Declaration of Commitment 2001

"Gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS [United Nations General Assembly Special"

An effective response to HIV is only possible if built with the participation of civil society, the government, and people living with HIV/AIDS.

UNGASS AIDS FORUM SOUTH AFRICA

MONITORING THE UNGASS GOALS ON SEXUAL AND REPRODUCTIVE HEALTH

2008
Cape Town

MOSAIC
TRAINING, SERVICE & HEALING CENTRE FOR WOMEN

HEALTH SYSTEMS TRUST

FACILITATED AND COLLATED BY MOSAIC AND HEALTH SYSTEMS TRUST

FOREWORD

This report is part of a bigger international effort through which NGOs from sixteen countries have collected strategic data on Sexual and Reproductive Health and Rights based on the goals in the 2001 UNGASS Declaration. The process was initiated by GESTOS Soropositividade, Comunicação e Gênero, an NGO in Brazil, and was funded by the Ford Foundation. The purpose of the study was to identify gaps and progresses in the implementation of activities addressing sexual and reproductive health and rights of women and girls in the fight against HIV and AIDS.

Participating organisations were:

- AIDS Legal Network (Cape Town)
- Gender Health and Justice Research Unit (University of Cape Town)
- Centre for the Study of AIDS (University of Pretoria)
- Centre for the AIDS Programme of Research in South Africa (CAPRISA – University of KwaZulu-Natal)
- Department of Obstetrics and Gynaecology – Nelson Mandela School of Medicine (University of KwaZulu-Natal)
- Health Systems Trust (HST)
- IPAS South Africa
- Mosaic Training, Service and Healing Centre for Women
- OUT LGBT Well-being (Pretoria)
- Rape Crisis (Cape Town)
- Reproductive Health Research Unit (RHRU)
- Reproductive Rights Alliance
- Tshwaranang Legal Advocacy Centre (TLAC)
- Western Cape Networking AIDS Community of South Africa (WCNACOSA)
- Women's Health Research Unit (University of Cape Town)

A first Forum 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. Collation of data was a dynamic iterative process with three drafts circulated for further comments. The present document is the third draft, collated by Marion Stevens (HST). Drafts were forwarded to the South African National AIDS Council process in drafting the South African 2008 country report. The third version of the document was circulated in November 2007 to additional organisations for comments, including:

- Sonke Gender Justice
- SWEAT
- Childline
- Children's Rights Centre
- Children's Institute
- Treatment Action Campaign
- AIDS Law Project
- Soul City
- Human Science Research Council

This draft was finalised in April 2008 and contributes to the UNGASS-AIDS 2008 Review process. It will be a shadow report and will be submitted to UNAIDS, as there is no mention of sexual and reproductive health and rights in the South Africa country report. A shadow report was also submitted in 2006.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic(s)
CBO	Community-based Organisation
FBO	Faith Based Organization
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
MSM	Men who have Sex with Men
NGO	Non-governmental Organisation(s)
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SANAC	South African National AIDS Council
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection(s)
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing

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SECTION 1: THE SOUTH AFRICAN CONTEXT

COUNTRY PROFILE AND INDICATORS

Population: 47.4 million[1]

Water access: 85% of households have access to piped water There is great variation in access to water across districts, with 90% of metros (cities) having access to piped water, yet some rural areas (particularly in the Eastern Cape) only having 28% access to piped water.[2]

Gini coefficient: 0.722[3]

Human development index: 0.653

Gender-related development index 0,646[3]

Unemployment: 26%[1]

Life expectancy: 47 years[1]

Energy supply 40% experienced at least periodic shortages of fuel for cooking or home heating. 61.3% used electricity for cooking.[1]

Mortality: HIV (51%) is the leading cause of death of women aged 15-54 years.[1]

Connectivity: 28 million out of 47 million people have cell phones. Over 90% of public health clinics have a cell phone.[4]

Women's health and sexual and reproductive health and rights

Rapes reported: 551 114 reported from April 2004 to March 2005.
Incidence: 143 per 100 000[1]

PPTCT: 68% of HIV-positive pregnant women accessed nevirapine[5]. Use of combination antiretroviral treatment in the Western Cape by HIV-positive pregnant women was shown to reduce perinatal transmission to below 2%[6].

Total fertility rate: 2.7[1]

Contraception rate: Use of contraception: 65% – generally the injectable[1]

Male condom distribution rate: 11.1 per man per year in 2005.[5] Female condoms thus far have only been available at pilot sites. Research is under way to determine the effectiveness of microbicides as a female-controlled HIV prevention method.[7]

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1 Ljumba, P. & Padarath, A. (2006). *South African Health Review.* Durban. Health Systems Trust.
2 Barron, P., Day, C., Monticelli, F., Vermaak, ,K., Okorafor, O., Moodley, K. & Doherty, T. (2006). *The District Health Barometer* 2005/06. Durban. Health Systems Trust.
3 UNDP (2007) http://hdr.undp.org/reports/global/
4 Benjamin, P. (2007). Cell Life, personal communication.
5 Barron, P., Day, C. & Monticelli, F. (2007). *District Health Barometer 2006/07.* Durban. Health Systems Trust.
6 Giddy, J., Roberts, C. & Reid, S. (2006). Less that 2% mother to child transmission (MTCT) of HIV achievable in South Africa. In XVI International AIDS Conference. Abstract MOPE0212: Toronto, CA.
7 Orner, P., Harries, J., Cooper, D., Moodley, J., Hoffman, M., Becker, J., McGrory, E., Dabash, R. & Bracken, H. (2006). Challenges to microbicide introduction in South Africa. *Social Science and Medicine, 6* (4): 968-978.

Delivery rate in facility: the average delivery rate in a facility was 81.1% in 2006.[14]

Antenatal care attendance: 77.7%.[5]

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%[8] reduction in maternal mortality and a 52%[9] reduction in morbidity in relation to abortion.

Abortion facilities: 51% of designated facilities are functioning.[8]

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) were made a notifiable condition in 1997. The National Committee for Confidential Enquiries into Maternal Death (NCCEMD) secretariat is responsible for co-ordinating the process or notification and reporting and making recommendations.[1]

Caesarean rate: 18.4%[14]

HIV/AIDS and other STIs

Estimated number of people living with HIV: 5.5 million[1]

Antenatal HIV prevalence: 29%[5]

Overall adult prevalence rate: 18.8%[1]

Average STI incidence: 4.9% (This indicator measures the percentage of people 15 years and older who have been treated for a new episode of a sexually transmitted infection.)[5]

HIV 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%.[1]

HAART treatment: January 2007: 250 000 on treatment in government public sector and 100 000 on treatment in the private sector.[10]

Treatment by gender: Within the private sector 60% of those on treatment are women and in the public sector, 65%.[11]

AIDS-defining illnesses: The incidence of cervical cancer is 30 per 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.[12]

Mortality: 51% of deaths of women between the ages of 15 and 54 are HIV related[1] .

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[8] Mosotho, G. Country Director of IPAS. Personal communication, 9 May 2007.
[9] Jewkes, R., Rees, H., Dickson, K., Brown, H. & Levin, J. (2005). The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. *BJOG*,*112*: 355-59.
[10] Xundu, N. (2007). 'Unveiling the NSP' by Thabane in *Mail and Guardian* April 13,11.
[11] Johnson, L. UCT Actuarial Science, personal communication, September 2007.
[12] Moodley, J. Director of the Women's Health Research Unit, personal communication, 9 May 2007.

OVERVIEW OF THE SOUTH AFRICAN HEALTH SYSTEM, 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, and framed to reduce black population numbers.

Following the change of government in 1994 rapid strides were taken to prioritise 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 years. 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 in the direction of an integrated and decentralised 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 realisation of these rights, (3) No one may be refused emergency care treatment.' [13]

While efforts have been made to implement this policy, with over 4 000 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[14]. In relation to broader determinants of public health many people do not have access to clean water, sanitation, nutrition, electricity and safety which facilitate 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 may not be able to 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, many hospitals and clinics face a huge increase in patients,

[13] Klugman, K., Stevens, M., Van Den Heever, A. & Federal, M. (1998). *From Words to Action: Sexual and Reproductive Rights, Health Policies and Programming in South Africa 1994-1998.* Women's Health Project.
[14] Barron, P., Day, C., Monticelli, F., Vermaak, ,K., Okorafor, O., Moodley, K. & Doherty, T. (2006) *The District Health Barometer 2005/06.* Durban, Health Systems Trust.

but there has not been an increase in numbers of 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'[15] during the period of 1994-1998. This period was characterised by a flow and political ease in which policy change at addressing the apartheid past was welcomed[16]. 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 characterised South Africa. As black women were known to have borne the brunt of apartheid's 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 of 1996
- The Choice on Termination of Pregnancy Amendment Act of 2008
- The Notification of and Confidential Enquiry into Maternal Deaths (NCCEMD)
- The Sterilization Act of 2000
- Contraception policy guidelines
- Policy Guidelines for the Management of Transmission of Human Immunodeficiency virus (HIV) and Sexually Transmitted Infections in Sexual Assault
- National Policy Guidelines for Victims of Sexual Offences.
- The HIV and AIDS and STI National Strategic Plan for South Africa, 2007-2011[17]
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007[18]
- 365 Day National Action Plan to end Gender Violence[19]
- South Africa ratified the Protocol to the African Charter on Human Rights and People's Rights of Women in Africa[20] on 17 December 2004: Article 14. Health and Reproductive Rights[21]

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15 Stevens, M. (undated). A Policy Analysis of the Choice on Termination of Pregnancy Act No 92 of 1996. Unpublished Masters Thesis. School of Management. University of the Witwaterstand.

16 Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L. & Hoffman. (2004). Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status. *Reproductive Health Matters, 24*(12): 70-85.

17 SANAC DOH. (2007). *HIV/AIDS and STI National Strategic Plan 2007-2011.*

18 The *Criminal Law (Sexual Offences and Related Matters) Amendment Act, No 21 0f 2007.*

19 365 Day National Action Plan to end Gender Violence, 8 March 2007.

20 http://www.unicri.it/wwd/trafficking/legal_framework/docs/protocol_on_rights_of_women_in_africa.pdf

21 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

- Supporting the Abuja Call for Action for African Heads of State and Government in May 2006, in which the failure to take into account the link between HIV and AIDS and sexual and reproductive health is mentioned as one of the main challenges and obstacles towards universal access to HIV/AIDS services in Africa
- Signing of the Maputo Plan of Action aimed at universal access to comprehensive sexual and reproductive health services in Africa by 2015.[22]

Highlighting a few of these areas:

1. While South Africa has liberal abortion laws which have 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. In 2006, services were suspended for two weeks in the Northern Cape as service providers thought the legislation had been repealed.
2. National Committee of Confidential Enquiry into Maternal Deaths. This committee is responsible for confidential enquiry into maternal mortality – it has developed a reporting system for maternal deaths. Confidential enquiry (CEMD) is systematic multidisciplinary anonymous investigation into maternal deaths in South Africa. However, this system is not designed to capture deaths which occur at home. It identifies the numbers, causes and avoidable factors associated with each maternal death. Lessons are learnt from each death. Evidence is acquired about major problems in the system and analysis of what needs to be done is undertaken. Recommendations for both health sectors and community action are developed, as well as guidelines for improving clinical practices. The committee publishes reports annually, and every three years a triennium bigger report is produced, called the Saving Mothers Report. According to the 2001-2004 report, there seems to be an increase in non-pregnancy related causes of death, and AIDS in

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This includes:
a) the right to control their fertility;
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;
d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
g) the right to have family planning education.
2. States Parties shall take all appropriate measures to:
a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."

[22] African Union. (2006). *Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010,* Special Session of the African Union Conference of Ministers of Health Maputo, Mozambique, 18-22 September, Sp/MIN/CAMH/5(1).

particular, rising from 17% (1999-2001) to 29% (2002- 2004) . It is evident that AIDS is proving to be the largest challenge to addressing maternal mortality in South Africa. [23].

3. As part of the HIV/AIDS continuum of care, the programme for the prevention of perinatal transmission was the first step in improving the health care of pregnant women infected with HIV. The South African Prevention of Mother-to-child Transmission (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 between the provinces differs[24,25]. The orientation of the programme has tended to emphasise children's health and not mothers' health, which has been problematic. However, increasingly this is being acknowledged and is beginning to be addressed. Women testing positive for HIV in vertical transmission programmes in some provinces continue on ARV treatment after birth, where appropriate. There are suggestions to reduce the CD4 count necessary to qualify for ARV treatment to 350 for HIV-positive pregnant women[4]. Dual therapy has also been an area of contestation, as the programme has been based on single nevirapine therapy, but dual therapy has now been approved. In early 2008, before this approval took place, charges were brought against Dr Colin Pfaff for providing dual therapy before it was approved by the Department of Health, indicating the complexities with treatment implementation in South Africa.

   The period of easy policy development has passed. Policy change is not as open and easy as it was in the late 1990s. The Sexual Offences Bill was passed by Parliament in 2007, and has been in the making for some ten years. While it has been welcomed by activists as a positive change, it still falls short of 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 prescribed by the legislation without involving civil society in the process.

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 per capita, rising from R168 in 2001 to R232 in 2005. The average clinical workload of a nurse was 31.6 patients a day in 2005. The primary health care utilisation rate is the average number of visits a person per year to a public PHC facility,

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[23] Department of Health. (2006b). *Saving Mothers Report. Confidential Enquiry into Maternal Deaths in South Africa.* Pretoria.

[24] McIntyre, J. (2005). Preventing mother-to-child transmission of HIV: successes and challenges. *BJOG: An International Journal of Obstetrics and Gynaecology, 112*:1196-1203.

[25] Meyers, T., Moultrie, H., Sherman, G., Cotton, M. & Eley, B. (2006). *Management of HIV-infected Children. South African Health Review.* Durban. Health Systems Trust.

which in 2005 was 2.1.[14] The challenges of South Africa are complex as it is a profoundly inequitable country, as shown by the Gini coefficient. Prior to 1994, the greatest proportion of health resources was allocated to the delivery of health care through the provision of curative, high-technology, hospital-based services to urban centres[26,13]. There are consistent efforts to spread resources and transform the health system through developing systems to increase the supply of health workers to 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 SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

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 past ten years South Africa's HIV/AIDS policy has been characterised 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 effecting legislative and policy change.

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

- abortion
- gender-based violence, and
- PMTCT and ARV treatment for HIV.[3]

In 2004, the country began to provide HAART as part of the continuum of HIV care within the public sector. Currently some 350 000 people are on treatment and an estimated 500 000 need to be on treatment[10]. In 2007 the government, in collaboration with many stakeholders (including civil society and 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, and 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 1: 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 3 of Research monitoring and surveillance. Currently reproductive health is

[26] Van Rensburg, H.C. & Harrison, D. (1995). History of health policy. In *Health Systems Trust. South African Health Review 1995.* Durban: Health Systems Trust.

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, and sexual violence is not part of the STI syndromic approach. Integrating HIV/AIDS into ongoing SRHR programmes and conversely SRHR issues into HIV/AIDS programmes remains a crucial area of development for South Africa.

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. 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 need to be refined.[27] The law and human rights sector is active, and policy issues are debated in this forum[28].

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. In concluding this section Shereen Essof argues, 'Perhaps the loudest story that can currently be told about the status of women in South Africa is linked to Jacob Zuma. Does Zuma's acquittal spell a loss for South African women in the campaign for full rights and freedoms? This case serves to highlight some of the dichotomies that exist when a ruling party espouses a progressive stand on gender relations, yet some of its leaders still cling to less progressive views about women, masquerading them as culture.'[29]

[27] Personal communication from Judi Merkel, SANAC Women's Sector Secretariat, 26 November 2007.
[28] Personal communication from Johanna Kehler, AIDS Legal Network, January 2008.
[29] Essof, S. (2008). 'Wathini'abafazi, Wathint' imbokodo – the left engendered. *Amandla,* March.

SECTION 2: UNGASS GOALS AND PROPOSED INDICATORS

Goal 37 – Government Leadership in 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 marginalisation; 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 co-operation; 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;"

Proposed indicators

- Effective participation and meaningful (quality) of representative of women and youth living with HIV in the HIV/AIDS programmes, including the decision making spaces and in the UNGASS monitoring actions.
- Participation of groups of women in assisting by the design, implementation, and evaluation of the programs directed towards them.

Issues concerning this indicator

- Do the women and girls participate in the decision-making processes in the HIV/AIDS National Programme? Describe and analyse;
- 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

The South African National AIDS Council (SANAC) is being revitalized but has thus far not had a dedicated and funded secretariat. This has led to difficulties in getting timeous notice out for meetings and ensuring adequate representation from the 17 sectors involved. While much work remains, recent developments indicate a positive trend.

Following the release of the nine 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. 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). The latter has subsequently resigned as a sector representative. The mandate of the women's sector is to identify issues that advance women's issues in SANAC to broaden their involvement in the NSP. The means by which they intend to do this is by support, co-ordination and communication within the sector. The women's sector is committed to ensuring transparency, mobilisation and accountability. Mechanisms to enable these processes still have to be developed. The women's sector is also represented on SANAC monitoring structures such as the Program Implementation Committee (PIC) and sector co-ordinating committees. In addition, a women's sector reference group was formed which has subsequently met twice. 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 representatives of Women in Partnership Against AIDS (WIPAA).

Since the ratification of the women's representatives by the Deputy President at the end of April 2007 little constructive work has been done. Two reference group meetings took place. At the meeting in October 2007 it was reported that Oxfam funding had been received to establish minimal infrastructure and a co-ordinator for a 4-month period. A draft implementation plan was submitted, including an intention to map the women's sector and establish a database of organisations by March 2008. Many organisations in the sector are dissatisfied with the slow progress and hope that the envisaged Women's Summit in April 2008 will bring more clarity and structure to the sector.

Although none of the three elected women's sector representatives were able to participate in this UNGASS report, many important organisations working in the SRHR and HIV/AIDS field who are members of the women's sector contributed to the report.

There is a youth sector, but not specifically a girls' sector, and girls are not active in the women's sector.

The 365 Day National Action Plan to end Gender Violence[17] 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[30] into corruption and accountability in HIV/AIDS prevention and treatment efforts in South Africa. The main findings are quoted below:

1. *Budgetary management and execution – in essence, budget tracking mechanisms – appear lacking, especially in relation to disaggregated expenditure data on donor funding.*
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 finance is distributed 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.

[30] Schulz-Herzenberg, C. (2007). A Lethal Cocktail. Exploring the Impact of Corruption on HIV/AIDS Prevention and Treatment Efforts in South Africa. Institute for Security Studies.

Goal 52 – Prevention (Wide range of programmes)

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 programmes for women and girls.
- Female and male condoms availability in the health services, schools and associations – a 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 the issue of Tik.

Issues related to this indicator

- What are the main elements that compose the prevention policy of the HIV/AIDS National Programme 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? Analyse 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 STD diagnosis and treatment available and accessible in the basic levels of attention to health? Are there statistical data and national campaigns related to STDs?
- Is there regular monitoring of sexual and reproductive health, HIV/AIDS, and control of STDs 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. [31] A number of NGOs have developed materials in partnership with government, for example, Soul City, Planned Parenthood, LoveLife[32] and WPF[33]. 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 spurred 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[34], many teachers and principals don't agree and say that it certainly plays a role[35]. 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.[36] 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.[37]

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.[38]

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 lesbian women and lubricant for MSM are not available in the public sector [39] 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. OUT has

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31 http://curriculum.wcape.school.za/

32 www.soulcity.org.za, www.ppasa.org.za, www.lovelife.org.za

33 Today's Choices

34 National Assembly. Written reply. Question 382. Internal Question Paper 09-2007.

35 "School pregnancy shock". *Sunday Times* 18 November 2007.

36 National Assembly. Oral reply Question 296. Internal Question Paper 29-2007.

37 Department of Education. (2007). *Strategic Plan 2007-2011.*

38 "Now universities mobilise for a massive HIV-testing drive", *Sunday Times* 9 September 2007.

39 www.out.org.za. For more information on barriers to HIV testing for lesbian and gay people see OUT LGBT Well-being. (2004). Overall research findings on levels of empowerment among Lesbian, Gay and Bisexual people in Gauteng, South Africa. Unpublished report. Polders, L. & Wells, H. Pretoria: OUT LGBT Well-being and OUT LGBT Well-being. Also see Levels of empowerment among lesbian, gay, bisexual and transgender people in KwaZulu-Natal, South Africa. Unpublished report. Wells, H. Pretoria: OUT LGBT Well-being.

published guidelines for service providers, giving information about challenges facing lesbian and gay South Africans. Similarly issues of HIV/AIDS[40] and abortion are stigmatised.

As noted in the indicator section, in 2005 some 8,8 male condoms were distributed per man. Femidoms are not widely available and are generally limited to research sites and programmes[41]. The Department of Health has now issued a 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, the incident left those dependent on these public-sector condoms mistrustful of condom safety.

Certain cultural issues have been debated recently, including dry sex[42], virginity testing and male circumcision. There are also concerns regarding the 'magic bullet' approach which might instill a sense of false confidence in men. Men may feel protected and this may reduce the practice of safer sex and diminish women's ability to assert their need for this[43]. The impact of male circumcision on women also needs to be addressed, as thus far no studies have shown a protective effect for surgical male circumcision in terms of 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 South Africa, also indicated that communication strategies with regard to circumcision will have to take human rights and gender issues into account.[44]

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.[45] . 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.[46]

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 this objective is to reach 40% of services by 2007 and 90% of services by 2011. This

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40 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.

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

42 www.rhru.co.za

43 Sawires, S., Dworkin, S. & Coates, T. 2006 *Male Circumcision and HIV/AIDS Opportunities and Challenges*. AIDS Policy Development Center, University of California.

44 www.iss.co.za. 25 April 2007. "Wisely and Slow: They stumble that run fast" – Male circumcision as a preventative strategy for HIV transmission.

45 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

46 "Zulu culture wears the pants", Sunday Times, 9 September 2007, 7.

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 strengthening life education in all primary and secondary schools.

Government has adopted provider initiated testing as part of the NSP. Goal 5 is to 'increase coverage of voluntary counselling and testing and promote regular HIV testing'. The psychological services attached to these services are a challenge.

There is a large issue of drug abuse with a drug called ' Tik' (crystal meth) that is very prevalent, particularly in the Western Cape. Young girls are manipulated into starting to use it as they attempt to lose weight.[47] Interventions for dealing with reducing recreational drug use for young people is noted in the NSP under objective 2.8. While South African offers drug treatment, there is an insufficient number of facilities and services are unaffordable for most drug users. Most drug treatment programmes do not address HIV prevention[48].

EngenderHealth is involved with developing alternative cervical cancer screenings that can be used everywhere. In South Africa, EngenderHealth collaborated with Columbia University, the University of Cape Town, and the Cancer Society of South Africa (CANSA) to investigate the safety, efficacy, and feasibility of the "screen and treat" approach, which relies on visual inspection of the cervix and DNA testing, followed by cryotherapy treatment for women testing positive. This low-cost strategy could save an estimated 250 000 lives annually. With the government of South Africa EngenderHealth has also assessed existing cervical cancer screening services and made recommendations for improving them. [49]

[47] http://forum.southafrica-direct.com/tik-crystal-meth-t283-1.html

[48] Needle,RH, Kroeger, K, Belani,H & Hegle,J. 2007. Substance abuse and HIV in sub-saharan Africa: Introduction to the Special Issue. SAfAIDS News Plus. SAfAIDS News 2, 2007 Vol 13.

[49] http://www.engenderhealth.org/our-work/maternal/cervical-cancer.php

Goal 53 – Prevention (HIV/AIDS information and education)

"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 HIV?
- Are there formal or informal barriers to offer services and/or instruments for prevention of HIV for youth below 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 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 the age of 12 years to obtain contraception. Similarly the Choice on Termination of Pregnancy Act of 1996 does not place an age restriction on abortion access.

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.[50]

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[51] *(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 programme 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?*[52] *Three adherence cost effectiveness studies have been conducted in relation to PEP.*[53]

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 a powerful intervention in the HIV/AIDS pandemic. GTZ is sponsoring the development of short courses and 28 scholarships in applied drama and theatre postgraduate studies in an effort to develop capacity in HIV/ AIDS education.

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50 MSF 2006. *Confronting the Health Care Worker Crisis to Explain Access to HIV/AIDS Treatment.* Johannesburg

51 www.tlac.org.za

52 Kim, J., Mokwena, L., Ntlemo, E., Dwane, N., Noholoza, A., Abramsky, T., Marinda, E., Askew, I., Chege, J., Mullick, S., Gerntholtz, L., Vetten, L. & Meerkotter, A. (2007). *Developing an Integrated Model for Post-rape Care and HIV Post-exposure Prophylaxis in Rural South Africa*. Rural AIDS and Development Action Research Programme (RADAR), School of Public Health, University of the Witwatersrand, Population Council, Frontiers in Reproductive Health and Tshwaranang Legal Advocacy Centre.

53 Roland, M., Myer, L., Chuunga, R., Martin, L., Maw, A., Coates, T. & Denny, L. (2005). A Prospective Study of Post-exposure Prophylaxis following Sexual Assault in South Africa (University of California, San Francisco; University of Cape Town, South Africa; and University of California, Los Angeles). Vetten, L. & Haffejee, S. (2005). *Factors Affecting Adherence to PEP in the Aftermath of Sexual Assault: Key Findings from Seven Sites in Gauteng Province*. Johannesburg, Centre for the Study of Violence and Reconciliation. Christofides, N., Muirhead, D., Jewkes, R., Penn-Kekana, L. & Conco, N. (2006). *Including Post-Exposure Prophylaxis to Prevent HIV/AIDS into Post-Sexual Assault Health Services in South Africa: Costs and Cost Effectiveness of User Preferred Approaches To Provision.* Pretoria: Medical Research Council.

Goal 54 – Prevention (Perinatal transmission)

"By 2005, reduce the amount of HIV-infected breastfed babies by about 20%, and by 2010 by 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 programmes 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 contraceptives are provided for the HIV-positive women? Do any contraceptives have the effect of inducing them to 'sterilise' themselves?
- What is your country's policy on abortion? How does public opinion consider the right of an HIV-positive woman to interrupt her pregnancy / choose to have an abortion?

Analysis of Goal 54

There has been considerable work in the area of prevention of peri-natal transmission. Government initially did not adopt the WHO guidelines in providing dual therapy of nevirapine and AZT. Currently this has only been provided in the Western Cape. As indicated in the indicator section, only 68% of HIV-positive pregnant women nationally access vertical transmission.. Goal number 3 in the NSP directly deals with 'reducing mother to child transmission of HIV and suggest[ing] 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 has begun to decline. This is thought to be due to successful vertical transmission programmes in these two provinces[54]. 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.[55] 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 poorly resourced 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. Services that are integrated and are able to provide services to the mother or pregnant women are limited. HAART treatment is not accessible to all pregnant women. Currently only 25% of all those who should be on treatment are on treatment, 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 first-line regimens, as the drugs of Tenofivir and Evafirenz are contra-indicated in pregnancy and breastfeeding. The male condom barrier method is generally suggested to women. Female-controlled barrier methods in the form of 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.[56]

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Syphilis testing and treatment is routinely done in pregnant women. However, this is not an equitable service[57] with vast differences in access through South Africa. The national figure for 2006 for syphilis was 1.6% for pregnant women attending public antenatal services.[58]

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54 Personal communication from David Bourne, 14 July 2007.

55 Tanya Doherty http://www.hst.org.za/publications/708

56 Moodley, J. (2007). *Serving the Contraceptive Needs of PMTCT Clients in South Africa*. Women's Health Research Unit and Family Health International.

57 Nkonki, L., Doherty, T., Hill, Z., Chopra, M., Schaay, N. & 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.

58 www.doh.gov.za/docs/reports/2007.

While health care workers have adopted the public-sector principle of 'Batho Pele" (people first) and the Patients' Rights Charter, health-care workers express their frustration that HIV-positive women should not be sexually active and should not have children. This may lead to abuses in pressurising HIV-positive women to have sterilisation 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 contraindicated for pregnancy and breast-feeding. [59,60,61] *Abortion is legal in South Africa. However, only 51% of designated facilities are functional. 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, was challenged by 'Doctors for Life' and sent back to Parliament to ensure greater public participation The Choice on Termination of Pregnancy Amendment Act was passed as a result of this in January 2008. 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 into being sterilized to obtain a legal abortion. There is being remedied through reproductive rights advocacy, possible research and litigation processes[62]*. In addition, knowledge of emergency contraception is inadequate, especially among HIV- positive women.*[63]

[59] 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 of women living with HIV and AIDS.

[60] 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

[61] Personal communication from Nokuthula Mabele, ICW, January 2008.

[62] Personal communication from Tyler Crone, Athena Network, December 2007.

[63] Cooper, D. *et al.* (2007). Addressing HIV-positive women and men's reproductive health policy and health care needs. American Public Health Association Conference, Washington DC, November.

Goal 59 – Human Rights (Promoting women's 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 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 Programmes
- 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 programmes 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 programmes destined to promote women's rights? If yes, is there a specific organism to co-ordinate 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 programmes?
- Are there strengthening actions developed with the HIV/AIDS programme or with the sexual and reproductive health programme? what are the main challenges and facilitators to establish a common programme?
- 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 HIV and other STIs? 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's 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[64]. 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[65]. There have been some shortcomings in the past in the treatment sector within the HIV/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 backed reproductive rights in supporting the Health Systems Trusts submission regarding the CTOP Amendment Act of 2004. .Yet in the April edition of TAC's newsletter Equal Treatment[66] *their article on 'Pregnancy and your choices' has an emphasis on medication abortion, which is not available in the public sector and not surgical abortion, which is currently provided to most women. Medication abortion is only available in the private sector within the first trimester. Research is being completed to explore the public health outcomes of medication abortion within a context of endemic HIV, given concerns with pregnancy anaemia and to determine whether this should be an inpatient procedure.*

There are gaps in certain service provision areas. 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 [67].

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 stated that the African Protocol had not yet been 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

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64 Cooper, D., Harries, J., Myer, L., Orner, P.,Bracken, H. & Zweigenthal, V. (2007). "Life is still going on": Reproductive intentions among HIV-positive women and men in South Africa. *Soc. Sci Med, 65*(2): 274-283.

65 Harries, J., Cooper, D., Myer, L., Bracken, H., Zweigenthal, V. & Orner, P. (2007). Policy maker and health care provider perspectives on reproductive decision-making amongst HIV-infected individuals in South Africa. *BMC Public Health, 7*:282 doi:10.1186/1471-2458-7-282.

66 www.tac.org.za

67 Moodley, J.R., Hoffman, N., Carrara, H., Allan, B.R., Cooper, D.D., Rosenberg, L., Denny, L.E., Shapiro, S. & Williamson, A.L. (2006). HIV and pre-neoplastic and neoplastic lesions of the cervix in South Africa: a case-control study. *BMC Cance*, *6*:135 doi:10.1186/1471-2407-6-135.

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.[68]

In November 2006 South Africa become the first African country to legalise same-sex unions when Parliament approved the Civil Union Bill[69]*. However, there is evidence that prejudice by marriage officers of the Department of Home Affairs causes delay and long waiting lists for the performing of marriages.*[70]

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 provided for. None of the reported crimes have seen any suspects arrested following an investigation of the crimes.

There have been activities, many initiated by NGOs, in dealing with sexism and men, such as the Men as Partners Project (Engender Health/Hope Worldwide), the Fatherhood Project (HSRC), One Man Can Campaign (Sonke Gender Justice Network), Shosholoza AIDS Project (Targeted AIDS Interventions) and Stepping Stones (MRC).
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The South Africa Country report[71] *on work with men prepared by Sonke Gender Justice and submitted to the CSW offers a critical overview of work with men in the country. Twelve important themes emerging from the report are quoted below:"*

- *Growing numbers of men are taking a stand against gender-based violence and for gender equality*
- *Groundbreaking work with men to achieve gender equality is occurring across South Africa*
- *There is visible support by some senior government officials for work with men – but more sustained commitment is needed*
- *Widespread adoption of work with men within government departments has occurred*
- *There is a need for greater clarity of purpose about the goals of work with men, as well as increased co-ordination and planning*
- *Men's violence against women remains unacceptably pervasive*
- *Greater dialogue and accountability between organisations working with men and women's rights organisations is needed*
- *Current efforts to increase men's involvement in achieving gender equality relies too heavily on workshops and community outreach*
- *Efforts to involve boys in achieving gender equality should be expanded*
- *South African funding for gender equality work with men is insufficient while some international funding comes with strings attached*

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[68] Serumaga, D. (2007). *Africa: South Africa's Reservations and the Protocol.* Fahamu (Oxford), 23 November.

[69] The Civil Union Act of 2006.

[70] "Rocky road for same-sex marriages", *Saturday Star*, 1 December 2007.

[71] Sonke Gender Justice Network on behalf of the Office on the Status of Women, Office of the Presidency, Government of the Republic of South Africa. 2007. South Africa Country Report (at the 51st session of the Commission on the Status of Women, New York, March 2007). Progress on commitments made at the 2004 United Nations Commission on the Status of Women on implementing recommendations aimed at involving men and boys in achieving gender equality.

- *Not enough work with men is taking place in rural parts of the country or with traditional leaders*
- *Very little work with men addresses broader socio-economic conditions exacerbating gender inequalities."*

The report also proposed the following guiding principles:

1. *Recognise that men have a stake in changing and can be important allies in achieving gender equality*
2. *Be accountable to, supportive of and in ongoing dialogue with women's rights organisations*
3. *Be committed to internal accountability through agreed upon codes of conduct*
4. *Emphasise a human-rights based and social justice approach*
5. *Affirm gay rights and make the connection between homophobia and rigid models of masculinity.*

Women are disproportionately infected and affected by the epidemic and the focus on men should not deter 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 companies' workforces[72]. 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 disproportionately employed in the informal economy, where there is a lack of formal protection of rights.

Unfair discrimination due to an employee or job applicant's alleged HIV status is prohibited by Section 6 of the Employment Equity Act (1998). HIV testing without Labour Court authorisation is prohibited by Section 7 of the Act. A Code of Good Practice on Key Aspects of HIV/AIDS and Employment is attached to the Act. It aims at giving guidance on creating a non-discriminatory environment and managing the impact of HIV/AIDS on the workplace. South Africa has also passed the Promotion of Equality and Prevention of Unfair Discrimination Act (Act No. 4 of 2000). This Act outlaws unfair discrimination. Section one of the Act defines unfair discrimination as being when something imposes a burden on someone or denies them an opportunity. For example, the Act says that it is unfair discrimination to prevent women from inheriting property as this places economic and social burdens on women. Although the Act does not list "HIV status" as one of the grounds on which a person cannot discriminate, its provisions are broad enough to include this kind of discrimination.[73]

The Department of Social Development in South Africa also recently integrated specific HIV-related clauses into the reform of childcare legislation. The new Children's Act (Act No. 38 of 2005) has HIV specific provisions and provisions dealing with the "health status" of children. Section 13 provides that every child (a person under the age of 18) has the right to privacy regarding their "health status".

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[72] Dickinson, D. (2006). *Report on Workplace HIV/AIDS Peer Educators in South African companies.* Wits Business School, University of the Witwatersrand.

[73] Strode, A., Meerkotter, A. & Lewis, M. (2006). HIV/AIDS and Human Rights in SADC. *An Evaluation of the Steps taken by Countries within the Southern African Development Community (SADC) Region to Implement the International Guidelines on HIV/AIDS and Human Rights.* ARASA.

The Act also deals with a child's right to confidentiality regarding their HIV status. Section 133 says that no person may disclose the fact that a child is HIV positive without consent, except in certain defined circumstances.[2]

The Commission of Gender Equality has recently published the second edition of its Working Women's Manual, *which is an excellent resource for the working woman with information on:*

- *The Basic Conditions of Employment Act*
- *The Labour Relations Act*
- *The CCMA and the Labour Court*
- *Domestic employees*
- *Equality*
- *Maternity and family responsibility*
- *Unemployment Insurance Act*
- *Sexual harassment*
- *Safety laws*
- *Employment benefits.*
- *Issues that may affect the performance of women at work*
- *Contact details of resource institutions in all provinces.*[74]

At an ARASA conference in 2006 Mark Heywood cited that the South African National Defence Force employs over 100 000 people and that allowing them to continue with unfair practices such as pre-employment HIV testing undermines national workplace strategies. Military HIV prevalence levels are cited as between 15% and 20% for South Africa[75]*, 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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[74] Commission on Gender Equality. (2007). *The Working Women's Manual.* 2nd Edition. Department of Public Education and Information.

[75] Prof Lindy Heinecken, University of Stellenbosch, paper presented at the 4-day Institute of Security Studies, December.

Goal 60 – Human Rights (Gender equality)

"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 programme actions for young women.
- Reach, adequateness, and effectiveness of non-formal sexual and reproductive health and rights education programmes that promote gender equality, considering aspects of maleness, heterophobia, homophobia, and misogyny - note the 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 programmes for HIV prevention?
- Are there legal or traditional barriers (informal, socio-cultural) that limit young women's ability 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.[31] *There have been efforts to train teachers to improve lifeskills education in partnership with the Department of Education. 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 behaviour 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 in 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'. The target of 50% of schools by 2008 has been set for 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 by circumcision and might not practise safer sex, and women may then not be able to assert their need for safer sex. 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. [76] *The Children's Act which prohibits virginity testing is a step that has been taken to protect young girls.*[77]

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 create a barrier[78]*.*

[76] Sawires, S., Dworkin, S. & Coates, T. (2006). *Male Circumcision and HIV/AIDS Opportunities and Challenges,* AIDS Policy Development Center, University of California. 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.

[77] Personal communication from Johanna Kehler, AIDS Legal Network, January 2008.

[78] Personal communication from Johanna Kehler, AIDS Legal Network, January 2008.

Goal 61 – Human Rights (Violence and sexual abuse)

"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 (provide restitution and compensation for) 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 who are victims of violence or sexual violence, with anti-HIV and anti-STI 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 we 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, STI 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 organised national campaigns to fight violence against women and sexual exploitation of girls? If yes, how do we 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 we 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 of 1998 was developed with the consultation of a number of civil society stakeholders. It addresses violence against women and articulates the mechanism for obtaining a protection order.[79]*The effectiveness of this Act is dependent on correct implementation by 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 in the implementation of the Act due to a number of factors, including police dereliction of duty, different interpretations of the Act by magistrates, and a lack of minimum standards and co-ordination of 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 implementation 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 was passed by Parliament in November 2007 was the subject of intense negotiation over the previous 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 sexual acts 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*

[79] http://www.info.gov.za/gazette/acts/1998/a116-98.pdf

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.*[80]

In addition to the need to implement the provisions of this Act, there are numerous challenges. These include developing 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 STIs in South Africa. Emergency contraception and post- exposure prophylaxis are a challenge within the public sector. Health information systems and crime information systems are a challenge, despite the fact that statistics are collected and published annually.

The South African Law Society and the National Working Group on Sexual Offences have monitored and commented on the sexual offences legislation reform, but have generally found an unwillingness in the Department of Justice and Constitutional Development to consider recommended changes to the Bill. Guidelines have been 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 alleged offenders. These are not widespread and state financial support for these is erratic.

[80] http://www.tlac.org.za/images/documents/sobill10nov06sobpc06.doc

In 2003 excellent guidelines were published to stimulate the development and implementation of policies and protocols to address domestic violence as part of a comprehensive health sector response. Documentation offered:

- *a conceptual framework for the development of the policy*
- *a policy framework for domestic violence*
- *a sample form for the screening of clients for domestic violence by health practitioners*
- *standardised management guidelines for management protocol*
- *a domestic violence examination form.*[81]

Very useful guidelines for magistrates to deal with sexual offences and HIV/AIDS issues have also been compiled by civil society. The guidelines put the intersection between sexual violence and HIV/AIDS into perspective and then cover important issues such as:

- *experiences with HIV/AIDS in the courtroom*
- *harmful HIV-related sexual conduct*
- *HIV testing of alleged offenders*
- *guidelines and recommendations.*[82]

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[83] *that was compiled in 2006:*

- *half of all South Africans (and 37% of women) still believed that men made better political leaders than women did*
- *23% of men and 17% of women still believed that a university education was more important for a boy than for a girl.*
- *Nearly 10% of South Africans believed that it was in some way justifiable for a man to beat his wife.*

There are a number of excellent NGOs working in this field which undertake significant work to further the ability of women to deal with the impact of violence directed against them. The 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[17] *launched on 8 March 2007 (International Women's Day). Issues of concern, however, are that:*

- *Since the launch of the plan there have been no further movements from the Programme Management Unit to co-ordinate 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*

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81 Martin, L.J. & Jacobs, T. (2003). *Screening for Domestic Violence: A Policy and Management Framework for the Health Sector.* Based on research conducted by the Consortium on Violence Against Women. Institute of Criminology, University of Cape Town.

82 Smythe, D., Jefthas, D., Hoffman-Wanderer, Y., Artz, L., & Chisala, S. (2007). *Sexual Offences and HIV/AIDS. Challenges Facing Magistrates.* Based on research and workshops conducted by the Law, Race and Gender Unit, Faculty of Law and the Gender, Health & Justice Research Unit, Faculty of Health Sciences, University of Cape Town.

83 Centre for International and Comparative Politics. (2007). *World Values Survey 1981-2006.* University of Stellenbosch.

- *The plan should use stronger language such as in the Maputo Plan of Action to address violence against women, and sexual and reproductive health and rights, and HIV/AIDS in the prevention, treatment and co-ordination sections.*

Oxfam recently commissioned a baseline study[84] in South Africa on organisations and campaigns currently addressing violence against women and HIV/AIDS, and studying the focus of the work and its impact. Important observations which were made included:

- *In order to have an impact on both epidemics (HIV/AIDS and violence against women) work needs to be done at community level*
- *Networking and collaboration is essential to make an impact*
- *The impact of campaigns and programmes in various sectors is unclear, especially with many different messages at different 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 Jacob Zuma rape trial brought the interface between violence against women and HIV/AIDS 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 in recent years*
- *Faith-based organisations should play a bigger role in the twin epidemics*
- *Men must be included in addressing the interface between the epidemics*
- *The relationship between government and civil society needs to be examined to smoothen interaction and increase effectivity.*

The most important gaps in the interface between the two pandemics were identified as:

- *The gap between policy and ground level is too large.*
- *Researchers are detached from communities – there is a gap between available information and its implementation in communities.*
- *There is a gap between what government says and does – implementation lags far behind.*
- *Different standards of services and variable access to services in different areas confuse the public, who hear about policies but who don't see them implemented.*
- *Quality of training at government and civil society level is poor, and there is no assessment or monitoring.*
- *Women's health has been reduced to HIV/AIDS and needs to be extended to include access to health care in a broader sense.*
- *NGOs need to do more review and engage in self-reflection.*

A recent Save the Children report[85] documents the experience of young SADC migrant children, and in particular young girls' vulnerability to rape and sexual violence by border guards, police and truckers. It reports that many migrant children resort to sex work in order to survive.

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84 De Bruyn, R. (2007). *Report to Oxfam on Baseline Study of Organisations and Campaigns in the Context of HIV and AIDS in South Africa to End Violence Against Women.*

85 *Children on the Move: Protecting Unaccompanied Migrant Children in South Africa and the Region.* (2007). Save the Children, South Africa.

In support of the recommendation paper[86] arising from the gender civil society parallel 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' sexual and reproductive health rights, gender-based violence 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 funds for gender-based violence and sexual and reproductive health-related programmes when the mid-term meeting to review the performance of the Global Fund takes place in 2009.[87]

[86] Civil Society Forum. (2007). *Civil Society Forum Recommendations towards a Gender-sensitive Response to AIDS, Tuberculosis and Malaria of the Global Fund.*

[87] The Global Fund. (2007). *Communiqué: The Global Fund's Second Replenishment (2008-2010)*. 2nd meeting, Berlin, 26-28 September 2007.

Goal 62 – Reduction of Vulnerability (Poverty, illiteracy, etc.)

"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 behaviour 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 programmes for vulnerable women;
- Reach, adequateness, and effectiveness of productive programmes or projects (small business) for vulnerable women – basic social security and socio-economic rights;
- Reach, adequateness, and effectiveness of human rights defence policies and programmes for vulnerable women;
- Reach, adequateness, and effectiveness of programmes that attend to the causes and structural problems of the human traffic of women and girls, without resorting to individual criminalising and discrimination towards commercial sex workers.
- Reach, adequateness, and effectiveness of 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 programmes to suppress women trafficking? If yes, how do we 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 called for the decriminalisation of sex work in 2002.[88]

The SALRC has also drafted legislation on trafficking which has yet to be introduced into 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 Organised 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. Decriminalisation 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 co-ordinated civil society structure to address trafficking.[89]

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 years. While commendable, these are seen as inadequate and there are campaigns in place for a basic income grant. Concern has been expressed by people living with HIV/AIDS that social grants they receive may be withdrawn when their CD4 count rises after receiving antiretroviral treatment. There are calls for a chronic disease grant to deal with this type of issue.[90]

Roughly half of South Africa's people live in poverty. 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*
- *promote family and community stability, and*
- *affirm and support the inherent dignity of all.*[91]

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 for Women. Mosaic and its partners are currently in the process of

88 Personal communication from N Fick, SWEAT, November 2007.
89 Personal communication from M. de Vos, December 2007.
90 Nonkhosi Khumalo ALP. SANAC human rights and stigma presentation, November 2006.
91 www.big.org.za

developing a best practice model for counselling and group work with male abusers.[92]

Given the instability in the SADC region, South Africa hosts a number of refugees. The 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 an imagined mecca of economic opportunity, or a haven from a war-torn or troubled homeland. 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.[93] 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.*[94]

Recently the Joint Civil Society Monitoring Forum issued a press statement[95] *condemning a South African police raid on the night of 30 January 2008 of the Central Methodist Church in Johannesburg, during which police beat, harassed and used pepper spray against several hundred people from Zimbabwe who were seeking refuge in the church. Many refugees 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 Cape Town often receive complaints from legal refugees and migrants of exceptionally poor reception and services at governmental clinics.*[75]

This situation was confirmed by a recent report by the SANAC Law and Human Rights Working Group that found that South Africa's legal framework is not being applied uniformly. Public hospitals and clinics appear to be creating policies which deny refugees access to health care services, violate legal and human rights and undermine the objectives of the NSP.

92 Personal communication from M de Vos, January 2008.

93 http://www.southafrica.info/public_services/foreigners/immigration/refugees_asylum.htm

94 Tal, Y. & Schuster. (2008). *Living on the Fence.* Poems by women who are refugees from various countries in Africa. Women's writing workshops.

95 JCSMF statement condemning SAPS action at the Central Methodist Church, 1 February 2008.

Goal 63 – Reduction of Vulnerability (SRHR Programmes)

"By 2003, establish and/or reinforce strategies, norms, and programmes 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 programmes 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 programmes, and the inclusion, as much as possible, of the families in the planning, execution, and evaluation of HIV/AIDS attention programmes;"

Proposed indicators

- Reach, adequateness, and effectiveness of programmes 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 programmes 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 programmes.
- 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 population's 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 textbooks adequate to a proposal of inclusive education with respect to differences?

Analysis of Goal 63

Given the history of 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.

Soul Buddyz a key intervention by Soul City which addresses children and includes areas of gender and sexuality. The intervention reaches over 85% of children and distributes Grade 7 materials to about 60% of schools. Soul Buddyz club deals with issues in an ongoing way and trains teachers to do this work. Currently there are about 3 500 Soul Buddyz clubs and the general age is 8-12 years, with members being mostly girls.

The child support grant provided to caregivers of children under the age of 18 years 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 more welcoming to young people. Minors can access services without parental consent, but there are anecdotal reports of judgemental and hostile health workers. The Children's Bill makes provision for young girls from the age of 12 years 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 years. The trend of children raping and sexually abusing other children is a serious sexual and reproductive health behavioural issue that needs to be researched and addressed to greater effect in South Africa. [96]

Joan Van Niekerk[97] *of Child Line notes the following legislative areas in process*

1. The Child Justice Bill
This draft legislation dealing with children in conflict with the law has also been in process for the past decade. A further version of this Bill has apparently been released by the Cabinet and will return to Parliament in 2008. In the meantime, despite the lack of formal legislative support, diversion of children in conflict with the law into programmes that address their behaviour and situations continues. Lobbying and advocacy is required to ensure that the latest version of the bill is taken forward as rapidly as possible. Motivation for public hearings on the latest version needs to take place to ensure that it meets the needs of children.

2. The Films and Publications Act and Amendments
Definitions of child pornography and crimes related to child pornography have been passed, as well as more severe sentences for any exploitation of children through the making, downloading, possession and/or exchange of child pornography or the exposure of children to child and adult pornography. However, new proposals in the form of amendments are now in Parliament. They were rejected by the Parliamentary Portfolio Committee on Home Affairs and have been returned to the State legal drafter for re-working.

Opportunities for action:

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96 "Our children are raping each other", *Sunday Times,* 18 November 2007.
97 Joan van Niekerk, Childline. 2007. South Africa - The National AIDS Plan. Law and Policy, Child Protection and the HIV/AIDS pandemic

- *Examine the appropriateness of the redrafted regulations when they are released*
- *Monitoring and evaluation*

3. The Victim's Charter
This policy document supposedly provides for the protection of the rights of victims. However it is adult centred and has little validity for children.

4. The National Strategy on Child Protection
This document has also been at least a decade in development. A draft has been submitted to Cabinet for final approval. The document is not yet at the point of implementation.
Opportunities for action

- *lobby with the DSD for the implementation of this policy document*
- *monitoring and evaluation of implementation.*

5. Judge Bertelsmann request for Amici in the case of S v Pashwane and Makoena
In August 2007, Judge Bertelsmann invited various organisations to approach his court as Amici and to make submissions and recommendations relating to the child witness. The two accused in this matter have been convicted of raping a child. Judge Bertelsmann, concerned about children who are involved in sexual offences matters, has begun hearing evidence in the High Court. This process will continue into December 2007 and may result in some rulings that will improve the situation of the child witness.

6. Children's access to justice
Child victims' access to justice has been impacted on by the decentralisation of the Child Protection Units. This appears to have severely disrupted the management of offences against children. RAPCAN is doing research at present on how this has impacted on the care and protection of children. However, there are indications that child protection services provided by the South African Police Services are in a state of disarray. Numerous examples of mismanagement can be given. As this is the child's entrance into the criminal justice system, problems encountered at this level may block or totally discourage children (and their caretakers) from reporting violations of children's rights, or continuing with criminal justice processes.
Guardianship of children and the protection of their property rights remains vested in the High Court, which is inaccessible to children. This is particularly problematic when children have been orphaned. Access to the High Court is very problematic for all poor children, but particularly for children in rural areas.

The lack of access to the child support grant for children over the age of 14 years is particularly concerning. This is when children are "high cost" and very vulnerable to all forms of exploitation.

Of enormous concern is the lack of inter-sector integration of sector policies relating to children generally, and to orphans and vulnerable children in particular. Of further concern is the lack of co-ordination of policy and implementation plans across directorates within sectors. For example in the Department of Social Development, the Directorates for Family, Child Protection, Victim Empowerment, HIV/AIDS all have separate policies, implementation plans and budgets. If comprehensive care and protection is to be provided to orphans and vulnerable children, the development of child-appropriate and child rights-protective legislation and policy, as well as its implementation must be prioritised, and once developed, the implementation of such law and policy must occur.

Goal 64 – Reduction of Vulnerability (Vulnerable women)

"By 2003, develop and/or strengthen national strategies, policies and programmes, 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 programmes 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 these indicators

- Are there specific actions or programmes to protect the health of women living with HIV/AIDS and/or members of most groups vulnerable to HIV infection? If yes, how do we evaluate their effectiveness?
- Are there specific programmes or actions to protect ethnical minority women's sexual and reproductive health, and to prevent their HIV infection?
- Are there legal or traditional (informal, social, cultural) barriers that limit the ability of 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.
- Has 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 mobilising 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 called '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[98] 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 or 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 women in prisons[99]. Similarly, the compilation of stories in 'Remember me' gives voice to women on farms and documents their daily experiences, and compares them to male partners and inherent challenges.[100].These stories paint a vivid picture of the constraints on women's sexual and reproductive health in these vulnerable contexts.

98 Pronyk, P., Hargreaves, J., Kin, J., Morison, L., Phetla, G., Watts, C., Busza, J., & Porter, J. (2006). Effect of a structural intervention for the prevention of intimate violence and HIV in rural South Africa: a cluster randomised trial. *The Lancet*, *368*, 2 December.

99 Landau, J. (2004). *Journey to Myself: Writings by Women from Prison in South Africa.* Footprint Publishers.

100 *Remember Me? Stories from Women who Work on Farms.* (2002). 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 HIV/AIDS programmes for orphans, 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 programmes for orphans and children infected and affected by HIV.
- Provision of and quality of shelters.
- Reach, adequateness, and effectiveness of educative programmes for orphans and in vulnerable situations because of AIDS.

Issues related to this indicator

- Has the 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 we 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[101]. Little is known of the extent of child abuse on South Africa, but anecdotal estimates suggest that it is extensive and needs to be monitored[102].

The child support grant has been an effective provision to enable orphans and children to obtain support until the age of 18 years. There are bureaucratic barriers in obtaining the grant, since children need identity documents and it takes some 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 throughout South Africa, and there are issues of sustainability to support exclusive feeding. Education is free to all children in the public school system for the first ten years. However, other expenses such as 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.[103] 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 a lack of statistics on children accommodated in these shelters and the number of shelters in South Africa. Different types of shelters have different provisions with regard to funding. Legal placement of children into shelters is not being completed due to outside social workers' heavy case-loads.

Soul City has a programme 'Schools as nodes of care for vulnerable children' (SNOC). This programme is being rolled out to the poorest quintile of schools in Mpumalanga and to all schools in the Western Cape.

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101 UNAIDS, UNICEF, USAID (2004). *Children on the Brink*. Geneva.

102 Kistner, U., Fox. & Parker, W. (2004). *Child Abuse in and HIV/AIDS in South Africa: A Review.* Johannesburg: CADRE/DOH.

103 Meintjes, H., Moses, S., Berry, L. & Mampane, R. (2007). *Home Truths: The Phenomenon of Residential Care for Children in a Time of AIDS.* Cape Town: Children's Institute, University of Cape Town & Centre for the Study of AIDS, University of Pretoria.

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 at 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 on 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/AIDS epidemic?
- Are the studies specified by sex?
- Is the information about the social and economic impact of HIV on women being clearly and transparently publicised?

Analysis of Goal 69

Rosen and colleagues[104] 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 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 research unit attached to the University of KwaZulu-Natal, has no information on its website dealing with the socio-economic impact of HIV/AIDS on women in South Africa. Similarly, the South African Business Coalition on HIV/AIDS has no specific focus or information on women and socio- economic impact on its website[105]. 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 a range in the quality of research where women are enrolled into studies. For example, research focusing on disinhibition[106] enrolled respondents from clinics and had a bias in the sample in that two thirds of the sample were women. The study had difficulty enrolling men as men don't frequent clinics in the same numbers that women do. The study concluded by default that women are not changing their sexual behaviour. There was little discussion of issues of individual agency in terms of violence against women (which is endemic) and as such the study is limited. In contrast, work done in shebeens in townships in South Africa confirms high numbers of sexual partners among men. One MRC study, of more than 400 men in Khayelitsha, showed some men having sex with as many as 39 different women in the space of only three months[107]. This research confirms existing knowledge and serves to sensationalise, as opposed to inform better prevention practices. Articles appeared in the press entitled 'Sugar daddies lure girls with freebies'[108], which does little to assist in mitigating these issues, and portrays Africans as having a sexuality that is uncontained. These studies are problematic and are of concern[109]. Some have suggested that South African research institutions are being used as 'vessels for imperialist research' and that we need to caution against being manipulated by foreign research organisations which want research to justify certain behavioural interventions.[110] New guidelines and regulations are being developed nationally to harmonise and set better standards for ethical clearance for studies by national research bodies.

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104 Rosen, S., Ketlhapile, Sanne, I. & De Silva Bachman, M. (2007). Costs to patients of obtaining treatment for HIV/AIDS in South Africa. *SAMJ*,*97*(7).

105 http://www.sabcoha.org/

106 Eisele, T., Mathews, C., Chopra, M., Lisanne Brown, M., Silvestre, E., Daries, V. & Kendall, C. (2007). 'High levels of risk behavior among people living with HIV initiating and waiting to start antiretroviral therapy in Cape Town, South Africa'. *AIDS Behavior.*

107 Chopra, M . (2007). 'HIV prevalence and associated risk behavioural surveillance among sugar daddies in Cape Town. South African AIDS Conference.

108 www.iol.co.za 18 June 2007. Di Caelers and Zama Feni.

109 Peacock, D. (2006). Sonke Gender Justice. Personal communication.

110 Rispel, L. (2006). Human Sciences Research Council. Personal communication.

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."[111] *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[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.*

[111] Pillay, S. UWC. (2007). Yesterday and today, but what of tomorrow? Comment article in *Mail&Guardian* 9 November 2007, p28.

Goal 72 – Research and Development

"Establish and evaluate adequate methods to investigate treatment efficacy, its toxicity, side-effects, different medicine interaction, and the resistance to them; establish methodologies to survey the treatment effects in HIV transmission and in risky behaviour."

Proposed indicators

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

Issues related to this indicator

- Is there specific research about the natural history of HIV in the female body?
- Is a satisfactory number of women included in clinical analysis?
- Are there incentives for women to participate in clinical analysis (viability, women's focus groups, publicising 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 participants' rights?
- Are HIV-infected women included in bioethics committees?
- Are women living with HIV included in the behavioural studies related to HIV infection?

Analysis of Goal 72

There are a variety of ethical committees based at different universities which have different methods of adjudicating proposals for research. There are efforts to develop one national committee to ensure standardisation[112]. 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, e.g. orifice neutral or a vaginal equivalent[113]. Similarly other studies[106,107] 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[59,114], HIV-positive women are generally not included in ethical review committees. Similarly some ART trials have community reference groups to ensure ethical practices.

A pregnancy register was to be set up by the University of the Orange Free State to monitor the impact of ART drugs, in particular those contra-indicated in pregnancy and breastfeeding (tenofovir and evavirenz) but this has not taken place as yet.[115]

South Africa has led and hosted research on a number of female-controlled method studies, including microbicides, femidoms and diaphragms. A number of lessons have been learnt in this process, including better research design and ethical issues.[116]

Women in KwaZulu-Natal 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.[117] Various microbicide trials in different stages are being conducted 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 to participants.

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.[118]

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112 Friedman, I. Research Director. Health Systems Trust, personal communication

113 Brouard., P. Centre for the Study of AIDS, and Goldstein, S. Soul City. Personal communication. NSP Research Colloquium. July 2007.

114 Mabele, P. Director, Positive Women's Network, personal communication, November 2007.

115 Personal communication from Prof. Gary Maartens. Pharmacology, University of Cape Town, July 2007

116 www.rhru.co.za, , Mantell, J. E., Myer, L., Carballo-Dieguez, A., Stein, Z., Ramjee, G., Morar, N. S., & Harrison, P. F. (2005). Microbicide acceptability research: Current approaches and future directions. *Social Science & Medicine*, *60*(2), 319-330. Coetzee, N., Blanchard, K., Ellertson, C., Hoosen, A. A., & Friedland, B. (2001). Acceptability and feasibility of Micralax® applicators and of methyl cellulose gel placebo for large-scale clinical trials of vaginal microbicides. *AIDS*, 15, 1837-1842.

117 http://www.tinyurl.com/ywvpc9

118 HSDRU. Trends in mortality from pulmonary tuberculosis and HIV/AIDS co-infection in rural South Africa Wits University (Agincourt) 2007.

There are many initiatives now using cell-phone technology to gather data for research. Cell Life[119]is using a mass channel system in collaboration with organisations such as Soul City to enable communication ways between researchers and communities to facilitate two-way communication and support.

[119] www.cell-life.org.za

SECTION 3: STRENGTHS AND CHALLENGES

Thinking about the data gathered above, 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 overcoming HIV/AIDS?

Strengths

- Good sexual and reproductive health policy
- Political will – government supports women's rights politically and in policy.

Challenges

- Lack of integration of sexual and reproductive health and HIV/AIDS practice
- HIV/AIDS politics
- Funding and leadership
- Conservatism and complex cultural issues not being addressed comprehensively
- Violence against women is endemic
- Lesbians have experienced violence
- There are no champions in SANAC who advance a sexual and reproductive health agenda, as evidenced by the South African country report not dealing with this issue