exceptionally poor reception and services at governmental clinics.
Goal 63 – Reduction of Vulnerability

“By 2003, establish and/or reinforce strategies, norms, and programs that recognize the importance of the family to reduce vulnerability, among other things, educating and orienting children, and that takes in consideration the cultural, religious, and ethical factors in order to reduce vulnerability of children and youth with the secured access to primary and secondary schools, with study programs for adolescents that include HIV/AIDS; protected and safe surroundings, specially for girls; broadening good quality services of information, sexual health education, and psychological support for youth; strengthening of sexual and reproductive health programs, and the inclusion, as much as possible, of the families in the planning, execution, and evaluation of HIV/AIDS attention programs;”

Proposed Indicators

• Reach, adequateness, and effectiveness of programs that consider cultures, religion and cultural contexts in the education strategies.
• Effectiveness and coverage of the implementation of safe and secure (housing/food and security) surroundings for vulnerable girls.
• Access to housing, education, social assistance, health care and food for HIV infected girls.
• Reach, adequateness, and effectiveness of integral health programs for adolescents and orphans and vulnerable children.
• Reach and adequateness of sexual and reproductive health counselling at health service centres.
• Effective participation of youth in the design, monitoring, and evaluation of programs.
• Reach, adequateness, and effectiveness of capacity building actions for teachers in the theme of sexual and reproductive health and rights.

Issues related to this indicator

• Is the concept used and recognized by the government in its strategies of family involvement adequate to the vulnerable populations’ reality?
• Does the government take a multicultural approach when formulating social policies?
• Are the HIV education activities of orientation and focus developed in schools adequate to an inclusive education with respect to differences?
• Is the content in the gratuitous text books adequate to a proposal of inclusive education with respect to differences?
ANALYSIS OF GOAL 63

Given the history within South Africa there is respect for difference and diversity. While education programmes are comprehensive, they may be limited by the facilitator or teacher who may object to the materials on sexual and reproductive health and rights. Distribution of free teaching materials for children is a challenge.

The Child Support Grant provided to caregivers of children under the age of 18 is an attempt by government to provide for vulnerable children. The public sector does have some youth clinic specific services, aimed to provide services that are private and friendlier and welcoming to young people. Minors can access services without their parental consent, but there are anecdotal reports of judgemental and hostile health workers. The Children’s Bill, makes provision for young girls from age 12 to obtain contraception.

Childline states that 43% of sexual crimes reported to the organisation’s hotline in 2007 were committed by children and Rapcan (an NGO fighting child abuse and neglect) said that 40% of reported rape cases in South Africa were perpetrated by people under 18. The trend of children raping and sexually abusing other children is a serious SRH behavioural issue that needs to be researched and addressed to greater effect in SA.

86 “Our children are raping each other”, Sunday Times November 18, 2007.
Goal 64 – Vulnerability Reduction

“By 2003, develop and/or strengthen national strategies, policies and programs, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise;”

Proposed Indicators

- Reach and effectiveness of government negotiation with regional or international partners to strengthen the specific attention programs and activities of sexual and reproductive health and rights to vulnerable women.
- Participation of vulnerable women in the regional or international articulation processes.

Issues related to this indicators

- Are there specific actions or programs to protect the health of women living with HIV/AIDS and/or members of most vulnerable groups to HIV infection? If yes, how do you evaluate their effectiveness?
- Are there specific programs or actions to protect ethnical minority women’s sexual and reproductive health, and to prevent them from HIV infection?
- Are there legal or traditional (informal, social, cultural) barriers that limit the ability for women, sex workers, and incarcerated women to receive care on sexual and reproductive health, and ARV treatment, when necessary? If yes, describe it giving specific examples.
- Have the government budget to work with excluded populations in the last five years been kept the same, increased, or decreased? Please, comment.
ANALYSIS OF GOAL 64

Government played a key role in the development of the Maputo Protocol and the Maputo Plan of Action (Plan of Action on Sexual and Reproductive Health and Rights) and the NSP contains priorities dealing with women, these are commendable but have limitations. In priority areas of Prevention: 2.2 – suggests ‘implement interventions targeted at reducing HIV infection in young people, focusing on young women’, 3 concerns the ‘reduction of mother to child transmission. Priority 2 relates to treatment and section 7.1 concerns ‘addressing the special needs of pregnant women and children. Key priority area 4 deals with Human Rights and Access to Justice and 19 focuses on the ‘human rights of women and girls, including people with disabilities, and mobilize society to promote gender and sexual equality to address gender based violence. This is the overall framework and there is a clear attempt to address some of these issues.

However, there are gaps for specific actions with women living with HIV/ADS. There is an organisation ‘the positive women’s network’ (PWN) which organises HIV positive women who have worked closely with government in developing the NSP. However, recently a lesbian fieldworker and her partner were murdered and this created capacity challenges. Sex work and transactional sex are noted in the NSP but it falls short of calling for decriminalising sex work

Paul Pronyk and colleagues\(^{87}\) have demonstrated by a clustered randomised control trial the benefit of a structured intervention that combined a microfinance programme with a gender and HIV training programme. The combination of this programme led to a statistically significant reduction in the levels of intimate partner violence in the programme participants. A clear conclusion is that social and economic development interventions have the potential to alter risk environments for HIV and intimate partner violence in South Africa. While intimate partner violence was reduced by 55%, the intervention did not reduce the affect the rate of unprotected sexual intercourse.

‘Journey to myself’ provides a compilation of women’s voices from prison which paints a picture of the challenges faced by this experience\(^ {88}\). Similarly, the compilation of stories in ‘Remember me’ gives voices to women on farms and documents diaries day by day and compares them to male partners and inherent challenges.\(^{89}\). These stories paint a vivid picture of the constraints on women’s sexual and reproductive health in these vulnerable contexts.

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\(^{89}\) Women on Farms. 2002. Remember me? Stories from women who work on Farms. Salti Print
Goal 65 – Orphans.

“By 2003, develop, and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide appropriate support, including the provision of appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;”

Proposed Indicators

• Reach, adequateness, and effectiveness of specific support programs for orphans and children infected and affected by HIV.
• Provision of and quality of shelters.
• Reach, adequateness, and effectiveness of educative programs for orphans and in vulnerable situation because of AIDS.

Issues related to this indicator

• Have your government implemented support strategies for HIV positive children, securing access to psychological and social support, education, shelter, nutrition, and health care services, while making sure there is no discrimination? If yes, how do you evaluate the coverage and effectiveness of these initiatives?

ANALYSIS OF GOAL 65

In 2004 it was estimated that there were 2.2 million orphaned children – some 13% of all children under 18 have lost either a mother or a father. Little is known of the extent of child abuse on South Africa, anecdotal estimates suggest that it is quite extensive and needs to be monitored.

The Child Support grant has been an effective provision to enable orphans and children to obtain support until the age of 18. There are bureaucratic barriers in obtaining the grant, in having to have identity documents and time to apply at local offices. In some rural areas, these barriers serve as a serious obstacle to obtaining the grant. Children born to HIV positive mothers are provided with free formula to enable exclusive feeding up until three months. This service is not equitable through out South Africa, and there are issues of sustainability to support exclusive feeding. Education is free to all children in the public system for

the first ten years, however, other expenses of uniforms, books and equipment, contributions to the school activities do add an additional burden. School psychological and support services are not equitable and are not provided for in all settings.

Helen Meintjes and colleagues provide a comprehensive picture of the provision and quality of shelters in South Africa. They note the challenges of legal status, funding and the diversity of arrangements that make provision for children. Policy and legal reform has made it difficult to ensure consistent care as changes in grant structures have evolved making contracts with different levels of government a maze of negotiations and procedures. The challenges encountered during the research included the lack of statistics on children accommodated in these shelters and the number of shelters existing in South Africa. Different types of shelters with different provisions with regard to funding. Legal placement of children into the shelters is not being completed due to outside social workers’ case load problems.

Goal 69 – Mitigation of social and economic effects

“By 2003, evaluate the HIV/AIDS epidemic’s social and economic effects and elaborate multi-sector strategies to face these effects in the individual, familial, community, and national levels; elaborate and accelerate the execution of national strategies to end poverty and face the epidemic in the places, the life styles, and access to basic social services, paying special attention to the people, the families, and the communities that are affected the most by the epidemic; study the social and economic impacts of HIV/AIDS in all social levels, specially women of age, particularly related to their function of support providers in the families affected by HIV/AIDS, and attend their special needs; adjust and adapt the social and economic development policies, including the policy of social protection, to face the effects of HIV/AIDS in the economic growth, in the essential economic services, labour productivity, fiscal income, and the prisons that produce a deficit in public resources;”

Proposed Indicators

- Availability of data or studies and access about the social and economic impact of HIV on women;
- Policies on social protection programmes

Issues related to the indicator

- Does the government develop studies about the social and economic impact of the HIV epidemic?
- Are the studies specified by sex?
- Is the information about the social and economic impact of HIV on women being clearly and transparently publicized?
ANALYSIS OF GOAL 69

Rosen and colleagues quantify other costs of obtaining ART treatment. These costs include transport, substitute labour, lost income, non prescription medicines and special food. Patients generally visit a treatment clinic at least six times a year in the year in which they start ART. The average cost per visit is R120, plus travel and waiting time. They argue that these costs should be considered in efforts to sustain adherence and in expanding access. It should be noted that only 25% of those who should be on treatment are accessing treatment presently, due to health systems and scaling up challenges. Costs for sicker patients also need to be considered as those who are ill and not accessing treatment would need hospitalisation or home care.

There has been limited work documenting the particular socio-economic impact of HIV on women and generally sex disaggregation is not done. The HEARD unit a health economics and HIV/AIDS unit attached to UKZN does not have any work on its website dealing with the impact on socio economic impact on women in South Africa. Similarly the South African Business Coalition on HIV/AIDS has no specific focus on information on women and socio economic impact on its website in the area of resources, projects and reports. The call papers for the Second Wits HIV/AIDS in the Workplace Symposium have added a section on ‘Sexuality and reproductive health in the workplace and beyond’

There is variety in the quality of research design as to the implications of what it would mean to study a particular group and the limitations it would have if it was an area that a bias of women would be enrolled into the sample. For example, research focusing on disinhibition enrolled respondents from clinics which made a bias in the sample in that two thirds of the sample are women. They had difficulty enrolling men as men don’t frequent clinics in the same numbers as women do. They conclude by default that women are not changing their sexual behaviour, which could be misinterpreted. There is little discussion about issues of individual agency in terms of violence against women which is endemic and as such the study could be viewed as limited. Similarly, work done in shebeens in townships in South Africa confirms high rates of promiscuity among men where infections rates are high. This study showed some men in Khayelitsha had had sex with as many as 39 different women in the space of only three months. The MRC study looked at more than 400 men, who reported anywhere between two and 39 different sexual partners in a three-month period. This research confirms existing knowledge and serves to sensationalise as opposed to inform better prevention practise. Articles appeared in

94 http://www.sabchoa.org/
the press later ‘Sugar Daddies lure girls with Freebies’\textsuperscript{97}, which does little to assist in mitigating these issues, and portrays African’s as having a sexuality that is not contained. These studies are problematic and are of concern\textsuperscript{98}. Some have suggested that South African research institutions are being used as ‘vessels for imperialist research’ and that we need to caution against being used by US research studies who want subjects to justify behavioural interventions.\textsuperscript{99} New guidelines and regulations are being developed nationally to harmonise and set better standards for ethical clearance for studies by national research bodies.

The 2007 Community Survey conducted by Statistics South Africa indicated increased social atomisation, with smaller and smaller units of living reshaping and disaggregating family interdependence.\textsuperscript{100} Because shared values and feelings of obligation towards others become more difficult to create in disaggregated households, role players will have to give more attention to policy implications of the impact of changing family structures on sexual practices and violence.

A recent ISS study\textsuperscript{24} mentioned anecdotal evidence from a variety of health practitioners that HIV-positive patients suppress their CD4 counts deliberately to remain or become ill to access the disability grant that is paid to afflicted persons. This needs to be investigated.

\textsuperscript{97} \url{www.iol.co.za} 18 June 2007 Di Caelers and Zama Feni
\textsuperscript{98} Dean Peacock. Sonke Gender Justice. November 2006. Personal Communication
\textsuperscript{100} Pillay, Suren. UWC. “Yesterday and today, but what of tomorrow?” Comment article in Mail&Guardian November 9 to 15, 2007, p28,
Goal 72 – Research and Development

“Establish and evaluate adequate methods to investigate the treatment efficacy, its toxicity, side effects, different medicines interaction, and the resistance to them; establish methodologies to survey the treatment effects in the HIV transmission and in risky behavior”

Proposed Indicators

• Reach and quality of surveillance systems to detect side effects of ARV independent of sex and gender.
• Adequateness of the health care service providers response to the resistance effects and side effects of ARV in women. - Microbicides

Issues related to this indicator

• Are there specific research about the HIV natural history in the female body?
• Are the number of women satisfactorily included in the clinical analysis when distinguishing it by sex?
• Are there incentives for women to participate in clinical analysis (viability, women’s focus groups, publicizing for women)?
• Is the release form freely and knowingly applied to the women that want to participate in clinical testing?
• Are there adequate mechanisms to protect the subject’s rights?
• Are the HIV infected women included in the bioethics committees?
• Are the women living with HIV included in the behavioural studies related to the HIV infection?
ANALYSIS OF GOAL 72

There are a variety of ethical committees based at different universities who have different methods of adjudicating proposals for research. There are efforts to have one national committee to ensure standardisation\textsuperscript{101}. Some research funded by international groupings is not well designed and can lead to unhelpful messaging. Some research reduces measures and interventions to women’s body parts – eg. Orifice neutral or a vaginal equivalent\textsuperscript{102}. Similarly other studies\textsuperscript{103,106} sensationalise sexuality or due to design and focus provide a limited and misleading picture that does not inform better prevention messaging.

While many participatory research proposals have included HIV women as focus group leaders and in the analysis\textsuperscript{52, 103}, there need to be moves to also include HIV positive women are generally not included in ethical review committees. Many participatory research proposals have included HIV women as focus group leaders and in the analysis\textsuperscript{52}. Similarly some ARV trials have community reference groups to ensure ethical practise of participants.

A Pregnancy register was to be set up to monitor the impact of ARV drugs in particular those contra-indicated in pregnancy and breast feeding (Tenofovir and Efavirenz) by the University of the Orange Free State but this has not taken place as yet\textsuperscript{104}.

South Africa has led and hosted a number of female controlled method studies – including microbicides, femidoms and diaphragms. A number of lessons have been learnt in this process, including better design and ethical issues\textsuperscript{105}.

Women in the Kwa Zulu-Natal province in South Africa are signing up for the safety and efficacy trials of a microbicide gel, formulated with tenofovir, which researchers hope will protect them from contracting HIV. This is viewed as “a second chance” for microbicides after three trials were stopped in the past year because the microbicide was ineffective or even harmful\textsuperscript{106}. Various microbicide trials in different stages are being held in South Africa given the large population of women at risk of contracting HIV/AIDS. The recent Carraguard phase 3 studies were released which showed no benefit or harm for participants.

\textsuperscript{101} Irwin Friedman. Research Director. Health Systems Trust. Personal Communication
\textsuperscript{102} Pierre Bruard Centre for the Study of AIDS, Sue Goldstein Soul City. Personal Communication. NSP Research Colloquium. July 2007
\textsuperscript{104} Personal Communication – Prof. Gary Maartens. Pharmacology University of Cape Town. July 2007
\textsuperscript{106} http://www.tinyurl.com/ywwpc9
A recent study looking at mortality trends from pulmonary tuberculosis (PTB) and HIV/AIDS co-infection in rural South Africa found that in the last three years, the HIV/AIDS epidemic has caused the number of persons dying of PTB to increase by +117%, with the mortality excess being higher in women (+164%) than in men (+103%). The recommendation was for strengthened combined PTB and HIV programme activities to respond to the increase in PTB mortality, particularly in women.\(^{107}\)

\(^{107}\) HSDRU. Trends in mortality from pulmonary tuberculosis and HIV/AIDS co-infection in rural South Africa Wits University (Agincourt) 2007
Please, think about the data gathered above and try and answer the following questions:

- What are the main strengths (partnerships and window of opportunities) to promote the advances in the sexual health of women living with HIV/AIDS to prevent the epidemic amongst women?

- What are the main gaps and deficiencies related to the articulation of sexual and reproductive health, HIV/AIDS, and the recommendations for its overcoming.

**Strengths**
- Good SRHR policy
- Political will – government supports women’s rights politically and in policy.

**Challenges**
- Lack of integration of SRHR and HIV
- HIV politics
- Funding and leadership
- Conservatism and complex cultural issues not being addressed comprehensive
- Violence against women is endemic
- Lesbians have experienced violence