
ARE WOMEN AT THE CENTRE?

A CRITICAL REVIEW OF THE NEW NSP RESPONSE
TO WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS

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INTRODUCTION:

.....
...the denial of human rights increases the risk of HIV infection, and HIV infection increases the risk of human rights violations. It is for this reason that a human rights approach has been a core principle of the HIV response. [NSP, p30]
.....

Women's HIV risks and vulnerabilities are well recognised, with data confirming that women are at disproportionate risk of HIV exposure and transmission, and are more likely to be subjected to stigma, discrimination, violence and other rights violations based on and in the context of HIV.¹ Similarly, the complexity of women's realities and risks, as well as the need to address their underlying factors, is widely acknowledged. There is also growing understanding and acknowledgement that effective responses to women and HIV require human rights to be at the centre of interventions and programmes, as well as enabling and supporting environments in which women are in the position to freely make informed choices about all matters affecting their bodies and lives, including choices about sex, sexuality and reproduction.²

Data indicates that an estimated 5.63 million adults and children are living with HIV in South Africa, 3.3 million (59%) of whom are women. Furthermore, young women (aged 15 to 24 years) are four times more likely to be living with HIV, as compared to their male counterparts of the same age, and HIV risks are further exacerbated for pregnant women and survivors of physical and/or intimate partner violence in this age group.³ In addition, the 2010 Antenatal Survey published by the Department

of Health in 2011, calculated the national prevalence of HIV among antenatal women aged 15 to 49 years at 30.2%, with the highest recorded prevalence of 39.4% in KwaZulu Natal. According to latest data, the peak of HIV prevalence now occurs in women between the ages of 30 to 34 years, with a prevalence rate of 42.6% in this age group.⁴

Data also confirms that women's HIV risks and vulnerabilities are further exacerbated by high levels of sexual and gender violence.⁵ According to UNAIDS, experiencing violence increases the risk of HIV transmission by a factor of three⁶, and women are more likely to experience violence and abuse based on their positive HIV diagnosis⁷.

In South Africa, cases of sexual assault and rape remain to be highly under-reported, with data from Gauteng indicating that only one out of every 25 rapes is reported to the police⁸, due to self-blame, fear of not being believed, trauma, and fear of secondary victimisation⁹. According to the South African Police Services (SAPS), 66 196 cases of sexual assault, including rape, have been reported between April 2010 and March 2011, with the highest number of reported cases (13 987) in Gauteng.¹⁰

However, despite all the evidence and recognition of women's realities and needs based on and in the context of HIV, as well as the commitments (globally and nationally) to address these, responses to women and HIV continue to be mostly inadequate and ineffective in addressing (and transforming) women's risks and vulnerabilities to HIV and related rights abuses. Similarly, gender inequality, patriarchal systems, violence, as well as social and cultural norms maintaining and condoning the very same, are well-recognised as '*drivers*' of especially women's HIV risks and vulnerabilities. Yet, there are very few '*successful*' programmes and interventions addressing the gendered societal context that defines '*who*' is at higher risk of HIV exposure and transmission, and '*who*' is more likely to experience violence, abuse and other rights violations.

The protection and advancement of women's rights, especially women's sexual and reproductive rights, are critical aspects of effective responses to HIV. However, a societal context filled with gendered norms and expectations around sex and sexuality severely limits women's access to and enjoyment of sexual rights and choices, while at the same time, societal expectations of motherhood, compromise women's rights to make informed reproductive choices. It is this very same societal context that also largely determines women's risks to HIV exposure and transmission, as well as to violence and abuse; their access to sexual and reproductive health services; and ultimately the extent to which available programmes and services are '*beneficial*' to women. Thus, effective and rights-based responses to women and HIV must as much recognise women's sexual and reproductive rights, as they must respond to women's sexual and

reproductive health needs. At the same time, the societal context in which these rights are claimed and services are accessed needs to be addressed and transformed for the national response to women and HIV to be effective.

One of the recognised challenges of the national AIDS response has been the lack of adequate programmes and interventions aimed at protecting and advancing women's sexual and reproductive rights and health needs in the context of HIV.¹¹ The new National Strategic Plan on HIV, STIs and TB, 2012 – 2016 (NSP) launched on 01 December 2011, making it thus crucial to review the *new* policy document designed to strategically guide the national response to HIV for the next five years.

It is within this context that this *review* examines the *new* NSP from a lens of women's sexual and reproductive rights, and raises the question as to whether or not the national response to women and HIV is indeed positioned to effectively address women's realities, risks and needs based on and in the context of HIV.

Written and designed with civil society stakeholders in mind, the aim of this review is to provide an '*advocacy tool*', a '*resource*', and '*food for thought*' on some of the pertinent aspects for effective rights-based responses to women and HIV. The publication includes an overview of the new NSP's goals, objectives and analytical framework (Part One); and a synopsis on women and HIV, with a particular focus on women's sexual and reproductive rights and health needs (Part Two). Part Three provides a critical analysis of selected objectives and interventions most relevant in the response to women's sexual and reproductive rights and HIV.

PART ONE: THE NSP

.....
*Fundamentally, we must endeavour to change the perception of viewing our response as an emergency that needs to be controlled and managed to positioning this response as an investment in the health of our people and our new democracy.*¹²
.....

The new National Strategic Plan on HIV, STIs and TB, 2012 – 2016, launched on 01 December 2011, provides ‘the strategic guide for the national response’, and aims to

*...inform national, provincial, district and community-level stakeholders on **strategic directions** to be taken into consideration when developing implementation plans. [NSP, p12]*

The NSP 2012 – 2016 reaffirms its commitment to a rights-based response to HIV, STIs and TB that ‘strives towards its ideals of human dignity, non-racism, non-sexism and the rule of law’ [NSP, p12]. It is within this context that the NSP identifies as one of its principles that the national response

...must be rooted firmly in the protection and promotion of human and legal rights, including prioritising gender equality and gender rights. [NSP, p22]

In line with the global vision of the ‘Three Zeros’ advocated by UNAIDS – Zero New Infections, Zero AIDS-related death, Zero Discrimination¹³ – the new NSP is ‘driven by a long-term vision for the country with respect to HIV and TB epidemics’ [NSP, p21]. The South African 20 year vision is:

- Zero new HIV and TB infections
- Zero new infections due to vertical transmission
- Zero preventable death associated with HIV and TB
- Zero discrimination associated with HIV, STIs and TB

Based on this vision, the new NSP identifies the following broad goals for the national response to HIV and TB:

- Reduce new HIV infections by at least 50% using combination prevention approaches
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation
- Reduce the number of new TB infections, as well as the number of TB death by 50%
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support the implementation of the NSP
- Reduce self-reported stigma and discrimination related to HIV and TB by 50%

CONTEXTUAL FRAMEWORK OF THE NSP

An understanding of the HIV epidemic and its key drivers are fundamental in guiding the NSP. [NSP, p22]

'KEY DETERMINANTS'

Building on the strength of the last NSP, whilst at the same time recognising and responding to its weaknesses and gaps, the new NSP is 'guided by' the findings of the *Know Your Epidemic Report*¹⁴, among other analyses, 'which identified the key determinants of the HIV epidemic in South Africa' [NSP, p22]. Recognising the multiplicity and interconnectedness of the various factors impacting on risks and vulnerabilities to both HIV transmission and rights abuses based on and in the context of HIV, the NSP identified 'key determinants' include:

...behavioural, social and biological factors – as well as underlying structural and societal factors, such as poverty, gender inequalities, human rights abuses and migrant labour. [NSP, p22]

ADVOCACY NOTES

The identification of 'key determinants' and 'actions' to address these is very commendable, as this approach is a crucial element for developing effective national responses to HIV risks and vulnerabilities. However, its adequacy can only be measured by the extent to which these 'determinants' will be translated into comprehensive and quality programmes and services – which are both responsive to the realities and needs of people and equally available and accessible to all.

Leading from its analysis of 'key drivers' and the review

of latest 'statistical evidence', the NSP highlights 'key determinants' and recommends various 'actions that will mitigate the impact of the epidemic' [NSP, p22-23], as well as guide the development process of implementation plans at a provincial, district, and community-based level. The 'key determinants' and 'recommended actions', as highlighted in the NSP, are:

Behavioural and social determinants

- **Sexual debut** – Tailored prevention interventions for the youth to facilitate delay of sexual debut and sustain protective behaviours
- **Multiple sexual partners** – Multi-level interventions that focus on sexual, social, cultural and gender norms and values
- **Condom use** – Increase consistent use, especially among key populations, including those involved in sex work
- **Age-disparate sexual (intergenerational) relationships** – Target prevention strategies at those men and women who have partners much younger/older than themselves, given that significant age discrepancy increases HIV exposure risk compared to people who reported partners of similar age
- **Alcohol and substance abuse** – Interventions to decrease alcohol abuse and other substance abuse (including illegal substances)
- **Prevention knowledge and risk perception** – Prevention strategies for people who expose themselves to the risk of HIV infection, including education and addressing of personal risk

ADVOCACY NOTES

It is crucial to ensure that interventions to address these various 'key determinants' are not implemented in isolation from one another, but instead be designed in such a way that acknowledges that all these 'determinants' are intrinsically linked.

For example: Increased and consistent 'condom use' by all who are at risk of sexual exposure and transmission of HIV can only be achieved if combined with enhanced levels of 'prevention knowledge and risk perception', especially individual perception of risk, as only a 'clear' and 'factual' understanding of 'who' is at risk of HIV and 'why', will ultimately lead to increased and consistent condom use.

Similarly, only as and when the 'large-scale rollout of a national medical circumcision programme' is taking into account the potential adverse impact on women (such as reduction in condom use, increase in men's 'risky sexual behaviour', and enhanced risks of gender violence), will medical male circumcision become an effective HIV prevention option.

Biological determinants

- **Mother-to-child transmission** – Strengthen the implementation of the four prongs of the PMTCT programme
- **Medical male circumcision** – Continue with large-scale rollout of a national medical male circumcision programme as part of a package of sexual and reproductive health services, which includes gender sensitisation
- **Other sexually transmitted infections** – Prevention and early treatment of STIs

- **Treatment as prevention** – Initiating all eligible people living with HIV to treatment according to national guidelines to improve their health outcomes and to reduce transmission

Structural determinants

- **Mobility and migration** – The risk of HIV infection is higher among individuals who either have personal migration experience or have sexual partners who are migrants and, therefore, appropriately targeted interventions are needed
- **Gender roles and norms** – Challenge the gender roles, norms and inequalities that increase women's vulnerability to HIV and compromise men's and women's health; address the position of women in society, particularly their economic standing; and engage with men on changing socialisation practices
- **Sexual abuse and intimate partner violence** – Implement interventions to prevent gender-based violence, as well as intimate partner violence, and educate men about women's rights

CHALLENGES/SHORTFALLS

Stigma and discrimination are well-recognised and evidenced to be as much a cause of increased risk of HIV exposure and transmission, as it is a consequence of a positive HIV diagnosis.¹⁵ Stigma and discrimination based on and in the context of HIV impact greatly on the extent to which available services are accessible, as well as on individual decisions as to whether or not and when to test for HIV, to disclose a positive HIV diagnosis, and to access treatment, care and support. Yet, stigma and discrimination are not explicitly mentioned as part

of the *'key determinants'* of the *new* NSP, despite the fact that stigma and discrimination are recognised barriers to effective responses to HIV.

Similarly, conditions of healthcare services – including lack of quality services and discriminatory attitudes and practices of healthcare providers – have often been cited as a barrier to effective HIV responses¹⁶, including the NSP acknowledgement that staff attitudes *'may discourage people from accessing services'* [NSP, 57]¹⁷. Yet, the *new* NSP fails to mention prevailing structural and institutional challenges encountered at healthcare settings as one of the *'key determinants'*.

These shortfalls, if not addressed by the implementation plans at a provincial, district and community level, will ultimately affect the effectiveness and *'success'* of the national response to HIV. In addition, the failure to acknowledge stigma and discrimination at a household/family and community level, as well as within healthcare provision, as a *'key determinant'* for the HIV pandemic, will further manifest existing risks and vulnerabilities to HIV and related rights abuses, instead of addressing them.

'KEY POPULATIONS'

In addition to defining *'key determinants'*, the NSP also identifies *'key populations'* for the HIV response. According to the NSP, *'key populations'* refer to:

...those most likely to be exposed to, or to transmit, HIV and/or TB...[and] include those who lack access to services, and for whom the risk of HIV infection and TB infection is also driven by inadequate protection of human rights, and by prejudice. [NSP, p25]

Although South Africa has a generalised HIV pandemic demanding programmes and interventions to address HIV realities and needs *'at a general population level'*, the NSP also emphasises the need for *'targeted'* and *'specific prevention, care, treatment and support interventions based on risk and need'* [NSP, p25] of *'key populations'*. Recognising *'higher levels of infection and transmission within certain geographic areas, as well as among some key populations'* [NSP, p25] within the context of a generalised HIV pandemic, the national response is designed to address HIV realities, risks and needs of both the *'general population'* and *'key populations'*. Based on this need for *'targeted'* interventions for *'key populations'*, the NSP underscores that *'their engagement is critical to a successful HIV and TB response'* [NSP, p25].

ADVOCACY NOTES

Given the South African context of a 'generalised pandemic', indeed the question could be raised as to whether or not there is a need to identify 'key populations'. However, it has to be acknowledged that the identification and design of 'targeted interventions' specifically addressing the realities, risks and needs of 'key populations' undoubtedly carries the potential of enhancing the effectiveness of the overall AIDS response. This 'dual approach' not only addresses the 'generalised pandemic' and 'caters' for HIV risks and vulnerabilities of the 'general population', but also responds to specific realities, risks and needs of 'key populations' and 'concentrated pandemics' within the 'generalised pandemic.'

This dual approach can potentially only be realised as and when programmes and interventions 'targeting

key populations' are inclusive of, and responsive to the realities, risks and needs of all people 'most likely to be exposed to, or to transmit, HIV'. It is also vital to ensure that 'targeted interventions for key populations' are not designed and/or implemented at the expense of effective and rights-based interventions and programmes responding to people's realities, risks and needs among the 'general population'.

According to the NSP, 'key populations' that are at 'higher risk' of HIV exposure and transmission include:

- Young women between the ages of 15 and 24 years
- People living or working along roads and highways
- People living in informal settlements
- Migrant populations
- Young people who are not attending school
- People with the lowest socio-economic status
- Uncircumcised men
- Persons with disabilities
- Men who have sex with men (MSM)
- Sex workers and their clients
- People who use illegal substances, especially those who inject drugs
- Alcohol abuse
- Transgender persons
- Orphans and vulnerable children and youth

Recognising the 'substantial geographic differences in HIV incidence' [NSP, p26], the NSP further stresses the need for 'the identification of key populations for targeted interventions' [NSP, p25] in the development and design of implementation plans at a provincial, district and community level.

CHALLENGES/SHORTFALLS

Notwithstanding the fact that 'young women' are at particular risk of HIV exposure, transmission, and related rights abuses, there is, however, an enormous evidence base indicating that women by virtue of birth (biological) and by virtue of the gendered societal context 'are most likely to be exposed to HIV', 'lack access to services', and are at heightened risk of rights abuses.¹⁸ Yet, the new NSP fails to recognise **women** as one of the 'key populations' in need of 'targeted interventions', despite the evidence of women's greater risk to HIV and related rights abuses.

Latest data from the 2010 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa¹⁹ clearly shows an increase in HIV prevalence among women in the age group 30 to 34 years from 40.4% in 2008 to 42.6% in 2010, which is far higher than the national antenatal HIV prevalence rate among women estimated to be at 30.2% in 2010. Data also indicates that 'married women' are at 'higher risk of HIV exposure and transmission'.²⁰

While the 'glossary of terms' of the NSP states that 'in all countries, key populations include people living with HIV' [NSP, p6], the identified 'key populations' for the national response to HIV fail to include people living with HIV. Given that the realities, risks and needs of **people living with HIV** should be at the core of the 'strategic guide for the national response', this 'oversight' is greatly disconcerting. A 'strategic guide', based on which implementation plans are to be developed, should explicitly mention people living with HIV as a 'key population', rather than assuming that this is implied. Furthermore, if the national response to HIV is indeed conceptualised and

designed to equally respond to the realities, risks and needs of people living with and people at risk of and vulnerable to HIV, it is almost impossible to understand and/or justify as to why people living with HIV are not a 'key population' in need of 'targeted interventions'.

In light of the specific realities, risks and needs in the context of HIV, it is highly commendable that 'men who have sex with men' and 'transgender persons' are included as 'key populations'. However, it is equally disturbing that **women who have sex with women** are not included as a 'key population'. Even more so since 'women who have sex with women' – as defined by the NSP²¹ – may also engage in heterosexual sexual relations and should thus form an integral part of the national response to HIV.

Although there might be limited 'evidence' as to HIV prevalence among women who have sex with women, and/or as to the risk of HIV exposure or transmission, there is 'evidence' as to the increased risk of sexual violence and rape, and other forms of 'hate crimes', for women who have sex with women. It is well-documented that women are 'targeted', raped, abused, violated and, at times, murdered, for reasons of their sexuality²² – yet, the NSP seems to lack the understanding that sexual orientation and/or gender identity is as much a 'high risk' factor for women who engage in same-sex relations, as it is for men who engage in same-sex relations. Failing to include women who have sex with women as a 'key population' is a clear indication that their realities, risks and needs based on and in the context of HIV will be excluded from the national response to HIV – thus manifesting the risks and vulnerabilities to HIV

and related rights abuses for women who have sex with women.

The inclusion of **sex workers and their clients** as 'key populations' in need of 'targeted interventions' is highly commendable, as it arguably gives due recognition to the specific realities, risks and needs of this particular group of people 'most likely to be exposed to, or to transmit HIV'. However, given the criminalisation of both sex workers and their clients within South Africa's legislative framework²³, the effectiveness of interventions and programmes 'targeted' at sex workers and their clients is highly questionable, as accessing available services may also potentially expose sex workers to 'prosecution', based on their 'criminal activities'. Thus, without the 'decriminalisation' of sex work, interventions and programmes for this 'key population' will, by design, be limited in both their access and effectiveness.

These 'shortfalls' arguably highlight not only the gaps in the 'contextual analysis' of the NSP, but also the limitations of the potential impact of this new NSP, as programmes and interventions are only as adequate as the 'analysis' they are based on.

ADVOCACY NOTES

In light of all these 'shortfalls' in the identification of 'key populations', it is critical to ensure that implementation plans are indeed based on especially women's realities, risks and needs based on and in the context HIV – thus leading to the inclusion of women in all their diversity as one of the 'key populations' in need for 'targeted and specific interventions'.

STRATEGIC OBJECTIVES OF THE NSP

Based on the 'contextual analysis', the NSP identifies strategic objectives for the 'collective response' aimed at providing 'the impetus to achieve the 20-year vision' [NSP, p27]. Thus, the national response to HIV will be informed by four strategic objectives, namely to

- *Address social and structural barriers to HIV and TB prevention, care and treatment* – the primary objective is to address societal norms and behaviours through structural interventions to reduce vulnerability to, and to mitigate the impacts of, HIV and TB
- *Prevent new HIV, STI and TB infections* – the primary objective is to ensure a multi-pronged approach to HIV, STI and TB prevention, which includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV, STI and TB infections
- *Sustain health and wellness* – the primary objective is to ensure access to quality treatment, care and support services for those with HIV, STIs and/or TB and to develop programmes to focus on wellness, inclusive of both physical and mental health
- *Ensure protection of human rights and increase access to justice* – the primary objective is to address issues of stigma, discrimination, human rights violations and gender inequality

The various recommended interventions on how to achieve each of these goals, and 'scale-up the response to HIV and TB', are categorised by the NSP as:

...those that **increase coverage**; those that **improve quality**; **new combinations** of interventions

*which take into account the specific nature of the epidemics in different provinces and within different municipalities; and those interventions that are **novel**.*

[NSP, p27]

PART TWO: WOMEN AND HIV

.....
*A true focus on women's rights in the context of HIV requires that all women and girls vulnerable to HIV benefit from a wide range of prevention, treatment, care and support programmes that are tailored to the particular realities of their lives.*²⁴
.....

As stated previously, women are not only at 'higher and disproportionate risk' of HIV exposure and transmission, but also at 'higher and disproportionate risk' of HIV-related stigma, discrimination, violence and other rights abuses. Effective HIV responses thus have to adequately address women's HIV realities, risks and needs. Similarly, the advancement and protection of human rights are widely recognised as key to effective responses to HIV at a national and global level. In addition, the adequacy of rights-based responses to women and HIV is largely determined by the extent to which women are in the position to claim and enjoy their rights, as well as the extent to which enabling and supportive environments – legal, policy and social environments – are available and accessible to women.

The 2011 Political Declaration on HIV/AIDS²⁵, which the 'NSP 2012 – 2016 aims to align and be consistent with' [NSP, p28], for example, recognises that women remain the most affected by the epidemic, and that

*...the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic and social status, insufficient access to healthcare and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation against them.*²⁶

Based on this recognition, governments 'pledge to eliminate gender inequalities and gender-based abuse', through among other, ensuring that

*...women can exercise their right to have control over and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence.*²⁷

Although failing to include women as a 'key population', the NSP does, however, recognise that 'women are particularly vulnerable to HIV infection because of biological vulnerability and gender norms, roles and practices' [NSP, p35]; that social norms 'that condone gender violence will make it difficult for abused women to seek redress' [NSP, p39]; and that women 'must also be supported and enabled to access a comprehensive package of services, including sexual and reproductive health services' [NSP, p53] – all of which seem to be 'aligned to and consistent' with global commitments as expressed in the 2011 Political Declaration.

ADVOCACY NOTES

If progress in and effectiveness of the response to women and HIV would solely be measured by the stated 'commitments' and 'rhetoric', then the recognition of women's risks and vulnerabilities

based on and in the context of HIV could potentially be seen as an 'indicator of success'. However, as the 'real progress' in the response to women and HIV can only be measured against programmes and interventions, which are responsive to the realities, risks and needs of all women, and services that are available and accessible to all women, it is the implementation of these commitments and women's actual enjoyment of rights and services, which will ultimately define 'progress'.

ENABLING AND SUPPORTIVE ENVIRONMENTS

...social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue to block universal access.²⁸

At the core of enabling and supportive environments lies the full recognition of fundamental rights and freedoms, including the right to equality, the right to human dignity, the right to life, the right to autonomy, and the right to be free from all forms of violence. Thus, enabling legal and policy environments are to be premised on the promotion, protection and realisation of human rights of all people. In the context of women and HIV, it is also essential that specific legislative and policy provisions are in place, which recognise and protect women's rights, particularly women's sexual and reproductive rights.

An enabling and supportive environment is also defined by equal access to rights and available resources, as well as by the extent to which people are in the position to effectively and actively participate in social, economic, political, religious and cultural activities.²⁹ Hence, enabling and supportive social environments in the context of women and HIV imply that women are in a position to claim and enjoy all rights and freedoms,

including sexual and reproductive rights, as well as to access, participate in, and benefit from available services and interventions, including sexual and reproductive health services. Hence, effective responses to women and HIV are to take into account (and address) women's realities, risks and needs, as well as the societal context in which 'choices' are made and services are accessed.

South Africa's national response to HIV, and particularly to women and HIV, is arguably placed within an enabling legal and policy environment, in that fundamental rights and freedoms, including women's sexual and reproductive rights, are constitutionally guaranteed and at the core of laws and policies. The national response to HIV, as underscored in the NSP, '*recognises the centrality of constitutional values and human rights*' [NSP, p53], which

...is based on the understanding that public interest is best served when the rights of those living with HIV and/or TB – or are at risk of infection – are respected, protected and promoted. [NSP, p53]

CHALLENGES/SHORTFALLS

Notwithstanding South Africa's overall enabling legal and policy framework, it is, however, the continuous criminalisation of sex work and sex workers, which is of grave concern. It is widely recognised that sex workers' criminalisation is one of the causes increasing the risks of both violence and HIV transmission, as sex workers often remain unreached by programmes, and access to services continues to be severely limited and/or denied, due to their '*criminalised status*'.³⁰

Given this '*evidence*', one of the major flaws of the new NSP is undoubtedly its failure to call for the '*decriminalisation*' of sex work, thus acknowledging

the effects of criminalisation on sex workers' risks and vulnerabilities to both HIV transmission and to violence and abuse.

Without the '*decriminalisation*' of sex work, the national response to HIV will continue to '*facilitate*' the abuse and violation of rights of sex workers, and fail to respond to the realities, risks and needs of people at risk of HIV exposure and transmission, instead of '*respecting, protecting and promoting*' sex workers' human rights.

In light of the fact that the 'last' NSP (2007 – 2011) included the call for '*decriminalisation*' of sex work, questions need to be raised as to the '*justification*' for the national response to HIV '*regressing*', rather than '*progressing*', in recognising sex workers' rights, realities and needs.

Despite the '*enabling legal and policy environment*', there is growing '*evidence*' that human rights are indeed compromised in the application and implementation of some of the laws and policies relevant to the response to women and HIV.³¹ As a result, laws and policies meant to '*protect*' women's rights and enhance the effectiveness of the response to HIV become, in reality, often '*barriers*' to service access. Especially in the context of HIV testing, as well as the prevention of vertical transmission of HIV, women's human rights are often compromised and violated, while policy implementation is generally '*gender biased*' and discriminatory against women.

The NSP, acknowledging the potential negative impact of policies and their implementation on the realisation of rights and access to services, states that

...in an attempt to address any barriers and shortcomings – legal, social or economic – that may exist and therefore could undermine the rights

of individuals, review and assessment of laws and policies that may impact negatively on the response to HIV and TB, will be conducted expeditiously.
[NSP, p53]

ADVOCACY NOTES

The recognition that laws and policies 'may impact negatively on the response to HIV' is, in and of itself, laudable. However, the 'review and assessment of laws and policies' (albeit 'expeditiously') can only be as 'good', as it is informed by the experiences and lived realities of people accessing services. It is thus imperative that this 'review and assessment' is informed by consultative processes and the meaningful involvement and participation of people 'affected' by these laws and policies.

Nonetheless, it is important to recognise that an enabling legal and policy environment does not automatically translate into a reality in which rights are equally accessible and realisable to everyone. Creating an enabling and supportive social environment for women and HIV would entail addressing (and ultimately transforming) the societal context determining women's risks and vulnerabilities based on and in the context of HIV; most notably gendered inequalities, power relations, patriarchal systems, gender violence and discrimination.

ADVOCACY NOTES

The gendered societal context places women in a position of lesser power to make informed decisions about sex and sexuality, and thus, impacts on women's access to, and realisation of, sexual and reproductive rights. Furthermore, the societal context in which, for instance, HIV prevention decisions are made is largely defined by gendered norms and expectations, including norms and expectations of

'appropriate' sexual behaviour; often leaving women with limited 'ability' to partake in HIV prevention choices. Research further suggests that women's risks and vulnerabilities to HIV exposure and transmission are created and perpetuated by multiple and intersecting levels of gender inequality, which are often re-informed by social, cultural and religious norms of 'appropriate' sexual behaviour.³²

Common societal perceptions that married women, as well as young women, have no 'need' for HIV prevention, such as condoms, as marriage is commonly perceived to be 'safe', and young women are to 'abstain' from sex until marriage and/or 'delay sexual debut', are but two of the examples how societal norms of 'appropriate' sexual behaviour limit women's rights and access to services.

Without vigorously addressing the gendered and normative context of society as an integral part of the national response to HIV, women's sexual and reproductive rights and access to sexual and reproductive health services remain limited and constrained by the societal context of gendered sexual norms and expectations – while at the same time women continue to be at 'high and disproportionate risk' of HIV exposure and transmission.

It is within the context of creating enabling and supportive environments that the NSP recognises the need to address both *'social and structural drivers of HIV'*, as well as the *'social and structural barriers to HIV prevention, care and treatment'* [NSP, Strategic Objective 1]. In so doing, the NSP strives to address *...deeply entrenched and long-established cultural, socio-economic and behavioural factors, such as economic inequality, gender inequality, marginalisation and lack of access to basic services.* [NSP, p18]

Stigma and discrimination are widely recognised and evidenced as main barriers to effective responses to HIV, in that stigma and discrimination manifest especially women's risks and vulnerabilities to HIV, as well as limit women's *'ability'* to access, participate in, and benefit from available HIV prevention, testing, treatment, care and support services. Effective national responses to HIV would thus demand that programmes and interventions are responsive to people's realities and risks – which include high prevalence of HIV-related stigma, discrimination, and other violations of rights – and address stigma and discrimination as both, a cause and a consequence of the HIV pandemic.

For the national response to women and HIV, it is essential to not only recognise, but adequately address through programmes and interventions, the particular impact of stigma, discrimination, and other violations of rights on women and women's risks and vulnerabilities to HIV exposure and transmission. As such, it is crucial to ensure that programmes and interventions adequately address the various causalities between stigma, discrimination, and women's vulnerabilities. For example, it is important to recognise that stigma and discrimination both stem from and fuel the lack of recognition of women's sexual and reproductive rights, as the patriarchal societal context continues to fail to afford women the equal recognition of, and access to, the right to make informed decisions about all aspects of their lives, including sex and sexuality.

ADVOCACY NOTES

High prevalence of HIV-related stigma and discrimination greatly impacts not only on women's risks and vulnerabilities to HIV and associated rights abuses, but also on the extent to which available information, programmes and services are accessible

and beneficial to women. Effective stigma mitigation programmes are, thus, to address not only prejudicial and discriminatory attitudes and practices at a community and society level, but also within service provision. Based on the principle of 'meaningful participation', one of the guiding principles adopted by the NSP, it is crucial that the lived experiences and needs of women, particularly women living with HIV, are at the centre of programme design and implementation.

Even though the NSP fails to explicitly mention stigma and discrimination as 'key determinants' to the HIV pandemic in South Africa, it does however recognise that

...TB and HIV infection both generate significant stigma due to a variety of factors, such as lack of understanding of the illness, inadequate access to knowledge, fear, prejudice and socially sensitive issues, such as sexuality and gender identity.
[NSP, p36]

Premised on this recognition, the NSP emphasises the need to 'reduce HIV and TB related stigma and discrimination' [NSP, Strategic Objective 1.6], and calls for 'a clear programme of action that covers innovative and established methods of stigma elimination' [NSP, p36], while highlighting that

...the greater involvement of people living with HIV and TB is key in such programmes to empower and educate communities and individuals. [NSP, p36]

Regrettably, the NSP Objective designed to 'reduce HIV-related stigma and discrimination' does not further elaborate on 'the innovative and established methods of stigma elimination', as it only makes reference to 'a Stigma Mitigation Framework' that 'will be implemented' and the fact that 'efforts to reduce stigma will be

monitored by a Stigma Index' [NSP, p36]. Thus, the development of 'a clear programme' and 'specific' interventions to address and reduce HIV-related stigma and discrimination appears to be 'delegated' to the realm of implementation plans at provincial, district and community levels.

CHALLENGES/SHORTFALLS

In light of the enormous impact of stigma and discrimination on the pandemic and the response to HIV, it is indeed disconcerting that the one objective of the NSP specifically designed to 'reduce HIV-related stigma and discrimination' seems rather 'vague' in both its conceptualisation and design of this particular objective. The NSP not only fails to recognise the gendered nature of HIV-related stigma and discrimination, but also 'falls short' of identifying specific interventions (beyond the 'implementation' of a Stigma Mitigation Framework, and the 'monitoring' through the Stigma Index) of how to 'reduce HIV-related stigma and discrimination'.

Any effort to 'reduce' stigma and discrimination based on and in the context of HIV (including the Stigma Mitigation Framework) is arguably only as effective as it recognises, addresses and subsequently transforms the 'societal norms and values' and prejudices that cause, manifest, perpetuate, and at times condone and justify HIV-related stigma, discrimination, and other rights abuses – steps, which are not featured in this objective.

Although 'gender roles and norms', as well as 'gender-based violence', are included in the list of 'key determinants', the NSP seems to 'fall short'

in its analysis, in that HIV-related stigma and discrimination do not appear to be 'understood' as an integral link in the 'cycle of violence and HIV'. HIV-related stigma and discrimination are often at the core of violence, abuse and other rights violations, including limited and/or denied access to services, yet, this NSP objective seems to 'respond' to HIV-related stigma and discrimination in a 'vacuum' and 'siloed' approach.

level, so as to ensure that the implementation plans do indeed include 'innovative and established methods of stigma elimination' – thus carrying the potential to address the multiple causes, forms and effects of stigma and discrimination based on and in the context of HIV, including their gendered dimensions.

Taking into account the prevalence of 'unfair discrimination' based on and in the context of HIV in 'specific' areas, the NSP highlights the need to address 'discrimination in the workplace' [NSP Objective 4.2] and 'discrimination in access to services' [NSP Objective 4.3]. 'Unfair discrimination' in the workplace and in access to services based on a person's HIV status is a critical aspect of HIV-related stigma and discrimination. Effective responses to HIV, however, need to address HIV-related stigma and discrimination not only in 'specific' areas, but instead in all aspects of society, including at the family/household and community level.

SEXUAL AND REPRODUCTIVE RIGHTS

...too often, the mutual responsibilities of both men and women in reducing the risks of HIV transmission cannot be realised, in part because women are excluded from sexual decision-making, have not had access to comprehensive sexuality education and have unequal access to prevention methods.³³

There has been much debate and acknowledgment that the protection and advancement of sexual and reproductive rights are key to effective rights-based responses to HIV; that women's risks and vulnerabilities to HIV and related rights abuses are intrinsically linked to the lack of access to and realisation of sexual and reproductive rights; and that guaranteeing free and informed sexual and reproductive choices are at the core of decreasing women's risks and vulnerabilities.³⁴ In reality, however, insufficient progress has been made in ensuring that women's rights are adequately addressed and responded to in HIV interventions and programmes.

Similarly, it is well recognised that sexual and reproductive rights are not realisable without access to comprehensive and quality sexual and reproductive healthcare, information and services, while sexual and reproductive healthcare will remain limited and/or denied without full recognition, protection and advancement of sexual and reproductive rights.³⁵

ADVOCACY NOTES

Considering that failing to effectively address HIV-related stigma and discrimination to an extent 'nullifies' the efforts to respond to HIV risks and vulnerabilities, it is imperative that the implementation plans at a provincial, district and community level include a more 'comprehensive' understanding and approach to 'reducing HIV-related stigma and discrimination'.

Furthermore, to ensure adequate interventions and programmes aimed at reducing HIV-related stigma and discrimination, it is vital to engage with relevant stakeholders at a provincial, district and community

DEFINING SEXUAL RIGHTS

The Fourth World Congress on Women (FWCW) Platform for Action, in 1995, defined 'sexual rights' as:

*...the human rights of women include their right to have control over and decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.*³⁶

The above definition clearly indicates that 'the right to choose' lies at the core of sexual rights, including 'the right to choose' whether or not, when, how, where and with whom to engage in sex. In addition, to be 'free of coercion, discrimination and violence' is an essential component of the 'right to choose'. In reality, however, women's 'right to choose' whether or not, when, how, where and with whom to engage in sex is not only severely limited and/or denied by gendered norms and expectations of 'appropriate' sexual behaviour and choices, but also often linked to 'coercion, discrimination and violence'.

DEFINING REPRODUCTIVE RIGHTS

In 1994, the International Conference on Population and Development (ICPD) Programme of Action defined 'reproductive rights' as:

*...the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; and the right to attain the highest standard of sexual and reproductive health, and to make decisions about reproduction free of discrimination, coercion and violence, as expressed in human rights documents.*³⁷

As with sexual rights, the 'right to choose', as well as the right to be 'free of discrimination, coercion and violence' are the key components of reproductive

rights. As such, at the core of 'reproductive rights' lies the 'right to choose' whether or not to have children, with whom, when and how many; and to do so freely. However, in a societal context that prescribes women largely by their 'reproductive role', with 'motherhood' at the core of 'womanhood', women's right to make informed and free choices about 'reproduction' seems almost impossible to realise, especially as a decision not to have children is often accompanied by negative 'repercussions', including stigma, discrimination, violence and abuse.

REALISING SEXUAL AND REPRODUCTIVE RIGHTS

The limitations to, and violations of, women's sexual and reproductive rights are further compounded in the context of HIV, as women have least control over their bodies, sexuality and reproduction. Hence, women are least in the position to 'have control over' their own HIV risks and prevention choices. In addition, women's 'ability' to make free and informed choices whether or not and when to access services are equally limited and often 'pre-described' by societal 'assumptions' about women's sexual and reproductive desires and needs. Subsequently, available services may not be accessible to women, while services women have access to may not be 'responsive' to women's sexual and reproductive desires and needs.

The general lack of understanding of and response to women in all their diversity also creates a situation in which access to sexual and reproductive rights, choices and services are further limited to women of 'key populations', including women living with HIV and women who have sex with women. Based on societal 'presumptions' of women's sexual and reproductive realities and needs, services often lack not only the 'ability' to respond to women's 'real' needs, but also fail to facilitate an 'enabling environment' ensuring service

access and provision that are rights protective and ‘free of discrimination, coercion and violence’.

ADVOCACY NOTES

Within the patriarchal paradigm, male dominance extends to matters of sex and sexuality, thus largely denying women the right to participate in sexual decisions. Furthermore, women’s sexuality is often prescribed in the context of monogamous and marital relationships, which is arguably indicative of a lack of recognition of women as sexual agents in their own right, and failure to acknowledge women’s sexual desires and needs.

The ‘moralisation’ of especially women’s sex and sexuality also leads to a situation in which ‘appropriate’ sex for women is primarily portrayed as a means of procreation, further manifesting societal ‘assumptions’ that women’s sexual needs and desires are purposed by their desires to have children.

The societal ‘expectations of motherhood’ are not only extremely limiting to women’s rights to make free and informed choices, but also greatly impacting on women’s access to comprehensive and quality sexual and reproductive health services, as health services are largely designed around women’s pre- and post-pregnancy health needs. A general lack of access to, and information about, contraceptive methods and choices, especially for young women and married women, is but one of the examples of the influence of ‘societal norms and expectations’ on women’s access to comprehensive and quality services.

It is ‘perceptions’ like these which manifest and perpetuate the violation of women rights based on and in the context of HIV. As long as women are not

‘understood’ as people in their own right, but instead as ‘extensions’ of their male counterparts and children, responses to HIV will remain ‘ineffective’ to women in all their diversities – thus, preserving and possibly advancing women’s risks and vulnerabilities, instead of ‘reducing’ them.

The adequacy of the national response to women in all their diversity in the context of HIV can arguably only be measured against the extent to which *all* women’s sexual and reproductive rights are promoted, respected and protected, as well as the extent to which sexual and reproductive health needs of *all* women are responded to and provided for in the new NSP.

The new NSP does not make specific reference to ‘sexual and reproductive rights’. Instead, the NSP refers to ‘sexual and reproductive health rights’, while recognising that ‘women living with HIV are denied their sexual and reproductive health rights’ [NSP Objective 4.1.1, p55], and emphasising that ‘particular attention’ should be given to ‘the violation of women’s sexual and reproductive health rights’ [NSP Objective 4.1.3, p55]. Although not defining ‘sexual and reproductive health rights’, the NSP provides a definition of ‘sexual and reproductive health services’ and states that these include:

...services for family planning; infertility services; prevention of unsafe abortion and post-abortion care; diagnosis and treatment of sexually transmitted infections, including HIV infection; reproductive tract infections, cervical cancer and other gynaecological morbidities; and the promotion of sexual health, including sexuality counselling. [NSP Glossary, p7]

CHALLENGES/SHORTFALLS

Considering the centrality of ‘sexual and reproductive rights’ for effective rights-based responses to women and HIV, the ‘omission’

of recognising that 'sexual and reproductive health rights' are only a 'fraction' of what 'sexual and reproductive rights' entail is indeed greatly 'disturbing'. Even more so as this seems to 'indicate' the NSP limitations (and/or lack of preparedness) to address the 'determinants' leading to the 'violation of women's sexual and reproductive health rights' – the lack of recognition of women's right 'to have control over' their sexuality and reproduction, and the 'right to choose' freely and without fear of 'discrimination, coercion, and violence' about all matters relating to their bodies, sexuality and reproduction.

Notwithstanding that 'sexual and reproductive health rights' are an essential component of 'sexual and reproductive rights', the apparent 'minimisation' of 'sexual and reproductive rights' to 'sexual and reproductive health rights' is highly problematic, as women's 'agency' should first and foremost be determined by the recognition of all their rights – of which 'health rights' are but one of many.

ADVOCACY NOTES

With an NSP giving 'strategic directions to be considered when developing implementation plans' [NSP, p5], the responsibility for ensuring the development of adequate, effective and rights-based responses to women's HIV realities, risks and needs is largely placed at a provincial, district and community level. However, given the 'challenge' of failing to recognise women's sexual and reproductive rights as part of the 'strategic direction' for the development of implementation plans, the extent to which interventions and programmes addressing women's risks and vulnerabilities can be developed at a provincial,

district and community level will arguably be limited accordingly.

Thus, it is crucial to engage at a provincial, district and community level with the processes of developing implementation plans so as to ensure that both women's sexual and reproductive rights and health rights and needs are at the centre of the response to HIV and women.

GENDER VIOLENCE AND HIV

...much greater investment should be made to address the intersection between HIV vulnerability, gender inequality and violence against women and girls.³⁸

Gender violence as both a cause and effect of HIV has long been recognised. It is also well-documented that high levels of sexual and gender violence exacerbate women's risks and vulnerabilities to HIV exposure and transmission, while a positive HIV status exacerbates women's risks and vulnerabilities to violence, abuse and other violations of rights.³⁹

The evidence clearly indicates that violence and/or the fear of violence greatly impact on the extent to which women are in the position to claim and exercise their rights, and to access and benefit from available HIV prevention, testing, treatment, care and support services.⁴⁰ Research also shows that violence, in its various forms, impacts on decisions as to whether or not and when to access services, including HIV prevention and testing; as well as whether or not and to whom to disclose an HIV positive diagnosis.⁴¹

Prevailing high levels of violence and other rights abuses against people living with HIV was also confirmed in

a recent study on HIV-related human rights violations in the Eastern Cape.⁴² The study revealed not only the various layers of violence and rights abuses people are subjected to, ranging from physical violence to rape and refusal of treatment, but also the gendered nature of HIV-related violence and other rights abuses (74% of people who reported rights abuses were women). In addition, the findings also suggest that violence based on and in the context of HIV is an ongoing process of violations, as compared to a 'single' incident, and that these violations mostly occur within families and households (58% of cases), within communities (24% of cases), and within healthcare provision (11% of cases).⁴³

High prevalence of HIV-related stigma and discrimination further lead to a situation in which especially women living with HIV are further subjected to violence and other rights abuses within their relationships, families, households, communities and service provision, as and when their positive HIV diagnosis becomes known. Within healthcare settings, women living with HIV are often exposed to discriminatory attitudes and practices from healthcare providers, and as a result, experience limited, delayed and/or denied access to services. There is also growing evidence that women are subjected to 'coercive' practices, especially in the context of sexual and reproductive healthcare, most notably 'coerced' termination of pregnancy and sterilisation without consent.⁴⁴

Within the context of HIV testing, including HIV testing during pregnancy, women and women's rights are frequently compromised and violated, as women find themselves often 'coerced' and/or 'forced' to test for HIV as a pre-requisite for accessing antenatal care and other sexual and reproductive health services.⁴⁵ Based on women's experiences, research suggests that HIV testing during pregnancy has 'become another form of gender

violence in women's lives',⁴⁶ whilst simultaneously increasing women's risks to gender violence at a family, household and community level.⁴⁷

A recent report on violence in the lives of women living with HIV⁴⁸ clearly highlights the many '*hidden forms of violence*' and their effects on women's lives. Women's experiences illustrate how

*...abuse extends beyond the family cycle to public health institutions and police stations. Even if there is no physical violence, women are subjected to various kinds of structural violence.*⁴⁹

The fact that '*violence needs to be dealt with as an integral part of multisectoral responses to HIV*'⁵⁰ is well-recognised. Thus, addressing gender violence has to be a key strategy for effective responses to women and HIV. In order to effectively address the '*intersections between HIV vulnerability, gender inequality and violence against women*', it is however imperative to recognise all aspects and forms of gender violence, and the multiplicity of links between gender violence, women's risks and HIV. Thus, '*effective responses*' are to be based on and informed by women's experiences of the multiple layers of violence and rights abuses, ranging from interpersonal to structural and institutional violence.

Based on its '*contextual analysis*', the NSP recognises both '*gender roles and norms*' and '*sexual abuse and intimate partner violence*' as '*structural determinants*' of HIV, and therefore proposes to

...implement interventions to prevent gender-based violence, as well as intimate partner violence, and educate men about women's rights. [NSP, p23]

Further noting that '*gender norms*' are '*drivers of behaviours that place individuals at increased risk of HIV*

acquisition' [NSP, p39], the NSP emphasises the need for *'social interventions'* to include *'efforts to change cultural and social norms'* [NSP, p39], as these *'norms may'* promote discrimination and *'condone gender violence'* impacting on, among others, women's *'ability'* to access services and to *'seek redress'*, as and when their rights have been violated.

It is within this context that the NSP includes various objectives and *'interventions'* aimed at changing social and cultural norms and practices that define and perpetuate *'increased risk'* of HIV exposure and transmission, ranging from addressing gender inequalities and gender-based violence (Objective 1.3), to implementing a comprehensive national social and behavioural change communication strategy with a focus on key populations (Objective 2.4), and providing training to prevent unfair discrimination in access to services (Objective 4.3).

Recognising that barriers to accessing services *'may exist'* and *'could undermine the rights of individuals'* [NSP, p53], the NSP also emphasises the need to ensure that rights are not violated when interventions are implemented (Objective 4.1), and that *'specific access needs of particular groups and key populations'*, as well as *'social, cultural, legal and other possible barriers to accessing services'* [NSP, p53] are recognised when planning and implementing interventions. Although not specifically mentioned as a *'barrier'* to accessing services, gender violence in all its forms has to be recognised and addressed as *the* *'barrier'* to especially women's *'ability'* to exercise their rights and to access services.

The details of how to achieve these objectives, as provided by the NSP, however, illustrate a rather narrow approach and/or understanding of the various forms and effects of gender violence based on and in the context

of HIV. Interventions meant to address *'gender-based violence'* seem to mainly focus on *'sexual violence'*, rather than *'gender violence'* in its entirety, and thus restricting the potential impact these interventions could have on women's realities, risks and needs. Similarly, interventions designed to address *'barriers'* to access services, albeit a crucial element of effective responses to women and HIV, seem to be mainly focusing on *'barriers'* at an *'institutionalised'* level (level of service provision), hence, failing to address *'barriers'* at family, household and community levels limit women's access to services *'outside'* service provision.

In the context of violence as an effect of a woman's positive HIV diagnosis, the NSP only makes specific reference to the violation of women's *'sexual and reproductive health rights, especially the desire to have children'* [NSP, p55] and fails to recognise the many layers and forms of violence women experience in all spheres of society, based on their HIV status.

ADVOCACY NOTES

While the recognition of 'gender-based violence' as a 'driver of HIV' is commendable, it is the seemingly limited understanding of the many forms and effects of gender violence based on and in the context of HIV that greatly impedes the potential progress that could have been made in the national response to women and HIV.

For programmes and interventions to effectively address the links between gender violence, women's risks and HIV, it is imperative to recognise (and respond to) the multiplicities of violence as causes of women's greater risks to HIV exposure and transmission and the multiplicities of violence as effects of an HIV positive diagnosis.

PART THREE: WOMEN AND HIV: OBJECTIVES AND INTERVENTIONS

.....
To ensure that national HIV programmes address the needs and rights of women and girls in the context of HIV, a much broader range of programmes are needed that address the HIV-related needs of girls and women across the span of their lives.⁵¹

The NSP outlines various strategic objectives and interventions as the basis for the national response to HIV for the next five years. Although the national response in its entirety will impact and affect women’s HIV risks, realities and needs, the following assessment is based on the principled understanding that some of the identified strategic objectives and initiatives are arguably most relevant in the response to women’s sexual and reproductive rights and HIV. Specifically focusing on Strategic Objectives 1, 2 and 4, these include:

- Mainstream HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments and all SANAC sectors
- Address social, economic and behavioural drivers of HIV, STIs and TB
- Implement interventions to address gender inequities and gender-based violence as drivers of HIV and STIs
- Reduce HIV- and TB-related stigma and discrimination
- Make accessible a package of sexual and reproductive health services
- Prevent transmission of HIV to reduce MTCT to

at least 2% at six weeks and to less than 5% at 18 months by 2016

- Implement a comprehensive national social and behavioural change communication strategy with particular focus on key populations
- Address sexual abuse and improve services for survivors of sexual assault
- Ensure that rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights
- Reduce discrimination in access to services

STRATEGIC OBJECTIVE 1:

ADDRESS SOCIAL AND STRUCTURAL DRIVERS OF HIV AND TB PREVENTION, CARE AND IMPACT

Objectives and interventions designed to ‘address social and structural drivers’ are based on the understanding that

...the impact of infection and disease on people living with HIV and TB, as well as their families and communities, is profound. [NSP, p34]

Based on its ‘contextual analysis’ and the identification of

'key determinants' and 'key populations', the NSP aims to 'address the social, economic, political, cultural and environment factors that lead to increased vulnerability' [NSP, p34]. Thus, this particular 'strategic objective' is set out to 'focus on key structural factors that need to change over the next five years' [NSP, p34]

ADVOCACY NOTES

Recognising women's 'increased vulnerability' to HIV exposure and transmission, as well as HIV-related stigma, discrimination and other violations of rights, this 'strategic objective' are to be key in responding to women's realities, risks and needs. Even more so, since women's 'increased and disproportionate risk' is largely defined by the multiplicities and intersections of 'social and structural drivers'.

To ensure effective rights-based responses to women and HIV, it is crucial to 'interrogate' the identified 'objectives and interventions' as to the extent to which women's realities and rights, particularly women's sexual and reproductive rights, are at the centre of these 'social and structural approaches'.

sectors' to 'mainstream' the 'gender- and rights-based dimensions' of HIV into their 'core mandates'.

COMMENTS

Considering the limited 'contextual analysis' of the NSP providing 'strategic guidance', it is of concern that the 'gender- and rights-based dimensions' of the HIV pandemic, which are to be 'mainstreamed', are not further specified in this objective. Although indicating that the 'DPSA guidelines for mainstreaming' will be finalised, the lack of proposed interventions for this objective is quite 'problematic', as there is no 'strategic guidance' provided to 'government departments and SANAC sectors' of how and to what end to 'mainstream' the 'gender- and rights-based dimensions' of HIV.

Since 'women' are not included as a 'key population' in need of 'targeted interventions', and women's sexual and reproductive rights are not explicitly recognised in the 'strategic guide', the question needs to be raised as to the extent to which 'mainstreaming' can potentially enhance the 'effectiveness' of the response to women and HIV.

Mainstream HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments and all SANAC sectors (Objective 1.1)

Acknowledging the responsibility of 'government in its entirety' [NSP, p34], the NSP highlights the 'critical role' every government department has 'to play in addressing the social, economic and structural factors driving these diseases' [NSP, p34]. To fulfil this 'critical role', the NSP calls on 'all government departments and all SANAC

Address social, economic and behavioural drivers of HIV, STIs and TB (Objective 1.2)

The Executive Summary of the NSP states that this objective includes

...addressing challenges posed by: socialisation practices, living in informal settlements, as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse. [NSP, p4]

The actual objective as outlined in the NSP, however, neglects to provide specific ‘guidance’ on ‘addressing challenges posed by socialisation practices’; instead it focuses on ‘transmission hotspots’ (‘informal settlements’ and ‘rural and hard-to-reach areas’), as well as ‘migration and mobility’ and ‘alcohol and substance abuse’.

Recognising that all these ‘drivers’ are ‘associated with an increased risk of HIV acquisition’ [NSP, 35], the NSP highlights the need to ‘develop and implement a comprehensive strategy to address the social, economic, infrastructural and governance challenges’ [NSP, p35] in rural areas; emphasises that ‘a comprehensive package of services is urgently needed’ for ‘migrant and mobile populations’ [NSP, p35]; and calls on the Inter-Ministerial Committee on Substance Abuse ‘to review research findings and develop appropriate policies and programmes to address’ [NSP, p35] the issue of ‘alcohol and substance abuse’. The NSP underscores that ‘strategies’ addressing alcohol and substance abuse, as one of the ‘drivers’ of HIV, ‘must also address the gender norms that equate alcohol consumption with masculinity’ [NSP, p35].

COMMENTS

Although the NSP provides some ‘guidance’ in addressing ‘the challenges posed by living in informal settlements, as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse’, the apparent failure to explicitly address the ‘challenges posed by socialisation practices’ as one of the ‘social drivers’ of HIV, will not only impact on the overall effectiveness of the response to HIV, but will also limit the NSP’s potential to address and

transform the very same ‘socialisation practices’ that largely define especially women’s risks and vulnerabilities to HIV and related rights abuses.

In addition, the ‘vagueness’ in determining ‘timelines’ in which these ‘strategies and packages’ are to be developed, as well as in identifying the ‘content and scope’ of what is to be included in the ‘comprehensive’ strategies and packages to ensure that the ‘drivers of HIV’ are effectively addressed, is rather disturbing, as this could be read as both a lack of ‘urgency’ and ‘strategic guidance’ in relation to the ‘how to’ and ‘when’ to address these ‘drivers of HIV’.

Implement interventions to address gender inequities and gender-based violence as drivers of HIV and STIs (Objective 1.3)

This objective is based on the premise that ‘women are particularly vulnerable to HIV infection because of biological vulnerability and gender norms, roles and practices’ [NSP, p35]. The NSP also recognises that

...South Africa is grappling with high levels of violence against women, with sexual assault and intimate partner violence contributing to increased risks for HIV infection. [NSP, p35]

Without identifying the ‘specific’ interventions, the NSP emphasises that ‘a comprehensive approach to reduce gender-based violence in society’ [NSP, p36] needs to be developed and should include ‘primary and secondary prevention and scaling-up social change communication programmes dealing with gender stereotypes and harmful norms’ [NSP, p36]. The responsibility to develop this ‘comprehensive approach’

is primarily placed with the ‘social and security clusters’ of government at provincial and national levels, SANAC, and the Department of Women, Children and People with Disabilities.

COMMENTS

Albeit the fact that ‘sexual assault and intimate partner violence’ contributes to women’s ‘higher and disproportionate risk’ of HIV exposure and transmission, it is the apparent ‘reduction’ of ‘gender violence’ to ‘sexual violence’, which is highly ‘problematic’. Without a ‘holistic approach’ to addressing gender violence in its entirety – both as a cause and effect of HIV – the response to women and HIV, including the links between violence, women’s risks and HIV, will remain limited and ineffective.

is of grave concern, especially in light of the impact of stigma and discrimination as both a cause and consequence of HIV and related rights abuses. To ensure that the ‘Stigma Mitigation Framework’ is indeed an ‘adequate tool’ to respond to the realities, risks and needs of all women, it is crucial that women living with and at risk of HIV are an integral part of programme implementation and monitoring.

STRATEGIC OBJECTIVE 2:

PREVENT NEW HIV, STI AND TB INFECTIONS

With the long-term vision of ‘zero new HIV and TB infections’, this strategic objective focuses primarily on ‘targeted, evidence-based combination prevention interventions’ [NSP, p39] to achieve the NSP goal of reducing new HIV infections by at least 50% by 2016.

Reduce HIV and TB related stigma and discrimination

(Objective 1.6)

Recognising that HIV ‘generates significant stigma due to a variety of factors’, the NSP highlights the need ‘for a clear programme of action’ to reduce HIV-related stigma, which includes ‘innovative and established methods of stigma elimination’ [NSP, p36].

Although not further elaborating on its scope and content, this NSP Objective makes reference to a ‘Stigma Mitigation Framework’ that will be implemented, and the progress ‘monitored by a Stigma Index’ [NSP, p36].

‘Combination prevention interventions’ are based on the recognition that ‘no single prevention intervention can adequately address’ HIV risks and vulnerabilities, and thus must be combined with ‘structural, biomedical and behavioural approaches’ to HIV prevention, so as to ensure the ‘greatest impact’ [NSP, p39]. In addition, ‘combination prevention interventions’ also highlight the need to focus prevention efforts ‘on high transmission areas and on key populations’, while at the same time ‘sustaining and expanding efforts in the general population’ [NSP, p39].

COMMENTS

As alluded to earlier, the ‘vagueness’ and lack of details of how to achieve this particular objective

Further elaborating on the meaning of these various ‘interventions’, the NSP makes reference to addressing ‘key high-risk determinants of HIV, STIs and TB’

(structural interventions); *'efforts to change cultural and social norms that increase vulnerability to HIV and STIs'* (social interventions); *'activities designed to encourage people to change behaviours that increase the risk of HIV'* (behavioural interventions); and medical male circumcision, female and male condoms, prevention of vertical transmission of HIV, and post-exposure prophylaxis as part of biomedical interventions. [NSP, p39]

ADVOCACY NOTES

The recognition that 'greatest impact' can be achieved through a 'combination' of efforts and approaches is arguably a critical aspect of effective responses to HIV, as this 'approach' also seems to acknowledge that HIV prevention realities, risks and needs do not exist in isolation, but instead are intrinsically linked to the contexts and environments in which these risks and vulnerabilities occur.

However, the 'success' and 'impact' of this approach will ultimately be measured by its adequate translation of the 'theory' of 'combination prevention interventions' into a 'reality' in which programmes and services are available and accessible to the 'combined' realities, risks and needs of all women.

Make accessible a package of sexual and reproductive health (SRH) services (Objective 2.2)

Taking into account the significance of the *'integration of services'* for effective HIV responses, this particular objective is based on the recognition that

...integrating HIV and STI prevention into a sexual and reproductive health framework is core to the success of the NSP. [NSP, p41]

The NSP outlines a number of interventions required to achieve this objective, including the *'delivery of an integrated package of SRH services'* at the level of primary healthcare *'within the district health system, with a focus on key populations'*, as well as the *'maximised coverage of male and female condoms through distribution in health facilities and non-traditional outlets'* [NSP, p41]. While neither of these approaches seem *'new'*, it is important to note that the NSP does make specific reference to the need to increase the *'range of contraceptive methods available to all women'* [NSP, p41], and to offer *'appropriate contraception'* to all women living with HIV.

Responding to the links between high levels of pregnancies and risks of HIV exposure and transmission among young women, the NSP underscores that *'special attention must be given to the issue of teenage pregnancy (planned and unplanned)'* [NSP, p41] and *'pregnancy prevention education'* must be provided to young people.

An integral part of this objective, as outlined in the NSP, is the focus on the provision of *'comprehensive education of sexuality, reproductive health, and reproductive rights'* in all schools, with the aim to

...build skills, increase knowledge and shift attitudes, change harmful social norms and risky behaviour, and promote human rights values. [NSP, p41]

Although the NSP focuses on *'maximising condom coverage'* and young women, as one of the identified *'key populations'*, the provision of condoms in schools seem to remain a *'contentious issue'*, as the NSP only

goes as far as stating in a footnote that the issue of condoms in schools *'will be explored during the NSP timeframe'* [NSP, p41]. The failure to afford women, including young women in and out of school, adequate access to condoms, most notably female condoms, seems contradictory to the NSP's stated goal of providing an accessible package of sexual and reproductive health services, *'with an emphasis on key populations'*.

needs, it is arguably only as and when *all* women have equal access to *'comprehensive'* sexual and reproductive health services that *'combination prevention interventions'* have the *'greatest impact'*.

COMMENTS

The extent to which women's sexual and reproductive rights are promoted, protected and respected is a critical component of women's *'ability'* to access and benefit from a *'package of sexual and reproductive health services'*. Yet, the NSP does not explicitly make reference to women's sexual and reproductive rights, which will arguably have an adverse impact on, for instance, women's access to the prevention methods, such as female condoms.

Although commendable that *'comprehensive education'* in schools forms an integral part of ensuring access to a *'package of sexual and reproductive health services'*, the apparent failure to equally emphasise the need for *'comprehensive education'* outside schools and at institutions of learning is greatly concerning; more especially in the context of prevailing *'social and cultural norms'* and prejudices *'restricting'* women's access to services, which are largely manifested and *'condoned'* at a household and community level.

Notwithstanding that *'special attention must be given'* to young women's realities, risks and

Prevent transmission of HIV to reduce mother-to-child transmission (Objective 2.3)

The goal of this objective is to reduce vertical transmission of HIV to at least 2% at six weeks and to less than 5% at 18 months by 2016, which is consistent with international *'targets'* in this regard. Providing a *'roadmap'* for ending new HIV infections in children and *'improving the health and wellbeing of mothers, partners and babies in South Africa'*, the Action Framework will be *'finalised and adopted and its implementation monitored'* [NSP, p42]. Regretably, the NSP does not provide a timeline in which this *'roadmap'* is to be *'finalised and adopted'*, or any indication as to *'who'* will be involved in the monitoring of its implementation, both of which may impact on the timely and effective implementation of this NSP objective.

According to the NSP Glossary, the *'prevention of mother-to-child transmission (PMTCT)'* refers to a *'four-pronged strategy to prevent new HIV infections in children, and keep mothers alive and families healthy'* [NSP, p7]. These four prongs are

...halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding; and providing care, treatment and support for mothers and their families. [NSP, p7]

These four prongs, as outlined in the NSP Glossary, however seem to differ to the four prongs as included in the Action Framework and referred to in the actual NSP Objective covering the *'prevention of mother to child transmission'*. The four prongs, as outlined in the objective, are:

1. *Primary prevention of HIV among young women, with specific interventions targeting women who test negative and specific positive prevention interventions*
2. *Prevention of unintended pregnancies for teenagers and HIV-positive women*
3. *Prevention of HIV transmission from HIV-positive women to their infants*
4. *Provision of appropriate treatment, care and support to HIV-positive mothers, their infants and family* [NSP, p42]

While these *'variations'* in Prong 1 and 2 between the NSP definition of the four-prong strategy and its actual interventions may seem *'minor'*, they will, however, have *'major'* implications for women, and the effectiveness of the NSP to respond to women's realities, risks and needs based on and in the context of HIV. *'Primary prevention of HIV among young women'* is undoubtedly a key component of *'halving HIV incidences in women'*, especially considering the specific realities, risks and needs of *'young women'*. Yet, prevention of HIV among *'young women'* by itself is not going to lead to *'halving'* HIV incidences among women, since the *'majority'* of women seem to be *'excluded'* from this *'primary prevention interventions'*.

Similarly, *'reducing the unmet needs for family planning'* entails a much broader concept than *'the prevention of unintended pregnancies for teenagers and HIV-positive women'*. Again, it is the *'reduction'* of *'unmet needs for family planning'* to *'unintended pregnancies'*, which among others also seems to confirm the *'stereotypical notion'* that women's family planning needs are *'solely'* linked to *'pregnancy'* – which is one of the *'social and cultural norms'* increasing women's risks to HIV exposure and transmission and related rights abuses. In addition, the apparent *'reduction'* of *'women'* to *'teenagers and HIV-positive women'* arguably neglects the fact that *all* women are to have equal access to *'prevention of unintended pregnancies interventions'* provided for by the national response to HIV. A national response to women and HIV that only affords interventions aimed at preventing *'unintended pregnancies for teenagers and HIV-positive women'* also seems to ignore evidence that suggests that in reality 50% of *all* pregnancies are *'unplanned'* and *'unintended'*⁵².

COMMENTS

As suggested above, the failure to translate the *'four prong strategy'* to the prevention of vertical transmission of HIV, as defined by the NSP, into NSP interventions reflecting the scope and content of its own definition is indeed extremely *'problematic'*. In addition, the *'variations'* (although this possibly may be *'justified'* by the *'drafters'* of the NSP with the analysis of the *'national context of women's risks'*) also carry the risk of further manifestation and perpetuation of the *'stigma'* associated with pregnancy among *'young*

women' and 'women living with HIV' – the very same 'stigma' the NSP should address.

Similarly, it is of grave concern that the 'global strategy' for the prevention of vertical transmission of HIV – to which the national response is closely linked to – includes in Prong 2 the provision of 'comprehensive reproductive health services to women living with HIV'. The South African 'interpretation' and subsequent 'translation' into the national response to women and HIV only focuses on the 'prevention of unintended pregnancies among women living with HIV' – thus neglecting positive women's rights to, and needs for, a whole range of reproductive health services beyond the issue of 'unintended pregnancies'.

The many barriers to women's access to prevention of vertical transmission services, including stigma and discrimination; violence and abuse; discriminatory and prejudicial attitudes and practices both within and outside service provision; patriarchal systems; and the lack of the meaningful involvement of women living with HIV, are well documented.⁵³ While this objective does not make any reference to potential barriers which have to be recognised and addressed in order to facilitate women's access to and benefit from these services, it is the 'successful translation' of 'combination prevention interventions' that would carry the potential to address this 'concern'.

Furthermore, there is 'much' evidence pointing to human rights violations in the context of accessing antenatal care,

especially in the context of HIV testing during pregnancy⁵⁴, which are often cited as the main 'barriers' and 'deterrents' for women's timely access to antenatal care. Without rigorously addressing these human rights abuses, available services will remain largely 'inaccessible' and 'ineffective' to women.

Implement a comprehensive national social and behavioural change communication strategy with particular focus on key populations (Objective 2.4)

The stated goal of this 'comprehensive national social and behavioural change communication strategy' is

...to increase demand and uptake in services, to promote positive norms and behaviours and to challenge those that place people at risk (including norms that discourage men from accessing HIV, STI and TB services, contribute to violence against women, multiple partnerships and those that encourage alcohol consumption). [NSP, p42]

Recognising the need to 'shift attitudes and behaviours' in order to achieve 'the reduction of HIV and STI transmission', the NSP further emphasises that this strategy 'must focus on consistent and correct condom use', as well as on 'delaying sexual debut and the reduction of age mixing, and reducing multiple concurrent partners' [NSP, p43]. In addition, 'the strategy' seeks to ensure 'that sex is always consensual' and 'that women can negotiate condom use' [NSP, p43].

COMMENTS

'Communication' relating to women's 'ability' and 'power' to negotiate both 'condom

use and *consensual sex* are pertinent in *shifting* attitudes and behaviours aimed at reducing women's risks to HIV exposure and transmission. Equally important, however, is the accurate understanding and assessment of *individual risks*, as this arguably forms the basis in deciding whether or not there is a *'need'* to *'use condoms'*.

Recognising the significance of *'accurate'* individual assessment of risk relating to HIV exposure and transmission, it is essential to also be *'accurate'* and specific in communication and messaging. In the context of women's HIV risks, it is not the *'time'* of sexual debut or the *'number'* of *'multiple and concurrent sexual partners'* that increase the risk of HIV exposure and transmission *per se*, but rather whether or not women have *'control over'* their sexual choices, including the *'power'* to negotiate *'correct and consistent condom use'*.

Address sexual abuse and improve services for survivors of sexual assault (Objective 2.7)

Sexual violence and abuse are well-recognised *'drivers'* of HIV exposure and transmission. Thus, the NSP underscores the need for *'a comprehensive package of services'* to

...prevent sexual abuse and to provide comprehensive post-sexual assault care, including PEP, medical care, counselling, access to justice, and protection services for rape survivors. [NSP, p45]

Setting a *'target of PEP provision to 100% of eligible children and adults'*, and recognising current challenges

in the availability of and access to PEP, the NSP calls for *'significantly scaled-up and improved'* systems for PEP provision, especially in rural areas. Further specifying its goal, the NSP highlights that

...PEP must be available at all healthcare sites for survivors of sexual violence and health workers must be trained to explain and administer PEP. [NSP, p45]

This objective also points to the importance of *'campaigns targeting adults and children'* to, among other, *'raise awareness of sexual abuse and exploitation'*, and to *'address the stigma associated with sexual abuse, which may prevent disclosure and hence, inhibit access to services'* [NSP, p45]

COMMENTS

It is notable that the *'comprehensive package of services'* includes both *'prevention'* and *'care'* aspects. The *'success'* of this approach can, however, only be measured against the extent to which *'prevention'* and *'care'* are equally available and accessible to women *in all their diversities*. Women in *'key populations'*, such as sex workers and women who have sex with women, are often *'targeted'* for sexual abuse and rape, yet, they are commonly *'excluded'* in the conceptualisation of programmes aimed at preventing sexual violence and abuse; are generally *'not catered for'* in *'post-sexual assault care'*; and are subject to extreme stigma and prejudices when accessing services. Without the inclusion of *all* women in programme design and implementation, interventions and services will continue to fail women who are at risk of and subjected to sexual violence and abuse.

The multiple challenges in accessing ‘post-sexual assault care’ have been documented and evidenced for a long time, ranging from lack of access to adequate medical and psychosocial care to judgemental attitudes by service providers and lack of access to justice for rape survivors.⁵⁵ Especially in the context of PEP, it is as much ‘poor’ services and lack of availability, as it is the lack of accurate information among women and service providers that impacts on women’s access to PEP, even if it is available. A recent study in three KZN communities found that only 7% of women participating knew about PEP⁵⁶; an alarming result given the high rates of sexual violence and rape in this province. Thus, enhancing the levels of knowledge among women regarding available PEP services have to become an integral part of ‘improving services’ for survivors of sexual assault.

STRATEGIC OBJECTIVE 4:

ENSURE PROTECTION OF HUMAN RIGHTS AND INCREASED ACCESS TO JUSTICE

Reaffirming ‘the centrality of constitutional values and human rights’, objectives and interventions designed to ‘ensure the protection of human rights and increased access to justice’ are based on

...the understanding that public interest is best served when the rights of those living with HIV and/or TB – or are at risk of infection – are respected, protected and promoted. [NSP, p53]

This strategic objective emphasises that interventions must

be ‘planned and implemented’ in a way that recognises ‘the specific access needs’ of particular groups of people and the ‘cultural, legal, economic and other possible barriers to accessing services’ [NSP, p53]. In addition, it is crucial to ensure that service provision ‘upholds the dignity of individuals, especially those living with HIV’ [NSP, p53].

The NSP further elaborates that

...in an attempt to address any barriers and shortcomings – legal, social or economic – that may exist and therefore could undermine the rights of individuals, reviews and assessment of laws and policies that may impact negatively on the response to HIV and TB, will be conducted expeditiously. [NSP, p53]

COMMENTS

The NSP seems to acknowledge the risks of ‘unintended’ negative effects of, and rights violations associated with the response to HIV, which is commendable. However, the ‘suggestive’ language used – in that ‘barriers’ **may** exist and **could** undermine people’s rights – is highly ‘problematic’, as it not only implies that ‘barriers’ to, and rights violations within, services **may not** exist, but also that the existing ‘evidence’, confirming these ‘barriers’ and rights violations, **may be inaccurate**.

In relation to women and HIV, this objective explicitly emphasises that ‘women and young girls’ must be ‘supported and enabled to access a comprehensive package of services, including sexual and reproductive health services’ [NSP, p53]; and stresses that ‘fertility

desires' of women living with HIV 'must be protected, respected and addressed', by means of, among other, training of healthcare providers.

It is also important to note that the introduction to this strategic objective includes a 'disclaimer' stating that this objective 'cannot address the sum total of all legal and human rights interventions', and thus will only focus 'on a limited number of achievable, measurable and mutually enforcing objectives and interventions' [NSP, p53]. With this 'disclaimer' in mind, the strategic objective seeks to:

- Ensure that rights are not violated when the intervention under the other three strategic objectives are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established
- Reduce HIV and TB discrimination, especially in the workplace, and
- Reduce unfair discrimination in access to social services. [NSP, p54]

ADVOCACY NOTES

While this strategic objective undoubtedly confirms the 'commitment' to the protection and advancement of human rights in the context of the HIV response, it is the adequate translation of this 'commitment' into 'tangible' programmes and interventions that will ultimately 'measure' whether or not human rights are indeed at the centre of the national response to HIV. Recognising that the 'commitment' to the protection of human rights in the response to HIV is only as effective as people are in the position to claim and realise their rights, it is crucial to 'move beyond the commitment'.

Ensure rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights (Objective 4.1)

The focus of this objective is to ensure that 'reasonable measures' are taken 'to guard against rights violations' in the implementation of interventions, and 'to advance the NSP's human rights agenda' [NSP, p54]. In addition, this objective calls for the creation of a 'coordinated framework'

...for (1) monitoring human rights abuses that have the potential to undermine the interventions set out in the NSP, and (2) ensuring that rights – where violated – may be vindicated efficiently and effectively. [NSP, p54]

To achieve this objective, the NSP further proposes to 'audit interventions to identify potential for human rights abuses' (Intervention 4.1.1); 'guard against rights violations as part of policy development and programme planning' (Intervention 4.1.2); 'use existing bodies to monitor human rights abuses and increase access to justice' (Intervention 4.1.3); and to 'build capacity within public institutions and civil society to increase access to justice and redress' (Intervention 4.1.4).

Audit interventions to identify potential for human rights abuses

All entities involved in 'coordinating, conceptualising, and/or implementing interventions and related policies' must conduct an audit and

...assess whether any such intervention or policy may result in a violation of human rights when, or as a result of being, implemented. [NSP, p55]

The NSP provides examples of potential rights violations, including HIV testing *'without proper informed consent'* and/or as a *'requirement'* for accessing other services, such as treatment for STIs. The NSP also specifically references the violation of *'sexual and reproductive health rights'* of women living with HIV, especially *'the desire to have children'*. In the context of access to PEP services, the NSP points to health workers who *'insist that a charge is laid at a police station by rape survivors before they are provided with PEP services'* [NSP, p55].

COMMENTS

As alluded to earlier, the *'suggestive'* nature of this objective, in that policies and interventions *'may'* result in the violation of human rights, are indeed gravely disconcerting, especially in light of the existing *'evidence'* documenting women's experiences of *'coercion, discrimination and violence'* in, for instance, the context of HIV testing.⁵⁷

Although laudable that such an *'assessment'* is included in the national response to HIV, the NSP, regrettably, does not provide sufficient *'guidance'* as to the *how, when* and *where* interventions and programmes will be assessed; *whose* experiences will form the basis for this *'assessment'*; and to what extent existing *'evidence'* of rights violations will be incorporated into the *'audit of interventions'*.

To effectively respond to women's human rights abuses, it is imperative that this *'audit'* and its subsequent *'measures'* are based on and informed by women's experiences of these violations, as well as women's recommendations for change.

Guard against rights violations as part of policy development and programme planning

Based on the outcome of the *'audit of interventions'*, all entities *'must take reasonable measures to guard against the potential rights violations identified'* [NSP, p55]. These *'reasonable measures'* could include *'actions against health workers'* who violate patients' rights, and *'training of healthcare providers'*.

Use existing bodies to monitor human rights abuses and increase access to justice

Noting that *'rights may be violated'* in various spheres of society, including *'the public sector, the private sector and within communities'*, this intervention tasks *'existing bodies'* to monitor human rights abuses of people living with HIV or those *'at the greatest risk of infection'*, as well as *'the appropriate referral to legal services providers'* as and when rights have been violated. [NSP, p55]

Notwithstanding that *'all rights violated should be addressed'*, the NSP emphasises that particular attention should be given to *'unfair discrimination on the basis of HIV'* and the *'violation of women's sexual and reproductive health rights'* [NSP, p55].

To effectively implement this intervention and *'increase access to justice'*, the NSP underscores the need to ensure *'coordinated and effective systems'* are in place to receive and process complaints, and *'necessary human and financial resources'* are available. Reports must be tabled at SANAC *'at least every six months'* on, among other,

...the nature of, and extent to which the right to be

free from unfair discrimination is being violated, and the sexual and reproductive health rights are being violated. [NSP, p56]

Build capacity within public institutions and civil society to increase access to justice and redress

In addition to the need to strengthen 'effective referral systems', the NSP also emphasises the need to 'build the capacity' so as to ensure increased access to justice and redress. Within the context of 'building capacity', the NSP proposes that the South African Human Rights Commission 'should assume responsibility for bringing together civil society organisations working on access to justice' [NSP, p56]. In addition, the NSP calls on civil society organisations to 'take joint responsibility for developing

...a plan of action to build the capacity of community-based organisations so that they are better placed to assist their members and communities in understanding and claiming their rights. [NSP, p56]

COMMENTS

Although civil society organisations may be 'best placed' to develop such a 'plan of action', questions need to be raised as to the 'resources' available within, and/or allocated to these organisations for both the development and implementation of this 'plan'.

Reduce discrimination in access to services (Objective 4.3)

Focusing on access to services, this objective is based on the premise that 'people may be denied access to HIV,

STI and TB services' [NSP, p57] on a range of grounds inconsistent with South Africa's constitutional and legal framework. In the broader context of 'protecting and respecting people's right to have access to services', this objective seeks to

...ensure that broader public health goals are achieved by ensuring that no person eligible for the identified service is denied access on an arbitrary basis. [NSP, p57]

Further elaborating on 'denial of access to services', the NSP recognises that this 'may take place in a number of ways', and makes specific reference to services that are 'provided in a manner that fails to address or understand a person's specific needs' [NSP, p57] as one of the ways by which access to services is denied. Staff attitudes, including prejudices, towards for instance young people accessing sexual and reproductive healthcare, as well as 'failing to recognise reasons for non-adherence, such as excessive use of alcohol or depression', are two of the examples provided in the NSP as to service conditions that can impact on access to services.

COMMENTS

For interventions aimed at reducing discrimination in access to healthcare to be 'effective' for women and women's risks, it is imperative that violence and/or the fear of violence – both 'within' and 'outside' service provision – is 'understood' as one of the ways by which access to services is 'denied'.

Especially recognising the adverse impact of violence on women's 'ability' to access

services and to fully participate and *'adhere to'* programmes and treatment regimens, responses to women and HIV have to guarantee that services are accessible to *all* women, and that choices can be made free of *'coercion, discrimination and violence'*.

To reduce discrimination in access to services, the NSP further proposes to *'ensure that oversight bodies receive and address complaints'* (Intervention 4.3.1), and to *'provide training to prevent unfair discrimination'* (Intervention 4.3.2) in service provision.

Provide training to prevent unfair discrimination

Recognising the importance *'to hold all social service providers to account through professional disciplinary mechanisms'* [NSP, p57], the NSP also emphasises that it is

...vital that such professionals have access to dedicated human rights training programmes designed to equip them with the necessary skills to respect, protect and promote equality in the provision of social services. [NSP, p57]

The intervention thus seeks to ensure that *'all entities'* providing training to service providers in the context of *'HIV, STI and TB care'*, as well as in the context of *'dedicated services for pregnant women, children and adolescents'* include *'modules dealing with unfair discrimination'* [NSP, p57].

COMMENTS

Providing training to service providers is unquestionably a critical aspect in preventing *'unfair discrimination'* and ensuring access to services. However, given the deeply entrenched societal *'social and cultural norms'* leading to the *'denial'* of especially women's access to services, it is crucial that these *'modules'* address not only the *'effects'*, but also the *'causes'* of *'unfair discrimination'*. Thus, for this intervention to *'effective'*, the scope and content of these *'modules'* must reflect women's realities, risks and needs based on and in the context of HIV, as well as access to HIV-related services.

CONCLUDING REMARKS AND REMAINING CHALLENGES

.....
...the NSP 2012 – 2016 recognises the need to continuously assess barriers to access to services and instances of stigma and discrimination and provides the framework for addressing such issues. [NSP, p58]
.....

The new NSP has to undoubtedly be commended for recognising the need to pay closer attention to the *'specific realities and needs'* of people; to the *'barriers'* that may impact on peoples' risks of HIV transmission and related abuses, as well as the extent to which rights are realisable and services are accessible; and to *'instances of stigma and discrimination'*. In reality, however, the *'commitment'* to rights protection in the response to HIV, as expressed in the NSP, can only be truly measured against the timely, adequate and effective implementation of the proposed objectives and interventions in a manner that is indeed protecting and advancing human rights.

As suggested earlier, there are a number of concerns with regard to the response to women and HIV, including the conceptualisation of women's realities, risks and

needs in the NSP. While some of these concerns could arguably be addressed in the implementation plans at a provincial, district and community level, this nonetheless places an enormous responsibility on provinces, districts and communities, especially since the NSP is meant to *'strategically guide'* the development of the implementation plans.

Without addressing the *'shortfalls'* of the new national response to HIV, interventions and programmes are unlikely to effectively address women's risks to HIV exposure and transmission, and to related rights abuses, including stigma, discrimination and violence.

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