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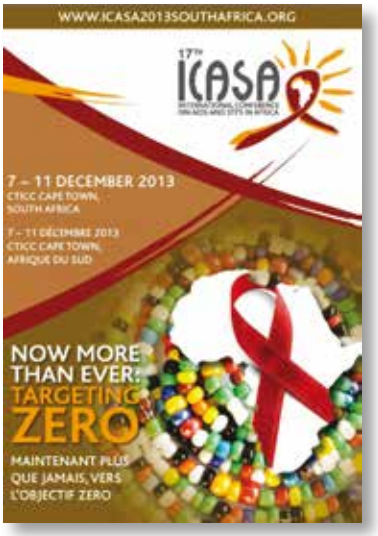
In Focus...

Gender, HIV, and treatment:

What is there to talk about?

The intersection between gender and HIV, and its devastating consequences for women, is by now well-documented, both nationally and globally.



South Africa's current and past National Strategic Plans on HIV, STIs and TB (NSP), as well as various other national and international bodies, including the International Community of Women Living with HIV/AIDS (ICW), South African National AIDS Council (SANAC), UNAIDS, and the World Health Organization (WHO), have acknowledged the deeply gendered nature of the effects of HIV.[1] It is widely accepted that poverty, social stigma, and lack of access to rights and services manifest in gendered ways and have disproportionately severe effects on the lives of women. Yet, despite repeated acknowledgement and despite government promises to address the '*feminisation*' of HIV, women's access to services, their ability to determine how their bodies are treated within the medical system and within national public health efforts, and their access to information and material resources that would allow them to make the most informed decisions about their own well-being continue to be extremely compromised.

Women attending state-run antenatal clinics continue to be the main population that the government derives its HIV prevalence data from and directs its HIV prevention efforts towards. Women who are pregnant '*constitute an easily identifiable, accessible and stable population*', making them the largest captive population available to government.[2] As a result, pregnant women are practically coerced into testing for HIV at antenatal clinics in South Africa. Women report that the move from the voluntary testing model to a provider-initiated model for HIV testing has resulted in even greater abuse of power by healthcare professionals, particularly nurses,

What's inside:

who routinely tell women that they have no choice, but to test for HIV, if they want to receive healthcare services.[3] Obviously, the socio-economically disenfranchised status of the vast majority of black women in South Africa means that the effects of HIV and of HIV prevention strategies are not only gendered, but also profoundly racialised and classed.[4]

Pregnant women are not the only ones being blackmailed into testing; the drive to meet the national goal of universal annual HIV testing, which is declared anew in each successive NSP, has resulted in all women facing pressure to test for HIV when they access public healthcare facilities. Often, the pressure to test is justified by claims that testing for HIV is for women's own benefit and by the discourse of '*responsibility*' – it is women's responsibility to test in order to prevent transmission to intimate partners, family members, and, crucially, in order to prevent mother-to-child transmission.[5] The discourse of responsibility and the corollary of it, that women who do not consent to being tested for HIV are selfish, promiscuous, and irresponsible women and mothers, make it almost impossible for women to freely exercise their right to give or deny consent to being tested. In the context of an epidemic that is feminised both in the sense that it affects women and girls disproportionately and in that the burden of providing unpaid or very poorly paid care to people living with HIV falls almost exclusively on women, the discourse of responsibility obscures women's fundamental rights to choose whether or not and when they will access testing and treatment services.[6]

Women on treatment

The coercion of women and the denial of their agency do not end with HIV testing. Once a woman who is pregnant tests HIV positive, she is placed on antiretroviral treatment after the first trimester (if her CD4 count is above 350), in order to prevent HIV transmission to the foetus. She may or may not be told what the CD4 count indicates but she certainly will not be told that she has the right to decide whether or not to take treatment. Thus, far too many women in South Africa find out that they are pregnant and HIV positive and are put on HIV treatment all in the space of a few days. Further, the lack of adequately trained staff in clinics and hospitals translates into poor or insufficient counselling. Women living with HIV who are not pregnant also face pressure to disclose their status and prevent transmission to their intimate partners.

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The new WHO guidelines adopted by South Africa that stipulate that people with CD4 counts of less than 350 should be '*encouraged*' to immediately begin treatment also undermine women's ability to decide whether or not they are prepared to start taking treatment. Although the law maintains that no one can be forced to either test or take treatment, the power imbalances between healthcare staff and women from resource-poor communities, and the impunity with which nurses and counselling staff abuse their power, translate into de facto coercion.[7]

Most of the discourse on treatment revolves around access to treatment. The literature acknowledges that women face particular barriers to accessing treatment – from logistical hurdles concerning lack of transport and childcare to economic and social barriers, including stigma and fear of rejection and

violence by male partners.[8] While some of the literature, notably by ICW, mentions the importance of addressing adverse side effects of ARV treatment on women, the bulk of the public discourse on treatment ignores the consequences of the side effects of treatment for women's self-esteem, health, livelihood, as well as the consequences for other women.[9] Women who complain to healthcare professionals about the side effects, particularly lipodystrophy, and seek to change their medication are told that they should be grateful to be alive, instead of complaining about trivial things such as body distortion.[10]

The dominant discourse on treatment paints it as an unmitigated good and seldom addresses the factors that enable or hinder women's ability to take treatment. Even the NSP recognises the deleterious effect of poor nutrition and poverty on people's ability to take treatment; yet, beyond unrealised promises of job creation and meagre grants, the government has consistently failed to alleviate the extreme poverty that characterises the lives of most black women in South Africa.[11] Beyond the economically precarious existence of the majority of black women, which forces them to '*hustle*' everyday just to ensure that they and their families have something to eat, the government's failure also results in a loss of dignity and self-worth among people, particularly women, arguably the most dangerous consequence of government impassivity, as it can lead over time to a loss of will to live.

The belief that HIV testing and taking treatment leads to behaviour change is not supported by women's life stories. Women state that in the absence of substantive change to the material conditions of their lives, characterised by poverty, lack of nutritious food, and lack of access to effective safer-sex measures that are in their control, testing HIV positive and being on treatment does not translate into behaviour change, as their economic needs remain as unmet after testing as before; if anything, their needs for healthy food, rest, leisure, bodily self-determination, and absence of stress increase upon testing positive for HIV. Further, the data from the National HIV Survey shows that about a third of all eligible participants are refusing to test their HIV status; this is not surprising, given the stigma, fear, and discrimination associated with HIV, and the increased economic burdens that follow HIV testing.[12]

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The strategy of forcing women to test and take treatment through applying social and peer pressure, however, appears to be backfiring. Anecdotal evidence suggests that women may be avoiding antenatal clinics when pregnant, choosing instead to give birth at home. Women who experience body distorting side effects may stop taking treatment, preferring to retain socially valued body shapes rather than being exposed as '*distorted*' HIV positive women. Because of the visible side effects of ARV treatment, particularly lipodystrophy, on other women's bodies, women who are recently diagnosed may choose to refuse taking treatment for fear that their bodies, too, will distort.

The insistence by counsellors that women disclose their HIV positive status to at least one person and bring along a '*treatment buddy*' in order to receive medication not only infantilises women, but also results in women foregoing treatment.[13] Moreover, the insulting

and demeaning attitude of healthcare staff, particularly nurses, towards HIV positive women, and their failure to maintain confidentiality also act as deterrents for women who may otherwise consider treatment. The stigma and discrimination attached to HIV, also feminised because of greatly uneven testing between women and men and because of the social devaluation of women as a whole, appear to be impossible to avoid in healthcare settings, both because of the infrastructure and because of the unprofessional behaviour by government employees.

In the light of the glaring absence of meaningful measures to address the structural, infrastructural, economic, social, and culturally sanctioned factors that promote gender inequality and maintain patriarchal systems that rely upon the exploitation of women's productive and reproductive labour, HIV testing, treatment, and prevention efforts aimed at women from resource-poor communities only exacerbate an already intolerable situation for black HIV positive women. In a socio-economic context in which most black women in South Africa have no options for being economically independent or self-sufficient and rely, at best, upon small grants and upon men for survival, testing and taking treatment may ensure that they live a little longer than they might otherwise have, but they do nothing to improve their quality of life.

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FOOTNOTES

1. Research conducted by local feminist advocacy organisations deepens the analysis of the gendered effects of HIV in South Africa. AIDS Legal Network. 2012. '*If I knew what would happen I would have kept it to myself': Gender Violence and HIV* [www.aln.org.za/article.asp?id=51]; One in Nine Campaign. 2012. '*We were never meant to survive': Violence in the lives of HIV positive women in South Africa*. [www.oneinnine.org.za]
2. [www.avert.org/south-africa-hiv-aids-statistics.htm]. Also see the National Strategic Plan for HIV, STIs and TB, 2012-2016, p22.
3. The issue of the erosion of informed consent in the context of provider-initiated, opt-out testing has also been documented. See Groves, AK. et al. 2010. 'The Complexity of Consent: Women's experiences of testing for HIV at an antenatal clinic in Durban, South Africa'. In: *AIDS Care*, Vol22, No5: pp538-544; and AIDS Legal Network, 2012.
4. This is true both domestically and globally, and it is reflected in the fact that more than two-thirds of the world's HIV positive population lives in sub-Saharan Africa. For a racialised breakdown of prevalence in South Africa see www.avert.org/south-africa-hiv-aids-statistics.htm.
5. AIDS Legal Network, 2012. While pregnant women are most vulnerable to the pressure to test, all women face this pressure, as healthcare staff are empowered to '*encourage*' all visitors to public healthcare facilities to test and as women make up the majority of the people in clinics.
6. Women and girls make up almost 60% of all people over the age of 15 living with HIV. One in three women between the ages of 25 and 29 is HIV positive, and about 30% of all pregnant women are HIV positive. For the predominance of women as caregivers, see the work of the Global Coalition on Women and AIDS at www.popline.org/node/233378 and www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub07/jc1279-gcwa-5_en.pdf.
7. For a summary of the research findings of AIDS Legal Network, 2012, see www.health24.com/Medical/HIV-AIDS/Women-and-HIV/HIV-testing-during-pregnancy-Human-Rights-for-Women-20120721.
8. International Community of Women Living with HIV/AIDS, Vision Paper 2, 2004, 'Access to Care, Treatment and Support (ACTS)'. [www.icw.org/Vision_Papers]
9. One in Nine Campaign, 2012, pp35-36.
10. Focus group discussions among HIV positive women at the One in Nine Campaign, 2013. Women report that beyond the direct effects of lipodystrophy, it also clearly and immediately signals women's HIV status, thereby violating their right to privacy and confidentiality. Disclosure, therefore, also ceases to be voluntary and in women's control.
11. The economic disenfranchisement of the majority of the population is intimately tied to the unjust distribution of land dating from the early twentieth century, the vast majority of which (about 80 per cent) still rests in the hands of white people. Lack of access to land has direct consequences for people's ability to sustain themselves, making them reliant on a small job market, mostly of demeaning and dangerous work.
12. [www.avert.org/south-africa-hiv-aids-statistics.htm]
13. Focus group discussions among HIV positive women at the One in Nine Campaign, 2013.

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Young peoples' voices…

Tyler Crone, Julie Mellin, Luisa Orza

A woman's body is not a war zone

There is so much stigma around HIV and AIDS, even now in 2013. It is still this dark cloud in our lives. Our families do not talk about it. How conservative they are. And infected people are sometimes treated as 'less'. Why is there so much shame? Why is sex not a topic of discussion with your children around the dinner table? Most parents only find out when their children become parents, that they are sexually active. Why?

[Bisexual young woman, Eastern and Southern Africa, GYCA-ATHENA consultation on SRHR and HIV, 2013]

As policy partners of Link Up[1], the Global Youth Coalition on HIV/AIDS (GYCA) and the ATHENA Network developed a virtual consultation and community dialogue process to create a platform for young people most affected by HIV to speak to their ***experiences, hopes, and vision*** for realising and claiming their sexual and reproductive health and rights (SRHR).

Our findings from across sub-Saharan Africa, and dialogues in Burundi, Ethiopia and Uganda, contribute to a growing body of evidence regarding the SRHR needs, rights, and priorities of young people living with and affected by HIV. Further, these findings represent a crucial step in ensuring that the voices of young people remain front and centre of the response to HIV, as African governments continue to refine, develop and implement their HIV response in a landscape of shifting global and regional priorities and financing opportunities.

Gender norms and sexual taboos present challenges for young people in general, and these are exacerbated for young people living with HIV and from key affected populations by stigma, discrimination and violence at the level of family/household, community and health services. Young women often lack the freedom to access family planning and contraceptives, for example, without parental consent, and young women living with HIV are often seen as people who are '*not supposed*' to have sexual relationships, creating a double barrier to contraceptive access. Policies which place age limits on family planning, HIV testing, and other sexual and reproductive health services, underpin these barriers to access.

Similarly, criminalisation – of HIV exposure and transmission, of same sex practices, and of sex work – is a strong disincentive for people living with HIV and from key affected populations to access SRH services, exacerbated by community curiosity, gossip, and disapprobation when it comes to young people exercising their sexual rights.

> *I no longer trust people at the centre of care, I'd go elsewhere because once I had an STI, the day after the doctor had consulted me, everyone knew my situation, I had become a subject of discussion.*

Frequent breaches of confidentiality, harassment, and discrimination at the health service level do nothing to assuage fears that health services may expose young people to humiliation and even arrest serve as further barriers to care.

Moreover, young people living with, or most at risk of, HIV are excluded from decision-making circles on the basis of their age, gender, HIV status, sexual orientation or gender identity, or on the basis of practices, such as sex work or drug use.

> *…young people especially in sub Saharan Africa have been completely ignored and left out in major programming and decision making processes.*

Young mothers living with HIV involved in community dialogues in Uganda had never met before as a group, and found the very experience of exchanging experiences – and more importantly, finding that their individual stories were not unique – extremely empowering.

> *Sharing personal experiences is powerful and renewing. Our stories show how human we are, they show that we laugh, we cry and have responsibilities just like any other human being especially the adults who despise us.*

As one young woman living with HIV commented, '*we need to be engaged, participate as productive citizens, and not as people who use ARVs, and wait for death.*'

So what are young people, especially those most affected by HIV, seeking to meet their sexual and reproductive health and rights visions and needs? What are the solutions they propose?

- *Human rights are the key to break gender based violence and domestic violence against MSM and LGBT to reduce HIV transmission.*

- [Create a] *safe world for young people; take away laws that violate women's rights, like forced sterilisation among women living with HIV. Make abortion legal to those who need it because it's not good to have unsafe abortion.*

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- *Protect property rights and strengthen social protection of women and girls living with HIV, including through safe housing and provision of shelter to women made destitute as a result of being HIV positive.*

- *Finance research based projects on sexual violence and the provision of a comprehensive medical legal package for survivors. Make society safe for women, young women specifically.…Teach young women how to protect themselves. And teach our young men how to handle themselves too and that a woman's body is not a war zone.*

- *I wish there was a law to protect the human and sexual rights of sex workers, and a law that encouraged sex workers to report any sexual abuse or sexual violence whenever it happens.*

- [Train] *health workers about the concept of transgender, how to reduce bias, responding to sexual violence, and specific health concerns to trans women.*

- [Make] *sexual and reproductive health services available within health clinics for young people. It is illegal in my country to have access to long-term contraception if you are below 18. Meaningfully and effectively involving young people in programming and decision-making. All players/stakeholders in health should prioritise this. Imposing programmes on young people without their say in designing them is old fashioned. It is very important to have young peoples' say in the initial stages of any programme you would love to have them be a part in implementation.*

FOOTNOTE:

1. Link Up is a five-country project and global initiative to advance the integration of HIV and sexual and reproductive health and rights for young people living with and affected by HIV.

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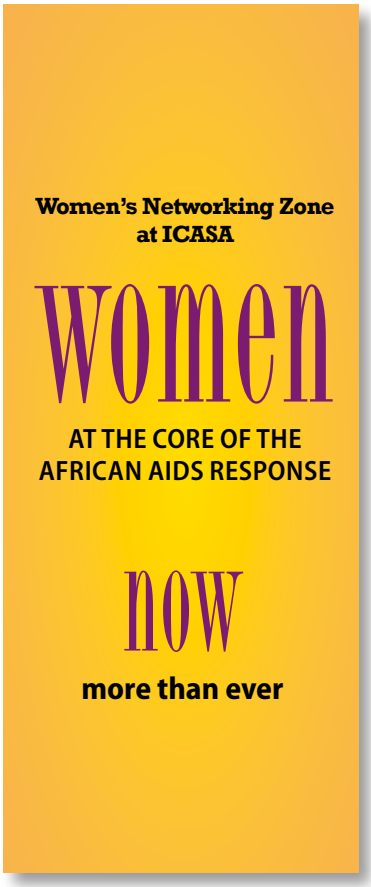
Women's Realities...

Sierra Mead

Female condoms and microbicides: How much control do women really have?

South Africa has one of the largest government funded public sector male and female condom distribution programmes in the world; a programme that promoted and distributed 1 billion male condoms and 11 million female condoms to service providers in 2011.[1]

Male condoms are readily available, which would ideally make them the most common, most accessible, and most useful method of HIV prevention. From a technical point of view, yes, male condoms are great: they are inexpensive, widely available, and prevent unintended pregnancies, and the spread of sexually transmitted infections, like HIV. Realistically however, male condoms are disproportionately available compared to female condoms, underutilised, and not a realistic prevention method for women seeking safer sex and the power to protect their bodies.



Women account for 60% of adults living with HIV in sub-Saharan Africa[2] and for women in South Africa, aged 25-29, the prevalence of HIV is 32.7%.[3] With these statistics, it is clear that efforts to promote abstinence, monogamy, or male condom use is not enough to effectively prevent the spread of HIV[4] and that women need protection that they personally can control, now more than ever. The female condom is a mirage; it seems as if it would be an ideal solution and an effective method to reduce these numbers but, in reality, there are too many barriers, like gender-based violence, expenses, lack of distributions, service provider attitudes, and lack of education, that keep women from utilising female condoms.

South Africa's National Contraceptive Policy lists male condoms as a '*core contraceptive method that should always be available in public sector facilities*', while the female condom is a '*method to be available in selected facilities*'.[5] When looking at condom distribution (remember in 2011, South Africa distributed 1 billion male condoms and only 11 million female condoms), there are discrepancies between female and male condom availability, favouring the male condoms and inadvertently giving the man a superior role in the sexual relationship. Unfortunately, when discussing condoms and other preventative measures, gender-based violence needs to be part of the conversation; in fact, numerous studies

…not a realistic prevention method for women seeking safer sex and the power to protect their bodies…

> *…have linked intimate partner violence with increased risk of HIV infection in South Africa, which has one of the highest rates of sexual violence worldwide.*[6]

Fortunately, the prevention research community has recognised the prejudiced gap in distribution, the restrictive nature of male condoms (for they do not give women control of the sexual encounter) and the male condom's inability to truly prevent the spread of HIV. Solutions for women are underway and spearheading this movement is the development of Microbicides. Microbicides are a relatively new development that could potentially help women avoid violent confrontations when it comes to protecting their body. Microbicide technology however, is too young to truly make a difference yet.

Condom availability, usage and barriers

In 1992, the South African National Department of Health (NDOH) implemented a national male condom programme that distributed male condoms through a range of non-governmental organisations.[7] The programme rebranded male condoms called '*choice*' that targets 18-35 year olds by repackaging the condoms in '*attractive colours*'.[8] Over 350 million male condoms were distributed annually in 2008 and 2009 through this programme.[9]

In 1998, the NDOH implemented the National Introduction of the Female Condom Programme, which expanded South African female condom distribution sites from 19 to 300 designated facilities today.[10] These facilities are primarily healthcare and clinical sites, but, as time goes on, non-governmental outlets have undertaken the task of distribution.[11] Unlike the male condom, female condoms were not given a '*flashy facelift*' to attract potential consumers and are

> *...only available directly through provider contact, not through condom cans and dispensers like the male condom.*[12]

The brazen discrepancy between male and female condom distribution aside, consistent condom usage, male or female, must improve, because '*male condom accessibility is reported to be high, with both youth and adults reporting they are easily accessible'*.[13] However, even with ample accessibility, usage remains limited.

When looking at usage of condoms, whether male or female, it is critical to examine exactly why usage is so inconsistent, as well as the impact of gender-based violence and women's inability to negotiate condom usage. Widening distribution of female condoms would

> *…increase women's choice of barrier methods, and some women may be better able to negotiate use of the female condom than the male condom.*[14]

Gender relations in South Africa are largely influenced by the socioeconomic inequalities that result in women being dependent on men, which, in turn, among other, '*reduces women's ability to control sexual encounters and condom use*'.[15] Male dominance is prevalent in social, economic and sexual realms; and with male condom distribution at such a higher rate than female condoms, women are put at a disadvantage to protect themselves, or negotiate condom use.

In 2012, AIDS Legal Network (ALN) conducted 2,354 surveys to gain a perspective on HIV-related violence and human rights abuses from different communities in South Africa, namely within the Eastern Cape, KwaZulu Natal, and the Western Cape. The research also focused on healthcare providers' perceptions and treatment towards women living

…favouring the male condoms and inadvertently giving the man a superior role in the sexual relationship…

with HIV. When asked about women living with HIV and their risk of violence and abuse, 36% of respondents indicated that

> *…women living with HIV would be 'abused', 'beaten by their partners', 'called names', and 'forced to have sex without a condom' and often subsequently experience a range of abuses.*[16]

Service providers who participated in the study also acknowledge

> *…the links between women insisting on condom use and the risk of violence, highlighting that the mere fact of women trying to introduce condom use in and of itself often causes various forms of abuse, ranging from accusations of being unfaithful and blaming women of not trusting their partners, to physical violence and forcing women to engage in sex without a condom.*[17]

Unfortunately, gender-based violence is not the only barrier keeping women from safer sex negotiations, but also discrimination from healthcare providers. The 2012 ALN research conducted concluded that access to healthcare is limited in the respect that women

> *…shared similar experience of ill-treatment by healthcare workers, and involuntary disclosure of their HIV status… women also spoke in depth about women avoiding going to the clinic and subsequently defaulting on their treatment as a result of healthcare providers' attitude.*[18]

The evidence clearly spells out that healthcare providers'

> *…attitudes and prejudices against women living with HIV not only limit women's access to quality healthcare free of fear, stigma and discrimination, but also deter women from accessing healthcare.*[19]

Women clearly do not always feel comfortable at clinics and other healthcare facilities and yet, these are the same providers that the South African government is relying on to distribute female condoms to women in need.

With discrimination against women both in the public health sector, as well as in the social context of South Africa, it is impractical for women to be able to rely on condoms as protection against HIV.

Additional prevention options

As mentioned before, there are possible advances for women to take charge of their sexual and reproductive health through the newly developing world of microbicides. However, even this solution may prove to be a feeble one.

Microbicides are emerging as potential tools women can use inconspicuously to protect themselves from HIV transmission through unprotected sex. This new science has potential to reduce the risk of HIV infection via sexual exposure but studies are still being conducted on their constancy and practicality.

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Microbicides come in different varieties, such as creams, gels, films, and vaginal rings[20] that are formulated with antiretroviral drugs. There are multiple ongoing trials on topical gel microbicides, vaginal rings, oral PrEP, and even as a preventative HIV Vaccine.[21] Because this technology is still developing, only a few completed trials can give us insight to the potential scientific advantages of microbicides. The social advantages however are clear: clearly female condoms are not as effective as they could be, and male condoms only perpetuate the gender inequalities between men and women. Microbicides, if proven effective, will act as an inconspicuous method of protection for women that are under threat of sexual

violence or unable to negotiate condom usage.

Tenofovir gel, the most promising microbicide currently being researched, was studied during the CAPRISA 004 trial. Tenofovir is an antiretroviral drug that is used to treat HIV. In 2010, the results showed that for 889 South African women

…the potential of microbicides cannot be understated…

> *…Tenofovir gel reduced women's risk of HIV infection via vaginal sex by 39 percent overall. Women in the trial were counselled to use the gel within 12 hours before and after sex*.[22]

Women who used the Tenofovir gel reduced their risk of contracting HIV by 39% compared to women who used the placebo gel.[23]

The National Institute of Health conducted the Microbicide Trials Network, or MTN-001, to examine differences in drug absorption, distribution, and elimination, as well as '*women's preference for and adherence to oral Tenofovir and Tenofovir gel*'.[24] The trial concluded that with daily use of Tenofovir gel, vaginal tissue drug levels were more than 130-times more than that of the oral tablet, suggesting that Tenofovir gel is significantly more effective than oral Tenofovir.[25] 94% of women said they like both products, but only 64% of participants took the tablets consistently.[26]

The VOICE (Vaginal and Oral Interventions to Control the Epidemic) trial was another evaluation that was conducted in South Africa, Uganda, and Zimbabwe in 2011. 5,029 women used both oral (pill form) or topical (gel form) of Tenofovir.[27] Halted in 2011, the trail showed that none of the interventions reduced the risk of HIV and that

> *…participants weren't using the interventions regularly enough to have detectable drug levels in their blood. This suggests that they didn't follow the daily regimen as prescribed*.[28]

Experts determined that while both the gel and tablets that were being tested in the trial were safe,

> *…neither was effective in preventing HIV compared to the matched placebos among the women in those groups, who were asked to use their assigned products daily*.[29]

The most important trial being conducted today is FACTS 001, which was launched in 2011 and expected to have results by 2014.[30] Because CAPRISA 004 has been the most encouraging trial to date, FACT 001 is testing the same dosing strategy and if results confirm the CAPRISA 004 results,

> *…the next step would be to present the data to regulatory authorities for possible product licensure and possible access*.[31]

Along with Tenofovir gel, the Dapirivine ring is being tested as a safe preventative measure that women can use. The Dapirivine ring is a vaginal ring that releases the antiretroviral drug Dapirivine over a course of four weeks.[32] This flexible plastic ring is ideal to deliver the antiretroviral drug, because it is virtually non-detectable and, therefore, give women the opportunity to take their sexual rights into their own hands. There are currently two ongoing trials to determine the safety and effectiveness of the ring to reduce the risk of HIV, ASPIRE and The Ring Study. Results from ASPIRE are expected in late 2014 and results from The Ring Study are expected in mid-2015.[33]

The potential of microbicides cannot be understated; it is possible that with this technology, women will be able to

finally have the ability to protect themselves from HIV regardless of whether or not their partner decides to wear a condom. Unfortunately, the technology is young and the preliminary results are mixed; not only are we unsure of whether or not topical or oral Tenofovir will prevent the transmission of HIV, but also if any microbicides can be proven to be effective. For any product, there would be substantial work to be done before it would be on the market, and women in need can access it. The product would have to be approved by national regulatory authorities, as well as international health organisations, like WHO.[34] Only after approval would manufacturing and licensing processes begin and national governments would need to develop budgets and plans to introduce the product to a global population.

Solutions for women?

In short, microbicides, along with female and male condoms, are not the solution for women. If, according to the National Contraceptive Policy, the '*core contraceptive method*' in South Africa is male condoms, how are women realistically expected to protect their body, or demand condom usage, in a situation that might lead to violence? Why are female condoms disproportionately represented in today's social climate as a nonviable prevention method? There are no licensed microbicides available today[35], and confirmatory research on the effectiveness of this new technology is not complete.

While it is noteworthy that prevention technologies for women are being developed, effective and easily accessible prevention strategies that place women in control remain to be urgently needed in today's social climate – and condoms are not enough.

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FOOTNOTES:

1. Match. Proc. of Developing a Strategy for Female Condom Parallel Programming, Durban, South Africa. Universal Access to Female Condoms Joint Programme, Nov. 2011. Web. 1 Nov. 2013. [www.match.org.za/news/Documents/Developing%20a%20Strategy%20for%20Female%20Condom.pdf]
2. 'Tenofovir Gel Wins Out in Drug Absorption Study, but HIV Prevention Trials Tell a Different Story'. Microbicides Trial Network, PLOS ONE, 30 Jan. 2013. Web1, Nov. 2013. [www.mtnstopshiv.org/node/4844]
3. Mags, BE, Smit, JA & Mantell, JE. 'Progress and Challenges to Male and Female Condom Use in South Africa'. NCBI. U.S. National Library of Medicine, 1 Mar. 2012. Web1 Nov. 2013. [www.ncbi.nlm.nih.gov/pmc/articles/PMC3286127/>. 51]
4. Microbicides Trial Network.
5. Mags et al.
6. *Ibid*, p56.
7. *Ibid*, p53.
8. *Ibid.*
9. *Ibid.*
10. *Ibid.*
11. Match, p6.
12. Mags et al, p53.
13. *Ibid*, p58.
14. *Ibid.*
15. *Ibid*, p57.
16. Kehler, J. et al. 2012. Gender Violence & HIV. Cape Town: AIDS Legal Network, 2012. p49. [www.aln.org.za/downloads/Gender%20Violence%20&%20HIV2.pdf]
17. *Ibid*, pp51-52.
18. *Ibid*, p34.
19. *Ibid*, pp34-35.
20. AVAC. Microbicides for HIV Prevention. Aug. 2013. Web. 1 Nov. 2013. [www.avac.org/ht/a/GetDocumentAction/i/51686]
21. *Ibid.*
22. *Ibid.*
23. Microbicides Trial Network.
24. *Ibid.*
25. *Ibid.*
26. *Ibid.*
27. AVAC.
28. *Ibid.*
29. Microbicides Trial Network.
30. AVAC.
31. *Ibid.*
32. *Ibid.*
33. *Ibid.*
34. *Ibid.*
35. *Ibid.*

Special report:
A *roadmap* to where...?

Michaela Clayton

The African Union roadmap on shared responsibility and global solidarity for the AIDS, TB and malaria response in Africa

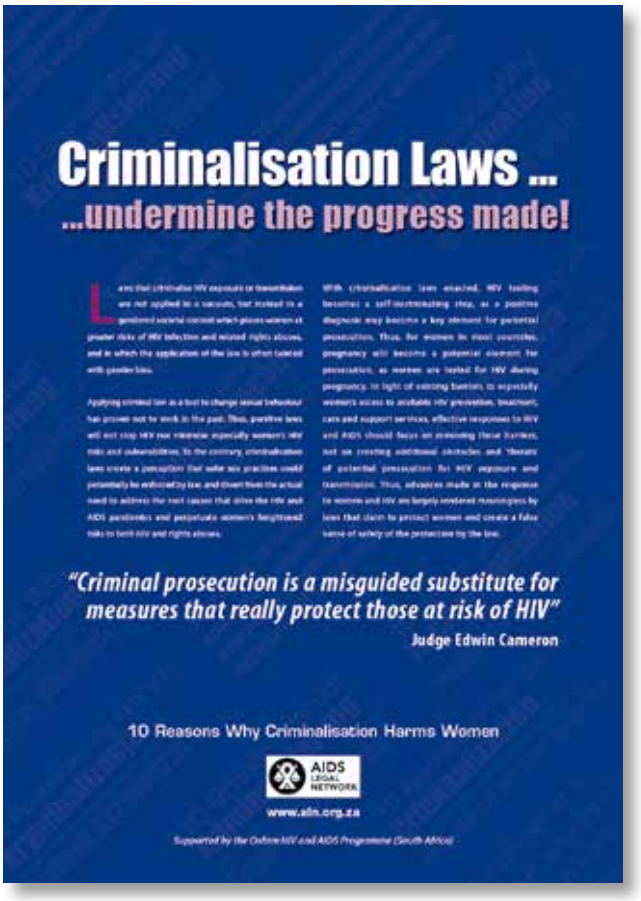
Adopted by the African Union in July 2012, and structured around three strategic pillars – diversified financing, access to medicines and health governance – the Roadmap offers a set of practical, Africa-owned solutions to enhance sustainable responses to HIV, TB and malaria.

It emphasises the importance of robust policy, oversight and accountability frameworks for investments in AIDS, TB and malaria, and defines goals, expected results, roles and responsibilities to hold the various stakeholders accountable for the realisation of these solutions between 2012 and 2015.

Of particular importance for advancing a human rights-based response to HIV is the third pillar on which the Roadmap is founded, which is ***enhanced leadership, governance and oversight to implement African solutions for AIDS in a sustainable manner with an emphasis on results, transparency and equity***. This is to be achieved through the use of strategic investment approaches which ensure more rigorous prioritisation and focus of HIV prevention investments geographically, by population and by intervention, as well as through ensuring that investments are efficient. In addition, the impact of basic programme investments will be increased by overcoming barriers to the adoption of evidence-based HIV policies and by addressing the factors that inhibit uptake.

Implementation risks and challenges

The Roadmap is certainly a step forward in moving towards an improved response to HIV, TB and malaria in Africa. From a human rights perspective it is significant that the Roadmap makes specific reference to the need for investment in programmes that support people and communities to prevent HIV, to know and claim their rights, and to enable effective participation in planning and evaluating programmes, as well as the need for ensuring legislative environments that make full use of TRIPS flexibilities. Also of significance is the fact that it proposes to increase the impact of basic programme investments by overcoming barriers to the adoption of evidence-based HIV policies and addressing factors that limit uptake.



However, there are certain risks associated with the

…successful HIV responses depend on interventions, which place human rights at the centre and promote the establishment and strengthening of an enabling legal, policy and social environment…

implementation of the Roadmap. The most significant of these is the fact that the Roadmap provides for increased country ownership. Whilst in principle this is a positive and much-needed development, in practice this may translate into many countries ignoring the needs of underserved populations, such as sex workers, men who have sex with men, people who use drugs, and detainees, in the design and financing of programmes, particularly given the fact that the Roadmap does not define key populations.

Over the past months there have been some disturbing indications that this is precisely the path being followed in several countries in southern Africa.

In August 2013, several SADC leaders lauded mandatory HIV testing as a viable strategy to curb the spread of HIV during a meeting of Heads of State and Governments under the banner of AIDS Watch Africa, held on the side-lines of the 33rd SADC summit in Lilongwe, Malawi.

In successive political declarations on HIV and AIDS, heads of state have acknowledged and committed to the full realisation of human rights and fundamental freedoms as crucial to the AIDS response, including eliminating discrimination against people living with HIV and key populations at higher risk of HIV, including men who have sex with men, sex workers and people who inject drugs, and ensuring the right to dignity, autonomy and confidentiality.

Despite this, unacceptably high levels of HIV-related stigma and discrimination and human rights violations at the hands of families, communities, law enforcement officials, healthcare providers and employers, as well as legal and policy frameworks, that fail to protect people living with HIV, women and key populations at higher risk of HIV, such as men who have sex with men and sex workers continue to present insurmountable barriers to HIV prevention efforts. It is, thus, not difficult to understand why it is so difficult for many to test for HIV and to access the HIV prevention and treatment services to which they are entitled.

Mandatory HIV testing will not address this problem. In fact, fears of mandatory testing and breaches of confidentiality drive individuals at higher risk of HIV away from testing services. Neither will mandatory testing ensure that people who need it can access life-saving antiretroviral treatment. While many countries in the region have significantly increased the numbers of people accessing treatment, only 5 countries have achieved coverage in excess of 80%. In fact the majority of countries in SADC are providing treatment to less than 60% of those who need it.

Thirty years into the HIV response, evidence has shown that successful HIV prevention interventions depend on an environment of safety in which people at risk of HIV can demand and seek services without fear of stigma, discrimination and abuse of their human rights. Successful HIV responses depend on interventions, which place human rights at the centre and promote the establishment and strengthening of an enabling legal, policy and social environment, in which all people who need it are able to access prevention services without discrimination.

Realities of regressive approaches

In April 2013, after appearing on a television programme and speaking out on how the protection of the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) people are crucial to addressing HIV in Zambia, Zambian human rights defender, Paul Kasonkomona, was

…a *'crackdown'* on sex workers and other marginalised communities also promotes a climate of fear and repression…

arrested and prosecuted under Section 178(g) of the Zambian Penal Code, which provides that '*every person who in any public place solicits for immoral purposes*' is deemed an idle and disorderly person, and liable to imprisonment for one month or to a fine. Apart from being a gross violation of his right to freedom of expression, Kasonkomona's arrest and charge are particularly concerning given that he was merely espousing the implementation of an evidence-based response to HIV, as contemplated in the Roadmap.

More recently in November 2013, the Botswana government has embarked on a campaign to arrest, detain and deport sex workers in its effort to curb HIV and AIDS in the country. The Botswana government's '*Draft Strategies to Address Key Populations*' has been reported by local and international media to include a recommendation to detain sex workers and deport '*foreign sex workers*'. This has materialised with the arrest of at least 30 women suspected of being sex workers earlier this month, some of whom the Botswana Police Services has confirmed are now under the custody of Botswana's Department of Immigration for possible deportation.[1]

Detaining women presumed to be sex workers violates the right to be free from arbitrary arrest or detention. A '*crackdown*' on sex workers and other marginalised communities also promotes a climate of fear and repression that wrests control from sex workers over their working conditions, discourages sex workers from carrying condoms and accessing sexual health services, and ultimately undermines any effort to address HIV. The Global Commission on HIV and the Law, tasked with making recommendations for rights-based law and policy in the context of HIV, has found that laws that penalise or criminalise sex work contribute to working conditions that increase sex workers' vulnerability to HIV.[2]

Rather than promoting a strategy that violates the human rights of Botswana's most marginalised communities, and undercuts an effective response to HIV, the government of Botswana should be focusing its efforts on removing barriers to the uptake of services by key populations.

Where to from here?

According to the UNAIDS 2013 report on the HIV epidemic in eastern and southern Africa, there has been a 30% reduction in new HIV infections between 2001 and 2011, as well as a 50% reduction in new child infections between 2001 and 2011 in the region. Introducing regressive approaches, such as mandatory testing, the prosecution of those advocating for evidence-based responses to HIV for men who have sex with men, and the arrest and deportation of sex workers that go against evidence of what works, carries with it a real risk of negating the gains made.

…we should all be seeking more effective and efficient ways of addressing HIV prevalence in the region…

During this time of dwindling resources for HIV interventions, we should all be seeking more effective and efficient ways of addressing HIV prevalence in the region. The Roadmap provides us with a vehicle for increasing the impact of basic programme investments by overcoming barriers to the adoption of evidence-based HIV policies and addressing factors that limit uptake. Let us use the Roadmap to call on governments in the region to focus on strategic investments and evidence-based responses that have been proven to work, such as addressing existing legal, social and economic barriers, as well as the range of human rights violations that fuel HIV vulnerability and impede access to testing, particularly among women and groups at higher risk of HIV.

FOOTNOTES:

1. Dube, M. 2013. 'Botswana starts purge against sex workers'. In: *Daily Nation*, November 6, 2013.
2. Global Commission on HIV and the Law. 2012. *HIV and the Law: Risks, Rights & Health*, p38.

Michaela is with the AIDS & Rights Alliance for Southern Africa (ARASA). For more information: michaela@arasa.org.na.

On the margins…

Leigh Ann van der Merwe

We are not fully recognised by our leaders

Transgender women encounter many different forms of violence from physical and emotional abuse to economic deprivation. There are well documented cases on violence against transgender women. Duanna Johnson and Gwen Araujo's cases are the embodiment of society's intolerance of gender diversity.

In South Africa and other parts of the African continent, our sisters die in large numbers as the result of HIV, as we are not fully recognised by our leaders. This will not change until we are recognised; epidemiological counts of HIV incidence and prevalence among trans women are conducted; and effective evidence-based programming is developed, that takes into account our unique needs as trans women. The conflation of trans women with MSM statistics is fundamentally flawed and pose a threat to the health and well-being of transgender women.[1]

While Gwen and Duanna's cases have helped us highlight the intolerable levels of violence against transgender women, it is sad that we have to continuously cite American cases of violence against transgender women. The cases worthy of media reporting and documentation are the ones sensational enough with blood, scars and murder. While we are not giving any less significance to these cases involving violence, there should also be a focus on the cases unspoken of and undocumented cases of HIV affecting African transgender women in large numbers. Trans women globally are infected with and affected by HIV, but even more so in the African context, due to the failure of African leaders to fully recognise trans women, and their specific HIV-related realities and risks.

The violence perpetuated by state actors often goes unnoticed, undocumented and unaccounted for. Our focus should be on the lack of effective HIV programming in a context characterised by high HIV prevalence. A recent reporte indicated that there is an infection rate of 19% of HIV among transgender women. However, the report lacks data from the African continent for a number of reasons. Ranking top among those reasons is the flawed approach of including transgender women in MSM (men sleeping with men) HIV response. Second to that would be the denial of African leaders of the existence of transgender women, and the issues persistently being framed as a sexual orientation issue, instead of being framed as a gender issue. Last, but not the least, would be the legal, structural and economic

barriers that transgender women encounter in accessing health services.

The current National Strategic Plan (2012 – 2016) for HIV/STI's and TB lists transgender people as a key population for HIV interventions, yet has no targeted programming for this vulnerable population. It is inadequate in its response to the issues faced by transgender women. This is highly problematic in a country where most transgender people still battle to access hormones and other forms of gender affirming therapies. While there is no reliable statistics on the prevalence of HIV among transgender women in South Africa, there also exists little to no information on the ways in which HIV impacts on transgender women, and on the continuum of transition. The issues of vulnerability to HIV pre- and post-surgery, as well as drug interactions between feminising hormones and ARV's, is one of the issues that need to be the cornerstone of this much needed and long overdue conversation. In addition, there is also a dire need to frame transgender women's health as a basic human right, position it in a broader sexual and reproductive health and rights context and response, which is clearly situated away from the responses to MSM.

…the flawed approach of including transgender women in MSM (men sleeping with men) HIV response…

…little to no information on the ways in which HIV impacts on transgender women, and on the continuum of transition…

There are simply not enough accountability mechanisms for government concerning the sexual and reproductive health and rights of minority groups, such as transgender women. We are thus appealing to the South African, as well as other leaders on the African continent, to initiate dialogues on the specific realities, risks and health needs of transgender women to ensure not only a better understanding of the very same, but also that subsequent design and implementation of programmes for transgender women is informed by such efforts.

FOOTNOTE:

1. Leigh Ann van der Merwe, Coordinator of S.H.E., 20 November 2013. For more information www.transfeminists.org.

Leigh Ann is with S.H.E. Feminist Collective of Transgender and Intersex Women of Africa. For more information: transfeminists@gmail.com.

Janet Nakuti, Cady Carlson

Regional Innovations...

Power and benefits...

Learning what it takes to prevent HIV

In sub-Saharan Africa, young women (ages 15-24 years old) are up to 8 times more likely to be infected with HIV than young men of the same age. The reason for this imbalance is not only caused by biological factors, but largely due to women's lack of power in their relationships.

Women who lack power in their relationships with men are less able to negotiate condom use, discuss multiple sexual partners, go for HIV testing, or receive care if they are HIV positive. However, traditional HIV prevention approaches have not necessarily focused on the imbalance of power between men and women. Our work in preventing violence against women has brought to the forefront the connection between violence, HIV and power imbalances between men and women.

Violence against women is both a cause and consequence of HIV. Men's use of violence against women puts women at increased risk of HIV. In addition, women who tell their male partners that they are HIV positive are often blamed for bringing the virus into the relationship, and put at increased risk of violence. Even men who know that it was themselves who brought HIV into the relationship, or had HIV before this relationship will often still blame women for '*misbehaving*' and '*forcing*' them to seek sex outside the relationship. The underlying factor contributing to this connection between violence against women and HIV is women's lack of power in relationships.

...indeed, changing social norms can seem overwhelming...

The power imbalance between men and women is deeply rooted in societal norms that uphold men's worth and authority over women. Although the need to address the underlying social norms in the prevention of HIV and violence against women has been recognised, many people find it a daunting task. Indeed, changing social norms can seem overwhelming. But, our experience has shown us that it is possible through a systematic, benefits-based approach that engages community members in discussions and critical reflection on power in relationships. We have integrated these approaches into an approach called SASA!

...to inspire, enable and structure effective community mobilisation and activism...

Addressing the link between HIV and violence against women through SASA!

SASA! is a methodology for addressing the link between violence against women and HIV by focusing on the

community social norms that uphold men's power over women. SASA! is meant to inspire, enable and structure effective community mobilisation and activism. Sasa is a Kiswahili word that means *now*. The term was chosen to emphasise the urgency of the problem and the need to act now. At its core, SASA! is an exploration of power – what it is, who has it, how it is used, how it is abused, and how power dynamics between men and women can change for the better.

The methodology is organised into four phases based on the Stages of Change Model. (SASA! also serves as an acronym for the phases of the approach: **S**tart, **A**wareness, **S**upport, and **A**ction.) During the first phase, *Start*, community members are encouraged to begin thinking about violence against women and HIV as interconnected issues and foster power within themselves to address these issues. The second phase, *Awareness*, aims to raise awareness about how communities' acceptance of men's use of power over women, fuels the dual pandemics of violence against women and HIV. Next, during the *Support* phase, community members focus on how they can support women experiencing violence, men committed to change, and activists speaking out on these issues by joining their power with *'others'*. During the final phase of *Action*, men and women take action using their power to prevent violence against women and HIV. Violence against women concerns and affects us all and hence the need for collective responsibility.

> …focusing on power and taking a benefits-based approach…

> …the language of power is provocative and minimises defensiveness of individuals about the problem and focuses the discussion on the issue regardless of context…

SASA! is based on the understanding that violence against women and HIV does not occur in isolation, but within families, communities, and societies. Thus, the approach encourages engagement at each of these levels using multiple strategies to reach diverse groups in different ways. The strategies used in SASA! include Local Activism, Media & Advocacy, Communication Materials, and Training. These various strategies are intended to reach different groups of the community more than once, since people need to hear or engage with new ideas more than once before they start to fully understand. Through our work we have learned that two key components are particularly important in understanding how to effectively prevent HIV: focusing on power and taking a benefits-based approach.

Why the emphasis on power?

At one time or another everyone has experienced either having more or less power than another person or group. By critically reflecting on these experiences and how they make us feel, everyone can relate to the concept of power and the challenges that an imbalance of power can have in our relationships and communities. The language of power is provocative and minimises defensiveness of individuals about the problem and focuses the discussion on the issue regardless of context. SASA! begins with personal reflection, questions, and conversations about power as a general issue in our lives and then brings the focus to power in relationships between men and women. We can all relate to challenges in relationships around communication and decision-making. If one person feels that their voice or opinion is not being heard by the other, SASA! helps people recognise how that might be rooted in an imbalance of power. The next step is to examine the ways that challenges in communication and decision-making

around sex, relationships and health can lead to increased risk for HIV and violence. Through this process of critical reflection and consciousness-raising – not just information giving or messaging – people begin to construct a narrative or story that is relevant to their own lives. This approach differs from some traditional HIV prevention programming that tends to provide information, simplistic solutions or talk about the problem of HIV in the abstract. Framing the discussion around power creates a story that people can relate to and better understand how they too could be affected.

We have found that a critical reflection on power has the potential to prevent HIV and violence against women in several ways. When people see how these issues can relate to their own life, they will naturally become more concerned with the need to address these issues in their own lives. For example, people may see that improved communication with their partner, such as negotiating safer sex, will ultimately protect them both from HIV. In addition, people will also start to see others who face these challenges with more empathy and less stigma, hence reducing levels of blame. Self-reflection on power in one's own life often gives people a sense of empowerment. By empathising with others and seeing these issues as linked to larger power imbalances and social injustice, people also often start to feel a sense of responsibility to make changes in their communities. Through this process, SASA! is meant to inspire, enable and structure effective community mobilisation and activism.

…a critical reflection on power has the potential to prevent HIV and violence against women…

Taking a benefits-based approach

Another aspect of the work that we have found critical is a benefits-based approach to talking about violence against women and HIV. Stigma and despair often exists around these issues, making it a taboo subject that people feel ashamed or reluctant to discuss. When we do discuss HIV and violence against women, the associated stigma makes it easy to fall into a pattern of blaming and shaming others. Instead of talking about why these problems are harmful and who we should blame, SASA! emphasises the positive effects of balancing power together – not just between men and women, but as a community. These positive effects include better couple communication, healthier and well-adjusted children and families, stronger community ties, and improved opportunities for economic development at different levels. By discussing the positive outcomes of sharing power it also injects a sense of hope and optimism into the HIV discussion when there is often not much hope to be found. Eliciting optimism, reducing stigma, blame and reclaiming power ultimately encourages a sense of motivation and courage that people can make their communities stronger. And this will be seen in couples making decisions together particularly around HIV testing and care.

…self-reflection on power in one's own life often gives people a sense of empowerment…

More to learn

As part of our effort to continue learning about SASA! and the key components of the approach, we recently collaborated with the Center for Domestic Violence Prevention (CEDOVIP) and London School of Hygiene and Tropical Medicine to conduct a cluster randomised controlled trial (RCT) evaluating the impact of SASA! on preventing violence against women and sexual risk behaviours associated with HIV in Kampala, Uganda. Preliminary study results have indicated the success of SASA! at reducing levels of community acceptability of violence, reducing

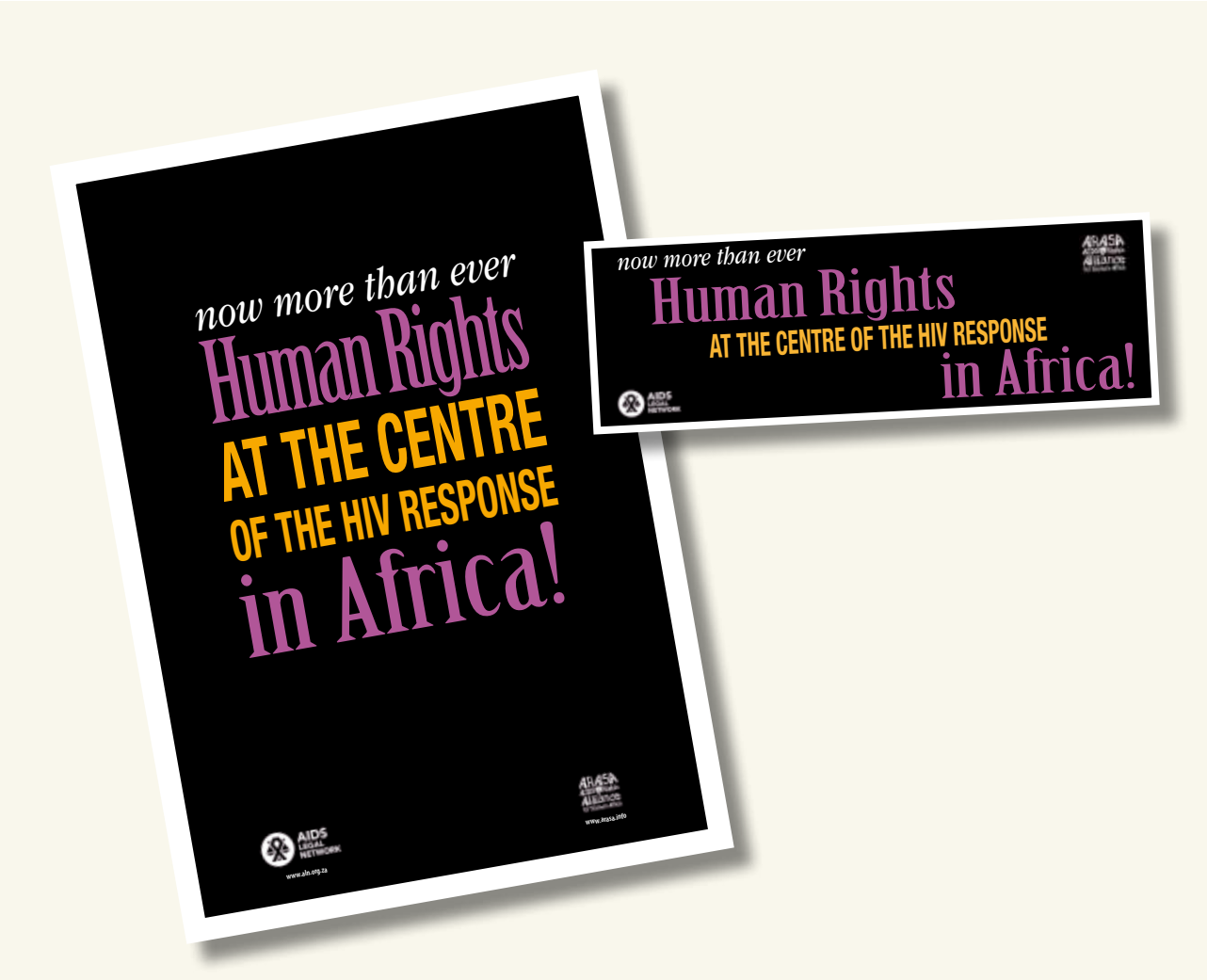
physical violence against women in intimate relationships, reducing men's number of concurrent sexual partners, and improving communication within couples.

SASA! is currently being adapted and implemented in several countries in Africa, as well as Haiti. This allows us the opportunity to continue understanding these concepts and how to best use these strategies when engaging with diverse communities and contexts.

…eliciting optimism, reducing stigma, blame and reclaiming power ultimately encourages a sense of motivation…

While we still have much to learn about the impact that SASA! can have on communities in different contexts and exactly how these changes occur, these results suggest the importance of addressing the power imbalance between men and women in the reduction of violence against women and HIV.

Janet and Cadi are with Raising Voices. For more information: janet@raisingvoices.org.



In my opinion…

Anna-Marie de Vos

Unthinking prejudicial mindsets…

In the course of my career at the bar I have often had to deal with unsavoury jokes and comments around issues of race and gender, which I have always found deeply offensive, and, which I believe, would be equally offensive to any right minded person.

Because of my strongly held convictions (and my personality) I have always found myself unable to keep quiet in the face of such prejudice, often thinly disguised as humour.

On 19 November 2013, while appearing in a case at the Supreme Court of Appeals, I once again found myself confronted by a comment, which offended me so deeply that I feel the need to make a statement regarding the so called *'jokes'* current amongst certain members of a profession, which is supposed to uphold the values of society against exactly such prejudices as these.

In the course of a case (which was going against me), I made a certain concession. During the tea break the opposing council, asked me to confirm that I had indeed made the concession. When I answered *'yes',* he responded by saying that *'if only women would make more concessions, there would be fewer cases of rape'.*

I was tempted to physically assault the man, but restrained myself and swore at him instead, and then excused myself as I was shaking with anger and disgust.

Realising how deeply he had offended me, he approached me and apologised, saying he had been joking and suggesting that he had been insensitive, as perhaps I myself had been a rape victim (which would then explain my *'irrational'* emotional reaction.) This only angered me more, and I pointed out to him that rape can never be a joking matter.

There is nothing humorous about rape. Ask any rape victim.

…a profession, which is supposed to uphold the values of society against exactly such prejudices as these…

…to disengage from these kinds of unthinking prejudicial mindsets…

In a country, such as ours, where abuse of women and children has reached epidemic proportions, it is the duty of those who have been put in a position to protect and defend the victims of such abuse to disengage from these kinds of unthinking prejudicial mindsets.

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Supporting women to prevent HIV…

FHI360, Sonke Gender Justice Network

Gender issues to consider in future microbicide programmes

Microbicides – which are still being tested in clinical trials – were originally conceived as a woman-initiated HIV prevention method.[1] If proven effective, microbicides would be the first HIV prevention product that women could use with or without their partner's knowledge.

Keeping gender on the agenda

Women, however, will likely face many gender-related barriers to accessing and adhering to microbicide products. To maximise microbicides' potential, these barriers must be identified and addressed in advance of rolling-out a product.

In April 2013, with support from USAID, FHI 360 conducted a gender analysis in Kenya and partnered with Sonke Gender Justice Network to conduct a gender analysis in South Africa. The analysis included a desk review, as well as nearly 40 interviews with government officials, NGO staff, healthcare providers, and funders in South Africa, to identify the key gender issues to address in future microbicide programmes.[2]

Central findings of this analysis include:

- Microbicides should be ***offered to all women*** *and* ***marketed to both women and couples***. Offering microbicides only to women perceived as high-risk is likely to stigmatise the product and ultimately make it less accessible to some of the groups that could most benefit, such as married women and adolescent girls.

  Microbicides should be for all women because otherwise our concept of the right to choose does not work if I then have to prove my demographic.

- To account for cost and travel barriers that women may face, microbicides ***should be subsidised*** and ***offered in health facilities that women already access*****.** If possible, microbicides should be **offered outside of clinics** in the future**.**

- ***Women have the right to decide whether or not to talk to their partners about microbicide*** **use** after being counselled at the clinic. Women know their partners best and should be supported to do what they think is best in their relationships. Healthcare providers

…offering microbicides only to women perceived as high-risk is likely to stigmatise the product…

should be trained on ***gender sensitivity***, intimate partner ***violence screening and referral***, ***adherence counselling***, and ***negotiation skills*** for enhanced partner communication.

- There is a need for ***safe spaces*** for women to discuss these issues with one another.
- Marketing should include: (1) microbicides' value for ***general sexual health***, (2) the ***specific HIV-related benefits*** of a microbicide, and information about the hierarchy of HIV protection (that is, condoms are still the most effective HIV prevention product, and microbicides should ideally be used with condoms, or in situations when condom use is not feasible), and (3) the potential for ***additional sexual pleasure*** from the gel as a lubricant.

> *Sexual pleasure should be promoted as a benefit– especially for women since pleasure is now just about men. We need to pay more attention to pleasure for women.*

> *We are in all the mess that we are in because of how stigmatised sex is, so yes,* [sexual pleasure] *should be part of messaging for microbicides… Currently, HIV prevention focuses on 'protect yourself, security' not pleasure.*

- Acceptance of a woman-initiated HIV-prevention method is ultimately related to overall gender norms in a given community. Engaging both women and men in ***critical examination of gender norms*** from an early age is paramount to promoting women's and men's health and well-being.
- ***Engaging men*** in programmes could promote acceptance and adherence to microbicides and improve relationships through increased communication about sex.

…women…should be supported to do what they think is best in their relationships…

While these findings are specifically related to the potential roll-out of microbicides, many of them have immediate relevance for existing sexual and reproductive health programmes, such female condom programmes, contraceptive access initiatives, and programmes that provide services to survivors of gender-based violence.

> *We have done this before from polio to condoms. It's not rocket science to campaign; what is difficult is the social argument. We need to marry the science with the social. We need to normalise the use of it and that makes it an easier sell.*

FOOTNOTES:

1. Stein, ZA. 1990. 'HIV prevention: The need for methods women can use'. In: American Journal of Public Health, April 1990. Vol.80, No.4, pp460-462.
2. For copies of the final report, please contact laura@genderjustice.org.za.

For more information: Tian Johnson at tian@africanalliance.org.za or Laura Pascoe at laura@genderjustice.org.za.

Upcoming events...

SATURDAY, 07 DECEMBER 2013

15:30-16:30 *Community Village Opening Ceremony* Community Village

17:30-18:20 *Cultural Opening* Plenary Hall

18:20-20:30 *Opening Session* Plenary Hall

SUNDAY, 08 DECEMBER 2013

08:45-10:15 *Sunday Plenary Session* Plenary Hall

10:15-12:15 *Rights, violations and redress* MR 4

11:30-13:00 *Some say female condoms will never work, why persist? What do YOU say?* Community Village, Main Stage

14:45-16:15 *Leadership for Change: Global Plan Towards the Elimination of the New HIV Infections by 2015 and Keeping Mothers Alive* Auditorium I

We are the women: The position, responsibility, and history of women in the AIDS epidemic MR 6

16:45-18:15 *Secrets and Lies: HIV and counselling* Ballroom East

Women and children first: Reverting new infections among children and keeping mothers alive Plenary Hall

Risks and challenges for vulnerable key populations Auditorium II

MONDAY, 09 DECEMBER 2013

08:45-10:15 *Monday Plenary Session* Plenary Hall

10:45-12:15 *Realising the sexual health and rights of LGBTi people in Africa* Plenary Hall

Who is 'the other'? Prevention programmes for specific groups MR 6

12:45-14:15 *Monitoring policy advocacy related to HIV and key populations: Concepts and approaches* Auditorium II

16:45-18:15 *Biomedical options for HIV prevention: Views, practices and successes* MR 4

TUESDAY, 10 DECEMBER 2013

08:45-10:15 *Tuesday Plenary Session* Plenary Hall

10:30 *Human Rights March*

10:45-12:15 *African women leadership for the HIV response: Myth or reality?* Ballroom West

11:30-13:00 *They say condoms encourage young people to have sex. What do YOU say?* Community Village, Main Stage

13:15-14:45 *Human rights* Community Village, Main Stage

14:45-16:15 *Access to SRH rights and friendly services for adolescents and young people* Auditorium I

Understanding the Global Fund New Funding Model MR 6

16:45-18:15 *Understanding and addressing stigma and discrimination breaking barriers* Auditorium I

Gender-based violence and HIV in Africa: Impact on girls Ballroom West

WEDNESDAY, 11 DECEMBER 2013

08:09:30 *Wednesday Plenary Session* Plenary Hall

10:00-11:30 *Involving FBOs in achieving Zero stigma and discrimination* Ballroom West

Religion, sexuality, and HIV Auditorium I

The role of health systems in improving care and support for PLWHIV MR 4

12:00-13:30 *Sex Workers: Rights, access and uptake in an environment of criminalisation* MR 6

14:00-15:30 *Recommendation of the Global Commission on HIV* Auditorium I

'Nothing about us, without us': A toolkit for injecting drug users MR 6

Research and collaborative action to improve young people's sexual and reproductive health in South Africa: A National Teenage Pregnancy Campaign MR 4

14:30-16:00 *Female condoms now and in the pipeline* Community Village, Main Stage

16:00-17:30 *Rapporteur and Closing Session* Plenary Hall

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