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

UNGASS AIDS FORUM SOUTH AFRICA

MONITORING THE UNGASS GOALS ON SEXUAL AND REPRODUCTIVE HEALTH

REPORT ON PROGRESS TOWARDS THE UNGASS GOALS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

UNGASS FORUM | FEBRUARY 2010

CONTENTS

		PAGE
EXECUTIVE SUMMARY		1
INTRODUCTION		6
SECTION I	Overview of the national health system and public policies in the fields of sexual and reproductive health and HIV/AIDS	10
SECTION II	Sexual and Reproductive Health Services	41
	[A] EDUCATION, INFORMATION, COMMUNICATION IN SEXUAL AND REPRODUCTIVE HEALTH	41
	[B] SEXUAL AND REPRODUCTIVE HEALTH CARE	54
	[C] ADDRESSING VIOLENCE AGAINST WOMEN	92
SECTION III	Allies, opportunities and Integration	53
ANNEX A	Questionnaire used for this report	106

TABLE 1: LINKAGES OF THIS REPORT WITH THE UNGASS INDICATORS
TABLE 2: IMBALANCES IN WOMEN'S HEALTH IN PUBLIC AND PRIVATE SECTORS
TABLE 3: MAIN LEGISLATIVE AND POLICY ADVANCES RELATED TO SRHR IN SOUTH AFRICA
TABLE 4: HIV/HIV&AIDS INCIDENCE RATES AND PREVALENCE BY SEX AND BY AGE GROUP
TABLE 5: NUMBER OF ADULTS AND CHILDREN ON TREATMENT
TABLE 6: STI SYMPTOMS EXPERIENCED BY RESPONDENTS 15+
TABLE 7: TCC CURRENT PRACTICE, AND RECOMMENDED STRATEGIES FOR IMPROVEMENT.
TABLE 8: RAPE PREVALENCE BY PROVINCE
BOX 1: ORGANISATIONS INVOLVED IN THE UNGASS FORUM DURING PHASE 2
FIGURE 1: INTEGRATED HEALTH-CARE PACKAGES AT FOUR LEVELS IN SOUTH AFRICA
FIGURE 2: HIV PREVALENCE BY AGE AND SEX
FIGURE 3: CONTRACEPTIVE PREVALENCE BY METHODS

Document collated by:
Marion Stevens, Nombulelo Bomela, Nicole Le Roux (Women and HIV/AIDS Gauge, Health Systems Trust)
Marieta de Vos (MOSAIC Training, Service and Healing Centre for Women)
Tian Johnson (The Thohoyandou Victim Empowerment Programme)
with inputs from member organisations listed on page 8.
Edited by Kgobati Magome, Community Innovations

with financial support from
FORD FOUNDATION - UNAIDS – OSISA

ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic(s)
ART	Antiretroviral Therapy
CBO	Community-based Organisation
CCMT	Comprehensive HIV&AIDS Care Management and Treatment
CSO	Civil Society Organisation
DV	Domestic Violence
DVA	Domestic Violence Act of 1998
EC	Emergency Contraception
FBO	Faith Based Organization
GCM	Global Campaign for Microbicides
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
MCP	Multiple Concurrent Partners
MDP	Microbicides Development Programme
MOSAIC	Mosaic Training, Service and Healing Centre for Women
MSM	Men who have Sex with Men
NDOH	National Department of Health
NGO	Non-governmental Organisation
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLHIV	People Living with HIV&AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SANAC	South African National AIDS Council
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV&AIDS
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WHG	Women and HIV/AIDS Gauge (Health Systems Trust)

Executive Summary

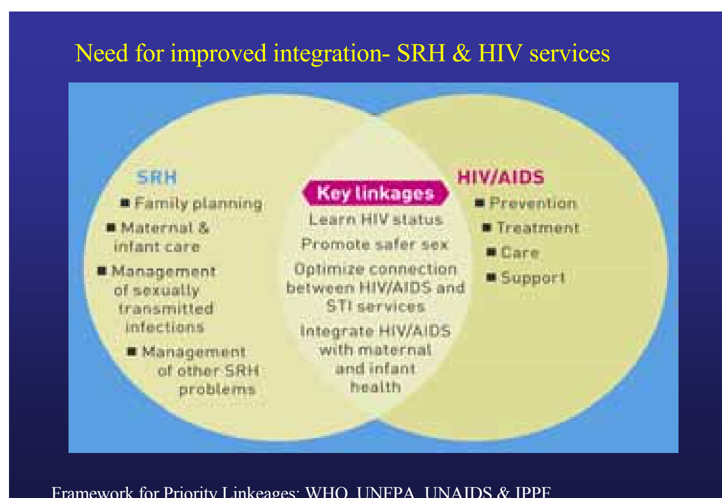
This report tracks the progress made by the South African Government towards achieving the UNGASS HIV&AIDS goals that relate to Women and Girls' Sexual and Reproductive Health and Rights (SRHR). It maps the SRHR responses implemented in the 2008-2009 UNGASS reporting period, and gives qualitative accounts of the experiences of women, girls and children in relation to the UNGASS indicators outlined by UNAIDS. The report goes beyond official statistics provided in the Government Report to analyse the experiences of the beneficiaries, to state what has worked well during the reporting period, and highlight those areas needing further work.

Problem Statement: The Case for the Integration of HIV&AIDS and SRHR

The association between Sexual and Reproductive Health (SRH) and HIV&AIDS has been proven and widely acknowledged. Most HIV infections are sexually transmitted or associated with pregnancy, childbirth or breastfeeding. In addition, reproductive ill-health and HIV&AIDS are both perpetuated by the same challenges- poverty, gender inequality and social marginalization of the most vulnerable populations among others.

Despite these associations, the responses to SRHR and HIV&AIDS have largely been separate and not integrated-with HIV&AIDS not seen as a sexual and reproductive health issue, but most often, only as an infectious disease. This artificial separation of HIV&AIDS from other SRHR issues has had an adverse effect on the response to HIV&AIDS, and has compromised efficiency and effectiveness within the health system.

There is evidence to show that creating closer linkages between reproductive health and HIV prevention, care and treatment would result in significant public health benefits, and facilitate the achievement of international development goals and targets such as the MDGs and UNGASS goals. The table (left) captures the argument, and outlines the opportunities for integration.



Framework for Priority Linkeages: WHO, UNFPA, UNAIDS & IPPF

Over the last few years, the South African Government has heeded this call, and made attempts towards integrating HIV&AIDS and SRHR responses.

SRHR and HIV&AIDS Progress in 2008/2009

The key progress areas in this reporting period are:

- The creation of a Ministry for Women, Children and Persons with Disabilities, along with the establishment of a Parliamentary Portfolio Committee on Women, Children, Youth and Persons with Disability. The two structures should increase parliament's ability to assess the extent to which legislation promoting women's rights is resourced and implemented. This has already had positive benefits- evidenced in the public hearings held by the Portfolio Committee as part of the review of the implementation of the Domestic Violence Act. The hope is that the new structures will translate into legislation and programming that addresses the vulnerabilities of women and girls, and empowers them to triumph over many of the challenges they are facing-including SRHR and HIV&AIDS.
- The Department of Health has formed a committee for the integration of HIV&AIDS and Sexual and Reproductive Health in the public Sector, a move that could begin to address a lot of the issues highlighted in this report.
- The Government has announced a change in HIV treatment guidelines for pregnant women with effect from April 2010. In terms of the new policy, pregnant women will qualify for ART when their CD4 count is 350 or less; and treatment will start from 14 weeks of pregnancy as opposed to the last term of pregnancy. All HIV-positive children under one year will also get ARVs. These policy changes are expected to improve the lives of women and children living with HIV&AIDS.
- The promulgation of the Sexual Offences Act, No 32 of 2007 has brought an additional instrument for responding to Violence Against Women.

The key areas needing further work are:

Legislation and Policies

1. The development of an overarching SRHR policy which integrates HIV&AIDS into SRHR programmes, and conversely, SRHR into HIV&AIDS programmes with a focus on women of all ages. The integration of the two has important public health benefits that have been proven both in SA and elsewhere.
2. Review the Domestic Violence (DV) legislation to adequately address issues of HIV/AIDS and SRHR of abused women; and develop an overarching policy framework with implementation guidelines. The lack of an overarching policy framework impedes the effectives of services rendered to women experiencing DV. Establishing a framework will ensure service norms and standards in relation to training, implementation, monitoring and reporting requirements. The newly established Ministry for Women, Children and Persons with Disabilities has a unique

opportunity to use the report of the Portfolio Committee on the DV hearings to compel the changes that have been recommended and adopted by Parliament.

3. Review and update contraception and abortion policies-with a view to providing comprehensive SRHR services and choice to People living with HIV&AIDS (PLHIV). This would include support for women living with HIV to plan families, address unintended pregnancies and prepare for safe, desired pregnancies. The high numbers of young women on ART implies that there are significant numbers of young women living with HIV who are reproductively healthy, and whose desire to start families is strong. A clear policy addressing this issue in a comprehensive manner is critical. It is also critical to finalise Medical abortion guidelines and train the public sector for effective implementation.
4. Finalise the integration of cervical cancer as an SRHR issue into the HIV policy, and make the HPV vaccine available to women and girls in the public sector.
5. Finalise the delayed National Policy Framework of the Sexual Offences Act, no 32 of 2007, to ensure co-ordinated implementation, monitoring and evaluation.
6. Decriminalise sex work to protect the health of sex workers, and of the public that utilises their services.

Structures and Tools

7. Develop a unified M&E framework that is informed by human rights; takes SRHR and quality of care issues into consideration more effectively; and allows for collection of disaggregated data on SRHR and HIV&AIDS at national, provincial and local levels. While an M&E framework for the NSP exists, the framework is not supported by community-based data collection structures, and women and SRHR organisations have found it difficult to feed the information they collect on lesbian, gay, bisexual, transgender and intersex (LGBTI's) and other Most at Risk Populations (MARPS) into the existing system.
8. Create systems that Monitor and Report Violations to the set service delivery standards.

Political Commitment, Resources and Financing

9. Ensure the adequate resourcing- financial and human- of the women SANAC sector and women representation in provincial AIDS councils
10. Improve access to services for under-serviced vulnerable populations such as LGBTIs, sex workers, and women with disabilities. Although people from all sexual orientations and physical abilities are welcome to attend health centres in SA, many of the women groups mentioned above still experience physical barriers and high levels of stigma, discouraging them from using the services. Some of these groups are also classified as MARPS, making their access to HIV&AIDS and SRHR services that much more critical.

11. Recommit to the implementation of the Maputo Plan of Action which aims to provide universal access to SRHR for all citizens, and provide technical skills in government departments to enable this.
12. Recommit to the implementation of the UNGASS Declaration and improved reporting that fully captures civil society experiences every two years.

Service Delivery

13. Improve the provision of service by TCC centres on the basis of recommendations given by CSOs outlined in section C of this document.
14. Increase the understanding and enforcement of GBV prosecution and sentencing guidelines within the justice sector.

Programme Content

15. Develop new elements of the sexuality education curricula that respond to new evidence on the disproportionate impact of HIV on women and girls. 60% of all people living with HIV are women and girls; and girls aged 15-24 had a 13% HIV prevalence, compared to 3% for boys of the same age.
16. Develop a large scale programme that works with traditional leaders and communities to resolutely interrogate cultural norms and traditional practices-only in as far as they increase women and girl vulnerability to HIV and other SRHR abuses.
17. Review Nursing, Medical and Community Health Worker curricula to integrate SRHR, HIV&AIDS care, as well as screening, counselling and referral of women experiencing domestic and sexual violence.
18. Regulate the training curriculum and the protocol for community health workers and counsellors to improve the quality of their service in VCT, PMTCT and ART where applicable.
19. Review and update ARV treatment guidelines to cover relevant SRHR issues beyond ARVs.
20. Implement large-scale programmes for abused women which provide economic opportunities and create conditions where women are no longer dependent on men for survival.

Research

21. Fund research to improve understanding of:
    - The epidemic among Women who have sex with Women (WSW), LGBTI groups, and other minority MARPS that are specific to SA;
    - Implementing integrated SRHR & HIV services targeting men and boys;
    - The linkages between HIV, SRHR and GBV and how their integration reduces risk for women and girls.

22. Upscale sites where SRHR and HIV&AIDS integration is happening and conduct action research to provide more information on successful practice.

Promotion and Advocacy

23. Promote and provide the Female Condom (FC) on a large scale throughout SA. The FC can be integrated through community-based distribution; STI and family planning services; HIV/AIDS/ STI prevention programmes with vulnerable populations, adolescent and reproductive health programmes, social marketing, work-place initiatives, peer education and male motivation programmes.

INTRODUCTION

Background

This report is phase two of a bigger international project to collect strategic data on women's Sexual & Reproductive Health Rights (SRHR) and HIV&AIDS, with the aim of mapping and tracking progress towards achieving the goals of the 2001 UNGASS Declaration on HIV&AIDS. The project is a collaborative effort of sixteen NGOs from twelve countries, intended to nurture a south-to-south community based research and advocacy network for monitoring and evaluating public policies on women's SRHR and HIV&AIDS. The process was initiated in July 2007 by GESTOS Soropositividade, Comunicação e Gênero, an NGO based in Brazil.

Phase 1 of this effort included the establishment of an UNGASS Forum in South Africa- constituted by member organisations working in the SRHR, Gender Based Violence, and HIV&AIDS fields across the country[1]. Following data collection and analysis by the UNGASS forum member organisations, a research report on SRHR and HIV&AIDS was submitted to SANAC, with the request that it be incorporated into the 2008 UNGASS country report. The data of the NGOs from the sixteen countries were also compiled into a comparative report entitled: *"Monitoring UNGASS-AIDS Goals on Sexual and Reproductive Health"*, edited by Gestos. The report was officially sent to UNAIDS in February 2008, and launched in June 2008 at the Ford Foundation in New York (www.ungassforum.org).

Aim and Structure of the Report

The goal of phase 2 is to focus on strengthening the advocacy actions at country level, while building further international momentum for the inclusion of SRHR as a priority area requiring attention amongst governments, HIV&AIDS donors, UN agencies, and Civil Society Organizations.

The report is structured first to provide answers to questions on the national health system, national policies, as well as three main areas of SRHR and HIV&AIDS - Sexuality Education, SRHR services, and Violence against Women; followed by a section outlining key recommendations on further work to be done. The UNGASS indicator addressed by each question is shown as a footnote for each question. In addition, Table 1below shows the indicators and the sections of the report responding to these indicators.

---

[1] **Error! Main Document Only.**List of member organisations in Annexure A

Methodology Used

An overarching research questionnaire outlining the key questions to be asked was developed collectively by the 12[2] participating countries at a workshop held in Cape Town, South Africa. Following this process, each country used the questionnaire to develop a country-specific questionnaire focussing on the national health system, national policies, as well as three areas of SRHR and HIV&AIDS - Education, information, communication (IEC); Sexual and reproductive health care; and Violence against women. The Questionnaire and the Indicators it is responding to are outlined in Table 1 below. The sections do NOT provide statistics, but rather experiences of women and CSOs serving them in relation to the Indicators, and the change desired. The organisations that participated in the South Africa UNGASS forum for phase 2 are listed in Box 1 below. Many of these organisations were also part of phase 1.

TABLE 1: LINKAGES OF THIS REPORT WITH THE UNGASS INDICATORS

#	INDICATOR	REPORT SECTION ADRESSING INDICATOR
NATIONAL COMMITMENT AND ACTION		
1	Domestic and international AIDS spending by categories and financing sources	Section 3 Q looks at the funding of women and SRHR organisations
POLICY DEVELOPMENT AND IMPLEMENTATION STATUS		
2	National Composite Policy Index	Section 1, Questions 1-13 provides an overview of the national health system and the policies that address SRHR and HIV&AIDS
NATIONAL PROGRAMMES		
3	Percentage of donated blood units screened for HIV in a quality secured manner	Not Addressed
4	Percentage of adults and children with advanced HIV infection receiving ART	Section 2
5	Proportion of HIV+ pregnant women receiving antiretroviral medicines to reduce the risk of mother-to-child transmission	Section 2, Part B
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Not Addressed
7	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	Not addressed
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Section 2, Part B and C
9	Percentage of most at risk populations reached with HIV prevention programmes	Section 2, Part B and C

[2] Argentina, Belize, Brazil, Chile, Indonesia, Kenya, Peru, South Africa, Thailand, Ukraine, Uruguay, Uganda

#	INDICATOR	REPORT SECTION ADRESSING INDICATOR
10	Percentage of orphaned and vulnerable children aged 0-17 years whose household received free basic external support in caring for the child	Section 2, Part B and C
11	Percentage of schools that provide life skills based HIV education within the last academic year	Section 2, Part B and C
KNOWLEDGE AND BEHAVIOUR		
12	Current school attendance among orphans aged 10-14	Section 2, Part B and C
12	Current school attendance among non-orphans aged 10-14	Not Addressed
13	Percentage of young women age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	Not Addressed
14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Section 2, Part B and C
15	Percentage of young women and men who have had sexual intercourse before the age of 15	?
16	Percentage of women aged 15-49 years who had sexual intercourse with more than one partner in last 12 months	Section 2, Part B and C
17	Percentage of women aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom during last intercourse	Section 2, Part B
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Section 2, Part B and C
19	Percentage of men reporting the use of condom the last time they had sex with a male partner	Section 2, Part B and C
20	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not addressed
21	Percentage of injecting drug users reporting the use of a condom during last sexual intercourse	Not addressed

IMPACT		
22	Percentage of young women aged 15-24 who are HIV infected	Section 2, Part B and C
23	Percentage of most at risk populations who are HIV infected:	Section 2, Part B and C
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Section 2, Part B and C
25	Percentage of infants born to HIV positive mothers who are infected	Section 2, Part B and C

IMPACT		
22	Percentage of young women aged 15-24 who are HIV infected	Section 2, Part B and C
23	Percentage of most at risk populations who are HIV infected:	Section 2, Part B and C
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Section 2, Part B and C
25	Percentage of infants born to HIV positive mothers who are infected	Section 2, Part B and C

BOX 1: ORGANISATIONS INVOLVED IN THE UNGASS FORUM DURING PHASE 2

Action Aid	AIDS Legal Network
Amanitare	Centre for Human Rights (UP)
Centre for the Study of Violence and Reconciliation (CSVR)	Denosa
EngenderHealth	Family Health and Communication
Ford Foundation	Gestos (Brazil)
Global Campaign for Microbicides	Health Systems Trust
Ipas SA	Lesbian and Gay Community and Health Centre
Masimanyane Women's Support Centre	MOSAIC Training, Service and Healing Centre for Women
NACOSA	
OUT	Partners in Sexual Health
Population Council	Positive Women's Network
Remmoho Women's Forum	Reproductive Rights Alliance
Sonke Gender Justice	South African Council of Churches
The Triangle Project	Thohoyandou Victim Empowerment Programme
Tshwaranang Legal Advocacy Centre	UNAIDS
University of Cape Town - Gender, Health and Justice Research Unit	University of Cape Town – Women's Health Research Unit
University of Stellenbosch - Emergency Contraception Project, Department of Obstetrics and Gynaecology	University of the Witwatersrand - Reproductive Health and HIV Research Unit
University of the Western Cape - Women's Legal Centre	Western Cape Network on Violence against Women
World AIDS Campaign	Treatment Action Campaign
Visionary Youth	

Data was sourced from members of the National UNGASS Forum, key informant interviews, focus groups, body mapping workshops, sector leadership gatherings, related symposia and summits as well as literature reviews and press reports. In addition, bibliographic reviews of relevant literature and research, government statistics, data supplied to the United Nations such as documents reporting on compliance To Cairo Platform and the Millennium Goals as well as governmental follow-up reports on UNGASS-AIDS 2008 were used.

The data collected is reported in the responses to the questions asked in sections I, II and III below. The questions are also presented in Annex A of this report The sections are followed by a set of recommendations for action.

SECTION I

Overview of the national health system and public policies in the fields of sexual and reproductive health and HIV/AIDS

Question 1: What are the main features of South Africa's health system? Is there universal access? Is it free-of-charge? Which health services does government provide and which does the citizen have to pay for?

Some 16 years after the first democratic elections, the dismantling of the country's race-based legislative & policy framework is complete. The Health system has been reoriented to focus on access and delivery of health care to all- a standard that has proven difficult to achieve due to the overwhelming demand placed on the services.

Previously, the public sector was oriented towards tertiary care, with hospitals assigned to particular racial groups- with a disproportionate concentration in white areas. With 14 different health departments, the system was characterised by fragmentation and duplication. There was no real attempt to deliver primary health care to the majority of South Africans, and the health sector was largely focused around hospitals. Those living in rural areas had to travel long distances for medical care. Since democracy however, efforts to increase access to health care continue- as clearly defined in the South African Constitution[3], section 27, clause *'Health care, food, water and social security'*. It states: *'(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water: and (c) social security, including, if they are unable to support themselves and their dependents appropriate social assistance. (2) The state must take reasonable legislative and other measures within its available resources, to achieve progressive realisation of these rights, (3) No one may be refused emergency care treatment.'*

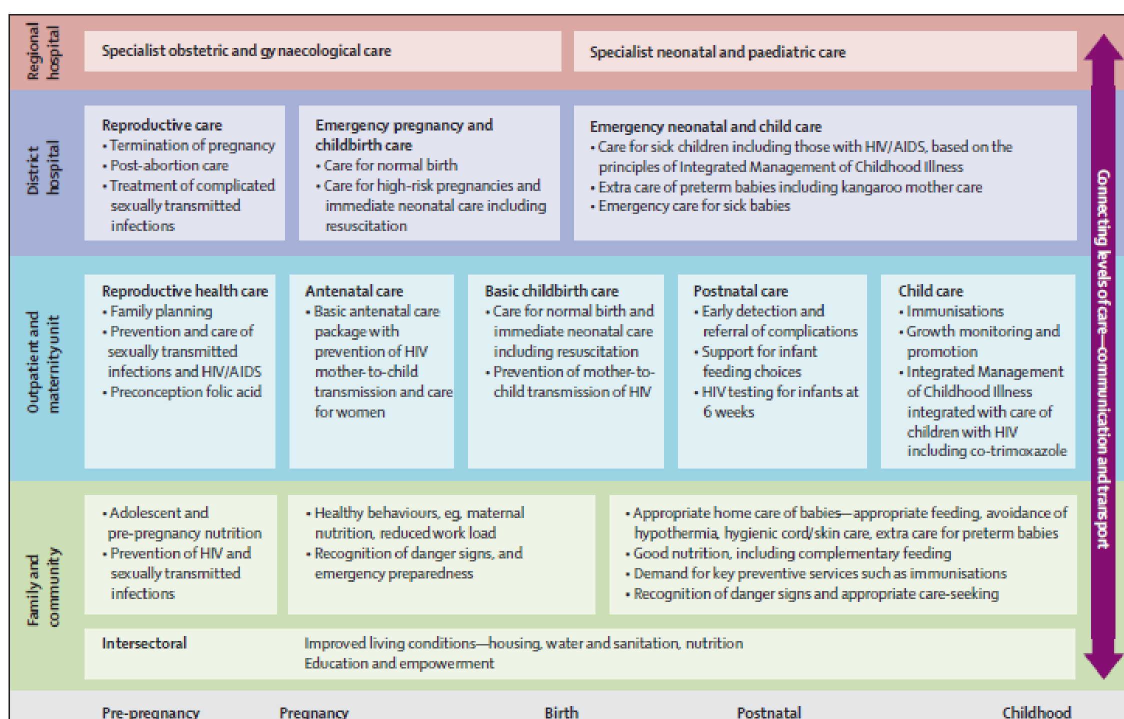
Figure 1[4] gives a good idea of the four-levels of care in the health system in South Africa, indicating the prevention and clinical packages for maternal, neonatal and child health in South Africa.

---

[3] 1996. South African Constitution. Bill of Rights. Section 27.
www.info.gov.za/documents/constitution/1996/96cons2.htm

[4] Chopra,M;Daviaud,E; Pattinson,R; Fonn,S & Lawn,J. *Health in South Africa 2. Saving the lives of South Africa's mothers, babies,and children: can the health system deliver?* The Lancet, Published online August 25, 2009

FIGURE 1: INTEGRATED HEALTH-CARE PACKAGES AT FOUR LEVELS IN SOUTH AFRICA



The Government is in the process of developing a district-based health system to ensure local control of public health services, to standardize basic health services around the country, and to ensure that health care is affordable and accessible to everyone. There are 42 health regions and 162 health districts in the country. A new administrative structure is being put in place which will see primary health care clinics fall under the auspices of district authorities, while hospitals remain under the control of provincial authorities. Since 1994, more than 700 clinics have been built, 2 298 clinics upgraded and given new equipment, and 125 new mobile clinics introduced. There are now more than 3 500 clinics in the public sector. Free health care for children under six, and for pregnant or breastfeeding mothers, is available at these clinics.

South Africa's health system is made up of the public and private sector, and is divided and inequitable. Most South Africans use the public health system because it is Government-subsidized

and therefore more affordable; yet the private sector has a significantly larger budget[5], and accommodates a small section of the population. The public sector delivers most of its care to the majority of the people through primary health care service points, while the private sector provides more individualised higher cost services to a limited group, typically those with access to Health Insurance (refer Table 2). The richest 20% of the population receive 36% of the benefits from using health care services-although they only account for 10% of the health care needs. The poorest 20% of the population receive less than 13% of the benefits but have more than 25% of the health care needs[6]. While efforts have been made to improve health systems, with over 4 000 public health facilities- including hospitals and clinics employing some 235 000 personnel, care is sometimes sub-optimal, facilities have long waiting times and primary care facilities have too few doctors.[7] In relation to broader determinants of public health significant numbers of people do not have access to clean water, sanitation, nutrition, electricity and safety. Poor people face the high costs of transport, medicines, and follow-up visits to doctors. Language barriers between patients and health workers mean that many may not be able to fully understand their treatment. Levels of domestic violence, sexual offences and other forms of violence against women are still high, and discriminatory attitudes amongst health care workers against people because of their race, gender and sexual orientation still persist. Because of the HIV&/AIDS crisis, many hospitals and clinics face a huge increase in patients, but there has not been an increase in numbers of doctors and nurses available to provide care. The health care system is better equipped and provides better services in provinces such as Gauteng and the Western Cape, as compared to provinces such as the Eastern Cape and Limpopo.

The system is further overburdened because of poor resource management and a population ravaged by the HIV pandemic, exacerbated by poverty. SA has a feminized epidemic with 60% of all HIV infections affecting women. Women are vulnerable to the infection not only because of their anatomy & physiology, but also owing to economic, cultural and political factors. Despite this evidence, the system has been slow to allocate resources accordingly to respond to the needs of women, and reduce their vulnerability to HIV&AIDS.

The only SRHR service available to women previously included a vertical family planning programme, which was implemented in 1974, and often perceived as a measure to keep black

---

[5] Miller, T. 2009. South Africa's Health System and Challenges.
http://www.pbs.org/newshour/globalhealth/jan-june09/sahealth_03-24.html

[6] McIntyre, D. 2009. NHI could spell health for all. Amandla Issue No 10. October 2009. pg 6.

[7] Barron, P., Day, C., Monticelli, F., Vermaak,K., Okorafor, O., Moodley, K. & Doherty, T. (2006) *The District Health Barometer 2005/06.* Durban, Health Systems Trust.

population numbers under control. Following the change of government in 1994 rapid strides were taken to prioritise women's health. In the first 100 days of President Mandela's presidency, the Government announced that primary health care was to be free to pregnant women and children under six years. This was to ensure that poor women and their children had access to health care. These broad strides were welcomed and heralded as a period of significant policy and legal change orientated to the poorest of the poor. This took place when the health care system itself was transforming in the direction of an integrated and decentralised health care system- based on primary health care. Subsequently primary health care was made freely available to all citizens in the public sector. Health workers were not prepared for this and in retrospect have become overwhelmed with what is commonly termed 'change fatigue'.

Currently the public sector does not make provision for certain HIV&AIDS treatment related services for women, for example, medical abortion, HPV vaccination and , cervical screening if below 30 years of age. The private sector does not include contraception as part of prescribed minimum benefits. In Table 2 Stevens[8] points out current imbalances with regard to women's health in the public and private sectors.

There are a range of treatment areas around HIV&/AIDS for women that are at the bottom of the AIDS treatment agenda and not integrated into services. For example, the NDOH developed and published cervical cancer screening policy guidelines in 2000[9]. During this policy development process, the association of cervical cancer with HIV&/AIDS was not yet clear[10],[11] resulting in the current National Cervical Cancer Screening Policy not accommodating HIV positive women. The NDOH has set up a task team to revise the Cervical Cancer policy to update it from the 1994 Women's Health Policy consensus, recently announced that cervical cancer will now be considered as an AIDS defining illness. Cervical cancer screening is an example of a service which really needs a functioning health system and with severe inequities it can work in some areas and not in others. The current cervical screening rate remains 20-30% of the 70% target. Challenges remain transport, laboratory services, tracing of results and referral for treatment &, supply of colposcopy equipment. More Civil Society engagement is needed in this area.

---

[8] Stevens, M. 2009. Everyone benefits. *Nursing Update,* Vol 33 No 11. December 2009.
[9] http://www.doh.gov.za/docs/factsheets/guidelines/cancer.pdf
[10] Department of Health, Western Cape. 2006. *Cervical Cancer Cytology Policy Statement.*

[11] Bomela, N & Stevens M. 2008 Cervical cancer and HIV/ADS: the intimate connection. Policy Brief. *www.hst.org.za*

TABLE 2: IMBALANCES IN WOMEN'S HEALTH IN PUBLIC AND PRIVATE SECTORS

Public sector	
Abortion services	• Designated surgical abortion services have decreased from 70% to only 43% of surgical abortion services being operational. 70% of first trimesters are done by nurses • Medical abortion is not available
Contraception	• Limited options available. Most women given injectable contraceptives • Limited range of oral contraceptives, IUCDs, female condoms • Post exposure prophylaxis and emergency contraception not widely available
Cervical cancer screening and treatment	Not widely implemented – limited recourse to treatment for those with positive smears
Cervical cancer HPV vaccines	Not available
Integration of HIV/AIDS services fertility planning	Limited policy on integration. Instances of forced abortion, denied abortion, forced contraception and sterilisation
Private sector	
Contraception	• Not viewed as prescribed minimum benefit and not paid for by medical aids • Post exposure prophylaxis and emergency contraception available • Not usually covered by medical aids Household insurance now provides options for coverage
Abortion	• Surgical abortion not widely available • Medical abortion widely available
Cervical cancer screening and treatment	Women who are screened tend to be over-serviced
Cervical cancer HPV vaccine	Available. Not covered by all medical aids

The country continues to suffer from a tremendous "brain drain" of South African doctors who are highly sought after in countries such as Britain and Canada because of the high standard of training and the medical experience they receive in South Africa. In 2000, 29 788 doctors in both public and private sectors were registered with the Health Professions Council of South Africa[12], the health practitioner watchdog body. Doctors must comply with the Continuing Professional Development System, which compels them to attend regular workshops, seminars and refresher courses to retain their yearly registration. To combat the long-standing shortage of doctors in rural areas, 450 foreign doctors, mainly from Cuba, were employed. The government has also made it easier for other foreign doctors to register to practice in the country. Newly graduating South African doctors and pharmacists now complete a year of compulsory community service in understaffed hospitals and clinics. To address some of the resource and personnel shortages facing the public sector, partnerships between the public and private sectors are slowly being forged. Some private hospitals are now offering beds and providing medical care to public sector patients. They are also beginning to offer post-graduate teaching facilities to university medical faculties in an effort to stop the flow of doctors out of the country.

Most experts agree that the HIV&AIDS NSP targets (halving infections by 2011 & providing treatment to 80% of people who need it) are now only realisable in the context of major health system reform and a more innovative approach to stretching limited resources. Some note that for

[12] www.hpcsa.co.za

the country to make a big leap in achieving its targets, there is need for innovation and a complete change in mindset- both technological and terms of delivery."[13]

New legislation

South Africa is in the process of establishing a national health insurance scheme that would support more equitable access to quality medical care for everybody. The scheme would help to overcome the imbalance between the quality of medical services available to South Africans-and the divide between the rich and the poor in relation to health care. This approach addresses a need for a fund that supports everybody's right to quality, safe health care.

The NHI[14] is based on the principle of national solidarity, where all those who can, would be required to make a financial contribution in the form of tax, from VAT to personal tax[15].

According to the ANC [16] the national health insurance will;

- **Create a publicly administered and publicly funded National Health Insurance Fund (NHIF)**: The NHIF will be a single-payer fund that receives funds, pool these resources and purchase services on behalf of the entire population (see box on Single Payer versus multi-Payer system).
- **Expand health coverage to all South Africans**. This effectively means there will be no financial barrier to access health care. Each South African will be equally covered by NHI to access comprehensive and quality health care services delivered. Health services covered by NHI will be a free at the point use – meaning no upfront payment will be required by the doctor or hospital. The only requirement is that the patient must produce an ID or NHI Card. This is like putting money for health care in the hands of the patient who then choose which facility to use in the district
- **Provide comprehensive coverage of health services.** South Africans will be entitled to a comprehensive range of health benefits, including primary care, inpatient and outpatient care, dental, prescription drugs and supplies. The services will be provided on a uniform basis at all health facilities

---

[13] PlusNews. 3 August 2009. South Africa: *No simple formula for universal access*. IRIN. www.plusnews.org/Report.aspx?Reportid=85555
[14] See a commentary on the proposed NHI here: http://www.hst.org.za/uploads/files/chap5_07.pdf
[15] Ross K. Sept 2009. 'Health-care situation makes NHI a necessity'.Daily News. www.iol.co. Accessed 10 September 2009
[16] African National Congress (ANC) Today: 25-30 July 2009. National Health Insurance: A unified, equitable and integrated national health system that benefits all South Africans VOL 9 No 29

- **Publicly and privately delivered health care**. NHI will be simply a financing system, with government collecting and allocating money for health care. Health care is provided by private and public sectors but paid for publicly by NHIF. To ensure improvement in quality standards, all providers will be accredited to meet quality standards *before* they are funded by NHI.
- **Social Solidarity**: Services delivered will be based on need rather than on ability to pay. In this case, coverage by NHI will not be interrupted and will be equal to everyone, thus ending the dependency of health on access upon employment status. Social solidarity also means those who can afford to pay for health care will subsidise those who cannot. **Save enough on excessive administrative costs** that characterize the current multi-payer medical scheme system, thus requiring no increase in total health care spending as a percentage of GDP.
- **Control costs through** cost-effective payment methods through negotiated capitation methods for doctors, global budgeting for hospitals and bulk purchasing of drugs and supplies.

NHI will be funded through a combination of current sources of government health spending, including the removal of tax subsidy for medical schemes and a modest mandatory or compulsory contribution by employer-employee contribution which will be split equally. Contribution will be less than what workers and employers pay to medical schemes. Certain categories of workers, due to their low income status, will be exempted from the contribution. The most recent 2010/11 national budget however did not include figures for the NHI with the Minister of Health stating that the country is not yet ready for implementation.

Question 2: Does the policy on HIV&AIDS include a National Plan with clearly defined strategic actions?

Yes, the policy on HIV&AIDS includes a National Plan with clearly defined strategic actions. In the last few months, SANAC set up an M&E task team which developed an M&E framework. The framework is new, not well-known, and civil society's role not clearly defined. There is no overall conceptual lens unpacking SRHR within the National Strategic AIDS Plan [17]. The language of SRHR is used in some of the priority focus areas of the NSP, but not fully threaded through the actual implementation. The following extracts from the NSP illustrate the point:

Priority area 1: Prevention; **Goal Two**: 'Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services'. This SRHR language is not

---

[17] SANAC. National Strategic AIDS Plan HIV/AIDS, STI 2007-2011.

continued into ***Priority area 2 of Treatment, Care and*** Support, and ***Priority area 3 of Research monitoring and surveillance***.

Currently reproductive health is not on the essential health priority list. This leaves gaps in terms of the continuum of care. For example, women living with HIV's sexual and reproductive intentions -of having children for example- are not provided for; abortion services are not regulated within HIV care, and sexual violence is not part of the STI syndromic approach. Integrating HIV&AIDS into ongoing SRHR programmes and conversely SRHR issues into HIV&AIDS programmes remains a crucial area of development for South Africa.[18] The maternal health paradigm dominates services with limited understanding of SRHR policy and implementation of services.

The DoH is making attempts to shift towards integrating SRHR and HIV&AIDS responses. In 2008 the DOH reported that Family Health International provided assistance to all but two of the Provinces in integrating HIV and SRHR services. Provinces, led by Family Planning Champions as coordinators, conducted rapid assessments to establish baselines; and developed their individual action plans. Service packages include all forms of contraception for ease of choice; VCT services; and where feasible, management of STI and screening for cancers of reproductive health. Provinces are at different stages of implementation.

Question 3: Is there an official policy on sexual and reproductive health in the country?

'Reproductive laws and policies in South Africa are among the most progressive in the world "in terms of the recognition that they give to human rights, including sexual and reproductive health rights[19]". However, while policy documents use the phrase sexual and reproductive health (SRH), there is ambiguity about the full content and scope of sexual health, reproductive health and women's health in South African policy. Smit, et al observe the propensity for SRH in South Africa to be stated in broad strokes and for various definitions to be cited, and hence, inconsistency to arise[20]. In sum, there is no official policy on SRHR in South Africa, but a list of SRHR-related policies that have been developed over the years, but not necessarily linked to each other. Table 3 below outlines the main legislative and policy advances related to SRHR in South Africa in the last number of years:

---

[18] Stevens, M. "Towards treatment guidelines for women of reproductive age: recognising the right to choose." AGENDA 75, 2008

[19] Cooper et al, 2004, p. 70 ' Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status' Reproductive Health Matters 2004;12(24):70–85.

TABLE 3: MAIN LEGISLATIVE AND POLICY ADVANCES RELATED TO SRHR IN SOUTH AFRICA

Date	Legislation \Policy
1994	Dept of Health reviews HIV&AIDS policy with a focus on preventing new HIV infections and treatment of HIV-related opportunistic infections, Free public health services for pregnant women and children under six
1994	Dept of Health reviews HIV&AIDS policy with a focus on preventing new HIV infections and treatment of HIV-related opportunistic infections, Free public health services for pregnant women and children under six
1995	UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) ratified by Government
1996	Choice on Termination of Pregnancy Act
1997	Maternal death made a notifiable condition Standing National Committee for Confidential Enquiries into Maternal Deaths established Patients' Rights Charter launched, giving patients the knowledge and rights to address quality in healthcare provision
1998	New Population Policy South African National AIDS Council established New Domestic Violence Act Sterilisation Act
1999	Prevention of Mother to Child Transmission Programmes (PMTCT) introduced in the Western Cape Province by *Médecins sans Frontières*
2000	National Guidelines for Cervical Screening Programme introduced
2001	PMTCT Programme introduced in Gauteng Province
2002	Treatment Action Campaign and Children's Rights Centre win Constitutional Court judgement instructing Dept of Health to roll out a national PMTCT programme National Contraception Policy Guidelines launched Government approves provision of post-exposure prophylaxis in public health facilities for rape survivors
2003	Government approves plan to provide national antiretroviral treatment programme through the public health sector at no charge
2004	National ART programme launched National Contraception Policy Guidelines
2005	National Sexual Assault Policy & National Management Guidelines for Sexual Assault Care South Africa adopts the Sexual and Reproductive Health Policy Framework at the 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH 2) in Gaborone, Botswana

[20] Smit J, Beksinska M, Ramkissoon A, Kunene A & Penn-Kekana P. 2003 South African Health Review (Durban, Health Systems Trust. Chapter 5. Pp. 59-81Reproductive health

Date	Legislation \Policy
2006	SA signs Maputo Plan Of Action for the operationalisation of the Continental Policy Framework for SRHR 2007-2010
2007	• Choice on Termination of Pregnancy Amendment Act • Medical Termination of Pregnancy Guidelines – *not yet released* • Draft Policy document on Fertility Options including HIV infected -2007 – discarded and *not released* • Updated Sexual Assault Care Training Manual – pilot phase completed
2008	• Criminal Law (Sexual Offences and related matters) Amendment Act
2009	• Accelerated PMTCT Guidelines and Implementation Plan • Draft framework for Male Circumcision – *not released* • SA signs Addis Call to Urgent Action for Maternal Health ■ Policy on Conscientious Objection to CTOP – not released ■ Family Planning Training Manual and Policy ■ Comprehensive Care, Management, Treatment and Support (CCMT &S) 2003

In the National Contraception Policy Guidelines (NCPG)[21], reproductive health is described as follows: "Reproductive health implies that people are able to have a responsible, satisfying and safe sex life; and have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of, and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go through pregnancy and childbirth safely and provide couples with the best chance of having a healthy infant". The definition above is not used consistently in other policy documents. Understanding what a concept entails is then made more difficult; as is the 'how' of translating the concept into services and rights that can be achieved. This task on the part of stakeholders such as government officials, advocates, and the public is not just challenging but a major stumbling block to policy implementation. [20]

In recent drafts of the Maternal, Child and Women's Health policy documentation, it is evident that there is poor conceptualization of the concepts of SRHR and how to translate these into programming and implementation strategies. The NDoH is aware of this gap and is participating in collaboration with the Health System's Trust to develop Treatment Guidelines for Women of Reproductive age as a means of addressing this.

[21] Department of Health. 2004. National Contraception Policy Guidelines (NCPG). See more on the NCPG at http://www.doh.gov.za/docs/factsheets/guidelines/contraception/contraception02.pdf

South Africa adopted the Sexual and Reproductive Health Policy Framework at the 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH 2) in Gaborone, Botswana 2005. This programme of action led to a Special Ministerial Conference on Sexual and Reproductive Health in September 2006 in Maputo. The theme of the Maputo conference was "Operationalisation of the SRHR Continental Policy Framework" its aim being to reposition SRHR as well as facilitate access to services for HIV&AIDS prevention, mitigation, treatment and care. The ensuing Maputo Plan of Action with the goal of universal access to comprehensive SRH services in Africa by 2015, is however relatively unknown by public health practitioners, NGOs and communities.[22]

Most recently on 26 October 2009, the Addis Call to Urgent Action for Maternal Health was signed. The Instrument is to be used by the President and Ministers to ensure that national and district health plans prioritize sexual and reproductive health, including maternal and newborn health, nutrition, family planning, STI/HIV prevention, and reproductive cancers by 2010. In addition, Governments are required to make plans, budgets and results public to promote monitoring, transparency and accountability. The policy does not however take the needs of positive women into account clearly. The particular needs of positive women with regard to reproductive cancers and STIs and how the syndromic approach has failed women. A 'one size fits all' approach does not work – it is not relevant to HIV positive women and it is not gendered.

Question 4: Is there any specific public policy addressing violence against women?

Yes. The South African government has legislation dealing with domestic violence (*Domestic Violence Act, No 116 of 1998*) and Sexual Violence [*Criminal Law (Sexual Offences) Amendment Act 32 of 2007*]. The legislation is supported by policies, directives and regulations. In addition, multi-sectoral public policy documents exist on violence against women. There are National Instructions for the Police on Domestic Violence (2006) and Sexual offences (2008).

The state has introduced a range of policy interventions addressing rape including:

- The Cabinet's decision in 2002 to provide antiretroviral drugs to rape survivors to prevent HIV infection
- The Department of Health's 2005 National management guidelines for Sexual Assault care and the National Sexual Assault Policy

---

[22] Marieta de Vos, Mosaic, Personal interview. December 2009.

- The 2004 Service Charter for Victims of Crime in SA, with the integrated victim empowerment policy[23].
- Enactment of the Criminal Law (sexual offences and related matters) Amendment Act, No 32 of 2007

The NSP contains several intervention packages referring to gender rights, gender-based violence and child abuse such as the *HIV prevention programme, interventions and curricula; Prevention package for sex workers and their clients; Early childhood development Care Package and the OVC package.* But there are several intervention packages that omit reference to GBV and child abuse. These include *Expanded PMTCT package; Youth friendly SRH services; Unwanted pregnancy package; Positive prevention package; Workplace prevention package; Prison prevention package; Wellness care package; Food support package; and HIV prevention package to higher risk occupational groups*[24]

In August 2009 the Southern African Development Community (SADC) adopted the Protocol on Gender and Development, obliging member states to amend their laws to ensure equal rights for women across a wide range of issues, from provisions to enshrine equality in their constitutions; to firm commitments to reduce maternal mortality by 75%. It sets a target of halving current levels of gender violence by 2015. However, the Protocol still does not refer explicitly to domestic violence, and it still doesn't oblige states to introduce legal provisions that criminalise marital rape.[25]

While the laws, policies and protocols are significant, they focus on responding to violence and its secondary prevention, and not on primary prevention. Currently implementation strategies based on knowledge of risk and protective factors as well as on proven strategies grounded on social theory are weak. For example, research has shown that microfinance and gender education interventions can lead to a reduction in intimate partner violence.[26] These strategies have accordingly been incorporated into the HIV&AIDS NSP with the objective to roll-out integrated microfinance and gender education interventions, but their implementation has been weak. Research has also shown that communication strategies which address the unacceptability of coercive sex, gendered power

---

[23] Vetten L, Kim J, Ntlemo E, Mokwena L. From paper to Practice: Lessons in the implementation of Health and Victim Empowerment Policy Applicable to Rape survivors.
[24] Meerkotter, A. 2009. Domestic Violence, Health and HIV. A mid-term review on progress made in addressing the health aspects of domestic violence through the HIV & AIDS and STI National Strategic Plan 2007-2011.
[25] Ali, N. 18 August 2009. *The costs of marital rape in Southern Africa*. Human Rights Watch. http://www.hrw.org/en/news/2008/08/18/costs-marital-rape-southern-africa

stereotypes and sexual behaviour, reduce gender-based violence.[27] The NSP focuses on the development of communication strategies by a whole range of government departments to address coercive sex, the perpetuation of gendered power stereotypes and the stigmatisation of rape survivors. Again there is no strategy for implementing this.

Government Structures

The lack of a common vision & clear implementation continues to show itself in the confusion around which Government Department is the lead on VAW. Following the establishment of the Ministry of Women, Children and Disability in April 2009, it is not clear which Department is driving the *Sixteen Days of Activism on VAW campaign* for example; and what the status of the *365 National Action Plan to End Gender Violence* adopted in March 2007 and co-ordinated by the National Prosecution Authority (NPA)[28] is. The implementation of the Domestic Violence Act requires adequate costing by the relevant government departments and the Minister of Finance needs to make the budgetary allocations.[29]

Furthermore, there are limited opportunities where both violence against women and HIV&AIDS can be synergistically addressed through multi-sectoral approaches. There is no policy framework linked to the Domestic Violence Act linking all the role players. So far, the Policies and legislation on HIV&AIDS and domestic sexual violence are separate and not integrated, leading to disjointed implementation. The goal is to work towards more synergized implementation.

Question 5: Are there sexuality education programmes implemented in schools?

The National Education Act of 1996 gives the base for a national HIV&AIDS policy and plan that fits into school's needs, ethos, and values. In keeping with this, the Department of Education developed a strategy on HIV&AIDS and several guideline documents to support implementation at school level[30].

---

[26] Pronyk P *et al* (2006) "Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: results of a cluster randomized trial" *The Lancet* Vol 368, 1973-1983, South African IMAGE Study on violence and HIV. Available at http://web.wits.ac.za/Academic/Health/PublicHealth/Radar/SocialInterventions/InterventionwithMicrofinanceforAIDSGenderEquity.htm

[27] Jewkes R *et al* (2007) "Evaluation of Stepping Stones: A gender transformative HIV prevention intervention" Policy Brief, Gender & Health Research Unit, Medical Research Council. Available at http://www.mrc.co.za/gender/reports.htm

[28] CSVR. 25 November 2009. *Back prevention, NGOs say as Sixteen Day campaign kicks off.* Press statement by 20 organisations at the "We can prevent Violence. Strengthening Primary Prevention of Gender-based Violence in South Africa Symposium", 23-25 November 2009, Johannesburg.

[29] CSVR. 2008. Conference Report: *The South African Domestic Violence Act: Lessons from a decade of legislation and implementation.* 26-28 November 2008, Johannesburg, South Africa.

[30] Priscilla Reddy, Shegs James and Ann McCauley. "Programming for HIV Prevention in South African Schools: A Report on Program Implementation." Horizons Program. Health Promotion Research and Development Unit, Medical Research Council, Cape Town, 2005. Pg 5.

This included the development of a curriculum on HIV&AIDS and life-skills as part of the Life Orientation Learning Area.

All (100%) schools are reported to have provided life-skills and HIV&AIDS education in 2008 as part of the Life Orientation Learning Area[31]. Sexuality education is available, but curriculum design and delivery of HIV&AIDS and SRH education requires additional work. The fact that the curriculum is exam-driven places less importance on the teaching of HIV&AIDS as it is part of the Life Orientation Learning Area- which is not an examinable part of the curriculum. Although substantive work has gone into training teachers, many still lack confidence & competence to teach the subject. The delivery of the lessons is also affected by teacher's personal bias and parents' occasional objections to the material. Ahmed, et al found that many educators are conflicted about HIV and sex education because they perceive it as contradictory to their values and beliefs about what children should know and do. Most educators were in favour of abstinence promotion and felt personally challenged to teach safer sex practices.[32]

The Department of Education has an equity office and is cognisant of the need to include issues of sexual orientation and heteronormativity in the curriculum[33]. In her 2009 paper, Mavengere explores sexual violence in schools, and argues that gender disparities are consistently reinforced within the school environment. These include teaching power structures in which males are more important than females, apparent school tolerance of sexual harassment of female learners by teachers, and the ambiguous and slow response to the rape of learners[34].

There is little hard evidence to show that current school-based approaches to HIV&AIDS education and, more generally, SRHR and life skills education have had a significant impact on sexual behaviour. In general, students are well informed about the causes and consequences of HIV&AIDS, but the translation of this knowledge into behaviour-change remains a major hurdle. Economic and socio-cultural pressures that fuel unsafe sexual behaviour among adolescents remain high, and are probably increasing in the poorer communities.

---

[31] Matjila, Maila and Anwar Hoosen, Anton Stoltz, Neil Cameron. "STIs, HIV&AIDS and TB: Progress and Challenge" South African Health Review. Health Systems Trust: Durban, November 2008. Pg 92
[32] Ahmed, N. Flisher A. Mathews C. Mukoma W. Jansen S. HIV education in South African schools: The dilemma and conflicts of educators. Scandinavian Journal of Public Health, Vol 37, No 2 Suppl 48-54, 2009.
[33] Lewin, Thandi. Department of Education. Director of Equity. Personal interview.August 2009
[34] Mavengere, L. 2009. 'A conspiracy of silence…sexual violence in schools. Aids Legal Quarterly June 2009

Several provincial Departments of Education have introduced peer education in the schools to supplement the curriculum-based HIV&AIDS programme. The programme aims to delay age of sexual onset, increase protective sex through regular and correct condom usage and encourage both primary and secondary abstinence[35].

Several NGOs are also collaborating with the provincial Departments of Education to implement school-based programmes that supplement the life skills and HIV&AIDS curriculum, and augment areas such as counselling and psychosocial support. Examples include *Today's Choices* developed by the University of Stellenbosch[36] together with educators, learners and the government, and the World Population Foundation (WPF); The *GOLD Peer Education Development Agency* trains teenage leaders to become change agents in their schools and communities[37]; *Respect4U* which aims to reduce intimate partner violence among adolescents [38]; and the *CRISP* project which provides psychological and psychosocial services to assist South African schools to deal with infected and affected learners.[39]

Government Departments within the Social Cluster are attempting to work together and strengthen each others efforts to reach children and young people. They have developed an Integrated Plan on Children Infected and Affected by HIV&AIDS. The plan calls on the Departments of Health, Welfare, and Education to coordinate their efforts and work together in an integrated manner. The plan has six components, two addressing life skills, and others addressing issues affecting youth in and out of school. "

Schools and LGBTI Issues

The South African Schools Act[40] makes it imperative that a school must serve the learners' educational requirements without unfair discrimination. This is to be achieved by ensuring a safe and affirming school environment that respects the rights of every learner. LGBTI issues are meant to be part of

---

[35] Gabula D.Partners in Sexual Health. Personal communication, January 2010.

[36] Dr Petrus Steyn, Department of Obstetrics and Gynaecology. University of Stellenbosch. South Africa. See this link for more : http://www.wpf.org/project/705

[37] Williamson, C. *The GOLD Peer Education Programme*.Paper delivered at the "We can prevent Violence. Strengthening Primary Prevention of Gender-based Violence in South Africa Symposium", 23-25 November 2009, Johannesburg.

[38] University of Cape Town, Pacific Institute for Research and Evaluation (US), MRC. 2009. *Respect4U. Developing Respect 4 U: A school-based Primary Prevention Programme to reduce Intimate Partner Violence among Adolescents.*

[39] Devnarain, B. 2009. *Crime reduction in schools Project – CRISP*. Paper delivered at the "We can prevent Violence. Strengthening Primary Prevention of Gender-based Violence in South Africa Symposium", 23-25 November 2009, Johannesburg.

Sexuality Education at schools, but their execution is not effective. Research studies conducted by OUT LGBT Well-being in both KwaZulu-Natal and Gauteng [41] concluded that discrimination and violence against lesbian and gay people in the school environment is widespread. In KwaZulu-Natal 42% of lesbian women and 68% of gay men had experienced hate speech at school, due to their sexual orientation. Violence committed against learners who do not conform to hetero-normative roles and behaviours, more specifically lesbian, gay, bisexual, transgender and intersex (LGBTI) learners, is pervasive in South African schools[42]. This violence largely goes unchallenged. There is a need to work with policy-makers and teachers to urgently take steps to ensure the safety of these learners, and promote school environments respectful of diversity and human rights.

Based on its history, South Africa is aware that prejudice is a breeding ground for violence. The school environment is no different to the rest of society in that, despite the legislative and policy frameworks that protects learners from discrimination, hate speech and hate crimes are still a common experience for LGBTI school-goers.

In Gauteng, 14% of gay men and lesbian women reported having experienced sexual violence at school, because of their sexual orientation. These figures were even higher in KwaZulu-Natal, where approximately 19% of both lesbian women and gay men reported being subjected to sexual violence whilst at school.

The research indicates that the main source of this violence are other learners, however teachers are also a source of victimisation and abuse. The research highlights that these human rights abuses negatively affect the psychological and physical well-being of LGBTIs. School-going years are a critical time in the formation of a person's individual and social identity. Part of this process is the learning of gender roles and identities. This takes place both within and outside of the classroom, largely based on the social construction of what it means to be a 'man' and a 'woman' in society.

The education sector has a powerful role to play in actively addressing prejudice and discrimination against LGBTI learners and teachers. Educators are leaders in transforming society to embrace difference and respect diversity. For this reason, OUT and GALA are working within the sector to sensitise policy-makers and teachers to issues that affect learners in relation to sexual orientation and gender identity.

---

[40] See this link for details: www.info.gov.za/acts/1996/a84-96.pdf
[41] http://www.out.org.za/images/library/pdf/OUT_Brochure.pdf
[42] http://www.out.org.za/images/library/pdf/OUT_Brochure.pdf

GBV in schools – policy

Violence against adolescent girls in South Africa takes place against a backdrop of pervasive gender violence in society and stems in part from unequal power relations and strong patriarchal values. The impact of such violence is extensive and detrimental, causing damage to adolescent girls' physical and psychological health as well as affecting school attendance and academic achievement. Efforts to address this violence need to be strengthened.

The Department of Education has published a set of guidelines[43] to support the prevention and management of sexual violence and harassment in public schools. The guidelines aim to create minimum standard procedures; assure good treatment of victims and perpetrators, and provide support to victims in the reporting and follow-up processes.

Despite this, the efforts are still inadequate. There is need for additional urgent intervention in schools, as well as communities and government, to address youth on gender-based violence and related issues such as sexuality, rights and empowerment. Adolescence presents an opportune time for intervention; youth are navigating relationships, making sense of the world and are open to suggestions and new experiences. Not intervening at this point is to miss an ideal opportunity.

Takalani Sesame

Sesame Workshop- known as Takalani Sesame in SA- has been running for almost 40 years worldwide. The local production — aimed at ages 3 to 6 — develops literacy, numeracy and has a special focus on HIV&AIDS education. Through its star character, Kami, the world's first HIV-positive Muppet, the show educates children on HIV&AIDS and stigma. Takalani Sesame has also run campaigns aimed at teenage youth and caregivers.

Question 6: Are there any sexuality education programmes for boys, girls, adolescents and young people that are outside of the school system?

There are many sexuality education and mass media programmes for the youth that are outside the school system and outside of school hours. These are many funded by Government and development agencies, and implemented by NGOs such as Love Life, Siyayincoba Beat It!, and many others to mention within the context of this report. [44],,[45], [46],[47].

---

[43] Department of Education. Guidelines for the prevention and management of sexual violence & harassment in public schools. May 2008.

[44] www.beatit.co.za

[45] www.schooltv.co.za/TakHome.htm

OUT LGBT and Triangle projects have outreach programmes to address LGBTI issues, but these are limited in reach.[48] Media programming and messaging has a long way to go in terms of addressing the needs of women living with HIV, and in particular being sensitive to their needs and how these needs are positioned and portrayed. Currently women living with HIV are either blamed or portrayed as victims.[49]

Question 7: Is there any technical sub-division of the National AIDS Programme solely dedicated to questions involving women and HIV&AIDS?

No, there is no technical sub-division of the National AIDS Programme solely dedicated to questions involving women and HIV&AIDS

However, SANAC- the advisory and oversight body for the HIV&AIDS response in the country, has four technical task teams on the four key priority areas of the *HIV & AIDS National Strategic Plan 2007-2011 namely* prevention, treatment, research and human rights. All these key priority areas have aspects relating to women and HIV within their objectives.

In addition, the women's sector is one of the 19 sectors of SANAC, but has been poorly resourced since its establishment. In 2009, the sector received funding from Irish AID to reorganise itself and ensure that it is represented on all the SANAC structures. As a result of this work, the Women's Sector has developed a strategic plan to ensure efficient operation of the Sector, especially in relation to communication with members, and women living with HIV in particular[50]. The plan also seeks to reframe the old paradigm that views women and AIDS issues in a maternal paradigm, to one that includes SRHR issues- encompassing all the priority aspects of prevention, treatment, human rigths and research. Influencing policies and programmes to incorporate women issues are some of the pillars of the plan.

The new Government notes that the AIDS treatment sector has neglected reproductive health, and that this has had a serious impact on women mortality and morbidity. In addition, SANAC has

---

[46] "Soul Buddyz – South Africa Programme Summary." *HIV/AIDS Where communication and media are central to the eradication of HIV/AIDS.* http://www.comminit.com/en/node/115715/347 , 2005
[47] http://www.lovelife.org.za/
[48] Van Dyk, D. OUTLGBT. Personal interview. November 2009.
[49] Mthembu, P. Personal interview. December 2009.
[50] Eland, Nomfundo. Personal Communication, December 2009

decided to create new sectors for LGBTI groups and Sex Workers, in recognition of the need to recognise and consult with these key women groups.

Question 8: Have policies been defined for controlling STIs?

Yes, the National Strategic Plan HIV&AIDS, STI, 2007-2011 defines policies for controlling STIs. The syndromic management approach which was introduced in the mid 1990s, together with the free availability of condoms have been major steps in rationalising and improving management of STIs in South Africa. As a result, the prevalence of certain STIs – notably syphilis, chancroid, gonorrhoea and trichomoniasis – has declined since the mid-1990s. STIs account for more than half of new HIV infections, and genital herpes is the most significant STI promoting the transmission of HIV. Syndromic management programmes reduced HIV incidence by 3-10% over the 1994-2004 decade following their introduction. Further reductions in HIV incidence could be achieved by promoting patient-initiated treatment of genital herpes, by addressing rising levels of drug resistance in gonococcal isolates, and by encouraging prompt health seeking for STIs.[51]

STI services have however not been well implemented and have lacked quality and consistency. In the case of cervical cancer for example, the screening programme is not well understood by clients; and the public health system only has 50% of the necessary radiation equipment to treat the cancer. This is different in the private sector though, where health services continue to surpass those in the public sector[52]. Two cervical cancer vaccines were registered in South Africa in 2008 and are available in the private sector, but not in the public sector[53]. This is a problem for women living with HIV in particular-since they are forty times more likely to contract cervical cancer than those not infected, essentially due to HPV transmission.

Question 9: What is South Africa's national policy on abortion? Is there any statistical data from polls revealing public opinion in regard to the right of HIV-infected women to interrupt a pregnancy?

The Choice on Termination of Pregnancy Act (CTOP) was promulgated in 1996[54] and enacted in February 1997. This law repealed the restrictive Abortion and Sterilisation Act. This was significant because during the apartheid era, abortion was largely inaccessible to black and poor women. The

---

[51] Johnson, L. 'The interaction between HIV and other sexually transmitted infections in South Africa: a model-based evaluation' .Ph.D Thesis, Department of Actuarial Science. University of Cape Town, November 2008.
[52] Schneider, H. , Chabikuli, N., Blaauw, D., Funani, I and Brugha, R. Improving the quality of STI care by private general practioners: a South African case study. *Sex Transmitted Infections* 2005: 81:419-420
[53] Cooper et al, 2004, p. 70 ' Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status' Reproductive Health Matters 2004;12(24):70–85.
[54] See link for act: www.info.gov.za/acts/1996/a92-96.pdf

new law stated that "the right to decide when and whether to have children" is a fundamental human right. Cathi Albertyn argues however that, "while women won the right to choose whether to have children or not in law, this right still needs to be won in their communities and in their homes." [55]

The Act allows for Termination upon the request of a pregnant woman during the first 12 weeks of pregnancy and under certain conditions from 13 to 20 weeks of pregnancy. The HIV status of the woman is not an indication for a termination under any of the conditions stipulated in the act. The act is called the CHOICE on Termination of Pregnancy Act (CTOP), putting the emphasis on the choice of the pregnant woman.

Services for abortion are not accessible and active, and the public sector designated facilities have decreased from 70 to 43%[56]. Abortion and HIV services are not integrated, linked or regulated. There have been reports of women being compelled to sign consent for an abortion or sterilisation in order to continue accessing HAART. While SA abortion law is viewed as liberal, currently only surgical abortion is available in the public sector. Medical abortion is only provided in the private sector for the first 63 days of pregnancy. The NSP suggests that the medical abortion guidelines for the public sector need to be finalised and medical abortion should be offered as part of the continuum of HIV&AIDS care. However, this is not on the treatment agenda yet.

Maternal Mortality was made a notifiable condition in 1997 and the Standing Committee for Confidential Enquiries into Maternal Deaths was established. Since the establishment of this committee three triennial reports have been released each highlighting the decrease in number of maternal deaths as a result of a decrease in the number of unsafe abortions. Sadly for South Africa, the 4th Saving Mothers report Executive Summary published on July 3rd 2009, indicates that this is no longer the case. During the reporting period 2005 to 2007, South Africa saw an increase from 4.7 to 4.9% in maternal deaths related to unsafe abortion.[57]

At a parliamentary briefing session in 2008 the Department of Health offered the following reasons for the decreased contraceptive use, and increased abortion figures in South Africa:

- Accessibility to family planning services is not the problem but rather that "young females got pregnant on the spur of the moment".

[55] Albertyn, Cathi. "Twelve Years of Choice" Khanya: A journal for activists. No 20, November 2008. Pg 5-6.
[56] Pillay, Y. National Department of Health. Personal Communication, March 2009
[57] Trueman, K. Director, Ipas South Africa.

- Young females were encouraged to carry condoms, but they did not. The problem was their attitude to life.
- There is always a high demand for abortions after holidays and music festivals.
- Young women are familiar with nurses working in clinics near their homes and are therefore shy to visit the clinics for contraception[58]

Public opinion on abortion remains conservative, and the Presidency has indicated an intention to "open the issue for debate" in response to demands from conservative religious organisations. A study by Orner *etal* (2009)[59] showed that HIV-positive pregnant women were considered irresponsible by others for not preventing pregnancy because:

- Male condoms and other contraceptive methods were considered "easily accessible"
- Pregnancy, together with HIV, was seen to irreversibly worsen health and likely lead to postnatal death
- Their children have a high risk of being HIV-positive

Difficulties with using male condoms and other prevention methods appeared somewhat unacknowledged and TOP as an option was generally unsupported in communities. Participants considered current TOP policy superior to former policy, and deemed it particularly beneficial for poor women. Most supported TOP and women's right to choose in certain circumstances but many remained wedded to the notion that TOP was equivalent to "murder" although their realities often made it a necessity. Orner concludes that, women living with HIV experienced social disapproval if they became pregnant knowing their HIV status. They perceived even stronger social and internalized disapproval when they considered or had an abortion. Most faced serious socioeconomic hardship (e.g., unemployment, dependent children, lack of partner and other social support. Specific health concerns and concerns about their children's health made reproductive decision-making a particularly difficult area in which to feel self-efficacy and agency

[58] Department of Health. 30 May 2008. Progress made in promoting women's reproductive health and rights with a special focus on HIV&AIDS. Briefing to the JMC on Improvement on Quality of Life and Status of Women.
[59] Orner, P., Cooper, D., Harries, J. and de Bryn, M. ' A qualitative exploration of HIV positive women's decision making regarding abortion in Cape Town, South Africa. XIX FIGO World Congress of Gynaecology and Obstetrics. 5 October 2009.

Question 10: What are the main social-cultural characteristics (beliefs, religions) of South Africa that interfere in the effective control of HIV?

South Africa is a diverse country with a range of religious and cultural beliefs. Both civil and customary marriages are legally recognised by the supreme law of the country, the constitution. There are a number of cultural sexual practices that are proving to be a challenge to effective HIV prevention-especially within the context of customary marriages. These include polygamy; widow inheritance; child abduction and forced marriage (ukuthwala) and extramarital relationships. The 2008 Human Development Report for Swaziland, indicates that polygamy in particular, has become an important driver of the HIV&AIDS epidemic in that country. It shows that most men in polygamous marriages, also engage in extramarital affairs or Multiple Concurrent Partners (MCP)- as this is often a pre-cursor to a marriage. This poses a challenge to effective HIV prevention as having MCPs has been established as an important factor underpinning rapid growth of the HIV epidemic – particularly in Southern Africa. While the NSP has clear targets of reversing MCP as one of its key focus areas, there is a tension between this and the traditional cultural practices South Africa.

In most traditional settings, women are not expected to talk about sex, and are viewed suspiciously if they raise issues related to sex. Male dominated beliefs and reports of women not permitted to touch their partner's penises unless granted permission[60], perpetuate perceptions that women are not expected to enjoy sex. These contexts have limited room for negotiation around prevention of HIV and pregnancy, among others. Women are however, expected to take responsibility for contraception, and therefore tend to choose contraceptive methods that are less cumbersome and almost "invisible" to their male partners such as Depo Provera.

While recent studies suggest that general condom use in the country has increased, consistent and correct condom use has not necessarily followed. There is no condom use in polygamous marriages, or it is inconsistent at best. Amongst people with concurrent partners, it has been found that condom use declines rapidly with a "main" partner, and is inconsistent with "other" partners. Few of the young women engaging in transactional sex with men five years older than themselves used condoms. 63% of the women surveyed said they were not using a condom with their main partner even though over 70% thought their man had other partners at the same time. Whilst condom promotion remains an important cornerstone to HIV prevention, in the present context of high HIV prevalence in conjunction with exposure to concentrated sexual networks, it is necessary to focus on reducing concurrency, and promoting correct and consistent condom use.

---

[60] Women's HIV Prevention Tracking Project .17 July 2009: Male circumcision and its impact for women. Cape Town

High levels of stigma in communities and in health care settings still make HIV testing uncomfortable in rural clinics. Misinformation on HIV&AIDS and STIs in communities creates a climate of confusion and prejudice towards HIV+ people.[61] There is a widely held perception that lesbian women are not at risk of contracting HIV. However, given the homophobic socio-cultural attitudes towards lesbian women, they often adopt a range of survival strategies, including choosing to be bisexual, thus exposing themselves to HIV. The use of rape to 'cure' or punish lesbians is an extreme and brutal expression of compulsory heterosexuality. While communities know of lesbians who are living with HIV and even of lesbians who have died of AIDS, there is an absence of research data on HIV prevalence among lesbian women and Women who have sex with Women (WSW) in South Africa and globally[62].

Other challenges to the effective prevention and management of HIV transmission among women in South Africa include: Orphans and Vulnerable Children and Child headed households with no parental guidance; Culture and tradition and the belief that traditional doctors can cure HIV; Resistance to condoms use; and lack of accurate knowledge on HIV, AIDS and STIs.

A recent study found that community-level violence was a significant social factor for HIV transmission. Youth from communities with higher sexual violence were significantly less likely to use condoms at their last sexual encounter and were more likely to be HIV positive or to have experienced an adolescent pregnancy as compared to youths from communities with lower sexual violence. The study also found that individual-level violence was only associated with condom use but not HIV infection or pregnancy. This was mainly because multiple other factors such as partner status; number of sexual partners; coital frequency; type of partnerships and age of sexual debut influence individual pregnancy and HIV[63]. This indicates the need to identify communities with high levels of violence, and ensure that there are adequate SRH services for women and girls in those areas.

Question 11: What percentage of national budget allocations are dedicated to sexual and reproductive health and combating HIV in South Africa? Has there been any increase in the amount or a reduction?

"South Africa spends more on health than any other African country—8·7% of its gross domestic product, just slightly less than Sweden (8·9%) and more than Hungary (7·8%) according to World

---

[61] Compass Project. 2009. *Scaling up for Success. A Community Implementer's Guide.* 4th South Arican AIDS Conference, 31 March – 3 April 2009, ICC Durban, South Africa. The Foundation for Professional Development (FPD).

[62] Triangle Project. 2009. Lesbian HIV Fact Sheet.

Bank figures from *World Development Indicators 2008*. Yet it is one of only 12 countries in which mortality for children younger than 5 years has actually increased since 1990. Despite an active, innovative, and internationally respected research community (especially in the fields of infectious diseases, violence and injury prevention), translation of evidence into local policies is hampered by ineffective leadership, inexperienced and unaccountable managers, and a weak health system."[64]

There are no specific allocations for SRHR – it is not a particular line item as there is no particular unit or policy that addresses SRHR in relation to HIV/AIDSHIV&AIDS[65]. Funding for reproductive health has suffered significantly since the targets were initially set fifteen years ago, largely due to budget shifts to HIV/AIDSHIV&AIDS. The UNFPA is currently supporting the Government's Social Development Committee to integrate HIV/HIV&AIDS and reproductive health responses[66], and increase budget allocations for population and development issues including SRHR[67].

The situation about insufficient budget for SRHR is well illustrated by the challenges experienced with the procurement, distribution and social marketing of Female Condoms, as well ART and Infant Formula. Following a TVEP facilitated National Dialogue[68] , the country's Human Rights Commission agreed that the lack of access to affordable female condoms is a human rights violation[69],[70]. The challenges pointed to both inadequate allocation to SRHR, as well as to inefficient National and Provincial Financial Management.

Question 12: Is teenage pregnancy a problem in South Africa and how is it being addressed?

The report of the Department of Basic Education to parliament indicates that 66% percent got pregnant because they did not use a condom, 28% because they wanted children to "gain respect" and others because they were coerced into having sex[71] . The 2009 report showed that there was a lack of vital statistics in South Africa but that overall fertility had been declining for the past fifty

---

[63] Speizer, IS; Pettifor, A; Cummings, S; MacPhail, C; Kleinschmidt, I & Ree, H. *Sexual violence and Reproductive Health Outcomes among South African female youths: A contextual analysis*. American Journal of Health, Supplement 2, 2009, Vol 99, NoS2.
[64] Kleinert,S & Horton, R. 2009. *South Africa's health: departing for a better future?* The Lancet, Published **Online** August 25, 2009
[65] Mhlanga, E. National Department of Health. Personal Communication. September 2009
[66] UNFPA, South Africa. Presentation to the National Assembly Committee on Social Development. 12 Oct 2009
[67] Annual National Plan 2008/09 -Department of Health; Annual Report 2008-National Department of Health
[68] See dialogue report: http://www.health-e.org.za/uploaded/eb36b4d2e02db96e65f255bf44498b38.pdf
[69] See: http://www.pmg.org.za/files/docs/091007agreport.pdf
[70] See: http://www.globalfundforwomen.org/cms/images/stories/downloads/GFW_2008-09_AR.pdf

years (78/1000 in 1996, to 65/1000 in 2001, to 54/1000 in 2007). The Department stated that there was a perception in the country that there was an upsurge in teenage pregnancy, because the pregnancies were seen more often in schools, in communities and amongst those collecting the Child Support Grant. Most teen pregnancies happened between the ages of seventeen and nineteen. The rise in learner pregnancy was most likely the result of improved reporting rather than a real increase. Learner pregnancy rates were higher in schools located in poor areas and in schools that were poorly resourced. There was no empirical evidence of a link between teen fertility and the Child Support Grant. Termination of pregnancy by teens had increased over time and there was in fact a low uptake of the Child Support Grant among teens. Data showed that an increase in education resulted in a decrease in fertility and that pregnancy was no longer causing students to drop out of school, although dropping out was a significant risk factor for early pregnancy and HIV. The Department noted that only about a third of teen mothers returned to school, and that in response to the challenge, the Department would develop a comprehensive strategy for the management and prevention of learner pregnancy, and explore the policy options relating to teen pregnancy in education. The strategy would include developing tools to identify high risk schools, developing early warning systems for schools to identify students likely to drop out, developing monitoring and evaluation tools, improving life skills programmes, and strengthening and supporting peer education.[72]

The Department proposed a 2-year period for teen mothers to return to school as there was a need for these mothers to care for their babies. Although this is not a policy, many schools and pregnant girls take it as a rule leading to many girls dropping out of school for good.

---

[71] Department of Basic Education. 2009. Teenage Pregnancy in South Africa – with a specific focus on school-going learners.
[72] Department of Basic Education. 1 Sep 2009. *Teenage pregnancy amongst school learners, and in SA generally: Departmental briefing. Briefing* to the Portfolio Committee on Basic Education. www.pmg.org.za/print/18022

LIST THE BASIC STATISTICS ON THE EPIDEMIC AND ON SEXUAL AND REPRODUCTIVE HEALTH: (OFFICIAL FIGURES ONLY FOR THE PERIOD 2008/2009)

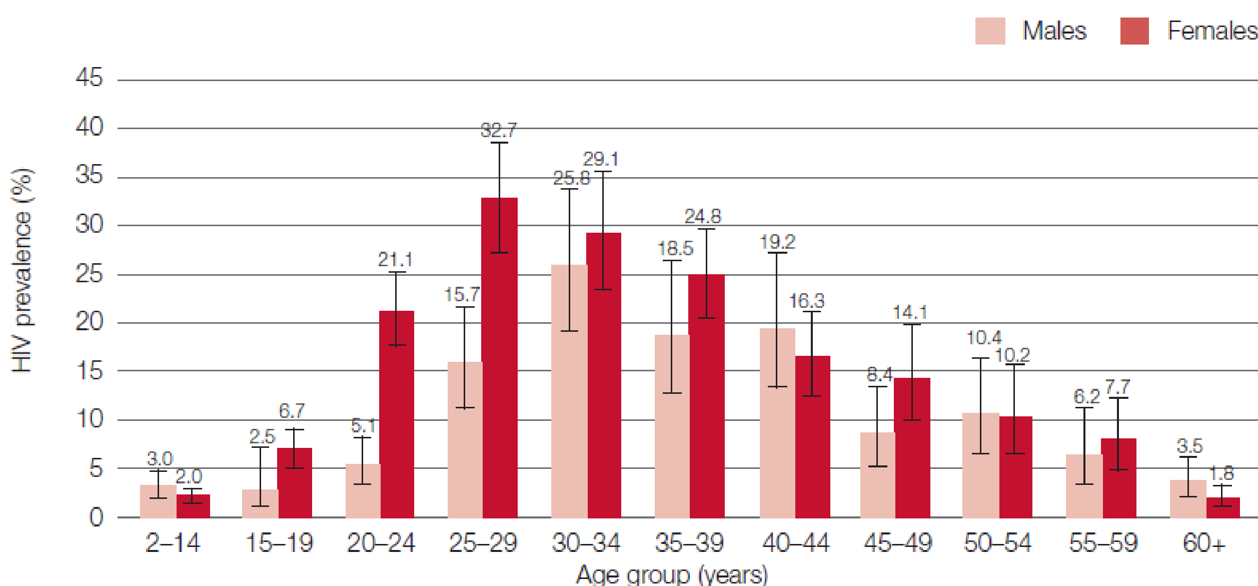
- **TABLE 4: HIV/HIV&AIDS INCIDENCE RATES AND PREVALENCE BY SEX AND BY AGE GROUP**

Data is only available for women as in the annual antenatal survey. The national antenatal prevalence rate for women in 2008 is 29.4 %[73].

Age	Prevalence Rate in %
15-19	14.1%
20-24	26.9%
25-30	37.9%
30-35	40.4%

The latest HSRC survey shows a peak in prevalence rates for women aged 25-29 and for men 30-34 years of age.[74]

FIGURE 2: HIV PREVALENCE BY AGE AND SEX



[73] **Error! Main Document Only.** www. doh.gov.za 2008 National Antenatal Sentinel HIV & Syphilis Prevalence Survey. September 2009

[74] HSRC, MRC, Cadre & NICD. 2009. South African National HIV prevalence. Incidence, behaviour and communication survey, 2008. A turning tide among teenagers? HSRC Press

ARV-use coverage, by sex

This data was provided by the National Department of Health[75]. The data is cumulative and is not disaggregated by age and sex.

TABLE 5: NUMBER OF ADULTS AND CHILDREN ON TREATMENT

MARCH 2009
National Comprehensive HIV and AIDS Plan Statistics*
Cumulative Number of Adults and Children on Comprehensive HIV and AIDS Treatment Plan

Province		EC	FS	GP	KZN	LP	MP	NW	NC	WC	Total
2005	Jan	3739	1015	9774	6696	935	936	2625	515	6660	32895
	Jun	6843	2027	19759	15245	2223	1792	5907	1135	9827	64758
	Dec	12382	2341	35033	27821	4661	3693	11749	1756	13939	113375
2006	Jan	13062	2520	36717	29223	5239	4529	12499	1838	14463	120090
	Jun	18515	3356	48251	48177	8497	6902	18157	2933	18917	173705
	Dec	24464	3812	63200	69252	12809	12345	25034	4876	23452	239244
2007	Jan	24136	3812	65830	69252	13726	13240	26088	4989	24117	245190
	Feb	26292	3812	69261	76670	14525	14063	27206	5370	24991	254772
	Mar	28447	3812	73229	77516	15433	16115	28378	5888	26090	274908
	Apr	30279	3812	76045	79328	16371	17053	30148	5920	26479	285435
	May	31848	3812	78246	90142	16707	17859	31303	6205	27666	303788
	Jun	33739	11728	80185	90969	17325	18196	31303	6561	28441	318447
	Jul	35135	13192	85772	107641	17325	19568	30683	6772	29541	345629
	Aug	35782	14493	88955	108191	18733	20561	31904	7026	30412	358173
	Sep	36549	15905	92545	110307	19937	22709	33150	7257	31303	369662
	Oct	39415	17998	96616	122507	19937	22913	34590	7499	32278	393674
	Nov	42132	20130	100401	127654	21366	23486	35978	7749	34350	408218
	Dec	42356	22830	102808	130183	22353	23785	37261	7518	34915	424009
2008	Jan	44083	25896	106300	134571	23762	25892	38543	7682	35631	442360
	Feb	45849	26545	111891	139891	25494	26297	40040	8013	37276	461296
	Mar	48010	27748	116237	142445	27150	28067	41366	8196	38227	477446
	Apr	52004	28787	121277	144932	28984	28561	42938	8451	39509	485571
	May	53471	29100	126153	151276	30686	30236	44491	8653	40211	502938
	Jun	55059	31032	131181	154611	32405	31840	45897	8901	41767	532693
	Jul	55820	32451	136567	166752	34164	32606	47469	9201	43500	558530
	Aug	58379	33916	141425	171178	35984	34340	48971	9498	44601	578292
	Sep	60647	35381	147045	176729	37912	36243	50746	9800	46053	600556
	Oct	60326	37029	153479	190816	39896	38129	53652	10106	47342	630775
	Nov	64854	37537	159561	202291	41764	38655	55332	10521	48317	658832
	Dec	68645	37678	163842	208168	43427	39878	56761	10768	49383	678550
2009	Jan	72159	37756	169415	216104	45196	41888	58700	11100	50974	703292
	Feb	73804	38069	175774	216623	47068	44534	60645	11458	52809	720784
	Mar	77030	40232	183656	216623	49421	46879	63045	11872	55040	743798

Source: Monitoring and Evaluation, Department of Health, SA

- EC = Eastern Cape, FS = Free State, GP = Gauteng, KZN = KwaZulu Natal, LP = Limpopo, MP = Mpumalanga, NC = Northern Cape, NW = North West and WC = Western Cape
- The interpretation of patient numbers on Comprehensive HIV and AIDS Treatment Plan for provinces **EC**, **GP**, **KZN**, **LP**, and **NW** should take into account the effect of patients who are lost to follow up, deregistered and those who died after the commencement of the treatment. This information is not currently captured. Provinces are in process to start reporting on these indicators.
- **KZN** submitted data on number of children for February 2009 and no data for adults on treatment.
- **KZN** did not submit data for March 2009.
- **NC**, **FS**, **MP** and **WC:** Data reflects transfer out (TFO), deaths (RIP) and loss to follow up. It is not accumulative but rather actual totals of patient in care in the province.
- Official statistics March 2009

- **Maternal Mortality Rate**

  Maternal deaths are defined as "deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes".There is no definitive epidemiological data providing a maternal mortality rate – however there is a process termed the '*Confidential Enquiries into Maternal Deaths'*. This is a systematic multi-disciplinary

[75] Ntuli, N. 2009. National Department of Health

anonymous investigation of all or a representative sample of maternal deaths occurring in an area, which identifies the numbers, causes and avoidable or remediable factors, associated with the deaths. The analysis of each woman's death and the aggregation of the data obtained enable *Confidential Enquiries* to provide pointers towards where the main problems in overcoming maternal mortality lie, and highlight the key areas for recommendations to the health sector and communities.

In the May 2009 report, the following is noted:

- In the 2005-2007 trienniums there was a 20.1% increase in the number of deaths compared with the previous triennium 2002-2004.
- The "big five" causes of maternal death have remained the same, namely non- pregnancy related infections – mainly AIDS (43.7%), complications of hypertension (15.7%), obstetric haemorrhage (ante-partum and postpartum haemorrhage; 12.4%), pregnancy-related sepsis (9.0%) and pre-existing maternal disease (6.0%).
- There has been a significant decrease (14%) in the institutional Maternal Mortality Ratio (MMR) for complications of hypertension. There was a significant increase (21%) in deaths due to non-pregnancy related infections. There were no other significant changes in the disease pattern.[76]
- The lack of training focus on issues of effective staff recruitment and retention, use and availability of technology, financial management and ethics are problematic.

Black *et al* (2009)[77] reviewed facility-based maternal deaths at a tertiary-level centre in Johannesburg, during a five year period (2003-2007). During this period, 106 maternal deaths occurred out of 36,708 births (facility maternal mortality ratio of 289/100 000). In 72% of the cases, HIV status was known (76/106); with the majority being HIV infected- 78% (59/76). Of those HIV+ women, only two had initiated HAART; and 70% of deaths were HIV related (41/59), mainly tuberculosis (21) and pneumonia (12). Direct obstetric deaths such as hypertension and pregnancy-related sepsis predominated in women who were HIV-negative or of unknown status-48 %(23/47)

---

[76] Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa. 2009. www.doh.gov.za/docs/reports/2007/savingmothers.pdf

[77] Black, V., Brooke, S. and Cherisich, F. (2009) 'Effect on Human Immunodeficiency Virus Treatment on Maternal Mortality at a Tertiary Center in South Africa.' Obstetrics and Gynaecology Vol 114, No 2, Part 1, August 2009.

- **Prevalence of Condom use**

The male condom distribution rate is based on the number of condoms that are distributed via public health facilities by the Departments of Health in a year to men 15 years, and older. The average condom distribution rate in South Africa, 2007/08 is 11.8 per man. There is significant variation in condom distribution depending on the geographic location. The highest rate is in Cape Town where 55.2 condoms are distributed per man per year as opposed to the lowest rate in Kgalagardi district where only 1.7 condoms per man per year are distributed. In 2007/08 the City of Cape Town's HIV/HIV&AIDS NGO sector combined efforts to dramatically scale up condom distribution over a three year period using a method proven successful in Khayelitsha in 2005. While Cape Town's rate

increased, eight of 12 rural districts showed a decrease in 2007/08 in distribution. [78] For more on Female Condom distribution and usage please go to www.tvep.org.za

- **Prevalence of use of contraceptives**

  The Rate at which women are protected against pregnancy- the Women year protection rate is 29.1[79] , the Rate at which couples and specifically women are protected against pregnancy- Couple year protection rate is 31.8[80]. The only recent data on contraceptive prevalence dates from 2003 – being 64.7% (SADS 2003). Teenage prevalence for the age group 15-24 is 58% (HIV Household survey 2005). These data is not viewed as reliable though[80].

---

[78] Stevens, Marion. "4.3 Male Condom Distribution Rate" District Health Barometer 2007/08. Health Systems Trust: Westville, June 2009 Pg 61-65
[79] NDOH DHIS Data Set. August 2009
[80] Day, C. and Gray, A. 2008. Health and Related Indicators. In Barron P, Roma-Reardon, J, editors. South African Health Review. Durban: Health Systems Trust Pg 319.

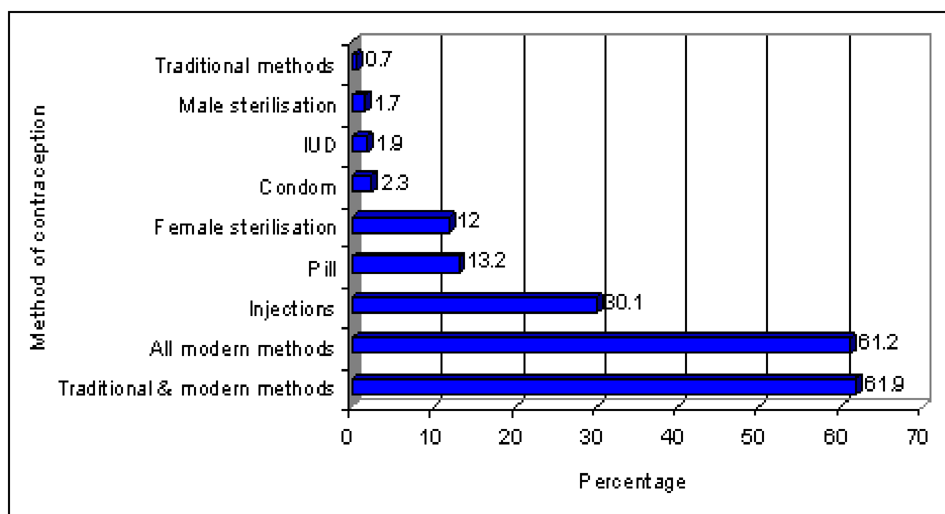


FIGURE 3: CONTRACEPTIVE PREVALENCE BY METHODS – DHS 1998[81]

- **Vertical Transmission rate for HIV**

  There has been an overall increase in the coverage of Nevirapine from a national coverage of 65% in 2006/07 to 76% in 2007/08.

Collection of data on Nevirapine coverage is particularly difficult due to the fact that the dose can be dispensed either in the antenatal clinic or the labour ward. Aggregation of data, which is not linked to individual patients from these two settings, has proven difficult. Furthermore, some women living with HIV may be reluctant to disclose their HIV status within labour ward settings and therefore may not be given a Nevirapine dose or may take a dose without informing staff, hence the dose would not be recorded in the routine records. These challenges can result in both under and over (double counting) recording of Nevirapine doses dispensed. It is expected that coverage of this component of the programme will improve with the introduction of dual therapy since it will no longer be an 'all or nothing' intervention. There were serious data quality problems with the Nevirapine uptake rate for newborns and this is occurring systematically in almost all the districts. In most years the uptake rate has been around 100%. The denominator used to calculate this indicator (live births to HIV positive women) generally gives an inflated picture of Nevirapine coverage to babies as far fewer deliveries to HIV positive women are recorded each month compared with the number of women testing HIV positive. There are also substantial differences in this discrepancy from year to year, so the effect of the bias is not consistent, with much higher denominators around 2006/07, resulting in a dip in the indicator values over the same period. The low recorded number of live births to HIV positive women suggests that either many HIV positive women are delivering at

home and are therefore not recorded in facility delivery records, or that HIV positive women are not identified in labour and are therefore not recorded as such in delivery registers. The first explanation is unlikely given that in South Africa overall 91% of births are assisted by a trained health care provider (SADHS 2003). The only year when the denominator is thought to be realistic was in 2006/07 when 81% of HIV positive mothers were identified on delivery, and the Nevirapine update rate among newborn babies was 57.3% [82]

- **% of births taking place under hospital care regime**
  84% of women delivered in a facility with skilled birth attendants, maternal mortality and perinatal mortality remain high in South Africa, and during the 2007/08 year the average delivery rate to minors in the age group 14 years old or under, and in the age group 15 to 18 was 80.6%[83].

- **% of births to minors in the age group 14 years old or under and in the age group 15 to 18.**
  Teenage fertility has declined by 10% between 1996 (78 per 1000) and 2001 (65 per 1000). A further decline in teenage fertility (54 per 1000) was reported in the 2007 Community Survey. Older adolescents aged 17-19 account form the bulk of teenage fertility in SA. While rates are significantly higher among Black (71 per 1000) and Coloured (60 per 1000) adolescents, fertility among White (14 per 1000) and Indian (22 per 1000) adolescents approximates that of developed countries.[84]

---

[81] SADHS Project Team, " South Africa in transition: selected findings from the South African Demographic and Health Survey" (Pretoria, Government Printers, 1998 http://www.sarpn.org.za/documents/d0000104/page2.php

[82] Doherty, Tanya. "4.4 PMTCT Indicators." District Health Barometer. District Health Barometer 2007/08. Health Systems Trust: Westville, June 2009 Pg. 66

[83] Nyawo, Khosi. "5.5.4 Delivery Rate in Facility." District Health Barometer. District Health Barometer 2007/08. Health Systems Trust: Westville, June 2009 Pg. 114

[84] Panday, S. etal. 2009. 'Teenage Pregnancy in South Africa – with a specific focus on School – going learners. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria: Department of Basic Education.

SECTION II

Sexual and Reproductive Health Services

[A] EDUCATION, INFORMATION, COMMUNICATION IN SEXUAL AND REPRODUCTIVE HEALTH

Question 1: What are the main elements of prevention directed at the sexual and reproductive health of women, young people and adolescents included in the National HIV/HIV&AIDS Policy?
Conceptually, prevention within a SRHR framework is not well defined within the NSP. However, some elements of SRHR are noted.

The main priority of prevention is to reduce the rate of new HIV infections by 50%, by 2011. The NSP on HIV& AIDS and STI 2007-2011 aims to reduce vulnerability through *women empowerment*, including reducing the rate of gender-based violence. Further, the plan seeks to reduce the rate of sexual transmission by using a wide range of communication modalities to *improve health-seeking behaviour* and *adoption of safe sex practices*. In addition it aims to ensure that a large proportion of youths (14 to17 years of age) *delay the initiation of sex*. Objective 3.1 notes "*the need to scale up contraceptives and increase access to TOP services including the finalization of medical abortion policy*".

The NSP aims to reduce incidence rates among Most at Risk Populations (MARPS) *and other marginalized groups* (including commercial sex workers (CSWs), men who have sex with men (MSM), intravenous drug users, economic migrants, refugees and other mobile populations). The objectives of NSP include: improving access to, and use of *male and female condoms*; reducing the spread of HIV through prevention programmes for people living with HIV; ensuring adequate *access to all relevant services for youths 15-24;* increasing access to a comprehensive management package on sexual assault; and ensuring effective management and *control of STIs* in the public and private health sectors, among others.

The NSP further aims to reduce the rate of HIV incidence among children < 5 years, by increasing PMTCT coverage and uptake by pregnant women, and minimizing the risk of HIV transmission and maternal mortality through *providing ART for all eligible pregnant women*.

A) Basic contents of the messages:
Within the NSP, the language of SRHR is used as part of priority area one: '*Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services*'.

An overarching concern is the lack of uniformity in the messaging, thereby diluting the impact of campaign work. In 2009, SANAC developed messaging that ALL Government Departments supported and promoted. The straplines for World AIDS Day 2009 were "I am responsible – We are responsible – South Africa is taking responsibility". The messaging is phrased as men and women have the right to take responsibility and care about the different facets of HIV&AIDS.

B) Most-used media strategies:

There are a range of creative media processes and strategies involving print and electronic media-including TV, radio and mobile phones. Large-scale communication campaigns such as Government's Khomanani, Soul City, Soul Buddyz and loveLife have been active for a number of years. Useful resource websites include: www.karabo.org.za; www.newstart.co.za and www.hiv911.org.za.[85]

WomensNet[86] started The Feminist Tech eXchange (FTX) programme to give activists, service providers, and women and girl rights' advocates practical skills for the strategic use of information and communication technologies in response to violence against women. The FTX aims to: Support the development of a community of trainers who augment knowledge and skills of women's rights and feminist advocates in different locales; Build the capacity of women and girls in the creative and strategic use of ICTs; Promote solidarity between women and girls working in the fields of ICTs and women's rights; and Provide a space for open discussions on the intersection between ICT issues and VAW, and women's rights issues more broadly. In addition, the FTX aims to transform the way women's rights organisations and activists view communication and information, as well as change their current information production and dissemination practices. Overall, transformation on a societal level will result in increased access to relevant, impactful information that improves women's access to their rights.

SAfAIDS developed a toolkit entitled "Changing the river's flow Series" for conducting community dialogues-mainly aimed at addressing cultural practices that are harmful and/or perpetuate women vulnerability. Positive results have been noted and documented[87].

---

[85] Compass Project. 2009. *Scaling up for Success. A Community Implementer's Guide.* 4th South Arican AIDS Conference, 31 March – 3 April 2009, ICC Durban, South Africa. The Foundation for Professional Development (FPD).
[86] Sally-Jean Shackleton, Executive Director Women'sNet.
[87] www.safaids.net

C) Promotion, availability and distribution of condoms:

Although condoms are widely accessible in South Africa, the UNAIDS AIDS epidemic update for 2008 indicates that the level of condom use is low for a population with such a high prevalence of HIV.[88] The average male condom distribution rate in South Africa for 2007/08 is 11.8 per man, while the data on female condom distribution rate was not available for this report. The distribution rate is based on the number of condoms that are distributed by the Departments of Health in a year to men and women 15 years and older. There is significant variation in condom distribution depending on the geographic location. The highest rate is in Cape Town where 55.2 condoms are distributed per man per year as opposed to the lowest rate in Kgalagadi district where only 1.7 condoms per man per year are distributed. In 2007/08, the City of Cape Town's HIV&AIDS NGO sector combined efforts to dramatically scale up condom distribution over a three year period using a method proven successful in Khayelitsha in 2005. While Cape Town's rate increased, eight of 12 rural districts showed a decrease in 2007/08 in distribution. [89]

While there has been significant talk about reducing women's vulnerability to HIV&AIDS, the talk has not been met with corresponding action. The NSP plans for the procurement and distribution of 425 million male condoms and only 3.5 million female condoms. The unequal procurement and distribution was based on the idea that women do not 'like' female condoms[90]. It is not clear how this conclusion was arrived at, because UN surveys indicate the contrary. In addition, it is not clear why this could have informed procurement decisions, as male condoms are generally not 'liked' either.

The 3.5 million female condoms procured are not enough for the number of sexually active women and girls in South Africa - calculated at one condom for every four women. This is a violation of the rights of women and men[91]." As a result of the low procurement numbers, the focus on female condoms is weak, and their marketing is ineffective.

D) Inclusion of civil society in the process of planning actions:

There is significant civil society participation in the planning of HIV&AIDS responses. The Women's sector is one of several civil society sub-sectors that participate in SANAC- Government's advisory

---

[88] Joint United Nations Programme on HIV/AIDS (UNAIDS). AIDS epidemic update 2008. Regional Sumary Sub-Saharan Africa. Geneva: UNAIDS; 2008. URL: *http://www.unaid.org*

[89] Stevens, Marion. "4.3 Male Condom Distribution Rate" District Health Barometer 2007/08. Health Systems Trust: Westville, June 2009 Pg 61-65

[90] The 2008 Thohoyandou Victim Empowerment Dialogues: Universal Access to Female Condoms - A Human Rights Issue! 10 – 11 September 2008.

[91] - Muhammad Aslam Panhwar, Peace Foundation Pakistan *http://lists.hst.org.za/mailman/private/60percent/2009-September/001507.html*

and oversight body for HIV&AIDS. So far, participation of the women's sector in SANAC is satisfactory, but could be improved by increased allocation of resources to function and convene the sector, as well as the inclusion of experienced champions of SRHR and women's issues in the Communications Technical Task Team. This would assist with stronger messaging on SRHR and women and girls' issues[92].

E) Inclusion of civil society in the implementation of activities:

Civil Society Organisations implement a significant portion of the NSP- funded by government through the Department of Social Development; local private Funders; as well as several international aid agencies.

Question 2: How would you assess the actions in the field of HIV prevention directed at women, young people and adolescents?

The ***Abstain, Be faithful, Condomise*** (ABC) message has been proven ineffective and no longer relevant to the South African context- given the research findings on sexual behaviour in this country. The messaging still persists however, because it has mainly been donor driven-by PEPFAR in particular. The ABC messaging focuses on limiting sexual activity, suggesting that if all else fails, use a condom, generally a male condom, due to the poorly funded and inequitably distributed female condom. Abstinence-only programmes have been found not to help youth to delay initiation of sexual intercourse; long-term demographic trends such as later ages at first marriage, suggest that policies and programmes promoting abstinence until marriage are unlikely to work.

For organisations in the women sector, the messaging is generalised and excludes invisible and most at risk groups such as older women, MSM, WSWs, Prisoners, and People Living with Disabilities etc. The messaging is also seldom focussed to address women and girls issues such as SRHR, VAW, and difficulties associated with negotiating condom use; and reduce their vulnerability as the majority of all people living with HIV&AIDS. Furthermore, the messaging is still more negative, implying women as transmitters of the disease and using *away-from* language such as "denying", "restricting", "stopping", or "avoiding" sexual practice among others. Some of the work done with young people indicates that messaging focussing on pleasure or marketing safer sex as pleasurable may be more appealing to youth and the wider population[93].

---

[92] Nono Eland. SANAC Women's Sector Rep. Personal Interview. July 2009
[93] Stevens, M. "Towards treatment guidelines for women of reproductive age: recognising the right to choose." AGENDA 75, 2008. Pg 68

The HSRC's third national HIV prevalence, incidence and communication survey that was conducted in 2008 noted an overall decline in HIV prevalence rates among teenagers 15-19; and a doubling of the percentage of those who reported awareness of their HIV status in the age group 15-49. However, the study's principal investigator said that there is a need for clear and unambiguous emphasis on teenagers having older partners and that interventions need to be targeted to the particular issues in each province in SA and communication programmes should expand their reach and intensify their messages.[94]

loveLife[95] launched their annual HIV Prevention Gauge in Nov 2009. The Gauge is unique in that it brings together all published information about the current state of the HIV epidemic in South Africa, based on both national and local studies - and identifies the top ten strategies for new gains in HIV prevention. It describes the state of the HIV epidemic, reviews the national response and makes recommendations for policy and planning. The HIV Prevention Gauge of 2009 shows that progress has been made in combating HIV, but that South Africa still doesn't invest enough in a fully-fledged national portfolio of programmes to prevent HIV. According to the Gauge the ten top strategies for new gains in HIV prevention are:

- Increase the supply of male and female condoms significantly
- Eliminate missed opportunities for PMTCT and refocus on protecting the health of pregnant women
- Scale up focused behaviour change programmes to achieve high levels of *inter-personal* coverage (programmes that help protect people through key life transitions like school-leaving. Young people who leave school without employment or further education prospects are at highest risk for HIV.)
- Focus on reducing risk tolerance
- Focus on reducing teen pregnancy and protecting pregnant teenagers (For every two pregnant teenagers, one has HIV - as a result of the biological and social vulnerabilities associated with pregnancy)
- Introduce routine testing in all public health facilities
- Institute a high-vigilance protocol for TB detection among people with HIV
- Introduce a package deal for people presenting with STIs
- Implement an intensive national quality improvement programme
- Initiate a male circumcision programme

[94] www.hsrc.ac.za/Media_Release-379.phtml
[95] Mohammed, F. loveLife National Office, Phone: 011 523 1000, Email: fmohammed@lovelife.org.za, www.lovelife.org.za

South Africa spends roughly a billion rand of public funds every year on HIV prevention - roughly one-sixth of total spending on HIV/HIV&AIDS programmes. The Gauge estimates that another billion rand is required to implement a national HIV prevention programme at full scale. It points out that, even under conservative projections of impact, net annual savings will be trebled within a decade

Question 3: Are there any STI statistics for women, young people and adolescents or national campaigns on STIs directed specifically at them?

The HSRC's 2008 survey[94] measured HIV risk-associated characteristics among respondents aged 15+ years. STI symptoms in the past twelve months were compared between those who were interviewed and tested compared to those who were interviewed but refused HIV testing. STI Symptoms related to sexually transmitted infections, such as vaginal discharge/urethral discharge, genital ulcers/sores, burning pain during urination.

TABLE 6: STI SYMPTOMS EXPERIENCED BY RESPONDENTS 15+

Symptom experienced	Interviewed and tested for HIV		Interviewed but not tested for HIV	
	N	%	N	%
Yes	435	7.1	90	5
No	5,685	92.9	1,706	95
Total	6,120	100	1,796	100

The report states that even though the rates of sexual debut before the age of 15 have declined over the past seven years, the fact that a small proportion of teenagers are still initiating sex at an early age has major implications for HIV and STI infection- because of linkages to more frequent sexual intercourse, more lifetime sexually transmitted infections, less consistent contraceptive use, and more sexual partners.[96]

---

[96] HSRC. 2008. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008
A Turning Tide Among Teenagers? HSRC.

Question 4: How is the issue of inequality (of gender, race/ethnic group, social class) approached in the educational programmes run by the government for prevention of STIs?

Issues of inequality are addressed through the various Government programmes focusing on the redress and transformation of the health system and access to care. The Government continues to ensure significant improvement in access to resources on prevention and treatment, among others. This is done through focusing on equitable distribution of the resources between the previously disadvantaged, and the rest of the citizenry. There are several policies focusing on addressing gender equity- the challenge is in the implementation of these policies[97].

The Life Skills and HIV&AIDS Curriculum is a compulsory component of the South African Schools curriculum which addresses all the issues outlined in this question.. The programme has been recognised as a key step towards providing a platform to discuss and address various social issues, but still lacks adequate impact to bring about behaviour change.

Question 5: Are health service staff trained adequately and prepared to offer effective counselling on prevention specifically for women, young people and adolescents?

Health Care Personnel who are already dealing with HIV&AIDS are trained to render counseling on prevention specifically for women, youth and adolescents. The typical services where this is applicable include PMTCT, Youth Friendly Clinics, and VCT. However, there are many challenges:

- The counseling system is fragmented and not comprehensive. In a scenario where a patient has a history of congenital abnormalities, wants to terminate a pregnancy and is HIV-positive, the system does not cater for a one-stop counseling service that deals with all these areas. Instead the patient will be referred to separate genetic, HIV&AIDS and termination of pregnancy counseling services.
- The training provided on counseling is inadequate and shallow in focus. The training does not ensure that a health care provider is able to take cognizance of gender, age and other issues that might be of great impact to the client during execution of counseling sessions. Even though programmes like PMTCT are aimed at women specifically, the counseling is often gender-blind, and the link between the process and fundamental women's issues such as SRHR is often missed.
- Counselling is not regulated or standardised and is provided by different cadres of health care workers including community health care workers- all with different levels of training.

[97] Bennett, Jane. African Gender Institute, University of Cape Town. Personal communication. October 2009

Whilst there are a wide variety of resources available to strengthen counselling services, these are rarely used in a standardised manner, resulting in the standard of counselling becoming very facility dependant.

Snap surveys done at the 4th South African AIDS Conference in 2009 suggest that counselors are not always adequately trained and therefore may lack sufficient medical knowledge on HIV, ARVs and other related issues. The survey further showed that they are often overworked- leading to indifference and a lack of motivation[98]. When nurses in the Eastern Cape and Mpumalanga were asked suggestions for improving PMTCT services, it was evident that many of them had not been trained on any of the PMTCT services. They however expressed a desire to be trained[99]. Counselling guidelines for children have not yet been developed.[100] Counsellors are also not sufficiently trained to counsel clients about the long term effects and complications of ART, including the emotional needs.[101]

In addition, the current undergraduate degree or diploma curriculum of prospective health care providers does not feature SRHR, gender issues and HIV&AIDS adequately- hence efforts by DENOSA and the **Health Systems Trust** to develop **HIV/AIDS Treatment Guidelines for Women of Reproductive Age[102].**

The NSP and SANAC's Treatment Task Team both recommended task-shifting, allowing nurses to initiate and manage ARV treatment, and lay counsellors to administer HIV rapid tests but the DOH has yet to act on these recommendations – currently only doctors can provide ARV treatment and only professional nurses can do HIV testing.[103]

Pre and post abortion counselling remains a significant concern because of provider opposition and a shortage of willing and trained abortion care providers[104]. The personal development of

---

[98] Compass Project. 2009. *Scaling up for Success. A Community Implementer's Guide.* 4th South Arican AIDS Conference, 31 March – 3 April 2009, ICC Durban, South Africa. The Foundation for Professional Development (FPD).
[99]. Ladzani, R. *PMTCT service delivery in rural areas – The Mpumalanga and Eastern Cape Province experience*. HSRC presentation on 9 November 2009.
[100] Compass Project. 2009. *Scaling up for Success. A Community Implementer's Guide.* 4th South Arican AIDS Conference, 31 March – 3 April 2009, ICC Durban, South Africa. The Foundation for Professional Development (FPD). p18
[101] Compass Project. 2009. *Scaling up for Success. A Community Implementer's Guide.* 4th South Arican AIDS Conference, 31 March – 3 April 2009, ICC Durban, South Africa. The Foundation for Professional Development (FPD). p34
[102] Sebopa, D. January 2010. Gender& HIV/AIDS in DENOSA
[103] PlusNews. 3 August 2009. South Africa: *No simple formula for universal access*. IRIN. www.plusnews.org/Report.aspx?Reportid=85555
[104] Harries J, Stinson K, Orner P. Women's Health Research Unit, School of Public Health and Family Medicine, Faculty of Health Sciences, UCT. Health care providers' attitudes towards termination of pregnancy:

counsellors as well as the importance of subsequent LGBTI and SGBV specific capacity building is often overlooked and significantly impacts the quality of counselling provided.

Question 6: Are there any government initiatives underway to provide capacity building in such counselling for health teams?

The government provides free tertiary education to social workers and nurses; however this is not a sustainable programme as some of these bursary holders often leave the country to provide their services to other countries.

Government initiatives include the training of employed health care providers by the Department of Health's HIV&AIDS Sectoral unit. The unit also offers training to CBO'S and NGO's who provide care to the population of the country. Various Sector Education and Training Authorities (SETAs), especially the Health & Welfare SETA offers learnerships and skills-development programmes on HIV&AIDS[105]. With provider initiated testing being implemented, counselling tends to be generic and is not tailored to the differences between men and women acknowledging both biological and gender issues. Providers acknowledge the need for better training and supervision under mentorship as an existing gap.

The Departments of Health and Social Development are in the process of developing a Policy Framework for Community Care–Workers. The policy framework includes VCT, ART adherence, as well as understanding of SRHR as one of the requirements for community care-worker training. [106]. In addition, the Traditional Health Practitioners Act[107] provides for the establishment of the Interim Traditional Health Practitioners Council-which will regulate the profession, provide for the registration and training of traditional practitioners, as well as protect the interests and rights of traditional practitioners' clients. Currently, the Department of Health supports collaboration with traditional practitioners on Primary Health Care as well as HIV&AIDS education; it however does not support referrals from the formal health system to traditional practitioners, principally because of a lack of research and regulation around the dosage and efficacy of traditional treatments.

A qualitative study in South Africa. *BMC Public Health*. 2009 9:296 or www.biomedcentral.com/1471-2458/9/296

[105]Sebopa, D. January 2010. Personal input. Gender& HIV/AIDS Coordinator, DENOSA

[106] Dept of Health, Dept of Social Development. 2009. Community Care Worker. Management Policy Framework. Draft version 6.0. (Working draft document.)

[107]See: www.info.gov.za/view/DownloadFileAction?id=67974

At a broader policy level, several development agencies such as the Nelson Mandela Foundation and the Population Council are collaborating with the National Department of Health to hold conversations with Traditional Leaders. This is in recognition of their critical gate-keeper role in traditional and cultural policy and practice in their villages. A more meaningfully lobbied and engaged traditional leadership has the ability to make long-lasting beneficial policy changes for their communities- which would address women and girl's SRHR needs, and reduce their vulnerability to HIV. The Southern African AIDS Information Dissemination Service[108] has launched a comprehensive new series that looks at Mainstreaming HIV, AIDS & Gender into Culture called "Changing the rivers flow". The series can be downloaded from the web.

Question 7: Has there been any discussion of male circumcision as a preventive measure in your country? In what terms?

Yes, there has been extensive discussion on Male Circumcision (MC) in the country-following the recommendations by WHO that MC has been shown to reduce HIV transmission by up to 60%. The discussion has involved all sectors of SANAC and all levels of Government-national, provincial and local. The NDoH has developed a draft policy on the expansion of MC in the public sector[109],[110]; and instituted a situation analysis to guide implementation. The policy encourages facilities at Primary Health Care level to implement male circumcision on a large scale, and acknowledges the need to create appropriate messages for males- emphasising that male circumcision is a prevention tool aimed solely at men, and that benefits to women are expected to accrue in the long-term. The policy does not distinguish between medical and traditional forms of male circumcision.

SANAC has held consultations with its multiple sectors on the MC policy-revealing lack of consensus between academics, researchers, and women's organisations on the adequacy of the evidence on MC and HIV prevention. Representatives from the Congress of Traditional Leaders (CONTRALESA) expressed a need for traditionally relevant, concrete evidence prior to MC policy formulation and implementation in traditional contexts. The women sectors also raised the need to integrate MC, SRHR, and HIV&AIDS policies, and communicate the implications of MC on women and men accurately.[111] The issues needing clear communication included that:

- Male circumcision is good for men's sexual health and protects against sexually transmitted infections, but it does not protect against HIV completely.

---

[108] http://www.safaids.net/
[109] National Department of Health. September 2009. Framework for the Implementation of Male Circumcision MC). Draft.
[110] Rees, H. January 2010. Personal input. Reproductive Health and HIV Research Unit, Wits University.

- Men who are circumcised still need to use condoms, reduce sexual partners, and delay having sex.
- Transactional sex, intergenerational sex and sex when drunk are all high risk behaviours for HIV, whether a person is circumcised or not.
- If you are HIV positive, male circumcision does not protect you or your partner
- Male Circumcision does not protect men who have sex with men
- If a man is circumcised it does not mean he is HIV negative.
- Women's risk to HIV still needs to be a critical component of MC messaging.
- Traditional circumcision practices and boys' behaviour when leaving the bush need to be reviewed.
- Ccontext-specific regulation and guidelines need to be provided for both medical and traditional circumcision.

Following these SANAC consultations, the advisory body's Communications Technical Task Team was mandated to develop a communications plan on MC.

WHIPT- consultative process with AVAC and ATHENA in South Africa, Namibia and Swaziland - is currently exploring the implications of MC implementation for women. Critical research areas related to monitoring and evaluation of the effects of male circumcision includes: monitoring the potential harm to women in key areas including violence against women; women's abilities to negotiate condom use; changes in the sexual behaviour of men and women; incidence of HIV and sexually transmitted diseases; etc. The study- funded by the the Bill & Melinda Gates Foundation- will also investigate the perceptions and understanding of male circumcision, the healing period and benefits to women[112].

The 60% mailing list dialogue –an e-discussion group on HIV&AIDS in SA- has also engaged with this issue, looking at complications and concerns about tradition, raising gender and public health challenges regarding MC. This e-list articulated women's challenges, policy and gender inequities.[113]

---

[111] SANAC. Civil society meeting. 7 July 2009 .Johannesburg
[112] Women's HIV Prevention Tracking Project .17 July 2009: Male circumcision and its impact for women. Cape Town
[113] 60% e-list. Diologue on medical male circumcision. http://lists.hst.org.za/mailman/listinfo/60percent/. 2009

Question 8: Are there any campaigns, policies or programmes designed to stimulate prevention against HIV directed at the male heterosexual population?

Yes. The *One Man Can Campaign* supports men and boys to take action to end domestic and sexual violence and to promote healthy, equitable relationships that men and women can enjoy - passionately, respectfully and fully. The One Man Can Campaign promotes the idea that each one of us has a role to play, that each one of us can create a better, more equitable and more just world. During the last reporting period, the campaign has encouraged men to work together with other men and with women to take action - to build a movement, to demand justice, to claim human rights and to change the world.

The Brothers for Life campaign *was* launched in Kwamashu, Durban, in August 2009. It is a joint effort by the South African National AIDS Council, the Department of Health, USAID/PEPFAR, Johns Hopkins Health Education in South Africa (JHHESA), Sonke Gender Justice and the United Nations System in South Africa. This a media programme that embraces the principle of brotherhood and which uses advertisements to address HIV prevention efforts for both male and females. The campaign's main aim is to mobilise men towards improving their health and social outcomes; as well as improving the health and wellbeing of women and children. Brothers for Life focuses on the role that men have to play in a world with HIV&AIDS; and men taking responsibility for their actions[114]

Grassroots Soccer (GRS), initiated the Football for Hope Movement through which health promotion, peace building, children's rights, anti-discrimination and social integration are addressed. Their *Football for an HIV Free Generation (F4)* initiative includes a coordinated media campaign using football to address gender inequality and HIV prevention.[115] Together with Sonke Gender Justice they also use the Skillz Magazine which is an insert of the Sunday Times and Sowetan newspapers, and mainly read by boys. The Skillz Programme also conducts Skillz interventions in schools, soccer pitches, holiday camps and VCT events.

Several other NGOs have initiated men's programmes as part of their overall strategy such as ADAPT (counselling and support services for men), MOSAIC (counselling of male abusers), NICRO (perpetrator programmes), National Association of People Living with HIV&AIDS (NAPWA)-*the Men*

---

[114] HIV/AIDS news. 2009. Brothers for Life launches in South Africa www.brothersforlife.org.
[115] Sonke Gender Justice Network & Grassroots Soccer. June 2009. Report on: Men, Gender and 2010.

care campaign, FAMSA, etc. The CSVR produced an awareness raising booklet to address common misconceptions about sex and sexual violence and condom distribution in men's prisons.[116]

Question 9: Is there any investigation underway into alternative forms of prevention for women (e.g. new designs of female condoms, micro biocides and others)?

Yes, there are numerous studies underway on alternative forms of prevention for women. These include: structural drivers of the epidemic -e.g. Reproductive Health and HIV Research Unit (RHRU)'s conditional cash transfer grant for young women to keep them in school; Studies and trials on Microbicides, Post-exposure Prophylaxis (PrEP), and HIV vaccine among others.[117]

The SANAC Women's Sector, in collaboration with the Treatment Action Campaign (TAC); the RHRU; International AIDS Vaccine Initiative (IAVI); and the Global Campaign for Microbicides (GCM) convened a South African women's prevention summit to outline and discuss the HIV prevention agenda for women in August 2009. The summit considered the prevention targets set out in the South African National Strategic Plan for HIV&AIDS and STDs which are to: "*Reduce the rate of new HIV infections by 50% by 2011*, and *Research, Monitoring and Evaluation on the development of prevention technologies*".

The Microbicides Development Programme (MDP) announced the highly anticipated results of MDP 301 study testing the safety and effectiveness of 0.5% PRO 2000 in December 2009. The trial took place between September 2005 and September 2009 and enrolled 9385 women at 6 research centres in South Africa, Tanzania, Uganda and Zambia. The trial demonstrated that the vaginal Microbicide gel PRO 2000 (0.5%) while safe, it *does not prevent* HIV infection in women.[118] PATH, a South African member of the Global Campaign for Microbicides (GCM)[119], has trained a number of South African civil society organisations in South Africa on issues related to Microbicides including the 34 members of the Positive Women's Network (PWN)[120].

---

[116] Gear, S. November 2009. Myths and Common Concerns about Sex and Sexual Violence in Men's Prisons. Centre for the Study of Violence and Reconciliation.
[117] Rees, H. January 2010. Personal input. Reproductive Health and AIDS Research Unit, Wits University.
[118] Microbicides Development Programme (MDP). 14 December 2009. *Quick Facts about MDP301 Trial.* www.global-campaign.org/clientfiles/MDP301%20Trial%20Quick%20Facts%20121209.pdf
[119] http://www.global-campaign.org/
[120] http://www.global-campaign.org/clientfiles/MeetingReportPWN.pdf

Question 10: Are there any programmes or actions in sexual and reproductive health or prevention of HIV directed specifically at women belonging to ethnic minorities?

The NSP government report of 2009 noted incremental rollout of comprehensive customized HIV prevention packages for MSM, lesbians, Women who have Sex with Women (WSW) and transsexuals including the promotion of VCT and access to male and female condoms and STI symptom recognition. The 2008 target was to reach 40%, while the 2009 target was to reach 70% of the groups.

Positive Muslims[121]- a Muslim HIV&AIDS organisation- was established in the year 2000 to offer services from an Islamic perspective to all of humanity. Despite this, Muslim women remain underserved, and efforts to reach them remain weak. The exclusion of Muslim women, lesbians and WSW from HIV&AIDS discourses increases their vulnerability, and results in a denial of HIV risk among these groups. It further results in an absence of funding for essential research; a lack of information and knowledge about transmission and safer sex; the unavailability of appropriate safer-sex and prevention materials; the lack of appropriate and non-discriminatory health services; as well as the lack of HIV&AIDS prevention, treatment and care programmes that address the intersecting factors that make Muslim women, lesbians vulnerable to HIV infection. [122]. The South African Human Sciences Research Council published a report, *'From Social Science to social science: same-sex sexuality, HIV&AIDS and Gender in South Africa'* in 2009. The chapter on *Sexing women-Young Black lesbians' reflections on sex and responses to safer(s) sex* is an enlightening chapter on the issues of safer sex and women. [123]

B] SEXUAL AND REPRODUCTIVE HEALTH CARE

Question 1: Is HIV testing available and accessible to all women throughout the country?

South Africa has wide availability and awareness of Voluntary Counseling and Testing (VCT) services. However, testing rates remain low for most patient groups. A streamlined approach aimed at scaling up testing has been developed and entitled-*Provider-initiated HIV testing and counseling (PITC*). In the PITC, all patients in medical settings are offered testing. The results of the first PITC pilot have shown an increase in the testing rate; but raised concerns that this approach may compromise informed decision-making and lead to coercive practices, especially in poorly resourced

---

[121] www.positivemuslims.org.za
[122] Triangle Project. 2009. Lesbian HIV Fact Sheet.
[123] Reddy, V., Sandfort, T. and Rispel, L. 2009. ' From Social Science to social science: same-sex sexuality, HIV&AIDS and Gender in South Africa'HSRC Press. Cape Town

health systems. All patients who participated in the pilot, including those who declined testing, expressed a preference for the PITC approach, citing the increased opportunity this provides with many wanting to see client-initiated VCT retained as well.[124]

Although HIV testing is widely available for women throughout the country, it is not available to all women equally. While younger women get testing through PMTCT services, older women can only access testing services from VCT services.[125]. In addition, disabled women do not have easy accesss to health care services.

The Women and HIV&AIDS Gauge conducted two focus groups with sixteen HIV positive women in 2009 to track progress towards the UNGASS indicators on testing. The purpose of the focus group was to find out how women experience testing and what they know of current practices on Counseling, Consent and Confidentiality- the three Cs. The findings showed many similar experiences about the three C's, with a few differences of experience. Some women in the group indicated that they tested because they were pregnant, and were concerned about the child's health. Some further expressed concern about explaining the pill to their families, or hiding it.[126].

The HIV&AIDS NSP (2007 -2011) recognises disabled people as a vulnerable group, and has specific targets related to the disabled. The sector is fully represented at SANAC, and within the HIV&AIDS implementation structure. Disabled women still face some challenges however- including:

- Access to Health Care facilities. This includes both transport to reach facilities as well as access to the buildings themselves.
- Discrimination by Health Care Professionals. The belief that disabled women should not be sexually active is still prominent among Health Care Professionals. As a result, the professionals are not always welcoming to disabled women presenting with SRHR and HIV&AIDS issues. Disabled people therefore experience double stigma-for being disabled and further for being HIV positive.
- Disabled women are more at risk to get infected with HIV, because of their vulnerability to being raped or being in unbalanced power relationships.

---

[124] Leon N, Informed decision making in provider initiated or opt- out testing in Cape Town. Health Systems Research Unit, Medical Research Council & University of Cape Town.
[125] Rees, H. January 2010. Personal input. Reproductive Health and AIDS Research Unit, Wits University.
[126] Bomela, N and Stevens, M. 2009. Experiences of women testing positive – poor counselling and recourse to treatment. Women and HIV/AIDS Health Systems Trust

- There is a need to sensitised Health Care Professionals about the needs of disabled women in relation to HIV&AIDS and reproductive health.[127]

Question 2: Is HIV testing available in maternity hospitals and maternity wards?

Yes, coverage of HIV testing is about 80% in PMTCT services overall. Although all in-patients should be receiving HIV testing, there are some gaps in the data from hospital wards on testing coverage[128]. The 2007-2011 HIV&AIDS NSP's target is to reach 95% coverage by 2011 through the antenatal care. In order to access PMTCT services, a pregnant woman needs to know her HIV status. South Africa has a high antenatal coverage rate of 92%[129]., indicating the high numbers of women who attend ANC. It is also important to note that some mothers who tested positive present late in pregnancy some having tested negative earlier in pregnancy.

Question 3: Is good quality counselling associated to all HIV testing carried out in the sphere of the antenatal services?

In general, South Africa's testing policies include VCT- which is client-initiated-, and the recent PICT. The voluntary nature of the process is however not guaranteed in antenatal contexts, as every pregnant woman is tested for HIV in order to protect the foetus from HIV transmission. The focus groups conducted indicated some incidents of women being tested without having signed a consent form, and the low levels of emotional and psycho-social support in pre and post testing. Some women expressed reservation on the adequacy of the counselling to address issues around disclosure and to support them in dealing with their families and communities. Routine testing of all pregnant women was not supported by the participants in the focus groups conducted. [126]8.

Many policies recommend academic training for counselors to qualify as providers of counseling that is ethical and professional. At the moment, the counseling profession is not regulated, and there are no detailed requirements about who is qualified to provide counseling. In pregnancy-specific contexts, the policies for testing pregnant women are often adhered to as per the general guidelines provided by the DOH.[130]

---

[127] Burrows, G. January 2010. National HIV&AIDS Coordinator, Disabled People South Africa (DPSA). Info from research study on HIV&AIDS and Sexuality amongst people with disabilities in South Africa - November 2009.

[128]Rees, H. January 2010. Personal input. Reproductive Health and AIDS Research Unit, Wits University.
[129] Health Systems Trust. 2007/2008. District Health Barometer . PMTCT indicators pg 66-88
[130] Maman S, Groves A, King E, Pierce M, Wyckoff S. 2008 HIV Testing During Pregnancy : A Literature and Policy Review . Open Society Institute Law and Health Initiative

The focus groups conducted on some key aspects of counseling yielded the following results: **Pre-Counseling**: Six women identified that counseling was not done properly, while one woman who tested twice indicated that the counselor was not friendly at all- to an extent that she went home to introspect herself as she was worried about her unborn child. She then decided to go to another clinic where she got all the support and treatment. One woman was never counseled before testing. **Post-counseling:** they all noted that post counseling in the public sector is not effective as they were only counseled to check for their legibility for ARV treatment. After positive diagnosis, health providers would 'throw comments about sexual behavior to them'. One of the participants indicated that her hospital bed was taken and she was told that she is 'different' from other people. Th e focus group participants indicated that this kind of behavior from the nurses (specifically) pushed them away from the public sector to seek assistance from other HIV&AIDS organizations and support groups. They all identified that they have received proper counseling and support from the support groups that welcomed them after HIV diagnosis. **Consent**: Three women were tested without their consent, with no signed consent forms. One woman who had TB and was very sick, was tested, and her sister was informed of her HIV positive status and that she was going to die in three months. **Confidentiality:** all the participants noted that there is limited to no confidentiality in the clinics and hospitals. Even with these experiences they still believed that VCT is the only practice that relate to the South African context because a client is given the space to decide. Own decision to test ensures that one is ready to know his/her status and will be able to face the challenges of taking treatment for life, protecting loved ones from HIV transmission, and dealing with stigma and discrimination from the community. Furthermore, the patient folders and cards are colour coded to differentiate between HIV positive and negative patients. [126]

All the women did not support the PITC, seeing it as a wasteful use of resources. Firstly, they indicated that they would agree to the PITC out of fear of being denied the services they came to the health centre for. But that once they got served, they most probably would not return to collect the results because they've been cured or treated of whatever ailment they had. They further expressed the fear that PITC might push people away from accessing services in the public sector to traditional healers and private practitioners, as most fear to take an HIV test unprepared. The same individual will do a repeat HIV test when they are ready to test and accept the results. They also noted that adequate counseling is an important prerequisite for HIV testing, and yet PITC provides only about five minutes for pre-counseling. Their view was that PITC is not a solution to the South African context as it does not clearly articulate the rights of individuals, does not include the social aspects of stigma and violence as they apply to shared confidentiality, and breaks the ethics of confidentiality in the consultation room.[126]

Question 4: Is there any nutritional support provided to pregnant women with HIV infections? How is the distribution of nutritional support carried out?

The Government nutritional support to women during pregnancy is limited to the provision of supplementary vitamins C and B complex. After birth, women do get patchy nutritional support provided by NGOs. The rates of malnutrition are persistently high: one in three women and children are anemic; one in three children and one in four women has sub-clinical vitamin A deficiency; and 45% of children have inadequate zinc status. A systematic process for behaviour change messaging is absent; especially for important maternal issues such as appropriate feeding and recognition of danger signs. Civil society advocacy on these issues is also limited.[62]

The mothers2mothers[131] programme provides nutritional education and support to women in areas where they are active. The mothers2mothers Mentors and Site Coordinators use the curriculum to discuss nutrition as a key component of keeping a mother's health mind and body in good in good shape, and aware of all the options available for proper nutrition for the family. Additional curriculum materials are shown, with pictures and key points. Additionally, in some of m2m's sites staffs have begun to grow gardens to use the produce for the support group meals.[132]

Question 5: Is anti-HIV prophylaxis at the moment of birth available and accessible throughout the country?

Yes, Nevirapine was registered in April 2001, and has been used as the drug for PMTCT administered to women and their babies at birth since 2003. In January 2008, a new dual-antiretroviral prophylaxis policy was introduced. Pregnant women enrolled in PMTCT programmes started receiving AZT from 28 weeks of pregnancy until labour, at which point a single dose of Nevirapine would be administered to prevent mother-to-child-transmission of HIV[133]. Further to this, infants would be given a single dose of Nevirapine after birth and short course of AZT for seven days[134].

In December 2009, the President announced a new policy that with effect from April 2010, pregnant women will qualify for ART when their CD4 count is 350 or less; and treatment will start from 14 weeks of pregnancy as opposed to the last term of pregnancy. All HIV-positive children under one

---

131 *See:* www.m2m.org
132 http://www.m2m.org/programmes/how-we-work.html. Accessed October 2009.
133 TAC. 2008. Department of Health Announces New PMTCT Guidelines
134 Fact Sheet, Perinatal HIV Research Unit

year will also get ARVs. This policy applies to all provinces except the Western Cape, where triple antiretroviral therapy and not Nevirapine is being used.

The rate of uptake among pregnant HIV positive women is measured by the proportion of HIV positive pregnant women who received Nevirapine dose during either antenatal care or while in labour. There has been a national coverage increase from 65% in 2006/07 to 76% in 2007/08. It remains much lower than the 95% target stated in the NSP for 2011.

The rate of Nevirapine uptake among babies born to HIV positive pregnant women is measured by the percentage of babies of HIV positive women who received Nevirapine within 72 hours of birth, out of the number of live births in facilities to HIV positive women.

Large variations in Nevirapine coverage have been recorded across the districts; but the reasons are not clear as there are data quality issues. The only data that is considered to be realistic is from 2006/07 at 81%[135]. In Lejweleputswa, the lowest rate of 12% was found, while in Uthukela, research showed the highest rate of 108%. In the Free State coverage rates declined, but the data is hard to accept as there have been data-quality issues reported for the province. More work on data collection systems is needed.

Chopra, et al[62] estimated that 11 500 infants' lives could be saved by effective implementation of basic neonatal care at 95% coverage. Similar coverage of dual-therapy PMTCT transmission with appropriate feeding choices could save 37 200 children's lives in South Africa per year in 2015 compared with 2008. The interventions would also avert many maternal deaths and stillbirths. They calculated that the total cost of such a target package would be US$1·5 billion per year, 24% of the public-sector health expenditure; with an incremental cost of $220 million per year. These affordable costs would put South Africa squarely on track to meet MDG 4 and MDG 5.

However, leadership and effective implementation at every level of the health system, including national and local accountability for service provision would be a prerequisite.

---

[135] "4.4.2 HIV Prevalence amongst antenatal clients tested." District Health Barometer 2007/08. Health Systems Trust: Westville, June 2009 Pg 72-85.

Question 6: Is formula milk substitute for the children of HIV infected mothers easily available and readily accessible throughout the country?

Formula milk is available to children of HIV infected mothers, but not to all- as seen by the elements of the NSP reflected below. **Intervention 8** of the HIV/AIDS/STI NSP of 2007- 2011 states:

"There should be a provision of nutritional support to HIV-infected women choosing to exclusively breast feed. The 2008 target is 20% of women covered. Framework for implementing nutritional interventions and national guidelines for people living with TB, HIV&AIDS is being implemented. Infant and child feeding policy is currently being implemented. All accredited service points providing nutritional support to HIV infected women"

Intervention 9 of the HIV/AIDS/STI NSP of 2007- 2011 states*: "Provide formula milk to children of HIV-positive women who choose and are eligible to practice replacement feeding. The 2008 target is 45%. 66% of babies are receiving formula"*[136].

The targets as outlined above have not been fully met as there have been health systems' constraints with providing regular supply of infant formula. A recent HSRC study in Eastern Cape and Mpumalanga provinces found only 54% and 75% respectively adequate supply of free infant formula. In the EC, a number of clinics experienced milk shortage every three months. In Mpumalanga, there were formula milk shortages in about 10 clinics in the past months, in some cases for up to a year. Nurses also reported that clients do not want to be seen collecting infant formula due to the association of milk formula with HIV positive sero-status, and the associated stigma. There have also been cases of mothers selling the infant formula given to them for free.

The reported tender irregularities and corrupt practices by a few health practitioners such as nurses stealing formula and selling it for personal gain are currently being dealt with by the police, the justice system, as well as the Health system to tighten up loopholes and controls.

The integration of SRHR and HIV&AIDS was very low In Mpumalanga: the promotion of contraceptives through talks, posters and videos was done 39% of the time; the promotion of VCT

[136] National Strategic Plan HIV/AIDS & STI. Create an enabling environment for HIV testing. Government Report. March 2009.

during family planning clinic sessions was at 44%; and the promotion of family planning during ANC and PNC was 39%. [137]

There is also substantial debate as to whether exclusive breastfeeding is a realistic option for most traditional settings- given the culture of mixed feeding and the water supply constraints experienced by most rural communities.[138]

Question 7: Do the public and private services that deal with pregnant women offer them information, counselling and anti-HIV testing?

Pregnant women's access to these services is generally variable, with most getting information, counselling and anti-HIV testing in the context of PMTCT. There has not been successful integration of FP and HIV services, thus making it unlikely for these services to be provided together.

In the private sector, counselling takes the form of information-giving by a nurse, using a computer software programme where a checklist of all necessary is listed and ticked off as communicated to the client. This is in contrast to what happens in the public sector, where counselling is viewed as inadequate and variable in quality. The provision of counselling has become a competency that has been shifted down to community health workers and HIV-treatment literacy practitioners, who are typically unregulated and under-remunerated, and yet provide a valuable service. With recent shifts in HIV-testing practices – from VCT to PITC – pre-test counselling is under pressure, with limited time allocated to this crucial stage, and more time being provided for post-test counselling. PITC has deterred women from using services since they realise that they might be subject to HIV testing when they are not prepared for a positive diagnosis" [139]

The focus group that was conducted by Women and HIV&AIDS gauge found that not all women were provided with VCT during their pregnancy. In cases where VCT took place, the emphasis was on protecting the child and not on the mother. Their discussion further concluded that even though it is advisable for women to test because of pregnancy, they should still be given a choice to decide whether or not to test. They relayed incidences of intentional HIV transmission due to women resisting the forced nature of the testing and denial.[126]

---

[137] Ladzani, R. *PMTCT service delivery in rural areas – The Mpumalanga and Eastern Cape Province experience*. HSRC presentation on 9 November 2009.
[138] http://www.mg.co.za/article/2009-08-25-professors-provoke-breastfeeding-outrage

Various NGOs such as the Population Council and Family Health International have developed strategies to integrate FP and HIV testing services[140]. The Balanced Counselling Strategy Plus (BCS+) toolkit was developed and tested by Population Council in South Africa and Kenya to improve the quality of FP consultation and HIV integration. A video was developed to assist the providers on how to use the BCS+. The toolkit is available at http://www.popcouncil.org/frontiers/bestpractices/BCSPlus_102008.html
The implementation of these strategies has Human Resource, and infrastructure challenges among others.

Question 8: In the case of sero-positive pregnant women, is treatment offered to reduce the risk of transmission of HIV from mother to child during pregnancy? Is any psycho-social support made available?

PMTCT services in South Africa provide services to reduce the risk of transmission of HIV from mother to child during pregnancy; and provide psycho-social support to women during and after pregnancy. However in reality these services are lagging behind- as implementation of these still needs to be strengthened.[141]

HIV sero-positive women receive treatment to reduce the risk of transmission of HIV from mother to child through government's PMTCT programme. After much criticism of the PMTCT programme which recommended the initiation of antiretroviral therapy of all HIV sero-positive pregnant women with CD4 counts of 200 cells/mm3 and below, the President announced a policy change on World AIDS Day 2009. In terms of the new policy, pregnant women who are HIV sero-positive will receive treatment when their CD4 counts is 350cells/mm3 and below. All other HIV-positive pregnant women will also begin receiving treatment at 14 weeks rather than in the last term of pregnancy. The changes will take effect from April 2010.

The routine testing of infants for HIV in order to establish the effectiveness of the new PMTCT interventions will also change-in terms of new policy. Babies will be tested for HIV at six weeks using the PCR method, and will receive an antibody test at 18 months[142]. Even though these are outlined clearly, the implementation and the lack of information on the part of women and health providers is

---

[139] Stevens, Marion. "From HIV prevention to reproductive health choices: HIV/AIDS treatment guidelines for women of reproductive age". AJAR . 2008, 7(3). 354.
[140] http://www.popcouncil.org/frontiers/bestpractices/BCSPlus_102008.html
[141] Nkonki. Lungiswa, Tanya Doherty, Zelee Hill, Mickey Chopra, Nikki Schaay, Carl Kendall. 2007. Missed opportunities for Participation in PMTCT Programmes: Simplicity of Nevirapine Does Not Necessarily Lead to Optimal Uptake: A Qualitative Study. *AIDS Research and Therapy* 4: 27-45.
[142] DOH . 2008 Policy and Guidelines for the implementation of the PMTCT programme.

expected to be challenge.[143] Lamivadine which is safe and inexpensive is not incorporated into the new PMTCT package[144].

PMTCT programmes also provide ongoing psycho-social support which addresses issues such as disclosure, infant feeding choices and positive living. The programme further gives an opportunity for ongoing psychosocial support, counselling and referral for family planning services as evidenced by the high rates of disclosure and use of prevention methods. This may be a vital entry point for secondary prevention efforts. A Soweto study conducted in South Africa used a sub-sample of 547 women presenting for follow-up in one year. It was found that 431 (78%) women had disclosed their HIV status to one or more people: 69% disclosed to primary sexual partners; 68% to their mothers; 25% to siblings; and 20% to others such as friends or neighbours. The outcomes of disclosure included disbelief (16%); support (74%); violence (2%); desertion (12%); or others such as grief or denial (4%). Reported uptake of family planning (62%), and use of HIV prevention methods such as male condom use (76%) was high[145].

Question 9: What orientation has been given to women infected with HIV in regard to the question of contraception?

South Africa does not have a clear policy on contraception for women living with HIV. This has opened the space up for various confusing practices across the health centres in the country. In general, women are advised to use condoms- male or female- to avoid re-infection with HIV.

Recent research shows that the IUCD might be a safer and more acceptable contraceptive method for positive women[146], [147]. However, most women in rural settings use the injectable contraceptives such as Depo Provera because it requires fewer visits to the FP clinic. There are reports of injectable contraceptives being given as part of the first line regimen as it is contraindicated when taking Efavirenz., [139] In addition, some women living with HIV have reported not being accepted into the ART clinics without their contraceptive card being stamped with an injectable contraceptive.

---

[143] TAC. 2008 Department of Health Announces New PMTCT Guidelines.

[144] HIV Treat Bull - 2008 March-April; 9(3/4): New PMTCT guidelines for South Africa. http://www.aegis.com/pubs/i-base/2008/IB080903-26.html

[145] Violari A, Fiamma A, Duvenhage M, Gray G, McIntyre J; 2004 : Psychosocial support and disclosure outcomes at one year postpartum in HIV positive women attending a PMTCT program in Soweto, South Africa. International Conference on AIDS. 15: abstract no. WePeE6788

[146] Stringer, E. etal 2009. HIV disease progression by hormonal contraceptive method: secondary analysis of a randomized trial. AIDS 2009, 23:1377–1382

[147] Darney, P. Reproductive Decision making for people with HIV/AIDS. Federation of International Obstetricians and Gynaecology Conference. 2009.

South Africa is going to need to come with a clear policy to ensure reproductive choice and improved access to contraception to avoid further harm to the health of women living with HIV. Especially in the light of evidence suggesting that younger women living with HIV should not be using oral contraceptives[148], and also given the controversy around whether injectable contraceptives do indeed accelerate HIV disease progression into AIDS; and increase genital shedding.

Question 10: Is there any form of encouragement given for women to undergo sterilisation? (Are there any reports of such encouragement?)

Yes, there have been such reports. In a loose network of women, 20 women reported to have experienced forced sterilization over the past ten years. Eighteen women have been identified in the past five years, and WHG is currently in partnership with Her Right Initiative (HRI)- a national positive women's organisation- to systematically quantify these experiences[149]. In starting to give voice to this area of work, HRI connected WHG with six women to participate in a series of experimental body mapping research activities-with the view to collate qualitative data on areas that are complex and difficult to reflect.

Because of the nature of the research topic as well as the methodology which requires one to see the topic within your own body, a significant time was focused on developing strength and safety. The body maps were outlined with the participant's favourite colours. Then, they added people who were a support to them, talked about where they come from and what their dreams were. After sharing their body maps, participants were asked to find a way of expressing their HIV status on their body maps. All participants self identified as living with HIV. The emphasis was placed on making choices. For example, choose to put HIV on your body or choose not to put it there. Choose to speak about a certain part of the body map or choose to keep it silent. Women put their messages and experiences on sterilization on their body maps.

The study showed how the coerced sterilization happened- some during the process of procuring an abortion, and others through false information given. Some of the women were told that they need to sterilize or they will die if they try to have another child. The women felt that they were not empowered to make choices, and felt manipulated so that they were not strong enough to say No. All the women said that they did not know what the word "sterilization" meant initially. They also

---

[148] Rees, H. Contraception and HIV. Federation of International Obstetricians and Gynaecology Conference. 2009.

were not informed as to how they were sterilized- whether a hysterectomy; clips; or tied fallopian tubes.

The research notes how women often feel like 'they are bargaining, they forfeit one right to gain access to another right- as in the access to care or treatment; or an abortion or HAART. It further reiterates that positive women desire to have children just like any other woman for reasons of identity, security or socio-economic status. Common themes reflected by the participants include, the experience that living with HIV is better than being infertile; that they were being punished by male doctors or a patriarchal health culture; and that the experience of being infertile was 'like having ones life taken away, being killed, being chained – described as a real loss'.[150].

Question 11: Is emergency contraception (EC) readily available and accessible throughout?

Yes, Emergency Contraception (EC) is available, but variable in access. EC is part of the national guidelines for Contraception, and the combined regimen- (cut-up Ovral)-, should be available at all clinics. The dedicated EC product- Norlevo- is not on national contraceptive tender, and therefore not available in public health facilities. Norlevo is more effective in preventing unwanted pregnancies, has less side-effects and less contra-indications than the combined regimen. Although there is a policy on bridging to regular contraception at the time of EC request, this is rarely practiced.

To address the need for improved contraception information and services, and the benefits of emergency contraception, a 24-hour toll-free hotline was established in October 2003 in the Western Cape Province and extended to the nationwide (0800246432) and a website (www.not-2-late) was established. The hotline provides information on the appropriateness and usage of EC and the website details on the location where EC is available. Training on EC is offered to providers working in centers throughout the Western Cape Province, KwaZulu-Natal and other provinces. A lot of training in bridging and providing EC is still required and the hotline is struggling to financially survive at the moment.[151]

Question 12: Are there any specific programmes or actions designed to protect the sexual and reproductive health of women living with HIV&AIDS?

The NDoH is in the process of developing a policy to address the reproductive health needs of women living with HIV. While this work is in progress, several NGOs are filling the gap. The Women

---

[149] Le Roux, N. Stevens, M. 2009(forthcoming. Reflective crafted tales (RCTs): mapping women's lived experience of HIV/AIDS. WHG/HST . Draft report

[150] Le Roux, N. and Stevens, M. 2009. Bodymapping painting giving voice to Women and HIV/AIDS Gauge, HST

[151]. Steyn, P. Department of Obstetrics and Gynaecology. University of Stellenbosch. South Africa

and HIV&AIDS Gauge (HST) currently has an advocacy process of developing HIV&AIDS Guidelines for women of reproductive age. The project is being initiated and facilitated by WHG in partnership with a range of local groupings and stakeholders including the NDoH and UNAIDS. The ten focus points areas to begin the process include: Testing practices and criminalization of transmission of HIV; Fertility planning- contraception and sterilization; Sexual health, rights and desire; Abortion; Sexually transmitted infections (STIs); Reproductive Cancers, including cervical cancer; Anxiety; Addiction and Depression, Violence against women (VAW); Highly active antiretroviral therapy (HAART) regimens; Lesbian health; and the care economy, including the gendered burden of care[152].

A new national positive women's organization called *'Her Right Initiative'* has been formed and is addressing certain SRHR issues including cervical cancer, sterilization and gender based violence. The Population Council supports a small number of organizations (TLAC; TVEP; GRIP) to pilot and implement a comprehensive and integrated model of care, support and prevention of sexual and gender-based violence.[153] The Women's Health Research Project (UCT) is collaborating on a project with Columbia University in the Western Cape. The project has revised training for HIV counselors and nurses to provide substantial information and advice in assisting clients to draw up action plans on SRHR issues including fertility desires; sexual desire and functioning; contraception; emergency contraception; abortion; pap smears; cancer of the prostate; menopause and aging in men. There is on-site availability of contraceptives; safer conception advice and referrals; emergency contraception; abortion referrals; psycho social referrals through links with other organizations-all within the HIV care unit. There are two intervention clinics in the public sector with high HIV client load, and two control sites. The two will be evaluated and compared for effectiveness.

Question 13: Do women living with HIV have access to assisted reproduction services?

Except for a few tertiary hospitals in the public sector, assisted reproduction services are not available in the public sector. There is also limited provision of these services within the private sector, HIV&AIDS treatment programmes – known as disease management programmes within the private sector- focus on HAART provision and are separate from gynaecology services and not integrated. [154] The University of Cape Town is running a fertility programme on a small number of

---

[152] Stevens, M. 2009. Developed of HIV/AIDS Treatment Guidelines for Women of Reproductive Age. Health Systems Trust. Policy Brief.
[153] Population Council. Sexual and Gender based Violence in Africa: Key issues for Programming. Population Council.
[154] Stevens, M. 2007. HIV/AIDS, STIs and TB in the Private Sector, South African Health Review

couples who have received assisted reproductive services.[155] . The results of this work are not yet available.

Question 14: What advice is given to women living with HIV that wish to become pregnant?

In general, the public health system does not encourage women living with HIV&AIDS to have babies. The advice given to women would therefore mostly be **not** to fall pregnant, and in worst cases, women have experienced forced contraception and sterilization as reported earlier. The PMTCT programme does however provide for women, once they are pregnant.

The HIV Clinicians Society is in the process of developing fertility guidelines-mainly to address the SRHR of PLWHIV, and their rights to have children.[156] The development of these guidelines will be vital in South Africa. .

Question 16: Are there any legal or traditional (informal, social-cultural) barriers that make it difficult for young women to obtain sexual and reproductive health care and ARV therapy should they prove necessary?

The Government has made attempts to roll out youth-friendly clinics to allow young people to access care. Health workers have been trained to work with youth and provide them service. In traditional and rural contexts however, access to Health Centres to seek SRHR related services from a nurse who knows you, your mother and most probably your entire family may discourage most youth from accessing care.

In addition there is a bottleneck to accessing ARV's as well as cervical cancer screening services. The National cervical cancer screening policy has an age restriction of thirty years. This is a challenge to young women as they commonly experience morbidity and mortality of cervical cancer in their early and late twenties.

---

[155] Dyer, S. 2009. Assisted reproduction services . Federation of International Obstetricians and Gynaecology Conference.

[156] Bekker, LG. 'SA HIV Clinicians Fertility Guidelines – work in progress.' 60% dialogue session on HIV/AIDS and SRHR. IAS Conference. July 2009

Question 17: What is the status of LGBTI health in South Africa?

Both the Triangle Project and the Equality Project are concerned about transformation in South Africa with regard to LGBTI issues. The projects and their affiliates experience the Civil Union Act legalising same-sex marriages as a paper law due to the lack of respect for diversities and violent attacks on lesbians. Sexual minority organizations are joining forces with other social movements and human rights organizations to challenge generic movements to recognize sexual diversities, and to act as allies to sexual minority movements.[157].

---

[157] Muthien, B. 2009. The status of sexual minorities in Southern Africa. Engender. For Oxfam Australia in South Africa.

C] ADDRESSING VIOLENCE AGAINST WOMEN

Question 1: Are the laws specifically designed to prevent violence against women (and children), punish perpetrators and repair the harm done effectively complied with?

Laws specifically designed to prevent Violence Against Women (VAW) and children exist, but compliance to the stipulations of the law such as minimum sentencing still needs to be strengthened. Women and children from under-resourced backgrounds still experience difficulty with accessing the law, mostly manifesting as challenges with the police, difficulty with access to legal aid, and consequent lack of legal representation.

The following are the main laws that apply to VAW in South Africa:

Domestic Violence Act (DVA) 116 of 1998[158] – The Act gives authority and responsibility to the police to respond to reports of incidents of domestic violence. It provides for a protection order/interdict as a remedy to domestic violence and makes the breach of such an order a criminal offence. The Act and its related National Instructions and Regulations are now in existence for more than ten years.

While the Act has served many women well, significant numbers of women have experienced challenges with the implementation of the Act- clearly pointing to the need to strengthen implementation further. The budget allocated to the Act has not allowed for consistent high-quality training of the police and the courts- thus leading to inequality in the application of the law. The Parliamentary Portfolio Committee on Women, Children and Persons with Disability, held public hearings on the implementation of the Domestic Violence Act in 2009. The hearings noted the enormous challenges women face to exercise their rights contained in the law and its failure to protect women from Domestic Violence. Some of the most important recommendations relevant to SRHR and HIV&AIDS in the report[159] are:

- The need to develop an overarching policy framework to address DV. The absence of such a framework severely impedes the effectiveness of services rendered to victims of DV. Establishing a framework for the DVA will ensure service norms and standards, and will improve training, implementation, monitoring and reporting requirements.

---

[158] *www.info.gov.za/view/DownloadFileAction?id=706*

[159] Research Unit. 16 February 2010. Strategic Report on Public Hearing on Implementation of Domestic Violence Act for Portfolio Committee on Women, Youth, Children and Persons with Disabilities. Parliament of the Republic of South Africa

- In the context of the HIV and AIDS pandemic, the DOH should develop a plan stipulating how the existing public communication campaigns address domestic violence. A targeted strategy is required to deal with women in abusive relationships who have limited choices in terms of applying the Department's current prevention strategies (abstain, be faithful, use a condom)
- The DVA does not overtly state the need for health care services to be rendered to victims of domestic violence, nor does it specify the direct role of the DOH. A legislative amendment to this end is proposed with specifications followed up in the regulations.
- Thuthuzela Care Centres and the services offered should be made available for victims of DV and not only be limited to rape survivors.

To date, twelve published studies have been completed covering a total of 22 courts in the provinces of the Western Cape[160],[161]; Gauteng[162],[163],[164]; KwaZulu-Natal[165]; Mpumalanga[99];and Free State. Even though the Act makes provision for all, the LGBTI populations have had particular difficulty accessing the law because of the stigma and the lack of seriousness with which the police and the Court personnel deals with their cases.

Criminal Law (Sexual Offences) Amendment Act, No 32 of 2007 – The Act replaces the Sexual Offences Act of 1957 and redefines many sexual offences and creates new offences. It has expanded the

---

[160] Vetten L et al (2009) "Implementing the Domestic Violence Act in Acornhoek, Mpumalanga" Tshwaranang Research Brief number 2.

[161] Vetten et al (2008) *Tracking justice: the Attrition of rape cases through the criminal justice system in Gauteng,* research report, Tshwaranang Legal Advocacy Centre, Medical Research Council and Centre for the Study of Violence and Reconciliation, available on www.tlac.org.za

[162] Vetten, L. (2005). " 'Show Me the Money': A Review of Budgets Allocated towards the Implementation of South Africa's Domestic Violence Act" in *Politikon* (November 2005), 32(2), 277 – 295.

[163] Schneider, V and Vetten, L. (2006). Going somewhere slowly? A comparison of the implementation of the Domestic Violence Act (no. 116 of 1998) in an urban and semi-urban site. Unpublished research report, Centre for the Study of Violence and Reconciliation.

[164] Naidoo, K. (2006). " "Justice at a snail's pace": The implementation of the Domestic Violence Act (Act 116 of 1998) at the Johannesburg Family Court" in *Acta Criminologica* 19 (1) 2006, 77 – 88.

[165] Meyer, L., McConnell, J., Fensham, R., Groth, L., Jansen, R. and Phillips, V. (2007). Assessment of the Implementation of the Domestic Violence Act and its Effects on the Lives of Women Seeking Protection Orders – A Study of Abused Women at Four Courts in eThekwini. Report prepared by Development Resources Africa, Lawyers for Human Rights and Advice Desk for the Abused.

definition of rape and created offences such as sexual grooming and sexual exploitation of children. The National Policy Framework associated with the Act is not yet available, and training on the law has been limited. As a result, the law is still largely unknown, and its implementation is weak.

The Criminal Justice system has been experiencing difficulties, leading to high attrition rates: A recent study in Gauteng revealed that there is a high attrition of rape cases through the criminal justice system.[166] Of the 2 064 cases in the study:

- Half of the cases resulted in arrests, (50.5%); but only 42.8% were charged in court.
- Trials commenced in less than one in five cases, (17.3%).
- Only 1 in 20 (6.2%) cases resulted in all convictions.. However, some of these convictions were for lesser charges so overall only 4.1% of cases reported as rape resulted in convictions for rape.
- 15.6% of rape convictions received less than the mandated 10 years minimum sentence. The other prescribed sentence for rape, life imprisonment, was very rarely observed. Thirty-four (or 41%) of men convicted of rape were eligible for life imprisonment. This was handed down in only three cases.

The ***Criminal Procedure Act of 1977*** attempts to address some of the procedural problems with the criminal justice system. In terms of section 276A of this Act, punishment of a convicted person for a sexual crime can now include attendance and participation in a specific treatment programme for sex offenders. The convicted person must be able to show that he has the potential to benefit from treatment, and he must cover the cost of the programme. The cost requirement makes such programmes inaccessible to most sex offenders in prison, thus little happens to ameliorate the chances of the offender committing the offence again. The issue of corrective rape is not adequately dealt with and this remains an area for further improvement and lobby work.

The court may, in terms of section 300 of the *Criminal Procedure Act,* order the convicted person to compensate the complainant for costs incurred as a result of the crime, including: medical expenses; cost of alternative accommodation if forced to leave home; cost of counselling for the complainant; cost of

[166] Vetten et al (2008) *Tracking justice: the Attrition of rape cases through the criminal justice system in Gauteng,* research report, Tshwaranang Legal Advocacy Centre, Medical Research Council and Centre for the Study of Violence and Reconciliation, available on www.tlac.org.za

replacement of destroyed property; and wages lost due to attending court proceedings. An application for such costs must be made at the end of the criminal proceedings and will have the effect of a civil judgment. The complainant must be able to prove her damages. Once such an order has been granted, the complainant will not be able to approach a civil court afterwards for damages.

Minimum sentences for rape were introduced by the *Criminal Law Amendment Act 105 of 1997*:

Number of Offences	Minimum Sentence
First offence	10 years
Second offence	15 years
Third offence	20 years

Under certain circumstances, rape could lead to a minimum sentence of life imprisonment -25 years. This is in cases such as where the complainant was raped more than once; was gang raped; or where she was under 16; physically disabled; or mentally ill. It also applies where the accused has previous rape convictions or knew that he was HIV positive at the time of the rape. The courts are allowed to deviate from the prescribed minimum sentence if **substantial and compelling circumstances** exist requiring a lesser sentence. The courts have interpreted this provision differently and have seldom implemented the minimum sentences legislation.

To respond to the differences in the application of this law, the ***Criminal Law (Sentencing) Amendment Act (no. 38 of 2007)*** was enacted with effect from 31 December 2008. The amendment outlines certain factors which the courts may **not** consider as substantial and/or compelling in their decisions to comply with the prescribed minimum sentence regulation. These factors include:

- The complainant's previous sexual history;
- The apparent lack of physical injury to the complainant;
- The accused's cultural or religious beliefs about rape; and
- That a relationship existed between the accused and complainant before the rape.

There are a great number of cases where women have been threatened or even killed by their partners after they had acquired protection orders or instituted legal proceedings against them- pointing to the need to provide stronger protections and security to women- especially once they have reported the threats to the police.

Government has stated that the process towards the re-establishment of specialised police units dealing with domestic and sexual offences and other crimes against women and children has begun. In the past years where these units were fully operational, the success rate in the prosecution and protection of women's rights was much higher. In addition to the specialised police units, dedicated Sexual Offences Courts have been developed and are operational in some provinces.

In addition, a Directory on Services for Victims of Violence and Crime which contains services provided by over 1 500 government and civil society organisations in all provinces has been developed. The directory is mainly used for referrals.

Other legislation that is relevant to protecting women against violence:

- *Promotion of Equality and Prevention of Unfair Discrimination Act, of 2000.* The act was passed to ensure that Constitutional rights are enjoyed by all persons, and that women have equal rights and freedoms in addressing the wrongs of the past.
- *The Employment Equity Act, of 1998*. The Act was passed to ensure that discrimination in employment, occupation and income is curtailed. It encourages equitable representation of women and other historically disadvantaged persons at all levels of public and private entities, and sexual harassment extensively.

A recent Advocacy Alert on VAW by the Ungass Forum summarises some of the key challenges and recommendations on Domestic Violence & HIV.

Challenges	Advocacy Objectives
Many of the interventions on GBV in the NSP focus on communication strategies to empower women, and education addressing coercive sex, and the perpetuation of gendered power stereotypes. Government departments might not have the capacity to develop and evaluate programmes that will address Goal 1 adequately.	✓ Government must allocate sufficient financial resources to address the quality of content of communication materials and training of community facilitators. ✓ Community facilitators must be trained on dealing with gender stereotypes, gender discrimination, social determinants of HIV and violence against women, and HIV-related health risks of harmful traditional and formal practices. Facilitators must understand the link between violence and condom use and how it increases the risk of contracting the disease.
South African research showed that there is a significant correlation between physical violence and HIV, more so than between rape and HIV.	✓ *Abused women* should form part of the vulnerable or marginalised groups mentioned in NSP Goal 16. ✓ Specific programme packages must be developed for abused women. ✓ Gender-based violence should be included as an important part of the core content of various intervention packages that are mentioned in the NSP.[2]

The DVA is not mentioned separately under Goal 19 although marital rape and forced sex is one of the main drivers of HIV in South Africa. The DVA does not link domestic violence and HIV but mentions that SAPS should accompany an abused person to a health facility when it is needed.	✓ Police officers and volunteers at trauma rooms must be trained on the intersection between DV and HIV so as to *not* only focus on the civil/criminal justice (secondary prevention) aspects. ✓ The DVA should have a National Policy Framework linking the policies, national instructions, protocols and responsibilities of the various role players with regard to DV and HIV/AIDS. ✓ Inter-sectoral collaboration at national/provincial/district/service delivery levels is crucial to ensure successful integration of DV and HIV.
The NSP's health focus is lacking in terms of domestic violence, no specific interventions are mentioned for the health needs of abused women.	✓ The DOH must acknowledge DV as a health problem and develop a formal health policy addressing DV in all relevant health services, including its intersection with HIV-infection. The Millennium Development Goals should provide a useful framework for a South African health policy which is more nuanced and reflects a better understanding of the health consequences of domestic violence. ✓ Health service practitioners at all levels should be trained fully on the policy and its implications for implementation. ✓ The DOH must report in terms of their responsibility to train health workers on the HIV Counselling and Testing Policy ✓ The DOH should report on their progress with the implementation of policy (ie on the 5-year VEP Implementation Plan)

The NSP requires scaling up of the coverage of the comprehensive care and treatment package. Research has shown that women with violent partners are significantly more likely to report that they knew their partners had had other sexual partners while in a relationship with them, than women whose partners were not violent.[2] Various studies have shown that abusive partners generally engage in more high-risk sexual behaviour such as simultaneous partners and transactional sex. Accordingly, they are more at risk of contracting HIV,[b] placing their partners at increased risk of HIV infection.[c]	✓ Health service providers at all levels should be trained *how* to recognise abuse (whether it is child abuse, abuse of elder persons or domestic violence) and to respond appropriately and with sensitivity. ✓ Training should include the proper documentation of the abuse, *always* recording the presence of domestic violence, and enquiring into whom had caused the assault, or referring the patient to other support services. ✓ Training should address related factors such as improving the quality of wellness programmes, providing psycho-social support, implementing integrated contraceptive services for women and implementing facility and community based adherence support strategies and programmes. ✓ HIV counselling and testing provides a good avenue to discuss barriers to HIV status disclosure resulting from a fear of violence. HIV counsellors should address this fear when discussing disclosure and be prepared to refer women to DV services or social workers.[d]
The NSP aims to broaden existing PMTCT services to include other related services and target groups. Research has shown that pregnant women are more vulnerable to domestic violence and that the lowest rates for disclosure of HIV status as a result of fear from their partners are amongst pregnant women. The highest rates of disclosure-related violence were reported among women at antenatal clinics.[25]	✓ The *Policy and Guidelines for the Implementation of PMTCT* should support the implementation of women empowerment programmes and actions against GBV should be elaborated on further to prevent it getting lost during implementation. ✓ The policy should address DV as part of post-HIV test counseling. ✓ Maternal health programmes should include measures to identify and deal with intimate partner violence.

Legislation focussing on children

- *The Maintenance Act, 1998*. The act guarantees the child's right to a living standard that is adequate for physical, mental, spiritual and social development. It further ensures that maintenance for the child is recovered from the parents or other persons financially responsible for the child.
- *The Children Rights Charter* is currently under review to include emerging challenges such as use of children as subjects of pornography
- **The Children's Act of 2005, and Children's Amendment Act of 2007-** enacted to protect a child from maltreatment, neglect, abuse or degradation.

Government and Civil Society have also begun to respond to the practice of forced marriages of children to adults under the pretext of a traditional practice called "Ukuthwala". The response is to ensure that traditional and other practices are in line with the Constitution and relevant legislation.

The ***Child Justice Act** o*f 2009, allows for children accused in criminal cases to be diverted from the criminal justice system to alternatives other than correctional facilities and detention centres. This means that the *Child Justice Act* differentiates between Schedule 1 offences (such as bestiality or consensual sexual penetration); Schedule 2 offences (such as sexual assault without the infliction of harm); and Schedule 3 offences (such as rape, sexual assault where grievous bodily harm was inflicted, sexual exploitation or grooming). Diversion for Schedule 3 offences is only allowed if exceptional circumstances exist and permission for such diversion is given by the Director of Public Prosecutions. The Act outlines a wide range of diversion options, from an apology to injured parties to attendance of a treatment programme and supervision by a probation officer. Where a diversion order has been complied with, prosecution will not be instituted against the child.

Question 2: Are there any specific actions underway against the sexual exploitation of girls and adolescents?

The new *Criminal Law (Sexual Offences) Amendment Act 32 of 2007* includes a detailed section which criminalises sexual exploitation of children under the age of 18. The Act also provides for mandatory reporting of sexual abuse. Mandatory reporting by everyone aware of the abuse of a child, including sexual abuse, is also imposed by the *Children's Act 38 of 2005.*

The *Criminal Law (Sexual Offences) Amendment Act 32 of 2007* does not allow the employment of persons who have been found guilty (convicted) of committing a sexual crime against a child or a

person with a mental disability, in certain circumstances. Such persons are not allowed to, for example, work with a child or person with a mental disability, or become a foster parent.

The South African Law Reform Commission has explored the issue of child exploitation further and its Discussion Paper on this issue (Number 103) can be found at www.doj.gov.za/salrc/dpapers.htm.

The Centre for the Study of Violence and Recreation (CSVR) has initiated an ***Engendering School Safety Project*** focussing on creating a change in the individual, the peer group, and the school environment to prevent gender-based violence in schools. The project supports the development of positive identities by creating opportunities for girls and boys to speak out, challenging stereotypes, providing counselling and support, promoting a human rights culture and building life-skills.[167] . This project not operational in all schools, but, where operational, it supplements the life-skills programme that is part of the life orientation curriculum of all South African schools.

Question 3: Are services in place throughout South Africa to provide care and address the needs of women and girl victims of violence and/or sexual violence? If the answer is Yes, are such services readily accessible?

Services such as counseling; care centres and shelters; and trauma rooms are available, but variable in access within the provinces and rural/urban settings.

There are currently 17 *Thuthuzela Care Centres (TCC)* established across the country in communities with high incidents of sexual violence. These centres are in addition to other centres run by NGOs such as Thohoyandou Victim Empowerment Centre TVEP in Thohoyandou, Limpopo, and Mosaic in Cape Town, Western Cape. The TCCs provide professional health and welfare services; and initiate processes for effective reporting and prosecution of offences in a dignified and caring environment. The model has the potential to provide excellent, sustainable services to victims of both sexual assault and domestic violence. Its efficacy is however currently limited because of the following concerns noted by TVEP[168]:

- Three TCC evaluations have been conducted, but the results of all three have been embargoed, and not released to the public.

---

[167] Mabusela, E. *Preventing gender-based violence in schools*. Paper delivered at at the "We can prevent Violence. Strengthening Primary Prevention of Gender-based Violence in South Africa Symposium", 23-25 November 2009, Johannesburg. CSVR.

[168] Fiona Nicholson. 2009. Director. TVEP.

- The current TCC model requires the staff of under-resourced, under-capacitated hospitals to co-ordinate all client services after-hours/public holidays/weekends, despite the fact that they are themselves operating on skeleton staff. This has hampered delivery of services during these times. The situation has at times been so desperate, that local NGOs were co-opted to assist without remuneration of their services.
- The current TCC model requires officials from one government department to effectively hold officials from other departments accountable for their mandates. This requires a nurse to call a policeman and essentially give him orders to react promptly etc.
- The current TCC model does not provide for civilian input or oversight. Departments monitor and evaluate their own deliverables. Spaces to ensure that the extremely disempowered and traumatized people with whom the centre works are able to have their voices heard, have not been created.

Based on these observations, it seems relevant to accommodate NGO participation within TCCs. NGOs would provide assistance to a) ensure the provision of 24/7/365 services to victims, b) co-ordinate the services of all stakeholders; and c) provide oversight to ensure accountability

TABLE 7: TCC CURRENT PRACTICE, AND RECOMMENDED STRATEGIES FOR IMPROVEMENT.

Type of Service	**Current TCC Practice**	**Recommendation**
Service Delivery at Intake	TCC staff on duty for office hours only. During the traditionally busy periods, i.e. weekends, evenings & public holidays, they either: 1. Rely on over-stretched hospital staff to co-ordinate & monitor the debriefing of the client, provision of VCT, provision of PEP, medical examination, forensic collection, medicine explanation, SAPS statement taking, victim counseling & support etc. or: 2. An NGO is co-opted to provide counselling services, and in a few cases, to staff the Centre after hours, - *but they are not funded for this because they are not regarded as an integral part of the TCC Model.*	Dedicated staff on duty 24/7 to ensure coordination and provision of all services in terms of respective departmental protocols & policies.

Type of Service	Current TCC Practice	Recommendation
Client Intake Restrictions	Rules vary between various TCC's; some admit only adult rape victims, some admit children as well, but most do not provide assistance to victims of domestic violence.	All victims of sexual assault or domestic violence are assisted, irrespective of age
Accountability, & efficacy of Coordination of Services	Needs to be strengthened. It is unusual for Government Officials to hold Officials from other departments accountable. If the medical examination is delayed, for example, the NPA Official does not have authority to demand prompt service from the Health official and be heard.	Officials need to be capacitated to hold all stakeholders accountable to their mandates, so as to ensure prompt and efficient service.
Continuity of Support Services	TCC has one Case Manager on duty during normal office hours. S/he usually follows up on client by phone. Home visits are not conducted; ongoing or after-service is only provided if the client returns to the Centre – for which they are not provided a transport subsidy.	Need for a buddy system, and for the person who first served the client to remain the client's main support. This is to avoid re-living the trauma every time a client has to tell the story to a new service provider. This will ensure that one person is responsible for the holistic management of all aspects of the client's case until it reaches conclusion, i.e. the trial is over, all counselling sessions concluded. This includes home visit, PEP monitoring, liaison between SAPS & client, referrals for psychological support, court preparation, etc
Victim Adherence to PEP	Not monitored by TCC; hospitals are held responsible for this service (but none are providing it)	The staff responsible for the case needs to visit each client 3 days after the assault to encourage & document

Type of Service	Current TCC Practice	Recommendation
		compliance levels and side effects. Follow-up may also be performed by NGO staff if trained by medical expert.
Victim Retesting	Not monitored by TCC; responsibility of hospitals	Client follow-up is necessary to encourage clients to return to the hospital for re-testing, and are given public transport assistance if impoverished. Documentation and reporting on compliance levels & Sero-conversions done and followed up.
Efficiency of SAPS investigation	In theory, there are Prosecution Guided Investigations. In practice, NPA Officials have neither the authority nor the capacity to hold any other stakeholders accountable.	Need for TCC to have more authority to guide investigations, actively lobby for reforms, recommend further training, take a stance against corruption & abuse, and report on transgressions, among others.
Case Flow Management	Dedicated prosecutor employed by NPA	A necessary and useful step. Needs to be strengthened.
M&E Efficacy	Negligible. Government officials monitor their own services. No civilian oversight, despite the acknowledged high levels of disempowerment amongst South African women.	Civilian participation and oversight to be encouraged, with prompt action taken to address stakeholder malpractices before they have a negative impact on either the client or the case.
Sustainability	There is potential for financial sustainability- given the extent of the partners who are collaborating with government to deliver TCCs	NGOs involved should be financed by the NPA per case to ensure financial sustainability

One aspect that needs particular attention in the health sector is the documentation of injuries sustained by rape victims at health settings. A recent study on the processing of rape cases by South African Police Services (SAPS) and courts showed the value of adequate documentation of injuries, as compared to the more expensive DNA evidence in assisting courts in rape cases. The study indicated that health care providers (esp. forensic medical examiners) need training to provide high quality care responses after rape, and that the core elements of the medico-legal response, require little technology. The study also raised important questions about the value of forensic laboratory evidence in countries such as South Africa that have substantial inefficiencies in their police services. However, the system for collecting and analyzing DNA evidence needs to be improved to cater for the high level of non-intimate partner rapes.[169]

While Thuthuzela and similar NGO centres are trying to offer integrated services for survivors of sexual violence, not enough attention is being given to women who experience Intimate Partner Violence (IVP). A study by Dunkle et al[170] showed that high levels of male control and IPV are associated with HIV for women. This finding should raise concerns and prioritise women who apply for protection orders under the Domestic Violence Act, and do not visit clinics or centres where they can access PEP in time. Mosaic's Court Support Project which assists approximately 20,000 people in Cape

---

[169] Jewkes, R; Christofides, N; Vetten, L; Jina,R; Sigsworth,R & Loots,L. 2009. Medico-legal findings, legal case progression, and Outcomes in South African Rape Cases: Retrospective Review. PloS Medicine, October 200, Vol 6, Issue 10. www.plosmedicine.org

[170] Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. 2004. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet. 2004 May 1;363 (419): 1410-1

Town DV courts per year, found that about 15% of cases involve sexual abuse where HIV&AIDS services should form part of the application process for a protection order.[171]

Shelters

The Domestic Violence Act provides for shelters to be established. There are currently 96 shelters in South Africa, from 39 in 2001[172]. In October 2008, the National Working Group on Sexual Offences, a group of 26 civil society organisations launched ***'Shukumisa,'*** a campaign calling the state to account for its responses to survivors of sexual violence. During the 16 days of activism to end violence against women, the Campaign piloted a method of civil society monitoring that reviewed service delivery by the courts and police to survivors of rape. The results[173] of the monitoring highlighted huge discrepancies between national laws and policies and their implementation, as well as disparities between services in different areas. The pilot also illustrated that many public servants are unaccustomed to being asked questions about their service delivery by the community and do not see themselves as accountable to community members.

It is well documented that witnessing or experiencing (sexual) abuse/violence in childhood increases the risk of abuse or perpetration as adults. The numbers of children affected by abuse in South African households are significant, but this intergenerational cycle of violence needs to be acknowledged, and met with an appropriate response to stop it. Children are exposed to information about violence at

---

[171] M. de Vos. Mosaic Training, Service and Healing Centre for Women. **Full reference**
[172] Nxumalo, C. 15 Sep 2009. Presentation by the Department of Social Development to the Portfolio Committee on Social Development. *Overview of the Victim Empowerment Programme*..
[173] Tshwaranang, 2009. Shukumisa Campaign. First Monitoring Report for the period 25 November – 10 December 2008

school through Life Orientation curriculum but the emotional and psychological support needed for children to come out and speak about these challenges is largely lacking-both at home and at school.

Hate crimes against lesbians who transgress gender roles, especially those who dress more masculine, are a big concern in South Africa. By May 2009, there were 20 documented cases of murder of lesbians in South Africa of which only 2 had trials going. Both cases had committed and qualified prosecutors, but the prosecutors failed to see the way that transgressing of gender roles contributed to the murders.[174] Negative perceptions about lesbian and gay people are still prevalent in SA youth.[175]

The Victims Charter[176] is comprehensive and human rights based but needs corresponding comprehensive implementation in all areas.

Economic empowerment of women

The evaluation of micro-credit programmes suggest that they empower women by improving their decision-making in the household, as well as provide health benefits such as improved nutrition, child health and contraceptive use. A study on the intervention *Microfinance for AIDS and Gender Equity* (**IMAGE**) showed that a combined microfinance and training intervention can lead to reductions in levels

---

[174] Mtetwa,P. 2009. Sexual orientation, violence and AIDS. Equality Project. Paper delivered at Population Coucil on Multi-Sectoral Approaches for addressing and preventing Sexual Assault And Domestic Violence – A Collective Force To Stop The Violence, 6-7 May 2009.

[175] Nomampondo Barnabas. Personal Communication. 8 Nov 2009.

[176] http://www.justice.gov.za/VC/docs/vc/2007%20Service%20charter%20ENG.pdf

of intimate-partner violence, thus emphasizing the potential for social and economic development interventions to alter risk environments for HIV and intimate-partner violence[177].

Question 4: Are prophylaxis against HIV & STDs, emergency contraception and legal abortion made available in those services?

Yes prophylaxis against HIV & STDs, emergency contraception and legal abortion are made available, but are variable as per table in question 3 above. The referral systems and associated network is not standardised, and levels of care vary based on geographical location-with centres based in urban communities more equipped and able to deliver services better than the ones in rural communities.

Question 5: Is there a public information system for gathering and publicising data concerning violence inflicted on women and girls?

There is no public information system for gathering and publicising data about violence against women and girls in South Africa. The only information system for gathering information on violence inflicted on women and girls, is the records kept by the police; and the studies done by the Government, South African universities, research institutions, and NGOs. These studies are managing to indicate the challenges to women and to the system in relation to sexual and intimate partner violence in South Africa. The studies are however mostly confined to a specific area or to a couple of provinces only. The country needs a well defined, agreed upon system of institutional, service and outcome indicators which

---

[177] P. Pronyk, J. Hargreaves, J. Kim, L. Morison, G. Phetla, C. Watts, J. Busza, J. Porter . Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *The Lancet*, 2006, Volume 368, Issue 9551, Pages 1973-1983

is measured and analyzed regularly to provide a national picture of violence against women in South Africa.

During the nine-month period April – December 2007, 36 190 rapes were reported to the South African Police Service (SAPS).[178] In August 2009, the number had increased to **39 946. The** Minister of Justice reported that the highest numbers of rape cases appearing in court over the past year were in KwaZulu-Natal - 7278 cases; followed by Western Cape's 6411[179]. Northern Cape enrolled the least number of cases at 1462. Statistics for the period 1 July 2008 until 30 June 2009 are indicated in the table below:-

TABLE 8: RAPE PREVALENCE BY PROVINCE

PROVINCE	NO OF CASES ENROLLED	PERCENTAGE
EASTERN CAPE	5858	14.66
FREE STATE	2834	7.09
GAUTENG	4566	11.43
KWAZULU NATAL	7278	18.22
LIMPOPO	4335	10.85

178 The legal definition of rape was altered and expanded with the introduction of the *Criminal Law (Sexual Offences) Amendment Act 32 of 2007* in December 2007. To prevent an increase in the statistics caused purely by the inclusion of acts previously not defined as rape, the police only provided figures for the nine-month period prior to the Act's promulgation.

179 Question & Replies No 726 to 750. http://www.pmg.org.za/node/17944

MMPUMALANGA	2870	7.18
NORTHERN CAPE	1462	3.66
NORTH WEST	4332	10.84
WESTERN CAPE	6411	16.05
TOTAL	39 946	

There are however various concerns around how the police collect and report on statistics. SAPS statistics on rape and domestic violence are released at irregular intervals while some information can be sourced from the minutes of submissions by SAPS and Department of Justice to Parliamentary Portfolio Committees. Recently NGO suspicions were confirmed when several police stations were caught manipulating reported rape cases into lesser crimes and even not registering cases, a result of extreme pressure from above to show a drop in crime rates![180] The CEDAW Report of 2008 only mentions the number of reported Domestic violence incidents in 2006/07 (almost 90,000) but this information is too scant to indicate anything. The Department of Justice Annual Report for 2007/08 recorded the number of protection order applications, but no analysis is made of the attrition rate of nearly 50%.

Police figures tend to represent but the tip of the iceberg. The Demographic and Health Survey (DHS) of 1998 was the first attempt at national prevalence rates for women experiencing violence ever in

[180] http://censorbugbear-reports.blogspot.com/2009/06/crime-stats-manipulated-heres-proof_26.html

their lifetime and over the last 12 months. Although there was underreporting, the study was useful indicating a lifetime prevalence of physical violence of 25% and past-year prevalence of 10% in adult women in three provinces[181], However, the same measurements were not repeated in the 2003 DHS. In 2002, research found only one in nine women report being raped to the police, and one in four men (27.6%) surveyed in three districts in the Eastern Cape and KwaZulu-Natal admitted to having forced a woman or girl into sex (Jewkes *et al,* 2009). The prevalence of HIV amongst men who admitted to rape was found to be 19.6% in one study (Jewkes *et al,* 2009). When coupled with the high prevalence of injuries (58%) found in rapes reported to the police (Vetten *et al*, 2008), this illustrates the significant risk of HIV infection faced by rape survivors.

Under the list of statistics, there is a need to include statistics on post-exposure prophylaxis of HIV (PEP). Currently the SA government provides PEP free of charge at public health facilities. It is impossible however to determine the extent to which these services are provided, because there has been little training for provincial health departments and local health facilities on what the indicators mean.

Currently statistics are collected for the number of rape survivors tested for HIV, the number who test positive and the number for whom a 3 day PEP starter-pack is provided. No statistics are being collected on adherence to PEP or whether a full 28 day course was provided. Currently, statistics on the number of health workers trained on PEP are kept. The additional info needed is the areas from which those participants come from, and whether they are in a position in the health facility to implementing what they have learnt. This is an important issue since research studies have indicated low adherence to

[181] Jewkes R, Penn-Kekana L, Levin J. Risk factors for domestic violence: findings from a South African cross-sectional study.

PEP, particularly as a result of lack of training of health care workers.[182] In one study, the provision of a full course of PEP at the initial visit; the provision of anti-emetics and food supplements; as well as a follow-up home visit were factors associated with increased adherence, yet these research findings have not translated into follow-up programmes for rape patients subsequent to the prescription of PEP.[183]

Question 6: Are national campaigns to combat violence against women and the sexual exploitation of girls carried out on a regular basis?

Yes, the 16 Days of Activism against Violence against Women is a national campaign that is contributed to by most government departments and NGOs in the gender-based violence and SRHR fields. This 16-day period also highlights other significant dates including November 29, International Women Human Rights Defenders Day, December 1, World AIDS Day, and December 6, which marks the Anniversary of the Montreal Massacre. There were plans to turn the 16days into a 365-day campaign with the establishment of the 365 Day National Action Plan to End Gender Violence, which was launched on 8 March 2007. This plan has not been followed by action though- to date, no activities have been implemented as part of the plan. .

Other national campaigns include: The 1 in 9 campaign; The 07-07-07 End Hate Campaign; Men as Partners; The Women Won't Wait Campaign; Sonke Gender Justice's *The One Man Can*; Khomanani Beat It! Campaign , and the Shukumisa Campaign.

Soc Sci Med 2002; 55: 1603–18.

[182] Vetten, L. and Haffejee, S. (2005). Factors Affecting Adherence to Post-Exposure Prophylaxis in the Aftermath of Sexual Assault: Key Findings from Seven Sites in Gauteng Province. Report prepared for the Gauteng Department of Health.

Even though civil society organizations sometimes work together to campaign against national issues, campaign work in South Africa is largely not integrated; making the monitoring and evaluation of the work difficult. Oxfam recently commissioned a baseline study on the focus of the campaign work on VAW in SA, and its impact. The key findings of the study included the need to coordinate organizational work at community level; and ensure that the messaging is integrated and not contradicting each other. The study found examples of organizations working in the same community, but giving out different messaging on the same issue

In addition to campaigns there are some examples of gender transformative programmes such as the Stepping Stones that showed huge reductions in both infections with genital herpes as well as perpetration of physical and or sexual intimate partner violence after two years of implementation. Wide-scale implementation of these programmes is however not happening.

Question 7: Are there any specific actions underway directed at suppressing trafficking in women?

Legislation against trafficking is contextualised in three pieces of legislation in SA: *The Children's Act* which provides for combating the trafficking of children; The *Sexual Offences Act, No 32 of 2007* which criminalises persons for trafficking for purposes of sexual exploitation; and *Combating of Trafficking in Persons Bill-*, which criminalises the trafficker (supply side) and the procurer (demand side) but not

---

[183183183] Christofides NJ, Muirhead D, Jewkes RK, Penn-Kekana L and Conco DN (2005) "Women's experiences of and preferences for services after rape in South Africa: Interview study" *BMJ* 2006; 332; 209-213.

equally. The Bill identifies causes, has a preventative component, provides for compensation, asset forfeiture, and victim support services[184]

With its strong economic position and political stability, SA is a leading destination for migrants from neighboring Southern African countries and the wider African continent. Since the collapse of apartheid, the number of people crossing borders into SA has increased significantly with Africans from other countries viewing SA as a place to study, trade, shop, get essential services such as medical care, and seek asylum **IOM**[185].

Since the 1990s, traditional movement of organized labour across borders – for example, men from Mozambique and Lesotho migrating to work in South Africa's mines – has expanded, and now includes traders working in the burgeoning cross-border trading sector, and irregular migrants taking advantage of SA's porous borders to flee economic hardship or conflict at home. Migrant smuggling and trafficking across SA's borders is a significant concern.

This migrant smuggling, and the trafficking of women and children, is expected to increase in view of the 2010 soccer world cup to be held in SA. SA's government is getting assistance from the International Organization of Migration (IOM), United Nations Human Rights Commission for Refugees (UNHCR); and several other organizations such as the Consortium for Refugees Affairs- CORMA to respond to migration and trafficking in particular. Several local organizations such as Child Welfare

---

[184] Seethal, C. & Ngwira C. Department of Geography and Environmental Science, University of Fort Hare. Human trafficking in South Africa – Perspectives from the Eastern Cape. Paper delivered at the Society of South African Geographers Conference, 1-3 September 2009.

[185] *www.**iom**.org.za*

South Africa - (CWSA) and the Nelson Mandela Children's Fund (NMCF) have launched national Trafficking and Exploitation Prevention Programmes focusing on children, and women.

IOM's regional office for Southern Africa is based in South Africa and targets all Southern African Development Community (SADC) countries including South Africa. It is assisting governments in the SADC region to deal with its migration challenges by providing technical cooperation assistance on migration management and furthering the understanding of migration in the region. It also implements a number of regional programmes of which South Africa is one of the beneficiaries.

CORMSA - The Consortium for Refugees and Migrants in South Africa (CORMSA), formerly known as the National Consortium for Refugee Affairs, is a registered Non Profit Organisation tasked with promoting and protecting refugee and migrant rights. It is comprised of a number of member organisations including legal practitioners, research units, and refugee and migrant communities. The Consortium's mandate involves strengthening the partnerships between refugee and migrant service providers to provide improved co-ordination of activities. This includes developing working relationships with other concerned organisations to provide an effective forum for advocacy and action.

Child Welfare South Africa - (CWSA) has recently launched a national Child Trafficking and Exploitation Prevention Programme in partnership with Absa Bank. There are several other public-private initiatives going on in view of next year's FIFA World Cup 2010.

Question 8: Are there any records of women living with HIV that suffered violence as a direct consequence of the revelation of their sero-status?

The most known incident of violence as a direct consequence of the revelation of an HIV positive sero-status was that of Gugu Dlamini, who was murdered for her HIV status in December 1998. Since then, women who live with HIV are still at an increased risk of violence, but these are not documented.

Question 9: Has your government implemented any strategies to support boys and girls with HIV&AIDS and provide them with psycho-social care, education, shelter, nutrition, health services and guarantees of non-discrimination?

Yes, the government has a wide range of social security and social development programmes aimed at providing boys and girls with psycho-social care, education, shelter, nutrition, health services and guarantees of non-discrimination-all underpinned by the Constitution, the Children Act and several other legislative instruments. The support is in the form of grants, exemption from school fees, and other services outlined below. The most critical gap is the implementation of the law and policy; and the prevention of orphanhood through outreach to parents whose health appears compromised and supporting them to access medical assessment and care

Social Security for Children

Currently 13-million South Africans, 9-million of whom are children, are currently receiving social assistance benefits. In 2009, child support grants were increased from R240 to R250 with a phased-in extension of the grant until the child is 18 years old; foster care grants from R650 to R680; and care dependency grants from R960 to R1 010.

Foster child grant

This grant is for children who have been placed in foster care by a court of law. To qualify for this grant:

- A child (under the age of 18) or the applicant, must be resident in South Africa at the time of the application;
- Foster parents and children need not be SA citizens; and
- There must be a Children's Court order-not any other court- proving that the child has been placed in foster care.

Care-dependency grant

- This grant is intended for parents/ foster parents who have a child under the age of 18 who requires and receives permanent home care because the child has a severe mental and/or physical disability.

To qualify for the grant:

- The primary care givers must be SA citizens, although foster parents do not need to be SA citizens.
- The child must be an SA citizen.
- The child must be between the ages of 1 and18.
- A medical assessment must confirm that the child has a permanent disability.
- The applicant and their spouse must meet the criteria of the means test. This does not, however, apply in the case of foster parents as their income is not taken into account.
- The child must not be permanently looked after in one of the state's institutions.

Child support grant

The child support grant is paid to a primary care-giver, who is regarded as any person, whether related to the child or not, who takes primary responsibility for providing the child's daily needs.

The purpose of the grant is to supplement the income of poor families. It forms part of the broader package of social assistance to poor children, which includes free health care, exemption from school fees, nutritional services and subsidized pre-school education.

To qualify for this grant:

- The primary care giver and the child must be SA citizens or permanent residents and resident in South Africa at the time of application;
- The child must be under the age of 15;
- The applicant and their spouse must meet the requirements of the means test;
- The grant cannot be issued for more than six non-biological children. There is no limit on the number of biological children for whom you may claim.

While these grants and social provisions are life-changing for most children, the challenge remains implementation. Many children in receipt of grants are told they have to pay school fees – or asked to pay for school admission forms for the following year, or for their children's reports.

Significant effort has also gone into supporting communities to develop context-specific, community-driven responses to orphans and vulnerable children (OVC). This was informed by the need to ensure that OVC responses are not based on western ideas of family form and care arrangements, but on

appropriate African traditional and cultural contexts and therefore sustainable over the long term. The programmes include parenting and supervision by community care givers; home within their extended family context, food, and education support including exemption from school fees.

9.1. And in the case of orphans?

In addition to the grants outlined above that OVC qualify for; there is a Policy framework for orphans and other children made vulnerable by HIV & AIDS.

9.2. Are specific budget allocations made for such actions?

Yes, although gross inadequate.

9.3. Which sphere of government is directly responsible for their implementation?

The Office on the Rights of the Child based in the Presidency has the responsibility for monitoring service delivery to children, which is at provincial and local level. The provincial and local governments work in collaboration with Civil Society Organisations to deliver social development programmes to children. The key departments involved are the Education, Social Development, and Health.

Question 10: What is the status of sex work in South Africa?

The Sexual Offences Act of 1957 prohibits all sex work, and any activity associated with it. According to the act- actions associated with buying sexual services; keeping or participating in the management of a brothel; procuring someone to become a sex worker; soliciting or selling sex; and living off the earnings of a sex worker –are criminal offences. This has driven sex work under ground, and made it difficult to manage the role of sex workers in HIV transmission.

Civil Society's efforts to have sex work decriminalized have received a boost following supporting remarks by the newly installed premier of the country's richest province- Gauteng. The South African Law Reform Commission (SALRC) is now leading the process of reviewing the legislation.

In support of this review, the SANAC civil society sector, in collaboration with the Sex Workers Education and Advocacy Task Force[186] (SWEAT) held a consultation on Sex Work and the 2010 Soccer World Cup with the theme '*Human Rights, Public Health, Soccer and Beyond*'. With the influx of an estimated 450,000 visitors to the SA, and with high rates of HIV within the country, sex work is expected to increase. It is therefore critical that the country's laws create an environment that enables the best possible public health outcomes to be achieved.

The Sex workers expressed that they are not looking for special rights, but rather protection of their basic human rights- .Right to safety and protection; sexual health; Access to sexual health services; Lawful, responsible and respectful police behavior; Freedom of movement in one's living environment; and Dignity.

---

[186] www.sweat.org.za

Section III – VIOLENCE AGAINST WOMEN

Question 1: Who are the main allies in promoting the sexual and reproductive health of women living with HIV&AIDS in your country?

The constitution is the ultimate ally as it provides for various protections of women rights and HIV&AIDS. In addition, the main allies are the academics in health, gender and legal rights; the NGOs working in the field; and several development agencies[187] . The following is a list of the Civil Society Groups and development agencies that continue to make contributions in this space.

Positive Women's Groups

HRI – Her Rights Initiative

PWN – Positive Women's Network

Human Rights Sector

The AIDS Legal Network

Termination of Pregnancy sector

Ipas SA-http://www.ipas.org

LGBTI Sector

The Triangle Project – www.triangel.org.za

OUT - **www.out.org.za**

The Lesbian and Gay Equality Group (LAGEP) - **www.equality.org.za**

Research Institutions

RHRU-www.rhru.co.za

Health Systems Trust-www.hst.org.za

---

[187] Rees, H. January 2010. Personal input. Reproductive Health and AIDS Research Unit, Wits University.

Medical Research Council-www.mrc.ac.za

CSVR – www.csvr.org.za

Trade Unions, Professional Associations and Societies

DENOSA

COSATU

NEHAWU

FEDUSA

Regional and International Networks

Athena

Amanitare

Donors and UN Agencies focusing on SRHR issues

Ford Foundation

OSISA

CIDA

Global Fund for Women

Norwegian Church Aid

Noraid

African Women's Development Fund

The Population Council

UNFPA

Question 2: What are the principal windows of opportunity for prevention of the epidemic among women?

Heterosexual intercourse remains the primary risk factor for HIV infection among women in SA. Although correct and consistent use of male condoms has been shown to prevent HIV infection, women often do not have a choice on whether or not they are used. This is especially true in traditional patriarchal communities where some cultural practices increase women's vulnerability to HIV&AIDS. The need to engage these traditional systems, as well as develop women-controlled prevention methodologies is paramount.

The following are the windows of opportunity that exist for women and girls' HIV prevention in SA:

- **Responding to customary and traditional practices that make girls and women vulnerable** such as: initiation schools (for circumcision) and rape of elderly women, female genital mutilation, promoting the rape and abduction of young girls for Ukhutwala, unwanted pregnancy. Women organisations have a unique opportunity to lead public and community conversations on polygamous marriages and what this means for women-mainly because they have the evidence of the impact of these practises on women's SRHR and dignity, among others.
- *Microbicide Development*

  Despite recent setbacks showing that the PRO 2000 Microbicide is not effective in preventing HIV among women, research in search for safe and effective women-controlled strategies to prevent HIV is continuing. Several trials focusing on the use of ARVs in prevention- in pills; vaginal gels; and ring forms- are currently underway. One ARV-based Microbicide, Tenofovir gel, is being evaluated in two Phase IIb clinical trials. The Centre for the AIDS Programme of Research in South Africa (CAPRISA) is evaluating use before and after sexual intercourse, while VOICE is testing the daily use of Tenofovir gel as well as daily use of an ARV tablet for

preventing sexual transmission of HIV in women. The studies are conducted by the Medical Research Council's HIV Prevention Unit and the Microbicide Trials Network, and are being conducted simultaneously in South Africa, Uganda, Zambia and Zimbabwe.

- **Temporary and limited decriminalization of sex work**

  The possible temporary decriminalization of sex work for the duration of the World Cup might be an opportunity to fast track decriminalization of sex work for good.

- *Efficient, Accountable, Universal Access to Female Condoms*

  Female condoms give the power of HIV prevention back to women- to some extent. In some cases, their use depends on the power relations between man and woman in the relationship, and on the woman's negotiation skills. An envisaged enquiry into tender irregularities with regard to female condoms might offer some opportunity to advocate for more effective and adequate provision of female condoms in South Africa.

- *Vaccine Development*

  The US National Institute of Allergy and Infectious Diseases and the Bill & Melinda Gates Foundation are two of several organizations that have placed significant resources in the development of an HIV Vaccine

- **Funding**

  Whilst there are still ways that women's organisations can improve the way they work together and strengthen their collective power, women's organisations have gained strategic political spaces, and have been able to pressure donors and other development actors to shift the conventional approaches to women issues, and have in many cases revised their own power dynamics and structures to ensure that more comprehensive and democratic processes prevail within their organisations.

A number of bilateral agencies have significantly escalated their contributions to civil society organisations doing women's rights work. Large private foundations are giving big grants to a small number of well established organisations, and recently founded philanthropic institutions are moving towards supporting initiatives for the advancement of women. Examples include the Dutch government's *"MDG3 Fund: Investing in Equality"*, and the Novo foundation.

The four-year research conducted by AWID shows that most women's rights organisations establish individual relationships with donors and have their own fundraising strategies or practices. Only about 25% of AWID's survey sample reported to have had experiences of joint resource mobilization, with good results. Some of the pros mentioned by respondents were the confidence donors had on the possible results when they received a joint project; the possibility of accessing larger amounts of funds; the increased coordination among organisations; and the greater impact and outreach their work had.

In the context of the economic crisis that has hit the globe and SA, the opportunity exists for women organisations to adapt to the changes. The organisations might be well served to consider how best to organise themselves, so as to adopt joint resource mobilization strategies and pool resources.

Question 3: What are the main obstacles and drawbacks to the integration of actions designed to promote Sexual and Reproductive Health, prevent HIV and confront violence against women, in regard to official policies on AIDS and official policies for women?

The importance of the integration of SRHR and HIV&AIDS is still not well understood by policy makers and therefore still receives too low a priority. While at some level there is commitment from policymakers to address issues such as violence against women and children, the interventions are often

unimaginative and have been implemented for a number of years with little impact. Furthermore, 30% of pregnant women in SA are infected with HIV, and yet the scale of the response has still not reflected this public health emergency.[188]. There needs to be greater appreciation of the critical importance of the integration of HIV&AIDS and SRHR, as well as much bolder leadership and innovation to bring about change.

The obstacles include:

- **Absence of an integrated SRH National Policy**

  As indicated in section 1 of this report, there are a number of SRHR-related legislative and policy instruments that have been developed over the years, but which are not necessarily linked to each other. The individual pieces of legislation and policies are interpreted individually and differently by the different sectors of Government and society, thus resulting in a fragmented and ineffective service to women and girls.[189]

- **Fragmented systems of care** and lack of multi-skilled health care workers that can provide holistic service and care to clients.

- **The HIV&AIDS NSP weak accountability and M&E Systems**

  The HIV&AIDS NSP is all encompassing, but not specific and detailed enough on SRHR and vulnerability issues for women and girls.

  The NSP has been in effect for a number of years, and does not necessarily hold ministries- other than those in the social cluster- accountable for implementation. The weak accountability and M&E Systems has allowed other sectors of Government to lag behind in the implementation

[188]Rees, H. January 2010. Personal input. Reproductive Health and AIDS Research Unit, Wits University.

of the policy and several other elements that impact on SRHR for women. Furthermore, SANAC sectors are struggling to operate with lack of resources for co-ordination and participation. The functioning of AIDS Councils at provincial level is also sub-optimal and clearly does not facilitate effective planning and co-ordination in provinces.

- **Inadequate attention to marginalised groups of women such as LGBTIs and CSWs**

  The policies generally view women as a homogenous group, and as a result women who belong to marginalized groups such as LGBTIs and CSWs are not fully catered for, and still experience high levels of stigma and discrimination in their attempts to access services.

- **Inadequate integration of HIV&AIDS, SRHR, and gender into medical training**

  Lack of intense gender-specific pedagogy at undergraduate and postgraduate training of health care providers.

- **Impact of International organisations and development agencies**

  International organisations and development agencies often set the agenda of what's important for CSOs in SA, and perpetuate fragmentation of issues based on their own structures and institutions- e.g. UNFPA, UNIFEM, UNAIDS- all deal with some aspect of SRHR and HIV&AIDS. This is disempowering as organizations end up working according to what Funders consider to be priority issues so as to access resources.

- **Inadequate Funding & Sustainability of women organisations**

  Bilateral and multilateral agencies provide most of the resources for women's organisations, but trends indicate that Women's Funds are also disbursing resources in the form of small grants to

---

[189] Sebopa, D. January 2010. Gender & HIV/AIDS COORDINATOR, DENOSA.

small women's organisations for supporting the organizational development of their grantees[190].

The impact of the progress around funding is set back by the duration of the funding - 56% of grants made in 2007 were for a one-year project. A flow-on effect of this is that these grants "tend to sustain organisations rather than allow for investments in long range planning, realizing ambitions and building and growing for the future. As a consequence, many organisations are still in survival mode, and have difficulties in implementing solid programmes with lasting impact. In addition, it was found that "most of the funding accessed by these organisations is for projects and not core-funding, which means that in many instances organisations are not able to set their own priorities".

The new dual track financing of the Global Fund together with their Gender Strategy is an opportunity for women's organisations to mobilize for joint funding focusing on SRHR and HIV&AIDS in SA.

Question 4: What are the main obstacles and drawbacks to the integration of actions designed to promote Sexual and Reproductive Health, prevent HIV&AIDS and confront violence against women, in regard to the articulation of the various sectors of civil society?

- International and national focus on HIV&AIDS has taken the focus away from women's SRHR issues, and re-diverted resources to HIV. As a result, many women organisations have closed down, thus shrinking their space to influence policy. This has created competition for resources

[190]. Awid Women's Rights. 2008. **FundHer Brief 2008. Money Watch for Women's Rights Movements and Organizations.** Association for Women's Rigths in Development

among the organisations a wider divide between what communities need and what national and international programs provide.

Question 5: What are the main recommendations for overcoming such obstacles put forward by the UNGASS Forum and Civil Society in your country?

The main recommendations outline key actions that need to be taken by the Government and its partners on the one hand, and by Women civil society organisations on the other.

TABLE 9: UNGASS FORUM RECOMMENDATIONS

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
LEGISLATION AND POLICIES	
An overarching SRHR policy which integrates HIV&AIDS into SRHR programmes, and conversely, SRHR into HIV&AIDS programmes. The integration of the two has important public health benefits that have been proven both in SA and elsewhere[191].	Publicise and Share current examples of good practise that have successfully linked HIV& AIDS and SRHR and highlight the public health benefits that Gender Responses Advocate and lobby to Increase Political Will and leadership on the need to integrate HIV&AIDS into SRHR. Produce policy briefs and lessons from communities, and get the attention of Parliamentary Committees and bodies.
Review the Domestic Violence legislation and policies to address issues of HIV/AIDS and SRHR adequately	
Develop an overarching policy on VAW and a National Policy Framework linked to the Domestic Violence Act guiding implementation	Champion the implementation of the VAW and integrated SRHR &HIV policies; and Participate meaningfully in Provincial AIDS councils and other local structures
Review and Update contraception and abortion	Provide information on abortion issues i.e. lack of

[191]. **Error! Main Document Only.**A framework for priority linkages- WHO, UNFPA, UNAIDS, IPPF, 2008

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
policies-with a view to providing comprehensive SRHR services and choice to PLHIV. This would include support for women living with HIV to plan families, address unintended pregnancies and plan for safe, desired pregnancies. The high numbers of young women on ART implies that there are significant numbers of young women living with HIV who are "healthy", and whose desire to start families should be anticipated. A clear policy addressing this issue in a comprehensive manner is critical. This includes the institution of the Medical abortion policy.	access, illegal providers and positive use of medical abortion method
Ensuring the adequate resourcing, capacity, accountability and service delivery of SANAC sectors and provincial AIDS councils	Participate in and influence district and provincial AIDS councils with regards to keeping SRHR on the agenda
Develop a unified M&E framework that is informed by human rights; takes SRHR and quality of care issues into consideration more effectively; and allows for collection of disaggregated data on SRHR at national, provincial and local levels. While an M&E framework for the NSP exists, the framework is not supported by community-based structures to collect data, and women and SRHR organisations have found it difficult to feed the information they collect on LGBTI's and other MARPS into the existing system.	Continue collecting data at community level, and participate in the development of a unified system through SANAC and other national and local structures. Monitor service delivery, record successes, and report abuses and transgressions

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
Create systems that Monitor and Report Violations to the set service delivery status.	
Review Nursing, Medical and Community Health Worker College curricula to integrate SRHR, HIV&AIDS care, and comprehensive counselling.	Work with national and international donors specialising in the linkages between HIV and SRHR to support the development of these curricula.
Finalise integration of cervical cancer as an SRHR issue into the HIV policy, and make the HPV vaccine available to youth in the public sector	
Decriminalise sex work to protect the health of sex workers, and of the public that utilises their services.	
Recommit to the implementation of the Maputo Plan of Action (MpoA), which aims to provide universal access to SRHR for all citizens, and provide technical skills in government departments to enable this.	Popularise the MpoA so that it is known to the public, civil society providers and communities. CSOs to further build their capacity to play a meaningful Monitoring role of the
Recommit to the implementation of the UNGASS Declaration and improved reporting every two years	Continue to monitor progress in SRHR and HIV&AIDS. Review the questions of the UNGASS country report format and suggest improvements to UNAIDS
PROGRAMMES AND IMPLEMENTATION **Community Based Responses and Sexuality Education**	
Develop a large scale programme that works with traditional leaders and communities to resolutely interrogate cultural norms and traditional practices-only in as far as they increase women and girl vulnerability to HIV and other SRHR abuses.	Campaign against the adulteration of culture and traditional practises; Highlight that which is protective and work with traditional leaders to review that which is decimating and dis-empowering women and girl populations.

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
Develop new elements of the sexuality education curricula that respond to new evidence on the disproportionate impact of HIV on women and girls. 60% of all people living with HIV are women and girls; and girls aged 15-24 had a 13% HIV prevalence, compared to 3% for boys of the same age, according to the HSRC Household survey of 2008.	Participate in the development of the strategies and programmes that reduce women and girl's vulnerability to HIV&AIDS at community level focussing on women's awareness of their reproductive functioning and rights and access to reproductive health care
Regulate the training curriculum and the protocol for community health workers and counsellors to improve the quality of their service in VCT, PMTCT and ART where applicable.	
Improve access to services for under-serviced vulnerable populations such as LGBTIs, sex workers, and women with disabilities. Although people from all sexual orientations and physical abilities are welcome to attend health centres in SA, many still experience high levels of stigma, and physical barriers to accessing the centres- and thus end up opting out of the services. Some of these groups are also classified as MARPS, making their access to HIV&AIDS and SRHR services that much more critical.	
SRHR SERVICES	
Upscale sites where integration are being launched and do action research to provide more information on best practices	Monitoring service delivery and report abuses and transgressions
Promote and provide the FC on a large scale throughout SA. The FC can be integrated through community-based distribution, STI and family	Integrate the FC into existing reproductive health programmes, family planning and prevention programmes. Interventions should upscale efforts

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
planning services, HIV/AIDS/ STI prevention programmes with vulnerable populations, adolescent and reproductive health programmes, social marketing, work-place initiatives, peer education and male motivation programmes.	to promote the FC and its accessibility and acceptability by focussing on the technology but also considering user perspectives and service delivery aspects.
Treatment guidelines should be updated and should be viewed much broader than only ARV treatment	Increase knowledge about treatment guidelines to enable close monitoring of service delivery at local level
VIOLENCE AGAINST WOMEN	
Implement large-scale programmes for abused women which provide economic opportunities and create conditions where women are no longer dependent on men for survival.	Use group interventions and micro-credit to reduce violence
Increase the understanding and enforcement of GBV prosecution and sentencing guidelines within the justice sector.	Upscale the implementation of transformative programmes- with men in particular- that link gender equality and prevention of violence against women and sexual risk taking. Review and work with communities to address social ideals of masculinity that encourage multiple partnering and legitimise the use of violence in controlling female partners
Improve the provision of service by TCC centres- PEP included-, on the basis of recommendations given by CSOs outlined in section C above.	
RESEARCH	
Fund research to improve understanding of: ♦ The epidemic among Women who have sex with Women (WSW), LGBTI groups, and other minority MARPS that are specific to SA.	Participate in community based research- in collaboration with institutions of higher learning and research institutions. This allows CSOs the opportunity to inform research and to get answers to some of their own questions.

CHANGE NEEDED	CIVIL SOCIETY ACTIONS REQUIRED
♦ Implementing integrated SRHR & HIV services targeting men and boys ♦ The linkages between HIV, SRHR and GBV and how it should be used for integrated service delivery that addresses increased risk for women and girls ♦ Upscale sites where integration is launched and conduct action research to provide more information on best practices	Develop data collection mechanisms in CSO- however rudimentary, and work to link with the new national M&E system that is being developed.

ANNEXURE A: QUESTIONNAIRE USED FOR THIS REPORT

SECTION I	Overview of the national health system and public policies in the fields of sexual and reproductive health and HIV/AIDS	
1	What are the main features of your country's health system? Is there universal access? Is it free of charge? Which health services does government provide and which does the citizen have to pay for?	
2	Does policy on HIV/AIDS include a National Plan with clearly defined strategic actions?	
3	Is there an official policy on sexual and reproductive health in SA?	
4	Is there a specific public policy for addressing the issue of violence against women?	
5	Are there sexuality education programmes in schools?	
6	Are there Sexuality education programmes for youth (boys, girls, adolescents and young people) outside of the school system?	
7	Is there technical sub-division of the NSP (National AIDS Programme) solely dedicated to women and HIV/AIDS?	
8	Have policies been defined for controlling STIs?	
9	What is SA's national policy on abortion? Are there statistical data showing public opinion re right of HIV+ women to interrupt a pregnancy?	
10	What are SA's main social-cultural characteristics (beliefs, religions, etc) that interfere with effective control of HIV?	
11	What % of national budget is allocated to SRH and HIV in SA. Has there been an increase or reduction?	
12	Do we want to add a question on Teenage pregnancy – this was indicated at June workshop?	
13	List the basic statistics on the epidemic and on sexual and reproductive health	

SECTION II Sexual and Reproductive Health Services		
[A] EDUCATION, INFORMATION, COMMUNICATION IN SEXUAL AND REPRODUCTIVE HEALTH		
1	What are the main elements of prevention directed at the SRH of women, youth & adolescents in the National HIV/AIDS policy? A) Basic contents of the messages B) Most-used media and strategies C) Promotion, availability and distribution of condoms D) Inclusion of civil society in the process of planning actions E) Inclusion of civil society in the implementation of activities	
2	How would you assess the actions in the field of HIV prevention directed at women, youth and adolescents?	
3	Are there any STI stats for women, young people and adolescents or national campaigns on STIs directed specifically at them?	
4	How is the issue of inequality (gender, race/ethnic group, social class) approached in the educational programmes run by the government for prevention of STIs?	
5	Are health service staff trained adequately and prepared to offer effective counseling on prevention specifically for women, youth and adolescents?	
6	Are there any Govt initiatives underway to provide capacity building in such counseling for health teams?	
7	Has there been any discussion of male circumcision as a preventative measure in SA?	
8	Are there any campaigns, policies or programmes designed to stimulate prevention against HIV directed at male heterosexual population?	
9	Is there investigation underway into alternative forms of prevention for women	
10	Are there any programmes or actions in SRH or prevention of HIV directed specifically at women belonging to ethnic minorities?	

B] SEXUAL AND REPRODUCTIVE HEALTH CARE		
1	Is HIV testing available and accessible to all women throughout SA?	
2	Is HIV testing available in maternity hospitals and wards?	
3	Is good quality counselling associated to all HIV testing in the sphere of antenatal services?	
4	Is there any nutritional support for HIV+ pregnant women? How is the distribution of nutritional support carried out?	
5	Is anti-HIV prophylaxis at the moment of birth available and accessible throughout SA?	
6	Is formula milk substitute for the children of HIV infected mothers easily available and readily accessible throughout SA?	
7	Do public and private services that deal with pregnant women offer them information, counseling and testing?	
8	In the case of HIV+ pregnant women, is treatment offered (throughout SA) to reduce the risk of transmission to the child? Is any psycho-social support made available?	
9	What orientation as been given to HIV+ women re contraception?	
10	Is there any form of encouragement given for women to undergo sterilization? Are there reports on this?	
11	Is emergency contraception readily available and accessible throughout SA?	
12	Are there any specific programmes designed to protect the SRH of women living with HIV?	
13	Do women living with HIV have access to assisted reproduction services?	
14	What advice is given to HIV+ women that wish to become pregnant?	
15	And for sero-discordant couples (one is HIV positive)?	
16	Are there any legal or traditional barriers that make it difficult for young women to obtain SRH care and ART should they prove necessary?	
17	What is the status of LGBTI health in South Africa?	

[C] ADDRESSING VIOLENCE AGAINST WOMEN		
1	Are the laws specifically designed to prevent VAW, punish perpetrators and repair the harm done, effectively complied with?	
2	Are there specific actions underway against the sexual exploitation of girls and adolescents?	
3	Are services in place throughout SA to provide care and address the needs of women and girl victims of violence and/or sexual violence? If yes, are they readily accessible?	
4	Are prophylaxis against HIV & STIs, Emergency Contraception and legal abortion made available in those services?	
5	Is there a public information system for gathering and publicizing data re VAW and girls?	
6	Are national campaigns to combat VAW & girls carried out on a regular basis?	
7	Any specific actions underway directed at suppressing trafficking women?	
8	Are there any records of HIV+ women that suffered violence as a direct consequence of the revelation of their serum status?	
9	Does SA have strategies to support boys & girls with HIV/AIDS and provide them with psycho-social care, education, shelter, nutrition, health services and guarantees of non-discrimination 9.1. And in the case of orphans 9.2. Are specific budget allocations made for such actions 9.3. Which sphere of government is directly responsible for their implementation?	
10	What is the status of sex work in South Africa?	

SECTION III	Allies, opportunities and Integration	
1	Who are the main allies in promoting the sexual and reproductive health of women living with HIV/AIDS in your country?	
2	What are the main obstacles and drawbacks to the integration of actions designed to promote Sexual and Reproductive Health, prevent HIV/AIDS and confront violence against women, in regard to official policies on AIDS and official policies for women?	
3	What are the main recommendations for overcoming such obstacles put forward by the UNGASS Forum and Civil Society in your country?	