the right to access safe and legal abortion
without fear
Wednesday • 22 July 2009
Mujeres Adelante
without the fear of criminalization
without coercion
Newsletter on women's rights and HIV – IAS 2009
the right to safe, healthy motherhood

In Focus...

'Remember the ladies'...

Anna Forbes

In 1776, American feminist Abigail Adams wrote to her husband, and the other men, drafting the United States' new constitution:

> *I desire you would remember the ladies and be more generous and favourable to them than your ancestors... Men of sense in all ages abhor those customs which treat us only as the (servants) of your sex; regard us then as being placed by Providence under your protection.*

Two hundred and thirty three years later, Stephen Lewis – a pre-eminent man of sense – must reiterate the imperative.

> *This business of discrimination against and oppression of women is the world's most poisonous curse.*

Among other areas, the need for its reiteration is evident in the research, policy making and funding agendas guiding the search for more and better HIV prevention tools. Look for it in the omissions – the lack of explicit, responsive attention to how the new tools and strategies will work in the real lives of the women who need them most.

Since the 2006 IAS meeting in Toronto, four candidate microbicides (tools explicitly designed around the prevention needs of '*the ladies*') have yielded unsatisfactory results in late-stage trials, triggering a decline in public interest in this strategy. Simultaneously, we have witnessed increased interest in male circumcision, a strategy that reduces men's individual risk of HIV; and PrEP, as we optimistically await the results of its first effectiveness trials.

Identifying key drivers of the epidemic (multiple, concurrent partnerships; low condom use; intergenerational sex; etc.) has compelled us to look at the structural factors feeding HIV risk. It not only shines a spotlight on why HIV incidence among young women is so high (economic need, lack of social power and autonomy), but also underscores the fact that disabling these drivers is not a task that can be rapidly accomplished.

We are left pondering the prevention tools we have, and those on the horizon, and wondering how we can best apply them to the challenges at hand. Implementing their effective use in real life (as opposed to clinical trial) settings presents daunting complexities. Does promoting circumcision, in communities that do not yet have the medical capacity to meet higher demand, lead to an increase in deaths from botched '*traditional*' procedures? Do women really want access to female condoms and, if so, isn't the fact that over 99% of the condoms distributed last year were male condoms[1], inherently counter-productive?

In the face of such intractable challenges, it is tempting to let our attention wander from the problems at hand to more pleasant contemplation of how beneficial the next technology on the horizon might be. Won't it be great if PrEP works – it's so much easier to get people to take pills! How about those '*treatment as prevention*' numbers? We could meet the goals of getting everyone with HIV on treatment AND preventing new infections at the same time!

Unfortunately, even these optimistic fantasies hit the brick wall of reality, when we consider what would actually be required for wide-spread scale-up and use. At the Global Campaign for Microbicides (GCM), we strive to '*remember the ladies*' by talking about these unfamiliar HIV prevention tools with the women who need them most.[2] Through these conversations, we have begun to identify specific questions that must be addressed now, if the HIV prevention field is committed to assuring that the factors currently placing HIV prevention out of the reach of millions of women, will not also inhibit their access to emerging prevention tools. For example:

- We know that only people

Whats inside:

who are HIV negative will be able to use PrEP. People who use it (unknowingly) when they are already HIV positive are very likely to develop drug-resistant virus, which can then be transmitted to other people and which will make their own HIV disease harder to treat.[3] We also know that, in sub-Saharan Africa, 80-90% of the people estimated to be living with HIV do not know their HIV status.[4] Thus, any plan for PrEP introduction must start with figuring out how to make HIV testing much more widely accessible and acceptable. But, on hearing about the possibility of PrEP, ***women are asking***: If PrEP is only available by prescription to '*high risk*' people (including those in sero-discordant relationships) will I be able to get it, if my partner refuses to be tested? Or will it be reserved for women who can prove that they are at '*high-risk*', such as sex workers, and women who know for sure that their partners are positive?

- We know that women experience high rates of violence and abandonment, if they are found to be HIV positive, when the male partner is HIV negative or does not know his HIV status. But messages promoting circumcision has led some men to see the procedure as conferring '*immunity*' to HIV infection. ***Women are asking***: How will I ever get him to use condoms, if he is circumcised? And if he doesn't use condoms, what happens to me, if I become HIV positive? He will see it as proof that I have been unfaithful and his reaction will be awful!
- We know that women (especially in impoverished situations) are frequently expected to sacrifice what they have for the '*greater good*' of the family. Reports already abound of HIV positive women, whose prescribed ARVs are voluntarily given, or forcibly taken, for use by her partner or another family member viewed as needing them more. This is likely to become a more frequent occurrence, if proof that PrEP works, generates more 'black market' demand for ARVs. The value of the Tenofovir or Truvada that a woman receives for her own use (either as PrEP or part of her treatment regimen) will increase, if it can be sold to people who want access to PrEP, without having to take an HIV test. ***Women are asking***: Will I be allowed to keep ARVs prescribed to me for my own use?
- We know that, while prices vary, the public sector price (paid by governments and international development agencies) for the most widely distributed female condom is about US 60 cents.[5] The public sector price of another women's condom, now under development, may be as low as US 30 cents. By contrast, male condoms cost less than US 04 cents each. This substantially higher cost per unit, together with claims that women '*do not like*' female condoms[6], have made several major donors and governments reluctant to fund large female condom purchases and the programming needed to assure good uptake of the product. As a result, female condoms are completely absent in most non-urban communities where HIV incidence is high, and are unaffordable to most women in the communities where they are available. ***Women are asking***: If there is a condom that I could use to protect myself from HIV, why can't I get it?

…even these optimistic fantasies hit the brick wall of reality…

Even though real life barriers of this type have potent impacts, they are often '*swept under the rug*' as incidental issues to be addressed once generalised roll-out of an intervention has been achieved. But we submit that core issues such as cost; how '*high risk*' is defined; how an intervention (like circumcision) is perceived; and how threats, like 'black-market demand' are handled are fundamental and must be addressed from the out-set. They are a vital element of a '*community readiness*'; that is, putting systems in place before roll-out that pro-actively promote the conditions needed for its safe and effective use by people who need it most.

Factors that inhibit women's ability to protect themselves from HIV are generally culturally embedded and rooted in women's lack of autonomy and control over resources. The programmes that address these factors successfully are usually those designed by the women they intend to serve. In countries most heavily burdened by HIV (as elsewhere), women are the experts on where and how HIV testing and prevention services must be offered to enable women to access them safely. They can envision how new tools should be packaged, and by whom they must be promoted, to minimise a woman's risk of stigma, if she chooses to use them. They can be instrumental in crafting messages that a woman can use, when talking with their partners about what the tools are for, and why she needs to use them, instead of giving them up for another family member.

Developing these approaches targeted to women is not easy or inexpensive. And many policy makers are not likely to see such specific community readiness steps as necessary – or why the active involvement of women in the target user communities in such planning is essential. As advocates, however, we do understand the necessity for this work.

It is up to us, then, to rally local and international leaders to demand the funding necessary to make such planning a reality. Without it, we can expect that PrEP – like condoms and circumcision – may primarily become an HIV prevention tool for men. But if we press for the field to '*remember the ladies*', and draw on lived expertise to identify and tackle the real life barriers that women face (of which those listed above are only a small sample), we can harness this period of innovation to help put much-needed HIV prevention tools into women's hands.

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Footnotes:

1. In 2008, the Female Health Company sold 34.7 million female condoms [Female Health Company: www.femalehealth.com] About 10 billion male condoms are distributed globally each year [AVERT, The Female Condom Fact Sheet: www.avert.org/femcond.htm]; and even that number does not meet the worldwide need for them. Thus, 99.6% of the condoms distributed globally are male condoms.
2. For more information on this, please see Global Campaign for Microbicides's website section: 'What does it mean for women?'. [www.global-campaign.org]
3. To learn more about this, see the Global Campaign for Microbicides' fact sheet *Understanding Drug Resistance*. [www.global-campaign.org/clientfiles/FS-DrugResistance%5bE%5d.pdf]
4. Dr. Kevin De Cock, Director of HIV/AIDS at HIV/AIDS Department said in an interview appearing in the January 2008 issue of the *Lancet Student* online blog that 'Knowledge of HIV serostatus is extremely low worldwide. Several studies in sub-Saharan Africa suggest that only about 12% of men and 10% of women had actually been tested for HIV and knew their HIV status'. Transcript of this interview is available at [www.thelancetstudent.com/2008/01/29/an-interview-with-kevin-de-cock-director-of-whos-hivaids-department/]
5. Associated Press. 'New version of female condom touted'. 19 April 2009. [www.msnbc.msn.com/id/30250550/]
6. These claims are refuted by the fact that studies done in more than 40 countries demonstrate its acceptability among people from a wide range of social and economic backgrounds and ages. See: UNDP/UNFPA/WHO/World Bank Special Programme of Research on Human Reproduction. *The Female Condom: A Review*. Geneva: World Health Organization, 1997; Cecil H, Perry MH, Seal DW, et al. The female condom: what we have learned thus far. *AIDS and Behavior* 998:2(3):241-56.

Women's Realities...

Kate Griffiths

Patients' and Participants' Rights

When it comes to research and treatment, physicians and practitioners bear a lot of responsibility for protecting the rights of patients, and research participants, to bodily autonomy; alerting us to the potential costs and benefits of treatments.

In two of the satellite sessions at the IAS Conference, these ethical and moral dimensions of HIV and AIDS treatment and research were highlighted by physicians seeking to develop a strategic plan for further human trials of '*live-attenuated*' HIV vaccines, by doctors seeking to develop guidelines for physicians on the reproductive and sexual rights of HIV positive patients, and by activists, bringing attention to the most pressing violations of ethics and patients rights that women in South Africa and Namibia are facing.

The discussion around vaccine trials pointed out that despite recent successes in this area, the impact for individual participants could be exactly the opposite. That '*people are going to sero-convert*' during vaccine trials is made explicit in the report by the SERIALC Committee of the Global Vaccine Enterprise. The committee is conceived as one that will initiate a '*participatory and inclusive process*' to take on the social side of this research, dealing with issues, such as whether or not drug companies or governments will take responsibility for the treatment of people inevitably infected in the name of scientific and public health progress.

While the ethical difficulties presented by human-subjects vaccine trials are fundamentally a matter of the conflicts between individual and public benefit; the satellite session on *Sexual and Reproductive Health and Rights* made it clear that patients are, at times, discriminated against, and harmed by, the doctors meant to treat them. Reports from representatives of Her Right Initiative, Durban Lesbian and Gay Community Health Centre, and the Namibian Women's Health Network (NWHN) highlighted not only common rights abuses, but also areas where standard guidelines for physicians can protect the rights of women and other patients.

> ...treatment of people inevitably infected in the name of scientific and public health progress...

In Namibia and South Africa, reports of forced and coerced sterilisation of HIV positive women stood out in a long list of shocking concerns women face, while interacting with the health system.

> ...discriminated against, and harmed by, the doctors meant to treat them...

High rates of cervical cancer among HIV positive women, lack of access to contraceptives and abortion, lack of support for HV positive women's rights to conceive safely, and stigma and discrimination also made the list. Nonhlanhla Mkhize highlighted the particular rights concerns of lesbian, gay, bisexual, transgender and intersex people, when it comes to accessing healthcare, as well as low levels of interest in, and research on, the sexual health needs of lesbian women; and the importance of clear communication and respect for patients' identities on the part of physicians and other healthcare providers.

The sessions' goals of developing clear guidelines for physicians outlining best practices for protecting the rights of their patients and participants, is a welcomed one and the importance of educating doctors about discrimination against HIV positive and lesbian women is evident. At the same time, however, many of the ongoing abuses described by advocates at the session are already clearly prohibited by the standards of informed consent, and basic Hippocratic ethics.

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Looking forward to Vienna...

My expectations for AIDS2010 will be to see a lot of communities coming from Africa to participate in the Vienna AIDS Conference. We need to focus on bringing a lot of women, especially women living with HIV from the grassroots, as part of the communities and as part of the Conference. We need to bring their issues to the Conference. We need to bring their voices to the Conference.

We also need to have criteria, which are very simple and clear, to make it possible for women at the grassroots to be a part of the Conference, and to develop their own abstracts, so to bring their issues to the programme.

Looking at the Universal Access and beyond, I think the 2010 AIDS Conference will be very critical. We are at the tipping point, because what we don't know now is what, with our governments looking at Abuja Declaration, will happen in 2010. Will our governments be in a position to fulfil the Abuja Declaration, when we know that they will not be able to meet the 2010 targets?

We will need the community voices to be the focus factor at the Vienna AIDS Conference.

Jennifer Gatsi, Namibia Women's Health Network, Co-Chair of the Community Programming Committee for AIDS2010 in Vienna

Activists Voices...

Eradicate ARV waiting lists!

On 19 July 2009, hundreds of AIDS activists, led by the Treatment Action Campaign (TAC), marched through the streets of Cape Town.

Marching to the Cape Town International Convention Centre, the venue where the IAS Conference was about to be officially opened, the message was loud and clear – we demand the speedy implementation of the NSP, South Africa's national strategic plan for HIV and AIDS, 2007 to 2011. Highlighting that the country's healthcare system is in shambles, banners and posters called on government to '*Eradicate ARV waiting lists*', '*Treat at 350*', and '*Integrate TB and HIV treatment*'. Shortage of finances and the lack of adequate resource allocation for the healthcare system were the main concerns raised by several speakers – demanding an increased investment in public health and HIV treatment.

As Nonkosi Khumalo, the chairperson of the Treatment Action Campaign, points out:

> *…the aim of TAC is to put pressure on the government, to move away from using single-dose therapy (Nevirapine), when it comes to pregnant women. It has been proven, beyond reasonable doubt, that dual or triple therapy is very effective in PMTCT. We fail to understand why the government is dragging its feet in making this available to pregnant mothers.*

AIDS activists also reminded the scientists and participants at the IAS Conference of the importance to link the scientific debates of the conference to the lived realities of people in South Africa and the world over, and to be mindful of the many people who depend on the public health system for their survival, while deliberating scientific responses to the HIV and AIDS pandemic.

Denis Matwa, AIDS Legal Network.

While we die, they profit!

Late Tuesday afternoon, a small group of activists representing ACTUP groups from Europe, USA, Asia and Africa marched through the IAS exhibition hall, past dozens of elaborate, colourful, interactive, multi-media advertisements by drug companies promoting the latest ARVs, anti-fungal, HIV tests and antibiotics, shouting *'While we die, they profit!'.*

Aimed at highlighting the continued high cost of treatment, marchers held stark black and white signs detailing the infection and death rates from HIV and AIDS in various countries.

Women's Voices...

Kate Griffiths

Women respond to HIV criminalisation...

10 Reasons Why Criminalisation of HIV Exposure or Transmission *Hurts* Women

Ten Reasons, One Tool

The IAS 2009 provides not only the opportunity for researchers to discuss the latest advances in scientific and public health responses to HIV and AIDS, it is also an all-to-rare opportunity for rights advocates to share and debate common agendas. On Tuesday, 21 July 2009, members of civil society organisations, including groups representing women, particularly HIV positive women, treatment advocates, as well as representatives from the Commission on Gender Equality, came together to discuss the draft document *10 Reasons Why Criminalization of HIV Exposure or Transmission Hurts Women,* drafted by the Johanna Kehler of the AIDS Legal Network (ALN) and Michaela Clayton of AIDS & Rights Alliance of Southern Africa (ARASA). Tyler Crone of the ATHENA Network and Kehler introduced the topic and provided a short overview of the legislative trends towards the criminalisation of HIV transmission and exposure, as well as insights into the collaborative processes leading up the development of the *'10 Reasons*'; and the initial version of the document itself to an appreciative, critical and engaged audience.

10 Reasons, written in response to a similar gender-neutral anti-criminalisation document, is designed as a tool that civil society advocates can use in the efforts to intervene in an ongoing wave of new laws in African countries, and around the world, that increasingly define transmission, and even exposure to the HI virus, as a crime.

Often promoted as protection for women against unfaithful or abusive men, the laws have already come under scrutiny from the human rights community, on the grounds that these '*HIV criminalisation laws*' violate the fundamental rights of citizens, potentially defining all people living with HIV as criminals. The document argues that, because women already bear the brunt of the HIV and AIDS pandemic, these laws will not protect women. Instead, they will impact women disproportionately, with particularly negative consequences for poor women, women in abusive relationships, mothers, sex workers, and women in same-sex relationships.

The Impacts

10 Reasons highlights the situation of women in countries with HIV transmission and exposure laws already passed, or being proposed, arguing first and foremost that because women are more likely to know their HIV status – and are more likely to be compelled to test for HIV by public health measures aimed at preventing mother-to-child transmission – it is women, who are mostly likely to be prosecuted, as knowledge of one's HIV status is a legal pre-requisite for criminal transmission or exposure. Women, too, are already more likely to face stigma, as a result of knowing their status, without legal codification of blame.

The document further argues that the risk of domestic violence against women will increase with criminalisation; that women facing potential prosecution will be less likely to access the services for HIV testing, treatment, and prenatal care, that are central to any programme of '*scaling-up*' the '*testing as treatment*' model, promoted as the ideal for practitioners at this week's conference; and that women will be at increased risk of new infections, as a result of these misguided laws. Perhaps most frighteningly, the laws implicitly – and at times explicitly – criminalise motherhood for HIV positive women, making transmission between mother and child an illegal act, punishing women in contexts where lack of health services and restrictive laws already limit their sexual and reproductive health rights, including the right to access family planning and abortion services.

New Ideas

The first draft of the *10 Reasons* document provoked discussion, dissent and new '*reasons*' why criminalisation harms women. Participants noted that criminalisation policies take place in a context in which the tools available for preventing transmission of HIV – from condoms, to male circumcision, to abstinence and monogamy – are already disproportionately controlled by men, and in which women have limited capacity to negotiate safer sex.

Promise Mthembu, of Her Right Initiative, argued that governments themselves bear some responsibility for the continued high rates of new HIV infections, and pointed out that criminalisation policies could potentially '*systematically divide women*' on the basis of HIV status. Jennifer Gatsi, of the Namibian Women's Health Network, felt strongly that the potentially dangerous interactions between cultural practices that disempower women and criminalisation efforts are areas that need more consideration and debates.

Several discussants noted the significance of poverty and gendered economic inequality, arguing that criminalisation of HIV transmission ultimately '*criminalises poverty*' in a global context, where poverty and inequality are on the rise. Others speculated about the potential reach of such laws, which could potentially '*turn the body of an HIV infected person into a deadly weapon*', noting the recent case in Texas in which Willie Campbell, an HIV positive man was convicted of assault for spitting on a police officer. Other participants again reflected on the capacities of police and legal systems, already inadequate to the task of prosecuting high levels of rape and sexual assault worldwide, to fairly enforce such broad measures.

...punishing women in contexts where lack of health services and restrictive laws already limit their sexual and reproductive health rights...

Reflecting on the document itself, participants suggested that the inclusion of specific '*case studies*' highlighting each reason, along with clear, simple language, would improve its usefulness as an organising and advocacy tool.

Next Steps

Kehler and Crone outlined a process of further consultation for the final draft, through future face-to-face meetings and email discussions, inviting interested parties to view the draft document and comment. The document can be viewed on www.aln.org.za or on www.athenanetwork.org.

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Special Report

Nyaradzo Chari-Imbayago

Upping the Ante on Muted Facets of Women's Right to Health

The discourse on human rights and HIV and AIDS has in the past been somewhat muffled around issues of sexual and reproductive health, for women, in particular. Increasingly however, sexual and reproductive health is becoming a central debate in the context of HIV and AIDS and the right to health. Sexual and reproductive health (SRH) cannot be divorced from HIV and AIDS, in much the same way that HIV and AIDS cannot be effectively addressed in isolation of sexual and reproductive health and rights (SRHR).

The 1994 International Conference on Population and Development (ICPD) convened in Cairo, Egypt, and attended by delegates from 179 countries and more than 1200 non-governmental organisations (NGOs), marked a shift in paradigms and discussions around population, health, human rights and SRHR. Of critical importance was the acknowledgement that population, poverty, health, education, patterns of production and consumption and the environment are all inextricably linked.[1] Several universally recognised human rights underpinned the Plan of Action that arose from the ICPD, amongst which the advancement of gender equality and equity, the empowerment of women, the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, which are the cornerstones of population and development-related programmes.[2] Critical to the realisation of these rights is the need to prioritise research, financing, legislative reform and enforcement and advocacy in response to the myriad factors that inform SRHR and violence against women.

The World Health Organisation (WHO) asserts the importance of linking SRHR and HIV as being widely recognised, with agreement in the international community that the Millennium Development Goals (MDGs) will not be achieved without ensuring universal access to SRH and HIV prevention, treatment, care and support.[3] The Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health stated in a 2004 report that rights to sexual and reproductive health have an indispensable role to play in the '*struggle*' against intolerance, gender inequality, HIV and AIDS, and poverty, and that there is need for increased attention to be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights.

The 20 year ICPD Plan of Action calls for the achievement of universal access to basic reproductive health services by 2015, and for specific measures to foster human development, with particular attention to women. A long definition is given of reproductive health, which is inclusive of sexual health:

> *Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.*[4]

…a concerted effort be made to safeguard the rights…

…sexual violence… a widespread and pervasive reality shaping the lives of women across the Southern African region…

Recent focus on SRHR has been heightened by the adoption, by the Human Rights Council, of a ground-breaking resolution on maternal mortality and morbidity, on June 17, 2009, on *Preventable Maternal Mortality and Morbidity and Human Rights*. This Resolution strengthens the link between SRHR, maternal mortality and human

rights generally, by recognising that a human rights perspective in international and national responses to maternal mortality and morbidity contributes positively to the common goal of reducing the unacceptably high rate of maternal mortality. The Resolution specifically requests the Human Rights Council, in consultation with the World Health Organisation (WHO), United Nations Population Fund (UNFPA), and other relevant stakeholders, to prepare a thematic study on maternal mortality, morbidity and human rights in order to better understand the factors that contribute to preventable maternal mortality, in what is roundly perceived as a welcome move that will resuscitate international discourse around the human rights issues attending maternal health.

Sexual and reproductive health rights have a direct relationship to the Millennium Development Goals (MDGs) relating to maternal health, child health and HIV and AIDS, and it is asserted that sexual and reproductive health and rights must be realised in order to make progress and realise these MDGs. Critical to the realisation of sexual and reproductive health and the contiguous rights, is the need to address gender-based violence, in particular sexual violence, directed primarily against women and girls. Sexual violence, as a facet of gender-based violence, is a widespread and pervasive reality shaping the lives of women across the Southern African region. Acts of rape, sexual assault, practices in service of harmful traditional and/or cultural beliefs and norms, domestic violence, and most recently sterilisation of HIV positive women without consent, constitute the ugly face of gender-based violence in Southern Africa. This situation cannot be maintained.

In 2008, a series of consultations with stakeholders, emanating in a workshop attended by over 35 partners in 15 countries across Southern Africa, was convened by the AIDS and Rights Alliance of Southern Africa (ARASA) around SRHR and related issues in the context of HIV and AIDS and human rights. Key discussions brought to the fore priority areas, which had previously been neglected in the various national and regional responses to HIV and AIDS. Noted as being of particular urgency, were cases of sterilisation of HIV positive women without consent in Namibia, with recent reports coming out of similar practices occurring in Zambia, South Africa and the Democratic Republic of the Congo; widespread gender-based violence against women and girls across the region, fuelled by harmful cultural, traditional, religious practices that are reinforced by legal policy and enforcement, or the lack thereof; as well as conflicting, divisive and potentially dangerous policies and practices around the messaging, financing, and scale-up of male circumcision as a gender-specific singular prevention intervention. In very many countries in the region, the minimum package of SRH services include, family planning services, antenatal and post-natal care, sexually transmitted infection (STI) care, HIV voluntary counselling and testing (VCT), cancer screening, prevention of mother-to-child-transmission (PMTCT), antiretroviral treatment (ART), male and female condoms, information on HIV prevention, male circumcision, post–abortion care and counselling, as well as maternity/birthing services, are not available for all who need it. In response to these and other issues related to government accountability in promoting and protecting SRHR, a regional follow-up workshop will be held with various stakeholders in August 2009 with the aim of developing an evidence-based advocacy framework and strategy to address these issues at a country, as well as a regional level, and to forge and strengthen advocacy on these issues in the region.

…resuscitate international discourse around the human rights issues attending maternal health…

…increased attention to be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights…

There is need for strong and effective leadership to push for the advancement and protection of sexual and reproductive health and rights – **NOW MORE THAN EVER**. The health financing crisis that sits at the region's doorstep, coupled with the prospects of diminished resourcing of HIV and AIDS specific initiatives, all of which will have a disproportionately large impact on women and girls in Southern Africa, and indeed the world over, require that a concerted effort be made to safeguard the rights of our mothers, sisters, daughters and selves, with renewed focus on issues of sexual and reproductive health which cannot be divorced from the right to health, the realisation of human rights and the elimination of all forms of violence against women.

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Footnotes:

1. Glasier, A. et al. 2006. 'Sexual and Reproductive Health: A Matter of Life and Death'. In: *World Health Organisation (WHO) Journal Paper*, 2006, p1.
2. United Nations Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York: United Nations, 1995: Sales No. 95.XIII. 18.
3. World Health Organisation (WHO). 'Linkages Between Sexual and Reproductive Health (SRH) and HIV'. [www.who.int/reproductivehealth/topics/linkages/en/index.html]
4. United Nations Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York: United Nations, 1995: Sales No. 95.XIII. 18.

In my opinion…

Johanna Kehler

Women's rights and treatment needs…

Much has been said over the years about the many challenges of HIV treatment, most notably about the lack of access to treatment for people living with HIV; lack of access to adequate care and support, while on treatment; the impact of an already weakened and inadequate healthcare system on the '*quality*' of treatment programmes; long waiting lists and delays for people in need of treatment – and lately, the shortage of drugs for people enrolled in treatment programmes. There has also been much debate about the known barriers, deterring people from accessing much needed healthcare, such as HIV-related stigma, discrimination and other violations of rights. As for particular challenges facing women, most of the discourse centres on access to prevention of mother-to-child transmission of HIV (PMTCT) programmes.

While most of these issues have by now become part of '*mainstream*' debate and advocacy, thus '*acceptable*', there are also quite a number of issues, which are often excluded, not only from the '*agenda*' of the national responses to HIV and AIDS, but also the '*advocacy agenda*' of many human rights and AIDS organisations – issues highlighting both women's realities and needs and potential human rights abuses in the context of HIV treatment.

The design and understanding of PMTCT programmes – in that treatment is provided to a woman so as to decrease the risk of HIV transmission to her child, while little attention is given to the '*needs*' (or rights for that matter) of a pregnant woman – is, arguably, one of these issues. Notwithstanding the need for access to, or the '*success*' of, PMTCT programmes, it is crucial to recognise that programmes are currently designed and implemented in such a way that women's rights are compromised; the right of the '*unborn*' seems to be placed over the right of a woman to make a free and informed decision whether or not to access PMTCT programmes; and a woman's right to access treatment, in her own right as a person living with HIV, seems, at best, a secondary concern of PMTCT programmes. And yes, there are many arguments that accessing the PMTCT programme are '*right*' and in the '*best interest*' of the woman and her unborn child.

And while PMTCT programmes may be seen as an '*easy target*' for highlighting women's rights abuses in the context of HIV treatment, it has to also be recognised that this is but one of the many manifestations of the continuing failure to reconcile the need to '*scale-up*' access to treatment, and other services, with the obligation to protect people's rights in the process of '*scaling up*' these services – a challenge, arguably, exacerbated by growing needs to increase the access to HIV treatment. At the core of this '*failure*' lies, arguably, the '*inability*' to design and implement programmes that not only acknowledge, but indeed carry the potential to challenge and transform the unequal gendered context of society – a well-known, researched and evidenced '*driver*' of the HIV and AIDS pandemics. Similarly, plenty of research also indicates that the very context of society continues to define the extent to which especially women are in the position to claim their rights and to access available services without coercion and other violation of rights, and there is also plenty of evidence indicating that women are much more likely to be violated and abused in the context of HIV service provision, including HIV treatment services.

…it is crucial to recognise that programmes are currently designed and implemented in such a way that women's rights are compromised…

The need to '*scale-up*' access to HIV treatment is not questioned here, but instead the '*costs*' associated with it. And if these '*costs*' mean that human rights are to be compromised in the process of achieving the goal of greater access to treatment, then we are to '*speak out*' and '*question*' the means by which access to treatment is achieved. It is, therefore, argued that HIV treatment needs and goals cannot be achieved, or advocated for, at the expense of human rights. Instead, human rights are to be at the centre of HIV treatment services and programmes. Thus, an argument could be made that what is in need of '*scale-up*' is creating a societal context that facilitates women's equal and free access to HIV treatment services, and not a '*scale-up*' of treatment services for women per se.

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