



POSITIVE
-WOMEN'S NETWORK-
FOR WOMEN LIVING WITH HIV/AIDS

HIV AND WOMEN AT RISK

**An analysis of the policy, legal and socio-structural framework
gaps leading to gender disparities in South Africa**

2015

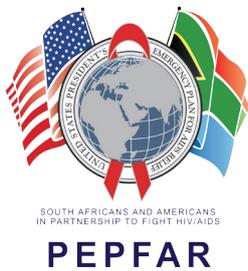
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PWN Research Team

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*“...by prioritising women’s vulnerability in the HIV response
we will start reducing HIV incidence in South Africa”*

Former Deputy President of South Africa
Kgalema Motlante, August 2010, at the Women’s HIV Prevention Summit

CONTACT DETAILS

Rosebank Office

Positive Women’s Network
Suite 2
2 Hood Avenue
Rosebank
2196

Tel: +27 11 447 7063

Fax: +27 11 447 7313

Braamfontein Office

Room 317 – 319
3rd Floor
Heerengracht Building
87 De Korte Street
Braamfontein
Johannesburg
2017

Tel: +27 11 339 7679

Acknowledgements

The Positive Women's Network (PWN) is committed to creating an environment in which women that live with and/or are affected by HIV and AIDS access quality services and are free from stigma and discrimination. As part of this initiative, the PWN's component forms one part of a programme which has been formulated in partnership with BroadReach Healthcare (BRHC) under a joint USAID-funded response. The PWN's efforts involve, amongst other things, developing district-specific innovative interventions to benefit women living with and affected by HIV and AIDS.

This study was commissioned by the PWN as part of a comprehensive response to provide essential packages of care for women living with HIV. This study would not have been possible without the collective efforts of a number of partners, stakeholders and individuals who worked tirelessly through the various stages of developing this document. These include the Presidential Emergency Plan for AIDS Relief (PEPFAR) through to the United States Agency for International Development (USAID) and BRHC.

Preface



Dr Fareed Abdullah, SANAC CEO

2015 is a special year for South Africa. We are commemorating the 60th anniversary of the Freedom Charter which was adopted in June 1955. At the same time, we have just celebrated twenty years since the first democratic elections in 1994. Added to that we are also looking forward to 2016, when South Africa will be celebrating a second decade since adopting its democratic Constitution.

Indeed the 1996 Constitution is highly regarded globally since it contains one of the most progressive Bill of Rights – one that deeply enshrines women’s rights. The rights of women are human rights, where the right to equality, non-discrimination, and health education and, of late, economic freedom, needs to reach all women, including young women and girls. As such the symbolic representation of women in South Africa as ooNonkululeko, is befitting for this report.

It is in the context of women’s rights that this report of ooNonkululeko’s daily struggles and encounters with HIV comes to the fore. The report comes as a welcome endeavour to continue the fight against HIV and AIDS, and ensures that the interests of young women and girls in particular, continue to be highlighted. The HIV epidemic, unfortunately, still bears the face of a woman, be she young or old. With as many as a thousand new infections occurring in South Africa every day, an urgent response in HIV programming – from preventing new infections among women to ensuring a gendered response along the HIV continuum – is needed.

This report gives women a voice and a platform from which to articulate their experiences on living with, and encountering, HIV. The analysis of the different systemic variables contributing to HIV, especially the socio-structural gaps, highlights

particular areas for government and its partners to focus on, so they in turn can further fine tune their response to HIV. In particular, the voices of ooNonkululeko on gender based violence and the livelihoods challenge takes centre stage in guiding the future programmes on HIV.

It is this pedagogy that changes the face of HIV and AIDS wherein ooNonkululeko link their own challenges with practical programming initiatives, that can assist PWN and many other institutions in South Africa, including the private sector, in achieving more tangible results.

This innovative and practical stance by PWN needs to be applauded as it follows the ideals of both the Women's Charter, the Freedom Charter and the Bill of Rights. The plans that we set for ourselves as a nation, such as the National Strategic Plan for HIV, TB and STIs (NSP), should not simply recognise our challenges, but facilitate successful implementation. It is this mindset that prompted us to ratify the International Covenant

on Economic, Social and Cultural Rights (ICESCR); that has encouraged us to roll out the largest antiretroviral (ART) programme in the world, and indeed to ensure that the national responses to HIV are accorded attention from the highest office in the land. We know what works - keeping girls at school helps avert new HIV infections - so let's make sure the school environment is conducive for ooNonkululeko to stay at school, that schools are safe, well equipped and provide quality education. The words of ooNonkululeko from 1954 when fighting for the Freedom Charter reflect the ones found in the narratives contained in this report. We hear these women's desire to tell a different story. A story that points to the need for a National Strategic Plan to Eradicate Violence Against Women and Girls; and that supports global efforts towards Zero New Infections, Zero Transversal Transmission and Zero Stigma and Discrimination. This challenge of effecting a better response to the needs of women and girls rests in our hands. Together we can find the strength to take on and overcome this challenge.

Dr Fareed Abdullah
SANAC CEO

Abbreviations and Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
ART	Antiretroviral Treatment
ALN	Aids Legal Network
BCC	Behaviour Change Communication
CBO	Community-based Organisation
CCC	Community Care Centres
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGE	Commission on Gender Equality
CSW	Commercial Sex Workers
DBE	Department of Basic Education
DIC	Drop-In Centres
DOH	Department of Health
DOSD	Department of Social Development
DOWCPD	Department of Women, Children and People with Disabilities
DOTS	Directly Observed Treatment Strategy [Tuberculosis]
FGD	Focus Group Discussion
FP	Family planning
FSW	Female Sex Workers
FWCW	Fourth World Conference on Women or Beijing Conference 1995
GBV	Gender-Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus

HRI	Her Rights Initiative
HSRC	Human Sciences Research Council
HST	Health Systems Trust
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IDASA	Institute of Democracy in Africa
KII	Key Informant Interview
KYE	Know Your Epidemic (assessment)
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MARPs	Most At Risk Populations
MCH	Maternal and Child Health
MRC	Medical Research Council
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
NSP	National Strategic Plan for HIV, TB and STIs
PHDP	Positive Health, Dignity and Prevention
PLHIV	People Living with HIV
PWN	Positive Women's Network
SANAC	South African National AIDS Council
TB	Tuberculosis
WHO	World Health Organization

Table of Contents

Acknowledgements.....	ii
Preface	iii
Abbreviations And Acronyms.....	v
Definition of Terms.....	viii
About The Positive Women’s Network.....	xiii
Executive Summary.....	xiv
1. Contextual Analysis.....	1
1.1. Introduction.....	2
1.2. Literature and Policy Review.....	5
1.2.1. Review Approach.....	5
1.2.2. Socio-Structural Gaps in the Response To HIV	7
1.2.3. Gaps in the Biomedical Approaches	13
1.2.4. Gaps in the Policy and Legal Frameworks.....	20
1.2.5. South Africa’s Regional and International Commitments.....	23
2. The PWN Research Initiative.....	36
2.1. Research Objectives	38
2.2. Research Methodology	38
2.3. Sampling	39
2.4. Introducing Oononkululeko	40
2.5. Data Collection and Analysis.....	41
2.6. Study Limitations	41
3. Oononkululeko’s Narratives on the HIV and TB Response in South Africa.....	42
3.1. Questions Related to Policies on HIV and TB.....	43
3.2. Questions Related to Livelihoods.....	44
3.3. Questions Related to HIV Testing and Prevention For Women	46
3.4. Questions Relating to Health System	47
3.5. Questions Relating to Gender-Based Violence as a Gap in the HIV Response.....	50
4. Questions Relating to Gender-Based Violence as a Gap in the HIV Response	52
4.1. Policy Gaps and Lack of a Concise HIV and AIDS Strategy for Women and Girls.....	53
4.2. Lack of Concise Strategies to Reduce Poverty.....	54
4.3. Gaps In Availability of HIV Prevention Tools.....	54
4.4. Health Systems Failure to Respond to Individualised Needs of Women	55
4.5. Lack of Gender Transformative Approaches Targeted at Reducing Gender-Based Violence.....	58
5. Recommendations for a Minimum Package for Young Women and Girls.....	59
5.1. Concise National Strategy Targeted at Young Women and Girls.....	61
5.2. Livelihood Strategies for Young Women and Girls and Economic Empowerment of Women.....	62
5.3. Expanding HIV Prevention Tools and Linked Them to Testing.....	63
5.4. Improving the Capacity of the Health System to Respond to Individualised Need of Women.....	63
5.5. Radical Transformation of the Gender-Based Violence Framework in South Africa	64
6. Our Starting Point: PWN’s Basic Intervention Package	68
7. Conclusion	73
8. Appendix: Essential Package for Young Women and Girls.....	76
9. References and Sources	77

Definition of Terms

Acquired immunity	Immunity that develops during a person's lifetime. There are two types of acquired immunity: active immunity and passive immunity.
Active immunity	Immunity that develops after exposure to a disease-causing infectious microorganism or other foreign substance, such as following infection or vaccination.
Acute HIV infection	Also known as: primary HIV infection, this is the early stage of HIV infection that extends approximately two to four weeks from initial infection until the body produces enough HIV antibodies to be detected by an HIV antibody test. Because the virus is replicating rapidly, HIV is highly infectious during this stage of infection.
Acquired Immunodeficiency Syndrome (AIDS)	A disease of the immune system due to infection with HIV. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. Acquired immunodeficiency syndrome (AIDS) is the most advanced stage of HIV infection.
Acquired resistance	Also known as: secondary resistance, this is when a drug-resistant strain of HIV emerges while a person is on antiretroviral therapy (ART) for the treatment of HIV infection.
Adherence	Taking medications exactly as prescribed. Poor adherence to an HIV treatment regimen increases the risk for developing drug-resistant HIV and virological failure.
Combination HIV prevention	The combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic.
Extra-pulmonary TB	TB disease in any part of the body other than the lungs; for example, the kidneys or lymph nodes.
Community systems strengthening	These are initiatives that contribute to the development and/or strengthening of community-based organisations in order to increase knowledge of, and access to, improved health service delivery.
Discordant couple	Sexual partners in which only one partner is infected with a sexually transmitted infection, such as HIV, and the other partner is not infected.
Dosage	The administration of individual doses of a medication as part of a medication regimen, usually expressed as quantity per unit of time. For example, a prescribed dosage might consist of 25 mg of a medication given 3 times a day for 6 days.
Drug resistance	When a bacteria, virus, or other microorganism mutates (changes form) and becomes insensitive to (resistant to) a drug that was previously effective. Drug resistance can be a cause of HIV treatment failure.

Efficacy	Effectiveness of a drug or other medical intervention. Drugs are tested for efficacy to ensure that they produce the desired effect on the disease or condition being treated.
Essential Package	Department of Women, Children and People with Disabilities
	Promotional materials on female-driven HIV-prevention methods such as female condoms, microbicides and PEP, Information leaflets/brochures that address stigma and its recourse, menstrual cup, advocacy for access to services for HIV and TB prevention, treatment, care and support.
Extensively drug-resistant tuberculosis (XDR-TB)	In addition to resistance to isoniazid and rifampicin, XDR-TB is also resistant to fluoroquinolones and at least one injectable second-line drug.
Gender	A culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements and obligations associated with being female and male, as well as the power relations between and among women and men, boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age and sexual orientation. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions.
Gender disparities	Health disparity has been defined by the World Health Organization as the differences in health care received by different groups of people that are not only unnecessary and avoidable but also unfair and unjust. Gender disparities exist where there is an unjust delivery of health care received by people because of their gender when this could be avoided.
Gender empowerment	Expansion of people's capacity to make and act on decisions affecting all aspects of their lives – including decisions related to health – by proactively addressing socioeconomic and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women because of the inequalities in their socioeconomic status ¹ .
Gender equity	The process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field ² .

Gender equality	Gender equality between men and women means that all human beings, men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles and prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services.
Gender identity	Gender identity refers to one's internal sense of being male, female, neither or both.
Gender integration	Strategies applied in programmatic design, implementation, monitoring and evaluation to take gender considerations (as defined above, in "gender") into account and to compensate for gender-based inequalities.
Gender mainstreaming	Process of incorporating a gender perspective into organisational policies, strategies, and administrative functions, as well as into the institutional culture of an organisation. This process at the organisational level ideally results in meaningful gender integration as outlined below.
Health system	A health system consists of all organisations and individuals whose actions are intended to promote, restore or maintain health. A health system involves a broad range of institutions and individuals; their actions help to ensure the efficient and effective delivery and use of products and information for the prevention, treatment, care, and support of people in need of these services.
Men who have sex with men (MSM)	The term "men who have sex with men" describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This description includes men who self-identify as heterosexual but have sex with other men.
Mobile population	These are individuals who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons, without changing place of habitual primary residence or home base. Mobile workers are usually in regular or constant transit, sometimes in (regular) circulatory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time.
Morbidity	The state of being ill or having a disease.
Mortality	An individual's death or decease; loss of life.
Multidrug-resistant tuberculosis (MDR-TB)	MDR-TB is a specific form of drug-resistant tuberculosis, due to a bacillus that is resistant to at least isoniazid and rifampicin, the two most powerful anti-tuberculosis drugs.

ooNonkululeko	This study refers to the women at the centre of the HIV epidemic as ooNonkululeko. Those who have inherited freedom in the era of AIDS.
Pharmacokinetics	This refers to the movement of drug into, through and out of the body – the time course of its absorption, bioavailability, distribution and metabolism.
Pharmacodynamics	The study of what a drug does to the body, whereas pharmacokinetics is the study of what the body does to a drug.
Post-exposure prophylaxis (PEP)	“PEP” refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a person living with HIV.
Pre-exposure prophylaxis (PrEP)	“PrEP” refers to antiretroviral medicines prescribed before exposure or possible exposure to HIV. PrEP strategies under evaluation increasingly involve the addition of a post-exposure dosage.
Positive health, dignity, and prevention	Previously referred to as “positive prevention”, it encompasses strategies to protect sexual and reproductive health and delay HIV disease progression. It includes individual health promotion, access to HIV and sexual and reproductive health services, community participation, advocacy and policy change.
Prevention of mother-to-child transmission (PMTCT)	“PMTCT” refers to a four-pronged strategy to prevent new HIV infections in children and to keep mothers alive and families healthy. The 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. Some countries prefer to use the term “vertical transmission” to acknowledge the role of the father/ male sexual partner in transmitting HIV to the woman and to encourage male involvement in HIV prevention.
Serodiscordant	“Serodiscordant” is a term used to describe a couple in which one partner is HIV positive and the other is HIV negative.
Sero-negative (HIV)	“Sero-negative” refers to the absence of the specific antibodies that were being tested for HIV.
Sexual and reproductive health	A state of physical, emotional, mental and social wellbeing in relation to sexuality, and in all matters relating to the reproductive system and its functions and processes. This includes 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.

Sexually transmitted infections (STIs)	<p>STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; chlamydia trachomatis; human papilloma virus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and cancrroid. More than 20 disease-causing organisms and syndromes are now recognised as belonging in this category.</p>
Vertical transmission	<p>Transmission of an infection such as HIV from mother to foetus via the placental circulation.</p>
Women who have sex with women (WSW)	<p>It includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women and those who self-identify as heterosexual but who have sex with other women.</p>

About The Positive Women's Network

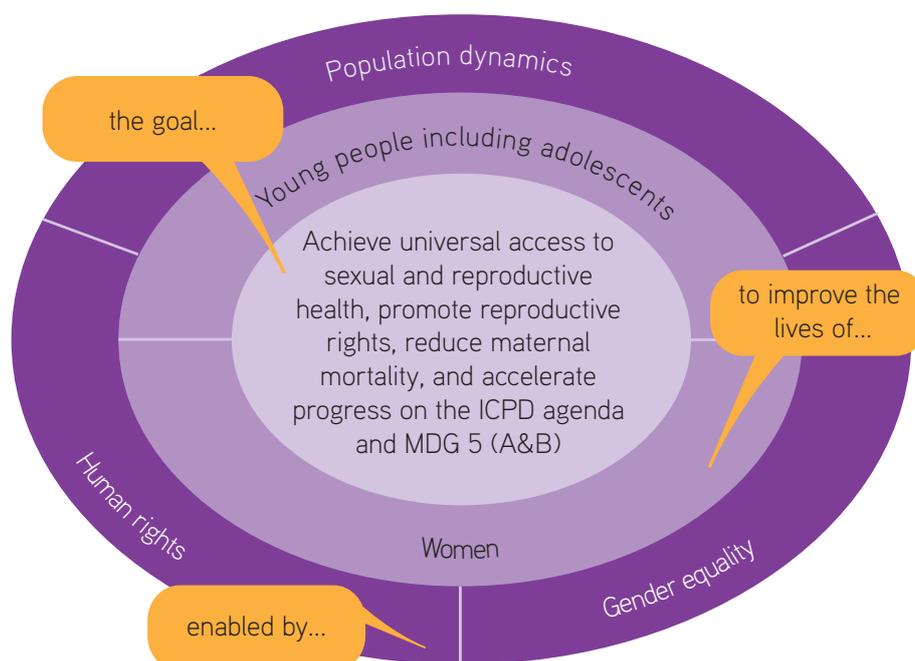
The Positive Women's Network (PWN) is a non-profit organisation committed to creating a world free of HIV and an environment in which women who live with and/or are affected by HIV and AIDS access quality services especially treatment and prevention; and are free from stigma and discrimination. This commitment translates into the promotion and protection of gender equality and equity, respect for human rights, and mobilisation of resources to enable access to prevention, care, support and treatment. The organisation aims to restore the dignity and improve the quality of life of infected and affected women and girls. It also advocates for appropriate and effective services at national, provincial and local levels.

In 1996, over 60 women ^{IV} united to create "a safe place" for women living with HIV. The first support group was founded outside the Ga-Rankuwa Hospital near Pretoria. It provided an outlet for HIV-positive women to express and share their feelings and needs regarding their HIV status. Since then, the organisation has grown tremendously. The PWN enjoys the support of reputable organisations such as the African Women's Development Fund, International

Development Fund, PEPFAR, USAID, BroadReach Healthcare, the Global Fund for Women and the Department of Health in South Africa.

The PWN operates mainly in impoverished and disadvantaged communities, townships and rural areas. Currently PWN support groups operate in the following provinces: Gauteng, North West, KwaZulu-Natal, Eastern Cape and Mpumalanga. The PWN employs the "Bulls Eye Model", which takes into consideration all the different structural drivers for the HIV epidemic as demonstrated in the figure below.

Having operated in these communities over a period of 18 years, the PWN has accumulated a formidable battery of resources. These include a collection of the personal narratives of women and girls affected and infected by HIV, working papers by activists and practitioners in the fields, presentations by researchers and partners at national, continental and international levels, and by policymakers, which provide unique vantage points from which the PWN is able to undertake this critical review of the policy, legal and socio-structural framework, which impact on the incidence and management of HIV and TB in South Africa.



(Source: UNFPA – New Strategic Direction 2014–2017)



Executive Summary

The HIV epidemic in South Africa continues to be driven by gender inequalities and harmful gender norms that promote unsafe sex and reduce access to sexual and reproductive health services for women, men, girls, boys and transgender people. This epidemic imposes a particular burden on women and girls due to their greater physiological susceptibility to HIV infection and the social, legal and economic disadvantages that increase their risk and vulnerability to infection. In particular, the statistics reflect the increased vulnerability of African women and girls, who feature disproportionately amongst those infected and affected by HIV.

Of the estimated 6.4 million South African people living with HIV, 3.87 million are women and 2.53 million are men. Girls and young women aged 15–24 constitute one of the most vulnerable sub-populations in South Africa – HIV prevalence has

consistently been highest among girls and young women in this age group in comparison to boys and young men in the same age group.

With the Global AIDS Response Progress Report (GARPR); 2014, recognising that gender equality is vital to an effective HIV response; there is still an urgent need for the articulation of specific interventions to HIV that speak to women. This study not only focuses on gender equality in the response, but realises that women need to be given a platform from which to articulate their own narratives on their encounters with HIV. Furthermore, meaningful involvement of those who are vulnerable is required, including funded implementation plans, focused budgetary allocations, dedicated political leadership and administrative will at the highest level of government as well as civil society.

Objectives of the Study

The main objectives of the study were to draw from the experiences and narratives of women and girls living with HIV in order to:

1. Review the impact of the current national response to HIV and AIDS, taking stock of what has worked thus far, whilst also pointing to new initiatives which need to be put in place.
2. Point to the critical interventions required in order to effect the intended outcomes articulated in the NSP 2012 – 2016, for women.
3. Identify the most critical policy, legal and structural (social, cultural, economic) gaps that contribute to the existing gender-based disparities.
4. Contribute to the development of appropriate policy-level responses at all levels related to HIV and TB prevention, treatment and care.
5. Highlight the differences which exist amongst women according to such factors as race, age, locality type, sexual orientation and disability – and that these differences have to be taken into account in developing an HIV and TB response which is responsive and does not leave anyone behind.
6. Develop and implement an essential package of gender interventions and services to address key identified gaps at the national, provincial, district, institutional and community levels respectively to mitigate the gender-based disparities related to HIV and TB prevention, treatment and care

The secondary objectives of the study were as follows:

1. To substantively input towards the development of training material for various stakeholders in the HIV and TB prevention, treatment and care continuum.
2. To articulate the provisions contained in key international instruments including CEDAW, The Protocol on the African Charter on Human Rights, and pertaining to women's rights with regards gender HIV and AIDS, women's reproductive health and rights, disability, and sexual orientation.
3. To provide an assessment of the extent to which South Africa has or has not complied with the provisions of the international instruments pertaining to women and girls living with HIV, women's reproductive health and rights, and gender based violence as well as women's empowerment.

Research Methodology

Women's narratives are central to this study. These narratives are routinely shared in PWN's support groups through focus group discussions, one-on-one interviews and through shared best practices emerging from the PWN's interactions with the global community of WLWHIV. In addition, consensus on basic packages was done using the Delphi technique. All narratives, besides the experts used in the Delphi techniques in this study, are of women living with HIV and AIDS, some also with TB. The study therefore reviews the national health care response from the vantage point by women living with HIV; drawing experiences of the rigorous research that has taken place not only in South Africa but elsewhere in the continent.

In addition to the narratives, the study draws on the rich resource of evidence-based research from such institutions as the HSRC, SANAC the NDOH, CAPRISA and BroadReach Healthcare, as well as a broad ranging desk top literature review in order to contextualise the experiences of ooNonkululeko. This approach is consistent with the emerging international studies which prioritise the views of WLWHIV in assessing the impact of the global HIV response. Therefore, it provides a more comprehensive insight into the extent of the scourge of HIV and TB infections in SA.

Triangulation is an important tool used in this study in order to ensure recommendations that go beyond the limited, though critical, narratives of ooNonkululeko.

xvi

Limitations of the Research

The research undertaken here is the first phase of a series of studies drawing on the PWN constituency's experiences of the health care system. It is limited to the geographical locations PWN was operating in at the inception of the study. Primarily these were women living in formal and informal areas in Gauteng.

There is therefore a need to expand the study to include the following, who exhibit a different level of vulnerability; Women with disabilities and Commercial Sex Workers

In addition future studies should also include communities who have not tested positive, but are at risk and vulnerable to infection; this study largely captured the perspectives of women living with HIV.

Key Findings

From the literature and policy review, the research findings were categorised into policy framework relating to women.

1. While structures such as the women's sector exist with SANAC, women living with HIV, and women in general, are not recognised as a target group within the NSP with a funded coordination strategy to address that vulnerability.
2. This study like many others recognises the vulnerability of women between the age group 15 – 24 are recognised; yet there is no funded coordinated response that addresses vulnerability issues in this age group.
3. While the Ministry of Women, Children and People with Disabilities is working on a GBV strategy, GBV, especially intimate partner violence is still one of the major drivers of HIV. However, there is no costed policy framework that comprehensively addresses gender based violence in South Africa, and hence efforts against GBV lack focussed collaboration.
4. Despite poverty being a driver and perpetuating the untoward effects of living with HIV for women, eradicating poverty remains a challenge in the country.

From the narratives of ooNonkululeko, these findings were not only confirmed but further issues were raised that perpetuate gender disparities in the HIV response.

5. Nuanced in the poverty debate is the issue of basic livelihoods, wherein young girls are exposed to destitution, going without even sanitary towels, which inadvertently exposes them to transactional sex.
6. There are gaps in the delivery of HIV care, particularly regards the lack of capacity of

frontline health care workers to adequately respond to the gendered needs of HIV positive women. This perpetuates stigma and discrimination.

7. Many women still experience shortages of drugs, diagnostics and deficiencies in cervical cancer and TB care.
8. Governance-related issues were raised from focus group discussions that pointed to the need to have women living with HIV being included in the governance structures of AIDS committees at a clinic, district or even provincial level.

Recommendations

To this end, a summary of recommendations that will form PWN's approach to this challenge are given below:

<i>Identified Gap</i>	<i>Summary of the Recommendations</i>
Women as targeted sector within the NSP	<ul style="list-style-type: none"> • Recognising that women are not a homogeneous lot, and that there are levels of vulnerability among them, the NSP should recognise women as a sector • Revise governance requirements at provincial, district and local AIDS councils to have a quarter for women Meaningful involvement by women living with, or affected by, HIV in leadership roles at provincial, district and local AIDS councils
A coordination framework to respond to the needs of young women and girls	<ul style="list-style-type: none"> • A written guidance document for a response on young women and girls will guide practitioners on evidence-based interventions and where to direct scarce resources • Young women and girls should lead this transformation and not be on the side-lines, often seen as beneficiaries only • Advocacy and leadership of young people as agents of change, focus on young women programmes for an HIV free generation with those born with HIV as champions for change
A gender violence strategic plan	<ul style="list-style-type: none"> • Involvement in the coordination structure to ensure that the interests of women living with HIV are heard • Support for a transformative GBV strategy with measurable outcomes • Improving the capacity of police force on handling GBV as it relates to HIV • Monitoring the functioning of Thuthuzela centres as a point of implementation of an integrated response, and rolling out some more centres should the monitoring prove to be effective • Training of health care workers at the Thuthuzela centres to implement an integrated approach that benefits women in the context of HIV

<i>Identified Gap</i>	<i>Summary of the Recommendations</i>
Strategies to eradicate poverty and address basic livelihood needs	<ul style="list-style-type: none"> • Transformative economic empowerment programmes targeted at HIV positive women; women in rural areas and in informal settlements • Analysis of the drivers of risky behaviour among young women – to introduce power packs that alleviate destitution especially around sanitary towels • Safer schools programming to use schools as an entry point for HIV prevention programmes • Supporting initiatives to keep girls at school for longer • Enterprise development and life skills building targeting especially unemployed school leavers • Pilot to turn social grant programmes into conditional grants twinned with educational outcomes
Health systems' failure to comprehensively respond to individualised needs of women in the context of HIV and GBV	<ul style="list-style-type: none"> • Gearing the health system to be responsive and able to service/fit-for-purpose to the individual needs of women and girls • Draft a programme of response for health systems at primary health care level and for emergency departments • Capacity building of frontline health workers on response • Expanding and supporting a national research agenda for women and HIV, along the health care continuum for HIV, for continuous improvement in the health system • Conditional grants/incentives to keep girls at school for longer and involving health worker representatives in drafting responses targeted at women and girls • Community strengthening teams established by, and including, the women living with HIV in clinic committees • Information packs for communities targeted at pregnant women on the comorbidities of HIV and TB, particularly in pregnancy • Investigations into the bottle necks on obtaining either results from screening, or an intervention thereafter, may require better use of innovations such as m-health and telemedicine to be deployed to reach out to more women who need screening

1

Contextual Analysis



*"...AIDS is no longer just a disease;
it is a human rights issue..."*

Nelson Mandela, Green Point Stadium, Cape Town, 29 November 2003

1.1 Introduction

There are two slightly different narratives about the patterns that prevail in South Africa on the prevalence and incidence of HIV and behavioural factors such as the age of sexual activity, condom use and the incidence of multiple concurrent partnerships. According to the mainstream narrative from UNAIDS, a total of 6.1 million adults and children were living with HIV in 2012³. The HSRC reported an increase in the HIV prevalence rate with an estimated 6.4 million South Africans living with HIV⁴. Indeed, efforts to increase the number of people on ARVs has yielded fruit, also resulting in higher prevalence, and is commendable.

UNAIDS, using its SPECTRUM model of estimation, estimated 370 000 new HIV infections in 2012 in South Africa. Indeed, antenatal surveys conducted at public health institutions, illustrate that the prevalence rate of HIV has stabilised since the last five years, albeit at a high rate of 30% for antenatal women⁵. On the other hand, the HSRC survey estimated a higher number of new infections in 2012, at 469 000 in South Africa. The HSRC data further refers to a decline in condom use, an increase in the trend of multiple concurrent partnerships as well as a decrease in the age of sexual activity, while UNAIDS estimates stabilisation of these trends.

Nevertheless, whichever narrative one decides to lean towards, South Africa is still home to the largest number of people living with HIV and AIDS globally, with an increase in national HIV prevalence from 10.6% in 2008 to 12.3% in 2012, according to the HSRC 2012 Household Survey. South Africa is also home to the third highest incidence rate of tuberculosis (TB) in the world, following India and China⁶. HIV increases susceptibility to TB infection, and TB is a leading cause of death in South Africa, accounting for about 12% of deaths that occurred in 2010, and is the primary cause of mortality from infectious diseases for women in South Africa, as reported

in the South African Census of 2011⁷.

In light of these statistics, the South African government, in partnership with the international HIV community, has introduced various ways to reverse these trends. Gaps, particularly on addressing the vulnerability of women to HIV, still remain, with women accounting for the majority of new infections. In sub-Saharan Africa, women constitute 60% of people living with HIV. Literature indicates that black women in particular are at disproportionate risk to contract HIV and/or TB due to a range of factors which include, amongst others, lack of social and economic capital, gender-blind policies and the threat of gender-based violence. Further analysis from the HSRC report⁸ shows that the incidence of HIV remains high amongst young women aged between 15 and 24 years, with one in every four incidence of infections occurring in this age group.

These efforts have resulted in some progress although much still needs to be done. Multi-sectorial prevention and treatment programmes that include wide-scale rollout of antiretroviral therapy (ART) with approximately two million South Africans receiving treatments are part of the notable successes. Government efforts to halt the spread of new infections, particularly through the prevention of mother-to-child transmission (PMTCT), have been equally commendable⁹. Even though questions remain with regard to consistencies in continued access to, and use of, treatment, women are the largest beneficiaries to South Africa's ARV programme^{10,11}. The successful roll out of the national HIV counselling and testing (HCT) campaign, with over 20 million South Africans tested by end of 2012, is commendable; of which 63% of those tested were women¹². Progressive policies have been promulgated, with ambitious targets of halving the number of new infections and ensuring universal access to treatment.

But gaps still remain – and success cannot be measured only in numbers, but needs to include quality and accessibility of care for HIV. From



“For how long will women continue to beg to save their lives? Scaling up an HIV response is not adequate without a gendered analysis and action. We know what works but knowledge is not enough unless if we implement”

Sheila Tlou 2012, UNAIDS Regional Director Leadership through Accountability Plenary

the PWN’s perspective, success should also be measured through the reduction of incidence, and this could be achieved of HIV by reducing women’s vulnerability to HIV.

The gaps in the response stem from policy, legal and socio-structural discrepancies in implementing a gendered response. For example, at a policy level, there are documented conflicts between who should access contraception and termination of pregnancy (any woman above the age of 12) that contradicts the age of consent¹³. However consensual sex between two minors is not criminalised as per the 2013 Constitutional

Court ruling. There are huge gaps in the execution of policies on gender based violence where the ineffectiveness of the policing system is well documented¹⁴. South Africa has ratified several international and regional protocols on gender and HIV; yet the implementation of such intents is weak at local level, with vast differences in execution between rural and urban areas. Particularly worrisome is the weak implementation of both local and global policy frameworks to reduce gender based violence, with its effect on increasing women’s vulnerability to HIV.

Gaps also exist in implementation of the biomedical response to HIV, largely within the health care system. The absence of gender specific responses is wide ranging – from HIV prevention where lack of women-centred prevention methods and tools is paramount, to treatment and care where biological and social differences between men and women have not been addressed. This could be attributed to the assumption that a generic response to HIV is adequate in a generalised epidemic; and some of this lack of comprehensive data stems from a poor understanding of how the biological and socio-structural differences between men and women affect the outcomes of HIV in the South African context. If one follows the narrative from the HSRC¹⁵, there is still a continuous increase in HIV infections especially among young women and girls, a decrease in condom use, an increase in young women having age-disparate sex with older men, and a decline in the age of sexual activity. Despite the South African HIV treatment programme being the largest in the world, there are still many who require treatment who are not receiving it¹⁶. In addition, further analysis is needed on the impact of the various treatment regimens on women, especially around side effects and drug-to-drug interactions. Deeper analysis on what the gender disparities in the biomedical response are includes the need to stratify all data on which women are receiving treatment, and the conditions under which they do so.

These insights would greatly enrich, amongst other things, the development of an essential training package for health care workers that would include comprehensive sexuality education and the gender aspects of HIV management in the health sector. This is where multiple partnerships with government, including civil society, communities and households; would be powerful, in entrenching the capacity of the health sector to respond to the nuanced needs of women on the ground.

This study, therefore, establishes the need for the analysis of the gaps that exist in the legal, policy

and socio-structural frameworks in South Africa that contribute to women's vulnerability to HIV. This study seeks to inform an essential package that would form the basis of a comprehensive response to HIV targeted at young women and girls.

Whilst successive South African country reports, including the 2014 Global AIDS Response Progress Report (GARPR), demonstrate the recognition that gender equality is vital to an effective HIV response, there is still an urgent need for the articulation of specific interventions, including funded implementation plans, focused budgetary allocations, dedicated political leadership and administrative will at the highest level of government as well as civil society. Women and girls are critical to an effective national response to HIV and TB, which should:

1. Center the voices of women and girls as critical contributors to the national HIV and TB discourse.
2. Draw on the experiences of women and girls living with HIV in order to better understand the legal and socio-structural factors which account for gender disparities in accessing health care services at the local and community level in South Africa.
3. Highlight both the challenges and best practices women encounter as they navigate the health care system at the local and community level.
4. Inform the development of the essential packages, which address the identified gaps.
5. Provide a rigorous gender analysis of the national response NSP (2012 – 2016) and inform the development of NSP (2017 – 2021).

1.2 Literature and Policy Review

1.2.1 Review approach

Research reports were included in the review if they indicated that the research involved women and HIV and AIDS, were published in a refereed journal, and had implications for prevention of HIV among women. To ensure a thorough review, sampling of the literature occurred in three steps.

- First, computer database systems of Medline, PubMed, Google Scholar, Science Direct and CINAHL were searched with four key words in various combinations – women, HIV, AIDS, and prevention – and phrases such as *gender and HIV, economic empowerment and HIV, biological vulnerability of women to HIV* and gendered responses to HIV – producing a total of 150 possible papers done between 1999–2013, which were eventually narrowed to 20. In addition policy documents related to

the strategies on tackling HIV and gender, and regional and international policy documents to deal with HIV, were also reviewed, and an analysis of how South Africa is faring in implementation of those commitments was also conducted.

- Second, the reference lists from these initial articles and policy documents were examined for related research reports, and those meeting the inclusion criteria were included in the review.
- Third, journals associated with women's health and/or HIV were searched manually for relevant research. Prior published reviews assisted in focusing the scope of the present review. The topic of women and HIV and AIDS has been reviewed by authors in a variety of health-related disciplines and a list of authors that have published extensively is listed below with citations and major elements of each of the reports included in the analysis.
- Content analysis was used to evaluate the research reports and policy documents for the variables or concepts studied and their



relevance to the problem, the adequacy of the research methods, the interpretation of findings, and the applicability of findings to the problem of prevention of the spread of HIV disease among women.

South Africa has a total (documented) population of 51.7 million people of which 26.5 million (51.3%) are women¹⁷. Even though it has been pointed out that the national HIV dataset has been contested, national data from the NDOH, cited in the NSP 2012 – 2016, and the National Development Goals Country Report 2013, premised on the total number of 5.63 million women and men, girls and boys living with HIV in South Africa¹⁸. Of these 59% are women and an estimated 410 000 are children. While to a large extent prevalence seems to have stabilised, incidence is still high, being higher among young women in the age group of between 15 and 24 than men; and peaking at age group 24–35 for women¹⁹.

Researchers ascribe the slow progress in attaining gender equality in HIV to the often undocumented and misunderstood needs of women, and their complexities in the response to HIV and TB prevention, treatment and care²⁰. Research on the subject has been ongoing for a long time, but only recently has a concerted effort that recognises women’s risk to HIV been turned into attempts at getting policy documents aligned. It is clear that South Africa has to make significant strides in order to close the gender disparities that affect women, especially those in the lowest socio-economic groups. As Dr Josephine Odera, a sexual health and gender expert; remarked during the 2013 International Conference on AIDS and STIs in Africa (ICASA) 2013, “...gender determines power and increases the chances of one being more prone to HIV infection”.

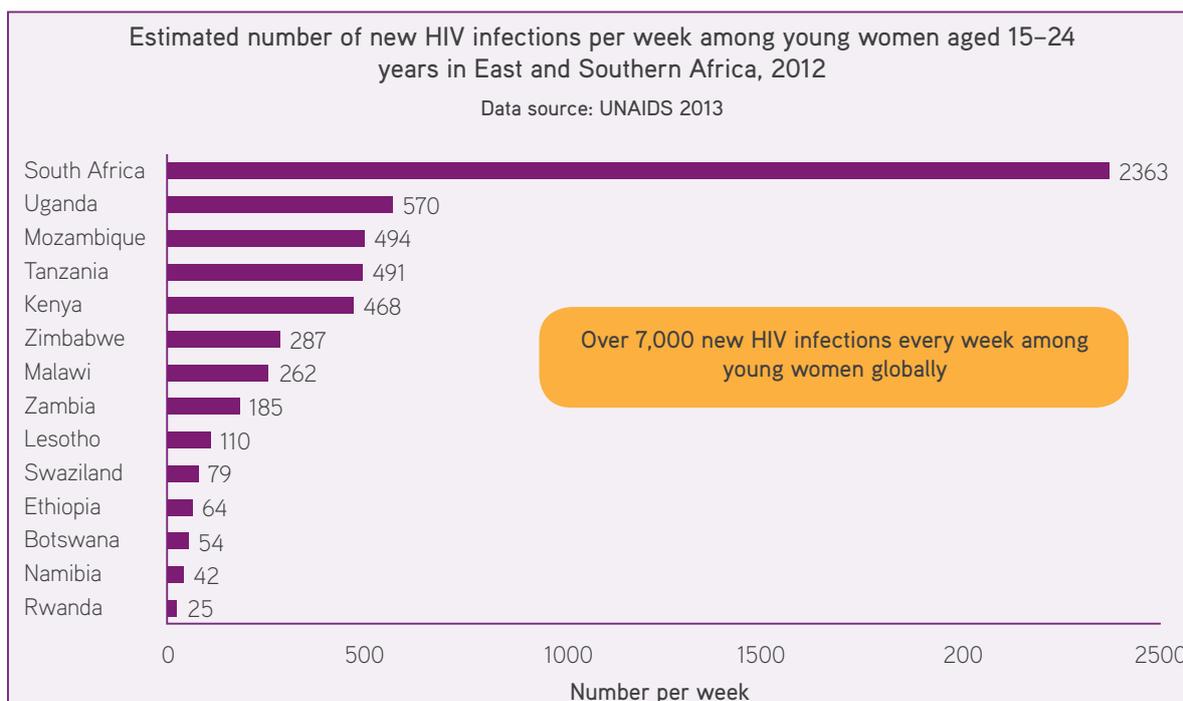


Figure 1: Incidence of HIV in South Africa (Source UNAIDS 2012)

1.2.2 Socio-Structural Gaps in the Response to HIV

1.2.2.1 Livelihoods and economic disenfranchisement of women

Some academic work reveals a direct correlation between high HIV incidence and economic disempowerment of women²¹. As illustrated in Figure 2, unemployment rates are higher amongst

Added to their risk of infection, women and girls carry the additional burden of caring for the sick. It was reported in the Stats SA 2012 report that women spend more time on care and household activities compared to men²². Where this fact remains unacknowledged, women's increased burden of care as a result of HIV and AIDS is still unaccounted for and unremunerated. Women, through their care work, continue to subsidise the health care system. This is especially true for women living in rural areas and in urban informal areas, where women report various challenges in attempting to access health care facilities²³. Lack of secure livelihoods forces families to live apart

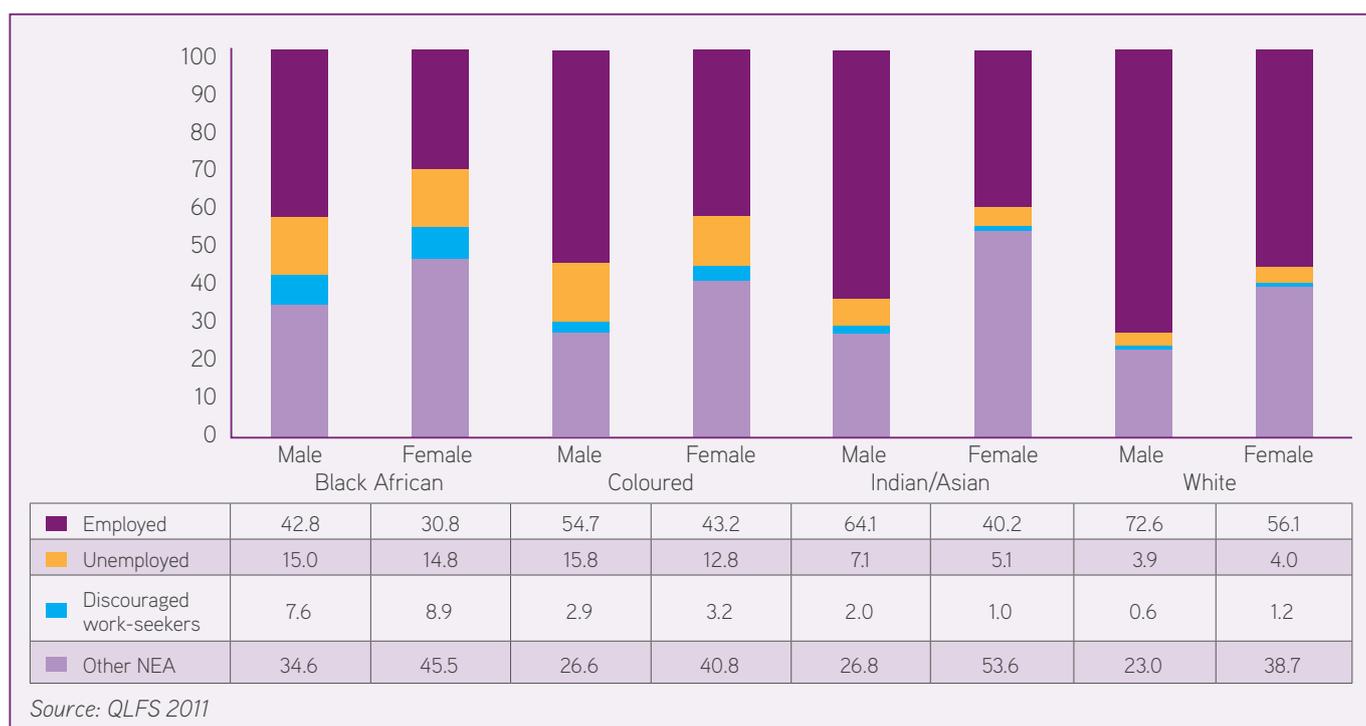


Figure 2: Unemployment rates are higher among women in South Africa and particularly among women in rural areas. Source – Stats SA 2012

women in South Africa, and especially women in rural areas. This trend perpetuates poverty and gender inequality, and indeed vulnerability to HIV acquisition, and reduces the much needed social capital to cope when one is infected. This has the greatest impact on black women who, according to HSRC, have the highest unemployment rate of 30.8% – and could be linked to black women's heightened risk of HIV.

as one partner migrates to look for work, and this separation of families fuels the spread of HIV²⁴.

Poverty and gender inequalities are underlying factors that contribute to women's vulnerability as they profoundly compromise their negotiating power in sexual relationships. OoNonkululeko depicts an employed primary school graduate who is struggling to raise her daughter and who,

by default of being a woman, earns almost 25% less than her male counterpart would²⁵. This results in her resorting to transactional sex work to provide for her daughter. It is here that she is left powerless to negotiate sexual terms (the how, when and where to have sex), making her more susceptible to contracting HIV, as some of her clients insist on having unprotected sex²⁶. This is worsened by the gender based violence that is rampant within sex work²⁷. The inability of commercial sex workers to access appropriate legal discourse is aggravated by the criminalisation of their work through the “The Sexual Offences Act of 1957” which prohibits all sex work, and any activity associated with it.

1.2.2.2 Inequality and violence against women

8

The landmark 2005 World Health Organization Multi-Country Study on Women’s Health and Violence against Women provided irrefutable evidence that violence against women is widespread globally and is a major contributor to

the ill-health of women^{28,29}. Gender-based violence exacerbates women’s susceptibility to, and risk of, HIV infection³⁰. In South Africa, according to a Statistics SA 2013 report, rape victims in the country were more likely to be young women aged between 16 and 25 years. Statistics revealed that relatives of victims or intimate partners committed 34, 6% of all rapes, casual acquaintances 26, 1%, while 24, 4% of all victims did not know their attackers³¹. In terms of location, 64% of rapes occurred either at or near home³². Additionally, health care facilities do not have protocols for routine screening for domestic and sexual violence, making it harder to quantify the true incidence of gender-based violence presenting in health care facilities³³. Due to a number of factors, including fear of secondary victimisation, women are more likely to report to health care facilities rather than a police station, especially if they are in need of medical attention³⁴. Although South Africa does have certain best practices such as the Thuthuzela courts and specialised, sexual offences courts, these are still too few and far between to cater for the widespread and often insidious nature of gender-based violence.



In addition, Stats SA noted that rape in South Africa happens under very violent conditions. More than half (56,1%) of the lone-offender attacks involved the use of a weapon. Traditionally, there is also a very low level of reporting incidences of rape in SA, with only 56,2% of the rape victims saying that they had reported the offence to the

police³⁵. The most common reasons given for not reporting the crime to police were that the victims feared reprisals (33,3%), the victims felt that the police would be unable to solve the crime (9,6%), or the victims feared embarrassment/discrimination (9,2%)³⁶.

Some Key Points on Gender-Based Violence in South Africa³⁷

1. South Africa faces a globally unprecedented burden of mortality and morbidity from violence and injuries.
2. Violence is the second leading cause of death in the country (after HIV) and the leading risk factor, after unsafe sex, for loss of Disability Adjusted Life Years.

Rape survivors

3. Some 54,926 rapes of women and children were reported to the police in 2005-6 (SAPS, 2008).
4. Research shows this was a small proportion of all rapes – at most one in nine rapes were reported, of which 4,500 resulted in convictions.

Violence against girls

5. 30% of girls in South Africa will have been raped by the time they are 18.
6. Girls between the ages of 15 and 19 are twice as likely to report sexual violations as women between the ages of 45 and 49. This is significant as girls between the ages of 15 and 19 are the demographic group most at risk of HIV infection.

Intimate partner violence and femicide

7. South Africa's rate of female homicide by an intimate partner is six times the global average, with a woman killed every six hours by her husband or boyfriend.
8. 25% of women in the general population and in 40–50% of targeted studies have been victims of physical intimate partner violence.
9. Over 40% of men have perpetrated violence against a female partner.

In an environment where people still believe that AIDS can be cured by sleeping with a virgin and where the incidence of rape among young girls is extremely high, the young ooNonkululeko is at risk of being the bait for this supposed 'cure'^{38,39,40,41}. ooNonkululeko also depicts a picture of a young black female residing in Kwa-Zulu Natal with a tertiary education, who comes from a patriarchal community that has always taught her to be submissive to her male counterparts, and possibly where the occurrence of rape within marriage is unrecognised. This picture emanates from the evidence of ukuthwala in some rural areas of South Africa.

As the above review indicates, young women and girls in South Africa are disproportionately vulnerable to HIV stemming from the bidirectional relationship between gender-based violence and HIV⁴². A proactive plan of action geared at redressing women and girls' vulnerability to HIV would need to incorporate poverty, gender inequality, gender-based violence, and sexual and reproductive health and rights into the continuum of prevention, treatment and care.

1.2.2.3 Behavioural determinants of risk to HIV

The physical environment where women live also contributes to risky behaviours making them vulnerable to HIV. It is important therefore that categorisation of behavioural drivers of HIV acquisition and response to treatment be contextualised within socio-structural barriers stated above. The current HIV prevention programmes have been criticised by some scholars as focussing mainly at the point of transmission, whilst lacking a focus on upstream interventions⁴³. A focus on upstream interventions allows for multiple benefits including a reduction in unwanted pregnancies and early marriages, and an increased chance for a better livelihood⁴⁴.

There is a gap in effectiveness of interventions

that addresses the following challenges in South Africa.

1.2.2.4 Access to education

Keeping girls at school for longer has been identified as a protective factor against the acquisition of HIV. In South Africa several notable initiatives are worth mentioning, including the integrated school health programme which is a joint initiative between the Department of Health and the Department of Basic Education. A school creates an environment wherein learners can be guided to make healthier lifestyle choices⁴⁵. However, criticisms around the quality of schools and the prevailing conditions of education abound in South Africa. The Equal Education⁴⁶ campaign for example reports that a number of schools do not have access to running water and sanitation, making it difficult to retain female learners, especially at school that lack such facilities. It has been noted that some girls miss up to 50 days of school annually; because they have no access to sanitary towels, sanitation and running water⁴⁷. Furthermore, gender-based violence has been reported in many schools, making the school environment less enabling for HIV interventions⁴⁸. The number of teenage pregnancies in South Africa is equally alarming, reflecting not only the practice of unprotected sex but a lack of contraceptive use in general and restricted access to pregnancy terminations⁴⁹.

Another area of concern is the emerging missing "middle" in South Africa – the young women who fall in the economically active population, who have just matriculated, but are found neither in tertiary colleges nor in the work place. This is recognised as a dangerous group to be in, as, driven by the need to earn an income of sorts, risky behaviours tend to escalate with many girls participating in transactional sex. This reinforces the belief that keeping girls at school for longer might indeed be a game changer in South Africa⁵⁰. However, the quality of the school environment

and those who are no longer at school, have to be considered. Research on the effectiveness of various incentives in order to achieve this longevity in schools, such as cash transfers, are ongoing and are commendable^{51,52}.

1.2.2.5 HIV stigma and decriminalisation of sex work

Negative social responses to HIV remain pervasive in many communities in South Africa⁵³. Stigma interferes with HIV prevention, diagnosis and treatment, inhibiting people's access to the social capital needed to cope with HIV when infected, or to access HIV prevention tools when required⁵⁴. While this is an acknowledged gap in a rights-based approach to the HIV response, intervention designs thus far seem to have functioned as identified by Freire (1970) as a 'banking' theory of pedagogy⁵⁵. His theory vividly depicts the lack of impact of interventions wherein the perceived deficit accounts of those being 'educated' are somehow 'filled' by intervention specialists who presume they know the truth about what is needed⁵⁶. Some authors assert that with regards to women and the narrative that the PWN seeks to advance, women are the masters of their own narratives and consequently should be the authors of interventions to reduce stigma in their communities^{57,58,59}.

In addition, the criminalisation of supplying sex work – and not the demand thereof – fuels the stigma against sex workers and affects the rate of access to services. The concepts of stigma and criminalisation become intertwined somewhat, especially when discussing the rights of commercial sex workers and the challenge of ensuring effective HIV prevention efforts⁶⁰. For many women, particularly commercial sex workers and those living with HIV, there are no clear strategies to address stigma, either in the communities they live in or in the facilities they go to for medical care, especially hospitals⁶¹.

Furthermore criminalisation of sex work makes it difficult for sex workers to access justice in South Africa, consequently predisposing them further to gender-based violence and HIV infections⁶². Indeed, a study that explored this concept in Zimbabwe revealed that from a health care worker's viewpoint, sex workers are seen as wasting medicine when they access care and treatment⁶³, and criminalisation of sex work increases the risk of HIV, with anecdotal reports pointing to police officers confiscating condoms from sex workers.

Vulnerability is a layered concept in South Africa, exacerbated by other socio-structural factors such as migration. While migration has fuelled the transmission of HIV and TB in South Africa, it is important to note that there are many young women who leave neighbouring countries in search for work, but end up trading sex in South Africa⁶⁴. This is an issue that needs a systemic response, and gaps have been identified by some authors⁶⁵.

1.2.2.6 Early sexual debut

There is evidence that initiating sexual activity at an early age increases one's lifetime risk of acquiring HIV. While evidence from the 2012 HSRC survey indicates that the age of sexual activity is decreasing in South Africa, research on the age group 15-24 years shows that 10.7% had initiated sex before the age of 15, with more males initiating sex before the age of 15 than females⁶⁶. In addition, as the HSRC (2012) survey reveals, the prevalence of age disparate sex is worrisome in South Africa.

1.2.2.7 Condom use and distribution

While condoms are currently the most effective and inexpensive method of preventing HIV transmission and unintended pregnancies, condom

use among the age group 15 – 24 is decreasing in South Africa⁶⁷. Furthermore, the inability of adolescents to negotiate safe sexual relations even when condoms are available is compounded by the lack of access to condoms at the point of use⁶⁸. This could explain the worrying downward trend of both male and female condom distribution stated in the 2012 DHIS survey⁶⁹.

Sub-Saharan Africa, the risk of HIV acquisition increases with alcohol abuse⁷², and interventions that have been prescribed to date call for tougher state laws and for communities to work together to reduce the effects of alcohol, particularly focusing on reducing violence against women⁷³.

1.2.2.8 Alcohol and substance abuse

There is evidence that alcohol and substance abuse contributes to HIV transmission through various means, including aggravating gender-based violence^{70,71}. Across many countries in



Figure 3: PWN reaching out to girls through education on condoms

1.2.3 Gaps in the Biomedical Approaches

1.2.3.1 Understanding physiological vulnerability

Women's biological vulnerability to HIV has been well established⁷⁴. For example, where there is vaginal intercourse, it is understood that the mucosal surface of the female reproductive tract is the primary site of transmission for HIV, representing a significant burden upon women's health. Some of it stems from the regulation of the reproductive tract by cyclical changes of the sex hormones estradiol and progesterone across the menstrual cycle⁷⁵. This unfortunately, leads to the creation of a window of vulnerability during the secretory stage of the menstrual cycle, when the risk of HIV transmission is increased⁷⁶.

Whilst physiological vulnerability is widely acknowledged, the experiences thereof are highly individual. The female genital tract is made up of a larger exposed area. Semen has a higher viral load than vaginal fluids and the semen stays longer in the female genital tract after acts of sex, increasing the chances of HIV transmission. It has also been demonstrated that the genital tract of young girls is immature and thus more prone to invasion by HIV.

Sexually transmitted infections, which increase the chances of HIV transmission and acquisition of HIV as a result of the damage they can cause to the genital tract, can occur in women asymptotically and without being recognised – particularly because government clinics do not routinely test for chlamydia and gonorrhoea but utilise syndromic approach to STI management. This increases the chances of HIV transmission and acquisition by women. Furthermore, some women in South Africa use herbs to remove vaginal lubrication and tighten the vagina to create “dry sex” (often considered the sexual preference of men in sub-Saharan Africa)^{77,78}.

Dry sex is associated with increased health risks and can result in tearing the genital tract during sex, thus further increasing a woman's chance of transmitting or acquiring HIV⁷⁹. This also happens in instances of rape, and given the extremely high incidence of rape in South Africa, this is another way that gender-based violence increases vulnerability to HIV. Harmful vaginal health practices, often passed from one generation to another and from one peer to another, reflect the paucity of information available to these young women, adding to their natural biological vulnerability. There are times when fertility intentions clash with the desire to protect oneself from HIV, pointing to the need to have a wider range of HIV prevention methods beyond barrier methods. If one conducts an analysis of such practices, it is evident that women often practice dry sex not for their own pleasure but for their male partners.

Sexual violence which is common but rarely reported by women increases the chances of HIV transmission. As the scientific community advances tools such as microbicides to counter this vulnerability, the daily experiences of women's lives and how these new technologies can fit in, should not be ignored. Hormonal, biological vulnerability and the reproductive health and HIV trade-offs are still being debated. When women are infected there are clearly different pharmacodynamic and pharmacokinetic considerations to ART that should be reflected in programming but that are currently ignored. For example the long term effects of tenofovir on women need careful monitoring.

1.2.3.2 Gaps in HIV prevention

The prevalence of HIV has stabilised in South Africa due to the widespread use of ARVs, and in some parts of South Africa is still over 10%⁸⁰. However, incidence of HIV has not stabilised with incidence peaks for young women between years

25 – 34⁸¹. The high HIV incidence is in part a result of paucity of prevention services for young women and girls⁸².

Academic analysis of currently available HIV prevention options for women has shown that there is much that needs to be done in terms of making available new biomedical prevention options such as microbicides and PrEP. The progress report from SANAC⁸³ states the need to focus on HIV prevention amongst young women and girls going towards 2016. Of concern, according to the SANAC progress report, is the reduction in the numbers of condoms distributed, for both male and female condoms. Given the slippage effects between distribution and ultimate use, this is a gap that needs to be addressed urgently, particularly among young people⁸⁴. In the report it is stated that in total, 4 309 146 female condoms were distributed during 2012, a 16% reduction from the 2011 numbers⁸⁵. The SANAC report recommends prioritising female condom distribution in South Africa towards the 2016 targets for the NSP.

In the first few years of the HIV epidemic⁸⁶, there was a global call to action on the urgent need to get methods that women could use to prevent HIV transmission. The inherent biological vulnerability of women to HIV had been established, but for many women, sociocultural and structural settings made it impossible to negotiate safer sex⁸⁷. To be safe from HIV infection, heterosexual women need to rely not only on their own skill, attitude, and efficacy concerning sexual behaviours and condom use, but also on their ability to negotiate condom usage with their male sexual partners⁸⁸.

This sad scenario extended to the treatment arena, where lack of adherence is an issue for women, side effects are not attended to in a gender specific way and the burden of HIV care still falls to women across the country, albeit unpaid⁸⁹. These issues are explored in a South African context but make reference to the global stratosphere where several studies have been done to understand gender inequities along the

HIV care continuum.

No woman-initiated HIV prevention tool exists, except the female condom for women. In addition, evidence shows that even though women have good knowledge of the female condom there is low uptake⁹⁰. The past 12 years has seen a proliferation of prevention research where priorities have expanded from biomedical discovery to include implementation, effectiveness, and the effect of combination prevention at the population level, which should benefit women. Even when tools such a male condoms are available, women find it difficult to negotiate for safer sex and this applies to HIV positive women as well⁹¹.

A new direction for HIV prevention research is needed, that focuses on the implementation of effective and efficient combination prevention strategies to turn the tide on the HIV pandemic for women. Further, gendered trend analysis is needed on HIV incidence, some of which is currently provided by the HSRC data for 2012⁹². The challenge of implementation science calls for practitioners to pay adequate attention to constructions of gender and sexuality in relation to HIV transmission. While the body of literature examining these themes is growing and becoming more nuanced, there is still a significant gap in our understanding of the relationship between gendered vulnerabilities to HIV disease. With regards this report, the assumption of heterosexual sex is not intentional, but points to the lack of existing knowledge on HIV transmission among women having sex with women.

1.2.3.3 HIV testing and gender dynamics

South Africa has done well in improving access to testing services through onsite rapid testing and provider-initiated testing, but methods to mitigate fear and the threat of violence are still needed. In 2012 an HIV testing campaign was rolled out in

South Africa where more than 20 million people were tested for HIV in 20 months. HIV testing is recognised as a crucial part of almost all programmes for HIV prevention, especially if any of the new developments in HIV prevention with antiretroviral drugs where for women microbicides and PrEP are successful, could play a significant role. HIV testing helps to link women to services for the purpose of HIV prevention and care.

Although HIV testing has historically been combined with risk reduction counselling, the challenges facing women make the results of risk reduction difficult to see. Even where women have tested for HIV, the failure to negotiate safe sex because of the power dynamics that exist in sexual relationships is hard to surpass⁹³. Models of service delivery to optimise uptake of testing and linkage to care and treatment, while protecting patient rights and confidentiality, also need to

focus on protecting women’s rights⁹⁴. In this way, both supply-side and demand-side barriers as well as inefficiencies need to be addressed in order to improve accessibility to this key entry point to HIV prevention services for women.

1.2.3.4 Treating HIV in South Africa – what does it mean for women?

For many countries, including South Africa, treatment programme scale up is not just about receiving treatment, but about addressing the holistic health needs of people living with HIV⁹⁵. These include the sexual health and reproductive rights for women living with HIV, addressing adverse effects of drugs, and unintended consequences of long term exposure to ART medication such as metabolic disorders and

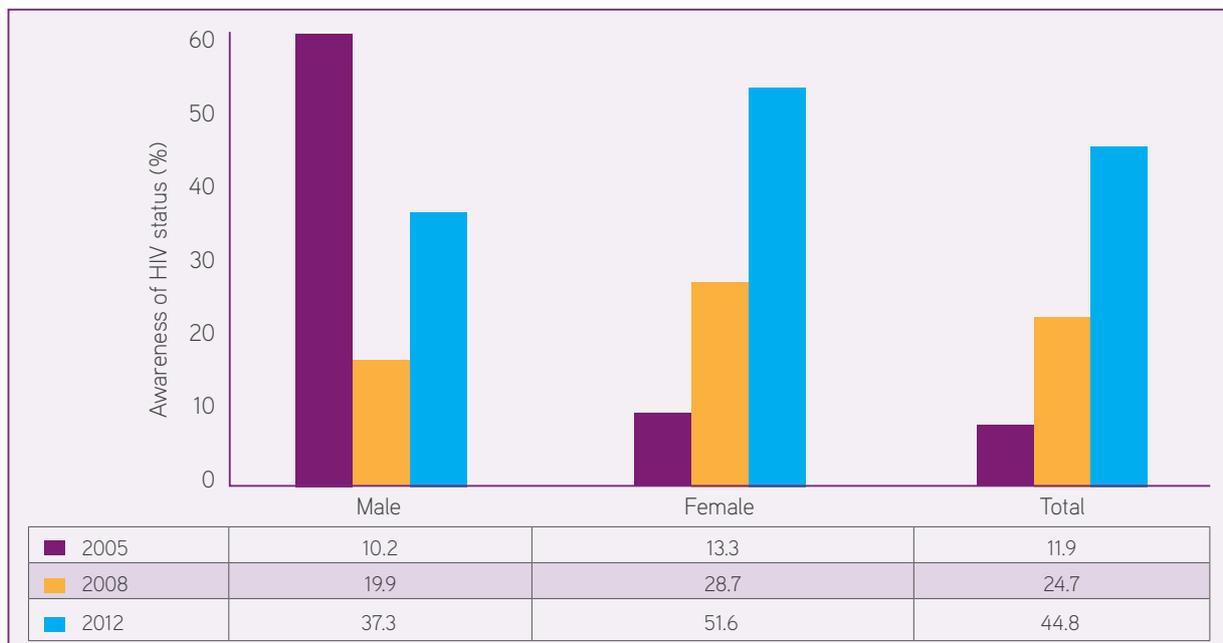


Figure 4: Source: South African National HIV Prevalence, Incidence and Behaviour Survey, 2012, Human Sciences Research Council

premature aging⁹⁶. Even though treatment is lifesaving, it has both short and long-term side effects, some of which are gender specific, affecting women disparately. Solutions to these gender issues are far and between, often relying on expert opinion rather than systematic longitudinal research.

Access to ART has increased substantially and significantly in the past few years in South Africa as evidenced by the table below, with 2,411, 653 adults accessing treatment according to the DHIS in 2012⁹⁷. The delivery of HAART is rapidly being scaled up in South Africa with women accessing HAART. Women's access to treatment could be reduced if existing gender attitudes prevent them from seeking testing or returning for results as was shown in a qualitative study in Zimbabwe⁹⁸, but in South Africa the entry point is mainly through antenatal care, hence the higher number of women accessing ARVs⁹⁹. Access to treatment has many facets, including the ability to get to a health care facility, the cost thereof (affordability) and the opportunities to receive quality TB and HIV care – of which the latter is highly contested in South Africa. In addition, access is also about the way patients are treated by various health care workers¹⁰⁰, enabling them to return for services. New guidelines have expanded treatment for all – however, we still need to increase testing and linkage to care.

1.2.3.5 Women's representation in research

Women represent the bulk of research participants when it comes to HIV especially with the proliferation of HIV prevention trials on PrEP and microbicides, which is commendable¹⁰¹. However, gaps exist on understanding the gender nuances of ART. Despite the aforementioned epidemiology, studies on treatment are often underpowered to provide gender analysis or simply not analysed by gender to provide especially gender specific pharmacokinetics of ART¹⁰². Where studies of

women do exist, these are most often confined to the issue of pregnancy and PMTCT, a vital area of interest in relation to women, but not representing the totality of the female experience in the HIV continuum¹⁰³.

At times gender aspects of ART focusses on the adherence aspects of ARVs rather than on longitudinal analysis of side effects to non-pregnant women. Following this realisation, the effects of hormones, both on HIV acquisition and interactions with ARVs, has been a focus area for some researchers¹⁰⁴. Overcoming these barriers is crucial to increasing meaningful female participation in clinical research and to producing gender-specific knowledge on treatment regimens upfront.

1.2.3.6 Initiation and response to therapy

There is conflicting evidence on whether the biological differences between men and women put them on different trajectories in disease progression. Some studies suggest that women have a higher CD4 count and therefore seem to progress better if one measures only CD4 count in disease progression¹⁰⁵. This may be deceptive. Using CD4 count-based treatment recommendations, twice as many men as women are eligible for treatment during the first year after sero-conversion. In addition; women have lower plasma HIV RNA levels than men¹⁰⁶. Since such measures influence the timing of ART initiation, it is plausible that women may start treatment later than men, a phenomenon that may contribute to poorer clinical outcomes. This requires further research.

Gender equity in access to care and treatment for HIV infection is a complex issue. Women are more vulnerable than men to becoming infected with HIV, and yet are equally or more likely than men to start ARVs, which is commendable.

1.2.3.7 Adherence to ART

Women who are receiving ART might also have their adherence or response to treatment impaired by their disproportionate burden of caregiving and other responsibilities, difficulty in taking medicines openly at home, and clinical conditions, such as anaemia. In one study a higher prevalence of anaemia and severe anaemia in women than in men was found¹⁰⁷. This might be expected to worsen the survival of women starting HAART because anaemia has been shown to be associated with disease progression, independent of CD4 cell count¹⁰⁸. Again there is conflicting data in this area. Some studies reveal that women are less likely to discontinue treatment than men¹⁰⁹, whereas others reported that women were more likely to discontinue therapy due to toxicities^{110,111}.

The type of regimen a patient is taking is associated with time to initial therapy change or discontinuation. In particular, and in comparison to protease inhibitor-based regimens, non-nucleoside reverse transcriptase inhibitor (NNRTI)-based regimens fared the best in delaying the time to regimen change¹¹². Therefore, depending on the type of regimen administered, rates of discontinuation may be found to be higher in women than in men, but are generally higher in men resulting in adverse mortality outcomes¹¹³.

1.2.3.8 Side effects of ART

According to some authors, women may experience more lactic acidosis, drug toxicity and hypersensitivity reactions on antiretroviral therapy, which may contribute to decreased adherence and treatment interruption¹¹⁴. Some studies also indicate that women have higher rates of clinical progression to AIDS and death while others have suggested the opposite, meaning multiple influencing factors need to be considered when it comes to ART side effects rather than just gender. A better understanding of gender differences in treatment is warranted to provide the most

efficient care that is less likely to result in therapy failure during follow-up.

From the limited literature available on this topic, women differ from men in a few important aspects of treatment but it may not be easy to reach a conclusion on the implications of these in relation to legal and policy gaps. However, careful follow up and emphasis is needed on specific drugs currently available in the South African ART guidelines.

Drugs that have an effect and are used widely in South Africa with specific effects on women include:

- **Nevirapine:** Even though not as widely used as in the past, women are more prone to nevirapine rash than men, and in one study they were likely to discontinue use of nevirapine¹¹⁵. In addition, women who are on ethinyl estradiol have a significant reduced area under the pharmacokinetic curve when on nevirapine¹¹⁶, have a higher CD4 count and are particularly at high risk of hepatotoxicity. The good news is that in South Africa this drug is not widely used
- **Stavudine:** Fortunately not widely used as well, caused severe stunting and lactic acidosis, especially among black women. These side effects should always be picked up and noted in gendered guidelines. It could have been useful to introduce tenofovir for example, to women first in South Africa. However this drug is not widely used in South Africa any more
- **Efavirenz:** Side effects could be compounded by symptoms of HIV progression or toxicities of ARV agents such as dizziness occurring with efavirenz reported more in women than men¹¹⁷
- **Tenofovir:** In studies, women on treatment demonstrated reduced bone density, which exacerbates osteoporosis in women¹¹⁸. This warrants long term follow up for women as their oestrogen levels decreases, and consideration should therefore be given to testing bone density in HIV-infected women with risk factors for osteopenia
- **Zidovudine:** one of the contraindications for the use of AZT is underlying anaemia. Women often

have lower levels of haemoglobin compared to men, and this may limit choice of therapy in instances where AZT is contraindicated. In addition, AZT exposure during pregnancy as well as after birth resulted in significant haematological alterations for women¹¹⁹.

1.2.3.9 Hormonal changes and contraceptives

The biological difference between men and women is profound because of the effects of hormones, which occur at different levels in any given phase of a woman's life. It is possible, for example, that ARVs contribute to delaying puberty even though they reverse the endocrine-disrupting effects of chronic HIV. In addition some studies have found vulnerability increases during pregnancy¹²⁰. Differential access to care for women between studies may be an important factor explaining these discrepancies, but the pharmacodynamics of ARVs on hormones is still under extensive research with notable advances being made especially on implications for HIV prevention¹²¹. In the development of ARVs however, specific needs for women need to be singled out.

A WHO expert group in February 2012 issued a consensus statement on contraception and HIV, which was reviewed by experts who came to the conclusion that the body of evidence was insufficient to warrant policy change in member countries. There is now a yet-to-be-published consensus in South Africa even though new contraceptive guidelines have been revised to expand the contraceptive mix¹²². Some studies suggest that women using progestogen-only injectable contraception may be at increased risk of HIV acquisition, but other studies fail to show this association¹²³. If further evidence is found to support progestogen-only injectable contraception as a risk factor, women may need to make trade-offs between reproductive rights and HIV prevention, particularly in light of the widespread prevalence of progestogen-only contraceptives

and the higher cost of alternatives such as combined oral contraceptives.

- In the South African NSP, guidance for the continuous use of ARVs in a woman who decides to have a child, or in a woman who has chosen to breastfeed is not very clear in terms of hormonal changes. The administration of ARVs is only a tiny component of treatment¹²⁴. Hormonal changes in a woman during her menstrual cycle and at menopause and corresponding reactions to ARVs have not been thoroughly researched.
- The debate around the use of hormonal contraceptives and the suspected increase in HIV susceptibility needs attention^{125,126}. Depot medroxy-progesterone acetate (DMPA) given as 150 mg intramuscular injection every three months, is a highly effective contraceptive agent, used by millions of women in South Africa but could possibly be predisposing them to HIV. There is little data assessing the safety and tolerability of DMPA among HIV-infected women, especially those also receiving ARV therapy¹²⁷. A study is planned to answer this question.
- HIV vulnerability during menstruation has also been documented¹²⁸. The inflammatory cytokines were found in some of the women who seroconverted during a tenofovir gel microbicide trial¹²⁹.

1.2.3.10 Gaps in the TB response

TB is a major cause of mortality from an infectious disease among women, with pregnant women particularly being at a higher risk of dying¹³⁰. South Africa has a TB incidence rate close to 1000 per 100 000 population, making it one of the highest TB incidence rates in the world¹³¹, especially as a comorbid condition with HIV. For the PWN, TB incidence is of particular interest when it comes to understanding the major drivers of mortality for women living with HIV, as comorbidities are common. There is evidence of under notification of women with TB, and this could be a result of the poor access to health care among women

¹³². In South Africa for example, there are lower notification rates for pregnant women based on symptom screening – this may point to the need for advanced screening techniques for women ¹³³. Women are also at increased risk of infection during reproductive years since this is the time most of them acquire HIV¹³⁴.

Gender influences TB outcomes^{135,136}. Some studies outside South Africa show that lives in informal settlements are uniquely organised by multiple discourses that contribute to the gender makings of TB¹³⁷. Sex-specific features of nutrition and metabolism may also be associated with susceptibility or resistance to *M. tuberculosis*. Iron, for instance, is a crucial component of several enzymes and redox systems in mycobacteria, as in all living organisms, and is essential in the acquisition of TB¹³⁸. Research has demonstrated iron deficiency among women from developing countries¹³⁹. It remains unclear from literature whether anaemia is correlated with greater drug resistance in women, thus both drug resistance and gender are examined in turn.

More women than men are also infected with drug resistant TB in South Africa. Supporting this is data from observational studies of drug-resistant TB in South Africa where MDR has been noted to be more prevalent among women and where women admitted with drug-resistant TB to KGHV were 38% more likely than men to have XDR TB¹⁴⁰. However, studies from low-prevalence HIV settings report fewer women with drug-resistant TB. Thus in these settings, women with drug-resistant TB are likely to adhere to ART, leading to improved survival, and therefore increased time for XDR TB to develop^{141,142}. Factors associated with secondary development of XDR TB, such as TB medication adherence or previous MDR TB treatment, could explain the association between XDR TB and female gender. Gender-sensitive interventions to improve diagnosis, treatment, and prevention for drug-resistant TB and HIV are thus needed. Leaving aside sociocultural biases re access to health care services, biological factors leading to differences in resistance to infection/

disease between men and women may account, at least in part, for the worldwide excess of male pulmonary TB cases detected by case notification and from epidemiological surveys¹⁴³.

1.2.3.11 TB in pregnancy

Data illustrates the significance of TB infection as a major cause of maternal mortality, especially in the context of HIV co-infection^{144,145}. However this could potentially be the misdiagnosis of TB as cause of death. In an audit of maternal mortality in Johannesburg, 70% of deaths in women who were infected with HIV were HIV-related, rather than from obstetric causes, and mainly from TB and pneumonia¹⁴⁶.

TB infection in pregnancy may present with diagnostic challenges, mainly because of the often non-specific nature of the early symptoms of the infection, such as malaise and fatigue, which may be attributed to pregnancy and not raise the suspicion of TB infection¹⁴⁷. It calls for reason therefore that the most important step in making the diagnosis of TB in pregnancy is the identification of its risk factors, and specific enquiry about the symptoms that may be suggestive of infection¹⁴⁸. While South Africa is scaling up routine screening of all HIV positive pregnant women for TB, implementation and diagnostic challenges still occur and for many women, access to screening is still an issue¹⁴⁹. If routine screening for TB in pregnancy – which is often inadequate- is not offered, delay in the diagnosis of TB will also contribute to maternal mortality. This is illustrated from one of the case files from PWN, showing the need to diagnose TB early in pregnancy. Some studies have suggested that, with timely and appropriate treatment, TB infection does not have a negative effect on pregnancy outcomes where in HIV-infected pregnant women, the effect on TB appears to be related more to HIV disease rather than to the pregnancy itself¹⁵⁰.

Improved diagnosis and treatment of TB in pregnant women are important interventions for both maternal and child health. There are also key strategies to halt the spread of TB, and to begin reversing the worldwide TB incidence by 2015. Tuberculosis co-infection is common, and will require a range of interventions, including the screening of all pregnant women for TB, preventative therapy for HIV-infected pregnant women after the exclusion of active TB, treatment of active TB and forging stronger links to local TB services for longer term care. This should, in particular, include all women, and especially migrant women¹⁵¹.

incompetence results in the violation of the rights of women and men at local and community levels. Worsening the situation is the fact that various policies are contradictory as has been illustrated in the foregoing literature review. For example, the South African Constitution, and the Children's Act No 38 of 2005 prioritises the best interests of the "Child" (defined as a person below the age of 18). However the age of consent in South Africa is 16 years, therefore legislating sex with a person below the age of 16 as statutory rape. In this context, the Department of Education has been very hesitant (tentative) in ensuring that teachers who have sex with learners are appropriately prosecuted, resulting in an attitude of impunity and the unabated rise in numbers of learners who get pregnant in schools.

1.2.4 Gaps in the Policy and Legal Frameworks

1.2.4.1 The South African National Policy Framework for HIV

A Gendered Review of NSP (2012 – 2016)

The gap between policy intentions and implementation has been, and remains, an issue of concern in South Africa. Stated differently, this is the distance between political will and administrative will. This is evidenced by the fact that despite the South African Constitution guaranteeing gender equality, women do not enjoy gender equality on many fronts. Also, despite the existence of a nationwide monitoring and evaluation framework allocating the responsibility for the implementation of the HIV response to all sectors of government, there is no effective accountability framework. Consequently, key policies are not implemented, and the ambitious strategies are not translated into appropriate implementation plans. Further, there are seldom any consequences for public servants who fail to carry out their duties related to key national programmes, even if their negligence and

When examining the national response to HIV from a women's rights perspective, it is necessary to question whether or not the new National Strategic Plan on HIV, STIs and TB (2012 – 2016) is positioned to address women's realities, risks and needs effectively, based on, and in the context of, HIV. Such analysis is critical as the NSP is meant to provide strategic guidance 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".

Key determinants of HIV in South Africa as identified by the NSP

<i>Behavioural and Social Determinants</i>	<i>Behavioural and Social Determinants</i>	<i>Biological Determinants Structural Determinants</i>
Sexual debut	Mother-to-child transmission	Mobility and migration
Multiple sexual partners	Medical male circumcision	Gender roles and norms
Condom use	Other sexually transmitted infections	Sexual abuse and intimate partner violence
Age disparate sexual relations	Treatment as prevention	Financial dependency
Alcohol and substance abuse		Prevention knowledge and perception

The identification of these key determinants in the NSP can only be meaningful based on the extent to which they can be translated into comprehensive quality programmes, which are both responsive to the realities and needs of women and men, girls and boys and are equally available and accessible to all.

Similarly any omissions of identified key determinants will lead to critical gaps in programming at both the community and district levels. In the case of the NSP (2012 – 2016), it is worrying that stigma and discrimination are not recognised as key determinants, despite the fact that stigma and discrimination are barriers to effective responses to HIV.

In addition to key determinants, the NSP also identifies key populations for the HIV response. 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 is also driven by inadequate protection of human rights, and by prejudice.”

The effective implementation of the NSP requires targeted interventions aimed at key populations to be included in all implementation plans at national, provincial and local levels.

The key populations identified in the NSP are the following:

- Young women between the ages of 15 and 24
- People living or working along national roads and highways
- People living in informal settlements (people living in informal areas in urban areas have the highest prevalence of the four residential types, which are urban formal and informal as well as rural formal and informal)
- Migrant populations
- Young people who are not attending school
- People with the lowest socioeconomic status (this category includes those who work in the informal sector and, among women, those with little disposable income have a higher risk of being HIV positive)
- Uncircumcised men
- People with disabilities
- Men who have sex with men (MSM)
- Sex workers with their clients
- People who use illegal substances, especially those who inject drugs
- Alcohol abusers
- Transgender persons
- Orphans and other vulnerable children and youth.

Given the substantial geographic and contextual differences in South Africa that impact on key populations, the NSP emphasises the need for the “Know Your Epidemic (KYE)” assessments to be conducted in order to enable appropriate targeting at provincial and local levels.

A major concern however, is that women as a sector are not recognised as a key population in the NSP, this despite the evidence base that indicates that women by virtue of their sex (biological) and by virtue of the gendered social context “are more likely to

- a. be exposed to HIV,
- b. lack access to services and
- c. be at heightened risk of rights abuses.

The KYE analysis would reflect that women are not homogeneous, greatly enabling more effective targeting and better programme planning. For instance, the 2012 National HIV Prevalence, Incidence and Behaviour Survey found that HIV prevalence among women in the 32-34 age categories was at 36%, while the figure for males in the same age category was 25.6%. This is an improvement from the 2008 and 2010 figures, which were 40.4% and 42.6% respectively; however, for women the figure is much higher than the antenatal HIV prevalence rate in 2010, which was estimated at 30.2%. Young girls between 15 and 19 are identified as a key population group in the NSP. However, from a prevention perspective, it is quite worrying that girls below 15 are not specifically targeted for prevention-oriented behavioural change programmes. Disturbingly aging women also are marginalised, despite the increasingly evident percentage increase in the number of elderly women living with HIV.

Whilst it is commendable that sex workers and their clients are recognised as a key population group in the NSP, it is questionable that targeted interventions in this particular group of women most likely to be exposed to HIV, will be developed at local and district levels, given the criminalisation of their work within the South African legislative

framework. Even if these programmes were to be developed, there are narratives from sex workers claiming that accessing such services exposes them to prosecution. This has the effect of limiting health-seeking behaviour from this key population group.

Thus, without decriminalisation of sex work, interventions and programmes addressed at this key population will be limited in both their access and efficacy. Likewise, without the decriminalisation of sex work, the national response to HIV continues to facilitate the abuse and violation of the rights of sex workers instead of “respecting, protecting and promoting sex workers’ human rights.” This is particularly concerning, as the previous NSP (2007 – 2011) did, in fact, call for the decriminalisation of sex work.

The biggest omission in the NSP, however, is that people living with HIV are not identified as a key population group that requires targeted interventions and programming. Even though, in the Glossary of Terms (p. 6), the NSP states that “In all countries key populations include people living with HIV”, it is disconcerting that the same NSP fails to include people living with HIV and people with TB among those identified as key populations.

Strategic Interventions Identified in the NSP

Strategic Objective 1 of the NSP addresses the “social and structural drivers of HIV and TB prevention, care and impact.” Whilst there is immediate buy-in by activists working on women’s rights for this objective, the frustration emanates from the fact that at local level social and structural drivers of HIV are not identified and incorporated into action-plans¹⁵².

Poverty and inequality (particularly gender inequality) continue to be the most pervasive structural drivers of HIV. However, while this fact is acknowledged in the NSP, it is yet to be

addressed meaningfully. Complicating matters here is the admission that redressing the structural drivers of HIV and TB are not within the remit of the NSP and a broader, more aggressive poverty eradication programme is required on the ground.

Strategic Objective 2 of the NSP importantly addresses “Preventing New HIV and TB Infections.” The data, however, reflects that this is where the NSP has been found most wanting in its implementation. “The rate of new infections continues to outpace our prevention efforts.” It is also in this area that organisations like the PWN find themselves subsidising government, particularly by addressing the social and behavioural interventions identified in the NSP. Such responses by civil society are however piecemeal and there is need for more aggressive initiatives at the public sector level to drive a comprehensive prevention strategy which would entail the following:

- Integration of government departments and sectors with operational plans with HIV, TB and related gender and rights-based dimensions
- Municipalities with at least one informal settlement to implement targeted comprehensive HIV, STI and TB services

Importantly, Sub-Objective 2.2 of the NSP addresses “making accessible a package of sexual and reproductive health services.” This study maintains there are limitations to implementation in this matter. While the study is not sufficiently representative to make conclusive statements in this regard, it illustrates the need for more research to be undertaken in this area.

Strategic Objective 3 of the NSP addresses “Sustaining Health and Wellness.” This has been an area where arguably there has been greater progress in the biomedical approaches.

Strategic Objective 4 of the NSP addresses “Ensuring protection of Human Rights and improving access to Justice.” In this regard, the

NSP evokes the Constitution of South Africa (Act 108 of 1996) and asserts “the constitutional recognition that access to healthcare and other social services – which includes reproductive health care – is itself a right enshrined in the South African Constitution.”

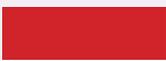
When observing implementation levels, it is apparent this area requires extensive scrutiny and justifiably is a much contested aspect of the NSP. The NSP states that “Women living with HIV in particular have fertility desires which must be protected, respected and addressed. Curricula for training health care providers in these areas must be prioritised; such a curriculum should include a module on human rights.” This statement should also make reference to women’s rights.

1.2.5 South Africa’s Regional and International Commitments

As a sovereign country, South Africa is signatory to a number of regional and international treaties. For the PWN the pertinent agreements affirm the government’s commitments to addressing women’s rights, access to health care, sexual and reproductive health and rights, and violence against women and girls, as well as women’s socioeconomic empowerment. These agreements are typically referenced in key national policy pronouncements e.g. the Beijing Declaration and its Plan of Action, the Convention on the Elimination of All Forms of Discrimination Against Women (dubbed the Bill of Human Rights for Women); and the International Conference on Population and Development (ICPD), as well as other continental and regional agreements.

Although referenced in the NSP (2012 – 2016), the specific provisions pertaining to WLWHIV, sexual reproductive health and rights (SRHR) are seldom spelt out, and therefore the relevant government functionaries required to implement them are often oblivious to them.

In this section, a rapid review is provided of the key obligations to which South Africa is party, the provisions contained in these obligations, and the extent to which government has progressed in complying with each specific relevant provision pertaining to the interests of WLWA. Each provision in the international obligations is assessed using a three point scale as follows:

	No performance in this area
	There are some initiatives in place, but they are not effective
	Commitment achieved

United Nations General Assembly Special Session (UNGASS) on HIV/AIDS – 2001

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>At UNGASS the heads of state agreed to:</p> <ul style="list-style-type: none"> • integrate HIV/AIDS prevention, care, treatment and support; • impact-mitigation priorities into the mainstream of development planning, including poverty eradication strategies, national budget allocations and sectorial development plans at the national level by 2003. 	<ul style="list-style-type: none"> • South Africa does not have a comprehensive poverty eradication strategy – however, the programmes in place are limited in their impact. • Women constitute the highest population among the poor and the unemployed. • Female-headed homes are among the poorest. In addition, women are more likely than men to be found in households with the lowest income. 	
<ul style="list-style-type: none"> • Foster stronger collaboration and the development of innovative partnerships between the public and private sectors, and by 2003 establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS at the regional and sub-regional level. 	<ul style="list-style-type: none"> • While there are a number of private public partnerships (PPPs), much of the support work for people living with HIV continues to be implemented by civil society organisations. • The SA government has effectively driven the bio-medical response to HIV; however, much of the behavioural change, prevention and stigma work is addressed by NGOs such as the PWN. • SANAC is working towards a multi-sectorial approach to the HIV response, which seeks to co-ordinate different government departments, the private sector and civil society. 	

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> By 2003, to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV and AIDS and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic. 	<ul style="list-style-type: none"> The SA Constitution (Act 108) of 1996 prohibits all forms of discrimination, including discrimination on the basis of gender, and sexual orientation. This also includes discrimination against people living with HIV and AIDS. The Bill of Rights in the SA Constitution upholds the right to dignity, etc. – which addresses stigma. The Bill of Rights also recognises socio-economic rights and the right to health. However, at the implementation level, as reflected by the narratives of ooNonkululeko, stigma and discrimination remain major challenges for people living with HIV and AIDS. Only recently (2014) the PWN, NAPWA, TAC, SANAC and the HSRC initiated research towards a Stigma Index. 	
<ul style="list-style-type: none"> By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework. 	<ul style="list-style-type: none"> The SA government does not have interventions in place that specifically target women and adolescent girls. This is despite the fact that women constitute the highest proportion of the unemployed and discouraged jobseekers, and young women being most likely to be infected with HIV and AIDS. However, there are some civil society initiatives driven by Lovelife, Soul City and the PWN, which address young women and adolescent girls as a key population for their interventions. From ooNonkululeko’s narratives, health-seeking behaviour by women and young girls is discouraged by the negative attitudes of health care workers. This is especially true when it comes to accessing sexual and reproductive health services. Furthermore, ooNonkululeko bemoan the fact that they do not receive sufficient information about their condition from the health care professionals and therefore have to rely on information provided by organisations such as the PWN. 	

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> Develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care, including that provided by the informal sector, and healthcare systems to provide and monitor treatment to people living with HIV/AIDS, including infected children and to support individuals, households, families and communities affected by HIV/AIDS by 2005. 	<ul style="list-style-type: none"> Civil society organisations carry out much of the work in communities caring for people living with HIV; this suggests that, the government is not doing enough in this regard. For the most part care work is un-remunerated¹⁵³ and is carried out by women. Recent initiatives by government to re-engineer the primary health care system are still in the initial phases. 	
<ul style="list-style-type: none"> To ensure that national strategies are developed in order to provide psychosocial care for individuals, families and communities affected by HIV/AIDS. 	<ul style="list-style-type: none"> The Department of Social Development has programmes in place aimed at addressing psychosocial care. However, due to constrained human and capital resources, these have limited reach. Most ooNonkululeko do not access these services. 	
<ul style="list-style-type: none"> Develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights, promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection by 2005. 	<ul style="list-style-type: none"> Both the SA Constitution and the NSP recognise and promote the advancement of all women's human rights. Female condoms are not easily accessible; the SA government provides fewer female condoms than required even though there are more women than men in the country, and women constitute the highest proportion of those infected. Even though there are strategies that promote the advancement of women and women's full enjoyment of all human rights, women are still disproportionately amongst the poor, unemployed and discouraged job seekers. 	

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Dec 1979

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>Article 1 For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.</p>	<ul style="list-style-type: none"> • Gender equality is enshrined in the Bill of Rights (Section 2) of the South African Constitution. 	
<p>Article 3 States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.</p>	<ul style="list-style-type: none"> • An elaborate legislative framework is in place, however no comprehensive gender programme is established. 	
<p>The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.</p>	<ul style="list-style-type: none"> • The right to safety at work is recognised for women and men. However women’s reproductive rights are compromised. 	

Fourth World Conference on Women: Beijing Declaration, 1995

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> Promote women's economic independence, including employment, and eradicate the persistent and increasing burden of poverty on women by addressing the structural causes of poverty through changes uneconomic, ensuring equal access for all women, including those in rural areas, as vital development agents, to productive resources, opportunities and public services. 	<ul style="list-style-type: none"> Even though there are funds allocated by government to support economic projects initiated by women, such programmes are not easily accessible or known by women at the grass-root level. Also the allocations from these funds are biased and very low. Consequently they have no impact on transforming the structural causes that affect and perpetuate women's poverty, especially those women who live in rural areas. 	
<ul style="list-style-type: none"> Prevent and eliminate all forms of violence against women and girls. 	<ul style="list-style-type: none"> Violence against women and girls is endemic in South Africa. Despite annual campaigns – including the Sixteen Days Campaign on No Violence Against Women and Children, which has been extended to a national 365 days campaign – the judiciary has been notoriously unable to respond appropriately to cases of GBV, with exceptionally low conviction rates and very long periods before individual cases are finalised. The moratorium of specialised courts has only recently been removed, but the Department of Justice has stated it does not have sufficient funds to roll out the envisaged/requisite number of such courts. A National Advisory Council has recently been established and is in the process of compiling a national action plan on gender and violence. 	
<ul style="list-style-type: none"> Ensure equal access to and equal treatment of women and men in education and health care and enhance women's sexual and reproductive health as well as education. 	<ul style="list-style-type: none"> South Africa has moved extensively to ensure universal access to education and to eliminate differences in access to education between women and men. At the level of access to reproductive health services and rights, serious challenges remain. This is particularly true for young women, women living with HIV and women with disabilities, thus increasing their vulnerability and risk of HIV. 	
<ul style="list-style-type: none"> Promote and protect all human rights of women and girls. 	<ul style="list-style-type: none"> The Constitution of South Africa protects and promotes gender equality and established a Commission on Gender Equality (CGE), a statutory body established to promote and protect gender equality in South Africa. However, despite this, gender disparities persist, as do women's vulnerability and risk in terms of GBV, poverty and HIV infection. 	

Millennium Development Goals (MDGs)

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>Goal 3: Promote gender equality and empower women Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.</p>	<ul style="list-style-type: none"> • Much progress has been made in this regard. Ref. S.A. MDG goals report on MDG Goal 3. 	
<p>Goal 6: Combat HIV/AIDS, malaria and other diseases Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.</p>	<ul style="list-style-type: none"> • Much progress has been made in decreasing vertical transmission of HIV. However, the age of sexual debut has decreased, as has the use of condoms. However – MDG 6 still does not call for disaggregated gender reporting on HIV and TB. 	

Specific Provisions In AU Obligations

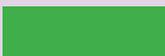
The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003)

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>Article 14 states that State parties shall ensure that the right to the health of women, including sexual and reproductive health is respected and promoted including:</p> <ul style="list-style-type: none"> • the right to control their fertility • the right to decide whether to have children and the number and the spacing of children • the right to choose any method of contraception, and • the right to have family planning education. 	<ul style="list-style-type: none"> • These rights are protected, however given the uneven conditions in health facilities nationally, not all public facilities are able to deliver. 	
<p>The right to self-protection and to be protected against sexually transmitted infections, including HIV.</p> <p>The right to be informed on one's health status and on the health status of one's partner, particularly if infected with STIs, including HIV/AIDS.</p>	<ul style="list-style-type: none"> • Theoretically this right exists, however given the financial dependency of women, the choices they make of survivalist and health focussed (as attested by ooNonkululeko). The Constitution guarantees the right to privacy and therefore does not enable one to be informed of one's partner's health status. 	
<p>To provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas.</p>	<ul style="list-style-type: none"> • In the area of TB treatment there has been much progress, including in the areas of research and the introduction of new diagnostic tools such as the GeneXpert machines. 	
<p>To establish and strengthen existing pre-natal, delivery and post-natal and nutritional services for women during pregnancy and while they are breast feeding.</p>	<ul style="list-style-type: none"> • Very little evidence of this in place especially in areas where there is need. 	
<p>To protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother and the foetus.</p>	<ul style="list-style-type: none"> • All women have the right to choice in SA. 	

Solemn Declaration on Gender Equality in Africa – 2004

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> Accelerate the implementation of gender specific economic, social and legal measures aimed at combatting the HIV/AIDS pandemic and effectively implementing both Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis (TB) and other Related Infectious Disease. 	<ul style="list-style-type: none"> Key in the Abuja Declaration is the call for 15% of the national health budget to be allocated for HIV and AIDS in their national health budgets. In 2011, the health allocation for SA was 11% It must be noted however that this declaration should be contextualised within the country's broader socioeconomic framework . 	
<ul style="list-style-type: none"> Ensuring that treatment and social services are available to women at the local level, making it more responsive to the needs of families that are providing care; enact legislation to end discrimination against women living with HIV/AIDS, and for the protection and care of people living with HIV/AIDS, particularly women, increase budgetary allocations in these sectors so as to alleviate women's burden of care. 	<ul style="list-style-type: none"> One of the major challenges is the geographical variation within South Africa with vast rural urban disparities. Therefore, there is lack of consistency in the delivery of health care services. Women continue to carry the burden of health care within their own communities and homes. 	

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases – April 2001

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> To take personal responsibility and provide leadership for the activities of the national AIDS Commissions/Councils and to lead the battle against HIV/AIDS, TB and other related infectious diseases by personally mobilising societies as a whole. 	<ul style="list-style-type: none"> SANAC is chaired by the deputy president of SA, and co-chaired the civil society forum representative, who is a woman. Therefore, the HIV response is driven from the highest office in the land – the Presidency. The Executive Director of the PWN is the deputy chair of Civil Society at SANAC and the sector leader for persons living with HIV. 	
<ul style="list-style-type: none"> To endorse the Abuja Declaration on HIV/AIDS, TB and other infectious diseases. Promoting advocacy at the national, regional and international levels. 	<ul style="list-style-type: none"> The SA government has endorsed the Abuja Declaration and continues to promote advocacy on HIV at national, regional and international levels. 	

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>Poverty Reduction, Health and Development</p> <ul style="list-style-type: none"> To ensure the integration of HIV and AIDS, TB and Malaria programmes into Poverty Reduction Strategies and Programmes and country programmes; and thus ensure access to adequate nutrition and food security by pursuing the realisation of an integrated African food production, storage and distribution plan, and other social protection measures including adequate social security schemes to address sustainability of treatment as well as treatment, care and support, ensuring community involvement and participation. 	<ul style="list-style-type: none"> Refer to similar UNGASS Declaration 	
<p>Strengthening Health Systems</p> <ul style="list-style-type: none"> To strengthen health systems and build on existing structures (infrastructure, human resource, financing, supplies etc.) for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria. 	<ul style="list-style-type: none"> The SA government in partnership with other government organisations such as PEPFAR, USAID, CDC, including SADC member states, is engaged in programmes to strengthen health systems. 	
<p>Prevention, Treatment, Care and Support</p> <ul style="list-style-type: none"> To invest heavily in evidence-based prevention as the most cost-effective intervention with focus on young people, women, girls and other vulnerable groups. 	<ul style="list-style-type: none"> The SA government has invested largely in HIV and AIDS treatment. By 2012, ART rollout had reached 2 million people. However, prevention remains a challenge. A lot of research has been carried out, including the KYE studies, the microbicides study, periodic HSRC prevalence studies and behavioural change studies. 	

Special Summit of African Union on HIV and AIDS, Tuberculosis and Malaria (ATM): May 2006, Abuja

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<ul style="list-style-type: none"> To ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV and AIDS, and sexually transmitted infections (STIs) (including post-exposure prophylaxis following sexual violence), TB and malaria, reduction of vulnerability to HIV and AIDS, TB and malaria. 	<ul style="list-style-type: none"> Services addressing secondary infections are available and accessible in the public health system. The challenge as indicated by ooNonkululeko is the negative attitudes of health care workers and the stigma, specifically in relation to medical treatment for secondary infections. 	
<ul style="list-style-type: none"> To disseminate, correct, reader-friendly information on prevention, treatment, care and support on HIV and AIDS, malaria and tuberculosis. 	<ul style="list-style-type: none"> There are a variety of accessible communication tools – the challenge remains the variations at the health service level. 	
<ul style="list-style-type: none"> To ensure universal access to male and female condoms for all sexually active persons. 	<ul style="list-style-type: none"> There is still a dominance of male condoms in the market; however, some rollouts of male condoms happen in limited numbers. 	
<ul style="list-style-type: none"> To integrate HIV and AIDS issues into ongoing immunization programmes and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV and AIDS programmes. 	<ul style="list-style-type: none"> There has been progress in mainstreaming HIV and AIDS in health services. 	

Agreements at the Southern African Development Community (SADC) Level: SADC Protocol on Gender and Development

<i>Commitment</i>	<i>Status</i>	<i>Assessment</i>
<p>Article 26 implores state parties to adopt and implement legislative frameworks, policies programmes and services to enhance gender sensitive, appropriate and affordable quality health care, in particular to:</p> <ul style="list-style-type: none"> • reduce the maternal mortality ratio by 75% by 2015; • develop and implement policies and programmes to address the mental, sexual and reproductive health needs of women and men, girls and boys; and • ensure the provision of hygiene and sanitary facilities and nutritional needs of women including women in prisons. 	<ul style="list-style-type: none"> • Maternal mortality remains a serious challenge but South Africa has made commendable strides in the last decade. • Mental health remains unattended to in the majority of cases, based on ooNonkululeko’s narratives. • Sanitary towels and nutrition remains a serious concern for women and girls, especially girls at schools. Very little research is available on the situation of women in prisons. 	
<p>Article 27 implores parties to adopt and implement gender sensitive policies and programmes and enact legislation, that will address prevention, treatment, care and support in accordance with, but not limited to the Maseru Declaration on HIV and AIDS.</p>	<ul style="list-style-type: none"> • SA has adopted all relevant gender sensitive policies, however implementation remains a serious challenge. 	
<p>Take into account the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected by HIV and AIDS.</p>	<ul style="list-style-type: none"> • The SA government has invested largely in HIV and AIDS treatment. By 2012, ART rollout had reached 2 million people. However, prevention remains a challenge. • A lot of research has been carried out, including the KYE studies, the microbicides study, periodic HSRC prevalence studies and behavioural change studies. 	

Agreements at the Southern African Development Community (SADC) Level: SADC Protocol on Gender and Development

Commitment	Status	Assessment
<p>By 2015 :</p> <ul style="list-style-type: none"> • develop gender sensitive strategies to prevent new infections; • ensure universal access to HIV and AIDS treatment for affected women and men, girls and boys; • develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, the allocation of resources and the psychological support for care givers as well as promote the involvement of men in the care and support of people living with HIV and AIDS. 	<ul style="list-style-type: none"> • Prevention strategies, especially women-driven prevention tools remain a key challenge. • Treatment has been a major success story in SA, given the expanded roll out of ART. • Very little regard is afforded care-givers and their needs. 	<div style="background-color: yellow; width: 50px; height: 20px; margin: 0 auto;"></div>

South Africa has adopted all relevant gender sensitive policies; however implementation thereof remains a serious challenge. These observations call on policy makers to ensure that South Africa moves more in the direction of the green rating. It should start with the NSP, where women as a sector are not recognised as a key population group. Even though girls aged 15-19 are recognised as a key population, *ukuthwala* is not named as a harmful practice that needs to be eliminated in any of the policies, and this needs to be addressed.

In the NSP, there is also a need to develop gender sensitive strategies to prevent new infections, in line with the goal of halving new infections. However, challenges remain. Women bear the brunt of HIV care in homes but are not remunerated, and it is therefore important that policies and programmes ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, and that resources are allocated accordingly, along with providing psychological support for care givers. Additionally, the involvement of men in the care and support of people living with HIV and AIDS should be encouraged and supported.

Another disparity in the HIV continuum is the availability of HIV prevention tools that are specific to women. An HIV prevention strategy for South Africa should be drawn up, pointing to the specific needs of women and girls, and supporting endeavours such as microbicides and PrEP on the biomedical front, cash transfers to keep girls at school for longer on the socio-structural front and strategies to reduce levels of alcohol consumption. The latter could be supported by policies on locations of taverns and advertising of alcohol.

It is important to note that most of the policies referred to above highlight the number of documents that South Africa is party to, but that real change will come only when implementation is localised. This is the gap that the PWN seeks to fill; localisation of the response and being part of the solution that places daily realities of women onto all programming agendas. Only then will the legal and policy documents start transforming into tangible results.

2

The PWN Research Initiative



“In many parts of the world, women and girls are especially vulnerable to HIV AND AIDS because they lack control over most aspects of their life. Cultural expectations and gender roles expose women and girls to violence, sexual exploitation and far greater risk for infection.”

Hilary Clinton, International HIV Conference 2008

The PWN seeks to put the voices and insights of women and girls living with HIV at the centre of the national discourse on HIV and TB infection, having reviewed the current NSP (2012 – 2016) and in anticipation of participating in the drafting of the following NSP (2017 – 2020). From the vantage point of the PWN, this study enables policymakers, health care providers and programme implementers to see and understand the legal and structural (social, cultural, economic) gaps that contribute to gender-based disparities in the way women and children who live with HIV encounter and experience the health care system in South Africa.

For almost two decades, the Positive Women's Network (PWN) has created a platform for women to engage in various dialogues about their lived experiences as an endeavour to close programming gaps. PWN affirms women at risk as knowledge producers of their own daily life stories. Furthermore, PWN asserts that women like ooNonkululeko have a rightful space in the global discussions on HIV; and believes that no one is voiceless – they are very capable of speaking for themselves and can articulate their realities when given the opportunity. Thus, the narrative discussed herein emanates from granting women the opportunity to articulate their realities in the hope of closing gender-based disparities related to HIV and TB prevention, treatment and care.

The study draws first on a comprehensive literature review, and also directly from women's narratives sourced through case studies and focus group discussions. These are women who are affected, infected or at risk of being infected by TB and HIV. Secondly, through the use of themes from the literature review, the narratives from women were then structured categorically into policy, legal and sociocultural frameworks and analysed against the current NSP.

This was done to ensure that in the next two years strategic information gleaned through this study can be used to formulate interventions that could optimise/maximise the impact of the upcoming NSP.

2.1 Research Objectives

The specific objectives of the research were to:

1. Identify the most critical policy, legal and structural (social, cultural, economic) gaps that contribute to gender-based disparities and drive appropriate policy-level responses at all levels related to HIV and TB prevention, treatment and care
2. Recommend an essential package of gender interventions and services to address key identified gaps at national, provincial, district, institutional and community levels respectively in order to mitigate the gender-based disparities related to HIV and TB prevention, treatment and care

38 Through this report, the PWN points to the limitations of the assumption that a generic response to HIV is adequate in a generalised epidemic. It emphasises the need for comprehensive data to enhance understanding among policymakers and health workers on how differences between women and men, girls and boys, affect the outcomes of HIV interventions in the South African context. The report also directs focus to the gender disparities in the national HIV and TB response. It draws on the inputs of women living with HIV to highlight the kind of interventions that would ensure a national HIV and TB response that works for women and girls.

2.2 Research Methodology

This study utilised mixed approaches of qualitative inquiry that included focus group discussions and in-depth interviews for data collection. Employing the qualitative research method best serves the objectives of the PWN as it enables the PWN to bring the experiences of women living with HIV to the attention of key stakeholders such as policymakers and health care providers. The participants in this research, who are women

living with HIV, narrate their experiences of navigating the health care system and the everyday challenges they face at community level.

The themes obtained from the initial responses were verified through further focus group discussions. Additionally, as stated in the objectives of this research in order to draw a basic package for a response targeted at women and girls, a Delphi technique was used to reach consensus. The seven member expert group consisted of representatives from institutions either conducting research on gender and HIV, young women and girl's responses to HIV and other interventions related to women and HIV. In addition, some of the group members were implementers of the interventions drawn from international consensus or from the National Department of Health as they related to gender.

Due to the exploratory nature of the study, a qualitative methodology suitably allows the researcher to obtain themes from narratives derived from focus group discussions and in-depth interviews. These themes can be used to design a minimum package of interventions to respond to the challenges that lead to gender disparities in HIV.

Focus group discussions:

A FGD guide was developed to identify and obtain relevant information for the study. A total of four FGDs were conducted and all were audio recorded and transcribed verbatim. FGDs are best utilised in qualitative research as they create an informal and more natural environment that enables the participants to express their views openly.

In-depth interviews:

Individual in-depth interviews were conducted using an interview guide. According to Bell (2003), interviews are central to narrative research as they allow participants to make explicit certain feelings, beliefs and opinions that might have passed unnoticed otherwise.

Case studies:

Enable detailed contextual analysis of a limited number of events or conditions and their relationships¹⁵⁴. As part of the methodology, a set of individual case studies were used. These were in-depth interviews with individual women who narrated their encounters with the health care system whilst living with HIV.

Delphi technique:

The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise. This enabled the researchers to build consensus by using a series of questionnaires delivered using multiple iterations to collect data from a panel of selected subjects.

Overall this research sought both the narratives of experts in the field of Gender and HIV in South Africa, and more importantly experiential narratives of women at risk of contracting HIV and those living with HIV. Indeed as a PWN concept this approach seems to depart from the pedagogy of the oppressed by letting women be authors of progress in the HIV response. According to Bell (2003), "narrative is fundamental to the way humans organise experience, not only as individuals, but as communities and societies".

The results were grouped into three categories, socio-structural gaps when the results related to the systemic issues that result in HIV; legal and policy gaps when the response was in a policy, legal document or any statute ratified by the South African Government, and biomedical gaps for any response related to the biomedical aspects of HIV and TB testing, prevention and treatment as they pertain to women. These results are categorised into sections A, B and C.

2.3 Sampling

Having highlighted women and girls as being one of the most at risk groups in South Africa, closing these social, structural and legal gaps requires an understanding of vulnerability from the eyes of the vulnerable "*from our own eyes*"¹⁵⁵; and to craft implementation strategies that will address the gendered HIV dynamics. Understanding the various elements of the issue is crucial to closing these gaps. HIV programming strategies have resulted in some progress, for example the reported increase in the distribution of female condoms in South Africa in 2012, and that more women are accessing treatment, albeit through the ANC and PMTCT programmes¹⁵⁶. However, the journey is still in its infancy and there is much work to be done to ensure the reduction in incidence of HIV in women.

As this is an exploratory research study, a non-probability convenience sampling technique was used with a snowball approach, in which research participants were selected as a result of their convenient accessibility and proximity to the researcher¹⁵⁷.

A total of 84 women were interviewed, and five focus group discussions were conducted, consisting of seven people on average. In addition four in-depth case studies were carried out, and an expert group comprising seven people was utilised throughout the research study.

2.4 Introducing ooNonkululeko

In South Africa, HIV wears the faces of myriad South African women, ooNonkululeko. They are the women and girls who are living with HIV and TB and are at the centre of the epidemic. In this study they are called “ooNonkululeko”. “iNkululeko” (in the Nguni languages) is a literal that means freedom. OoNonkululeko, living in free South Africa, born before the democratic dispensation, or “born free” after 1994, all have narratives of living with HIV, which, if known publicly, could shape a more responsive national response to HIV and TB infection.

At one time or another, or throughout their lifetime, the majority of ooNonkululeko, who are African, will experience the triple oppression that black women in South Africa encounter by virtue of their race, class and gender. With an estimated life expectancy of 59.1 at birth, and at higher risk of contracting HIV, ooNonkululeko’s journeys are

characterised by various social struggles that can ultimately result in their contracting HIV and/or TB, at some stage of their life-cycle, in part, due to the historical and social injustices that continue to plague post-apartheid South Africa.

It is important to distinguish between risk and vulnerability when engaging with ooNonkululeko’s narratives, and to address both. Risk factors are those that one person alone can sometimes control; e.g. condom use. Vulnerability factors are factors that cannot be controlled by ooNonkululeko through their own actions, such as through behaviour change. Instead, vulnerability factors require societal and community change. Further, vulnerability and risk are contextual. For ooNonkululeko, it is culture, geographic location, social and economic status and the power dynamics between women and men that increase the risk of HIV infection and exposure to stigma and discrimination.



2.5 Data Collection and Analysis

Data was collected through Focus Group Discussions (FGDs) and In-depth interviews using a questionnaire in which women narrated their own experiences and encounters within the HIV continuum. Thematic analysis was deployed as a categorising strategy for qualitative data, in which patterns and themes were developed from the data.

2.6 Study Limitations

Women are not homogenous; as a result the study has not reached South African women in their diversity to include other races such as white women. Nor has it incorporated women living in neither rural nor peri-urban areas, nor the experiences of ooNonkululeko who are women with disabilities living with HIV and AIDS. Another area not reached was the ooNonkululeko who are nurses, and themselves living with HIV.

The study did not probe issues related to gender-based violence in the interviews and FGDs. This was because in the first phase it was important to focus on the themes that ooNonkululeko themselves raised as the challenges they confront as women living with HIV. Probing participants could have resulted in unintended consequences, with participants being reminded of previous difficult experiences.

3

ooNonkululeko's Narratives on the HIV and TB Response in South Africa



“We will not attain a sustainable response if we do not invest in women with education and economic empowerment.”

Siphiwe Hlophe, co-founder of Swaziland for Positive Living

The research findings confirmed the well-known fact that the HIV epidemic in South Africa is highly feminised, disproportionately affecting women and girls in terms of new infections. Defined in the study as “ooNonkululeko”, young women and girls particularly are at higher risk, evidenced by the incidence figures demonstrated in the literature review.

From the socio-structural gap analysis, poverty, stigma, inequality and gender-based violence remain the key drivers of HIV acquisition and consequently ooNonkululeko’s failure to cope when diagnosed with HIV. ooNonkululeko report consciously engaging in unprotected sex in order to address their own survival needs, as well as the basic needs for their children, including food, shelter and school-fees. Behavioural drivers were well articulated in the context of socio-structural dynamics, and these included reduced condom distribution and use, alcohol and substance abuse, and the reduction in the age of sexual activity. The resultant risky sexual behaviours are key drivers of unprotected sex.

The research questions were divided into the following themes:

1. Gaps related to contradictory or insufficient policy issues and lack of an HIV and TB coordination framework to respond to the challenges faced by women and girls
2. Gaps in poverty reduction strategies and lack of meaningful economic empowerment of women
3. Lack of HIV prevention tools for women and linking testing to HIV prevention for young women and girls especially HIV testing and prevention for women
4. Failure of the health system to implement responses and to respond to the individual needs of women and girls at a facility level
5. Lack of clear transformative approaches to reduce gender-based violence in communities as a driver to HIV acquisition

and a factor that denies women social capital required to cope when infected with HIV

The research findings related to these themes are:

3.1 Questions related to policies on HIV and TB

In the focus group discussions, many women expressed the need to ensure the current National Strategic Plan (NSP) for HIV is understood by the foot soldiers of the HIV response. More importantly, the specific needs of women and girls should be highlighted either within the NSP or as a separate framework. Emerging as a major theme, ooNonkululeko cited the need for a separate framework focusing on young women and girls. This was especially voiced by the outreach coordinators who want a government strategy linked to their daily experiences. Of a total of 84 responses, 53 expressed the need for a separately coordinated response to HIV that speaks specifically to women and girls.

“We hear about the NSP, it’s only a few people in South Africa who understand what it is meant to do. For a country that has such a high prevalence we need a simplified version of the NSP that people can relate to,” said a respondent from a focus group discussion.

This was reiterated by another respondent who said:

“It is important that women understand their rights when it comes to HIV but they cannot understand this NSP as is. A simplified version that relates to women will be easy for us reaching out to women to understand.”

A separate response was linked to the health system needs, wherein respondents recognized that health care workers needed to understand the way the NSP was working, especially as relates to women.

"We are privileged that we now know the nurses in our communities, but nurses will shout at you."

On issues related to sex workers, the participants discussed what they had heard on decriminalisation of sex work, and of negative experiences with the police.

"The women are often told not to lay charges at the police station. The tendency is for women to report near death experiences, then, it will be too late for them to reverse the cycle – the damage is done. We need to educate police officers on nature of violence that goes unreported in these communities."

Discussions moved on to their experiences around termination of pregnancy and the age of consent in South Africa, and they mentioned that the current programming strategies exhibit a form of hypocrisy, where even parents do not acknowledge that their children are sexually active and yet teenage pregnancy rates are high. There is a need therefore to look into the contradictory policies; although the participants acknowledged that what is more important is how teachers and parents interpret these laws.

"We were distributing condoms once and when one child took the condoms, she was told by one teacher." I will tell your mother you took condoms from school'. This is worrying because the same child is now at home, nursing a baby."

This could demonstrate the realities of adolescent sexual behaviour in South Africa. Furthermore, the fact that TOP can be performed on teenagers was seen as troubling by some participants

"The law is above parents hands and as a result they are not in charge of this HIV, but are only required when there are problems. Communities can't tell children what to do anymore because they have more rights."

3.2 Questions related to livelihoods

In almost every conversation with ooNonkululeko, the poverty issue came to the fore, and was seen as a key determinant of HIV infection across all age groups. Various forms were described, resulting in a complex mix of poverty related issues. Most of the women interviewed (46/84) narrated their own experiences of poverty as the main driver of HIV acquisition. Poverty exacerbates gender-based violence, and affects women's ability to negotiate safe sex thereby rendering them more vulnerable to HIV. For ooNonkululeko, there are not many options available to them for dealing with HIV, and they often stay in abusive relationships, thwarting their ability to fully develop themselves. The narratives also related to the intertwined nature of poverty and other risky behaviours that women find themselves engaging in.

Examples from one focus group are:

"The truth is that we want to live decent lives but how do we do that, I am in an abusive relationship for a long time but kept on asking myself a question ... if I leave who will look after me and my children? Who will take me with the virus?"

A factor that surfaced in Eastern Cape was the high prevalence of separation of families, resulting in higher incidence of multiple concurrent partnerships and HIV acquisition.

"Here in Eastern Cape, many people migrate either to Western Cape or Gauteng to look for jobs. This makes the HIV transmission worse, but what we do, we do because of poverty".

The discussion on poverty, particularly among young women and girls, revealed:

"Early marriages are a common phenomenon, communities at times do not fight them too and

because they are getting something out of this ukuthwala arrangement,” said one member who hailed from Eastern Cape where the practice is common.

However even for older women, choices of survival are often made, in order to look after children or siblings:

“As women, we have to make choices when we have children, to make ends meet we have to take risks that are unhealthy for us, such as unprotected sex. In addition, I grew up having to take care of my siblings, and I didn’t want to see my sisters hungry so I risked my life. That’s how I contracted HIV”

In some circumstances poverty leads to destitution and girls particularly find themselves in difficult situations, as one outreach worker narrates:

“Young women and girls from poor families in particular would miss school because they do not have sanitary towels. Some stay up to 50 days without going to school. This level of destitution needs interventions because we want them to stay in school but at school they can’t go without sanitary towels”

Poverty also leads to other situations such as being in multiple concurrent relationships. On consciously remaining in multi-concurrent relationships while not practising safe sex, ooNonkululeko point out that poverty is still a major driver:

“He will tell you that he only has the one person at home so why should you use a condom? And because of the things he is giving me ... and that when I want something he gives it to me ... so I do not think about the other person at home ... I only think about what I am getting ”

ooNonkululeko look at each day as having to survive in a complex mix of vulnerability, risk and hunger. As one ooNonkululeko says:

“Understand that I have a total of five children and [if] I force the man [to use a condom] I will not have somewhere to live.”

“In 2014 I am still alive. The government has told us to make sure that we have to make sure that we eat ... but there are no jobs. And even now I am sitting here worried because I am wondering where I can find a job....”

Hunger and destitution leads to the failure of programmes aimed at the empowerment of women.

“So when I try to talk to women ... I can’t because they are hungry ... If you are giving education to communities there should be something tangible you are giving them besides education (treatment literacy) If we have a way to make sure that people do not get hungry it will help. At least there is something we can do.”

“But ooNonkululeko often find that their attempts at income generation are impeded by stigma and discrimination.”

It seems from the discussions that ooNonkululeko experience different faces of poverty and destitution, some of which result in their not attending school, remaining in abusive relationships, and even unable to attend activities and events that will help them get out of poverty. ooNonkululeko however we’re seeing light at the end of the tunnel:

“We tried here in Wadeville support group to have gardens but there is still lack of skills, and gardens can’t be spinach everyday... we are willing to get into cooperatives so that we have something to do, why are we importing chickens from [China] when we can go into poultry farming ... the challenge is registering a farm and ensuring the necessary skills, but am sure government can support us as PWN ... Look some people like Dali Tambo have employed so many women who are earning a fixed salary

every month making their communities cleaner ... here in Eastern Cape, but there was no proper market for our projects. We all want to lead decent lives but end up involved in transactional sex because of desperation."

Young people were also a target for livelihood interventions but some efforts were hindered by a severe lack of even basics:

"We also try as support group members to encourage youths to do something meaningful with their lives. Unfortunately some lack even R100 to go and attend these skills building sessions."

Another added:

"How then do we get out of this mess when we do not have any skills and any money? I encourage organisations and companies to partner with people living with HIV and enrol them in FET colleges so that they can earn a livelihood later on, even if they are slightly older. We need to get out of the dependency syndrome but a focus on getting the bread for today makes us not to think long term"

3.3 Questions related to HIV testing and prevention for women

From the discussions held almost all the women understood the need for HIV prevention tools that would work in any given individual situation, citing that distribution of condoms to clinics and schools is not enough to change the course of the epidemic. Linked to the HIV prevention agenda, about 50 respondents stated that while testing has been successfully rolled out and is accessible, what happens after the testing is crucial.

As the narratives of ooNonkululeko indicate, there is a need to reach out to all women and not to regard them as homogeneous. Faith based organisations provide an efficient platform to reach many women.

For some women, HIV testing represents a host of challenges that discourage women from accessing testing services. These include; fear, stigma, the threat of violence when they test positive, and even health systems challenges; as this expression from a FGD shows:



Figure 5: A PWN training reaching out to faith-based organisations

“After being married for 20 years we trust each other and you can’t talk about testing as the husband will tell you off or even beat you up.”

“To go and test at a health facility is not possible for many adolescents, but we are trying to have more youth friendly service as we partner with clinics.”

Although the participant in this FGD mentioned 20 years, for young women, long term could be just a few months and once the issue of trust has been raised, it appears that testing is less likely to be a priority. This means that even where HIV prevention tools and services are available, gaps in knowledge and gendered implementation challenges remain.

“If you use condoms for around three times, your partner trusts you and the question is for how long are we going to use these condoms. Trust is an emotional thing, it can’t be measured, it is influenced by how [you] feel in any given circumstance. It would be better if you started by testing before you sleep together.”

This conversation reflects the complex issues that ooNonkululeko face when it comes to testing, where the word Trust comes up for many women in long-term relationships and testing falls from their agendas. This links to the need to escalate prevention efforts as reflected in this statement from one ooNonkululeko:

“Even after testing, like if I tell my partner to use a condom then [he assumes] I am automatically telling him that I am sick.”

“Another thing to see [understand] is that when we say we want to use condoms, they say we are sleeping around and that we are dating someone, but when I find out that he’s [the one who is cheating] and I ask him to use a condom, he is against the use of condoms.”

Another issue raised under this theme was the availability of HIV prevention tools that women could use. Given the majority of participants

interviewed belonged to PWN, they had heard about microbicides and spoke of the need to ensure that research responds to this existing gap. Further, 22/84 women reiterated that HIV prevention cannot be complete if the fact that older women are sexually active is ignored or unacknowledged.

“If I see an elderly woman, can you imagine one wearing a church uniform, I will not think of giving her a condom at all. Our prevention efforts assume that she is not sexually active. We need interventions that also focus on older women.”

In addition, the unavailability of female condoms and lack of knowledge among health care workers on how to use them was criticised as fuelling the vulnerability of women to HIV.

“We are part of clinic committees and the nurses do not want us to roll out programmes that seem to threaten the health care promoters employed by government. We know more than them and it will be good if we engage in meaningful partnerships to teach people to use condoms. There will be a huge uptake if we do that.”

3.4 Questions relating to health system

The health system questions covered ooNonkululeko’s interface with the health care facilities in accessing testing, prevention and treatment. The entry point to the health care system for most of the women (45/84) was through PMTCT services during pregnancy. Others went for routine testing during campaigns such as the Shukumisa campaign. However the majority of women interviewed (76/84) were part of PWN membership, who were living with HIV and therefore had interfaced with the healthcare system in one way or the other when accessing ART. It is not surprising therefore that ooNonkululeko’s narrative in this regard was rich

with day to day encounters with nursing staff along the HIV care continuum.

Many women acknowledged that for them the success of the treatment programme has been through the PMTCT programme, beyond which there are gaps in looking at holistic care needs of women living with HIV.

".....I started taking ARVs during pregnancy and it was easier for me to work through the ANC. However ever since I delivered I see that I am not really a priority , screening for TB, my challenge with depression and the management of my cervical cancer is such a struggle...."

During focus group discussions a theme that generated a good deal of discussion related to the attitudes of nurses towards HIV positive women. They were regarded at worst as appalling, ranging from failure to explain basic issues such as side effects of drugs to utter rudeness.

"We often accompany many young women living with HIV (to the health care facilities), because they are afraid that when they get into the clinic the nurses treat them roughly, asking why they are at the facility."

Nurses have been reported as making discouraging comments such as:

"Wow! Here is [using the patient's name] who is pregnant; that means she is sleeping with AIDS. Such comments would not be made to men... Come and see a 16 year old who has AIDS."

The participants explained that such remarks are a reflection of stigma that is inherent in society, since the nurses come from the same communities that harbour such stigma. It was also telling that ooNonkululeko seek to be part of the solution to reduce stigma and discrimination, particularly by partnering with clinics. In some circumstances they would narrate their experiences of such partnerships.

Other experiences with the health system included screening for cervical cancer where women stated that they often did not get results after a pap smear and they could return up to four times to a facility, only to be told that the nurse who did the screening was not available.

I often asked why there is only one person who can do a pap smear, even if the results came she could not interpret them for me and I had to wait for a doctor

Another stated:

"I went to a facility three times before I could get my result, why can't they use health promoters for such activities?"

Another issue raised by ooNonkululeko was the lack of an individualised approach, especially when dealing with side effects of ART, with the unintended consequences of long-term exposure to ART medication such as metabolic disorders for women who were still on stavudine, and with the need for psychosocial support. This led on to a heated discussion on hysterectomies and sterilisation to which a number of women had been subjected.

"At that time, I didn't know what was happening, they just told me that my pap smear results were bad and I was going to die so they removed imbeleko [uterus]."

"Mina [I] had my tubes tied after giving birth because they told me I shouldn't have more children, but that was a long time ago."

On the issue of treatment, some women from focus group discussions stated that it was not often difficult for them to be put onto ART regimens, even though numerous visits were necessary when CD4 count results went missing. The clear protocols on initiating women on ART have helped most of the HIV positive women to access ART, but numerous reasons were given as to why some women still do not have access to ART. Some of the problems include:

- The physical ability to get to a health care facility
- The availability of health care facilities within reachable distances
- The availability of appropriate treatment within the facility and (affordability)
- The health care providers act as a barrier to accessing treatment

The PWN outreach coordinators were offering various solutions to some of the health systems issues, including the use of support clubs as a distribution centre for ARVs. They acknowledged that many women on ART could be referred from the clinics to communities for more support and to receive treatment, as long as they remained stable. As one ooNonkululeko asserted:

“I don’t like going to the clinic, it’s a lot of work and time, but can get my three months’ supply from my support group because I am stable. I think we should roll out these clubs throughout the country”

Such suggestions were made so as to avoid overburdening the health system with patients that simply needed a refill, and who did not even have to have their blood pressure taken.

Another health system challenge was identified from an experience of one ooNonkululeko from an in-depth interview on TB, and was then also verified through focus group discussions. The challenges especially related to the often protracted nature of TB investigations, which become worse during pregnancy. The narrative below illustrates this.

“And then I was pregnant in 2008. And still they couldn’t see what was wrong with me. I was getting tired. I was tired most of the time. I could say that, and complaining with a chest pain. Cough and get better, cough and get better. Until I was ... I think I was eight-months pregnant. Then a nurse in a clinic that I was attending decided I should go and see a doctor before I come for my treatment every time I have been seeing that doctor for almost four months, and

then the new doctor arrived. I believe she was a student doctor. And only that doctor could realise that there was something wrong. But she just didn’t know how to treat me.

What she said was that the high blood pills I can continue with, just to reduce water in my body. That’s what she said. She said I might have TB in my lungs. But she can’t see it clearly because herself she needed to be helped with some things as she was still a student. Then she gave me the letter to go to the hospital. And then at the hospital I came back with the results saying that I had no TB at all. And I continued taking those high blood pills and my ARVs until I delivered my baby. When my child was six months old, I started getting very, very sick; I couldn’t eat ... it was only eight months later that TB was diagnosed, and then I was almost dead.”

Often, the biomedical challenges related to TB diagnosis in general become exacerbated when women are pregnant, especially with comorbidity with HIV. Whereas there are screening procedures for every woman, ooNonkululeko cited delays when infected with TB as this narrative also illustrates:

“I was on being treated for asthma for four months even if I told them I never had asthma before until they took an X ray when I was not getting better. That’s when they discovered that I had TB.”

3.5 Questions relating to gender-based violence as a gap in the HIV response

Gender-based violence was identified as a major challenge that women face, leading to increased opportunities to acquire HIV. This for some was exacerbated by a weak policing system that discourages women from reporting incidences of abuse

“There was this man who used a gun towards his partner and then shot a stranger accidentally. Now the police are saying the woman has never reported that she is undergoing violence, and apportioning blame to her unnecessarily.”

In addition, some women stated that it was difficult to leave abusive relationships because gender-based violence is related to poverty, in turn impacting women’s ability to make strategic choices regarding their future:

“You stay in a relationship even if kunzima [it’s hard] because you have nowhere to go. Even if you report, there is no one who takes you seriously - but this man has a small house (has extramarital affairs).”

Gender-based violence was also seen as not only emanating from women’s sexual partners, but often from extended families that unite against the women should they test positive for HIV. Being seen as vectors for transmission was particularly painful for women in long term relationships, and they were adamant there be more information campaigns about the extent of GBV in communities.



Figure 6: The police are an integral part of the response against gender-based violence in South Africa

"...this woman infected our child with a disease and she thinks we should just accept her here... it's better to isolate her until she leaves our home...."

"I suffered at the hands of my mother-in-law when I tested HIV positive, it was disheartening to see another woman treat you like that. Not knowing it's her son who used to beat me up and infected me ..."

Gender-based violence was raised as a major issue amongst sex workers, and is exacerbated by poor access to the judiciary system. In addition an observation made by one ooNonkululeko was that there are categories of sex workers, some who are more privileged than others. Their exposure to gender-based violence and access to justice was also different and there is a need to recognise these differences when making interventions.

There are escorts who seem to know their rights better than some of the women who literally market their services from the bush. These are the ones who often get beaten up, limiting their ability to have safer sex options. Then there are these who are at [Rex]. Everyone knows where they operate from and police raid them, take their money and throw away their condoms, with reports of rape coming from these women, but never go far because some are illegal immigrants and the police are involved.

On reaching out to commercial sex workers with interventions, one ooNonkululeko appeared enlightened on the issue of decriminalisation of sex work in South Africa .

"The problem is that it is hard to help the commercial sex workers when you are coming from PWN, they think you have come to take their clients. If we decriminalise sex work, it will become easier for the women to open up, and the police will not behave in such a barbaric manner."

4

Discussion: Our Perspectives on the Research Findings



“The disproportionately high HIV prevalence levels among young females in the country, however, require a rethinking of conventional approaches to HIV prevention that address the underlying socio-cultural norms including getting married. Also because young males have become complacent when it comes to condom use this needs to be addressed as well.”

It is important to distinguish between risk and vulnerability when engaging with ooNonkululeko's narratives, and to address both. Risk factors are those that one person alone can sometimes control; e.g. condom use. Vulnerability factors are factors that cannot be controlled by ooNonkululeko through their own efforts, such as through behaviour change. Instead, vulnerability factors require societal and community change. Furthermore, vulnerability and risk are influenced by the context. For ooNonkululeko, it is culture, geographic location, social and economic status and the power dynamics between women and men that increase risk of HIV infection and exposure to stigma and discrimination.

4.1 Policy gaps and lack of a concise HIV AND AIDS strategy for women and girls

One of the goals of the NSP is to halve the HIV incidence 2015. Literature illustrates that the highest incidence rate is within the 15-24 age group, who make up 40% of all new infections; and yet there are no specific interventions aimed specifically at reducing HIV amongst this population group¹⁵⁸. For instance, three in every four HIV-positive people between the ages of 15 and 24 are women, and women are estimated to contract HIV five years earlier in their lives than men do. Further stratification highlights an even more alarming picture, where one in three South African women between the ages of 25 and 29 is HIV positive. About 30% of pregnant women who access antenatal care services are HIV positive. HIV prevalence is highest among women between the ages of 30 and 34 (36%), while for males between the ages of 35 and 39 the prevalence was 31.6%¹⁵⁹.

Young people's risk of HIV infection is closely correlated with age of sexual debut. Abstinence from sexual intercourse or delayed sexual activity

is among the central aims of HIV prevention efforts for young people. Decreasing the number of sexual partners and increasing access to, and utilisation of, comprehensive prevention services, including prevention education and provision of condoms, are essential for young people who are sexually active.

Furthermore, there is the emerging challenge of young people born with HIV who have now reached adulthood. The paucity of interventions means they are not being used to champion an HIV-free generation and the challenges they face for being on ART for such a long time have not been addressed.

This finding from the research is consistent with scholarly assertions from some authors^{161, 162, 163, 164, 165, 166}. The need to concisely target young people in HIV interventions in South Africa is clear. A package of interventions therefore is crucial for such an endeavour.

In addition the decriminalisation of sex work would go a long way in affording sex workers opportunities to seek legal recourse in cases of abuse. Particularly vulnerable are illegal immigrants and the poorer commercial sex workers who, despite knowing their rights, may be cowed in the presence of police officers, as confirmed by ooNonkululeko.

While the need exists to correct policy contradictions on statutory rape and TOP, ooNonkululeko highlighted their experiences when distributing condoms in schools; that the expectations of teachers and parents are far removed from the realities of adolescents, specifically that adolescents are sexually active and parents and teachers assume they are not. This makes it harder to intervene to prevent both unwanted pregnancies and HIV in adolescents. Part of this dichotomy was attributed to the contradictory laws, although further research is needed to verify the impact of this confusion on the ground.

4.2 Lack of concise strategies to reduce poverty

It is difficult, if not impossible, to distinguish between HIV vulnerability and the daily experiences of ooNonkululeko, especially as they relate to poverty and these realities exist in a continuum. In South Africa poverty is a key determinant for HIV infection across all age groups. Young women who are heads of household are more likely to be poor and more likely to be HIV positive¹⁶⁷.

The ooNonkululeko's narrations reveal how poverty drives women towards unhealthy behaviours regarding HIV, and how it is linked to gender-based violence. This supports the findings of other studies¹⁶⁸ particularly that of Rodrigo and Rajapakse (2010), where the poverty effect is shown to have a higher impact on women¹⁶⁹.

What stands out in the narratives given by ooNonkululeko is the desire to be an author of the solutions. For example, the creation of cooperatives that focus on farming, the need to go to school and receive tertiary qualifications, and the recognition of the need to keep the girl child in school for longer, are all in line with findings in literature. Further, ooNonkululeko have volunteered to be the foot soldiers in the implementation of such strategies, claiming they know their communities and are able to match the need to the correct solution. It is up to policy makers and practitioners to take up this offer, and incorporate the assistance of women living with HIV in their programming strategies, particularly regards increasing the quality of education and reducing poverty in such communities.

4.3 Gaps in availability of HIV prevention tools

The narratives of ooNonkululeko, as elsewhere in literature, reveal that prevention is not sufficiently addressed in the HIV response in South Africa. In the NSP, prevention is still limited to such measures as Medical Male Circumcision, Prevention of Mother-To-Child Transmission (PMTCT), and the distribution of mostly male condoms. What is glaringly apparent is the limited attention given to scaling up of behavioural change initiatives directed at women and girls, and the criticisms of rolling out initiatives such as cash transfers to keep girls at school for longer. Linked to prevention is the issue of testing, where more women are being tested than men, often accessing facilities through ANC, and for a variety of reasons, of which ooNonkululeko speak. This is an area of research that has traction both from a socio-structural and biomedical perspective in the global HIV response. It is the hope of PWN that, as some of the biomedical advances are made, particularly in microbicides, the realities of ooNonkululeko as they relate to poverty, access to health care, access to education, and employment opportunities, will be better addressed.

However, despite young women and girls having the highest prevalence and incidence of HIV and TB infection, the NSP (2012 – 2016) does not recognise 'all' women as a key population in the HIV response focussing prevention efforts. The NSP only recognises girls from 15 – 24 as a key population group for prevention programmes (including behavioural change programmes).

To be more effective, the NSP will need to be age disaggregated and address all age cohorts. Currently, prevention services directed at women are not clearly specified in the National Department of Health's (NDOH) annual report. The only focus is on preventing vertical transmission (thus women's reproductive roles) and on indicators such as the distribution of female condoms. However, no satisfactory data

exists on condom usage. For instance, in the NDOH annual report, it is stated that a total of 6,353,000 female condoms were distributed during 2011/12. This, according to the NDOH, exceeded the annual target of 6 million. However, no explanation is provided of how the figure of six million female condoms was reached. At the same time, other reports have indicated that, instead of being accessible to women, many of the female condoms are being used by men having sex with men (MSM).

Few woman-focused HIV prevention tools exist, but even those that do are not easily accessible. The past 12 years has seen a proliferation of prevention research, where priorities have expanded from biomedical discovery to include implementation, effectiveness, and the effect of combination prevention at the population level, which should also benefit women. In the absence of access to such interventions, however, women find it difficult to negotiate safe sex through the use of male-driven biomedical prevention. As ooNonkululeko's narratives reflect, insisting on male condom usage can result in victimisation and increase the threat of gender-based violence (GBV).

Because of this, much attention on HIV prevention for women has focused on a male involvement agenda and indeed amplified the male circumcision agenda to the detriment of women's needs and visibility. This further perpetuates gender discrimination. It can be claimed that emphasis on male involvement programmes may paradoxically affirm women as vectors of HIV, leading to further stigmatising and discrimination of women.

The high incidence of rape, unfavourable economic positions, and the inability to insist on condom usage impact South African women's ability to negotiate the timing of sex and the conditions under which it occurs. This lack of agency may render ooNonkululeko powerless in preventing HIV infection. Testing also remains a gendered phenomenon in South Africa, with more women

being tested than men, for a variety of reasons which ooNonkululeko speak of. Consequently women bear the brunt of the stigma and discrimination associated with HIV and AIDS. The narratives of ooNonkululeko clearly reveal that prevention is not sufficiently addressed in the current HIV response in South Africa.

4.4 Health systems failure to respond to individualised needs of women

Treatment programme scale up is not just about ART; it requires addressing the holistic health needs of people living with HIV. These include sexual health and reproductive rights for women living with HIV as well as addressing the adverse effects of drugs, and unintended consequences of long-term exposure to ART medication such as metabolic disorders and the need for psychosocial support. Further, even though ARTs are lifesaving, they come with both short- and long-term side effects, some of which are gender specific.

By and large, there are no marked differences in diagnostic accuracy of tests, and response to therapy when it comes to gender. However, as stated in the literature above, women face peculiar challenges when it comes to the timing of the diagnosis due to socio-behavioural issues and more importantly for this research, when it comes to pregnancy^{170, 171}. TB in pregnancy is still a challenging area in HIV co-infected women, often with high morbidity. This is illustrated clearly as one of the in-depth interviews revealed there is still a need for better knowledge on TB in pregnancy and, health systems failure in managing patients with multiple conditions that are also related to poverty, became evident. It is urgent, therefore, that institutions dealing with TB address this programming gap, both in knowledge and in implementation of existing protocols.

Evidence that points to the possibility of

DepoProvera increasing the risk of acquisition of HIV also needs the health system's attention and longitudinal follow up. Sadly women may need to make some reproductive health trade-offs, between HIV and unwanted pregnancies. Individualised needs of women are not simply concerned with treatment level, they also exist at the complex interaction of hormonal contraceptives and both at the stage of transmission and when a woman is now on ARVs.

Cervical cancer is one of the causes of death among women living with HIV. As the experiences of ooNonkululeko illustrate, the challenge is being screened on time and getting results timeously. Seemingly intertwined with the health systems challenge stated above, there is a need for innovation around obtaining results once a pap smear is done, and rolling out more innovative approaches could improve access – such as the visual inspection using acetic acid¹⁷². For some women knowledge of cervical cancer progression was lacking with unnecessary demands and burden being put on the health system. Some wanted to screen at every visit, while, on the other end of the spectrum, some women delayed seeking help thinking they had an STI, resulting in increased morbidity. Indeed the availability of the HPV vaccine for some was seen as a cure for cervical cancer, which was also worrying.

Cervical cancer screening programmes should thus be part of the essential package and need to be accompanied by information packs on the sexual and reproductive needs of women. Demand creation strategies are required but these need to be balanced with supply, given the incidence of cervical cancer among HIV positive women.

All the complex issues that make women a unique challenge in managing HIV underscores the need for capacity building of health care workers in order that they may be able to meet individual needs. Additionally, what needs addressing in this capacity building is the issue of leadership, accountability and responsibility among nurses so as to reduce incidences of ill treatment that

patients experience in health facilities. This will reduce levels of stigmatisation and will improve the client-nurse relationship, in turn leading to improved outcomes.

4.5 Lack of gender transformative approaches targeted at reducing gender-based violence

The link between gender-based violence and HIV is well established in the literature. However, interventions to transform this dynamic are still weak, often accommodative in nature rather than transformative. When it comes to the GBV/HIV nexus, interventions that acknowledge the multidimensional nature of the interaction are needed. As ooNonkululeko reflect, it is hard to effectively adopt new HIV prevention methods when one is in an abusive relationship; it is also impossible to use condoms when one's partner does not want to use them and one is economically dependent on him. Rape in particular is a scourge that fans transmission dynamics in South Africa, with a high prevalence among sex workers^{173,174}. Gender-based violence incidences revealed in the study call for a concerted effort from government and civil society to deal effectively with the various causes related to GBV, as many have asserted in the literature on GBV^{175, 176}.

The gender transformative approaches require that the policy ambiguities that currently exist need to be addressed, and also call for a NSP that allows gender practitioners to demonstrate collaborative efforts towards a national agenda. The analysis provided from the FGD reveals that HIV, especially given gender-based violence and its nuances, is a societal transformation agenda that may require community participants to talk to each other. Without an understanding of the power dynamics that exist in the ecological model continuum, PWN may also fall into the trap of the “pedagogy of the oppressed”, where those who

feel they are experienced enough want to always “educate” those who are relatively inexperienced.

Patriarchy is still deeply entrenched in the societies interviewed, and systemic approaches are required to effect change in these communities. Community dialogues are suggested as a solution to open up conversations aimed at dissecting and challenging these entrenched norms around gender in South Africa. Effectively used by PWN before, they encourage transformation at a relationship level and are recommended as a starting point for PWN to effect change. At a national level however, multi-pronged approaches are required since GBV has multiple root causes. It is recommended a national strategic plan is devised that allows gender practitioners to direct efforts toward a more visible agenda against GBV. Furthermore, a national plan sends a message to communities on the importance and weight of the issue, in itself being a societal transformation endeavor.

5

Recommendations for a Minimum Package for Young Women and Girls



“At a time when adolescent girls and young women are reaching their prime, they are at greater risk for HIV AND AIDS. We have to do more to prevent HIV infection”

Ambassador Deborah L Birx, MD.

This study demonstrates the gaps that exist in the legal, socio-structural and policy frameworks resulting in gender disparities and negatively affecting intervention packages. As the study is based on a human rights approach; accepting that women's rights are human rights, the recommendations here are intended to ensure a coordinated health care system which is responsive to the needs of women and girls. An effective HIV response requires comprehensive attention to redressing and eradicating the structural determinants and drivers of HIV.

The recommendations are in two categories:

1. Recommendations on what should constitute a basic essential intervention package for young women and girls.
2. Recommendations to specific constituencies on what should be done to reverse the vulnerability of young women and girls to HIV, specifically to HIV practitioners, gender practitioners, health care workers, and the judicial system.

These recommendations emanate from the gaps identified in the interviews, the literature reviews and the expert discussions which verified the data:

<i>Identified Gap</i>	<i>Summary of the Recommendations</i>
Concise HIV related policies and strategies targeted at women and girls	<ul style="list-style-type: none"> • Meaningful involvement by women living with or affected by HIV in leadership roles at provincial, district and local AIDS councils • Advocacy and leadership of young people as agents of change, focus on young women programmes for an HIV free generation with those born with HIV as champions for change • Young women and girls should lead this transformation and not be on the sidelines as beneficiaries only • A written guidance document for a response on young women and girls will guide practitioners on evidence-based interventions and where to direct scarce resources • Address policy ambiguities relating to sexual health and reproductive rights of young women and girls • Advocacy on the laws that need to be tabled in parliament to avoid confusion, with engagement of SRHR organisations • Advocacy and leadership needed for these conversations, with progressive engagement of sex worker organisations

Table 1: Identified gaps in the study and a summary of recommendations

<i>Identified Gap</i>	<i>Summary of the Recommendations</i>
Livelihoods strategies for women and girls and economic empowerment of women	<ul style="list-style-type: none"> • Transformative economic empowerment programmes targeted at HIV positive women; women in rural areas and in informal settlements • Analysis of the drivers of risky behaviour among young women – to introduce power packs that alleviate destitution • Safer schools programming to use schools as an entry point for HIV prevention programmes • Supporting initiatives that keep girls at school for longer • Enterprise development and life skills building targeting especially school leavers who are unemployed • Pilot to turn social grant programmes into conditional grants twinned with educational outcomes
Gaps in availability of HIV prevention	<ul style="list-style-type: none"> • Expanding and supporting a national research agenda for women and HIV, along the health care continuum for HIV, but with a focus on dismantling • Conditional grants to keep girls at school for longer
Health systems failure to respond to individualised needs of women	<ul style="list-style-type: none"> • Involving health worker representatives in drafting responses targeted at women and girls • Use of participatory methodologies for health care workers on unique needs that women have on HIV, on gender-based violence and on TB and pregnancy • Community strengthening teams established by including the women living with HIV in clinic committees • Bottle neck analysis in obtaining TB results • Information packs for communities targeted at pregnant women on the comorbidities of HIV and TB particularly in pregnancy • Investigations into the bottle necks on obtaining either results from screening, or an intervention thereafter may require better use of innovations such as m-health and telemedicine to be deployed to reach out to more women who need screening
Lack of gender transformative approaches targeted at reducing gender-based violence	<ul style="list-style-type: none"> • Support for a transformative GBV strategy with measurable outcomes • Improving the capacity of police force on handling GBV as it relates to HIV • Monitoring the functioning of Thuthuzela centres as a point of implementation of an integrated response, and rolling out some more centres should the monitoring prove to be progressive • Training of health care workers at the Thuthuzela centres in implementing an integrated approach that benefits women in the context of HIV

These interventions are described in detail below, and form the basic package that is the main objective of this study

5.1 Strategy targeted at young women and girls

An effective NSP requires the articulation and implementation of a national coordination framework which specifies all key stakeholders, their roles and responsibilities as well key outputs, deliverables and clear timeframes. However, the current NSP does not specify strategies that deal with women as a separate group needing specific interventions. Indeed from the progress report of the NSP, there is no data disaggregation on how many women are accessing ART and the nuances related to women taking ART. Such monitoring is left to gender practitioners who have a special interest on HIV. The result therefore is that data on how ART affects women, adherence issues specific to women, socio-structural challenges that affect women and especially gender-based violence, are not monitored within the perimeter of the NSP. Such a strategy has been articulated by groups like Athena and HEARD, partnering with several institutions including PWN to ensure that current NSPs in Southern and Eastern Africa support the accelerated agenda for women and girls.

This plan will contain an tailored evidence-based national HIV response that analyses and prioritises the specific needs of women and girls, protects their rights in the context of HIV, and guarantees their equal access to HIV services. In addition the plan will give guidance Concrete actions, policies, and programmes ensure women and girls have equal access to HIV prevention, care, treatment, and support services that address their needs and rights in the context of HIV. An effective Information Management System (IMS) is a critical component of an effective coordination framework. It enables planning, effective implementation, and efficient monitoring and evaluation.

It is recommended that PWN, working with the

ALN, Soul City, Lovelife and other sexual health and rights institutions, table a paper that describes the effects of the policy ambiguity on sexual health and reproductive rights of young women and girls. It is critical that policy ambiguities are clarified in the coordination framework so as to eliminate inertia at the level of implementation - for instance, the age of consent is 16 years, and sex with a person under 16 is statutory rape. While it is important that perpetrators of statutory rape are subjected to the law, there is ambiguity where both parties are under 16.

In addition to this advocacy to avoid such contradictions, specific reproductive health messages should be relayed. For example, empirical evidence from the teenage pregnancy report points to the fact that girls under 16 are having sex, getting pregnant and being infected with HIV, leading to the need for the following interventions:

- Sex education needs to target children of 14 years (or younger) in order they delay becoming sexually active, and to reduce GBV incidence, early pregnancies and HIV infection.
- Schools are the best entry points for the provision of sex education and reproductive health education and services.

Advocacy strategies should also cover the policy ambiguities on statutory rape and termination of pregnancy. In addition, there are organisations such as the ALN that have been advancing the decriminalisation of sex work in South Africa that need support from institutions like PWN. PWN seeks to support and use its structures to reach out to ooNonkululeko who are not easily accessible. PWN support groups have access to groups of commercial sex workers and propose to reach out to them with supportive information and condoms.

5.2 Livelihood strategies for young women and girls and economic empowerment of women

As revealed by study participants, and from academic literature, poverty is a major driver of HIV acquisition in South Africa. A basic power package will help transform ooNonkululeko's realities. For example, amongst the challenges faced by young women in the lower socioeconomic strata, accessing sanitary towels is a huge issue. It is recommended that a basic power package to alleviate destitution in a young woman's life be provided. Such destitution, for example when linked to sanitary towels, has dire consequences with young girls missing an estimated five school days a month and 50 days a year, resulting in poor education outcomes.

Lack of access to sanitary towels not only compromises schooling for girls, but also denies them their constitutional right to dignity. Funding and strategies that encourage unemployed women to establish business ventures are vital and highly recommended by organisations such as the Business Partners in South Africa. A study carried out by the Business Partners in South Africa found that when female entrepreneurs are funded, the opportunities and wealth they create with the funding are likely to spread further than when males are funded. This is essentially because females are more likely to share wealth and resources with family, employees and shareholders. Unfortunately for the majority in South Africans, access to information on enterprise development is lacking, leaving women behind both in building the nation's wealth and in building their own wealth.

Short term responses include innovative ways to utilise the current social welfare system to improve education outcomes and to relieve destitution especially among school going girls. Long term approaches include strategies for enterprise and

skills development through formal and informal education.

Short term strategies:

- Providing an **essential power package** with information on HIV and sexual and reproductive health and rights (SRHR), with a basic survival pack for young women through the integrated school health programme. Appendix 1 gives an overview of what the power pack should comprise.
- Bursaries provided through partnerships with higher education and PWN in order that positive women can access tertiary education, especially at FET colleges.
- Safer schools programming to ensure adherence to standards for schools especially in informal settlements and in rural areas.

Long term strategies:

- Educational subsidies for girls in rural areas to be implemented in piloted phases. PWN would convene an implementation strategy that has HIV incidence outcomes as part of the measurements.
- Advocacy to include initiatives such as the RIVA programme to keep girls at school for longer as a strategy to reduce HIV incidence.
- Transformative economic empowerment programmes targeted at HIV positive women; women in rural areas and in informal settlements. These include:
 - Cooperatives for poultry farming for young women, especially HIV positive women; women in rural areas and in informal settlements;
 - Enterprise development and life skills building targeting especially school leavers who are unemployed; and
 - Conduct a pilot to turn social grant

programmes into conditional grants based on educational outcomes

5.3 Expanding HIV prevention tools and linking them to testing

From the recommendations of women who participated in the study, it is evident there is need for continuous education and information on HIV prevention directed at those who are negative (typically HIV interventions are directed to those who are HIV positive which also exacerbates stigma and discrimination). In addition, there is the need to give ooNonkululeko a platform and a voice with which to articulate their needs and empower them to take control of their own journey. ooNonkululeko's expertise has been untapped in preventing HIV infections, GBV and early pregnancies. Many of the women who participated in the study are already living with HIV, but seek to assist with the prevention of new infections through their community outreach work as well as through their engagement with young women and girls in their communities. In addition, change agents who are HIV negative are needed, and this constituency is reached by organisations such as LoveLife.

In the FGD discussions, it became evident that the current campaigns were ineffective and the approach should rather include continuous interventions targeted at averting infections, teenage pregnancies and HIV infections, and at preventing stigma and discrimination:

Therefore this study recommends:

- That HIV prevention programmes utilise women (of all ages) living with HIV to upscale their interventions by recognising and strengthening their capacity to administer community-based prevention programmes;
- Formalising and upscaling

ooNonkululeko's peer support and training interventions;

- Ensuring the enforcement of the law and an ending to impunity;
- Funding ongoing continuous prevention interventions meant at averting HIV for as long as possible;
- Developing specific interventions which target women as a whole as a key population, and which are aimed at women in different age cohorts, taking into account the needs of women with disabilities, women in different localities including informal settlements and rural areas, and sex workers;
- Clearly defining what is to be prevented in order to effectively plan, act and monitor outcomes.

5.4 Improving the capacity of the health system to respond to individualised needs of women

There is a myriad challenges facing the health system in South Africa, although progress is being seen when it comes to HIV, particularly the PMTCT programme. Specific challenges have been singled out by women living with HIV, such as (un)availability of diagnostics. For ooNonkululeko access to diagnostics is a critical component of a national response to HIV, and they continue to advocate for the development of information on CD4 and Viral Load and diagnostics. The available diagnostic testing facilities are limited and mostly located in cities. This places the burden of increased indirect health expenses for women who live in areas where such facilities are not available. Possible solutions necessitate the private sector interacting with government, and having difficult conversations with, for example, institutions such as the National Health Laboratory Service (NHLS) that provide such diagnostic services.

Inadvertently the way health care workers manage or fail to manage HIV may perpetuate stigma, particularly for the newly diagnosed. To effectively minimise the impact of stigma and discrimination on the lives of women and girls living with HIV and TB, ooNonkululeko recommend the following:

- Ensure that people living with HIV understand their rights, which are enshrined in the SA Constitution (Act 108) of 1996, prohibiting all forms of discrimination, including discrimination on the basis of gender and sexual orientation.
- Promote laws and policies that ensure the full realisation of all human rights and fundamental freedoms.

64

However support groups for young people living with HIV are also needed to combat this challenge. In addition, training of health care workers is required that deals not only with the technical subject of HIV, but also with other softer aspects that affect programme outcomes, such as leadership and accountability.

Another health system challenge is the ability to cope with the demand for cancer screening activities. As the national cervical cancer screening policy was established before the link between cervical cancer and HIV and AIDS was firmly established, there is currently a gap in the cervical screening policy. While the need for cervical cancer services is addressed in the NSP, it is not clearly articulated or completely integrated within the broad range of services that would constitute an effective response to these twin diseases.

Researchers suggest that as women are living longer due to access to HAART, they are at an increased risk of contracting cervical cancer. While access to antiretroviral therapy is beginning to reduce AIDS mortality, gynaecologic oncologists warn that women being treated for AIDS could end up dying of cervical cancer unless they have

access to appropriate screening and treatment. Health workers are finding that many women diagnosed with HIV and AIDS commonly show cervical abnormalities.

There are a variety of factors that make women vulnerable to contracting both HIV and cervical cancer. It has been noted for example, that cervical cancer is a disease of poverty and inequity and is more prevalent in developing countries than in richer countries¹⁷⁷. In addition, the high rate of violence against women and girls has resulted in greater vulnerability to contracting these diseases. However, in their encounters with the health care system, ooNonkululeko bemoan the fact that they are not able to receive services beyond ART.

5.5 Radical transformation of the gender-based violence framework in South Africa

There is a need to ensure that available legislation is properly enforced and that perpetrators of sexual violence against women and girls are brought to book. At present the rate of rape reporting remains low, and where rape is reported, the number of successfully prosecuted cases is very low, even in instances where girls are impregnated by those who are supposed to protect them, for example teachers¹⁷⁸.

In many South African schools, educators have sexually harassed and abused the learners in their care. This serious human rights violation is widespread and well known. However, its actual incidence is difficult to determine as many cases of educator-learner abuse are never reported.

Gender inequality is a fundamental driver of GBV being both a cause and possibly a consequence of HIV transmission¹⁷⁹. Addressing GBV, in particular the epidemic of violence against girls and women is an urgent priority across South Africa. More recently the broader range of harmful effects

of GBV on health and economic development is becoming increasingly better understood.

A need exists to eliminate gender inequalities and gender-based abuse and violence, and increase the capacity of women and girls to protect themselves from HIV. Women who live with HIV may experience more violence because of their sero-status. As many women and girls are raped by those who should be taking care of them, including teachers and police, there is a need for enforcement of existing legislation in order to ensure an end to impunity. Sexual, physical and emotional abuse of women living with HIV can take place within an intimate partnership, in the broader family or community, and even at points of medical care. The experience of violence in addition to the direct damage to physical and emotional health can lead to long-term problems.

While there are many factors, both social and political, that contribute to school-based sexual violence, the inadequacy of structures and processes capable of ensuring educator accountability is one of the most crucial. Educators who sexually abuse learners seldom face full or meaningful consequences for their actions. Government actors and institutions are not held responsible for their failure to prevent and respond to such abuse. In the absence of accountability, there is rampant impunity. Tragically, this enables the abuse to continue unchecked. ooNonkululeko seek to reduce the high incidence of pregnancies amongst young women and girls. Early pregnancies are especially high in the case of paternal, maternal and double orphans, as well as amongst girls who are abducted in a perverted form of “ukuthwala” as currently practiced in parts of the Eastern Cape and in KwaZulu-Natal.

A notable factor that stands out in the research on adolescent sexual practices and HIV infection is the low correlation between infection rates in girls and boys. Specifically, young women and girls are not being infected by their peers; however there are gaps in the research.

As Warren Parker (2013¹⁸⁰) points out:

- Very little is known about the partners of girls and young women who are sexually active, pregnant, HIV positive
- Little is known about the extent of abandonment of young mothers, children, fatherhood practices, age and other information about male partners/fathers
- Little is known about the extent of, or challenges relating to, teen pregnancy/ termination of pregnancy
- Little is known about the extent to which the law or community support has been leveraged in relation to statutory rape, coercion/violence

In South Africa teenage pregnancies result in up to 36% of maternal deaths, despite only constituting 8% of the total number of pregnancies. Therefore, more research is needed in order to fully understand the dynamics around young people, teenage pregnancy and HIV. To turn the tide, it is imperative that a NSP on GBV is put in place and rigorously enforced. Community participation is a key component to ensuring an effective national response to HIV, in particular to achieve zero new infections, zero transversal transmission, and zero stigma and discrimination. With health services centralised in major cities, making it difficult for people who live in rural areas to access services due to transport issues, community mobilisation and activism have to be increased. The most important intervention for making ARVs accessible is to bring ART services as close to communities as possible.

This analysis will not be complete without recommendations directed at different constituencies and practitioners in the HIV field related to gender.

Recommendations for HIV practitioners

1. HIV practitioners should have focussed collaboration on HIV targeted at young women and girls
2. Training of frontline health care workers on gender, sexuality, sexual health and reproductive rights in every facility delivering HIV care. PWN has suggestions on the content of such training as the gender blind treatment that women living with HIV get in these facilities stems largely from lack of knowledge on the intersection of gender and HIV
3. More HIV prevention tools for women are needed and, as such, should go beyond just distribution but be entrenched in the realities of ooNonkululeko's every day life.
4. A major obstacle in understanding gains made in implementing the NSP was the paucity of data, and especially gender-disaggregated data. All forms of data for public use should provide gender disaggregated data and proper gender analysis. This includes but is not limited to Stats SA, the national HIV prevalence survey and facility level data collection tools. The use of community-based systems is suggested to track the quality of services that women receive in the context of sexual health and reproductive rights. This would be in the form of a survey of the first 50 000 women attending public health facilities at random, to access cervical cancer screening, family planning services etc. This will help to objectively determine the quality of care that women get from public health facilities. This could be augmented by the stigma index tracker or a discrimination index tracker that would work better for women.
5. It is also recommended that the central repository of information be updated

regularly and that it be mandatory to ensure that all information is gender disaggregated. This would enable one to track where inequities remain. To practitioners in the field of HIV, it is suggested that women's narratives be captured as a way of monitoring progress in policy implementation.

Recommendations for researchers and academics

1. Training on gender is needed for frontline health workers, whose ability to screen gender-based violence would go a long way in reducing the rate of new infections among women. It is recommended that the NDOH adopt and roll out a basic course for all in-service personnel and that such training be rolled out in academic institutions training health care workers
2. A concerted effort is needed to ensure that women are included in clinical research, so that clinical data is available for drugs from the start. Pharmacovigilance on HIV needs to be strengthened as currently no data was available from the pharmacovigilance centres in the Free State University or from Medunsa on the pharmacodynamics and pharmacokinetics of drugs among women. For every research project on HIV and TB, institutions that have churned world-class research should conduct gender analysis on research protocols, and if possible, move such protocols along the gender continuum towards being transformative.
3. This review revealed that there is a need to focus on poverty as a primary driver of vulnerability to HIV in South Africa. Revealed in this research through testimonies of women living with HIV, poverty drives women into more vulnerability and distress. While expensive, there is need for more data that demonstrates the benefits of solely

focussing on poverty as a developmental issue when tackling HIV. This calls for prevention trials that can measure HIV incidence data after a socio-structural intervention.

Recommendations to policy makers

1. Policy support for women's economic advancement is urgently needed from the upper echelons of power.
2. Decisive action to support the endeavour towards the NSP on Gender Based Violence is urgently needed, at least as a starting point. This research revealed that gender-based violence is a systemic challenge, and requires a systematic multi-pronged response involving various departments. It is therefore essential that a multi-sectorial working group lead the conceptualisation and implementation of this process, which would eventually put a name to, characterise and deal with gender-based violence by giving it a home. Both policy changes and service strengthening are needed to effectively enforce legislation that protects women and girls from gender-based violence and enables effective care and legal redress and protection for survivors.
3. A recommendation to government is to make HIV prevention guidelines available. Working towards HIV prevention guidelines for women and girls would help practitioners in the field roll out practical prevention programmes that help women in negotiating for safer sex in the broader context of reproductive health and rights.
4. The policy ambiguity on TOP and on statutory rape needs to be resolved. Likewise, a resolution on the decriminalisation of sex work is needed in South Africa, and it is up to the policy makers to facilitate and resource these discussions.

Recommendations for donor agencies

1. The challenges that women face when it comes to HIV cannot be solved by South Africa alone. It is necessary donor agencies come forward with financing concerning reproductive health and rights of women, of which young women and people living with HIV need considerable attention.
2. Gender issues related to HIV not only need direct funding, but continued efforts on gender integration in most donor programmes will lead to transformative efforts on the ground.
3. Programmes implemented in HIV need to be gender accommodating at the very least but ideally gender transformative. Therefore it is recommended that RFPs for management of HIV from the start be gender transformative. As this may not be mainstream ideology within an agency, PWN, with this ethos, has become available for capacity building on gender and HIV.

6

Our Starting Point: PWN's Basic Intervention Package



“Learning is not enough, we must know. Knowing is not enough, we must do.”

Goethe

Our strength as an organisation has traditionally been our members, our ability to reach the unnoticed women in the HIV discourse and to provide her with a platform not only from which to narrate her experiences along the HIV continuum, but to be an author of solutions of these challenges. The basic package takes these principles into account, as we believe localisation of the response to an individual's psychosocial framework, relationship power dynamics, household realities and community norms, will feed into the social transformation needed to tackle HIV challenges.

There are four basic categories of gaps that lead to the gender-based disparities in HIV identified in this study. The first is about the gaps in policy frameworks that target women, including some contradictions in policies related to sexual health and reproductive rights; the second set relates

to poverty reduction and creation of economic empowerment opportunities for women living with HIV and young girls; the third set relates to health system challenges that result in stigma, and the last set is about continued efforts to generate evidence for best practice in HIV care.

Using the ecological model approach, PWN proposes the following as a starting point to intervene in the gaps listed above. The recommendations section articulates what needs to be scaled up overall, but this needs to be broken into several strategies that will enable the practitioners to have a starting point on this long journey. The table below categorises two ecological model frameworks where PWN could intervene. Other institutions like Soul City, Lovelife and ZAZI have gone further to intervene at relationship and individual level.

<i>Ecological framework level</i>	<i>Gaps in policy frameworks</i>	<i>Livelihoods</i>	<i>Health systems</i>	<i>Reducing gender based violence</i>	<i>Generating evidence for best practice in HIV care</i>
National	<ul style="list-style-type: none"> • Strategy for women and girls • Advocacy programme 	<ul style="list-style-type: none"> • Power packs to relieve destitution among girls • Keeping girls at school • Quality infrastructure in schools • Quality education 	<ul style="list-style-type: none"> • Training programmes for nurses 	<ul style="list-style-type: none"> • National strategic plan to reduce • GBV in South Africa 	<ul style="list-style-type: none"> • Generating evidence on experiences of WLHIV
Community	<ul style="list-style-type: none"> • Women in leadership in PACS, DACS and WACs • Mapping power dynamics in each community 	<ul style="list-style-type: none"> • Community specific projects such as cooperatives for poultry farming 	<ul style="list-style-type: none"> • PWN members in clinic committees • Community dialogues 	<ul style="list-style-type: none"> • Community dialogues 	<ul style="list-style-type: none"> • Platforms for narrating experiences

Table 2: Responding to the research findings through an ecological framework lens

At a national level

1. Spearhead an HIV strategy for women and girls that clarifies who does what, where and when, particularly with greater visibility of provincial, district and ward AIDS Councils.
2. To ensure greater involvement of women PWN will roll out **a structured advocacy and thought leadership to support all the deliverables for the minimum package and other specifics that include:**
 - A structured HIV agenda for women and girls
 - Campaigns to expand HIV prevention options for women
 - Drafting strategies for innovative use of current social grants to include conditional cash transfers as a promising strategy that can enable girls to stay in school and may result in reduced incidence of HIV
 - Supporting national agenda on improving school infrastructure and quality of education
3. Using the knowledge repository of its members on the health systems, **PWN will partner with the National Department of Health to improve the capacity of health care workers** to respond to gender specifics of HIV, particularly nurses, on the following
 - Gender-based violence programmes, building on the current offering from training institutions like the Foundation for Professional Development (FPD) but focussing on nurses as agents for change
 - Nuances around side effects, hormonal differences and long term side effects of ARVs on women
 - Become conduits for community realities by incorporating PWN members into the clinic committees
 - Stigma reduction agenda through workshops on responsible leadership in the era of HIV. If nurses are made aware of the experiences that women living with HIV undergo, it is likely there will be a reduction in stigma
4. PWN will **support national research efforts to fill in information gaps** on evidence based programming of HIV, especially information on the demand side of HIV interventions. Particularly, PWN working with its members seeks to create a platform where our own narratives will be heard. This is a fundamental shift from being the researched to being authors of our experiences where PWN seeks to lead in the following research areas:
 - Better understanding of the realities of fertility and family planning usage among women living with HIV
 - Mapping sexual networks through working with its membership , to offer real field perspectives of transmission dynamics prevalent in South Africa
 - Longitudinal follow up to document experiences of ooNonkuleko on ARVs, pertaining adherence, long term side effects, quality of life and gendered aspects of ARV provision
 - Local institutions can be effective at monitoring realities after an intervention roll out, for example on behavioural risk interventions
 - Through focussed collaborations, PWN will partner with research institutions to document and present women’s realities for rolling out any biomedical prevention strategies such as microbicides and PrEP

At a community level

1. PWN will conduct **community dialogues** to encourage conversations in communities about HIV and as a route to convey critical messages. The specific objectives on reaching these communities will be to:
 - Rapidly increase the risk perception of young women especially when involved in age disparate relationships
 - Garner community driven messages to discourage intergenerational sex
 - Map power dynamics that exist in each community for an effective gender-based violence programme
 - Introduce conversations that will result in reduction of stigma in these communities
 - Utilise mass media and social marketing activities to reach young women and girls in a focused and coordinated way to effectively reach large numbers of young women. Messages on SRHR and on HIV prevention will form the core of the messaging. Partnerships with institutions like Soul City, Lovelife and ZAZI are recommended
2. PWN will **spearhead strategies for economic empowerment of women** by identifying specific sustainable enterprise development activities in each community where HIV positive women live and work. Such activities will be categorised in two:
 - Those targeted at economic empowerment for young women, women living with HIV and women living in rural areas. Partnerships with institutions such as the National Empowerment Fund, the DTI, Intonga Women's Fund and Business Partners, will be established to reach out to assist in enterprise development activities in communities
 - Those targeted at ensuring youths, and specifically young girls, get access to life skills and education. Ensuring access to education remains a major route out of women's ongoing poverty and dependency. Programmes aimed at keeping girls in the education system must be linked and expanded
3. PWN advocates **for expanding access to HIV testing, prevention and treatment services through creation of a layer of down referral to approved support groups at a community level.**
 - As an institution that has worked in these communities for 15 years, PWN is best placed to identify social needs in communities and provide long-term solutions, with ooNonkululeko being authors of these solutions. This strategy increases sustainability of initiatives
 - HIV prevention needs to be understood as part of societal transformation as there is a need to change values and norms, especially regarding relationships. Local relevance is therefore called for in any intervention. Women who participated in the study clearly articulated the need to understand their realities especially when rolling out any biomedical HIV prevention efforts. Hence the call to improve the capacity of local structures to convey messages on HIV prevention, and indeed that support groups form part of a national infrastructure for down referral to avoid congestion in these facilities
 - HIV testing for all adolescents and young adults Young people's service needs are frequently overlooked in HIV programming which is not specifically designed for adolescents. Providing clinic services that are acceptable and accessible to youth, conveniently located, affordable, confidential and non-judgmental is a promising way to increase the use of clinic reproductive health services, including HTC. Specific focus for PWN's campaigns will include community dialogues

These recommendations will inform PWN's programming approach on women and girls comprising the five bars below, with the development of a strategy to guide all actions as an overarching pillar.

These recommendations will inform PWN's programming approach on women and girls which comprises of the five bars below, with the development of a strategy to guide all actions as an overarching pillar. This is summarised in the figure below:



Figure 7: A summary of a suggested programming approach to tackle the gender disparities in the HIV response

7

Conclusion



“I ask no more of you than I ask of myself or of my children. To the millions of you who are grieving, who are frightened, who have suffered the ravages of AIDS first-hand: Have courage, and you will find support. To the millions who are strong, I issue the plea: Set aside prejudice and politics to make room for compassion and sound policy.”

This exploratory research study was successful in identifying critical policy, legal and structural (social, cultural, economic) gaps that contribute to gender-based disparities in South Africa, related to HIV and TB prevention, treatment and care. Furthermore, the findings of the study provided guidelines for the development of the essential package, which addresses access to services identified at national, provincial, district, institutional and community levels. The essential package is set to be a critical resource in addressing disparities related to HIV and TB prevention, treatment, support and care. The findings also provide opportunities for further research.

OoNonkululeko are among the 26 million women living in South Africa, of which 21 million are black women. They are also among the over six million people living with HIV in South Africa. They may be found residing in any of the provinces or districts in South Africa, in any village, and they may or may not have attended school and/or may or may not be employed. They may also be among the educated, economically mobile, who also navigate stigma and discrimination, while being rendered invisible in the mainstream narrative about HIV and AIDS in South Africa.

OoNonkululeko's physiological risks of HIV infection are well documented; however, less attention has been given to sociocultural factors that predominate as key drivers of HIV among women. The young ooNonkululeko may be among the 2.5 million known orphans in South Africa, who have lost one or both parents to HIV, or they may be among the 410,000 South African children living with HIV. In an environment where the incidence of rape among young girls is high, the young ooNonkululeko's vulnerability is increased. The young ooNonkululeko who live in the Eastern Cape, in poor female-headed households, may also be at risk of being subjected to harmful traditional practices, such as ukuthwala, and as a result may be further at risk of contracting HIV.

As patriarchy remains prevalent in South Africa,

ooNonkululeko are also among the educated and the affluent. Yet, in the mainstream narrative, there is the fallacious notion that HIV affects and infects only women who come from poor backgrounds. This is not true; there are also ooNonkululeko who are employed graduates. They too are not exempt from gender inequalities as, by virtue of being women, they earn on average almost 25% less than males in a similar position earn¹⁸¹.

Poverty and economic disenfranchisement was a key theme in the narratives of ooNonkululeko. They narrate that often, when faced with the financial challenges of raising children and looking after siblings and parents, they may make survival choices for which many may condemn them. These include having sex without condoms and/or staying in abusive relationships so as not to absolve their partners from the responsibility of caring for them and their children in instances where they have tested and are pronounced HIV positive. On remaining in abusive relationships, the information shared in the FGDs of the study is that ooNonkululeko, here too, make conscious choices informed by economic survival needs.

OoNonkululeko's narratives indicate that the HIV and AIDS epidemic in South Africa is characterised by gender inequalities in that South Africa remains a patriarchal society and that poverty is a social determinant of HIV infection. The vulnerability of women needs a higher profile within the NSP and in our response – this is in relation to biological, behavioural and structural levels. However to be sufficiently informative, a study of this nature should extend further into the community and reach a more diverse set of informants and respondents than this study was capable of doing.

Despite knowing that gender disparities drive vulnerability to HIV, the patterns of prevalence have more complex origins than biological vulnerability, and are driven by the various socio-structural and economic challenges that ooNonkululeko face. Indeed, as the literature demonstrates, a dangerous mix of biomedical,

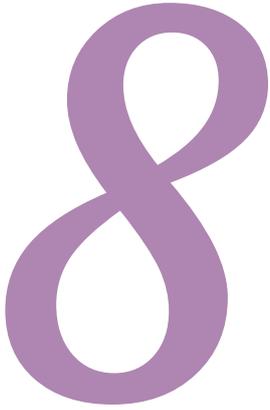
political, economic and cultural forces continue to shape the gendered dynamic of the HIV epidemic in South Africa.

Building on several narratives from ooNonkululeko, the gaps identified in this study were categorised into four. The first is the gaps in policy frameworks that target women, including some contradictions in policies related to sexual health and reproductive rights; the second set relates to poverty reduction and creation of economic empowerment opportunities for women living with HIV and young girls; the third set relates to health system challenges that result in stigma, and the last set is about continued efforts to generate evidence for best practice in HIV care.

PWN proposed, using the lens of the ecological model, an approach at national, community, relationship and individual levels. PWN's advocacy agenda will seek to change the policy narratives that are contradictory and deficient such as those relating to statutory rape, termination of pregnancy and the silent response to decriminalisation of sex work. HIV interventions cannot be complete without long term focus on economic empowerment, particularly the education of the girl child and meaningful enterprise development for the most vulnerable women. Using its experience of working in these communities, PWN seeks to partner with relevant institutions to advance the economic agenda for the most vulnerable women. Empowerment of health care workers to cope with the gender realities of HIV is proposed, through existing programmes from institutions such as FPD and others.

In reality, HIV prevention is a societal transformation phenomenon, and we conclude therefore that this cannot be achieved without dialogue with the affected communities. Using its current structures, PWN will conduct community dialogues which will also be used as platforms for condom distribution, but more importantly aim to encourage dialogue in relationships that will reduce the incidence of gender-based violence and stigma in the community. Lastly, the dearth of psychosocial interventions in HIV is visible from PWN experiences, and it is proposed that PWN takes a lead at local level to extend their support groups for access of services that not only include psychosocial support activities, especially to survivors of gender-based violence and those newly diagnosed with HIV.

These interventions form a starting point towards a minimum package for women when it comes to HIV, it is not exhaustive, but is a first step that meaningfully provides ooNonkululeko with platforms from which to narrate their own stories, and more importantly, be the authors of the solutions to challenges they face everyday living with HIV. The advancement of the truth is that they seek to live in a society where HIV incidence is lower than it is, and that their children, who are the youths discussed in this study, have access to better opportunities in life.



Appendix: Essential package for young women and girls

The essential package will consist of:

1. **The Dignity Dreams** reusable sanitary towel is a South African innovation which has sought a sustainable solution for the problem of access to sanitary towels – especially for girls at school. The Dignity Dreams packs consist of reusable sanitary items which last up to two years. Additionally, the ladies responsible for sewing the sanitary items are from disadvantaged backgrounds and now have jobs thanks to the initiative. The Dignity Dreams Pack includes:
 - Drawstring bag made from colourful poly-cotton and six x washable, absorbent pads. A Dignity Dreams pad has 2 layers of absorbent toweling; 1 layer waterproof plastic; 1 layer poly-cotton. The pad's wings are made out of colourful poly-cotton with a thin layer of plastic between the two layers for extra protection.
 - The menstrual cup (MPower Cup), made from 100% medical silicone, and thus is easy to clean, safe to use overnight and comfortable, is formulated as an alternative to sanitary pads and tampons. It is particularly attractive for ooNonkululeko as it is durable, lasting up to five years, and is said to be odourless and invisible.
2. **HIV prevention tools** which will include
 - Condoms
 - Female driven prevention tools, e.g. femidoms
 - Information on PEP
3. **Critical information about available services (by province)**
 - Information pack on PEP and contraception

9

References

- Adimora, A. A., et al. (2013). "Preventing HIV infection in women." *AIDS Journal of Acquired Immune Deficiency Syndromes* **63**: S168-S173.
- Alcaide, M. L., et al. (2013). "An Intervention to Decrease Intravaginal Practices in HIV-Infected Women in Zambia: A Pilot Study." *Journal of the Association of Nurses in AIDS Care* **24**(3): 219-226.
- Aweeka, F., et al. (2014). "Alteration in cytochrome P450 3A4 activity as measured by a urine cortisol assay in HIV-1-infected pregnant women and relationship to antiretroviral pharmacokinetics." *HIV Medicine*.
- Baird, S., et al. (2010). "The short-term impacts of a schooling conditional cash transfer program on the sexual behavior of young women." *Health Economics* **19**(S1): 55-68.
- Baird, S. J., et al. (2012). "Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial." *The Lancet* **379**(9823): 1320-1329.
- Barron, P., et al. (2013). "Eliminating mother-to-child HIV transmission in South Africa." *Bulletin of the World Health Organization* **91**(1): 70-74.
- Bekker, L.-G., et al. "Combination HIV prevention for female sex workers: what is the evidence?" *The Lancet* **385**(9962): 72-87.
- Bekker, L.-G., et al. (2015). "HIV and sex workers 2 Combination HIV prevention for female sex workers: what is the evidence?" *The Lancet* **385**: 72-87.
- Bor, J., et al. (2013). "Increases in adult life expectancy in rural South Africa: valuing the scale-up of HIV treatment." *Science* **339**(6122): 961-965.
- Braitstein, P., et al. (2008). "Gender and the use of antiretroviral treatment in resource-constrained settings: findings from a multicenter collaboration." *Journal of Women's Health* **17**(1): 47-55.
- Cloete, A., et al. (2008). "Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa." *AIDS Care* **20**(9): 1105-1110.
- Collazos, J., et al. (2007). "Sex differences in the clinical, immunological and virological parameters of HIV-infected patients treated with HAART." *Aids* **21**(7): 835-843.
- Feitsma, A. T., et al. (2007). "Experiences and Support Needs of Poverty-Stricken People Living With HIV in the Potchefstroom District in South Africa." *Journal of the Association of Nurses in AIDS Care* **18**(3): 55-64.
- Gausset, Q. (2001). "AIDS and cultural practices in Africa: the case of the Tonga (Zambia)." *Social Science & Medicine* **52**(4): 509-518.

Gordon, G. and V. Mwale (2006). "Preventing HIV with Young People: A Case Study from Zambia." Reproductive Health Matters **14**(28): 68-79.

Gruskin, S., et al. (2014). "HIV and gender-based violence: welcome policies and programmes, but is the research keeping up?" Reproductive Health Matters **22**(44): 174-184.

Guerra, F. M. and L. C. Simbayi (2014). "Prevalence of knowledge and use of the female condom in South Africa." AIDS and Behaviour **18**(1): 146-158.

Hawkins, C., et al. (2011). "Sex differences in antiretroviral treatment outcomes among HIV-infected adults in an urban Tanzanian setting." Aids **25**(9): 1189-1197.

Heffron, R., et al. (2012). "Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study." The Lancet Infectious Diseases **12**(1): 19-26.

Heise, L., et al. (2013). "Cash transfers for HIV prevention: considering their potential." Journal of the International AIDS Society **16**(1).

Jewkes, R. and R. Morrell (2010). "Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention." Journal of the International AIDS Society **13**(1): 6.

Jewkes, R. and R. Morrell (2012). "Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises." Social Science & Medicine **74**(11): 1729-1737.

Jewkes, R. and R. Morrell (2012). "Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises." Social Science & Medicine **74**(11): 1729-1737.

Jewkes, R. K., et al. "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study." The Lancet **376**(9734): 41-48.

Jewkes, R. K., et al. (2010). "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study." The Lancet **376**(9734): 41-48.

Jewkes, R. K., et al. (2003). "Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study." Social Science & Medicine **56**(1): 125-134.

Jina, R., et al. (2014). "A cross-sectional study on the effect of post-rape training on knowledge and confidence of health professionals in South Africa." International Journal of Gynaecology & Obstetrics **126**(2): 187-192.

Johnson, D., et al. (2011). "Hormonal contraceptive use and response to antiretroviral therapy among adolescent females." HIV & AIDS Review **10**(3): 65-69.

Jones, A., et al. "Transformation of HIV from pandemic to low-endemic levels: a public health approach to combination prevention." The Lancet **384**(9939): 272-279.

Kalichman, S. C., et al. (2013). "Bringing it home: community survey of HIV risks to primary sex partners of men and women in alcohol-serving establishments in Cape Town, South Africa." Sexually transmitted infections **89**(3): 231-236.

Karim, S. S. A., et al. "HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response." The Lancet **374**(9693): 921-933.

- Kilonzo, N., et al. (2009). "Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages." Reproductive Health Matters **17**(34): 10-19.
- Kim, J. C., et al. (2003). "Rape and HIV Post-Exposure Prophylaxis: Addressing the Dual Epidemics in South Africa." Reproductive Health Matters **11**(22): 101-112.
- Kyegombe, N., et al. (2014). "The impact of SASA!, a community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda." Journal of the International AIDS Society **17**(1).
- Lachaud, J.-P. (2007). "HIV prevalence and poverty in Africa: Micro- and macro-econometric evidences applied to Burkina Faso." Journal of Health Economics **26**(3): 483-504.
- Lee, L., et al. (2014). "Factors Informing HIV Providers' Decisions to Start Antiretroviral Therapy for Young People Living With Behaviorally Acquired HIV." Journal of Adolescent Health **55**(3): 358-365.
- Leggett, T. (2001). "Drugs, sex work, and HIV in three South African cities." Society in Transition **32**(1): 101-109.
- LeRoux, I. M. (2006). "Gender-specific aspects of the burden of HIV/AIDS in South Africa – Communicable diseases." Gender Medicine 3, Supplement **1**(0): S22.
- Long, N. H., et al. (1999). "Different tuberculosis in men and women: beliefs from focus groups in Vietnam." Social Science & Medicine **49**(6): 815-822.
- Loutfy, M. R., et al. (2013). "Factors affecting antiretroviral pharmacokinetics in HIV-infected women with virologic suppression on combination antiretroviral therapy: a cross-sectional study." BMC Infectious Diseases **13**(1): 256.
- Magcai, D. M., et al. (2013). "Black South African Farm Workers' Beliefs About HIV." Journal of the Association of Nurses in AIDS Care **24**(1): 61-70.
- Mannell, J. (2014). "Adopting, manipulating, transforming: Tactics used by gender practitioners in South African NGOs to translate international gender policies into local practice." Health & Place **30**(0): 4-12.
- Martin Hilber, A., et al. (2010). "A cross cultural study of vaginal practices and sexuality: Implications for sexual health." Social Science & Medicine **70**(3): 392-400.
- Martin Hilber, A., et al. (2012). "Vaginal practices as women's agency in Sub-Saharan Africa: A synthesis of meaning and motivation through meta-ethnography." Social Science & Medicine **74**(9): 1311-1323.
- Masaisa, F., et al. (2011). "Anaemia in Human Immunodeficiency Virus-Infected and Uninfected Women in Rwanda." The American Journal of Tropical Medicine and Hygiene **84**(3): 456-460.
- Masanjala, W. (2007). "The poverty-HIV/AIDS nexus in Africa: A livelihood approach." Social Science & Medicine **64**(5): 1032-1041.
- Masanjala, W. (2007). "The poverty-HIV/AIDS nexus in Africa: A livelihood approach." Social Science & Medicine **64**(5): 1032-1041.
- Massad, L. S., et al. (2010). "Knowledge of cervical cancer prevention and human papillomavirus among women with HIV." Gynaecologic Oncology **117**(1): 70-76.
- Mitton, J. (2000). "The Sociological Spread of HIV/AIDS in South Africa." Journal of the Association of Nurses in AIDS Care **11**(4): 17-26.

Monforte, A. d. A., et al. (2011). "Late presenters in new HIV diagnoses from an Italian cohort of HIV-infected patients: prevalence and clinical outcome." Antiviral Therapy **16**(7): 1103-1112.

Morrison, C. S., et al. (2012). "Hormonal contraception and the risk of HIV acquisition among women in South Africa." Aids **26**(4): 497-504.

Mosha, F., et al. (2013). "Gender differences in HIV disease progression and treatment outcomes among HIV patients one year after starting antiretroviral treatment (ART) in Dar es Salaam, Tanzania." BMC Public Health **13**(1): 38.

Mtetwa, S., et al. (2013). "You are wasting our drugs": Health Service Barriers to HIV Treatment for Sex Workers in Zimbabwe." BMC Public Health **13**(698): 10.1186.

Napierala Mavedzenge, S., et al. (2011). "The Epidemiology of HIV Among Young People in Sub-Saharan Africa: Know Your Local Epidemic and Its Implications for Prevention." Journal of Adolescent Health **49**(6): 559-567.

Nicastri, E., et al. (2007). "Sex issues in HIV-1-infected persons during highly active antiretroviral therapy: a systematic review." Journal of Antimicrobial Chemotherapy **60**(4): 724-732.

Okoror, T. A., et al. (2014). "HIV Positive Women's Perceptions of Stigma in Health Care Settings in Western Cape, South Africa." Health Care for Women International **35**(1): 27-49.

Onyejekwe, C. J. (2013). "The interrelationship between gender-based violence and HIV/AIDS in South Africa." Journal of International Women's Studies **6**(1): 34-40.

Orner, P., et al. (2006). "Challenges to microbicide introduction in South Africa." Social Science & Medicine **63**(4): 968-978.

Padian, N. S., et al. (2011). "HIV prevention transformed: the new prevention research agenda." The Lancet **378**(9787): 269-278.

Penn, C. and J. Watermeyer (2014). "Exploring Cultural Beliefs About "That Sickness": Grandmothers' Explanations of HIV in an Urban South African Context." Journal of the Association of Nurses in AIDS Care **25**(6): 508-519.

Petersen, I., et al. (2014). "A group-based counselling intervention for depression comorbid with HIV/AIDS using a task shifting approach in South Africa: A randomized controlled pilot study." Journal of Affective Disorders **158**(0): 78-84.

Pettifor, A. E., et al. (2011). "A Tale of Two Countries: Rethinking Sexual Risk for HIV Among Young People in South Africa and the United States." Journal of Adolescent Health **49**(3): 237-243.e231.

Pitpitan, E. V., et al. (2012). "Gender-based violence and HIV sexual risk behaviour: Alcohol use and mental health problems as mediators among women in drinking venues, Cape Town." Social Science & Medicine **75**(8): 1417-1425.

Pronyk, P. M., et al. "Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial." The Lancet **368**(9551): 1973-1983.

Pronyk, P. M., et al. (2008). "Is social capital associated with HIV risk in rural South Africa?" Social Science & Medicine **66**(9): 1999-2010.

Puskas, C. M., et al. (2011). "Women and vulnerability to HAART non-adherence: a literature review of treatment adherence by gender from 2000 to 2011." Current HIV/AIDS Reports **8**(4): 277-287.

- Rahangdale, L., et al. (2014). "Immunologic, Virologic, and Pharmacologic Characterization of the Female Upper Genital Tract in HIV-infected women." Journal of Acquired Immune Deficiency Syndromes (1999).
- Richter, M., et al. (2014). "Migration status, work conditions and health utilization of female sex workers in three South African cities." Journal of Immigrant and Minority Health **16**(1): 7-17.
- Robinson, J. A., et al. (2012). "Contraception for the HIV-positive woman: a review of interactions between hormonal contraception and antiretroviral therapy." Infectious Diseases in Obstetrics and Gynaecology 2012.
- Rodrigo, C. and S. Rajapakse (2010). "HIV, poverty and women." International Health **2**(1): 9-16.
- Ross, D. A., et al. (2006). "Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS Inter-agency Task Team on Young People."
- Rutenberg, N., et al. (2003). "Pregnant or Positive: Adolescent Childbearing and HIV Risk in KwaZulu Natal, South Africa." Reproductive Health Matters **11**(22): 122-133.
- Sankoh, O., et al. "Prevention, treatment and future challenges of HIV/AIDS: A decade of INDEPTH research." HIV & AIDS Review(0).
- Schatz, E., et al. (2011). "Female-headed households contending with AIDS-related hardship in rural South Africa." Health & Place **17**(2): 598-605.
- Seidel, G. and N. Ntuli (1996). "HIV, confidentiality, gender, and support in rural South Africa." The Lancet **347**(8999): 469.
- Sevinsky, H., et al. (2011). "The effect of efavirenz on the pharmacokinetics of an oral contraceptive containing ethinyl estradiol and norgestimate in healthy HIV-negative women." Antiviral Therapy **16**(2): 149.
- Shisana, O., et al. (2014). "South African national HIV prevalence, incidence and behaviour survey, 2012." Cape Town.
- Silverman, B., et al. "Collaborating for consensus: Considerations for convening Coalition stakeholders to promote a gender-based approach to addressing the health needs of sex workers." Evaluation and Program Planning (0).
- Singh, D., et al. (2011). "Stigma, burden, social support, and willingness to care among caregivers of PLWHA in home-based care in South Africa." AIDS Care **23**(7): 839-845.
- Singh, G. K., et al. (2012). "Global inequalities in cervical cancer incidence and mortality are linked to deprivation, low socioeconomic status, and human development." Int J MCH AIDS **1**(1): 17.
- Skovdal, M., et al. (2011). "When masculinity interferes with women's treatment of HIV infection: a qualitative study about adherence to antiretroviral therapy in Zimbabwe." Journal of the International AIDS Society **14**(1): 29.
- Smith, J., et al. (2014). "The Distribution of Sex Acts and Condom Use within Partnerships in a Rural Sub-Saharan African Population." PloS one **9**(2): e88378.
- Stadler, J. J., et al. (2008). "Women's perceptions and experiences of HIV prevention trials in Soweto, South Africa." Social Science & Medicine **66**(1): 189-200.
- Steenkamp, L., et al. (2014). "Socio-economic and demographic factors related to HIV status in urban informal settlements in the Eastern Cape, South Africa." African Journal of AIDS Research **13**(3): 271-279.

Sullivan, P. (2013). "Stigma, discrimination, and HIV: old problems, new thoughts." The Lancet Infectious Diseases **13**(11): 925.

Takarinda, K. C., et al. (2015). "Gender-related differences in outcomes and attrition on antiretroviral treatment among an HIV-infected patient cohort in Zimbabwe: 2007–2010." International Journal of Infectious Diseases **30**(0): 98-105.

Tenkorang, E. Y. and E. Maticka-Tyndale (2014). "Assessing young people's perceptions of HIV risks in Nyanza, Kenya: Are school and community level factors relevant?" Social Science & Medicine **116**(0): 93-101.

Tenkorang, E. Y. and S. Obeng Gyimah (2012). "Physical abuse in early childhood and transition to first sexual intercourse among youth in Cape Town, South Africa." Journal of Sex Research **49**(5): 508-517.

Thorson, A., et al. (2004). "Do women with tuberculosis have a lower likelihood of getting diagnosed?: Prevalence and case detection of sputum smear positive pulmonary TB, a population-based study from Vietnam." Journal of Clinical Epidemiology **57**(4): 398-402.

Trezza, C. R. and A. D. Kashuba (2014). "Pharmacokinetics of Antiretrovirals in Genital Secretions and Anatomic Sites of HIV Transmission: Implications for HIV Prevention." Clinical Pharmacokinetics: 1-14.

Türmen, T. (2003). "Gender and HIV/aids." International Journal of Gynaecology & Obstetrics **82**(3): 411-418.

Turnipseed, D. (2014). Criminalization of Sex Work in South Africa: A Modern Day Violation of Human Rights and a Threat to the Efforts to Reduce HIV/AIDS Infections. 142nd APHA Annual Meeting and Exposition (November 15-November 19, 2014), APHA.

Vujovic, M., et al. (2014). "Addressing the sexual and reproductive health needs of young adolescents living with HIV in South Africa." Children and Youth Services Review **45**(0): 122-128.

Waldman, L. and C. Overs (2014). "Sexuality and the Law: Case Studies from Cambodia, Egypt, Nepal and South Africa."

Watt, M. H., et al. (2012). "'Because he has bought for her, he wants to sleep with her': Alcohol as a currency for sexual exchange in South African drinking venues." Social Science & Medicine **74**(7): 1005-1012.

Winskell, K., et al. (2011). "Making sense of condoms: Social representations in young people's HIV-related narratives from six African countries." Social Science & Medicine **72**(6): 953-961.

Wong, L. H., et al. (2009). "Test and tell: correlates and consequences of testing and disclosure of HIV status in South Africa (HPTN 043 Project Accept)." Journal of Acquired Immune Deficiency Syndromes (1999) **50**(2): 215.

Woolf-King, S. E. and S. A. Maisto (2011). "Alcohol use and high-risk sexual behaviour in Sub-Saharan Africa: a narrative review." Archives of Sexual Behaviour **40**(1): 17-42.

Woolgar, H. L. and P. M. Mayers (2014). "The Perceived Benefit of the Disability Grant for Persons Living With HIV in an Informal Settlement Community in the Western Cape, South Africa." Journal of the Association of Nurses in AIDS Care **25**(6): 589-602.

Sources

1	Adapted from Naila Kabeer's definition of empowerment
2	Adapted from ICWG resources
3	UNAIDS. (2014). South Africa 2012 HIV Estimates and Projections Available: http://www.unaids.org/en/regionscountries/countries/southafrica/
4	Linde, I. (2013). Plenary Session 3, 20 June 2013. HIV/AIDS in South Africa: At last the glass is half full. HSRC. Available: http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/plenary-session-3-20-june-2013-hiv-aids-in-south-africa-at-last-the-glass-is-half-full
5	Ibid
6	WHO, Global Tuberculosis Report, 2013
7	STATS SA 2011 Census
8	Shisana, O., et al. (2014). "South African national HIV prevalence, incidence and behaviour survey, 2012." Cape Town.
9	Barron, P., et al. (2013). "Eliminating mother-to-child HIV transmission in South Africa." <i>Bulletin of the World Health Organization</i> 91(1): 70-74.
10	Ibid
11	Linde, I. (2013). Plenary Session 3, 20 June 2013. HIV/AIDS in South Africa: At last the glass is half full. HSRC. Available: http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/plenary-session-3-20-june-2013-hiv-aids-in-south-africa-at-last-the-glass-is-half-full
12	SAInfo. 17 June 2012. South Africa's HIV/Aids battle plan. Available: http://www.southafrica.info/about/health/aids-prevention.htm#.UuEZbylaltg
13	Waldman, L. and C. Overs (2014). "Sexuality and the Law: Case Studies from Cambodia, Egypt, Nepal and South Africa."
14	Onyejekwe, C. J. (2013). "The interrelationship between gender-based violence and HIV/AIDS in South Africa." <i>Journal of International Women's Studies</i> 6(1): 34-40.
15	Shisana, O., et al. (2014). "South African national HIV prevalence, incidence and behaviour survey, 2012." Cape Town.
16	Bor, J., et al. (2013). "Increases in adult life expectancy in rural South Africa: valuing the scale-up of HIV treatment." <i>Science</i> 339(6122): 961-965.
17	Stats SA 2012
18	NSP 2012-2016
19	{Peltzer, 2014 #410}
20	Crone, E.T., Gibbs, A. and Willan, S. (2011) <i>From Talk to Action: Review of Women, Girls, and Gender Equality in National Strategic Plans for HIV and AIDS in Southern and Eastern Africa</i> . HEARD and ATHENA Network: Durban, South Africa Kehler, J. (2012). <i>Are women at the centre: A critical review of the new NSP response to women's sexual and reproductive rights</i> . AIDS Legal Network

- 21 Greig, F. E. & Koopman, C. 2003. Multilevel analysis of women's empowerment and HIV prevention: quantitative survey results from a preliminary study in Botswana. *AIDS and Behavior*, 7, 195-208
- 22 Stats SA 2012
- 23 Steenkamp, L., et al. (2014). "Socio-economic and demographic factors related to HIV status in urban informal settlements in the Eastern Cape, South Africa." *African Journal of AIDS Research* 13(3): 271-279.
- 24 VEAREY, J. 2008. Migration, access to ART, and survivalist livelihood strategies in Johannesburg. *African Journal of AIDS Research*, 7, 361-374.
- 25 Statistics South Africa, Monthly earnings of South Africans 2010
- 26 S Gruskin et al. *Reproductive Health Matters* 2014;22(44):174-184
- 27 Kehler, J. (2012). Are women at the centre: A critical review of the new NSP response to women's sexual and reproductive rights. *AIDS Legal Network*
- 28 World Health Organization. WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva; 2005. http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf
- 29 S Gruskin et al. *Reproductive Health Matters* 2014;22(44):174-184
- 30 Jewkes, R. 2010. Gender inequities must be addressed in HIV prevention. *Science*, 329, 145-147.
- 31 Ibid
- 32 Stats SA, 2013
- 33 Ibid
- 34 Ibid
- 35 Jewkes, R. 2010. Gender inequities must be addressed in HIV prevention. *Science*, 329, 145-147.
- 36 Stats SA, 2012
- 37 Micheal Faul: *The World Post* 08-03 -2013 and Rachel Jewkes; Overview of GBV in SA: MRC
- 38 <http://www.theguardian.com/world/2003/jun/29/southafrica.aids> In why are we not outraged by Susan Nkomo
- 39 Gausset, Q. (2001). "AIDS and cultural practices in Africa: the case of the Tonga (Zambia)." *Social Science & Medicine* 52(4): 509-518.
- 40 Magcai, D. M., et al. (2013). "Black South African Farm Workers' Beliefs About HIV." *Journal of the Association of Nurses in AIDS Care* 24(1): 61-70.
- 41 Penn, C. and J. Watermeyer (2014). "Exploring Cultural Beliefs About "That Sickness": Grandmothers' Explanations of HIV in an Urban South African Context." *Journal of the Association of Nurses in AIDS Care* 25(6): 508-519.
- 42 Strebel, Anna, et al. "Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa: original article." *SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance* 3.3 (2006): p-516.
- 43 Abramsky, Tanya, et al. "What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence." *BMC Public Health* 11.1 (2011): 109.
- 44 Ibid

45	Baird, S., et al. (2010). "The short-term impacts of a schooling conditional cash transfer program on the sexual behaviour of young women." <i>Health Economics</i> 19(S1): 55-68.
46	Equal Education , 2014: http://www.equaleducation.org.za/article/2014-11-19-equal-education-marks-world-toilet-day-by-releasing-the-results-of-its-audit-of-tembisa-school-toilets
47	Ibid
48	Ibid
49	DOE: Teenage Pregnancy in South Africa: With a Specific Focus on School-going Learners: Executive Summary. Department of Basic Education, 2009.
50	Ibid
51	Baird, S. J., et al. (2012). "Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial." <i>The Lancet</i> 379(9823): 1320-1329.
52	Heise, L., et al. (2013). "Cash transfers for HIV prevention: considering their potential." <i>Journal of the International AIDS Society</i> 16(1).
53	Okoror, T. A., et al. (2014). "HIV Positive Women's Perceptions of Stigma in Health Care Settings in Western Cape, South Africa." <i>Health Care for Women International</i> 35(1): 27-49.
54	Ibid
55	Freire, P. (1970). <i>The pedagogy of the oppressed</i> . New York: Continuum.
56	Ibid
57	Klein, S. J., et al. (2002). "Interventions to prevent HIV-related stigma and discrimination: findings and recommendations for public health practice." <i>Journal of Public Health Management and Practice</i> 8(6): 44-53.
58	Sullivan, P. (2013). "Stigma, discrimination, and HIV: old problems, new thoughts." <i>The Lancet Infectious Diseases</i> 13(11): 925.
59	Cloete, A., et al. (2008). "Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa." <i>AIDS Care</i> 20(9): 1105-1110.
60	Leggett, T. (2001). "Drugs, sex work, and HIV in three South African cities." <i>Society in Transition</i> 32(1): 101-109.
61	Turnipseed, D. (2014). <i>Criminalization of Sex Work in South Africa: A Modern Day Violation of Human Rights and a Threat to the Efforts to Reduce HIV/AIDS Infections</i> . 142nd APHA Annual Meeting and Exposition (November 15-November 19, 2014), APHA.
62	Bekker, L.-G., et al. (2015). "HIV and sex workers 2 Combination HIV prevention for female sex workers: what is the evidence?" <i>The Lancet</i> 385: 72-87.
63	Mtewa, S., et al. (2013). "You are wasting our drugs": Health Service Barriers to HIV Treatment for Sex Workers in Zimbabwe." <i>BMC Public Health</i> 13(698): 10.1186.
64	Lurie, Mark N., et al. "The impact of migration on HIV-1 transmission in South Africa: a study of migrant and nonmigrant men and their partners." <i>Sexually transmitted diseases</i> 30.2 (2003): 149-156.
65	Richter, M., et al. (2014). "Migration status, work conditions and health utilization of female sex workers in three South African cities." <i>Journal of Immigrant and Minority Health</i> 16(1): 7-17
66	Hedden SL HA. Alcohol, Drug and Sexual risk Behaviour Correlates of Recent Transactional Sex Among Female Black South African Drug Users. <i>Journal of Substance Use</i> .2011; 16:57-67
67	DHIS 2012
68	SANAC 2014. NSP progress report 2012-2016

- 69 Ibid
- 70 Meade, C. S., et al. (2012). "Methamphetamine use is associated with childhood sexual abuse and HIV sexual risk behaviours among patrons of alcohol-serving venues in Cape Town, South Africa." *Drug and alcohol dependence* 126(1): 232-239.
- 71 Kalichman, S. C., et al. (2013). "Bringing it home: community survey of HIV risks to primary sex partners of men and women in alcohol-serving establishments in Cape Town, South Africa." *Sexually Transmitted Infections* 89(3): 231-236.
- 72 Woolf-King, S. E. and S. A. Maisto (2011). "Alcohol use and high-risk sexual behaviour in Sub-Saharan Africa: a narrative review." *Archives of Sexual Behaviour* 40(1): 17-42.
- 73 Ibid
- 74 García-Moreno, C., Jansen, H., Ellsberg, M., Heisie, L. & Watts, C. 2005. WHO multi-country study on women's health and domestic violence against women. Geneva: World Health Organization, 204.
- 75 Marta Rodriguez-Garcia et al, 2013. Innate and adaptive anti-HIV immune responses in the female reproductive tract. *Journal of Reproductive Immunology*
- 76 Ibid
- 77 Martin Hilber, A., et al. (2012). "Vaginal practices as women's agency in Sub-Saharan Africa: A synthesis of meaning and motivation through meta-ethnography." *Social Science & Medicine* 74(9): 1311-1323.
- 78 Ibid
- 79 Alcaide, M. L., et al. (2013). "An Intervention to Decrease Intravaginal Practices in HIV-Infected Women in Zambia: A Pilot Study." *Journal of the Association of Nurses in AIDS Care* 24(3): 219-226.
- 80 Shisana, O., Rehle, T., Simbayi, L., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., Davids, A. & Ramlagan, S. 2014. South African national HIV prevalence, incidence and behaviour survey, 2012. Cape Town.
- 81 Ibid
- 82 Roxby, A. C., et al. (2014). "A lifecycle approach to HIV prevention in African women and children." *Current HIV/AIDS Reports* 11(2): 119-127.
- 83 South African National AIDS Council, Progress Report on the National Strategic Plan for HIV, TB and STIs (2012-2016);2014.
- 84 Smith, J., et al. (2014). "The Distribution of Sex Acts and Condom Use within Partnerships in a Rural Sub-Saharan African Population." *PloS one* 9(2): e88378.
- 85 South African National AIDS Council, Progress Report on the National Strategic Plan for HIV, TB and STIs (2012-2016); 2014.
- 86 Stein, Z. A. 1990. HIV prevention: the need for methods women can use. *American Journal of Public Health*, 80, 460-462.
- 87 Ibid
- 88 Jewkes, R. K., et al. (2010). "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study." *The Lancet* 376(9734): 41-48.
- 89 Singh, D., et al. (2011). "Stigma, burden, social support, and willingness to care among caregivers of PLWHA in home-based care in South Africa." *AIDS Care* 23(7): 839-845.

- 90 Guerra, F. M. and L. C. Simbayi (2014). "Prevalence of knowledge and use of the female condom in South Africa." *AIDS and Behaviour* 18(1): 146-158.
- 91 Jewkes, R. K., et al. (2010). "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study." *The Lancet* 376(9734): 41-48.
- 92 Shisana, O., Rehle, T., Simbayi, L., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., Davids, A. & Ramlagan, S. 2014. South African national HIV prevalence, incidence and behaviour survey, 2012. Cape Town.
- 93 Jewkes, R. and R. Morrell (2010). "Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention." *Journal of the International AIDS Society* 13(1): 6.
- 94 Wong, L. H., et al. (2009). "Test and tell: correlates and consequences of testing and disclosure of HIV status in South Africa (HPTN 043 Project Accept)." *Journal of Acquired Immune Deficiency Syndromes* (1999) 50(2): 215.
- 95 Türmen, T. (2003). "Gender and HIV/aids." *International Journal of Gynaecology & Obstetrics* 82(3): 411-418.
- 96 Ibid
- 97 National Department of Health. District Health Management Information System Policy. Pretoria: National Department of Health, 2013.
- 98 Skovdal, M., et al. (2011). "When masculinity interferes with women's treatment of HIV infection: a qualitative study about adherence to antiretroviral therapy in Zimbabwe." *Journal of the International AIDS Society* 14(1): 29.
- 99 SANAC progress report on the NSP 2012-2016
- 100 Ibid
- 101 Padian, N. S., et al. (2011). "HIV prevention transformed: the new prevention research agenda." *The Lancet* 378(9787): 269-278.
- 102 Aweeka, F. T., et al. "Alteration in cytochrome P450 3A4 activity as measured by a urine cortisol assay in HIV-1-infected pregnant women and relationship to antiretroviral pharmacokinetics." *HIV Medicine* (2014).
- 103 Ibid
- 104 Heffron, R., et al. (2012). "Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study." *The Lancet Infectious Diseases* 12(1): 19-26.
- 105 Collazos, J., Asensi, V., Cartón, J. A. & Adherencia, G. E. P. E. E. M. D. L. 2007. Sex differences in the clinical, immunological and virological parameters of HIV-infected patients treated with HAART. *AIDS*, 21, 835-843.
- 106 Mosha, F., et al. (2013). "Gender differences in HIV disease progression and treatment outcomes among HIV patients one year after starting antiretroviral treatment (ART) in Dar es Salaam, Tanzania." *BMC Public Health* 13(1): 38.
- 107 Braitstein, P., et al. (2008). "Gender and the use of antiretroviral treatment in resource-constrained settings: findings from a multicenter collaboration." *Journal of Women's Health* 17(1): 47-55.
- 108 Masaisa, F., et al. (2011). "Anemia in Human Immunodeficiency Virus-Infected and Uninfected Women in Rwanda." *The American Journal of Tropical Medicine and Hygiene* 84(3): 456-460.
- 109 Monforte, A. d. A., et al. (2011). "Late presenters in new HIV diagnoses from an Italian cohort of HIV-infected patients: prevalence and clinical outcome." *Antiviral Therapy* 16(7): 1103-1112.

- 110 Loutfy, M. R., et al. (2013). "Factors affecting antiretroviral pharmacokinetics in HIV-infected women with virologic suppression on combination antiretroviral therapy: a cross-sectional study." *BMC Infectious Diseases* 13(1): 256.
- 111 Puskas, C. M., et al. (2011). "Women and vulnerability to HAART non-adherence: a literature review of treatment adherence by gender from 2000 to 2011." *Current HIV/AIDS Reports* 8(4): 277-287.
- 112 Collazos, J., et al. (2007). "Sex differences in the clinical, immunological and virological parameters of HIV-infected patients treated with HAART." *AIDS* 21(7): 835-843.
- 113 Hawkins, C., et al. (2011). "Sex differences in antiretroviral treatment outcomes among HIV-infected adults in an urban Tanzanian setting." *AIDS* 25(9): 1189-1197.
- 114 Nicastrì, E., et al. (2007). "Sex issues in HIV-1-infected persons during highly active antiretroviral therapy: a systematic review." *Journal of Antimicrobial Chemotherapy* 60(4): 724-732.
- 115 Bersoff-Matcha, S. J., Miller, W. C., Aberg, J. A., Van Der Horst, C., Hamrick, H. J., Powderly, W. G. & Mundy, L. M. 2001. Sex differences in nevirapine rash. *Clinical Infectious Diseases*, 32, 124-129.
- 116 Mildvan, D., Yarrish, R., Marshak, A., Hutman, H. W., Mcdonough, M., Lamson, M. & Robinson, P. 2002. Pharmacokinetic interaction between nevirapine and ethinyl estradiol/norethindrone when administered concurrently to HIV-infected women. *Journal of Acquired Immune Deficiency Syndromes* (1999), 29, 471-477.
- 117 Türmen, T. (2003). "Gender and HIV/aids." *International Journal of Gynaecology & Obstetrics* 82(3): 411-418.
- 118 Hamill, M., Ward, K., Pettifor, J., Norris, S. & Prentice, A. 2013. Bone mass, body composition and vitamin D status of ARV-naïve, urban, black South African women with HIV infection, stratified by CD4 count. *Osteoporosis International*, 1-7.
- 119 Ziske, J., Kunz, A., Sewangi, J., Lau, I., Dugange, F., Hauser, A., Kirschner, W., Harms, G. & Theuring, S. 2013. Hematological Changes in Women and Infants Exposed to an AZT-Containing Regimen for Prevention of Mother-to-Child-Transmission of HIV in Tanzania. *PloS one*, 8, e55633.
- 120 Gray, R. H., Li, X., Kigozi, G., Serwadda, D., Brahmbhatt, H., Wabwire-Mangen, F., Nalugoda, F., Kiddugavu, M., Sewankambo, N. & Quinn, T. C. 2005. Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study. *The Lancet*, 366, 1182-1188.
- 121 Trezza, C. R. and A. D. Kashuba (2014). "Pharmacokinetics of Antiretrovirals in Genital Secretions and Anatomic Sites of HIV Transmission: Implications for HIV Prevention." *Clinical Pharmacokinetics*: 1-14.
- 122 Contraceptive policy guidelines in South Africa 2013
- 123 Sevinsky, H., et al. (2011). "The effect of efavirenz on the pharmacokinetics of an oral contraceptive containing ethinyl estradiol and norgestimate in healthy HIV-negative women." *Antiviral Therapy* 16(2): 149.
- 124 Morrison, C. S., et al. (2012). "Hormonal contraception and the risk of HIV acquisition among women in South Africa." *Aids* 26(4): 497-504.
- 125 Ibid
- 126 Jones, H. E. & Schooling, C. M. 2012. Use of hormonal contraceptives and risk of HIV-1 transmission. *The Lancet infectious diseases*, 12, 509-510.
- 127 Ibid
- 128 Johnson, D., et al. (2011). "Hormonal contraceptive use and response to antiretroviral therapy among adolescent females." *HIV & AIDS Review* 10(3): 65-69.

- 129 Morrison, C. S., et al. (2012). "Hormonal contraception and the risk of HIV acquisition among women in South Africa." *Aids* 26(4): 497-504.
- 130 Hoffmann, C. J., Variava, E., Rakgokong, M., Masonoke, K., Van Der Watt, M., Chaisson, R. E. & Martinson, N. A. 2013. High Prevalence of Pulmonary Tuberculosis but Low Sensitivity of Symptom Screening among HIV-Infected Pregnant Women in South Africa. *PloS one*, 8, e62211.
- 131 KARIM, S. S. A., CHURCHYARD, G. J., KARIM, Q. A. & LAWN, S. D. 2009. HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *The Lancet*, 374, 921-933.
- 132 FISKE, C., GRIFFIN, M., ERIN, H., WARKENTIN, J., LISA, K., ARBOGAST, P. & STERLING, T. 2010. Black race, sex, and extrapulmonary tuberculosis risk: an observational study. *BMC Infectious Diseases*, 10, 16.
- 133 Hoffmann, C. J., Variava, E., Rakgokong, M., Masonoke, K., Van Der Watt, M., Chaisson, R. E. & Martinson, N. A. 2013. High Prevalence of Pulmonary Tuberculosis but Low Sensitivity of Symptom Screening among HIV-Infected Pregnant Women in South Africa. *PloS one*, 8, e62211.
- 134 Ibid
- 135 Karim, S. S. A., Churchyard, G. J., Karim, Q. A. & Lawn, S. D. 2009. HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *The Lancet*, 374, 921-933.
- 136 Hoffmann, C. J., Variava, E., Rakgokong, M., Masonoke, K., Van Der Watt, M., Chaisson, R. E. & Martinson, N. A. 2013. High Prevalence of Pulmonary Tuberculosis but Low Sensitivity of Symptom Screening among HIV-Infected Pregnant Women in South Africa. *PloS One*, 8, e62211.
- 137 Crampin, A., Glynn, J., Floyd, S., Malema, S., Mwinuka, V., Ngwira, B., Mwaungulu, F., Warndorff, D. & Fine, P. 2004. Tuberculosis and gender: exploring the patterns in a case control study in Malawi. *The International Journal of Tuberculosis and Lung Disease*, 8, 194-203.
- 138 Hoffmann, C. J., Variava, E., Rakgokong, M., Masonoke, K., Van Der Watt, M., Chaisson, R. E. & Martinson, N. A. 2013. High Prevalence of Pulmonary Tuberculosis but Low Sensitivity of Symptom Screening among HIV-Infected Pregnant Women in South Africa. *PloS one*, 8, e62211.
- 139 Thorson, A., Hoa, N., Long, N., Allebeck, P. & Diwan, V. 2004. Do women with tuberculosis have a lower likelihood of getting diagnosed?: Prevalence and case detection of sputum smear positive pulmonary TB, a population-based study from Vietnam. *Journal of clinical epidemiology*, 57, 398-402.
- 140 O'Donnell, M. R., Jarand, J., Loveday, M., Padayatchi, N., Zelnick, J., Werner, L., Naidoo, K., Master, I., Osburn, G. & Kvasnovsky, C. 2010. High incidence of hospital admissions with multidrug-resistant and extensively drug-resistant tuberculosis among South African health care workers. *Annals of internal medicine*, 153, 516-522.
- 141 Ibid
- 142 Ngadaya, E. S., Mfinanga, G. S., Wandwalo, E. R. & Morkve, O. 2009. Pulmonary tuberculosis among women with cough attending clinics for family planning and maternal and child health in Dar Es Salaam, Tanzania. *BMC Public Health*, 9, 278.
- 143 Ibid
- 144 Khan, M., Pillay, T., Moodley, J. M. & Connolly, C. A. 2001. Maternal mortality associated with tuberculosis-HIV-1 co-infection in Durban, South Africa. *AIDS*, 15, 1857-1863.
- 145 Grange, J., Adhikari, M., Ahmed, Y., Mwaba, P., Dheda, K., Hoelscher, M. & Zumla, A. 2010. Tuberculosis in association with HIV/AIDS emerges as a major nonobstetric cause of maternal mortality in Sub-Saharan Africa. *International Journal of Gynecology & Obstetrics*, 108, 181-183.

- 146 NDOH 2012. Enquiry on maternal deaths in South Africa Maternal deaths audit.
- 147 Mnyani, C. & Mcintyre, J. A. 2011. Tuberculosis in pregnancy. *BJOG: An International Journal of Obstetrics & Gynaecology*, 118, 226-231.
- 148 Zenner, D., Kruijshaar, M. E., Andrews, N. & Abubakar, I. 2012. Risk of Tuberculosis in Pregnancy: A National, Primary Care-based Cohort and Self-controlled Case Series Study. *American Journal of Respiratory and Critical Care Medicine*, 185, 779-784.
- 149 Hoffmann, C. J., Variava, E., Rakgokong, M., Masonoke, K., Van Der Watt, M., Chaisson, R. E. & Martinson, N. A. 2013. High Prevalence of Pulmonary Tuberculosis but Low Sensitivity of Symptom Screening among HIV-Infected Pregnant Women in South Africa. *PloS One*, 8, e6221
- 150 Casali, L. & Crapa, M. E. 2010. Women, immigration, poverty and tuberculosis. *Multidisciplinary Respiratory Medicine*, 5, 398.
- 151 Ibid
- 152 Stats SA, MDG report 2013. <http://beta2.statssa.gov.za/?p=1728>
- 153 <http://www.genderlinks.org.za/article/sadc-gender-protocol-2014-barometer-2014-07-25>
- 154 The Case Study as a Research Method: Spring 997 <https://www.ischool.utexas.edu/~ssoy/usesusers/l391d1b.htm>
- 155 Jewkes, R. & Morrell, R. 2012. Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises. *Social Science & Medicine*, 74, 1729-1737.
- 156 NDOH 2012a. Annual Report on Programme Performance 2011-2012 NDOH, 1, 50-58
- 157 Baker, R., Brick, J. M., Bates, N. A., Battaglia, M., Couper, M. P., Dever, J. A., Gile, K. J. & Tourangeau, R. 2013. Summary report of the AAPOR task force on non-probability sampling. *Journal of survey statistics and methodology*, smt008.
- 158 Napierala Mavedzenge, S., et al. (2011). "The Epidemiology of HIV Among Young People in Sub-Saharan Africa: Know Your Local Epidemic and Its Implications for Prevention." *Journal of Adolescent Health* 49(6): 559-567
- 159 Shisana, O., Rehle, T., Simbayi, L., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., Davids, A. & Ramlagan, S. 2014. South African national HIV prevalence, incidence and behaviour survey, 2012. Cape Town.
- 160 Ross, D. A., et al. (2006). "Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS Inter-agency Task Team on Young People."
- 161 Lee, L., et al. (2014). "Factors Informing HIV Providers' Decisions to Start Antiretroviral Therapy for Young People Living With Behaviourally Acquired HIV." *Journal of Adolescent Health* 55(3): 358-365.
- 162 Napierala Mavedzenge, S., et al. (2011). "The Epidemiology of HIV Among Young People in Sub-Saharan Africa: Know Your Local Epidemic and Its Implications for Prevention." *Journal of Adolescent Health* 49(6): 559-567
- 163 Pettifor, A. E., et al. (2011). "A Tale of Two Countries: Rethinking Sexual Risk for HIV Among Young People in South Africa and the United States." *Journal of Adolescent Health* 49(3): 237-243.e231.
- 164 Gordon, G. and V. Mwale (2006). "Preventing HIV with Young People: A Case Study from Zambia." *Reproductive Health Matters* 14(28): 68-79.
- 165 Tenkorang, E. Y. and E. Maticka-Tyndale (2014). "Assessing young people's perceptions of HIV risks in Nyanza, Kenya: Are school and community level factors relevant?" *Social Science & Medicine* 116(0): 93-101.

166 Winskell, K., et al. (2011). "Making sense of condoms: Social representations in young people's HIV-related narratives from six African countries." *Social Science & Medicine* 72(6): 953-961.

167 Shisana, et al. Gender and poverty in South Africa in the Era of HIV/AIDS

168 Feitsma, A. T., et al. (2007). "Experiences and Support Needs of Poverty-Stricken People Living With HIV in the Potchefstroom District in South Africa." *Journal of the Association of Nurses in AIDS Care* 18(3): 55-64.

169 Rodrigo, C. and S. Rajapakse (2010). "HIV, poverty and women." *International Health* 2(1): 9-16.

170 Thorson, A., et al. (2004). "Do women with tuberculosis have a lower likelihood of getting diagnosed?: Prevalence and case detection of sputum smear positive pulmonary TB, a population-based study from Vietnam." *Journal of Clinical Epidemiology* 57(4): 398-402.

171 Long, N. H., et al. (1999). "Different tuberculosis in men and women: beliefs from focus groups in Vietnam." *Social Science & Medicine* 49(6): 815-822.

172 Massad, L. S., et al. (2010). "Knowledge of cervical cancer prevention and human papillomavirus among women with HIV." *Gynaecologic Oncology* 117(1): 70-76.

173 Bekker, L.-G., et al. "Combination HIV prevention for female sex workers: what is the evidence?" *The Lancet* 385(9962): 72-87.

174 Silverman, B., et al. "Collaborating for consensus: Considerations for convening Coalition stakeholders to promote a gender-based approach to addressing the health needs of sex workers." *Evaluation and Program Planning*(0).

175 Jewkes, R. and R. Morrell (2012). "Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises." *Social Science & Medicine* 74(11): 1729-1737

176 Gruskin, S., et al. (2014). "HIV and gender-based violence: welcome policies and programmes, but is the research keeping up?" *Reproductive Health Matters* 22(44): 174-184.

177 Singh, G. K., et al. (2012). "Global inequalities in cervical cancer incidence and mortality are linked to deprivation, low socioeconomic status, and human development." *Int J MCH AIDS* 1(1): 17.

Tenkorang, E. Y. and S. Obeng Gyimah (2012). "Physical abuse in early childhood and transition to first sexual intercourse among youth in Cape Town, South Africa." *Journal of Sex Research* 49(5): 508-517.

178 Ibid

179 Pitpitan, E. V., et al. (2012). "Gender-based violence and HIV sexual risk behaviour: alcohol use and mental health problems as mediators among women in drinking venues, Cape Town." *Social Science & Medicine* 75(8): 1417-1425.

180 Warren Parker on SANAC Priorities for young people and HIV, presentation at a SANAC Workshop on 1 Dec 2013.

Notes

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