Feminisms, HIV and AIDS: addressing power to reduce women's vulnerability

Vicci Tallis

Submitted in fulfillment of the requirements for the

Degree of Doctor of Philosophy in the School of Developments Studies,

University of KwaZulu Natal.

December 2008

Abstract

Women globally, and especially in sub Saharan Africa, are disproportionately affected by HIV and AIDS. Factors driving the HIV and AIDS pandemics include the oppression of women and gender inequality. Despite an intensified focus on women and girls in an attempt to reduce vulnerability to HIV little real progress has been made. This is in part because the sophisticated analysis of risk, vulnerability and our understanding of the pandemics is not match by equally sophisticated responses to prevention, care, treatment and support.

Power over / male domination, evident at every level of society, fuels the pandemics, and makes women vulnerable. Using feminist understandings of power and domination this thesis explores the notion of subverting power. Through a series of case studies the notion of negative and positive power is explored; positive power includes power with, power to and power within. Examples of women's resistance individually and collectively using the different types of power are highlighted.

The thesis demonstrates that that women are not powerless and can and do affect change in their lives in all sites of struggle, that is can increase bodily autonomy, improve intimate relationships and challenge inequality in the households and community. Based on the learnings from the case study a theoretical model that addressed power as problem and solution in the context of HIV and AIDS is presented.

Preface

This thesis was carried out in the School of Development Studies, University of KwaZulu-Natal, Howard College Campus, Durban, from January 2000 to December 2008. The thesis has been completed under the supervision of Dr Pranitha Maharaj.

These studies represent original work by the author and have not otherwise been submitted in any form for any degree or diploma to any tertiary institution. Where use has been made of the work of others it is duly acknowledged in the text.

Signature

Contents

Chapter Three: Theories of Power. Feminism in Action

Chapter Four: Methodology

Chapter Five: Power over? The influence of donors

**Chapter Six: Power with: building global movements mobilising around identity
and issue**

Chapter Seven: Power with: Different oppressions, common goals. Trafficking, HIV and AIDS in South Asia

Chapter Ten: Power as Solution

List of tables and figures

Tables

Figures

List of Acronyms and Abbreviations

ABC	Abstain, Be faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
AusAID	Australian Agency for International Development
AWID	Association of Women in Development
CBO	Community Based Organisation
CCM	Country Coordination Mechanism
CEDAW	Convention on the Elimination of Discrimination Against Women
CIDA	Canadian International Development Agency
DAW	United Nations Division for the Advancement of Women
DOT	Directly Observed Treatment
DFID	Department for International Development, UK
GAD	Gender and Development
GAF	Gender AIDS Forum
GCM	Global Campaign for Microbicides
GDI	Gender-related Development Index
GFATM	Global Fund for AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with or Affected by AIDS
GTZ	German society for technical cooperation
HIV	Human Immunodeficiency Virus
HTA	High Transmission Areas
ICASO	International Council of AIDS Services Organizations
ICRW	International Centre for Research on Women
ICW	International Community of Women living with HIV & AIDS
INGO	International Non-Governmental Organisation
IPM	International Partnership on Microbicides
JOHAP	Joint Oxfam HIV and AIDS Programme
LGBTI	Lesbian, Gay, Bisexual, Transgendered, Intersex
LFA	Log Frame Analysis
MDG	Millennium Development Goals
MTCT	Mother to Child Transmission

NGO	Non-Governmental Organisation
NACP	National AIDS Control Programme
NASP	National AIDS Strategic Plan
NORAD	Norwegian Agency for Development Cooperation
Novib	Dutch Oxfam
OCAA	Oxfam Community Aid Abroad
ODA	Overseas Development Assistance
OSI	Open Society Institute
OSISA	Open Society Initiative of Southern Africa
PEP	Post-exposure Prophlaxyis
PEPFAR	Presidents Emergency Plan for AIDS Relief
PR	Principle Recipient
PMTCT	Prevention of mother to child transmission
Sida	Swedish International Development Cooperation Agency
SR	Sub Recipient
SRR	Sexual and Reproductive Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint UN Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
UNRISD	United Nations Research Institute for Social Development
UNSG	United Nations Secretary General
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WID	Women in Development
WSW	Women who have Sex with Women
YWD	Young Women's Dialogue
ZAR	South African Rand

Acknowledgements

I am extremely grateful to have had the support of many people in completing this thesis. I would like to thank the following people for their contributions:

My two excellent supervisors, Lisa Bornstein and Pranitha Maharaj who provided intellectual food for thought and guided me through the process.

The women who agreed to be interviewed and whose stories and experience shaped my thinking.

My work colleagues past and present with whom I have been on many journeys.

Laura Washington for her long term friendship, encouragement, insightful comments and for taking the time to edit the thesis.

Promise Mthembu whose fighting spirit and political activism is an inspiration to me.

Arien de Beer for drawing the diagrams.

My father for his belief in me.

My brother Richard who is always there for me.

Beth for her intensity and intelligence and for keeping me company in November 2008 during my intensive writing phase.

Caleb for his love of live and joyous spirit.

Liesl and Emil for their interest and support.

Finally, to my partner, Faye Reagon, who has taught me so much about life, love and balance.

This thesis is dedicated to two women who have profoundly influenced my life: my mother Jackie for her unconditional love and support, and to Gill Seidel for her belief in my work and for her generosity.

Chapter One: Background to the Study

1.0 Introduction

HIV and AIDS are entrenching and worsening gender inequality as women and girls are facing reversing trends that increase rather than decrease women's oppression. Women's increasing and disproportionate vulnerability to HIV and the negative experiences of the impacts of AIDS is undisputable. There has been a global focus on women, HIV and AIDS especially since the early 1990's, and much has been written about women's vulnerability and how to reduce it. However, despite all the research, funding and programming, the response to HIV and AIDS in general, and for women specifically, has done little, if anything, to reduce women's experiences of the pandemics. Greater visibility of women has not fundamentally changed the underlying assumptions which simultaneously make women both the 'innocent victim' and the 'vectors of transmission'. Differences in understanding women's status can't be reconciled to provide a single strategy.

> *"Women's position in the epidemic is understood radically differently depending on whether women's concerns are posed by governments of developed or developing countries, by gay-dominated groups, by women influenced by the women's health movement or by women influenced principally by AIDS activism".*[1]

The global reality is that the number of women and girls infected with HIV and living with AIDS is still increasing. Women continue to fight for, and in some cases lose, their reproductive and sexual rights. Increasingly women living with HIV and AIDS face violations of their reproductive rights, including forced terminations or

---

[1] Patton, C. 1994. p2

sterilisation. HIV infection has been linked to decreased fertility and women living with HIV have little access to assisted pregnancies.[2] The extreme load of care giving for family and communities deeply affected by AIDS falls on women and girls: for example, women are unable to juggle formal work commitments and care giving, and there are changing trends in girls' access to education as household income diminishes and boy's education is given priority or girls are kept at home to care for sick parents or relatives.[3] When the parent dies the girl child often has to take responsibility for her siblings and manage the household. Women, and in particular young women, are dying premature deaths. The impact of AIDS on women has been, and continues to be, devastating.

My work in HIV and AIDS spans three decades and through my work in non-governmental organisations, as a consultant, a donor, a researcher, an activist and a feminist I have been grappling with questions about why we have done relatively little to impact on women, HIV and AIDS. Whilst we have developed sophisticated analysis of factors driving the epidemic, and understand women's vulnerability, we have not translated this deep understanding into action. In short, I believe that the limited success is due to many factors and includes simplistic approaches to complex realities, lack of understanding and knowledge of women and gender issues by AIDS programmes, lack of acknowledgement of the profound role patriarchy plays in women's vulnerability, and lack of political will to address the fundamental causes of women's oppression.

This thesis seeks to both understand and provide some solutions to women's vulnerability to HIV and the impact of AIDS. The premise underlying this research is that patriarchy, and the nature of unequal power relationships, is a key driving factor to the pandemics. I believe that further analysing of patriarchy and its impact on women, HIV and AIDS is not a useful focus. My starting point is thus to study

---

[2] Mthembu. P 1998.

[3] Interviews Lesotho Department of Education, Zimbabwe Department of Education September – October 2003

efforts to resist such power, to alter relationships and to change the processes of power as 'problem' to power as 'solution'.

I have made a conscious decision to focus specifically on women in this thesis. Whilst it is acknowledged that one cannot understand power dynamics, gender inequality and oppression without understanding the role of men the premise of this thesis is that women, irrespective of men, are able to change their lives and assert their own power. This is not to say that transformatory work with men is not a critical element of addressing patriarchy in general and HIV and AIDS specifically: multiple approaches are needed to adequately address such complex issues. Whilst an analysis of such approaches are beyond the scope of this research, women's vulnerability to HIV and AIDS is framed within the context of patriarchy.

Before I expand on the key research questions it is necessary to contextualise the impact of the HIV and AIDS pandemics on women. The next section will provide a background to HIV and AIDS globally, with specific reference to the impact of the epidemics of women and girls.

1.1 Understanding the emerging epidemics.

The HIV and AIDS pandemics have rapidly spread throughout the world, especially in sub Saharan Africa, accompanied by suffering and hardship for those who are living with HIV, their family and friends, and the wider society in which they live. The HIV and AIDS epidemics are at their worst in regions where poverty and economic inequality is extensive and deep, where gender inequality is pervasive and access to public services is weak and uneven.[4] HIV and AIDS also act as a spotlight exposing global inequalities, including the inequality between women and men and girls and boys.

HIV and AIDS are impacting on the major demographic processes, that is, mortality and fertility, which could lead to changes in population growth and size. AIDS is

---

[4] Collins, J., and Rau, B. 2000

killing men, women and children who typically have the lowest mortality rates and this impacts on life expectancy. The impact on fertility is less well understood, however the impact is being felt in three ways: there will be fewer births if women die before reaching the end of their child-bearing years, women living with HIV and AIDS are less fertile and finally the use of prevention methods such as male and female condoms will also reduce fertility.[5]

HIV and AIDS are responsible for the single greatest global reversal in human development[6], and this will, and is, impacting of women's rights and development. If the epidemics are not dealt with effectively, there exists the potential to lose hard fought development gains. This is demonstrated in the rapidly declining life expectancy rates in Southern Africa; during the 70's to the early 90's life expectancy was steadily rising. However, in the countries that are most heavily affected, HIV has reduced life expectancy by more than 20 years: for example, Swaziland now has a life expectancy rate of just 30 years.[7] In the absence of effective prevention technologies or affordable treatment that is accessible to all, AIDS has the potential to wipe out half a century of development gains as measured by life expectancy at birth.[8]

The spread of HIV infection has shown regional differences. There is a distinction between countries in which women constitute the majority of those infected (mainly in the South) and countries in which women infected are in the minority (mainly in the North). The impact of HIV and AIDS is being felt most acutely in sub Saharan Africa, but all regions in the world have been affected by some degree by the pandemics. Gender inequality is a driving factor in the epidemic; although it is not the only factor, and therefore cannot account for regional difference. However, in regions where there are emerging epidemics, coupled with gross gender inequalities

---

[5] Whiteside, A. and Sunter, C. 2000

[6] Piot, P. in UNAIDS 2008

[7] UNAIDS 2008

[8] Barnett, T and Whiteside, A. 2002

it is probable that in the absence of effective programming women will be vulnerable to infection.

The global history of HIV and AIDS is complex: different communities, countries and regions experiencing the impacts of the epidemics in diverse ways. However, there are also significant common features among these histories. The vast majority of the total number of people living with HIV are in the 'developing' world, with 68% percent of the men, women and children infected living in sub-Saharan Africa.[9] In 2007 there were an estimated 33 million people living with HIV, 2.7 million new infections and 2 million deaths.[10] Of the estimated 2 million deaths from AIDS in 2007, 75% occurred in sub Saharan Africa.[11]

Some countries, mainly in Africa, have well established HIV epidemics and have began to deal with the impact of AIDS. In Lesotho, Namibia, South Africa and Swaziland, prevalence has stabilised but at "extraordinary high levels."[12] Other countries are beginning to see HIV prevalence rates creep up, and emerging epidemics are noted in both developed and developing countries, for example, China, Germany, Indonesia, Mozambique, Ukraine, United Kingdom and Vietnam.[13] Many countries with low national prevalence rates have hidden and serious epidemics initially concentrated in, and limited to, certain localities or among specific groups within the broader population. An example is that of Myanmar which has a national prevalence of less than 2% but infection rates as high as 60% among intravenous drug users and 40% prevalence rate amongst sex workers.[14] Throughout the world there are examples of countries that did not respond appropriately when the prevalence was low and in a short space of time have had to deal with serious epidemics.

---

[9] UNAIDS 2007

[10] UNAIDS 2008

[11] UNAIDS 2008

[12] UNAIDS. 2008 p 17

[13] UNAIDS. 2008

[14] UNAIDS. 2007

HIV and AIDS has been characterised by what is often seen as two global epidemics. The first epidemic, the HIV epidemic or the silent epidemic, is largely hidden and spreading rapidly throughout the world. Some countries and regions have growing HIV epidemics with high rates of infection in the 19 – 40 years age group, especially amongst women. The second epidemic is the AIDS epidemic, the visible consequences of HIV, including increasing illness and death. This epidemic lags some 5 – 10 years behind the first epidemic.

There is also a third epidemic,[15] that arising from the economic, social and political reaction to HIV and AIDS, which has translated to fear, stigma, discrimination and widespread prejudice.[16] The third epidemic moves beyond the medical to the political, social and economic realm. Denial, blame, stigmatisation, prejudice and discrimination are present in every country dealing with HIV and AIDS.[17] The third epidemic of "social, cultural, economic and political reaction to AIDS (…) is as central to the global challenge as AIDS itself."[18]

Globally we are thus facing a triple epidemic, with increasing HIV infections, rising numbers of deaths, and alarming levels of stigma and discrimination which intersect to impact negatively on local populations and nations. The impact of these three pandemics are felt at many different levels, individually, in the household, in the community, and women are disproportionately affected.

1.1.1 HIV and AIDS: The Current Situation

It is over 28 years since HIV and AIDS appeared as a global challenge. Since the onset of the HIV epidemic, more than 60 million people have been infected with HIV.[19] Initially HIV was thought to only affect men who have sex with men. However the first diagnosed case of AIDS in women was recorded as early as 1982.

---

[15] Panos.1990 a

[16] Panos. 1990 a

[17] Panos.1990 a

[18] Mann, J. in Panos, 1990 a p2.

[19] UNAIDS. 2007

In 1984, a joint United States/Belgian mission to Zaire clinically diagnosed almost as many women as men as HIV positive. Two studies conducted in 1986 disaggregated data by age and gender and found similar results. In Zambia, one in ten women attending ante-natal clinics was infected with HIV. In Zaire, a study on the first 500 cases of AIDS diagnosed in a particular hospital showed that as many women as men were diagnosed, although women were on average ten years younger, between the age of 20 – 29 years.[20]

Into the third decade of HIV and AIDS, we now find that women comprise a rising proportion of new infections and in many countries, especially in Africa, are the majority of the HIV positive population.[21] The HIV epidemic has been characterised by a rapid rise in infection rates and levels, with young people most affected, and women especially vulnerable to infection. Global statistics from the mid 1990's to date show a dramatic rise in the number of women living with HIV and AIDS. This is true even in countries that initially reported epidemics amongst men who have sex with men and among intravenous drug users. There are certain groups of women who are particularly vulnerable, for example, young women and women who have sex in exchange for goods, services or money. Such vulnerability is reflected in global data on HIV infection. For example, an analysis of data from epidemics around the world show a similar pattern of HIV in women – the prevalence of HIV infection is highest in women aged 15 – 25 and peaks in men between five to ten years later. The number of women infected continues to rise disproportionately. In sub Saharan Africa, almost 61% of the total number of adults living with HIV were women.[22] In the Caribbean for example the percentage of women infected with HIV rose from 37% to 43% over a five year period.

The numbers of women living with HIV in Latin America, Asia and Eastern Europe are also growing[23]. Even in the countries where the number of men infected is

---

[20] Reid, E and Bailey, M. 1992

[21] UNAIDS 2007, UNAIDS 2008

[22] UNAIDS. 2007

[23] UNAIDS. 2008

higher than that of women, there is a steady increase in the number of women infected. This may be intensified in certain groups of women who are particularly vulnerable, for example, young women or women who have sex for goods, services or money. Patton noted, as early as 1994,

"powerful political and social institutions continue strongly to constrain the AIDS policy landscape, despite efforts to accommodate the growing reality that women are the fastest growing group of people acquiring HIV infection".[24]

Often women living with HIV and AIDS are invisible in countries where the majority of infected people are men. This means that their needs are not articulated or if they are, they are not heard and not addressed. Even in countries where the majority of those infected are women, there is a failure by HIV and AIDS programmes to ensure that their needs are adequately addressed.

"Globally, women have frequently been the focus of attention as potential transmitters of the disease, or as the moral guardians of their male partners. Yet many are denied access to appropriate preventive and curative services, especially in parts of the world where their need is greatest. As the epidemic has progressed, women have taken increasing responsibility for those who are sick or orphaned by AIDS. However they have been allowed little influence over the relevant policy and planning decisions and are only beginning to have their own needs as people affected by HIV and AIDS taken seriously".[25]

A short overview of the status of the HIV epidemic in each region follows.

Sub Saharan Africa

---

[24] Patton, C. 1994 p6

[25] Doyal, L. 1995. p 87

Sub Saharan Africa carries the largest burden of disease, and is the only continent which has a higher ratio of female to male infection – over 61% of infections are amongst women.[26] Within the continent there are diverse epidemics which differ in terms of scale and maturity: there are also limited success stories with downward trends in prevalence rates. Despite successes, Southern Africa accounts for 35% of all people living with HIV and 32% of new global infections. By 2005 eight countries had prevalence rates exceeding 15% - Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.[27] A staggering 38% of all AIDS deaths in 2007 were in Southern Africa.[28]

Asia

The prevalence rates are the highest in South-East Asia, in a region that has wide variations in epidemic trends.[29] There has been a decline in rates in Cambodia, Myanmar and Thailand, with increases reported in Indonesia and Vietnam, mainly in groups of intra-venous drug users and people who buy and sell sex. Despite more accurate epidemiological information, India still has the highest number of people living with HIV in the region an estimated 2.5 million out of the regional estimate of 5 million.[30] In 2007 there were 380 000 new infections and an estimated 380 000 deaths in the region.[31]

Eastern Europe and Central Asia

During 2007 150 000 new infections occurred in the region – bringing the total number to 1.6 million – a 150% increase since 2001. The epidemic in the Russian Federation continues to grow, especially amongst women, who account for 44% of new infections. Ukraine has the fastest growing epidemic in the region – especially amongst intra-venous drug users and sex-workers. In fact, 90% of all infections in

---

[26] UNAIDS. 2007
[27] UNAIDS. 2007
[28] UNAIDS. 2008
[29] UNAIDS. 2008
[30] UNAIDS. 2008
[31] UNAIDS. 2008

the region are in the Russian Federation and the Ukraine. The region saw 100 000 new infections and 58 000 deaths during 2007.[32]

Caribbean

The adult prevalence in the region accounts for about 1% of the population, that is 230 000 people, with the highest prevalence rates in the Dominican Republic and Haiti. AIDS is now the leading cause of death in people between the ages of 25 and 44 years.   The primary mode of transmission in the region is heterosexual intercourse. Infection rates amongst female sex workers range from 3.5% to 31% in Guyana. There were 20 000 new infections and 14 000 deaths in 2007.[33]

Latin America

The epidemics in Latin America remain relatively stable.   Transmission occurs mainly in groups of sex workers and men who have sex with men. The region has a total number of 1.7 million infections, with one third of all regional infections in Brazil.[34] New infections in 2007 numbered 140 000, with 63 000 deaths reported.[35]

North America, Western & Central Europe

The total number of people living with HIV in the region is increasing due to a combination of factors: the life prolonging effects of anti-retroviral therapies (resulting in fewer deaths, that is 32000 in 2007) and an increase in the number of new infections in Western Europe. The estimated number of people in the region is 2.1 million, of which 1.2 million are in the United States of America. Although women of African American decent represent only 12% of American women, they account for 67% of all female AIDS cases in the country.[36]   Nearly 30% of new

---

[32] UNAIDS. 2007, UNAIDS. 2008

[33] UNAIDS .2008

[34] UNAIDS. 2007, UNAIDS. 2008

[35] UNAIDS. 2008

[36] Vyavaharkar, M.V, Moneyham, L and Corwin, S. 2008.

diagnoses in 2005 were in women.[37] In 2007 it is estimated that there were 81 000 new infections in the region and 31 000 deaths.[38]

Middle East & North Africa

Epidemiological surveillance in the region is limited: however, it is estimated that 40 000 new infections occurred in 2007, bringing the total of infections to 385 000.[39] Reported cases remain low. Most new infections occur amongst men – with the exception of Sudan, which has the highest prevalence in the region mainly due to unsafe heterosexual intercourse.[40]

Oceania

The prevalence rates in the region remain low – only 14 000 new infections were estimated in 2007, bringing to a total of 74 000 people living with HIV in the region.[41] Papua New Guinea has the highest burden of infection accounting for 70% of the total number of people living with HIV, mainly infected through unprotected heterosexual sex, with most of the men and women living with HIV in the rural areas.

1.1.2 The third epidemic: stigma and discrimination

Men, women and children living with HIV and AIDS often experience high levels of stigma and discrimination on the basis of their HIV status. HIV and AIDS related stigma, the third epidemic, is highly complex, dynamic, and deeply ingrained in society. It is linked to broader, existing inequalities evident in society, and in societies' often negative view of expressions of sexuality. Analyses of stigma seldom focus on the differences in how men and women are stigmatised and how

---

[37] Vyavaharker, M.V et al 2008

[38] UNAIDS. 2008

[39] UNAIDS. 2008

[40] UNAIDS. 2007

[41] UNAIDS .2008

they experience such stigma. The stigma surrounding HIV has silenced open discussion around both the causes of HIV infection as well as appropriate responses to deal with those consequences.[42] Link and Phelan[43] highlight four components of stigma pervasive in society around HIV and AIDS. These components are shaped by social, economic and political power and include the distinguishing and the labelling of difference, the association of human difference with negative attitudes, the separation of 'us' from 'them' and loss of status and resulting discrimination.

Stigma is evident in and impacts on all levels of the prevention-care continuum. For example, there is often a divide in national programmes between 'deviants' (such as gay men, lesbian women and sex workers) who require policing and the 'general public' who must be protected.[44] This adds to the 'us' and 'them' mentality that further marginalises vulnerable groups. Stigma also invokes powerful psychological feelings in people living with HIV and AIDS including how people view themselves. The fear of being stigmatised results in women, men and young people being unable to look after their sexual and reproductive health, for example, accessing sexual health information, treatment, and methods for HIV and sexually transmitted infections (STI) prevention, such as the female condom.

As with most aspects of the HIV and AIDS pandemics, gender inequality impacts on how stigma and discrimination is experienced - men and women thus feel stigma and discrimination differently.[45] This is partly due to the fact that women are often the first to find out their HIV status and are the ones to disclose to partners and family. Forms of stigma experienced by women include loss of marriage and childbearing opportunities, inferior treatment in health care settings and expressions of blame and shame.[46]

---

[42] Aggleton, P. and Parker, R. 2002

[43] Link and Phelan in ICRW. 2002

[44] Watney, S. 1997

[45] Lekas, H-M, Siegel, K and Schrimshaw, E.W. 2006

[46] Ogden, J and Nyblade, L. 2005

It was assumed that once HIV infection reached a certain level in a given society or community stigma would dissipate, however high levels of denial and an 'us and them' mentality is rife. Thus in all countries people living with HIV and AIDS experience high levels of stigma and discrimination which affects, for example, access to good healthcare, employment, reproductive rights, insurance and other financial services. Stigma, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and which increases the impact of the epidemic on individuals, families, communities and nations.[47]

1.2 The research question

Confronting power is an appropriate strategy in reducing women's vulnerability to the impact of HIV and AIDS. The central question of the research is how can power be challenged and subverted to reduce the structural, societal and personal circumstances of women in order to reduce vulnerability to HIV specifically and generally improve conditions and position of women's lives. The intention of the research is to add to understandings of power, women, HIV and AIDS and to examine, through case studies, examples of resistance in order to add to the theory of power and resistance and more importantly offer some possible practical alternatives to our current responses.

Feminist approaches of resistance over the past thirty years have focused on the causes and effects of women's oppression and have been somewhat effective in addressing issues such as rape, violence and sexual rights. However, the feminist movements have been less successful in addressing HIV and AIDS. This is less about strategies per se and more about the slowness of the feminist movement, bordering on reluctance, to address HIV and AIDS.[48] Part of the solution to the ever increasing pandemics and their effect on women could lie in feminist theory and experience. This research seeks to identify specific successful and innovative

---

[47] UNAIDS 1999

[48] Msimang, S. 2002.

strategies that have been used to reduce women's vulnerability, and to highlight strategies that could be effectively used in the future. The research answers the following questions:

- How can power be used in positive ways to reduce women's vulnerability to HIV and AIDS

- What is the power and influence of donors in determining agenda's through what does or does not get funded.

- How can organising and working together in solidarity based on identity (as in the case of women living with HIV) as well as working around an issue (advocating for a viable microbicide) further women's HIV agenda.

- Given that the same factors and circumstances that increase women's vulnerability to one issue intersect with other issues, how can activism addressing other issues affecting women impact on HIV and AIDS, such as trafficking in South Asia.

- What is the impact of individual power and individual acts of defiance and resistance.

The research draws heavily on feminist theory, particularly on theoretical approaches to power. Power is central to understanding the complexities of women's lives, especially how a combination of personal and societal factors impact on women's susceptibility to HIV infection. Power can also provide possible solutions to address the issues facing women. This thesis puts forward that an understanding of, and commitment to, addressing power as central to vulnerability is vital: as a mechanism to change women's lives in general and reduce the impact of HIV on women specifically.

Utilising theories of power (and influence) the research findings point to power as both problem and solution. The thesis explores the different levels of vulnerability put forward by Mann and Tarantola namely personal, programmatic and social.

Unequal power relations between men and women, in society generally and in their personal relationships, fuel the epidemic and increase women's vulnerability. Furthermore, power relations beyond the individual level –including unequal power relations at a programme level, for example, service providers (government, and non-governmental organisations [NGO's]) and communities may also increase women's vulnerability. The research also addresses the power dynamics between donors and NGO's and how this impacts on the funded organisations' ability to tackle issues around gender and HIV and AIDS.

The focus of this thesis is on women. It is acknowledged that gender power dynamics, by their very nature involve relationships between women and men. Furthermore, there are certain factors that render men vulnerable to HIV and men most certainly experience the impact of AIDS. I have chosen however to concentrate on the specific issues affecting women given their disproportionate vulnerability. This is in no way meant to undermine the experiences of men but more to analyse in greater depth the realities of women. There is an emerging body of knowledge on men and masculinities, HIV and AIDS. Further studies, addressing men and power may be needed to deepen understanding.

Furthermore it is beyond the scope of the thesis to fully address the extensive range of role-players and stakeholders involved in HIV and gender. Given that my experience is rooted more in work with non-governmental organisations as opposed to the state and international organisations I decided to focus more on this sector. This is not to say that other sectors do not have an important role to play in challenging gender inequality and impacting significantly on the trajectory of the pandemics; my experience suggests that other sectors are less likely to voluntary work on the intersection of HIV and gender, and if they do so tend to be more conservative in their approach.

1.3 Organisation of the dissertation

This research seeks to develop a theory of resisting oppressive power in order to reduce women's vulnerability to HIV and AIDS. Whilst power is a problem that impacts on women's vulnerability to HIV infection both directly and indirectly, the research also explores, through a series of case studies, how addressing power can in fact reduce women's vulnerability. Power as solution looks at three kinds of "positive" power – the power of resistance, that is the power to change, the power of solidarity and the power within, addressing individual power.

Chapter two provides a broad overview why a feminist approach to HIV and AIDS is necessary by analysing the position of women in the epidemic. It also highlights current responses to the epidemic to date.

Chapter three introduces the theoretical underpinnings of this thesis and examines various understandings of power and influence using different paradigms, with a focus on feminist theory.

Chapter four outlines and expands on the methodology used in data collection. Data for the different chapters was collected in different ways including in-depth interviews, focus groups and direct observation. This thesis is based heavily on my work in the women, HIV and AIDS field in Southern Africa and to a lesser extent South Asia. My work as a consultant to non-governmental organisations, international non-governmental organisations (INGO) United Nations (UN) agencies and government, as well as my experiences in being a leader of NGO's has enabled me to develop theory, but more importantly, put theories into practice.

Chapter five provides an example of power over, through analyisng the influence of donors in shaping the gendered agenda of NGO's and governments. Many donors insist on a gendered approach but the definition of gender is a contested one and how one applies gender is critical. The case study illustrates how gender as a concept can be distorted along the aid chain. This chapter was included to demonstrate at a more macro level how power impacts on programming and indirectly impacts on women's vulnerability.

Chapter six focuses on women working in solidarity Two social movements are discussed; The International Community of Women living with HIV and AIDS (ICW) organising around identity, and the various role-players organising around the issue of microbicides. The International Community of Women living with HIV and AIDS was formed in 1992 by a small group of women living with HIV who were attending the International AIDS Conference held in Florence. The organisation is an example of women working in solidarity to raise the issues of women living with HIV and AIDS. Their work addresses treatment issues for women as well as sexual and reproductive rights. Key strategies of the organisation are to provide women infected with HIV and AIDS with a voice and to enable women to influence national and international policy, such as ensuring that the policies are better aligned with the realities of women living with the virus.

The campaign for microbicides – supported by a wide range of AIDS activists, researchers and health professionals - highlights both the potential of solidarity to create new concentrations of power for change, and also the difficulties of maintaining group/movement cohesion given differing understandings of power in spreading HIV and AIDS, resulting in differences priorities, strategies, programmes and practices among those involved. Microbicides have the potential to change the face of the epidemic and provide women with an option for prevention that they can control. Investment and research into microbicides is increasing and this is mainly due to global advocacy and activism from AIDS organisations, scientists, researchers and those within the reproductive health sector. Whilst all role players are fighting for the overall goal of a viable microbicide there are tensions within the movement especially around how microbicides are positioned, either as women initiated or women controlled methods. For many activists microbicides as a women controlled method is non-negotiable because anything less negates women's potential ability to protect themselves.

In chapter seven, the factors that drive the trafficking of girls and women in South Asia are linked to factors driving HIV in the region. Women who have been trafficked are often assumed to be HIV positive; women who have been trafficked and who are living with HIV face double stigma in their family, community and even in institutions of 'rehabilitation'. There are established networks and responses to trafficking in the region but very little solidarity and action addressing women and HIV. Within the anti-trafficking sector there are two key responses – a welfare response and a more progressive, agenda setting response. Both responses provide an opportunity to integrate HIV and reduce women's vulnerability. At present being trafficked is a far greater reality for Asian women than HIV infection. However, the same root causes that are fuelling trafficking in Asia are increasing women's vulnerability to HIV and AIDS in Africa

An individual act of resistance, demonstrating power within is presented in chapter eight. Single acts of resistance can make a difference to addressing oppression in different sites of struggle. This is highlighted in the case of one woman laying a charge of rape against the then Deputy President of South Africa. Power was contested both in the trial process itself as well as outside the court-room. Often such an act of resistance is not the popular position. This was evident in the trial as many women supported Zuma as an authoritative patriarchal figure. This challenges the myth of "sisterhood" and demonstrates that it is simplistic to say that all women resist patriarchy.

Chapter nine highlights the work of a local NGO that has developed a successful model for empowering women. Women's empowerment is the backbone of many responses to HIV and AIDS. However efforts to empower women are often superficial and short term. Approaches may begin to address women's position yet do not move beyond the initial stages. The Gender AIDS Forum (GAF) is an NGO based in Durban that has developed a process of working over a six month period with grass-roots women to enhance their leadership potential. The programme focuses on the personal issues and experiences of oppression and powerlessness

and builds on these to develop a political understanding of women's oppression and galvanise collective action.

The concluding chapter, chapter ten, draws together the learnings from the various case studies, presents a model of power as problem and solution and makes practical suggestions that will impact on women's vulnerability to HIV and AIDS.

Chapter Two: Why a feminist response to HIV & AIDS is necessary: the vulnerability of women and girls

2.0 Introduction

Patriarchy creates and maintains gender inequality and a failure to recognise and uphold women's human rights: the oppression of women is pervasive and is reflected in the realities of many women's lives. These realities include, amongst other things, the violation of bodily integrity through gender based violence and the denying of sexual and reproductive rights, limited, unequal access and control over resources and the gendered division of labour which benefits men and disadvantages women.

Despite a more concerted effort in the past two decades at both a global and country level to address gender inequality through international instruments such as Convention to Eliminate all forms of Discrimination against Women (CEDAW), the implementation of the Millennium Development Goals (MDG) and national processes to lessen gender equality, the realities of most women and girls have not changed on a day to day level. Both in the literature reviewed and the experiences in the countries visited for this thesis, that is Africa and Asia, gender inequality is evident at all levels: society, community and household.

In many cases the realities of women's lives at the household and intimate relationships level are the most oppressive: gender inequality and unequal power relations at these level remain the most difficult to challenge. However, challenging power at a relationship and household level is critical if the vulnerability to, and the impact of, HIV and AIDS are to be effectively dealt with.

Table 2.1 shows a comparison of the Gender-related Development Indices (GDI) of selected countries in Southern Africa and South Asia.

Table 2.1. Gender-Related Development Index: Comparison of countries

Country	Gender-related Development Index (GDI)	
	Rank 2002[49]	Rank 2007/08[50]
Sri Lanka	80	89
South Africa	90	107
Namibia	100	108
Botswana	101	109
India	103	113
Swaziland	107	123
Lesotho	110	119
Bangladesh	112	121
Zimbabwe	113	130
Nepal	119	128
Pakistan	120	125
Malawi	132	143
Zambia	133	144
Mozambique	140	150

The 2008 Human Development Report reveals a worrying trend in the deterioration of women's lives in the selected countries, with significant losses in rankings being evident since 2002. The GDI is calculated by assessing gender differences in life expectancy, adult literacy rate and income, all of which are directly and/or indirectly affected by HIV and AIDS. Whilst it is difficult to extrapolate the direct impact of HIV and AIDS on these rankings, it could well be a contributing factor to declining ratings, especially with regard to life expectancy. Further research is needed to ascertain why there are substantial declines in the standards of the lives of women and how vulnerability to HIV has impacted on the GDI.

---

[49] UNDP. 2003

[50] UNDP. 2008

In an assessment of the MDG's, United Nations Secretary General (UNSG) Ban-Ki-moon suggested that whilst there has been progress in reducing poverty and hunger in some places, poverty, hunger, illiteracy and lack of basic health care are widespread and growing worse in some regions.[51] Africa lags behind Asia in meeting the MDG's, with not one single country in Africa on track to meet the MDG's, and according to UN statistics the number of poor in sub-Saharan Africa is rising and is projected to increase to 360 million by 2015.[52]

There are complex sets of micro and macro factors that are fuelling the HIV epidemic at a country, regional, continental and global level. Whilst the epidemics follow diverse courses in different countries, for example with regard to main modes of transmission and patterns of distribution, as discussed previously, there are common threads which help us account for the rapid spread over the virus globally over the last twenty eight years. The factors driving the epidemic can be viewed as "deep-seated and intransigent, embedded in the very power relations which define male and female roles and positions, both in intimate relations or the wider society".[53] These include certain cultural practices, inadequate access to and control of wealth and resources, especially health care, education and welfare, religious practices and beliefs, poor governance, migration, conflict, urbanisation, violence and stigma and discrimination of marginalised groups (for example, men who have sex with men, injecting drug-users, people in prisons). All of these factors have gender dimensions.

2.1 Vulnerability model

Mann and Tarantola outline three separate but interconnected sources of vulnerability to HIV and AIDS, namely, personal, programmatic and societal.[54] Vulnerability refers to a lack of power, opportunity and ability (skills) to make and implement decisions that impact on one's own life. Thus, vulnerability refers to the

---

[51] Schineller, S.J 2008

[52] Schineller, S.J. 2008

[53] Baylies, C. 2000. p1

[54] Mann, J. and Tarantola, D. 1996

extent to which an individual is able to make free and informed choices and decisions about his/her own life. The converse of vulnerability is empowerment. An empowered person is able to make free and informed decisions, and act according to these decisions. In contrast, a vulnerable person, due to lack of information, skills, opportunities or other external circumstances, is unable to make informed decisions freely. The model focuses on the individual in the context of societal and programmatic issues that impact on vulnerability.

Is vulnerability a useful concept to apply to women and HIV infection or other issues facing women such as trafficking, violence, given that the focus or 'blame' is placed on the individual and often women do not have complete control over their lives? The term vulnerability has been questioned[55] in that it can present an image of powerlessness and of victim-hood. It can lead to a focus exclusively on the ability of the individual to protect herself from harm. However, it is possible for women and girls to be vulnerable in certain aspects of their lives and at various times and in different contexts, and empowered in others. Thus, vulnerability is best used in the context of 'lived realities'[56] to explain individual and societal factors that may decrease or increase susceptibility, to HIV infection, violence and other oppressions.[57] Lived realities refer to the daily lives of women, the personal circumstances that are mediated by the political, social and economic context. Often the daily realities of women's are not addressed adequately.

Whilst it is acknowledged at the personal or individual level there is a set of circumstances or realities that may result in someone being more susceptible to being infected with HIV, it in no way implies that the individual is to 'blame'. Individual circumstances and contexts are themselves an outcome of societal or macro factors that help to create vulnerability. In reality, the economic and social changes over the past three decades in particular have created an enabling environment that has increased risk of HIV infection, making effective responses

---

[55] Collins, J. and Rau, B. 2000

[56] Cornwall, A and Welbourne, A. 2003

[57] Tallis, V. 2002 a

more difficult. The determinants of the epidemic go beyond individual volition. [58]

These concerns are noted. However, the Mann and Tarantola[59] vulnerability model in its entirety provides a useful framework to perform a detailed analysis of women (and men's) susceptibility to HIV infection, contextualise the lives of men and women, and to define solutions based on this context. It is especially useful in highlighting the role that programmes play in enhancing or reducing vulnerability, which is often overlooked when analysing factors driving the epidemic. Individual vulnerability is analysed and understood in the context of both societal factors and the response to HIV and AIDS and development, or lack thereof, by government and civil society.

Personal vulnerability refers to cognitive, behavioural and biological factors that put people at risk.   These include biomedical factors, for example, the stage of infection, presence of other STIs, gender of partner, availability of STI treatment and access to condoms. It also includes sexual behaviour, for example, the number of partners, rate of partner change, sexual practices and condom use. Personal vulnerability may vary over the individual's life-span and there are times when vulnerability is greater than at others. For example, the girl child and young women are more vulnerable to sexual transmission. The reasons for this are both biological, due to the pre and post pubertal conditions of the genital tract[60] and social with the early onset of sexual activity which is often coercive or violent.[61] Whilst the emphasis is on younger women, the vulnerability of older women must not be discounted as they are equally bound by the gendered power within their relationships, which is often mediated through marriage. Emerging epidemics are occurring amongst older women in many countries.[62]

---

[58] Collins, J. and Rau, B. 2000
[59] Mann, J. and Tarantola, D. 1996
[60] Loewenson, R. and Whiteside, A. 1997
[61] Abdool Karim, Q. 1998, Varga, C and Makubalo, L. 1996.
[62] UNAIDS 2000

Personal vulnerability is also heightened or reduced through individual perception of risk.[63]   Whilst in Eastern and Southern Africa, for example, both men and women have fairly detailed knowledge about HIV being sexually transmitted, and understand prevention methods; there are huge variations and discrepancies around individual perception of risk.   Perception of risk, whether correct or incorrect, is critical in personal behaviour[64] but is little understood and is often not part of HIV prevention programmes.

Programmatic vulnerability refers to the contributions of HIV and AIDS programmes and other responses, both governmental and non-governmental, that either increase or reduce vulnerability of individuals or groups.   Programmatic vulnerability can be conscious or unconscious, that is organisations may consciously decide to implement a specific programme even though they are aware of the implications of such a programme.   Alternatively, they may implement a programme that impacts negatively on women's vulnerability without understanding the implication of their actions.   For example, a National AIDS Control Programme (NACP) may make a conscious decision not to work with men who have sex with men (and many in Southern Africa don't), or provide needle exchange programmes, or may unconsciously promote a certain approach, in good faith, for example the abstain, be faithful, condomise (ABC) approach, not realising the effect of such programmes on women.[65]

In reflecting on the response to HIV and AIDS, there is a tendency of many organisations to design responses and programmes in a "one size fits all" approach. Programmes, projects and plans are generally prepared and designed based on what are assumed to be the problems and issues and what are assumed to be the types of responses that will help and make an impact: the realities of people, women, men, boys and girls, are seldom part of this list of assumptions.   Such approaches are generally ineffective as they are based on inaccurate beliefs and an

---

[63] Kohler, H-P, Behrman, JR and Watkins, S.C. 2007.

[64] UNAIDS cited in Kohler, H-P, Behrman, JR and Watkins, S.C. 2007.

[65] Tallis, V. 1998. Epstein, D., Morrell, R., Moletsane, R., and Unterhalter, E. 2004

incomplete understanding of peoples' lives. The realities and the meaning of these realities can only be known by those most directly involved. It is the most affected then who should be articulating, participating, leading and acting to confront and address the realities that face them. This is best done in solidarity with others with shared values that put people first, value every human being, embrace diversity and treat all people as truly equal.

Societal vulnerability refers to the broader context those impacts on the lives of men and women including economic, political, and social factors such as cultural, traditions, gender relations, religious beliefs, poverty and inequality, attitudes towards and norms related to sexuality.   Societal vulnerability incorporates the processes through which contextual conditions and factors make women, men and children vulnerable to the disease itself, as well as vulnerability to the social and economic impacts of the disease.[66]

The Mann and Tarantola vulnerability model does not specifically analyse women's and girls' vulnerability. A gender analysis of vulnerability is essential to highlight the socially constructed aspects of gender relations that underpin social behaviour in terms of driving the HIV and AIDS epidemics. A gender analysis also focuses on gender-based rules, norms and laws that govern the broader societal and institutional context which puts women at risk.[67] Unequal gender relations are key to women's vulnerability and also inhibit women's attempts at prevention and protection. The cultural and social implications of gendered relations of power have alarming implications for women's ability to prevent the sexual transmission of HIV, given that within the realm of intimate relationships, women have less power than men.[68] For example, questions can be asked about whether relationships are consensual or coercive and whether pleasure is equally given and received.[69] The extent to which the negotiation of sexual relations is possible and actually happens

---

[66] Barnett, T. and Grellier, R. 1996

[67] Baden, S. and Wach, H. 1998

[68] Wilton, T. 1997

[69] Wilton, T. 1997

determines the extent to which vulnerability to infection is increased or reduced.

For the purposes of this thesis, programmatic vulnerability and societal vulnerability are seen as more important sources of vulnerability. Whilst there are some personal or individual 'characteristics' increasing vulnerability, such as biological and physiological, the theory underpinning this research is that women's and girl's vulnerability will be reduced through addressing the societal factors driving the HIV and AIDS pandemics as well as ensuring that programmatic vulnerability is reduced by ensuring more effective responses based on our analysis of the problem are implemented.

Figure 2.1 shows the key elements and interconnectedness of the three types of vulnerability. Whilst gender is not an integrated concept in the Man and Tarantola model, and is located as a societal factor, I have adapted the model to see gender as a key factor in personal, programmatic and societal vulnerability.

Figure 2.1 Vulnerability Model[70]
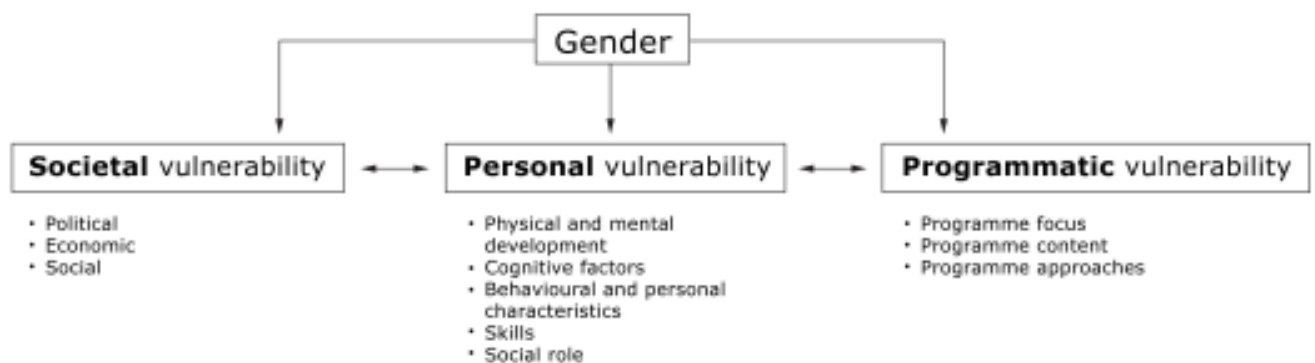
The following section will describe in more detail programmatic and societal vulnerability.

---

[70] Based on Mann, J and Tarantola, D. 1996

2.1.1. Programmatic vulnerability

In the 28 year history of HIV and AIDS infection the response to the pandemic has by and large been led by the health sector. Given that HIV and AIDS is clearly a development issue, a gender issue and a human rights issue it is obvious that a health response alone is grossly inadequate and ineffectual. Since the mid 1990's the global focus on HIV and AIDS has been towards an 'expanded response' which involves all sectors in society.

> *"If other sectors and partners are to address the epidemic, they need to understand HIV and AIDS as a social and development issue and not just one of health. This understanding on the one hand merits planning, for the social, economic, political and indeed all development related consequences of the epidemic, so as to mitigate its impact. On the other hand, it involves recognising that social and development programmes can themselves in fact exacerbate the epidemic and therefore, ensuring that appropriate measures are taken, especially in the case of those who are marginalised".*[71]

Programmatic vulnerability is determined by programme context, content and approach. It is important to understand that "programme" refers to responses to HIV and AIDS at a local, provincial, national, regional and global level. Programmatic vulnerability is very seldom acknowledged and yet is a key driver; ineffective programmes will not impact positively on the epidemics and may in fact fuel them.

The context in which the programme is operating is obviously a critical consideration for assessing whether a programme adds to or reduces vulnerability. Programmes must be context specific, and what is appropriate in one context might not be appropriate in another context. The assumption of this thesis is that gender

---

[71] Tarantola, D. 1998 p 10

inequality fuels the HIV epidemic and adds to the impact of AIDS. As such, gender inequality must be addressed in the response to HIV and AIDS. It is important that a gendered contextual analysis both informs the understanding of the problem and points to solutions if programmatic vulnerability is to be reduced.

Understanding the context means, for example, that programmes take into account the realities of women's lives and how their realities impact on their experiences of life in general, and HIV and AIDS specifically. Programmes need to adjust to the fact that that due to their low status in society, women and girls have limited access to health care, particularly more costly treatments and medication, which means that their symptoms often go unrecognised and untreated. For the most part understanding of treatment is gender neutral; women's issues have rarely featured in discussions of treatment access and more importantly treatment appropriateness.[72] Issues such as the need for more regular pap smears for women living with HIV have not been addressed. Differences in how HIV infection affects women and men have not been articulated and programmes have not taken such issues into account.

The complex nature and magnitude of the HIV and AIDS epidemics requires a co-ordinated response that is multi-levelled, multi-faceted, and multi-sectoral. A co-ordinated response involves actors from a variety of backgrounds, for example, local and international NGOs, government agencies, and academic institutions. However these approaches need to ensure that they include goals of empowerment and transformation. To reduce programmatic vulnerability in established and evolving epidemics the global response should address a range of issues by different stakeholders at different levels. The responsibility for these actions needs to be addressed by various agencies depending on:[73]

▪ The level at which a particular institution is operating, that is, global, national, or local.

---

[72] Tallis, V. 2000 . Stevens, M. 2008
[73] Tallis, V. 2002 a

- The core functions of the organisation (capacity building, service delivery, advocacy or research).
- The sector or thematic area the organisation is focusing on, for example, development, labour, rural, urban.
- Funding priorities.

The response to HIV and AIDS must be multi-levelled, that is simultaneously occurring at an international, national and local level. Each level has a unique contribution to the global response. It is important that the levels link and engage with one-another but that the agenda is not set top-down.

The strategies to deal with HIV and AIDS at a programme level are multi-faceted and include service delivery, capacity building, advocacy and research. Each of these four strategies must address the basic needs of men, women and children, as well as women's practical needs and strategic interests. It is important to address the context in which the epidemics flourish, that is inequality, as well as HIV specific issues, for example, treatment. The different facets include:

Service delivery: Whilst many are engaged in providing services to prevent, care for and treat HIV and AIDS, some service providers are devising strategies to make their work more gender sensitive, or at the very least, addressing women's practical needs. A focus on service delivery should not be confined to health services and true mainstreaming would require other sectors to incorporate approaches to addressing gender inequality and HIV and AIDS into service provision, for example, in the education sector.

Capacity building: Although many equate capacity building with training, it is used here in a broader way and refers to capacity building for institutions and individuals. Capacity building thus refers to a process of empowerment based on experiential learning principles that may involve skills building, mentoring and support. There is a general lack of understanding of how gender conditions peoples' well being and how to incorporate gender into programmes, demonstrating the

need for gender training, tools and guides.[74]   Building skills for better communication in personal relationships is vital. Although improving access to information about sexual health is important, it does not take into account the barriers that women and girls face in using this knowledge to achieve healthy relationships.

Advocacy: Advocacy for policy formulation, setting research agendas and the allocation of resources that take account of the differing needs and interests of women and men is critical. Ensuring that people are aware of differences based on gender and age, ethnicity, class, ability and sexuality help make sure that people are not marginalised.

Research: There is an enormous amount of HIV and AIDS related research, including epidemiology, clinical research, social science research, impact studies and programme evaluations. Due to male bias women have often been invisible in research,[75] for example the gender dimensions of treatment are not always considered.[76]

A critical component of the multi-sectoral approach is that of communication and co-ordination, which is often a weakness in the response at country, local and other levels. There are few examples of a co-ordinated multi-sectoral response that incorporate a gendered approach to HIV and AIDS. However, there are some good examples of how sectors outside of health have addressed gender and HIV and AIDS. Key aspects of a multi-sectoral response to HIV and AIDS:

- Consider HIV and AIDS and its implications in all areas of policy-making.
- Involve all sectors in developing a framework to respond to the epidemic, at international, regional, national, district and community levels.

---

[74] Tallis, V. 2002 a

[75] Doyal, L. 1995

[76] Tallis, V. 2000. a

- Identify the comparative advantages and roles of each sector in implementing the response, and where sectors need to take action together and individually.
- Encourage each sector to consider how it is affected by and affects the epidemic, and developing sectoral plans of action.
- Develop partnerships within government between ministries responsible for different sectors, and between the public sector and private sector and civil society.[77]

Programmatic vulnerability obviously has gendered implications. Organisations contribute to 'programmatic vulnerability' of women and girls and help sustain the core problem by failing to confront men's power over women and effectively develop women's power within themselves and power with other women to free themselves from oppression and to ensure their dignity and equality.

2.1.2 Societal Vulnerability

"The HIV and AIDS epidemic is a reflective surface. It throws into stark relief the fault lines of a society: the way power is exercised, gender constructed, socio-economic stratification exploited, the moral ambiguities, the interpersonal slippage's. But it also highlights the strengths: empathy, courage, compassion, commitment, intelligence, solidarity, faith".[78]

Societal vulnerability encompasses political, economic and social factors that are inter-related and determine the extent to which women and men as individuals and as groups are vulnerable to HIV and AIDS.

---

[77] Commonwealth Secretariat and the Maritime Centre of Excellence for Women's Health, 2002. p55
[78] Reid, E. 1995, p xi

Political factors

An effective response to the epidemics calls for political will and commitment at the highest possible level. Countries that have made some headway in reducing the spread of HIV and dealing with the impact of HIV and AIDS have in common a fairly high level of political commitment coupled with sustained public leadership, for example Uganda, Thailand and Brazil.[79] Whilst some countries have demonstrated leadership and commitment, it does not necessarily mean that the response falls within a gendered human-rights framework. An example is the homophobia of President Museveni of Uganda who, over a period of years, has systematically denied gay and lesbian people access to their rights and the existence of gay men and lesbian women in Uganda, increasing their marginalisation and vulnerability to HIV and AIDS.[80]

Lack of political will hampers effective prevention and care programmes by not providing a conducive or enabling environment. The most stark example of this is in South Africa with the lack of political will demonstrated by the then President, Thabo Mbeki and his denial of the link between HIV and AIDS, and the slow roll out of treatment.[81] This is an extreme example, yet the leaders of most countries have been slow to act to HIV and whilst pushes from civil society and UN agencies have resulted in greater leadership nationally and globally, it is evident that full scale responses to the pandemics were not introduced at the optimal time.

Severe economic impacts in Africa as a result of HIV and AIDS are already being experienced. The longer term effects will vary per country and are very much dependent on the severity of the epidemic as well as the structure of the national economies.[82] Critical economic factors that impact on vulnerability include macro-economic frameworks and policies, and poverty and inequality. The macro-political

---

[79] UNAIDS. 2007, UNAIDS. 2008

[80] http://www.hrw.org/en/news/2007/08/21/uganda-state-homophobia-threatens-health-and-human-rights

[81] Mbali, M. 2004. Sember, R. 2008.

[82] Stover, J. and Bollinger, L. 2006.

and economic factors that impact on development in general, located at a country, regional and global level, are increasingly impacting on access to socio-economic rights, and this, in turn, heightens vulnerability to HIV and AIDS.[83]   To an increasing extent, pressures that arise out of the global economy influence national government decision-making, and have a knock- on effect, for example, health and education. It is too early to discuss the impact of the current global economic crisis on developing nations, development goals and issues such as HIV and AIDS. However it is likely, for example, that developed nations will have less to give in aid, and this may impact severely on service delivery, access to treatment and prevention efforts.

National debt, capital speculation, the imposition of macro-economic adjustment programmes and jobless growth are some key processes in the global economy that influence negatively the health and well-being of poorer countries. Cut backs in social spending have been accompanied by the 'silent adjustment', the undue hardship and pressure that women experience as a result of financial policies,[84] and this situation could worsen in the current climate.   Adjustment policies may also influence pre-disposing factors for poor women.

The socio-economic conditions of women are determined by interacting hierarchical factors at a household (household income), meso (real wages, food prices, employment opportunities) and macro (economic policy, health policy and social welfare) level.[85] It is easy to see that HIV and AIDS impacts on all three levels: the first negative outcomes are felt by individuals and households but this soon has a ripple effect on businesses and the macro economy.[86] HIV morbidity and mortality affects household income and expenditure, and more and more families are resorting to survival strategies to alleviate loss of household labour and

---

[83] Tallis, V. 2002 a

[84] Kaihuzi, R.T 1999, Singh A. and Zammit, A. 2000. Rowbotham, S. and Linkogle, S. 2001. Riley, M. 2001.

[85] De Vogli, R., and Birbeck, G.L. 2005

[86] Stover, J. and Bollinger, L. 2006

income.[87] The direct and indirect costs of HIV and AIDS on the household increases with the severity of illness and with death.[88]

The impact of social spending cutbacks is more severe in the absence of alternative forms of livelihoods and social services to meet the basic needs of poor people. At a country level, the fiscal policies of governments mean that political choices are made which are often not in favour of the poor and marginalised, particularly poor women, rural women and groups such as intravenous drug users. One of the first areas to be impacted upon is that of health and development. The links to HIV infection are clear.

The relationship between HIV and poverty is complex - while most people living with HIV and AIDS are poor, many non-poor people are also affected and infected.[89] However, people living in poverty are more likely to become sick and generally die more quickly due to malnutrition and lack of access to appropriate health care. The HIV epidemic is bi-modal with peaks among the richer and better educated as well as amongst the poorest in society.[90]   The HIV epidemic among richer people is due to access to disposable income and position in society, including the ability to travel, which provides people with the opportunity to engage in sex that puts them at risk. According to Baylies it is mainly men that fall into this category and their behaviour is seen as an "expression of their power".[91] This contrasts with the situation of the poor, especially poor women, whose poverty may lead to risky actions for survival as well as preventing them from taking protective action.

The link between poverty and HIV serves to further stigmatise both the poor and those living with HIV and AIDS.[92] Poor households are often socially excluded

---

[87] Naidu, V., and Harris, G. 2006

[88] Naidu, V. and Harris, G. 2006

[89] Fraser-Hurt, N., Gorgens-Albino, M, Gelmon. L.J., Whitson, D.W. and Wilson D.   2008.

[90] Collins, J and Rau, B 2000

[91] Baylies, J. 2000, p 12

[92] Collins, J. and Rau, B. 2000, Cohen, D., and Reid. E. 1999

through a lack of financial and other assets as well as political and social marginalisation. This further increases their difficulty in accessing services focusing on prevention of HIV as well as in care of people and families affected by HIV. Specifically, HIV and AIDS programmes neglect the interests and reality of poverty and seldom relate to the needs of the poor.

The relationship between poverty and HIV and AIDS is bi-causal in that:
- Poverty is a causal factor in the transmission of HIV as well as exacerbating the impact of HIV and AIDS
- The experience of HIV and AIDS by individuals, households and communities that are poor often intensifies poverty. In some cases some individuals and households affected by HIV move from being non-poor to poor due to the severe economic burden of HIV and AIDS.

Poverty is not a gender neutral context and gender and poverty are inextricably linked in a complex relationship.[93] Gender inequality causes women to experience poverty differently. Policy and programme responses to poverty need to have gender at the centre if they are to be effective.

> "*The causes and outcomes of poverty are heavily engendered and yet traditional conceptualisations consistently fail to delineate poverty's gender dimensions resulting in policies and programmes which fail to improve the lives of poor women and their families*"[94]

Even when women have access to income and assets, such as land, equipment, employment, knowledge and skills, these are often controlled by men, and women are less able to move out of living in poverty.[95] Women are more likely to spend family income on the household than men do. When women's socio-economic conditions deteriorate, household standards and expenditure on children

---

[93] Razavi, S. 1998.

[94] Beneria and Bisnath in Cagatay, N. 1998. p2

[95] May, J. 2000.

decreases.[96] Much needs to be done to address gender inequality in Africa and globally if any impact is to be made in reverting the HIV and AIDS epidemics. Some examples of the link between gender, poverty and HIV include:

Bio-medical factors predisposing girls and women to increased risk of infection, including chronic anaemia and early first coitus, are exacerbated by poverty.[97] A lack of control by poor women over the circumstances in which intercourse occurs may increase the frequency of intercourse and lower the age at which sexual activity begins.

Economic violence refers to the complete control that one person has over another's money, resources or economic activities. It is more often than not a gendered phenomenon with male 'abusers' maintaining control of and taking decisions about the household finances.[98] Economic violence has been linked to deepening poverty, compromises in educational opportunities and slowing development gains for women. This impacts on the household as women are more likely to spend money on food and the well-being of children than men.[99] Economic violence is also linked to physical violence, promotes sexual exploitation and increases the risk of HIV infection, maternal morbidity, and trafficking of women and girls.[100]

> *"It is very hard for a positive woman to access services if she also lives in poverty, because not only does poverty weaken her body, but her mind and soul as well. For instance, I remember when I was still unemployed, facing family opposition and attacks, emotional and sexual abuse by the partner who was also the father of my child. It seemed as if the world was closing down on me. I had to depend on him for the food on my table, the child and my medical attention. I felt so trapped. I couldn't think beyond this situation-*

---

[96] Posel, D. 1997

[97] Farmer in Collins, J. and Rau, B. 2000

[98] Fawole, O.I. 2008

[99] Posel, D. in May, J. 2000

[100] Fawole, O.I. 2008

instead I was giving myself stupid-good reasons to stick to him-anyway he was footing the bill, where else was I 'supposed' to look. Life was bad-very bad. My self-esteem was crushed". [101]

Survival sex.   Evidence from all regions of the world suggests that the overwhelming motive behind the exchange of sexual services for the provider is economic opportunity.[102]   The context of some sex work in Africa is survival sex, and sex work is a means to make money for women and their families to remain alive. In this way, survival sex is a form of small-scale informal money making. Some women in the informal sector are simply extending their existing capabilities and livelihoods and doing work that is typified as women's work. They are seldom, as is usually the case with women's work, well paid for their efforts. Sex work that is poverty driven is more likely to foster behaviours that are risk-taking.

> *"The paradox of what we refer to as survival sex, be it strictly commercial or not, is that relatively short term (but none the less, pressing) social survival is achieved only at the expense of exposure to the long term risk of illness and death through HIV infection".[103]*

Sex workers, both those involved in survival sex and those who consciously chose to be engaged in sex work, experience multiple oppressions and human rights violations, which increase vulnerability to HIV infection.[104]   Police violence is rife, including sexual assault and rape, beatings and spraying sex workers genitals with pepper-spray.[105]

---

[101] Ndlovo, B, Masondo, T, Mthembu , P, Barnanbus, N, Silondo, P, Ntombela, A.,Telophi, R, and Tallis, V. 2003. p2

[102] Tawil et al in Collins J. and Rau, B. 2000.

[103] Preston Whyte , E., Varga, C., Oosterhuizen, H., Roberts, R. and Blose, F. 2000 p3

[104] Crago, A.N. and Arnott, J. 2008.   Kurtz, S.P., Surratt, H.L., Kiley, M.C. and Incaiardi, J.A. 2005.

[105] Crago, A.N. and Arnott, J. 2008

"The police come to your shack in the van. They take your money and sleep with you with no condoms. It is a rape because they force us. We are scared to report the rape because we are sex workers, so we are illegal". [106]

Attitudes of health care workers marginalise sex workers and deny them access to proper care. The behaviour of health care workers often results in sex workers deciding to explore other options for health services, or not attending to their health at all.

"I am positive, and at the hospital, they don't treat us like humans. They say loudly 'These ones they are selling themselves.' So now, the young sex workers won't go to the hospital because they are scared. Some women have chosen to die with no ARVs rather than go there, because if you are a sex worker and HIV+, you are in for it! They get angry at you if you are not using condoms, but we tell them: give us the skills to negotiate using a condom. We want these skills because we can see that like this we are dying slowly but surely".[107]

Sex workers, who are further marginalised, such as migrant sex workers who are HIV positive, are particularly excluded from access to treatment and care due to both xenophobia and lack of access to services restricted to nationals. Transgendered sex workers who seek trans-specific health care and gay male sex workers seeking non-judgmental health care are similarly neglected.[108]

"Twenty-three of my friends died of AIDS. Nineteen trans women and four women, all sex workers. None of them got ARV's. It was the fear of discrimination and abuse from the doctors that kept them from getting

---

[106] Priscilla and Pinki in Crago, A.N. and Arnott, J. 2008. p2

[107] Rashida in Crago, A.N. and Arnott, J. 2008. p4

[108] Crago, A.N. and Arnott, J. 2008

medication. The fear of what might be said and done to them, because being trans is something everyone sees and the doctors say nasty things to us."[109]

Mother to child transmission[110] Access to relatively inexpensive drugs that can reduce mother to child transmission substantially is still denied to many women who cannot afford them, or who do not have adequate knowledge or who do not have the means to go to clinics. Despite campaigns to promote exclusive breast feeding in developing countries bottle-feeding still remains a safer option. Poor women have neither the money to buy formula feed, nor the access to basic facilities and infrastructure, such as clean water, with which to prepare bottle feed and so reduce the risk of other infections.[111] Poor women have less privacy due to living in overcrowded and over populated conditions, and the decision not to breastfeed may be noticed by neighbours and lead to disclosure of HIV status.

Social

There are many social factors which impact on the spread of HIV. This section will focus on two aspects that are particularly relevant for women, that is sexuality and power and gender-based violence.

Sexuality and power

> *"Patriarchal relationships involve, to varying degrees and within different sites, inequalities of power, and without power women are likely to experience little control over sexual relations with men. It is within the context of unequal power relations that women are required to take*

---

[109] Midnight Monroe in Crago, A.N. and Arnott, J. 2008 p 3

[110] There are currently debates around the term mother to child transmission versus parent to child transmission. In an effort to remove the blame from women some prefer to focus on parent rather than mother. This term is commonly used in Zimbabwe for example with a focus on involving men from testing of the women through to after birth – addressing both prevention and care issues. Other activists believe that using the term "parent" masks the reality – that men are seldom involved in pregnancy, may reject a woman once she finds out her HIV status and are often not committed to providing care once the child is born (personal communications with women living with HIV and AIDS).

[111] Seidel, G. and Tallis, V.A. 1999

preventative and protective actions aimed at minimizing their risk of contracting HIV".[112]

HIV and AIDS has opened up debates around issues of gender and sexuality and has served to highlight the importance of gender equality in sexual relationships as well as the importance of equality and respect in all social relationships. Social constructions of femininity generally stipulate that women's sexuality should be invisible and that it needs to be controlled. Its association with masculinity and femininity is complex and differs in different historical and cultural contexts. Yet despite such differences both the social perception and the practices associated with heterosexuality have certain common elements. Different sexual roles are defined for men and women: however they are not just different, but also unequal. Almost everywhere, primacy is accorded to male desire and women are perceived to be the passive recipients of male passion.[113] Women are often socialised into believing that sex happens to them whilst men believe that sex is something that they do.

In many Asian, African and Latin American countries it is culturally determined that women carry out different so called 'interventions' on their genitals, for a variety of reasons, including hygiene, health, acceptable and expected social norms and control of women's sexuality.[114] A study with women in the Tete province of Mozambique investigated various vaginal practices, one of the most prevalent being the use of drying agents to ensure a non-lubricated vagina. Women use a variety of drying agents that can damage the vaginal walls. The practice of using drying agents has the sole purpose of enhancing sexual intercourse for men: thus women's vulnerability is increased with practices that promote the enhancement of male sexual pleasure. As one young male in the Bagnol and Mariano study noted:

"As far as I am concerned a good women has to be dry, in order to be able to

---

[112] Travers, M., and Bennett, L. 1999 p 67

[113] Doyal, L. 1994.

[114] Van de Wijert et al in Bagnol, B and Mariano, E. 2008

provide three rounds, it is not just one round and straightaway fill up with water ... she has to be dry, in order for me to be able to manage to ejaculate without feeling water in her body. I want a woman without water".[115]

Such practices, apart from being problematic in terms of controlling women's sexuality, also increase women's risk to STI's and HIV infection, by creating lesions and altering the flora of the vagina.[116]

Unequal power in sexual relations leads to the sexual double standard which has alarming implications for both men and women's ability to prevent the sexual transmission of HIV.[117] Unequal parties are not in a position to negotiate when they have sex, how often and how they can protect themselves from STIs and HIV. There are many difficulties for women in challenging male power "in the lonely moment of private relations and to negotiate for safer sex."[118] However, it is within the context of unequal power relations that women are required to take preventative and protective actions aimed at minimizing their risk of contracting HIV.[119] Generally there is a culture of silence about sex and sexuality – which enables male dominance, denies women their sexual rights and ensures that both men and women remain ignorant.

Globally, the condoning of multiple partner relationships for men is a social norm that increases women's vulnerability. In many cultures, both women and men believe that a variety of sexual partners is acceptable and essential for men but not appropriate for women. In a study of women from over ten countries undertaken by the International Centre for Research on Women (ICRW) the following was noted:

---

[115] Male respondent age 18-24 in Bagnol, B. and Mariano, E. 2008. p 578

[116] Bagnol, B and Marino, E. 2008.

[117] Wilton, T.1997.

[118] Baylies, C. and Bujra, J. 2000. pxii

[119] Travers, M. and Bennett, L. 1999. p67.

> *"Though many women expressed concern about the infidelities of their partners, they were resigned to their lack of control over the situation. Women from India, Jamaica, Papua New Guinea, Zimbabwe and Brazil report that raising the issue of their partners' infidelity can jeopardise their physical safety and family stability."*[120]

In a Malawian study it was evident that extramarital sex was not only more typical for men, it was also more accepted by women, "most likely because there is greater tolerance of male infidelity or because women are in a weaker position to initiate or enforce a divorce".[121] Furthermore the study revealed, not surprisingly, that men were better able than women to apply strategies to limit their risk of infection.[122]

There is growing concern amongst women's rights activists, women living with HIV and feminists involved in HIV and AIDS about the effect of male circumcision on women's vulnerability. Given the results of recent studies of the effectiveness of male circumcision, as a HIV prevention strategy for men the practise is being promoted as an effective prevention tool. However, this effectiveness is more likely to lead to increased vulnerability for women as it is postulated that circumcised men may be even less likely to use condoms.[123]

Young women have little power when it comes to deciding when, with whom and how to have sex - without power women are likely to experience little control over sexual relations with men. A lack of control over their own bodies and sexuality increases their vulnerability to HIV, STI's and pregnancy. Sex between older men and younger women and girls is referred to as intergenerational sex or age mixing. Relationships with older men or "sugar daddies" have been seen as a key driver of the epidemic: whilst biological factors may account for young women's greater susceptibility to HIV, there is clear empirical evidence that age-mixing between

---

[120] Gupta, GR and Weiss, E. 1993. p405
[121] Reniers, G. 2008. p 433
[122] Reniers, G. 2008.
[123] Nkosi, M. 2008

young women and older men plays an important role in observed differences in the epidemiological pattern.[124]   Studies indicate that relationships between young women and older men are common in many parts of sub Saharan Africa and are associated with unsafe sexual behaviour and increased HIV risk. These relationships are largely premised upon material gain, with studies revealing that the greater the economic asymmetries between partners and the greater the value of a gift, service, or money exchanged for sex, the less likely the practice of safer sex.[125] Unfortunately such relationships are often accepted, partially because even where families do not like it, older men are seen as providing much-needed material support   in the form of school fees, transport money, groceries and so on. Acceptance is also links in to the double standards placed on male and female sexuality. Men are protected by a society which condones the expression of male sexuality (including multiple partners and intergenerational sex) and women do not have sexual autonomy.

Age disparate relationships have elevated HIV risks for young women in partnerships with men who are five or more years older. In South Africa for example a very high HIV infection rate of 29.5% was found among girls 15-19 in sexual partnerships with an age disparity of five or more years.[126] A recent study in Botswana found that for every year's increase in the age difference between partners there was a 28% increase in the odds of having unprotected sex.[127]   It is important in discussions about young women's vulnerability to discuss sexual debut, as early sexual debut is a significant predictor of prevalent HIV infection. Delaying sexual debut to avoid HIV infection at this especially biologically and socially vulnerable period is a key HIV prevention strategy, and even more important when the young women may have sex with an older man.[128]   It is also

---

[124] LeClerc Madlala, S. 2008

[125] Leclerc Madlala, S. 2008

[126] Shisana, O. and Simbayi, L. 2002

[127] LeClerc Madlala, S. 2008

[128] Rees, H. 2008.

important to address the barriers that may prevent young women from delaying sex.[129]

Forced and early marriage also increases young women and girls vulnerability to HIV and is a feature in the lives of women in both Asia and Africa.[130]   Married adolescent girls have higher rates of HIV infection than do sexually active unmarried girls: early marriage increases coital frequency, decreases condom use, and virtually eliminates girls' ability to abstain from sex.[131]   Although married girls are less likely than single girls to have multiple partners, this protective behaviour could be outweighed by their greater exposure via unprotected sex with partners who have higher rates of infection.[132]

Gender based violence

One of the most serious implications of gendered relations of power is male violence against women and girls of all ages, which is pervasive in all societies and has serious implications for women's ability to protect themselves from HIV infection. Violence against women and girl children, physical, emotional and/or sexual, is a product of the social construction of masculinity, which often condones male dominance over women.[133]

The nature and extent of violence reflects the context of social, cultural and economic disparities between men and women. Acts of violence happen in many contexts – home, marriage, workplace, and in public spaces. All women and girls may live in fear of violence and this fear may be heightened in particular environments and at certain times. The link between violence against women and HIV and AIDS is increasingly being recognised, and includes:

---

[129] Pettifor, A E., van der Straten, A., Dunbar, M S Shiboski, S C; Padian, N. S. 2004.

[130] Germain, A and Woods, Z. 2005

[131] Clark, S. 2004

[132] Clark, S. 2004.

[133] Connell, R.W. 1987, Connell, R.W. 2005

- Forced or coerced sex, which is likely to cause vaginal or anal tearing, lacerations or abrasions, thus increasing the risk of contracting an STI or HIV.

- Violence following a woman's disclosure to her family of her sero-status. Many women and girls who disclose their HIV status to partners, family members, and communities are physically and emotionally abused. In December 1998, a young South African woman, Gugu Dlamini, was beaten to death by members of her community after disclosing her HIV status as she was seen to be a disgrace to the community.[134]

- Violence often increases in the home when household tasks cannot be completed due to the time taken to care for sick family members or from the caregiver's own illness.[135]

- Girls and women who are raped may be infected with HIV as a result of the rape. Women who are raped have no or limited access to post-exposure prophylaxis (PEP). For example, in the latest version of the Sexual Offences Act in South Africa, the provision of PEP is only available to women who report rape to the police, and given that most rapes are unreported access to PEP is compromised.[136]

- The fear of violence may prevent women insisting on the use of condoms or other safer sex methods.

- Myths such as the belief that having sex with a virgin is a cure for HIV[137] result in increased rape and sexual abuse. This is exacerbated when 'virgins' are publically identified – for example through virginity testing.

In war and conflict situations the risk and incidents of gender based violence escalate. This is due to a combination of factors, including the breakdown of law and order and large scale population movements, specifically of women and

---

[134] Vetten, L and Bhana, B. 2001

[135] Personal discussions with women living with HIV

[136] Killian, S. Suliman, S, Fakier, N Seedat, S. 2007

[136] Peltzer, K. Mngqundaniso, N. Petros, G. 2006

children.[138]   Violence against women in conflict situations is evident in counties in Southern Africa, for example, in Zimbabwe and the Democratic Republic of Congo.[139]   Conflict situations increase vulnerability of women and girls due to the rape of women and girls by opposing forces coupled with the fact that HIV rates are often higher in military personnel. Rape is also common in refugee camps, often by emergency personnel.[140]   Increased survival sex is a feature of conflict situations, as women deal with the loss of income, a home, and supportive family members.[141]

In the UNSG report[142] on women and girls, HIV and AIDS in Southern Africa it was found that most countries in the region have an adequate legal framework within which to address the issue of violence against women. The efforts of civil society, especially the women's sector, have in many cases advocated successfully for a change in legislation which addresses the issues, for example, changes in law to acknowledge marital rape and extended definitions of rape. Whilst legislation does exist, access to justice is not necessarily forthcoming. Often women are reluctant to report rape or domestic violence for a variety of reasons including attitude of the police and courts, fear of the consequences, limited access to support for rape survivors to assist in the reporting process, and women not knowing their rights.[143]

Given that there is generally a high level of tolerance towards violence against women in society, even when the perpetrator(s) are brought to court they are often not convicted or receive light sentences. The case study in chapter eight highlights the issues of violence against women and the power wielded by different institutions in upholding male privilege. In many instances the wheels of justice turn slowly. This is particularly traumatic for women and girls who reside in the same home or community as the perpetrator. In many cases women and girls

---

[138] Jewkes, R. 2007.

[139] Jewkes, R. 2007.

[140] Gordon, P. and Crehan, K . 2000.

[142] UNSG Task Force on women, girls and HIV/AIDS in Southern Africa. 2003

[143] UNSG Task Force on women, girls and HIV/AIDS in Southern Africa. 2003

believe that husbands / partners/ boyfriends have a right to physically assault them if they do not want to have sex.[144]

In summary, the vulnerability model provides a useful framework to understand why women and girls are experiencing high prevalence rates and are particularly susceptible to HIV infection.

2.2 Impact of the three epidemics on women and girls

Since 2000 AIDS has been the leading cause of death in Sub-Saharan Africa and the fourth cause of death globally.[145] The effects of HIV and AIDS have been devastating and have impacted at a micro and macro level, on society, communities, households and on individuals. Growing numbers of women and men are living with HIV and AIDS and have to deal with a multitude of complex mental, emotional, social and financial issues. HIV and AIDS affects all women and men regardless of class, race, sexual orientation and HIV status, however these other realities and subject positions will influence how HIV and AIDS impacts on their lives. Much has been written about the impact of HIV and AIDS and there is ample evidence that women are affected disproportionately.[146] A key impact of HIV and AIDS is the entrenching of gender inequalities and other factors that drive the epidemics.

The impact of HIV and AIDS on women has been referred to as `triple jeopardy'.[147] This term refers to and acknowledges the impact on the different key gender roles that women are generally expected to fill: that is productive; reproductive; and community. The gender division of labour clearly differentiates between men's work and women's work, and the reality is that men's work is valued while women's work is not. Women fulfil the following roles:

---

[144] UNSG Task Force on women, girls and HIV/AIDS in Southern Africa. 2003

[145] UNAIDS 2001

[146] Germain, A and Woods, Z. 2005

[147] Panos 1990 b

- *Reproductive role*: which includes the childbearing and rearing responsibilities as well as all domestic tasks
- *Productive role*: Women's (and men's) productive role comprises work that is done for payment or for kind.
- *Community managing*: Women's activities in the community are defined as an extension of their reproductive role. They may include the provision and maintenance of scarce resources of collective consumption such as water, health care and education – work that is undertaken voluntarily and undertaken in so called free time.[148]

The gender division of labour within the household means that women generally perform the bulk of child care and household activities. When in addition to household work, income generating activities are taken into account, women work significantly more hours than men. HIV and AIDS affects women as individuals, mothers and caregivers in these socially defined roles. The positioning of women throughout the history of the epidemic has been problematic, and has been influenced by how women are viewed: at various points in the epidemic, women have been referred to 'innocent victims' as well as 'vectors of transmission' to their partner and/or child. In many instances women have been viewed only in their role as mother, to the detriment of their own needs, treatment issues and prevention.[149]

The impact of HIV and AIDS has increased the responsibilities of women at a household and community level. Whilst care is often narrowly defined as care for the sick and dying in the home and community setting, the reality is that care is much more. It extends to emotional and mental care, care for children who have lost one or both parents, and palliative care. It also involves spiritual care, including attending funerals. One home-based care organisation noted that women staff are exhausted on Mondays because of the work they do at the weekend funerals of those they have cared for.[150]

---

[148] Moser , C. 1993

[149] Tallis,V. 2002 a. Discussions with young women living with HIV 2006, 2008

[150] Personal discussion, Laura Washington, Project Empower.

In a household study conducted in South Africa 68% of caregivers in the households surveyed were women or girls, with 7% younger than 18 and 23% older than 60. Over 40% of households reported that the primary caregiver had taken time off from formal or informal employment or schooling, which impacted on the economic situation of the family and the school attendance of girls.[151] It is common for women who are sick to be sent back to their family, whilst when men are sick it is expected that the wife or a female member of the wife's family will do the caring. Women and girls lost as much as 60% of time from other housework or gardening which affects the ability of poor households to grow food for consumption or sale.[152] Primary care givers also experience emotional strain.[153] Caring for a person living with HIV is often made more difficult by issues such as lack of access to water and sanitation.

Much of the care provided in both urban and rural areas in the region is provided by volunteers, the vast majority whom are women. Some women are spending hours every day providing primary care for children without parents, or tending to sick and dying people.[154] There is little in the way of care for caregivers who often experience exploitation, high levels of burn-out, low social status and recognition and may even be discriminated against. Many women receive no incentives for the work they do. Often the carer is as poverty stricken as the people she is assisting.

> …."for paltry sums of money or nothing at all, women are exposed to violence and harassment in people's home, often traipse around in the dark, are taken out of the circuit of looking for paid employment, use their own scarce resources to care for patients, are in the front line for exposure to opportunistic infections and TB especially, when many of them are

---

[151] Desmond, C. Micheal, K. and Gow, G. 2000.

[152] Desmond, C. Micheal, K. and Gow, G. 2000

[153] Desmond, C. Micheal, K. and Gow, G. 2000

[154] UNSG Task Force on women, girls and HIV/AIDS in Southern Africa. 2003

themselves living with HIV. So it is not gender blind or gender neutral but actually deepens oppression".[155]

May refers to the 'time poverty' experienced by women which is the result of the long hours women spend on their reproductive roles, collecting fire-wood and water, child care, cooking and cleaning, to the detriment of their own well-being.[156] Many women living with HIV also have the added pressure of being ill themselves and having to provide care for their partner and / or sick child. For a woman living with HIV, such an increase in workload often means that she does not have time to adequately care for herself and attend to her own needs.[157] As noted by Crewe, home-based care is a middle-class concept as it assumes that the resources (including human) are available in the home yet this is not always the case.[158] The contribution of women in prevention and care is seldom recognised and almost never quantified.

The social impacts do not just affect adults but children as well. A growing trend is to take children, especially girls, out of school to care for the sick and help with other household duties. For example in Swaziland school enrolment has fallen by 36% due to HIV and AIDS with girls most affected: this impacts on their education and future prospects.[159] Although withdrawal from school is often associated with girls, studies show that in certain cases boys are also withdrawn from schools when relatives become ill or die. However, it is more likely that they will be expected to supplement family labour on farms or in income generating activities.[160]

---

[155] Washington, in Tallis, V. 2008. p29-30

[156] May, J. 2000.

[157] Panos. 1990 b. Loewenson, R and Whiteside, A 1998.

[158] Crewe, M. 2000.

[159] UNAIDS, 2001, Desmond et al, 2000

[160] Bennell, P., Hyde, K, and Swainson, N. 2002

2.3 Understanding Programmatic Vulnerability. Current approaches to HIV & AIDS

In order to effectively address the three epidemics, and reduce programmatic vulnerability, it is vital that those working on HIV and AIDS understand the factors that drive men and women's increasing susceptibility to infection, as well as analyse the impact that HIV and AIDS is having on individuals, households, communities and society.

2.3.1 Traditional approaches

The initial response to HIV and AIDS in many countries was to view and address HIV as a health issue, ignoring the social, economic and human rights dimensions that impact on both prevention and care.   The response was "often reactionary, invoked in the name of public health and frequently at the expense of human rights."[161]   The health model views health as something over which the individual has personal control. Thus, the approach of the health framework is to give information and encourage 'healthy' choices. The responsibility for health is placed on the individual, in a social vacuum. This fails to acknowledge that choices and decisions will be shaped by what is known and also by fears and prejudices, as well as by limitations on the means of the individual to act.[162]   Such an approach can undermine the health and well-being of women and men.

Responses to HIV and AIDS occur along the prevention-care continuum which addresses the impact of the epidemics on people who are HIV negative as well as those affected and infected. Using such a framework requires comprehensive goals of integrated prevention, and care and support for individuals and families affected by HIV and AIDS. It is possible to do a gender analysis as gender inequality is evident at all stages of the prevention-care continuum, and affects among other things, the possibilities of prevention, access to appropriate materials, information

---

[161] Wiseberg, L.S., Hecht, M.E, and Reekie, K 1998 p1

[162] Richardson, D. 1996

and resources, the quality of care received, and chances of survival. However, it cannot be assumed that responses following this model do in fact address gender.

2.3.2 Human Rights approach

A human rights approach emphasises the claims or entitlements that all people have to a full and satisfying life, in which each person is able to develop to his or her full human potential. Human rights set global standards for human well being and development.[163]   HIV and AIDS is a human rights issue because:[164]

- The lack of access to prevention methods, appropriate information and materials, treatment and care, leading to vulnerability to HIV is linked to human rights violations such as poverty, inequality, racism, homophobia and sexism.
- People living with HIV and AIDS and those affected by these epidemics are often unable to live a life of equality, dignity and freedom as their rights are often violated on the basis of their HIV status. This includes the right to privacy, confidentiality, access to acceptable health care, reproductive and sexual health services, employment, education, freedom of movement and the right to travel.

A focus on the concept of human rights alone is, however, not sufficient as often articulations of human rights do not take women into account. Evidence of this can be seen on a daily basis where gender-based abuse and discrimination is sanctioned or tolerated by society.   Traditional human rights formulations are based on a typical male model and applied to women as an afterthought, if at all.[165] There is also a tension between acknowledgement of and implementation of human rights. For example, men may care about reproductive freedom, but their lives are not threatened by the lack of it, and they do not face the same consequences of

---

[163] United Nations Division for the Advancement of Women, World Health Organisation, UNAIDS., 2000

[164] International Council of AIDS Service Organisations (ICASO) 1999

[165] Charlesworth, H. 1995. Peters, J and Wolpe, A. 1995

failure to enjoy and access reproductive freedoms.[166]   Marginalised people are even more likely to be denied their rights.[167]

HIV and AIDS are clearly linked to reproductive and sexual rights. The social and cultural aspects of sexual and reproductive activity promote and entrench gender inequality and increase both women and men's vulnerability to HIV infection. Reproductive rights refer to rights that focus on and relate to the potential and ability to procreate. This includes issues such as fertility, family planning and termination of pregnancy. Reproductive rights take on another dimension in relation to HIV and AIDS, as hard-fought battles of the feminist movement are being eroded. An example of this is the control often exerted by health care workers over the reproductive choices of women living with HIV and AIDS. Incidents of women living with HIV requesting termination of pregnancy and being 'forced' into sterilisation have been noted.[168]   Often, women living with HIV and AIDS are not given accurate information regarding pregnancy and breast-feeding.[169]   Women face difficult decisions regarding breastfeeding as a culturally preferred option. A decision to not breastfeed can lead to a forced disclosure of women's HIV status.[170] Women have also reported judgmental and hostile attitudes from service providers, including testing without consent and refusal of services.[171]

Whilst reproductive rights are vitally important, they are by definition narrow, in that they normally address the rights of heterosexual men and women of child bearing age. It is important in the context of HIV and AIDS that we also talk about sexual rights, a more inclusive term which focuses on the ability of men and women to make choices about the expression of their sexuality and their sexual lives, including who they have sex with, how, and why.[172]   It is also important that sexual

---

[166] Cook, R.J. 1995

[167] Altman, D. 2007

[168] Mthembu, P. 1998.

[169] Seidel, G. and Tallis , V 1998.

[170] Paxton, S. 2001.

[171] Manchester , J and Mthembu, P 2002.

[172] Hlatshwayo, Z. and Klugman, B. 2001.

and reproductive rights include the rights of lesbian, gay, bisexual, transgended and intersex (LGBTI) communities.

A sexual rights framework for men and women embodies the right to:[173]
- Have control over one's own body.
- Have sex when, with whom and how one wants and not be forced to have sex.
- Make decisions about one's own sexuality.
- Have sexual enjoyment.
- Protect oneself from the risk of the consequences of sex, such as pregnancy, sexually transmitted infections and HIV.
- Have access to non-judgemental, responsive services which help deal with sexual health concerns.

Sexual and reproductive rights are seen as rights and freedoms for women and men. Sexual and reproductive rights are vital if women are to access quality of life and well being have increased options and if HIV and AIDS prevention and care efforts are to be successful. However, it is also critical that women enjoy other basic human rights if the broader inequalities that drive the epidemic are to be addressed.

There are different United Nations conventions, that is, pieces of international law which are signed by countries and are referred to as binding. These declarations have clauses that can be used in activism and advocacy to reduce vulnerability to and the impact of HIV and AIDS. For example, CEDAW is a critical tool to both understand and act against gender inequality and discrimination. Other important conventions include the Universal Declaration of Human Rights and the United National General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS.

---

[173] Hlatshwayo, Z. and Klugman, B. 2001.

2.3.3 Approaches to gender: what exists

The gendered nature of the response to HIV and AIDS can be plotted along a continuum ranging from promoting gender stereotypes through to the eradication of gender inequality through the transformation of society. Responses to HIV and AIDS may be positioned at any point along this continuum. The closer the response or particular intervention is to gender transformation the more fundamental the change that will emerge. It is clear that responses to HIV and AIDS have the potential to entrench or challenge the gender status quo which exists. To-date programmes have generally not successfully addressed the gendered challenges of HIV and AIDS, or have deliberately attempted to entrench existing structures of control over women, for example the President's Emergency Plan for AIDS Relief (PEPFAR) fund and its insistence on the promotion of abstinence before marriage and fidelity.   Gupta's[174] framework to assess the extent to which HIV and AIDS responses address gender identifies five levels: a focus on stereotypes, gender neutral, gender sensitive, transformatory and empowerment. The Gupta model is important as it provides a framework within which to locate responses to HIV and AIDS and programmes and has been specifically designed to address the gender/HIV interface.[175]

Focus on stereotypes

Many approaches use gender stereotypes to get their message across, which result in entrenching HIV and AIDS related stigma. Gupta describes this approach as programmes and or materials which promote a "predatory, violent, irresponsible image of male sexuality"[176] whilst women are portrayed as powerless victims. It also includes materials that focus on other stereotypes of women, like materials that portray sex workers as a source of infection. Some examples include a prevention poster in which a sex worker is depicted as a skeleton, with the caption

---

[174] Gupta, G.R. 2000.

[175] I believe that, although empowerment is an integral part of the transformation process, transformation of gender relations, rather than empowerment is the end goal. However, for the purpose of this chapter I discuss the model as put forward by Gupta.

[176] Gupta, G.R. 2000. p 8

'*What you see is not what you get: AIDS Kills*' and a prevention postcard which depicts the following: *Joystick* (on male body covering a penis) *Play-station* (on woman's body covering vagina) *Game over* (on picture of virus). Such images reaffirm the idea that men are active in sexual relationships and women are passive or that people who fall outside the remit of acceptable feminine or masculine behaviour, for example, sex workers are 'to blame' for the spread of the virus.[177] These images also portray a diagnosis of HIV as an instant death sentence that only serves to further stigmatise people living with HIV and AIDS.

Gender neutral programme

Gupta defines gender neutral programmes as programmes or materials that do not distinguish between the needs of women and men, and that do no harm. Examples given are messages such as 'be faithful', 'stick to one partner' or 'use a condom'. I would argue however, that gender neutral programmes or messages do, in fact, cause harm. If we analyse the example used by Gupta, messages such as 'be faithful' or 'stick to one partner', could, in fact, lead to increased vulnerability of women to HIV infection. This is due to the fact that many women who are faithful to their partner believe that because they are faithful, they are safe from HIV infection, when it is not necessarily the case.[178] Such messages also contribute to the third epidemic, stigma, by blaming those who have more than one partner.

Gender sensitive approaches

Gender sensitive approaches respond to the different needs and constraints of individuals based on their gender and sexuality. Many current AIDS programmes operate at this level, where women's practical needs are identified and attempts are made to meet those needs through service delivery. This includes programmes which focus on the provision of the female condom, income generation or increasing women's access to health services.

---

[177] Tallis, V. 2002 a.

[178] Abdool Karim, Q. 1998.

Approaches to working with men may also fall into this category, providing education to men that is based on their roles as decision makers in their relationships with women and help them look at how they can make better, safer decisions that can protect themselves, their female partners and their present and future offspring. These approaches often play into the concern of the man about his lineage being sustained, by encouraging him to keep negative and therefore have a healthy baby to carry on the family line. Gender sensitive programmes will impact on the immediate lives of women, but will not necessarily challenge the gender power relations. Such responses fall short of challenging the status quo whereby men hold decision making power and use this power to control the sexuality and sexual rights of their partners.[179]

Transformation

Gupta[180] focuses on relationships as the critical point at which transformation occurs. My definition of transformation is broader and includes radical change at personal, relationship (including the redefinition of heterosexual relations), community and societal levels, addressing the systems, mechanisms, policies and practices that are needed to support such genuine change. In a gendered approach, the transformation of gender relations leading to gender equality is the key objective, and must happen at a personal, organisational, programmatic and societal level. Whilst the initial point of entry may vary between these levels, it is vital that the progressive realisation of the transformation goal occurs at all four levels. This does not mean that each organisation has to engage at each level. Working towards a common goal, that of gender equality can be tackled from different angles.

Is working with men transformatory? Focusing on women alone may add to women's burden of HIV and often leads to the view that women are to blame.

---

[179] Tallis, V. 2002. a
[180] Gupta, G.R 2000.

However, the involvement of men does not necessarily improve the lives and health of women, and may in fact entrench the gender inequalities that exist in society. There has been a recent tendency in HIV and AIDS work to shift resources previously used for women towards projects targeting or involving men. Targeting men may run the risk of reinforcing the dominance of men over women in intimate relationships.[181]

The potential problems of focusing on men at the expense of women are highlighted in the debates around potential microbicides, with the enormous controversy over the potential for women to use a microbicide without their partner knowing. Covert use of microbicides is often seen as unacceptable and the involvement of men as paramount. However, it is important to understand why a microbicide is necessary in the first place and to look at the realities of women's lives - that many women are vulnerable to HIV and STIs for many reasons including the fact that they have little power in their relationships. Not all microbicide usage will be 'covert'; some women will be in a position to communicate with their partners. Many other women will not be able to, or will choose not to negotiate use of a microbicide with their sexual partners and for these women covert usage is one of necessity or choice.[182]

Despite the above reservations, working with men can provide opportunities to challenge the position/power they hold in society and in their relationships. Men's dominance in deciding how and when sex takes place, their use of violence against women, their reluctance to pay attention to their health needs and some men's resistance to using condoms are among the biggest challenges to reducing HIV risk worldwide.[183] Corresponding work aimed at women and men in the community should not be neglected because the wider community plays a crucial role in reaffirming negative constructions of masculinity. It is important to identify specific work with men that has been shown to significantly re-define masculinity in ways

---

[181] Bujra, J. 1999

[182] Tallis, V 2002 b

[183] Barker, G. 2000

that challenge the status quo and can impact on sexual vulnerability of both men and women.

Programmes with women, including married women, must continue to be supported. Whilst women may be vulnerable this does not mean that they are powerless. Programmes empowering women do work and provide an important arena for more focused work on their needs. Although gender-sensitive approaches are a good start, the empowerment of women is an important goal and a means to truly address the spread of HIV and AIDS. However in most societies empowered women are often mistrusted and marginalised within their own communities. Only with the transformation of gender relations at all levels of society will women and men be able to have healthy relationships.

Approaches that empower

Programmes that empower women focus on improving access to information, skills, services and technologies, but also go further to ensure participation in decision making at all levels.[184] Empowerment, in its most literal sense refers to people taking control over their own lives, gaining the ability to do things, to change and define their own agendas.[185] This view of empowerment implies collective and personal empowerment. Steps include building a positive self image and self confidence, developing the ability to think critically, building up group cohesion and fostering decision making and action.

Approaches that empower start with people's lived realities which are complex and diverse.[186] Lived realities are experienced differently by each individual through three critical and inter-linking levels, identity, services and institutions. These aspects and levels will be more or less important in different contexts and at different times in a person's life.

---

[184] Cornwall, A. and Welbourne, A. 2003
[185] Young, K. 1997
[186] Cornwall, A. and Welbourne, A. 2003

Empowerment requires genuine participation; the "intent to hand over power to interpret, analyse and come up with solutions".[187]   Participation can lead to more efficient development; participation is also empowering is an end in itself. People most affected by any development issue must be part of the process of defining the problem and finding solutions. In responding to HIV and AIDS, this will include the poor and the marginalised, for example, women, men who have sex with men and injecting drug users.

Empowerment can be seen as an end in itself, as well as a means to an end, that is, the transformation of gendered power relations. When women and men are empowered, they are able to take the necessary actions at a personal, group/collective 'community' level and at an institutional and broader societal level to confront, address and shift the inequality within gender power relations.

Claims of empowerment, however, are often just rhetoric.[188]   Given that HIV in Africa is transmitted largely through heterosexual sex in the context of gender inequality, impacting on the spread requires a transformation in gender relations. In this context, the focus has been on the 'empowerment of women' but in practice, transformations in gender relations are hard-won against the embedded structures of male power, even where, as in the case of AIDS, sexual relations put men at risk too. If the reality of power is neglected, the call for empowerment may remain little more than a slogan.[189]

2.4 Summary

The HIV and AIDS epidemics impact on women's lives in different ways. Women's vulnerability to HIV infection is drive by a complex combination of personal and societal factors.   Furthermore, the impact of AIDS programmes cannot be disregarded; depending on the underlying principles, content and programme

---

[187] Akerkar, S. 2001, p2
[188] Tallis, V. 2000. Baylies, C. and Bujra, J. 1995
[189] Baylies, C and Bujra, J 1995.

design, organisations and institutions responding to HIV and AIDS can either increase or decrease vulnerability.   The responses to date have fallen far short of what is needed to make a significant impact on the epidemics in general and on women's lives specifically.   Recent moves to scale up programmes in an attempt to make a greater impact, for example, male circumcision, will impact negatively on women.

Given the underlying causes of HIV and AIDS, and the current responses to date, it is obvious that alternative approaches to the pandemics are needed.   A feminist approach would be based on the fundamental belief in the need to challenge women's oppression and to transform society beyond ensuring women and men's equality.

Power is at the centre of understanding women's oppression.   Subverting power is also seen as a critical strategy in transforming patriarchal society.   Feminist responses are mindful of both women's position and condition, addressing the structural factors driving the epidemic, as well as ensuring that short term strategies, such as service provision, understand women's realities and integrate the realities into programming.   The next chapter explores in greater detail feminist approaches to power.

Chapter Three: Theories of power. Feminism in action

3.0 Introduction

The premise on which this thesis is based is that power can be seen as both a driving force on the pandemics, especially in relation to the position of women, and also as a potential solution to address and mitigate the impacts of the pandemics on women and girls.

There are two approaches to analysing and understanding power and gender.[190] Firstly, one can address the issue by taking gender as the central concept, and develop a specific feminist theory on power, inequality and the impact on women, men, girls and boys. Alternatively, one can take power as a central concept and integrate a feminist or gendered understanding to explain the realities of the lives of women and men. In reality, the two concepts are indivisible and therefore need to be addressed together. For the purposes of this thesis I have chosen the first option: to see gender and gender relations as the starting point, given that feminist theories of gender are also about power, whilst very few theorists on power take into account issues of gender.

This chapter provides a theoretical underpinning to the discussion on power as problem and power as solution. Although traditional theories of power will be touched upon, the discussion will be based on feminist theories of, and responses to, power, that is addressing three types of 'positive' power– power to, power with and power within.

Firstly it is important to define and analyse the contested term "gender".

---

[190] Davis, K. 2002

3.1 The 'problem' of gender

Gender is a critical core of feminist scholarship, and provides both a paradigm and an analytical tool to provide a detailed analysis of social life and the social order. The term was introduced by the feminist movement in the 1970's as a conceptual framework to understand the relationship between men and women and theorise patriarchy.   Patriarchy refers to a system of male domination which oppresses women through its social, political and economic institutions:[191] patriarchy / male dominance is evident at the different sites of struggle, women's bodies, intimate relationships, the household, family, community and society.   Characterised by power, dominance, hierarchy and competition,[192] patriarchy is a system that cannot be reformed but instead needs to be eradicated.   Patriarchy provides feminists with a concept that describes the totality of women's condition and position.

Some feminists[193] believe that patriarchy has been eroded in the past two decades. Whilst it may be true to say that in some parts of the world women have greater access to political processes as well as economic resources, this does not translate to the transformation of a patriarchal regime. Even in countries were the inequality gap has lessened, women are still oppressed in their personal domain; women's bodies and intimate relationships are still contested sites of struggle. In the South, male domination is very apparent and remains a useful concept to frame the realities of women's lives.   It is also important to locate, within a patriarchal framing, women's experiences of race, class, religion, sexual orientation, ethnicity etc.

As noted, gender has now become a multiply defined term and is open to different understandings. Whilst initially it was a political term, in recent years it has lost its political undercurrent: what is now known as a "gendered" approach is often at the expense of a feminist agenda which gives a high priority to help women change or

---

[191] Humm, M. 1995. Saunders, K. 2003

[192] Tong, R. 1997.

[193] Saunders, K. 2003, Humm, M 1995

transform power dynamics.[194]   Through the mainstreaming of gender, the understanding of the term has become descriptive, focusing on the roles and responsibilities of women and men as different but not problematised.[195]   Griffen cautions against the use of gender as an analytical tool as it distorts the real issues and only provides support for some levels of gender equality, which ignores the fundamentals of feminism.[196]   In a feminist use of the term, gender is "not simply regarded as matter of difference but rather as the power of asymmetry."[197]   Within this asymmetry there are three elements of gender to be considered: firstly, the individual, including how men and women behave, their beliefs and attitudes and gender identity; secondly, the social structure, including gendered divisions in the social activities of labour and thirdly the symbolic orders, including gender representations, and what is understood by masculinity and femininity.[198]   Critical to a feminist understanding, and not evident in more mainstream uses, is the power imbalance between women and men, and the resulting oppression of women.

The question is whether current gender discourse is diverting the feminist agenda, which is essentially to resist women's subordination and patriarchal institutions. For some feminists the term gender has become so distorted that its initial meaning has been lost and it has in fact become counterproductive to addressing women's oppression.   In short, gender is diverting the feminist agenda, which is first and foremost to resist women's subordination and patriarchal institutions.[199]

> *"The shift from tacking women's oppression under patriarchy (that is, feminism) to a focus on gender equality as a development issue (that is,*

---

[194] Baden, S., and Goetz, A.M. 1999

[195] Tallis, V. 2002 a.

[196] Griffen, V. 2002.

[197] Davis, K. 2002. p 210

[198] Davis, K. 2002.

[199] Griffen, V. 2002.

gender mainstreaming and gender sensitivity) has been a concern for some feminists because it has de-politicised the struggle for women's rights".[200]

Given that gender once was a political term, and that it has to some extent been accepted into traditional responses to HIV and AIDS, it is important to determine how to ensure that gender work does not lose track of feminist principles and objectives. A useful framework is that of Jahan who presents two gender-mainstreaming approaches[201] - integrationalist and agenda setting. The integrationalist approach[202] to gender mainstreaming builds gender issues within existing development paradigms. Whilst widening the concept of women in development to include men, the overall agenda is not transformed. Instead each issue is adapted to take into account women and gender concerns. Within the integrationalist approach, the term gender may be used, but not the concept as it was originally defined. The integrationalist approach is the most common way of understanding and operationalising mainstreaming.

An agenda setting approach looks at the transformation of the existing development agenda with a gender perspective. The key strategy is the participation of women in decision-making, and more importantly, women who are involved in development decisions need to represent the needs of women. In this way it is possible to bring about fundamental change. Women becoming part of and re-orientating the mainstream.

For many working in the HIV and AIDS sector, government, NGO and community based organisations (CBO) a technocratic, depoliticised view of gender is evident in policy, planning and programming. What constitutes a gendered approach should be defined by both who one is working with (women, men or men and women), as well as what one is doing. Initially a 'gendered' approach meant working with only women, for example, either working to address practical needs or attempts to

---

[200] Griffen, V. 2002. p7

[201] Jahan, R. 1997.

[202] Jahan, R. 1997.

empower. However, the belief that women are "powerless" and are unable to affect change on their own, given the many factors constraining women's ability to negotiate safer sex the focus has changed. For some, the "limitations" of working with women are couched in protectionist terms:

> *"Empowering women in contexts where gender inequalities are pervasive necessarily runs the risk of heightening tensions and increasing violence against women".*[203]

Even more problematic is the belief that empowerment of women actually increases the risk of HIV transmission

> ..."*when young girls, operating in an environment where human rights discourses are available, use the newly discovered power of their sexualised selves to take voluntarily numerous sexual partners.*"[204]

A gendered approach may now mean working with women and men, or with a focus solely on men. This is evident in HIV and AIDS where the focus of many programmes and campaigns is now on "involving" men. As discussed in chapter two, this is not a problem in and of itself, but when programmes targeting men are at the expense of programmes for women, or target men but do not challenge gender inequality or entrench the status quo, such approaches are counterproductive and dis-empower women.

The focus on gender inequality has heralded a move away from women's resistance to patriarchy, and from feminist concepts of transformation of social institutions to ensure women's rights and empowerment. There are concerns about gender as an analytical tool (and therefore a more technocratic approach) and the distortion it has caused by superficially supporting gender equality which ignores the fundamentals of feminism, that is the need for transformation of patriarchal

---

[203] Epstein, D, Morrell, R, Moletsane, R and Unterhalter, E. 2004. p7

[204] Hunter in Epstein, D, Morrell, R, Moletsane, R and Unterhalter, E. 2004. p7

institutions. Key to this discussion perhaps is in the agendas of who uses the concepts and the approaches. Although we have moved way beyond second wave feminist distinctions of liberal, radical and socialist feminism, there are still many types of feminisms, and different discourses and methodologies. In short, it is possible to still use gender tools in a way that keep the political understanding of the concept, and it is important to acknowledge that not all so called gendered approaches are political.

3.2 Understanding power

Literature on power over the decades clearly demonstrated that it too is a contested concept; there are many theories of power using different discourse and paradigms. Power can thus be seen as polysemic, in that it has multiple and diverse meanings which are appropriate to different settings and concerns.[205] The complexities of power are highlighted in the literature. Lukes cautions against attempting to define power, given that the multiple understandings of power are context sensitive and specific; however it is important to begin to define the concept, in order to better understand how power operates and how it can be subverted. As Allen[206] notes, the aim of definition is to provide a useful analysis for (feminist) theorists to seek to understand, analyse and contest women's oppression. As a starting point the following definition highlights some key aspects.

Power is

> .... *"a set of processes whereby one party (be it an individual, group, institution or state) can gain and maintain the capacity to impose its will repeatedly upon another, despite any opposition, by its potential to contribute or withhold critical resources from the central task, as well as by offering or withholding reward or by threatening or invoking punishment".[207]*

---

[205] Lukes, S. 2005

[206] Allen, A. 1999.

[207] Lipman-Bhimen , J. 1994. p110

There are important elements contained in this definition that have resonance with other mainstream definitions of power. Firstly, power is a process and secondly power over is a way of enforcing will through the utilisation of various coercive methods to maintain power.[208] Some elements of this definition are disputed. For example the notion of individual power is disputed by Arendts who states that

> *"Power corresponds to human ability not just to act but to act in concert. Power is never the property of an individual: it belongs to a group and remains in existence only as long as a group keeps together".[209]*

However, most feminist theorists believe in individual and collective power and the need to harness both. Power is seen to be fluid, pervasive and socially embedded,[210] and as such Morriss highlights the fact that power is obtained by virtue of one's position, and this position is guaranteed through group membership.[211]

Adding on from this definition Haugaard reflecting on Giddens[212] presents four aspects of power and relationship:

- Power is integral to social interaction, and is reflected at all levels not just social or political institutions.
- Power is intrinsic to human agency "it is that which mediates the desired or intended outcomes of social actors and the actual realisation of these outcomes in their daily social practices."[213]
- Power is relational, that is it involves two or more actors.

---

[208] Lukes, S. 2005. Morriss, P. 2002.

[209] Arendt in Lukes, S. 2005 p 32

[210] Kabeer, N. 1994.

[211] Morriss, P. 2007.

[212] Haugaard, M. 2002.

[213] Giddens in Haugaard, M. 2002. p214

- Power is enabling as well as constraining. Power can be viewed as structured forms of domination or power over.

3.2.1 Power over

The most perverse type of power is dominance. Lukes refers to power over as "power as potential" in that an agent (individual or group) has power over another individual or group.[214]   Power over is the "ability of an actor or set of actors to constrain the choices available to another actor or set of actors in non-trivial way."[215]   Foucault highlights the many diseases of power; fascism, patriarchy, racism, homophobia.[216]   In such power exists the ability to bring about significant outcomes. Power as domination is present wherever it furthers or does not harm the interests of the powerful and bears negatively upon the interests of those subject to it.[217]   Various mechanisms are used as means by which such power is able to secure compliance, for example, physical, emotional, economical or sexual control, confinement.   Power over is coercive, and it implies the compliance of the "weaker" group.

What does it mean to have power? Lukes believes that having power is being able to make or experience change and also have the ability to resist. This highlights the fact that both the "powerful" and the "weak" have power. Women have the power to, and do, resist, both collectively and individually. Lukes implies that power is a dispositional concept and identifies capacity.[218]   Furthermore he sees a relation between power over (dominance) and resistance, in that power over is maximised if resistance is minimized and power over can be diminished through resistance. This has important implications for utilizing strategies of power in reducing women's vulnerability to HIV and will be discussed in greater detail in the next section.

---

[214] Lukes, S. 2005
[215] Allen A. 1999 p123
[216] Foucault , M. 2002
[217] Lukes, S. 2005
[218] Lukes, S. 2005

How then does domination work? How do the powerful secure the compliance especially of those who are unwilling? And how do we know when domination is at work? Lukes notes that we need to search behind the appearances for hidden, least visible forms of power that may be the most insidious.

> "*Power of the powerful is to be viewed as ranging from across issues and contexts, as extending to some unintended consequences and as capable of being effective even without active intervention".[219]*

It is also important to note that power does not necessarily involve observable action and may also involve inaction. The expression of power may also be unconscious. Power is real and effective in a variety of ways some which are indirect and some which are direct. Based on Lukes theories Rao and Kellener discuss three types of power that add to understandings of how power is maintained: traditional power that is the power to make and enforce decisions, agenda power which is the power to decide what can or is considered in societal, organisational or institutional discourses and hidden power that shapes perceptions and preferences so that people accept that their place in the social / gendered order.[220]   In understanding power it is more important to interrogate forms and operations of power than to focus on who owns power.[221]

Lukes[222] presents three areas of contention in understanding power:

- Agency vs. structural determinism, that is the extent to which a person has freedom of choice

- The nature of power – "is power essentially a straight forward exercise of control or is it more likely to be elusive, ambiguous, complex or subtle?"[223]

---

[219] Lukes, S. 2005. p86
[220] Rao, A and Kellener, D. 2002.
[221] Brown, W. 2008
[222] Lukes, S. 2005.
[223] Lukes, S. 2005. p212

- Consensus or coercion – is power an essential or even desirable fact of a highly organized society or is it simple domination and authority?

According to Foucault, power relations are rooted in the whole network of society. The context is everything, and the study and understanding of power needs a starting point that is more empirical and more directly related to our present situation.[224] For Foucault studying resistance against power is such a starting point for a deeper understanding of what power relationships are about.[225] He articulates commonalities in modern struggles such as feminism, LGBTI rights, and race. These commonalities include the fact that they are transversal struggles, that are not limited to one country and that the target of the struggles are the effects of power. They are also immediate struggles in that the struggle is against those who are closest and who oppress the most. Although such struggles are urgent it is understood that an instant solution is not a reality. Feminism and other struggles are about questioning the position and status of individuals (who are part of a group and those who are not part of the group). Struggles against power often revolve around questions of identity, for example LGBTI or women.

The notion that power is everywhere does not necessarily mean that power touches all elements of society and it is clear that power does not belong equally to all. This does however, challenge the notion that power is only evident in domination and authority. Power is seen to "construct and organise subjects in a variety or domains and discourses" [226]

Power is a process that both reflects and produces great social change in the dynamic of human interaction.[227] Power dynamics take place between interacting members of a relationship, which is often reduced to the binary "powerful" and

---

[224] Foucault, M. 2002.

[225] Foucault, M. 2002.

[226] Brown, W, 2008. p 67

[227] Batiwala, S. 1994.

"weak". Janeway notes that there is no other way to describe the position of women except in terms of their relationship to, and the effect of power,[228] and that the view of power from below is a useful way of addressing power, in that it subverts power over and ensures that the starting point is not with the powerful. The complex nature of power highlights the need to engage on multiple strategies; whereas individual women experience and resist power over in their personal relationships and own sites of struggle, this is clearly not the only point of entry; resistance to power must also be at the "group" level, challenging patriarchal power at a society level to reduce the power it affords individual men.

In summary, power over is oppressive, divisive and destructive: the power of an individual or group to get another person or group to do something against their will. Power over is enforced through violence or fear or social rules. Power over can also be self-reinforced through fears or rules that women have 'learned' to impose on themselves. Power is about control, not only over human bodies and physical and financial resources but over the ideology which sets rules and ideas.[229] The next section identifies feminist responses to power.

3.2.2 Using feminist theory: Power as an Explanation for Vulnerability

Power over is integral to explaining the elements and experiences of gender inequality and women's oppression. Feminists initially utilised a simplistic understanding of power, that is, to reduce power to a commodity that men had and women did not have.[230] Over the years a more sophisticated analysis has developed, which views power as more than domination, and highlights the nuances and complexities of power as a process that to some extent ebbs and flows. For example, in intimate relations, which are a fundamental site of struggle for women, the interaction between man and woman may be at times friendly

---

[228] Janeway, E. 1981.

[229] Batilwala, S. 1994.

[230] Davis, K. in Haugaard, M. 2002.

pleasant and intimate.[231] However, at the same time, they can also be, and are for many women, sites of oppression, violence and coercion.

Figure 3.1 demonstrates the links between power and vulnerability. Power over or domination has a causal link to personal, programmatic and societal vulnerability.
Figure 3.1 Linking power and vulnerability
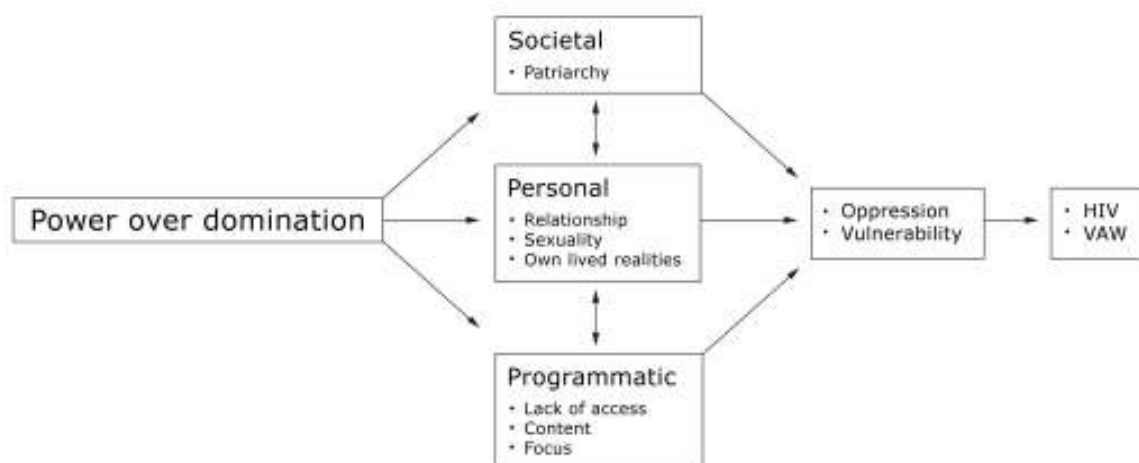
The figure demonstrates that male domination impacts on vulnerability leading to the oppression of women in general and on HIV and violence against women (VAW) in particular.

Allen describes three ways in which feminists analyse power:

- Power as a positive social good, a resource, the distribution of which is currently unequal between women and men. The goal of feminism is to redistribute power as a resource and thus adjust current inequalities.
- Power as a relation that is a relationship of male domination and female submission. Power is equated with domination that includes "a pervasive didactic master/subject relations through which gender is created and

---

[231] Davis,K. 2000.

reinforced".[232]   The goal of feminism is to dismantle the system of domination.

- ▪ Power as a positive conception of empowerment and transformation.

Allen postulates that:

> "A better feminist conception would be one that resisted the impulse to collapse power into either domination or empowerment, but instead highlighted the complicated interplay between these two modalities of power".[233]

This thesis presents case studies of activism that attempts to make sense of the interplay between dominance as problem and empowerment as solution. The aim is to add to knowledge about understanding the power that individual women and diverse groups of women can exercise.

Power is fundamentally relational and whilst feminist theories of power are aware of the impact of intersectionality, that is other identities which may or may not be marginalised and which influence experience and realities, at the centre is the power differentials between women and men.

> .... "masculine domination, and the way it is imposed and suffered, as the prime example of .. paradoxical submission, an effect of what I call symbolic violence, a gentle violence, imperceptible and invisible even to its victims exerted for the most part through the purely symbolic channels of communication and cognition (more precisely, misrecognition), recognition or even feeling".[234]

---

[232] Allen, A. 1999. p7

[233] Allen, A. 1999 p 8

[234] Bourdieu, P. 2001. p1-2

In feminist theory power over is thus a way to understand male domination; both the way it is enforced and the consequences of such domination.

> "*The particular strength of the masculine sociodicy comes from the fact that it combines and condenses two operations: it legitimates a relationship of domination by embedding it in a biological nature that is itself a social construction*".[235]

The precedence universally accorded to men is affirmed through social structures and organisation which includes productive or reproductive activities that are based on the sexual division of labour. This disadvantages women in different spheres of their life.[236] Although hegemonic masculinity, and understandings of the power of the elite, refers mainly to white, heterosexual men, all men benefit in some way from patriarchy and in this have access to power, at the very least in their intimate relationships and the household.

> "*(sexual) intercourse occurs in a context of power relation that is pervasive and incontrovertible. The context in which the act takes place … is one in which men have social, economic, political and physical power over women. Some men do not have all these kinds of power over all women, but all men have some kinds of power over all women; and most men have controlling power over what they call their women*"[237]

Given the relational nature of power and male dominance Davis argues [238] that there is a powerful – powerless binary which explains both women's condition and position in society. However, placing women in a category of complete powerlessness further diminishes whatever power she may in fact have access to. Some theorists, such as Janeway, Allen and Lukes have rejected the notion that

---

[235] Bourdieu, P. 2001. p 23
[236] Bourdieu, P. 2001. p 33
[237] Dworkin, A. in Allen, A. 1999.p 56
[238] Davis, K. 2002.

anyone is completely powerless.[239] No individual or group is either totally powerful or completely powerless:

> "Even the most downtrodden and disenfranchised control some measure of resources, from personal to social, political, financial and / or institutional or some combination thereof." [240]

Davis states that if power relations are strictly of a coercive or repressive kind, it is difficult to account for why women continue to go along with them. Implying that powerlessness is false consciousness, Davis fails to understand that some women simply do not have choices. This does not imply powerlessness necessarily, just that some women's daily, lived realities are of extreme hardship, with few options, such as independently controlled resources. This limits any real opportunity to exert control, for example to leave an oppressive intimate relationship. This reality underscores the complexities of making fundamental changes that will reduce women's vulnerability to HIV and AIDS. All women have some power to challenge and resist, and whether they do so or not is not based on whether power relationships are repressive and is more to do with her own consciousness, internal processes and beliefs and access to resources that enable her to act against oppression.

Allen[241] notes the elements of a feminist theory of power should consider foreground and background perspectives, subject positions, cultural meanings, institutions and structures. The foreground perspective enables an analysis of the bi-directional power relations that exist between individuals and groups, or groups and groups, for example, domination or resistance or solidarity. The background perspective on the other hand focuses on the complex social relationships in which every relationship of power exists, and which provides the context in which some groups/individuals become more or less powerful. Understanding the various

---

[239] Janeway, E, 1991. Lukes, S. 2005. Allen, A.1999.

[240] Lipman-Burmen, J. 1994. p113

[241] Allen, A. 1999

subject positions (and resulting conditions) of women and men in any given society or community, and the impact of power on women's position is critical. It is also important to examine power relations in terms of culturally encoded definitions and meanings, understanding that meanings of masculinity, femininity, sexuality may differ in different cultures, and this impacts on how understandings are intertwined with social practices. Finally, a study of power is not completed if the perspective of the institutional context in which positions, meanings and behaviours are embedded is not analysed. This including understanding the structural elements of power relations, including patterns of distribution and possibilities for resistance.

3.3 Feminism as resistance

"Feminist resistances challenge patriarchal power / knowledges and challenge institutionalized silencing of alternate discourses. Feminist resistances are community based, from the grassroots and are grounded in diverse women's beliefs in their rights but even more in their needs to transform the society in which they live, to change their relationships, home life and or workplaces".[242]

Where there is power there is resistance.[243] Resistance refers to the ability of an individual or group "to attain an end or series of ends that serve to challenge and/or subvert domination."[244] Feminism(s) is a spontaneous reaction against and a strategic resistance to existing power relations,[245] fighting against invisibility and silencing.[246] Power is central in understanding, criticising, challenging, subverting and ultimately overturning the multiple axes of stratification affecting women. Foucault urges using resistance as a "chemical catalyst so as to bring to light power relations, locate their positions, and find out their point of application and the

---

[242] Faith, K 1994. p61

[243] Lukes,S. 2005, Foucault, M. 2002, Faith, K. 1994. Janaway, E. 1991.

[244] Allen, A 1999. p 126

[245] Faith, K. 1994. p47

[246] Faith, K. 1994.

methods used."[247]   The starting point is to address the gender disparities as a universal, yet unnatural, socially constructed power reality, believing that as a structural process it can be deconstructed through consciousness raising and social change.   Feminist resistance is articulated through women's movements and through individuals' actions[248] .   Feminist resistance challenges the dominant and prevailing discourses and paradigms and de-legitimises the status quo that places women in an inferior position.

Some forms of feminism that have a strong belief in identity politics, assert that resistances are formed from the margins "from points of view that are disqualified by dominant discourses."[249]   Fuss warns that one should not romanticize marginalization, as endorsing a position of perpetual or even strategically locating one's self outside is not a viable political programme.[250] However, real or perceived margins can and do provide a metaphorical home and provide people with a voice, a sense of individual and collective empowerment which at the same time produces resistance.   Movements of women living with HIV and the LGBTI movements are examples of working in and from the margins.

> *"The margins which signify disqualification from dominant discourses are also locations from which transformative points of view and social action coalitions can be generated."[251]*

Resistance cannot simply defeat, overturn or suddenly transform power that dominates, but can re-situate the problematic of power abuse.[252] The end goal of resistance is not to overturn one system of dominance for another, but rather to deconstruct power relations by transforming or reconstructing social values and institutions.   Resistance itself is an "exercise of power, as a projection of alternative

---

[247] Foucault , M. 2002. p329

[248] Faith, K. 1994.

[249] Faith, K.1994. p38

[250] Fuss in Faith, K.1994

[251] Faith, K. 1994 p38

[252] Faith, K. 1994 p 39

truths[253]" Faith notes that there is no one resistance but rather infinite multiplicities of strategic resistance.

> *"Women's resistances are community based, from the grassroots and are grounded in diverse women's beliefs in their rights but even more in their needs to transform the society in which they live, to change their relationships, home life and or workplaces".[254]*

Resistance in and of itself, regardless of the outcome or ability to transform, is both an act and a process of power. As noted by Faith "disempowerment accrues from a lack of resistance." [255]   Resistance weakens processes of victimization and generates personal and political empowerment through acts of naming violations and refusing to collaborate with oppressors.

Foucault developed a concept of power that did not locate power in agencies and institutions but instead saw power evident in "micro-operations" utilising strategies and technologies of power.[256] This points to resistance being possible both through confronting state and also in daily interactions and in intimate relationships.
Resistance thus is possible at an individual and collective level. Charles notes that the feminist insistence of the importance of collective as well as individual action in order to transform social relations is critical.[257] There is a danger of focusing too exclusively on one at the expense of the other.

Feminism(s) has produced and continues to offer a mosaic of resistances which address multiple sites of oppression for example, family, education, religion, and heterosexism. Resistance has been on the basis of identity, for example, women, lesbian, or around specific issues, such as rape, violence against women, female genital mutilation, war or environmental issues. It is obvious that resistance is not

---

[253] Faith, K. 1994 p 53

[254] Faith, K. 1994 p64

[255] Faith, K. 1994 p56

[256] Barret in Charles, N. 1996

[257] Charles, N. 1996

static, monolithic or chronological; rather there are "multiplicities of strategic resistances".[258] The long history of the women's movement and the first, second and third waves of feminisms attest to this.

Understanding and addressing the oppression of women and addressing their development issues have undergone many different paradigms shifts over the past thirty years. The evolution of approaches has changed with deepening understandings of the ways men dominate women and how some women dominate other women. Intersectionality is an important aspect in understanding power, taking into account other oppressions based on race, class, ethnicity, age and sexual orientation. Feminist understandings of power thus illuminate a complex and interrelated array of systems of dominance that taken in to account the diversity of experience and circumstance, and have adapted the challenges to power to accommodate this nuanced and evolving understanding.

The long term goal of feminism is the eradication of gender as an organising paradigm of society. As noted by Davis, a social order without gender as an organising dimension and category can exist; what is socially constructed can be reconstructed and social relations can be rearranged.[259]

> *"Adequate feminist analysis of gender relations requires replacing a top down model of power with a model which treats power relations as something to be negotiated by parties who both have access to some resources, albeit unequal ones".[260]*

Feminism as an ideology and philosophy is fundamentally about resistance to the invisibility and silencing that leads to the oppression of women. Feminist resistance is articulated through women's movements and through individual's actions.

---

[258] Faith, K. 1994 p 57

[259] Davis, K. 2002.

[260] Davis, K. 2002 p 220

Resistance represents a particular way of exercising "power to" or empowerment. Resistance is actioned through exerting the power to, that is the fundamental power on which women must build the beginning of an answer to the powers of patriarchy and capitalism.[261]   Power to is the power to mobilise for change harnessing the power to do.[262]   Empowerment that is based on the power to involves gaining access to a full range of human abilities and potentials "resistance and empowerment understood in terms of power to, the capacity of an agent to act in spite of or in response to the power wielded over her by others."[263]   Actions are seen as creative and enabling, as women reconstruct and reinvent themselves, by rising above the barriers and doing things never thought possible.

3.3.1 Power as Solution

Gender oppression, upheld by and resulting in, unequal power relations, provides a context or environment in which, for example, violence against women, trafficking, feminisation of poverty and HIV and AIDS are able to happen. It is thus essential that the core of gender oppression, that is male dominance or power over, is challenged and that this is central to responses addressing women's vulnerability to and impact of HIV and AIDS.

 It is important to be mindful that the traditional socialisation of women is at variance with the skills and qualities generally associated with expressing power, for example, dependence, passivity, nurturance do not generally function to empower women.[264]   Furthermore, women are not a homogeneous group, but for the most part are oppressed and seen as a subordinate group, and the degrees of power women have are culturally and socially determined. It is fundamental that women must harness their own power as a response to addressing the powers of repressive societal norms, social and economic marginalisation and patriarchy. It is necessary to focus on the power that women retain, despite masculine domination.

---

[261] Allen, A. 1999

[262] Kabeer, N. 1995

[263] Allen, A. 1999. p125

[264] Travers, M. and Bennett, L. 1996

More positive forms of power that can be used to challenge and subvert power over, are, according to Allen viewing power as resource, as resistance and as empowerment[265]. Feminists writing about power highlight three types of positive power; the power to, power with and power within.[266]

Power to

Harnessing the power to is similar to resistance, the object being gaining access to the full range of human abilities and potentials. Power to is the power to mobilise for change and the power to fight for justice.[267] Actions that demonstrate the power to weaken processes of victimisation and oppression and generate personal and political empowerment through acts of naming violations and refusing to collaborate with oppressors.[268] Exercising power to is both an act of, and leads to, empowerment. The ultimate goal of empowerment is "the ability of the disempowered to act collectively in their own practical and strategic interests."[269]

Power within

Harnessing the power within, refers to a bottom up approach reflecting women as "competent but constrained actors who are capable of making choices, articulating priorities and taking responsibility."[270] Power from within is power that is self-generated. It is the recognition that one is not helpless and not the source of all one's own problems. Power within is the basis for self-acceptance and respect which extends to respect for and acceptance of others.

---

[265] Allen, A. 1999.

[266] Kabeer N 199. Allen, A. 1999.

[267] Kabeer , N. 1994.

[268] Allen, A. 1999.

[269] Kabeer, N. 1994. p256

[270] Kabeer, N. 1994. p 25

Understanding and using power within involves a consciousness raising process in which women are able to reflect, analyse and assess their lives, especially on what has so far been taken for granted.   This involves uncovering "the socially constructed and socially shared basis"[271] of the realities of women's lives. Empowerment strategies for women "must build on the power within as a necessary adjunct to improving their ability to control resources, to determine agenda's and make decisions."[272]

Power with

Power with is synonymous with acting in solidarity, and refers to collective action. Power with is the capacity to achieve with others what one could not achieve alone, to act together for the attainment of a commonly agreed goal, that is agreed-upon end of challenging, subverting, and, ultimately overturning a system of dominance[273]. It represents the kind of power that a diverse group of women can exercise collectively when working together to define and strive to achieve common aims. For example, women working together in solidarity include self-regulatory boards made up of sex-workers and brothel owners that seek to address trafficking and other issues facing sex workers.

It is important to stress that the notion of "sisterhood" as solidarity, where all women are motivated to fight gender inequality may be erroneous. Whist some women may stand together in solidarity it is in no way a given, and some women do not experience gender inequality as an issue. Such women may chose to collude with those opposed to feminist resistance, and stand firmly on the other side. An example of this is the polarised divide between women supporting the rape survivor and those supporting Jacob Zuma touched on in Chapter eight.

---

[271] Kabeer, N. 1994 p 245

[272] Kabeer, N. 1994 p 229

[273] Allen, A. 1999 p 127

This feeds into a short diversion into identity and power, a theme that runs through this thesis.

3.3.2. Identity and Power.

According to Mama, identity is "all about power and resistance, subjection and citizenship, action and reaction"[274]   It is important to rethink identity if we are to comprehend power.

Identities are hybrid constructions.[275]   As noted by Hall[276] identity is more than 'being' and should be viewed as a process rather than being static.   Essentially, identities are "fluid rather than fixed, constantly in the process of being constructed and deconstructed as the social context changes."[277]

Identities in this thesis are positioned in relation to geography and location, sexuality, political position, ideology, body and subject position – that is victim vs survivor.. Identity is fluid, circumstantial and yet many of the women interviewed for this study had strong sense of identity.   It is important to stress multiple identities, for example, defining one's identity as women, as black women, as black women living with HIV and AIDS.   The notion of changing identities, based on evolving and different contexts are evident in this research – and Jacobs notes that identity cannot be divorces from context – including material factors and historical legacies[278].

The link between identity and power is demonstrated in this thesis by different subject positions, such as woman, lesbian, trafficking survivor and the power and influence that they have, individually and collectively.   However, this cannot be reduced to a cause and effect, that is, although it is easy to relate different

---

[274] **Mama, A. in Daigne, S.B, Mama, A, Melber, H and Njamnjoh, F. B. 1995 p 13**

[275] Zegeye, A 2001

[276] In Wasserman, H and Jacobs, S 2003

[277] Wasserman, H and Jacobs, S 2003. p 15

[278] Jacobs, S. 2003

identities to powerless and powerful, these are not binary terms: that is although power and identity are linked one cannot only understand power through identity and vice versa.

3.4 Summary

Power is both the source of oppression and the source of empowerment and transformation.[279] The premise underlying my thesis is that patriarchy (which is driven and maintained by one group's power over another group) is the "problem" driving the pandemics, especially for women, and that such power can be challenged in various ways and therefore can also be viewed as a solution. This research seeks to examine how power can be used in positive and effective ways. That is, to understand how different applications of power can also provide solutions to challenging the gender inequality that drives the pandemics. Both individual and collective subversions of power are useful and necessary. Critical issues in how feminism can address power include how to achieve solidarity, how to minimize difference and how to challenge the status quo towards systematic change.

Through the presentation of case studies which examine power processes I hope to demonstrate concrete and practical examples of using different types of power, subverting power and individual and collective empowerment. The next chapter will outline the methodology used.

---

[279] Radke, H.L. and Stam, H.J. 1994

Chapter Four: Methodology

"Some of the most profound contributions of feminisms have been in the building of oppositional knowledge: knowledge that challenges the system of privilege, whether it be expressed at the social or interpersonal level. New and innovative methodologies are essential to this pursuit" [280]

4.0 Introduction

Methodology refers to both the theory and analysis of how research is carried out:[281] in this research, feminist methodology was used. Doing feminist research claims a particular theoretical position on the part of the researcher.[282] In other words, the researcher needs to have an understanding of feminist theories as well as an inherent belief in feminist principles and identify as a feminist. Feminism is a perspective or paradigm and not a method,[283] and although it informs methods used, it more importantly shapes the entire research process in a fundamental way.

Feminist social research methods are 'intrinsically political.'[284] The feminist researcher, more than likely has different identities over and above that of researcher which could include activist and advocate. Feminist activists as researchers see "the right to establish the facts as being central to the exercise of power" but also look at ways to ensure the right to research is part of resistance efforts as well.[285]

There are specific considerations that should be part of research generally but are highly significant in feminist methodology. Research methodologies using a

---

[280] Travis in Crawford, M and Kimmel, E 1999. p 2

[281] Harding, S. 1987. Beetham, G., and Demetiades, J. 2007.

[282] Watts, J 2006, Crawford, M and Kimmel, E. 1999.

[283] Crawford, M and Kimmel, E. 1999.

[284] Watts, J. 2006. p 386

[285] De Vault. M.L. 1999 p 1

feminist perspective[286] are critical of the hierarchical power relations between men and women that disadvantage women. This includes understanding gender inequality as inherent in what is being researched as well as being reflected in the research process itself. Over and above tackling gender oppression it is also important to take into account other layers of oppression and marginalization, and ensuring that the voices of the marginalized are integrated into all levels of the research process. Feminist research demands that women are at the centre of research, relationships between and among all involved in the research process are analysed and that any potential harm and control during the research process is minimised. Feminist research often utilises qualitative methods that are non-traditional in other research paradigms.

Critical to the outcomes of feminist research is knowledge that can be applied, and that is practical and concrete.[287] Feminist researchers create knowledge, but go beyond that to make social judgments about the applicability of the knowledge and advocate for social change to benefit girls and women. "Oppositional research" is a term used to describe feminist research that is committed to challenging gender inequality and oppression.[288] This was crucial in my decision to use such methodology: I wanted to ensure that the research was relevant, could be applied to the response to HIV and AIDS, and would make a fundamental difference to the lives of women and girls. Given that the research is about power, and that research is a political process, I also wanted to use a methodology that addressed power in the research process, as will be explored later in the chapter.

4.1 Aim of the research

A critical underpinning of all feminisms is that the personal is political; this refers to the situations of individual women but also reflects the belief that all actions that address women's issues and lives are also political in nature. The act of research is

---

[286] UN-INSTRAW in Beetham and Demetiades 2007. De Vault, M. 1999

[287] Crawford, M. and Kimmel, E. 1999.

[288] De Vault, M.L. 1999.

highly political, and this extends from formulating the initial research questions, to the decisions regarding data collection and analysis and importantly to what happens to the knowledge created after the research is completed. The fundamental aim of doing feminist research should be to improve and benefit women's lives. The researcher must demonstrate a commitment to both the group(s) of women who are directly part of the research process, and also add to the body of knowledge of the difficulties and challenges of women's lives in ways that can be applied to addressing the oppression of women and gender inequality.

A critical aspect of feminist research is thus carrying out research of value to women, which will contribute to social change. This may include changing theory, bringing new topics into the discipline, consciousness raising, producing data that will stimulate or support political action or policy change.[289]

The aim of this research is threefold:

- To add to the knowledge of women's vulnerability to HIV infection and the impact of AIDS on their lives,
- To add to the theory of power, specifically to identify ways in which subverting power can be instrumental in reducing women's vulnerabilities, and assist in improving women's lives,
- To produce knowledge that can be used for political action against women's oppressions, and inform specific areas for policy change that will benefit women.

As with all research there are certain limitations. The protracted nature of data collection, from 2000 – 2008 may limit the reliability of the data. However, in the case studies where the information was collected prior to 2004 follow up interviews yielding updated information has been added to supplement findings and this could be viewed as strength.

---

[289] UN-INSTRAW in Beetham, G. and Demetiades, J. 2007.

The focus of the thesis is mainly Southern Africa, although one chapter highlights experiences in South Asia. There is a plethora of responses to HIV and AIDS, albeit fewer examples that employ a feminist methodology. The region specific focus may have resulted in case studies that would have added more to the research This may have been compounded by my own bias for what I saw as specific examples of using power in different ways.

Feminist methodology, may, in some minds, be seen to compromise reliability and validity. I however believe that the methodology was appropriate for the subject of the thesis and that it added to rather than detracted from the overall acceptability of the findings.

4.2 Process and Power

This research is about power relations, with the belief that power can be subverted and used in different ways that are less dominating and hierarchical; however it is important to see that power is also inherent in the research process itself, and must be addressed as a critical issue in feminist research. The research process, especially the power relations between researcher and participant/interviewee, needs to be managed carefully and sensitively. In part, sensitivity of and awareness to, the different relations to the production of knowledge between researcher and the research participants, will minimise the power dynamics but in reality the researcher needs to be more conscious, and ensure certain steps are in place that concretely address the potential of inequality in the process.

Feminist perspectives are critical in examining gender and power relations in various sites of struggle. Feminist methodologies "emphasize participation, empowerment, and accountability during all stages of the research process".[290] In interviewing, especially interviewing the marginalised, the power of the researcher

---

[290] Beetham, G., and Demetiades, J. 2007 p 204

needs to articulated and challenged. Feminist researchers reflecting on method need to

> *"reassess the utility of models of power which constitute a rigid demarcation between oppressor and oppressed and perhaps critically appropriate a framework which imagines power as shifting, multiple and intersecting".[291]*

Understanding and challenging power is thus not only top down but also dispersed throughout the research relationship as well as the research process.[292]   It is important and achievable, to redefine the binary that is present in other research methodologies and models, that is that the researcher is powerful and the researched are powerless.

The process of knowledge production should always be visible, and the feminist researcher should find ways of recognizing and revealing to audiences the "micro-politics of the research situation and should take responsibility for representing those who participate in ways that do not reproduce harmful stereotypes.[293]   The focus of feminist research is first and foremost the lives and experiences of women and girls. Information from women's individualised and personal experiences are important, and understandings of women's condition and position are extrapolated from the personal stories.

Another important consideration is ensuring that the voices of those most marginalised in a particular group are also heard; for example, women living with HIV are not a homogenous group – the experiences of an HIV positive lesbian may be different to a young heterosexual woman living with HIV. Likewise, regional differences may be apparent, for example, there are different issues raised by women in Southern Africa to those in South Asia.

---

[291] Foucault , M. in Thapar-Bjorkert, S and Henry, M. 2004. p 364

[292] Thapar-Bjorkert, S and Henry, M . 2004.

[293] Bhavnani in De Vault, M.L. 1999.

In this research, I endeavored to present the voices and experiences of as many women as possible: women living with HIV, with different realities such as location, sexual orientation, class. The research also includes the other voices of women who are directly and indirectly affected by HIV and AIDS, for example, women who have been trafficked, sex workers, lesbian women. Thus, a diverse group of women were interviewed for this thesis in both Asia and Southern Africa that underscore differences in age, experience, HIV status, class, sexual orientation, location, race, religion, culture and tradition mindful that gender is only one component of identity.

My aim was to interview, and present, as many voices of those women most affected, including women leaders in the field, to ensure the amplification of marginalised voices. I was conscious of power in my various positions and tried to miminise that power in the research process, for example, by enabling women to comment on both the processes and the outcomes, allowing women to talk freely about their issues and to make the interview environment (and workshops) as safe and comfortable as possible.

In some instances, for example, the paper on the realities of women living with HIV as well as the research into the sexual and reproductive rights of women living with HIV, I created knowledge with others. For both these pieces of work I was contracted to produce paper. However, I wanted to involve those most affected as an integral part of the knowledge process and not do research as a top down, extractive process. In situations where I collected and analysed knowledge on my own I held feedback meetings with participants when appropriate and possible.

Whilst the power differentials between researcher and those being "researched" are a reality, it is possible to do research that minimizes power and control, does no harm, and in fact provides new information and adds to the body of theory that will in some way contribute to reducing women's oppression.

4. 3 Research methods

The nature of women's oppression in general, and HIV and AIDS in particular, demands methodologies that are responsive and able to adequately deal with the subject matter. Sensitive methodologies need to be able to adapt to "different circumstances and situations".[294] For example, when interviewing women living with HIV with issues of confidentiality are of the utmost importance, along with often dealing with painful experiences and the impact of exploring those in an interview or workshop has to be handled carefully. Another example is the implications of interviewing sex workers in contexts where sex work is illegal: the prime objective should be to ensure that the women interviewed are safe and that no harm is done either before, after or during the interviews.

Feminist researchers have modified rather than invented research methods; however, the body of feminist writing on research is where feminist methodologies can be located.[295] For example,

> *"important to the concept of research from a feminist perspective is the recognition that there is not one specific method or combination of methods that makes research feminist but rather that the research comes from an approach that is considerate of the multifaceted nature of gender".[296]*

The fact that feminist methods are in many cases adapted from more traditional research methodologies does not mean that feminist research methods are not innovative. Innovative feminist research methods are characterised by an awareness of the personhood and involvement of the researcher[297] in ways that she or he is able to collect vital, rich information that is relevant.

In general, the complex realities of women's lives are seldom reflected in more generalised research which does not have at its core, at the very least, a gendered

---

[294] Beetham, G., and Demetiades, J. 2007.p 199

[295] De Vault , M.L 1999.

[296] Beetham, G., and Demetiades , J. 2007. p 199

[297] De Vault . M.L 1999.

framework. Feminist research methods are about excavation: that is, the recovery of unrecognised, distorted and suppressed aspects of women's experience. Feminist researchers spend time in the field, to look closely and unobtrusively, in order to develop analyses that aim for faithfulness to what is actually happening in particular local settings; that is, women's experiences, in order to add to the body of knowledge on the complexities of women's oppression.[298] Often to do these traditional methods need to be adapted, in order to meet the criteria for doing feminist research. More specifically, researching the nature and complexities of power relations, is difficult and "a diversity of tools and angles are needed to disentangle and contest them."[299]

I used different methods to collect the data for each of the chapters, such as in-depth interviews, observation and document analysis. Feminist research methodology acknowledges the different roles of the "researcher" which may include activist, advocate, service provider or facilitator: I collected some data when my primary role was as an activist and some when my primary role was as a researcher. Data collected as "researcher" followed guidelines set out in literature on feminist research methodologies. Data collected as an 'activist' enabled me to gather rich data and deepen my understanding through the varied work I was involved in. Whilst this was not always a conscious process in that I was not operating as a "researcher", the information collected during different processes, be it facilitating a workshop, participating in meetings or in my activism, informed my thinking and added to the body of knowledge when I was writing the different chapters. In some instances I have included other research that I carried out in my working role, research within research, some of which has already been integrated into advocacy strategies.

It is important to note that some of the research methodologies were chosen purposefully, whilst others were more 'opportunistic' in that if a situation or process occurred which I was involved in, and which added to my knowledge, I used the

---

[298] De Vault, M.L. 1999.

[299] Lewis in Beetham, G., and Demetiades , J. 2007. p200

information to inform and extend the thesis. The different methodologies are described below, with a more detailed explanation of why specific methodologies were chosen over others.

Chapter five highlights the specific role that donors play in influencing the agenda of NGO's and CBO's through the areas that they fund, their policies on gender and or women and the technical assistance they offer. The data for this chapter was collected in two stages. Stage one involved a detailed study of one donor, the Joint Oxfam HIV/AIDS Programme (JOHAP) based in KwaZulu Natal, South Africa during 2002/2003. In-depth, structured interviews were conducted with key stakeholders at all levels of the of the aid chain, including the lead donor, other donors in the partnership and funded organisations. In-depth interviews, using broad and open ended questions allowed me to explore different themes with key role players, giving more control in the interviewing process but also enabling the voice and experience of those being interviewed to strongly emerge.

A document analysis of donor policies, procedures and requirements was done; this included policies of the back-donor, the lead agency and the partner donor organisations. My personal experience as a board member of a funded organisation, who participated in various processes organized by the donor provided me with useful information regarding how the donor interacted with partners and I attended two partner platforms (JOHAP meetings on specific themes with all its partners held once a year) in this role. Furthermore, I was a consultant for the donor featured in the case study which gave me inside knowledge of the organisation philosophy and practices. Finally, I attended an evaluation meeting with the lead organisation, Oxfam Community Aid Abroad, (OCAA) in Australia.

Stage two was conducted during May and June 2008. In-depth interviews were held with six INGO's and Private Foundations to determine funding priorities and to ascertain how much money was going to address women, girls HIV and AIDS. One of the organisations interviewed was JOHAP, providing an opportunity to validate information contained in the case study. In an effort to verify the information

collected from donors, and to understand the experiences of the grantee or partner, the experiences of six NGO's and CBO's who represented either a women's organisation working on HIV and AIDS, or an AIDS organisation with a strong women centred agenda were captured through in-depth interviews. At the onset, the challenges in the research process reflected power dynamics inherent in the donor relationship. The data collection phase was much longer than originally anticipated, and it proved difficult to secure and conduct all the interviews. Furthermore it was difficult to get the information required, partly because people interviewed did not necessarily have the details readily available and partly because information about funding strategies, policies and amounts is sensitive.

Chapter six provides two case studies of social movements – one organising around identity and the other organising around an issue. For the purposes of the study, and to raise specifically a women centred agenda, I chose to examine the work of the International Community of Women Living with HIV and AIDS (ICW) as for many years it was the only organisation specifically for women living with HIV and AIDS. I chose to focus on microbicides for the second case study given that the need for a woman controlled prevention technology was initially advocated for by women's rights activists, and will be a critical part of the prevention response to reduce women's vulnerability.

Information for case study one was gathered in different ways over an extended time, from 1998 to 2008. Interviews with women living with HIV and AIDS were held over the time period noted and included informal personal communication around different issues and challenges as well as more formal interviews using a questionnaire. In 2002, I was hired by ICW to write a paper on women's experiences which would be presented at the Gender AIDS Forum (GAF)/ICW conference *"Confronting Marginalisation"*, and be used as an advocacy tool to raise the issues of HIV positive women. Rather than interview women and write up their experiences, I decided on a more participatory approach which ensured that the women themselves were more involved in the research process. I designed and

facilitated a workshop with seven women and encouraged them to talk about their lives. I then asked each woman to write out her own stories and identify key challenges and issues. Based on all the writings I wrote a paper incorporating the voices of the seven women, and cited them as co-authors. The paper was further discussed in a follow up workshop and then finalised. The process gave me some rich information about women living with HIV and their life and experiences in KwaZulu Natal.

Further ICW consultancy work included the design, facilitation and documentation of workshops for women living with HIV. The first workshop was held in Zimbabwe in 2002 with 23 women living with HIV and AIDS who had been trained as data collectors for the Voices and Choices project, which focused on sexual and reproductive rights. The purpose of the 5 day workshop was to build skills in and develop an advocacy plan for HIV positive women in Zimbabwe.

I designed and facilitated four Young Women's Dialogues – a project aimed at raising consciousness and to identify the issues specific to young (between the ages of 18 – 30) HIV positive women. The first of the 5 day workshop was held in Durban in 2004 with 21 women from Eastern and Southern Africa. Subsequent workshops were held in countries: Swaziland with 21 participants in 2004, South Africa 25 participants in 2006, and Namibia 26 participants in 2008.

In 2005 I facilitated two four day workshops, one in Swaziland and one in Lesotho with women living with HIV that were designed to mobilize political commitments. Women in the workshop identified specific issues that they want addressed and an advocacy tool was developed to assist women in assessing the extent of denial of rights and ways to address policy makers. In 2007 I facilitated a workshop for 15 women living with HIV and AIDS in South Africa to analyse the situation regarding forced and coerced sterilisation and to design a strategy to address the problem.

In 2006 GAF was approached by Ipas to write a paper on experiences of women living with HIV in South African in accessing their sexual and reproductive rights in health care settings. As the lead researcher I developed a methodology to ensure that the participation of women most affected was integrated into the research process, and that HIV positive women were part of the research conceptualization, data collection, analysis and writing. The group consisted of eleven women; only three had ever done research before. The majority of the women in the team were HIV positive. We split into three teams and interviewed both health care providers in various clinics in KwaZulu Natal as well as HIV and AIDS organisations that specifically work with women living with HIV. Nine focus groups with 8-10 women living with HIV were conducted. At the end of the focus group women were asked if they wished to be interviewed; in-depth, semi-structured interviews were conducted with those women who agreed. Given the sensitive nature of the interviews this recruitment method was used so that women were clear, based on their participation in the focus groups, as to what to expect in the one-one interview. This research gave excellent in-depth insights into the experiences of HIV positive women accessing services and defined an advocacy agenda for women living with HIV.

Data for case study two on microbicides was collected from 2000 – 2005 during my activist involvement in microbicides processes, including attending meetings in Johannesburg on community participation facilitated by the Global Campaign for Microbicides (GCM) and the GCM board and strategy meeting held in London during December 2005. Further data was collected through research and interviews done as a key correspondent on microbicides for Health and Development Network, from 2002 to 2004. During 2005 – 2006, I designed and facilitated three workshops with women to conscientise them around their sexual and reproductive rights and to mobilize them to get involved in microbicide activism for GAF.

In 2005, GAF was approached to research and write a paper for the International Partnership on Microbicides (IPM) to determine civil society's readiness for microbicides. As a co-author on the paper I conducted 10 interviews with civil

society organisations and microbicide activists to understand their knowledge about and attitudes towards microbicides.

Chapter seven analyses the links between trafficking and HIV and AIDS. Data for this chapter was collected during a seven week visit to five countries in South Asia (Bangladesh, India, Nepal, Pakistan, and Sri Lanka) in November – December 2003. I conducted in-depth interviews with organisations fighting trafficking and women who had been trafficked in the five countries.

In each country I had a host organisation working on trafficking that facilitated access to different organisations as well as providing translation where necessary. The host organisation also organized field visits to brothels in Bangladesh, India and Nepal, where in-depth interviews with sex workers, through a translator were conducted. I also went on field visits to rescue facilities in Bangladesh, India, Nepal, Pakistan and Sri Lanka and interviewed staff: the girls at the rescue facilities were aged from seven to fifteen and it was unethical to interview them about their deeply painful experiences. However I was able to observe the routines of the institutions and see how the girls related to their care givers, as well as interview staff. Visits to HIV and AIDS organisations enabled me to have in-depth interviews with staff and volunteers as well as people living with HIV and AIDS in Bangladesh, India, Nepal, Pakistan, Sri Lanka.

Finally, a critical source of data was through the ten one day workshops, two per country that I facilitated. The workshops were attended by a range of key role players (UN staff, donors, government and civil society) in HIV and AIDS and/or trafficking, and were attended by fifteen to thirty five people per workshop. The workshops were specifically for role players to discuss the intersections between HIV and trafficking and to begin to come up with some possible areas for working together. The workshops were vibrant, with lots of discussion and yielded rich data about the nature of trafficking and the various ways of tackling it depending on the

source of the information. However, given the relatively new HIV epidemics in the region the discussions were dominated by organisations involved in trafficking.

Active and meaningful participation of those most affected was a critical aspect of the research process. Every attempt was made to hear the voices of women living with HIV and AIDS and women and girls who had been trafficked. However, in many settings and communities the stigma and marginalisation is so great that women and girls are reluctant to be identified. It was thus been important to turn to secondary sources of data, relying on the experiences of people within organisations working with these women and girls and also on the literature provided by the organisations. This information helped to highlight the lived realities of women and girls who have been trafficked and to a lesser extent the experiences of women and girls living with HIV and AIDS. In cases where little literature on the lives of women living with HIV and AIDS in Asia exists, experiences from other parts of the global south have been reflected, when appropriate.

Chapter eight presents an analysis of an individual act of resistance and focuses on the Jacob Zuma rape trial. Data for the chapter was collected through interviews with activists present at the court, and involved in solidarity around the trial. Personal discussions with Khwezi[300] the woman who laid the charge, these conversations were telephonic, a brief conversation during a visit to my home, and one visit to meet her at the 'safe house' on the day of the judgement in which Khwezi had been staying since a few days after the charge had be filed. It is important to note that these conversations were of a personal nature, and not for research purposes. Whilst they may have helped shape my thoughts they are not reflected in the chapter per se, rather they are evident in the framing of the discussion.   Data was also gathered through the direct observation of trial procedures, although I was not present for the entire trial. I was there during Khwezi's evidence and cross-examination as well as part of Zuma's evidence and for the issuing of the judgement.   Furthermore, I analysed both the full court

---

[300] Named by her supporters from the One-in-Nine Campaign. Khwezi is the Zulu word for star.

proceedings and the transcript of the judgement. Finally, my personal experience of activism surrounding the trial, as part of the organising and taking part in the daily protests outside the court provided me with deeper insights into the acts of courage from Khwezi and all those women that stood in solidarity with her.

The final case study, *chapter nine*, highlights the work of a local NGO, GAF and analyses their success in applying approaches addressing power to empower women. Data for this chapter was collected through my personal experience of the organisation in different roles: as a founder member, a board member and a staff member of the management team. I also had personal experience in designing, developing and implementing various programmes, including the women in leadership programme which is discussed in the chapter. A document analysis of strategy documents, policies and reports provided knowledge about organisational processes. The two external evaluation reports of the women in leadership programme provided qualitative data about the impact of the programme on the women involved. Finally my personal interactions and conversations with staff, board, partners and donors of the organisation, as well as involvement in organisational process provided me with further information.

During 2000 – 2008 I have also been involved in other research processes that have fed into the thesis as a whole. These processes include interviews and site visits carried out in 2005 in KwaZulu Natal, Limpopo, Mpumalanga, Gauteng, Eastern Cape and the Western Cape for an evaluation of the impact of five Dutch funding agencies. I worked in a three person team on the report for the United Nations Secretary General on the realities of women and girls, HIV and AIDS in Southern Africa during 2003. I was responsible for the reports on Lesotho, Swaziland and Zimbabwe and spent one week in each country interviewing key role players and communities.

It is clear from the explanation that the research methods were not orthodox in that they follow defined guidelines of research practice. However, the methodology

does fit into the feminist research methodological paradigm in that it is critical of the hierarchical power relations between men and women, it takes into account other layers of oppression and marginalisation, and ensures that the voices of the marginalised are integrated into all levels of the research process. Furthermore the research process minimised potential harm and control and was mindful of the power relations inherent in research.

It is important to discuss the ethical considerations in feminist research methodology. Ethical research refers to the process of moral deliberation, choices made and accountability to the participants on the part of researchers throughout the research process.[301] Ethics are central and inherent in practices of feminist research methodology. Whatever my primary role the ethical considerations most appropriate to my role were observed. Confidentiality was an over lapping concept and was of the utmost importance, especially given the extreme sensitivity of the subject matter.[302] Confidentiality was discussed and guaranteed prior to the commencement of the interviews or other data gathering techniques. Data gathered from workshops and meeting is used as background information, adding richness but in no way compromising confidentiality.

The rationale for the selection of the organisations / issues presented in the case studies was to look for examples of how the three types of subversive power, that is power to, with and within, are illustrated. I looked for specific examples for case studies that I felt most succinctly demonstrated the type of power I was describing. The research has a variety of 'samples'; in many cases I chose what I was familiar with and what I had access to through my work. For example, I wanted to explore the experiences of women living with HIV. Given my links to, and work with, ICW it made sense to choose the organisation to do the case study on. This facilitated my access to many women living with HIV that I would otherwise have not been able to identify.

---

[301] Edwards, R and Mauthner, M. 2002
[302] Bell, L and Nutt, L. 2002

As noted in Chapter one, given the context of my different roles as academic, researcher, activist in the field of HIV and AIDS over the past two decades, some of the ideas in this thesis have already been published although in different ways to how they are articulated in the thesis. When ideas previously published have been discussed references to previous articles or publications have been given.

4.4 Role of the researcher

It is obvious from the section on methods used that a combination of more traditional methods, such as interviewing, is combined with less traditional methods, including my personal history as an HIV activist and feminist involved in HIV and AIDS since 1986. The self, and our personal / work experiences, are not discounted in feminist research methodologies: but instead are encouraged, as adding to the research process.   Feminist research methodologies encourage disciplined self reflection; on who we are, how our identities[303] influence our work and in turn, how our work influences aspects of self.

I was aware of my subject position as a white, HIV negative, middle-class woman and the possible power dynamics this may have in the research process. I was open, when appropriate, about other identities, as a long term HIV and AIDS activist, and a lesbian woman, that placed me in a different position, for example, as having a marginalised sexual identity. As feminist researchers it is critical to "situate ourselves within the process of research and at the same time be aware of the interconnections we make through our social and cultural locations and positions."[304]

Feminist reflexivity is the recognition that the researcher is inextricably part of what is being studied.[305]   This is highly appropriate in feminist methodology, as the researcher is seen as a "real, historical individual with concrete, specific desires and

---

[303] De Vault, M.L 1999

[304] Thapar-Bjorkert, S and Henry, M. 2004 p 371

[305] Hammersley and Atkinson in Maxwell , J.A. 1996

interests."[306] This can be extended to include the value of the experiences of the researcher – both personally and politically. The beliefs, behaviours and experiences of the researcher are part of the empirical evidence, and can add value to the research.

A challenging aspect of the research was dealing with my shifting and multiple identities of researcher, activist and someone actively involved in HIV and AIDS work. For example, chapter nine focuses on the experiences of a local NGO, GAF, of which I was one of the founding members, a board member for 8 years, and a staff member for three years who introduced the theoretical paradigms and was also instrumental in designing various programmes. Key issues include how "objective" feminist research methodology is, if the researcher has different roles, some of which mean that she or he is integrally involved in implementation. The fact that the specific programme that is discussed in the chapter has been evaluated in two separate evaluation processes in some way overcomes the challenge of objectivity.

Feminists lay claim to "situated knowledge"[307] which gives credibility to knowledge that is created when the researcher is an integral part of what is being researched, and addresses concerns about objectivity. My experiences, which I present as situated knowledge, are both coupled with, as well as confirmed by, the voices those most affected. It is hoped that this dual approach adds to the objectivity, validity and reliability of the research.

As stated, this research is also a reflection of my work around women's issues and HIV and AIDS. During my working life I have obviously collaborated with others in various ways and in doing so have been exposed to different ideas that have informed my thinking and understanding. I have acknowledged, where appropriate, work that I have done with others. I would like to assert however that whilst the

---

[306] Harding, S. 1987

[307] Haraway, D..1988.

theory of power as problem and solution is taken from Allen,[308] principle ideas around power as problem and solution in the context of women, HIV and AIDS have been created and developed by myself, and remain my own contribution to the research findings and conclusions.

4.5 Summary

The research set about trying to identify successful ways to address power over or domination that leads to oppression. It was critical to see whether the various forms of resistance and solidarity both empowered on an individual level as well as brought about some change at the level of intimate relationship, household or community level. I collected a range of data, on complex subjects, and wanted to ensure that although the research was not specifically about women's individual experiences, such experiences were vital in analysing whether the hypothesised models of addressing power worked. The challenge was how to measure empowerment and how to measure change.

Kabeer presented a useful way to think about subverted power, or resistance, as the ability of women to make choices and affect changes in their lives,[309] for example, the decision to insist on condom use and what the woman does if this request is denied. Empowerment can be measured by actions but more importantly is about the "meaning, motivation and purpose that individuals bring to their actions, their sense of agency or self-worth."[310] Empowerment is viewed as a process:

> "by those which have been denied power gain power, in particular the capacity to make strategic life choices. Yet because of the importance of

---

[308] Allen, A. 1999.

[309] Kabeer 2005 in Beetham, G., and Demetiades, J. 2007

[310] Kabeer 2005 in Beetham, G., and Demetiades , J. 2007 p207

beliefs and values in legitimating gender equality, a process of empowerment often begins from within, which makes it difficult to measure."[311]

The process of deriving conclusions in feminist research is seen as a "political, contested and unstable process between the lives of the researcher and the researched."[312] In this process the social (and one could argue political) location or position requires understanding of power relations. Watts notes that "all qualitative social research must operate on a parallel continuum of abstraction and compromise between assigning meaning and letting the data have their own voice."[313] The purpose of the thesis is to identify specific strategies that are applicable to the condition and position of women in general and to the current complex context of women, HIV and AIDS specifically. It is hoped that these strategies are reflective of women's voices and experiences and as such are realistic possibilities for change.

---

[311] Kabeer 2005 in Beetham, G., and Demetiades, J. 2007p207

[312] Holland and Ramazanoglu 1994, in Coy, M 2006 p 427

[313] Watts, J 2006. p391

Chapter Five: Power Over? The influence of donors

"Today we are facing a paradox of plenty: there is more money for AIDS in circulation, but not always enough human capacity and resources to make money work ... in everyday conversation, many southern Africans will say there is too much money out there. This, of course, is not factually correct – there is a globally acknowledged shortfall of resources to combat the epidemic. But there is no denying that the perception that there is too much money for AIDS points to systemic problems in AIDS funding modalities. It is plain to all of us that work at country level that there are real questions that need to be addressed by governments, donors and NGO's about how AIDS funds are used, by whom and to what end".[314]

5.0 Introduction

Whilst there is a growing acknowledgment of the interface between HIV and AIDS and gender inequality amongst those working in the field, much still needs to done to translate this into effective action: foremost in this debate is "who gives funding and resources and for what?" Although the funding for HIV and AIDS globally and in South Africa is not sufficient to meet the needs of the pandemics, it can be argued that the sector attracts substantial funding – both to official governmental HIV and AIDS programmes and to civil society in general. The rhetoric around women; HIV and AIDS is increasing; however, this has not necessarily led to more funding for women and / or women's rights work. Traditional areas of HIV and AIDS responses that attract increased funding, for example, treatment, are treated as gender neutral and do not differentiate between men and women's treatment issues and needs.   Women do not specifically benefit from such increases or funding sources. Programmes that could in some way benefit women, for example, giving home-based care programmes an injection of funds to ensure women benefit

---

[314] Sterling, M in Birdsall ,K ., and Kelly, K. 2007 p iii

financially for the care they are doing, do not get sufficient financial resources.

The enormous impact of HIV and AIDS has initiated changes in the funding environment; there have been shifts from funding family planning, reproductive and sexual health to HIV and AIDS. Initially the violence against women sector was also affected, although since the links between HIV and violence have been underscored more funding is being channelled to violence against women organisations.[315] Women's organisations are often compelled to do HIV and AIDS work firstly because it is a critical issue for women and also because there are more funds for HIV than other issues.[316] It is important to note that even given the increase in funding to HIV and AIDS, women's organisations addressing women's rights receive very little of a large pool of funding.[317]

It is clear that donors are in a position of power over the organisations that they fund as well as over the agenda's of potential partners. This chapter provides a brief overview on funding trends in South Africa for women, HIV and AIDS and is based on interviews carried out in 2008.[318]   This second part of the chapter explores the influence and power of a donor organisation operating in South Africa on the understanding of, and action around, gender inequality and its role in increasing vulnerability to, and the impact of, HIV and AIDS.

There are a number of international donors funding HIV and AIDS in South Africa; this chapter will focus on the Oxfam initiative, JOHAP, which aims, amongst other things, to support the integration of gender into the work of partner organisations. JOHAP has been funding gender and HIV and AIDS work since 2000. The case

---

[315] Fried, S. 2007.

[316] Clark, C., Sprenger, E., and VeneKlasen, L. 2006. Tallis, V., Hopenhaym, F and Knab, M. 2008

[317] Tallis, V., Hopenhaym, F and Knab, M. 2008

[318] In 2005 AWID (Association of Women's Rights in Development) commissioned a study *Money to fight HIV and AIDS through promoting women's rights: A case study of funding available for non-governmental agencies in South Africa.* The focus of the study, was to look at the contributions made by bilateral donors and also addressed their approach to gender. A follow up paper summarizes the findings from phase one, and develops added themes from interviews with different role players, that is organisations involved in women's rights and HIV and AIDS, and donor organisations such as international NGO's and Foundations. This chapter is partly drawn from the follow up paper which I researched and wrote from May – September 2008.

study tracks in detail the work of JOHAP from 2000 – 2003. Supplementary information is based on an interview in 2008. It is argued that despite the power that donors have there are some areas available to redefine the power dynamics between funder and grantee/partner.

5.1 The funding terrain of organisations addressing women, HIV & AIDS in South Africa

There are three main potential funding sources for HIV and AIDS and/or women's organisations addressing the gendered nature of the epidemic: government funding (providing money to parastatals and civil society), bilateral donors (providing money to government, government-related / parastatal organisations, and/or civil society organisations) and international donor NGO's and foundations who mainly fund civil society.

A study conducted in 2007,[319] which examined the funding trends on civil society funding to NGO's and Community Based Organisations (CBO's) for HIV and AIDS in Southern Africa, noted that funding to civil society is skewed in favour of service delivery, with only 1% of funding awarded for advocacy or rights based campaigns. Service delivery refers to care and support services, treatment and prevention programmes. Figure 5.1 provides a breakdown of funding per category.

---

[319] Birdsall, K., and Kelly, K. 2007

Figure 5. 1 Breakdown of donor funding per category
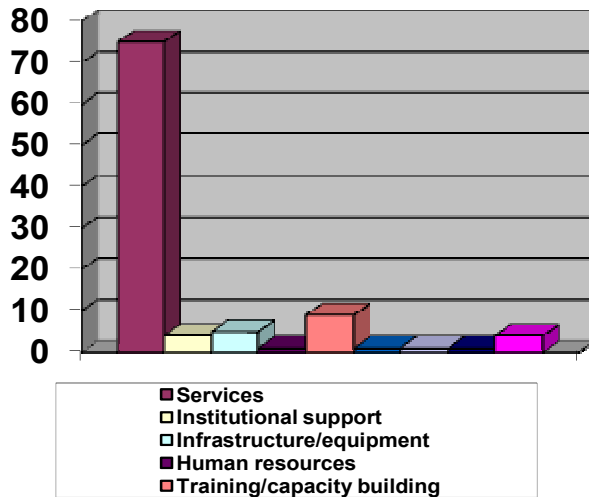
Figure 5.1 demonstrates the relatively small window of funding opportunity for the type of activities that are needed to tackle women's oppression.

5.1.1 Government Funding

Government commitment to HIV and AIDS spending has increased annually. The 2006 South African National Health budget demonstrated the biggest growth in the HIV and AIDS sub programme in the Strategic Health Programmes, which rose from ZAR454, 6 million to ZAR2, 2 billion from 2002/3 to 2008/9.[320]   In 2007/2008 the National Government had allocated ZAR56 million to civil society organisations involved in HIV and AIDS. The specific areas of government funding include:

- Prevention interventions including Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission of HIV, (PMCT) youth life skills and High Transmission Areas Interventions (HTA)[321]
- Community mobilisation for AIDS competence including home-based care
- support for people living with HIV and AIDS (PLHA)

---

[320] Ndlovu, N. 2006

[321] High Transmission Areas refer to known sex work areas such as truck stops.

- Treatment adherence counselling
- Governance and leadership development

The process for accessing funding includes a call for proposals and a standard application. In neither the call for proposals nor the application form is specific mention made about women or gender.[322] It would seem that whilst such funding is available, very little, if any, could be accessed for women's rights focused HIV and AIDS work. Whilst the National AIDS Strategic Plan (NASP) does make mention of women's vulnerability, specific objectives that will impact on women are not evident, and despite South Africa having a history of gender budgeting, a gender audit of funding on AIDS has not been done.

5.1.2 Bilateral Funding

Bilateral donors are an important source of funds in the funding landscape. Estimates are quoted that total Overseas Development Assistance (ODA) to South Africa reached its peak at ZAR3,8 billion in 1997, and then declined to less than ZAR1,5 billion in 1999.[323] Between 1994 and 1999, a total of ZAR10,745 million in ODA was received. Of this, 55% went to government, 24% to parastatals, 11% to NGOs and 10% to the private sector.

Ndlovu[324] reports on ODA funding to HIV and AIDS as reflected in the Department of Health Donor Matrix: twenty five donors are mentioned, who in the period between 1997 – 2008 provided funding of ZAR 2 341 401 117-00. Clearly monies are available, yet not necessarily for women and AIDS initiatives. Out of the thirteen organisations interviewed only two accessed money from bilateral donors.

Reasons for this include the fact that most NGO's and CBO's do not have the systems (management or financial) in place or the perceived capacity to receive

---

[322] http://www.doh.gov.za

[323] Budlender, D. and Kuhn, J. 2007

[324] Ndlovu, N. 2005

and utilise the amounts of money that bilateral donors donate. Some of the processes to apply for bilateral donor money are so onerous that NGO's often do not have the time, capacity and in some instances money, to affect the changes needed to ensure funding. As one respondent noted:

"New initiatives by most ODA's, linked for example to MDG 3, have led to renewed concern for women's issues. However, it is difficult for smaller groups and organisations to access such money as they do not have established programmes and established relationships"[325]

The most common approach of bilateral donors since the early 1990's has been 'mainstreaming' gender. Most donors, for example, Australian Aid (Aus AID), Canadian International Development Agency (CIDA) and Department for International Development (DFID), have gender policies and guidelines outlining a gender mainstreaming approach to HIV and AIDS. Some donors offer technical support to partners. German Society for Technical Cooperation (GTZ) has formed a theme group on HIV and AIDS with other German donors. They have developed a global response to HIV which is 'gender-sensitive and transformative', and have a strong commitment to taking into account gender which they define broadly to include the 'specific needs of women and sexual minorities.'[326]

Donor funding patterns show a worrying trend that is reflected in the broader HIV and AIDS sector, that is, shifting the gender focus from women to men. Donors pointed to what they saw as a problematic 'bias' towards women, stating that organisations were often misled into thinking that "gender was equal to women". [327] Such views reflect a lack of understanding and gender consciousness on the part of donors, who are in positions of power with regard to making decisions regarding what gets funded and what does not. It is important that funding for programmes that target women continue and that increased resources are accessed to work with

---

[325] Interview with NGO 2008

[326] Personal communication GTZ staff July 2008

[327] Interview donor May 2008

men in programmes that reshape masculinities. Bilateral donors are thus an important target for extensive advocacy to both increase funding and to ensure that there is equity in distribution of funds..

5.1.3 The Global Fund: A potential donor to address women's rights and HIV and AIDS

A major and expanding donor in the arena of HIV and AIDS funding is the Global Fund to Fight AIDS, TB and Malaria (GFATM). Through sizable donations from the G8 countries, and private foundations the GFATM is able to provide large amounts of funding to country programmes, for example, to date, South Africa has received US $ 138 958 876.00.[328] The last money received was Round 6, an amount of US$ 11 540 005.00. It is unclear as to the breakdown of funding received to civil society, and also how much money has been channelled into addressing HIV, AIDS and women.

The procedures to access Global Fund money are complex and time consuming; to date globally women's organisations have not really benefited from the fund. Traditionally the process is governed by the Country Coordinating Mechanism (CCM), which may not have a good understanding of women's issues and HIV.[329] Principal Recipients (PR) and Sub Recipients (SR) for GFATM money have to demonstrate a huge capacity to receive, manage and monitor money which excludes many organisations from this powerful role. However, due to sustained advocacy by civil society the GFATM has constantly evolved mechanisms for funding which has increased the chance of civil societies accessing funding; with dual track funding two principle recipients are allowed, and it is suggested that one is from civil society. Recipients of GFATM money can use the funds to build the capacity of their organisation.

---

[328] http://www.theglobalfund.org/Programs/portfolio.aspx?countryID=SAF&lang=en

[329] Discussions at Global Fund evaluation meeting OSISA/OSI October 2008

The GFATM have also begun to take gender more seriously and have finalised their gender strategy which includes a focus on women and girls as well as sexual minorities. They have also employed a gender consultant. The recommendations from two consultations on the gender strategy, one held in South Africa and the other in Nepal, will be integrated and presented to the Board of the GFATM for its approval by the end of 2008.[330]

For the past two rounds of GFATM funding the Open Society Initiative of Southern Africa (OSISA) and Open Society Institute (OSI) have implemented a project to build the capacity of women's organisations to access women's funds. Women's coalitions have been set up in seven countries and funded to work together to submit proposals to the CCM for inclusion in the main proposal. OSISA/OSI have provided technical support to each women's coalition by supplying consultants who are experts in the GFATM processes and who have extensive knowledge in women, HIV and AIDS.

5.1.4 International NGO's and Foundations

International NGO's and Foundations are an important source of funding for civil society organisations. Given difficulties in accessing bilateral funding most NGO's and CBO's are reliant on INGO's and foundations for their funding. Generally INGO/Foundation funding is viewed as more flexible, for example, they may fund core costs, are more reasonable when it comes to flexibility around movement of funds, have fewer and more user friendly conditions. Even though the amounts of money granted by INGO's and Foundations per organisation may not be on the scale that bilateral donors are able to give, such funding is viewed by recipients as more effective. In the interviews with NGO's it was evident that the power of receiving such money had impact beyond the monetary value of the donation:

> "We have had experience last year of piloting a small experiment to secure unrestricted funds at a regional level which proved successful, and which we

---

[330] Personal communication with Diane Stewart, Global Fund. July 2008

are prioritizing this year. On a positive side, donor trends seem to focus on making funding accessible in the regions which is in itself a very supportive environment. The regional office has often been able also to secure support in-kind and partnerships lifting some of the financial and resources weight as well as building a conducing environment in support of women living with HIV and AIDS. Donor relationship established with x donor has been so far received as a very supportive and constructive relationship".[331]

"The relationship with our core donor is a good one. They have funded us for a number of years and even provided bridging funding during a time of crisis in the organisation. They are quite a 'hands-off' donor, but their interest in and awareness of the organisation's functioning are clearly demonstrated during the annual site visits that they make. They have encouraged us to set our own agenda in our programme work and are fully supportive of our efforts to work for gender equality in South Africa".[332]

Organisations noted that whilst getting money for certain HIV and AIDS programmes that targeted women, it was still difficult to get money for advocacy and women's rights work. However, most donors that supported such work tended to be long term donors, who were not averse to providing core funding. Organisations interviewed reported good working relationships with such donors, and believed they had a good knowledge of women's rights, HIV and AIDS and the intersections between the two issues.

"...has a long history of engaging with women's and gender organisations that are working to end gender oppression. As far as we can tell, their understanding is well-informed by current thinking in the development field on the role that gender inequality plays in diminishing the overall quality of

---

[331] Interview NGO. June 2008.

[332] Interview NGO. June 2008.

life for all, and on the importance of initiatives to empower women to have greater agency and control of their lives".[333]

However, there are a finite number of INGO's and Foundations that have women's rights and HIV and AIDS as a critical objective, and many of the CBO's and NGO's interviewed have the same donors.   Funding for women, HIV and AIDS is not a given and most organisations have to constantly focus on finding money and looking for new donors:

"Although it is widely suggested that there is a lot of money for HIV/AIDS, we do not have that experience. Although our financial situation has improved overall over the last three years, we can never guarantee this is going to be long-lasting especially if the international level that influences largely donor priorities tend to minimise the link between HIV/AIDS and women and ignore the experience of HIV positive women".[334]

Clearly the funding pool for NGO's engaged in women's rights, HIV and AIDS is small with a handful of donor committed to the issues. This impacts on the number of organisations that are funded, the type of work that is done and the attention that is placed on the transformation agenda. The next section provides a case study of an INGO donor working in South Africa and examines in greater detail the levels and power dynamics between donor and partners.

5.2 Case Study: The Joint Oxfam HIV and AIDS Programme (JOHAP)

The Oxfam programme has been chosen for several reasons. Firstly, JOHAP was one of the first in South Africa in which donors seriously looked at, and funded, partners' work on gender and HIV and AIDS. The programme was seen as cutting edge in addressing the interface between gender, HIV and AIDS by many in the HIV and AIDS sector.   Secondly, the Oxfam agencies, often seen as progressive

---

[333] Interview NGO. June 2008.

[334] Interview NGO June 2008.

international donor NGOs, have a long history of addressing gender. This has been documented more by some Oxfam's more than others. For example, Oxfam Great Britain publishes widely on the issue, and Novib, the Dutch Oxfam, have released an extensive evaluation on the effectiveness of their approach to gender. The third reason is based on my personal experiences of working with the JOHAP programme as both a gender consultant, a staff member of a JOHAP funded organisation and later, as a Board member of another JOHAP funded organisation. This personal experience has resulted in a particular understanding of many of the agencies that make up the aid chain to which JOHAP is linked, in-depth knowledge and experience of the gender processes adopted by JOHAP, and facilitated a willingness by those interviewed to be open and transparent in their reflections.

This case study presents the background and structure of the JOHAP programme, highlighting the seven levels of the aid chain. The role of donors in pushing the gendered agenda is discussed. The relationship between the donor and the partners using theories of power is analysed. Finally, JOHAP's approach to gender mainstreaming is discussed in relation to key challenges identified.

5.2.1 Background: The JOHAP aid chain

JOHAP was set up in 1998, as a harmonised programme led by Oxfam Australia: Community Aid Abroad, in partnership with Novib (Oxfam Netherlands) and Oxfam Canada. The vision of JOHAP in South Africa is to contribute to the development of the Southern Africa region by reducing the impact of HIV and AIDS and by promoting a culture of human rights with and for those who are living with and affected by HIV and AIDS.[335] The aim was thus to strengthen civil society responses to HIV and AIDS, especially through community based and non-governmental organisations, so that the response was creative, dynamic, relevant and appropriate.[336]

---

[335] JOHAP 1998
[336] JOHAP 1998

The principles and foundation on which the programme operates includes the promotion of a development approach (a multi-sectoral, integrated and holistic framework as opposed to locating HIV and AIDS in a health paradigm); the promotion of a human rights approach, and the integration of gender into all HIV and AIDS interventions.[337] These principles were reflected in the first three year strategic plan but were less explicit in the second strategic plan. However, gender remains a critical area for JOHAP to date.

In the first three-year cycle JOHAP provided about eleven organisations with a total of approximately ZAR 2 million. The strategy was to place money with NGO's and CBO's involved in a range of HIV and AIDS work falling into JOHAP strategic areas, in an attempt to make maximum impact on the epidemic with the few resources that were available. These funds were spread across three provinces in South Africa. The organisation funded partners involved in capacity building, service delivery and advocacy. In phase one, JOHAP worked in partnership with a number of civil society organisations to support innovative work in HIV prevention and care, as well as legal services for and advocacy with people living with HIV and AIDS. Through its special projects, JOHAP supported capacity building in programme management skills and HIV and AIDS mainstreaming, as well as the development of a model for capacity building in behaviour change interventions. These were considered to be critical priorities at the time as these skills had been named as gaps in the South African civil society response that were forming a barrier to effective prevention and care.

Plans in the second three-year cycle, with an increased pool of money, were to increase the number of partners to twenty and to consider extending funds to two other provinces. The programme at in this phase supported thirty two organisations. The conceptual framework that replaced the earlier 'key areas' for funding included three program objectives:

---

[337] JOHAP 1998

Objective one: To strengthen approaches to HIV and STI prevention work that effectively address gender and sexuality issues, with a particular focus on young people.

Objective two: To strengthen HIV and AIDS care, support and treatment services.

Objective three: To create an enabling environment with a particular focus on the rights of people living with and affected by HIV and AIDS.[338]

Each organisation funded was 'assigned' to one of the three key objectives listed above. This distinction was however artificial with many organisations spanning at least two or all three of the themes. Whilst gender was still seen as a cross-cutting issue the fact that it was central to objective one, but not explicitly mentioned in objectives two and three was in some instances interpreted as not being equally as important in all three objectives.[339]

These three objectives are still core to the programme, although the programme has grown to include JOHAP, the Australian Partnership with African Communities, the Southern African Children's Social Protection Programmes and uMkhanyakude Partnership Programme that focuses on food security. The total number of partners across the programmes is fifty five.[340]

The JOHAP Aid chain (see Figure 5.2) can be represented seven levels, which include:

Level one: Back donors in different countries, including governments, fund the different OXFAMS. An example of a back-donor is AusAID who provide funding to Oxfam Australia. The South African office and partners do not often interface with the back donors.

---

[338] http://www.oxfam.org.au/world/africa/south_africa/hiv-aids.html
[339] Interviews partners July 2003
[340] Interview JOHAP July 2008

Level two: As noted the original three OXFAMS involved in JOHAP were Canada, Novib and OCAA. During the second funding cycle Canada withdrew and Oxfam Hong Kong and Oxfam Ireland joined. Each Oxfam contributes a different amount to JOHAP, although this does not affect the decision making powers of the various Oxfams.

Level three: The Oxfam Programme Committee, made up of one representative from each of the contributing Oxfam, informs the programme in terms of overall strategy and direction as well as reviewing progress and contributing to problem solving. Management of the programme is located within OCAA. Local staff, level four below, attend programme committee meetings to provide information but not necessarily to make decisions.

Level four: An advisory board comprised of South African experts was set up at the beginning of the programme to ensure local participation in overall strategic direction of the programme. The structure is made up of local experts with experience in human rights, gender and HIV and AIDS as well as women living with HIV and AIDS. In the 2001 evaluation of JOHAP it was suggested that the local expertise on the Committee were being under-utilised and should be more involved in shaping the programme.[341]

Level five: JOHAP set up a South African office and employs local staff to oversee and manage the programme in South Africa. Since 1998 there have been three coordinators managing the South African office, each with varying degrees of experience and skills in gender. In the first year the coordinator worked alone until an administrator was appointed. The organisation has grown substantially and in 2008 the total number of staff was eight.

Level six: In 2003 there were thirty two partners, operating in the three provinces

---

[341] Lee, S. and Kroon, A. 2001.

and nationally being funded. The majority were involved in service delivery, with a few others involved in capacity building or advocacy work. This trend continues in 2008.

Level 7: JOHAP partners work with both functional and geographical communities. Geographical communities include women, men and children in cities, townships, villages and rural areas. Functional communities, include sectors such as youth, women, LGBTI, and male soccer players. Some partners work directly with other NGO's and CBO's and others with policy and decision makers. Figure 5.1 depicts the levels in the aid chain.

Figure 5.1 Joint Oxfam HIV and AIDS Programme. Aid Chain
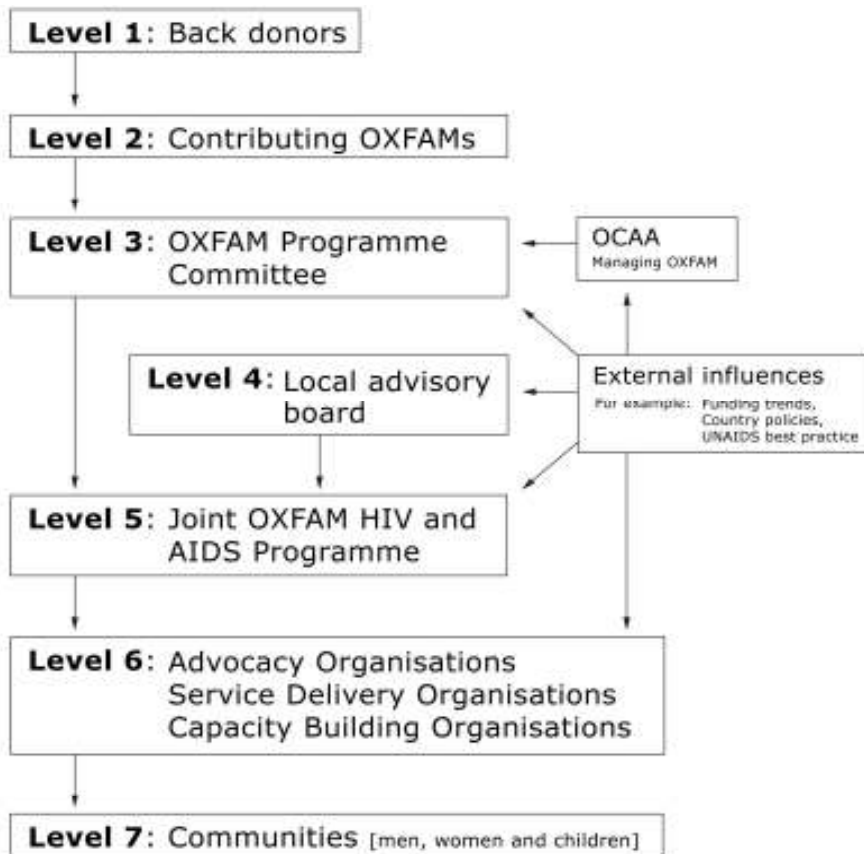
5.2.2 Defining the role of donors

The primary role of a donor is to provide money for specific activities or programmes. Whilst on the surface donors provide money to promote development, the reality is more complex – roles vary from donor to donor and often there may be an obvious, stated role and a less obvious, unstated agenda. According to Smith and Bornstein[342] the influence of donors is achieved both through their funding strategies as well as through the management requirements attached to the distribution of funds.

JOHAP has, relatively speaking, small amounts of money to give to partners. However, funds were initially committed to partners for a three year period renewable annually (in comparison to many other donors who fund on a year by year basis), and most organisations were taken into the second three-year phase of funding. Many of the initial partners are still funded by JOHAP.[343]

The placement of money is seldom the only role of donors. In South Africa, prior to democracy, international civil society donors, including NGOs, churches and so on, provided funds to organisations as a sign of solidarity with them in their struggles for equality and freedom. The international organisations lobbied internationally at various sites of power for the goals of their South African partners to be advanced. This highlighted a second role for international civil society donors – advocacy and activism on behalf of and in solidarity with the struggles of local people and their organisations.[344]

Advocacy is a key function for the various Oxfams.[345] Advocacy tends to take two forms for Oxfams: direct advocacy work by the Oxfam themselves in their country of origin and internationally as well as funding of 'overseas' partners involved in advocacy. A third form of donor advocacy includes influencing the agendas of

---

[342] Smith, T., and Bornstein, L. 2001

[343] Interview JOHAP July 2008.

[344] Smith, T. 2001

[345] Interview OCAA July 2003. Interview Novib July 2003.

partners, for example, to change organisations approaches - such as raising gender consciousness or influencing issues addressed.[346]   This influence may be stated or un-stated.

At the time of the initial study JOHAP funded two organisations that are involved in advocacy under the key theme of promoting an 'enabling environment'.[347]   These organisations are involved in legal / human rights issues. One organisation was specifically addressing gender issues, whilst the other has attempted to integrate gender into their various advocacy campaigns.   JOHAP have, from the outset, promoted gender as a critical component of any HIV and AIDS programme, and have played a direct role at influencing partners to address gender inequality.   This will be elaborated on below.

The funding climate has changed radically. This change is explained by those who drive the agenda as increasing accountability and the need for evidence that expected results are achieved, this has a ripple effect on the entire aid chain. In the funding environment, 'lack of capacity' has been identified as the key barrier to effectiveness, impact, and development rationalizing the need for increased accountability. The structural causes of the failure of development are seldom seen and articulated.

For many donors a critical role is providing technical assistance or capacity building. The role of donors in capacity building is a contentious issue currently being debated in the literature and increasingly in civil society. As noted by Seekings[348] the issue of capacity building has been at the core of donor support for CBO's for a long time.   Capacity building is articulated by donors as an investment in helping achieve long-term goals. What is not clear is whose long term goals the capacity building serves. According to Seekings the key objective of capacity building is to focus on building the organisation and not only the individual to develop "new forms

---

[346] Interview OCAA July 2003. Interview Novib July 2003.

[347] Interview JOHAP July 2003.

[348] Seekings, J. 2001.

of action on a sustained and sustainable basis".[349] The notion of capacity building is a profoundly political activity. Key questions include who develops the capacity building agenda and who determines who builds capacity and how capacity is built.

Capacity building needs are often defined by the donor, and frequently centre on enabling organisations to fit into the management and reporting approaches proposed by the donor. Some international donors may utilise their own staff, often from the North, to provide capacity building support. Sometimes local consultants, again often identified by the donor, provide the technical support. Even where donors do encourage their partners to identify and articulate their own capacity building needs, they may still influence decision making about and the actual capacity building process. Furthermore, when they control this process, they could, yet often do not, contract local organisations with expertise to undertake capacity building programmes, preferring to rely on consultants. This means that even though the capacity builder is a local consultant, the donor is their client and it is the donor needs, specifications and terms of reference that shapes the agenda.[350]

JOHAP has a strong, stated emphasis on capacity building. In the first phase, the aim was to enable local organisations to, in a short space of time, drive their own agendas and work in ways that would impact most effectively based on HIV and AIDS. This was implemented mainly through the funding of capacity building organisations to provide support to other local organisations. For example, JOHAP initiated an eighteen month capacity building process which was led by local consultants who formed a partnership. The three areas of focus had been set, using the findings from the initial Oxfam situational analysis as well as the South African National AIDS Review. However, the consultants were given the space to and did, deviate substantially from the original plan. Furthermore, JOHAP funded GAF whose key objective is to build capacity to address gender and HIV and AIDS in organisations.[351]

---

[349] Seekings, J. 2001 p 5

[350] Interview JOHAP coordinator July 2003.

[351] Interview with JOHAP staff July 2003.

In the second phase, this approach changed to a directly implemented, technical and externally led process as noted in the strategic plan[352]

> *"JOHAP's programme strategies will produce a number of outputs in order to achieve the stated objectives. These will include: partners having the technical and organisational capacities they need to work effectively; a curriculum on Rights-Based Approaches to HIV and AIDS; at least two Community Learning Sites; two Good Practice Guides and skills building workshops based on the lessons learned under each objective; and JOHAP external relations and advocacy initiatives".[353]*

The thrust of the programme has been, and continues to be, short term contracts with consultants (local and international) to do specific pieces of capacity building – and not as a coherent process with room for change. The result has been a series of capacity building workshops and using the partner platforms as spaces to address the donor identified themes.[354]

5.2.3 Relationship between donors and funded organisations

The relationship between donor and funded organisation is essentially one of power.[355] However, more careful analysis, based on specific organisational relationships, is needed to understand how power is deployed and with what consequences. Batilwala notes that power is about control over physical and financial resources as well as over the ideology which sets rules and ideas.[356] The three types of power defined by Allen,[357] domination, resistance and solidarity can be applied to the donor – funded organisation relationship to understand the power dynamics at play.

---

[352] JOHAP 2001

[353] JOHAP 2001 p 6

[354] Interviews with JOHAP Staff

[355] Tallis, V. 2000

[356] Batilwala, S. 1994

[357] Allen, A. 1999

What is the type of power between donor and partners? It is clear that donor organisations can and do wield power over those organisations they fund, in respect of what the organisation does, how it does it and how success is measured. Power is also evident in the "ownership" of ideas, materials and programmes that are developed. Often copyright rests with the donor and not the partner, or donors claim the success and learnings of a particular project or organisation as their own.[358] The ultimate power lies in the fact that the donor can at any time, and for any reason, pull the plug on the funding.

It is possible that the donor and funded NGO can work together more as equals. This requires an upfront negotiation of power, acknowledgement of the different contributions each party brings to the process, methods to make the relationship less hierarchical and a built in, neutral accountability mechanism. JOHAP view their relationships with funded organisations as 'partnerships'. Partnership should "help set a consensus framework within which different parties and their interests can be negotiated."[359] As such, a partnership could imply mutuality, interdependence, power-balance, and fairness. Given the nature of the relationship between funder and recipient, it is critical to acknowledge and then discuss the issue of power and to analyse whether such relationships can be 'equal' and whether they can be viewed as a partnership.

Crucial to such a discussion is to debate what is valued in the partnership. During the research a key JOHAP staff member questioned whether the partnership can be an equal relationship when one partner has the money.[360] Funded organisation's expertise, understanding and relationship with community and the ability to deliver, (the very reasons why the organisation received funding in the first place), are not given equal value as the monetary input. Similar findings were noted by Smith and

---

[358] Interviews with JOHAP partners. July 2003.

[359] Fowler, A. 2001. p 6

[360] Interview JOHAP staff. July 2003.

Bornstein.[361]

So whilst the donor articulates the relationship as a partnership, the possibility of an equal partnership is ruled out. This is illustrated in the following example. JOHAP had, in late 2002, organised a two day capacity building workshop to build skills in monitoring and evaluation using as an example the Logical Framework Analysis (LFA) as a possible tool. In early 2003, at the JOHAP Partner Platform (a forum bringing together JOHAP staff and partners) when the LFA was again presented, partners began to realise that this was a management requirement of JOHAP, rather than an option as they had initially assumed.

One partner organisation argued that the LFA was not the only tool for planning, and based on their experience of using it they had problems with its linear nature and rigidity and already had plans to use alternative, more qualitative frameworks. This was turned down by JOHAP on the grounds that use of the LFA had become a management requirement as well the fact that partners had attended the capacity building and in doing so had endorsed the plan. An intense debate ensued between the objecting organisation and the donor, with the facilitator, who was a JOHAP consultant, interjecting and accusing the organisation of "not being fair" to the donor by insisting on using an alternative method for monitoring and evaluation. This was challenged by the partner organisation, drawing on an earlier discussion about power in the partnership. The organisation stated that their understanding of Partner Platforms, with the designated time for discussions and debates, gave the impression that JOHAP was opening up space in which the relationship between donor and partners could be developed through open and honest, dialogue which could include disagreeing with each other. After a 'cooling off period' JOHAP finally agreed to allow the organisation to use an alternative planning, monitoring and evaluation framework.[362]

It is important to note that whilst this particular organisation was able to challenge

---

[361] Smith, T., and Bornstein , L. 2001

[362] Interview JOHAP partner. July 2003.

the donor, at least in the short term, not all are able to. The interpretation of the silence of most of the partners, is that many organisations are not comfortable with disagreeing with donors for fear of losing support; not 'biting the hand that feeds'. In this case other organisations did not take part in the discussions partly because they view JOHAP as a 'good donor' and did not want to appear 'ungrateful', did not want to incur the wrath of the facilitator and also because they did not necessarily know of other alternatives to do their monitoring and evaluation, mainly because other alternatives had not been presented at the monitoring and evaluation workshop.

Individuals within the organisation under discussion had a history of challenging donors in general and JOHAP in particular and had internal debates about role and influence of donors. Whilst the debate in the meeting was tense and unpleasant the organisation did not fear that JOHAP would at any stage not fund them. Subsequently, other organisations approached JOHAP to use similar qualitative methods and were told they were unable to do so. In the end, the organisation eventually ultimately submitted to the donor requirements for "the sake of salvaging the relationship which had soured to some degree".[363]

In conclusion, partnerships need buy in from each side of the relationship. Organisations are linked not only through the shared goal of enabling development, but because each entity needs the support of others for its change process to have a positive impact. The challenge is to recognise, acknowledge and negotiate the power imbalance and set in place mechanisms to reduce this.

5.2.4 Whose agenda is gender? JOHAP's approach to gender and mainstreaming

There has been extensive debate and discussion around who pushes the gender agenda.[364] For example, some writers acknowledge that gender has been heavily

---

[363] Personal correspondence JOHAP partner. April 2004.

[364] MacDonald, M, Sprenger, E and Dubel, I. 1997.

promoted in international development circles by gender policy advocates, who represent a relatively small group of bilateral agencies (for example, CIDA, SIDA), sometimes leading to accusations of a donor driven agenda. However with the absence of guiding policies produced by governments at country level, donors were 'forced' to write their own Women in Development (WID) and/or Gender and Development (GAD) strategies.[365] Such strategies are limited in scope and are often not based on the context into which they will be implemented. They are products of the donors' biases and planned programmes. According to Jackson "the procedures of gender mainstreaming - gender guidelines, gender training programme and gender toolkits cannot be relied upon to deliver WID/gender objectives; nor should the pressure for institutional change be conceptualised as deriving entirely from organised external pressure groups such as donors."[366]

The role of the gender policy for donor agencies should be to underpin and define the practice of the organisation. Furthermore the policy should form a link between internal institutional issues (such as who makes policy, how does gender policy rank with the organisation's other policies, is the organisation hierarchical or participatory) and external programmes (for example, relationships with partners, and balance of power between donor, partner and partners constituencies).

AusAID (level one) have had a gender and development policy since 1997, when they shifted from exclusively addressing women's needs to a "broader approach that considers the gender roles, needs and opportunities available to women and men." [367] AusAID aims to ensure that this gender perspective is integrated throughout the aid policy; they will fund organisations that fulfil certain criteria and hold those recipient organisations accountable should they, in turn, fund other organisations. Hunt[368] notes a tendency to 'get stuck' on the practical gender needs and that not enough attention is focused on strategic interests. This is echoed in the AusAID evaluation:

---

[365] Himmelstrand, K. 1997

[366] Jackson, C. 1997 p 175

[367] AusAID 2002 p1

[368] Hunt , J. Presentation to OCAA staff December 2000

"More than half the activities reviewed revealed that women's practical gender needs such as greater access to education and health were addressed. However there was insufficient information to demonstrate that the activities were meeting women's strategic interests, such as greater participation in decision making".[369]

In 2002, OCAA (level two) developed their mainstreaming gender policy, a cross-cutting theme for 2002-2005. In the policy gender is defined as "different roles and responsibilities adopted by women and men; these are learnt and vary between cultures and localities and may change over time."[370] Mainstreaming gender is outlined as "ensuring that gender analysis and planning informs all of an agency's actions, including policy formulation, agenda setting, planning, human resource management, programme management, information management and resource allocation".[371] Analysing both the definition of gender and gender mainstreaming, it is obvious that the mainstreaming process is technical and not a political process.

The key objectives in the OCAA policy include an awareness of gender relations in the programme and projects that OCAA supports in order to encourage partners' efforts to change practices which are considered to be harmful or discriminatory. The policy states if it is perceived that a project in its current form will in anyway have a serious negative impact on women, the project proposal will not be accepted for funding. However, the notion of serious negative impact is not fully articulated in the policy and there are no guidelines. Therefore decisions regarding funding are left up to the field staff to determine. Their responses will obviously be based on their own understanding of gender, which may not be as complete as the staff who drew up the policy:[372] it is noted that the document reflects the gender ideologies and institutional practices of the Australian offices. International staff acknowledged

---

[369] AusAID 2002: p4

[370] OCAA 2002 p 4

[371] OCAA 2002 p 4

[372] OCAA 1998

that the process of moving from policy to programme has been a slow.[373]

Jackson[374] questions who can express women's gender interests and how legitimate it is for 'outsiders', such as development agencies, to impose concepts such as the separate interests of gender and the subordination of women in the face of apparent disregard of local contexts and cultures.   In exploring the relationship between donor and funded organisations, in this case JOHAP and its partners, it emerges that donors influence the local development agenda, and that of their partners through their funding strategy, management requirements, advocacy strategies to change issues and through capacity building, using donor conceptualised frameworks, ideologies and approaches.   This is clearly not a neutral, apolitical process or relationship. The reality is that donors do define and set development agendas, often because they set the policy and hold the purse strings.   Development aid is a political process and is often in the interest of the donors, who have subtle and not so subtle ways of directing the aid process.[375]

> "*Aid donors give aid on the basis of their ideas of what constitutes development, which spring not only from their own ideologies and systems of values, but from their prejudices and fears".[376]*

A number of donor agencies have played a role in raising awareness of the need to integrate gender into policy and programmes.[377] They have had varying success at both integrating gender into their own institutions and into that of the organisations or institutions that they fund. Amongst donors, the international NGO's were the first to promote a gendered approach to development.

Smith[378] in a paper on donor influence on CBO's in South Africa argues that since

---

[373] Interviews OCAA

[374] Jackson , C. 1997

[375] Macdonald, M. 1994.   Sogge, D. 2002. Fowler, A. 2001.

[376] MacDonald, M.1994. p18

[377] For example Oxfam, GTZ

[378] Smith, T. 2001

1994 donors have had more of an influence on what South African NGO's do and on how they operate.

> "Donor influence on NGO's is typically seen only in negative terms. There are, however, some areas where donors have had an important positive influence. For example, many donors have contributed significantly to making South African NGO's more aware of the importance of issues such as gender and HIV and AIDS in their work, and have provided capacity building and other resources to increase the ability of NGO's to deal with such issues".[379]

However, Smith also notes that donor NGO's are more open to influence by partners or recipient organisations.

Accepting money from donors means agreeing to the conditionalities and contracts made: "the acceptance of increasing volumes of foreign aid involves entering into agreements about what is done, and how it is to be reported and accounted for." [380] Giving money and resources allows donors power over partners. Donors may want to influence change on the basis of what their own ideological position is. For example, Oxfam has a long history of working for gender justice and this is explicit in their approach to HIV and AIDS, that is addressing gender is critical to effective programming. Whether it is acceptable or not it is a reality that donors do and will continue to influence agendas.

Given that the influence of donors is a reality it is thus vital to examine how they influence partners – both the process of influencing and the mechanisms used to affect their influence. In terms of the process of influencing gender integration some key issues are; whether the intention to influence is stated or unstated, is top down, negotiated or participatory, and whether funding dependant is on addressing gender. If the donor approaches gender in a feminist way the reality of power will

---

[379] Smith, T. 2001 p 12

[380] Hulme, D., and Edwards, M. 1997 p 8

be recognised and negotiated. The fundamental question is whether organisations want to integrate gender. In other words, do funded organisations have a choice - is it acceptable to 'force' gender mainstreaming or should it be a more organic process?

Insisting on gender may result in a ritualistic and meaningless insertion of gender which has no consequence on actual project performance.[381] It is important to see this discussion in the light of the debates about whether donors should be involved in capacity building of their partners. This links to the point made by Macdonald[382] that even if the donor organisation has established credibility, the role they should or can play in pushing a gendered agenda still needs to be questioned. For example, it is important to interrogate who influences the pace and direction of the dialogue and determine what is the most appropriate role of the donor in support and capacity building.

A critical part of the research was to understand the role that both staff (international and local) and partners felt JOHAP played or should play in influencing gender integration. One of the international staff from Novib, noted that gender mainstreaming, or the integration of gender as a donor driven process, "cannot be escaped but can be done sensitively".[383] Their approach is transparent and they negotiate power from the outset of the relationship, long before funding is received. Partners know that they are expected to address gender inequality and Novib have developed a set of guidelines and stages which are shared with partners.[384] Novib are clear that they do not do capacity building – although they do facilitate dialogue between partners by bringing them together to discuss gender.[385]

JOHAP's approach is somewhat different, with more hands on gender

---

[381] Geisler, G,. 1999

[382] MacDonald 1994

[383] Interview Novib. November 2002.

[384] Novib 1995. Nugteren, M. 2001.

[385] Interview Novib July 2003.

mainstreaming training, often facilitated by consultants from the North.

Specific strategies used by JOHAP to monitor gender include asking specific gender questions in the proposal, a gender checklist that has to be completed when applying for funds, holding partner platforms that may deal with gender issues, conducting site visits, through monitoring and support where specific questions around gender are asked and funding specific organisations that deal with gender and HIV and AIDS.[386]

Partners' responses to JOHAPs role in influencing their work on gender were mixed.[387]   One person interviewed noted that they know that JOHAP is "gender sensitive but that they do not push the line".[388]   Another respondent noted that JOHAP "did not push the gender agenda hard enough and that there was something lacking in their approach."[389]   Generally JOHAP are viewed as flexible funders who are prepared to fund broadly; whilst they do 'insist' that partners look at gender, this is acceptable to most of the partners.[390]

JOHAP commissioned an evaluation between March and May 2001 in which the gender sensitivity of JOHAP was reviewed with respect to all three programme objectives: partnership, governance, management and leadership. The evaluation showed that in relation to gender, JOHAP is seen as having pioneered attention to gender's links with HIV and AIDS in South Africa, and has enabled partners to develop strong sensitivity to the subject.[391]   Partners were positive about JOHAP's guidance in relation to gender. Based on the evaluation findings the following recommendations were made:

- The inclusion of a gender analysis in the problem description of project proposals,

---

[386] Interviews JOHAP staff. July 2003. July 2008.

[387] Interviews JOHAP partner July 2003.

[388] Interview JOHAP partner July 2003.

[389] Interview JOHAP partner July 2003.

[390] Interviews with JOHAP partners July 2003.

[391] Lee, S. and Kroon, A. 2001.

- The development of gender-sensitive strategies and indicators that reflect a gender analysis,

- Enabling partners to acquire the knowledge, skills and resources that they need in order to mainstream gender into their work,

- Focusing on gender issues, in both partners' projects and organisations, in quarterly monitoring visits and reporting mechanisms, and internal and external evaluations,

- Monitoring and evaluating of JOHAP's performance in achieving gender equity in all aspects of its programme management and governance, and organisational development.[392]

Whilst these objectives demonstrate a clear plan to highlight gender, they are mechanistic and focusing on the technical and less on the political. Such an approach requires that partners and JOHAP have specific gender expertise. JOHAP have no clear indicators of 'successful' gender mainstreaming. Whilst indicators may not be the best way to measure success there are clear indicators for all other objectives of the programme – the lack of gendered indicators is thus telling. Partner organisations also did not have gendered indicators. Whilst organisations are addressing gender issues it is often because of the demands of the epidemic and not because the organisation uses a gender discourse and lens.[393]

A key challenge to the JOHAP programme is the integration of gender at all levels of the aid chain. Whilst one Oxfam may be committed to gender mainstreaming, another may not be as committed. The same may go for back donors who may have different interests and issues to be highlighted. By the time money is placed with partners the influence and interpretation of gender and what it means to integrate or mainstream has gone through five levels. A further possible barrier to the success of gender programmes is that the partners themselves may not have either the skills to mainstream gender within the organisation, or the inclination

---

[392] JOHAP 2001

[393] Interview with JOHAP partner July 2003.

and will to do so.

What is the benefit of gender mainstreaming for target populations?[394]   Does mainstreaming actually change the way target groups and stakeholders are dealt with at the project level?   The research confirmed observations made by other researchers, that often gender mainstreaming is made into the goal itself, rather than being a means to the goal of gender equity.[395] Success of programme ability and progress in gender mainstreaming can only be measured at the field level. The Novib programme officer noted a concern that "the gender framework of the programme has not always been strongly maintained in practice."[396]

The research showed that at the local level the JOHAP South African office have not benefited from development processes of OCAA. Furthermore, the vast experience of Novib has also not been absorbed. Local staff noted difficulties in gender mainstreaming internally and it appears that no one person is really pushing a gendered agenda beyond the need for partners to acknowledge the link between gender and HIV and AIDS and to provide gender de-segregated data. Local staff understanding and experience of working on gender issues has differed over time and this difference in expertise was reflected in partners' experience of the help provided by JOHAP staff.

Many partners have a similar understanding of gender to JOHAP addressing difference but not gender inequality using power discourses.   For many organisations addressing gender is done because of women's increased vulnerability to HIV and AIDS.   Some partners noted the need for JOHAP to make more explicit why they need to include gender issues in order to make the issues more real.

Gender mainstreaming is a complex process.   Whilst many individuals and organisations are committed to mainstreaming gender at a policy, programme and

---

[394] Geisler, G. 1999

[395] Jahan, R. 1997

[396] Interview Novib 2003

project level, they lack the necessary planning skills and tools. Another school of thought questions the need for tools and guidelines, toolkits and manuals. For the tools to be successful they must be "conceptualised together with users and must be sector specific".[397]

Capacity to apply a technical approach to mainstreaming is needed by both JOHAP staff and partners. A key objective of OCAA is to explore gender issues with all staff and counterparts and be responsible for following through on these issues by proving adequate support including, where appropriate, assisting with strategies, recommendations and appropriate training. However, the research suggests that JOHAP staff have not tapped into the resources and experiences from local organisations, the head office or other Oxfams.

JOHAP has made efforts to build capacity in partners in the following ways:

- The use of external consultants – for example to offer training to partners or to assist in the drawing up of policy.
- Site visits – at which questions around gender aimed to get organisations to reflect on gender issues. This has been less effective in phase two according to partners, due to change in management at JOHAP
- Partner platforms - which bring partners together to share learning and provide capacity building around certain issues

Most of the other partners interviewed expressed a lack of confidence in themselves to properly address gender issues and highlighted the need for support.[398] If partners are to successfully mainstream gender using the technocratic approach required by JOHAP they need to build upon their theoretical understanding, and to develop practical skills to integrate gender into their everyday work. Similarly, a plan for JOHAP staff is also needed.

---

[397] Razavi and Miller quoted in Jackson 1997:175.

[398] Interview JOHAP partners 2003

A feminist interpretation of gender sees as central an understanding of the unequal power relationships between men and women: the key concern is power dynamics that oppress women and add to their vulnerability. A feminist approach to gender sees gender as a political issue that is about power, seeking to bring the private into the public arena of debate and action. High priority is given to helping women transform the prevailing power dynamics.[399] In short, whilst JOHAP have had some successes in addressing gender and in influencing their partners to consider gender, their response falls way short of a feminist approach. In the 'non-feminist' definitions and approaches, gender becomes descriptive, focusing on the different roles and responsibilities of women and men, but does not challenge the power imbalance:[400] a focus on gender in programmes is often not sufficient to address women's oppression. Although the gender discourse has filtered through to policy-making institutions, the concept of gender has been re-interpreted to suit institutional needs. This has included using gender to side-step a focus on women and the radical policy implications of overcoming women's lack of privilege.[401] The key must be a concern with gender justice as a core value.[402]

5. 3 Summary

Donor behaviour is profoundly political, with both the role and relationship reflecting the power dynamics between the funder and the funded. Whilst international NGO donor agencies are often more mindful of the power issues, they are increasingly bound by the demands of back donors which are linked to so called evidence based interventions and specific notions of what constitutes 'success' and 'impact'. The rising pressure for this kind of outcome is shifted onto the partner, with donors introducing stricter management requirements and increasingly, more technocratic approaches to measure success. JOHAP are no exception, having introduced more management requirements as well as a much tighter capacity building programme which is based on their own conceptual frameworks,

---

[399] Helzner, J. and Shepard, B. 1997: p175

[400] Razavi and Miller in Baden, S., and Goetz, A-M. 1998

[401] Razavi and Miller in Baden, S. and Goetz, A.M. 1998: p21

[402] Goetz, A.M. 1997

assumptions and language in phase two – thus progressively constricting the space that partners have for setting their own agendas.

Relationships of power and influence is not one sided.[403] Current debates in donor agencies around good governance and participation provide a platform for questioning the nature of participation and politics from a feminist perspective. Negotiating power with the donor may not be easy, and it is possible. What is needed is a consciousness by organisations being funded about the power they do have, an increase in the level of dialogue on a one to one basis between partner organisation and donor as well as collective action by an organized civil society, especially the NGO sector so that donor domination is at the very least exposed and ideally challenged and the basis for such re negotiation of power established.

Donors in South Africa, especially international NGOs who articulate their commitment to working in solidarity with local organisations and in this case, JOHAP, together with partners are faced with the challenge of making these elements an integral part of their value systems, thinking and approach and consequently, their strategy. The rhetoric as well as the genuine intention to 'do something' about gender is apparent, and the research suggests that more could be done, and importantly what is being done could be more effective with more meaningful partnership and a mix of technical and political elements to gendering.

Donors clearly have power over non-governmental and governmental organisations and institutions responding to HIV and AIDS. Whilst there is an increasing flow of resources this research has demonstrated that in general there is a gap in funding for organisations that address HIV and AIDS through a women's rights lens. Whilst some more established organisations, with track records and long term relationships have secured funding for women's rights work, there are others who battle for funding. Even for those organisations with multiple donors there is often a challenge to secure long term funding which addresses the need for core and

---

[403] Hulme, D and Edwards, M. 1997.

unrestricted funding. Clearly, the increased funding for HIV and AIDS is not being accessed by organisations involved in women and AIDS in a way that matches the disproportionate impact of HIV and AIDS on women's lives.   Furthermore, organisations addressing HIV and AIDS through fighting for women's rights are even less likely to get funding for their work – partly because they are often unable to prove the impact of their work on the two epidemics.

The choices that donors make to fund women, HIV and AIDS or not, impacts on different levels of vulnerability. Donors lack of funding to address women, HIV and AIDS is a concrete example of programmatic vulnerability, where funding decisions to support or not support specific projects or programmes, have a positive or negative impact on women's lives, abilities to protect herself and her access to treatment, support and services. There are donors who understand and define gender in a political way, that is, power relations are at the centre of their analysis. If donors adopt a feminist approach and understanding of gender, this analysis should be applied to the relationship between donor and partner, and they should be mindful of, and develop steps to mitigate, the effects of power in the relationship.

The next chapter will address social movements and provide examples of women (and men) working together in solidarity around identity and issue.

Chapter Six: Power with. Building global movements. Mobilising around identity & issue

6.0 Introduction

Action is reflection and consciousness in practice.[404] Over the last thirty years there has been a substantial growth in, and participation by, civil society, as greater awareness and consciousness about problems has resulted in increased action at a local and global level.[405] Women have been at the forefront on many struggles and yet have received little recognition for their contribution to social, economic and political change in struggles other than the women's movement. Women's collective actions have remained invisible, just as women's contributions generally have been absent from historical and social studies.[406]

Politics and protest as portrayed by the media remains a male domain: women are visible in protest mainly through their participation in feminist causes.[407] However, women have initiated and been part of struggles for their survival as women in their many devalued and identities roles in patriarchal society.[408]

Power with, or working in solidarity for a common cause with others, is undoubtedly effective, although results may not be realised in the short term. Women have secured major victories over the past decades. Furthermore, the women's movement in particular, and women acting in solidarity in general, have learned many lessons about how to organise together, how to strategise and how to effect change.

---

[404] Murphy, B.K. 1999.

[405] De Senillosa, I. 1999.

[406] West ,G and Blumberg, R.L 1990.

[407] West ,G and Blumberg, R.L 1990.

[408] West ,G and Blumberg, R.L 1990.

This chapter explores how mobilisation around identity and issue, that is organising together around a common theme, is an effective strategy to addressing women's vulnerability and empowerment. A discussion of social movements follows. Two case studies are presented. Case study one looks at mobilising around identity: women living with HIV. The chapter draws on the experiences of an international network and its attempts at building solidarity amongst women in southern Africa through capacity building in advocacy. Case study two examines mobilising around an issue: microbicides as a potential woman-controlled prevention technology.

6.1 Social movements, women's movements

A social movement is a means of organising around conflict, through taking private disputes and making them political ones.[409]   AIDS impacts on and is driven by personal and political aspects, and lends itself to social movement building. The importance of international social movements in playing a leading role in setting norms for both the NGO and governmental sector, nationally and internationally cannot be understated. The treatment movement in South Africa and globally has been extremely effective in ensuring that treatment access is high on the national and global agenda's and that more and more people are accessing treatment. However, social movements do not necessarily take up women's rights issues, and the treatment movement is a case in point.

The transformation of gendered power relations is essentially being driven by the women's movement. The general goal of the women's / feminist movement is to empower women. This implies "fundamental changes in gender relations as well as in political, economic and social structures that relegate women to less powerful positions." [410]   Feminist movement building refers to the power that a diverse group of women can exercise collectively when working together to define and strive to achieve feminist aims. The movement is "engaged in changing the way

---

[409] Kardem, N. 1991.

[410] Kardem, N. 1991. p 15

development issues are defined,"[411] transforming those agenda's in a way that benefits and changes women's lives.

At the core of the feminist movement is recognition of patriarchy as a system of male oppression and domination which has a material /economic base. The movement strives for democracy and equal rights within the feminist tradition whilst acknowledging that equal rights are a necessary step towards transformation but they are not an end in themselves. The movement thus seeks more holistic and structural transformation of society, and a transformation of all relationships including the personal.[412]

What is the state of the women's movement? There is ongoing commitment among feminists to some kind of women's movement even if there is a dissent about what form it currently takes and what form it may take in the future.[413]

> *"The movement is not an amorphous whole it may even be fragmented, but in each of the fragments the idea of a political project is alive and well. In some parts of the globe there is no questioning of whether there is a women's movement. It is visible and strong and focused on struggles of life and death against poverty and exploitation".*[414]

There are different types of issues that have drawn women into social protest such as economic survival, nationalist and racial/ethnic struggles, peace, environmental justice, education and health. In different eras, the boundaries shift (not only over periods of time but also in different parts of the world) and different issues are taken up as women's rights issues. Feminist agendas change over time, in the context of general societal and historical developments. Women's protests have ranged from securing the vote to reproductive rights, addressing the feminisation of

---

[411] Kardem, N. 1991. p1

[412] Ali, S, Coate, K, and WaGoro, W. 2000.

[413] Ali, S, Coate, K, and WaGoro, W. 2000.

[414] Ali, S, Coate, K, and WaGoro, W. 2000. p 3

poverty and violence against women. However, some issues remain constant over time for example, the regulation of women through control of the body and sexuality. There is still an urgent need for feminist action within political, social and institutional contexts, to deal with the regulation of women through sexuality / body and identity and diversity, amongst other things.

> *"Challenging orthodoxies, questioning the taken for granted – stirring it – is the business of feminists, and we are at a historical moment where feminist dynamism is much needed".* [415]

The women's movement consists of social and political actors, aiming to make visible and change the inequality and oppression suffered by women at a local, national and international level. The movement encompasses diversity and difference.[416] The recent Association of Women's Rights in Development (AWID) forum held in Cape Town during November 2008 highlights the diversity and vibrancy of the movement. Entitled *The Power of Movements* the forum brought together over 2000 feminists and women's rights activists involved in HIV and AIDS, sexual and reproductive rights, environmental issues, sex worker rights, anti-war, knowledge rights and the fight against religious fundamentalism.

Like any other issue, activities of the movement get defined by the agendas and constraints of funding agencies; political and progressive movements are increasingly being subsumed by funded 'professional' activities and other major issues.[417] However, despite funding constraints and other barriers the AWID forum demonstrated that the women's movement is active, at least in some way, in every region.

---

[415] Griffin, V. 2002. p1

[416] Braig, M. and Wolte, S. 2002

[417] Kahn in Ali, S et al 2000

6.1.1 Women's involvement in HIV and AIDS

Since the beginning of the epidemic women have been, in many countries, at the fore-front of both prevention and care interventions.[418]

> "When the HIV epidemic emerged in the early 1980's women were immediately affected. They were present as care-takers, educators, physicians, public health officials, community activists and patients."[419]

This trend continues with women taking on the bulk of efforts to address HIV and AIDS, mainly in service delivery, but increasingly more women are involved in advocacy and activism. It is also acknowledged that women living with HIV and AIDS have played a vital role in the fight against AIDS.[420] What is less obvious is the role of women's organisations as part of the broader feminist / women's movement in HIV and AIDS. It is important to make the distinction between interventions that are essentially feminist in nature and the involvement of women's organisations who are not necessarily progressive, and who would not define themselves as part of the women's movement. From the late 1980's there have been some feminist academics writing and researching issues around gender and HIV and AIDS from a United Kingdom / United States of America perspective.[421] This chapter, whilst drawing on the theories of such writers, will focus more on issues around activism, on movements taking up the many issues presented by the HIV and AIDS epidemics.

The first case study to be presented in this chapter demonstrates the intersection of HIV, lost rights and the need to fight together to mitigate the impact of HIV. The essential elements of solidarity include a personal commitment to the issue that is long term.[422] Activism is a combination of a personal and a political

---

[418] Patton, C 1994

[419] Stoller, N. 1997 p25

[420] Rudd, A. and Taylor, D. 1992.

[421] Patton, C 1994. Richardson, D. 1989, 1996. Roth, N.L and Hogan, K. 1998. Doyal, L 1994. Wilton, T, 1997. Stoller, N 1997.

[422] Sobrino, S.J. in Kothari, M. 1999

relationship to the issue.[423]   Existence of just one of the two connections, that is personal or political, is not sufficient to motivate women to activism.[424] Explanations for activism are more complex than simple explanations of solidarity, and there is a need to look at self-interest. Boehmer [425]outlines the process from personal to political to action. At the point of diagnosis the personal becomes political.   Community activism follows as women whose identities are already overlapping with collective identities, for example, women living with HIV, start working with others, this could be in support groups, or involvement in local organisations. The final stage is when women have more of a political / ideological approach which is motivated by a collective identity. It is important to note that personal identity does not necessarily match collective identity, for example, white people may be involved in anti-racism just as HIV negative women are involved in the HIV positive women's movement.[426]   Critical to this involvement however, is that those most affected should be at the forefront of the struggle and provide leadership and vision based on their personal experiences.

6.2 Case Study: Organising around Identity: Women living with HIV and AIDS

As noted in chapter four, since 1998 I have had many opportunities to facilitate processes for women living with HIV and AIDS, many of them around the multiple identities of HIV positive women and assisting in developing advocacy strategies to increase voice, participation and raising specific issues to effect policy and practice change.   Through these processes I have had an opportunity to deepen my understanding of the myriad of issues affecting women living with HIV, identify the multiple discriminations and hardships that are both HIV and non-HIV related, begin to explore the issue of identity on the basis of HIV status and gain insight into the reality of being HIV positive.

---

[423] Boehmer, U. 2000

[424] Boehmer, U. 2000

[425] Boehner, U. 2000

[426] Boehmer, U. 2000

This case study, based on a combination of those experiences, as well as individual interactions and interviews with women living with HIV and AIDS, seeks to understand the power of solidarity and organising around the issue of a shared identity. This chapter, more than others, is illustrated by the voices of those most affected, highlighting experiences of vulnerability, oppression and empowerment.

6.2.1 Mobilising around identity

Marginalisation is a both a process and a result of a process, which ensures that certain people are excluded from accessing and enjoying the same benefits, rights and claims that others in that society access.[427] This exclusion may be conscious or unconscious, on the part of both the marginalisers and the marginalised. It may be embedded in the "system" or inflicted by individuals, groups, communities and societies in general, who set up and maintain the "system". Marginalised people may also unconsciously reinforce such marginalisation. This deepens silence and invisibility and helps amplify stigma and discrimination. Marginalised people may experience levels of marginalisation; firstly they are marginalised on the basis of different identities and realities, for example, gender, sexuality, age, HIV status, geography and location and secondly they are marginalised by the very people and processes that are meant to ensure their well-being and uphold their rights, by exclusion in the design and implementation of policies and programmes. Addressing marginalisation means mobilising a more effective response where people can represent themselves, their own realities and find their own solutions, rather than only and always being represented by others.[428]

Identity politics refers to claiming ones identity as a member of an oppressed or marginalised group, and using identity as a political point of departures.[429] Identity is a major factor in political mobilisation. HIV status has raised a new

---

[427] Gender AIDS Forum. 2003 b

[428] Gender AIDS Forum. 2003. B. Gender AIDS Forum. 2008.

[429] Woodward, K. 1997

identity politics: the identity as a person living with HIV and AIDS. People living with HIV and AIDS have been at the forefront of the struggle for rights and access to treatment since the beginning of the pandemic.

Initially, following the history of the epidemic, men living with HIV were leading the fight for treatment.[430] In the late 1980's and early 1990's women and men living with HIV and AIDS organised globally under the banner of the Global Network of Positive People (GNP+). As in broader social movements, women as leaders and women's issues were marginalised in the politics of people living with HIV. Although women's issues around being marginalised on the basis of their HIV status were in some way addressed in this movement, the different realities of predominately white, gay men, did not match the realities of women living with HIV and AIDS, many of whom were poorer, black women from Africa.

Women therefore needed a home for their activism, a place to address their different realities and experiences of HIV, AIDS, vulnerability, blame, stigma and discrimination. In 1992, at the 8th International Conference on AIDS held in Amsterdam, a group of women living with HIV from different countries met to share experiences and develop strategies for future action. At this meeting the ICW, was established. ICW is the "only international network run for and by HIV positive women"[431] although this has become less true in recent times given that the head office in London is staffed, managed and led by HIV negative women.[432] ICW was founded in response to the lack of support, information and services available to women living with HIV worldwide and the need for women living with HIV to influence and input on policy development.[433]

The focus of ICW is based on identity politics, the need for women living with HIV and AIDS to be visible, vocal and have their different needs based on gender, class,

---

[430] Shilts, R. 2007.

[431] http://www.icw.org

[432] Personal discussions ICW members

[433] http://www.icw.org

regional differences, sexual orientation addressed. ICW is striving for a world where all HIV positive women:

- Engage in meaningful involvement at all political levels, local, national, regional, and international, especially where decisions that affect women's lives are being made;
- Have full access to care and treatment; and
- Enjoy full rights, particularly sexual, reproductive, legal, financial and general health rights irrespective of culture, age, religion, sexuality, social or economic status/class and race.[434]

How do women living with HIV and AIDS identify themselves? The following extract from a paper written by a group of seven women living with HIV, highlights multiple identities and the impact of living with HIV.

> "We are women living with HIV and AIDS but are so many other things as well. We are breadwinners, home-makers, activists, mothers, daughters, counsellors, lesbians, community members, leaders. We are doctors, domestic workers, accountants, unemployed. We are white, black, Christian, Muslim. Because of these realities some of us are more marginalised than others.
>
> We need to be acknowledged as sexual beings – both as women and as women living with HIV. We need to be seen as more than 'reproductive machines'.
>
> We are all unique. As women living with HIV we experience many of the same things but we also experience living with HIV and AIDS differently. The lives of rural and urban women are not the same – working women and unemployed women face many different challenges.

---

[434] http://www.icw.org

Often our own response to HIV and AIDS, and the expectations placed on women by society, echoes our tradition role as women. We are seen as care-givers, to our partners, children and family– we are expected to put the needs of others before ourselves. This is not good for us – for our health and well-being - it means that not only are we fighting a virus but we are also challenging the system which sees the needs of our children and our partners as more important that our needs as women.[435]

The realities of women living with HIV and their challenges are clearly illustrated. Some identities and roles may be in conflict with each other, for example, societal expectations of what it means to be a mother and a partner are often seen as more important than women's own needs. Having an HIV positive identity can transcend other identities; that is the experiences of being a women living with HIV, including oppression, marginalisation, blame and stigma, are so overwhelming and so acute that women are able to come together, despite differences, in order to address the inequalities experienced by HIV positive women.

For many women, realising their identity as a woman living with HIV, as with any other identity, is a process. It is not uncommon for oppressed groups to internalise such oppression, and a conscientisation process, similar to that experienced by women in the feminist movement of the 1960's and 1970's is necessary. For example, at the first ICW Young Women's Dialogue (YWD), a young Namibian woman stood up at the end of the workshop and said, "I have a new identity – I am not a person living with HIV, I am a young woman living with HIV".[436] In the past she had disregarded her identity as a woman, and in doing so paid little attention to her realities as a women living with HIV. The workshop allowed her to reflect on her life and her oppression and deepen her understanding of the links between her experiences and her gender.

---

[435] Ndlovo, B, Masondo, T, Mthembu , P, Barnanbus, N, Silondo, P, Ntombela, A.,Telophi, R, and Tallis, V. 2003.

[436] Workshop participant YWD Durban.

A second, more recent example of internalised oppression occurred at the YWD Namibia in January 2008. Many of the young women present believed strongly that women living with HIV 'should not have children' that it was 'irresponsible' and did not take the interest of the child into account.[437] Such beliefs mirror societal messages that seek to control HIV positive women's reproductive and sexual rights. Through a process of exploring such beliefs, their origin and purpose, young women were able to understand better their rights, responsibilities and internalise issues around bodily autonomy. It is only through such processes, which build solidarity amongst women living with HIV at the same time as challenging individual beliefs around gender, power and rights, that such widespread beliefs can be challenged and reversed. The goal is for women to acknowledge their rights at the same time understanding that everyone is entitled to exercise their own choices without fear of discrimination.

A key part of mobilising around identity is to build consciousness and solidarity:

> *"As a young women living with HIV and AIDS I need to understand my rights and to use this to help others".[438]*

> *"This workshop empowered me to deal with my fears – I know if I don't make changes in my life and don't tell other women they will suffer in silence".[439]*

Through conscientising processes, in which women come to realise the political nature of their personal oppression, solidarity is built. Women living with HIV have a history of sharing their issues and concerns through support groups. The work that ICW does is built on the experiences of women 'sharing problems' to politicise such experiences and mobilising women into action. A key part of the YWD's for

---

[437] Workshop discussion, Namibia

[438] Workshop participant, Namibia

[439] Workshop participant, South Africa

example was to develop action plans based on the issues identified by the groups of young women, for example, economic empowerment and forced and coerced sterilisation which will be discussed later.

6.2.2 Why is a movement of women living with HIV necessary?

"W*omen's history in the epidemic was one of unrelenting marginalisation.*"[440]

The issues facing women living with HIV and AIDS are many and varied. Women face multiple marginalisations on the basis of race, class, gender, sexual orientation, urban and rural divide.   HIV intensifies already existing marginalisations and oppressions.   Part of building solidarity is to ensure that women speak in an amplified voice – "we will not get things on a silver platter, sometimes we must demand what we want."[441]

For the purpose of this case study, I will explore the lack of access to sexual and reproductive rights faced by women living with HIV and AIDS, and examine the ongoing solidarity, activism and advocacy by women living with HIV in Southern Africa.   In 2005, a ten country study, commissioned by an organisation called Ipas, examined the experiences of women living with HIV and AIDS and their ability to access sexual and reproductive health and rights.   In Southern Africa, the study explored the realities of women in South Africa, Lesotho and Swaziland. The South African study was conducted by GAF.   The study uncovered shocking practices around the denial of rights in the health care setting.   A brief synopsis of this research defines the context of women living with HIV, rights and access and highlights why women need to mobilise and act in solidarity.

The current health care service in South Africa is still battling with the legacy of apartheid: most women, especially poor, marginalised women, have never accessed acceptable standards of sexual and reproductive health.   Transformation

---

[440] Patricia Flemming, US Government spokesperson quoted in Stoller, N. 1997. p 11

[441] Participant, ICW Young Women's Dialogue, South Africa

has been hampered by many issues including an increasing burden of HIV and AIDS and a steady 'brain drain' of skilled and experienced health care workers.

HIV status has now become a reason for exclusion from, and denial of, services. Stigma and discrimination against women living with HIV has become common, this is experienced on many levels across the prevention-care continuum, from difficulties in accessing treatment for opportunistic infections, antiretroviral therapy, to lack of access to adequate care and support.

One specific way that women experience this exclusion is through the lack of control and access to sexual and reproductive health and rights. The *Platform of Action for the World Conference on Women in Beijing* states that the human rights of women include the "right to have control over and decide freely and responsibly matters relating to their own sexuality."[442] The reality is that, globally, women are from a world in which such rights are nowhere near to being attained.[443] Previous oppressive and controlling policies in South Africa, pre 1994, have certainly formed the backdrop for future sexual and reproductive control albeit on different grounds, that of HIV status.

The following extract from an interview from the GAF/Ipas study with a woman living with HIV highlights the realities of women's lives, and underlines the many difficulties and challenges for women to realise their sexual and reproductive rights:

> "We, as women, have no support from our husbands and the health care centers, my husband beats me even for burning the food, I was kicked and blamed for bringing HIV and AIDS in his house. I used to attend the support group. He followed me to stop me from attending and beat me all the way home. At home he threw chairs and bottles of beer at me threatening to kill me with a gun if I continued with the support group. I cried for help but my

---

[442] Berer, M. 2000 p 6

[443] Berer, M. 2000

husband grabbed me to his bed for sex. The children were screaming in the next bedroom and they noticed that something bad was happening to me.

He disclosed my status to the children shouting to the children that their mother was HIV positive, that is why she is attending support groups. She is running away to infect more men. My husband never tested but insisted I should give him my treatment, which I did because I had no option. My husband had STI's, but he was always in denial and I had a lot of bleeding after sex and had to rush to the clinic and got no support from health workers and they blamed me for refusing to have sex with my husband. That is when I disappeared with my children to save my life

I went to my mother to tell her that I had had enough and that I was coming back home but I had no support. The issue according to her was that the man had paid lobola[444] and I'm supposed to die there. I have built my own house with my children and I am a free woman without a husband. I will never divorce him because he will kill me and it is worse because my parents are on his side. As women we are given access to antenatal services and the first to be tested for HIV but always blamed by partners for the spread".[445]

The issues raised in this story; violence, abuse, lack of support, rape, forced disclosure are common themes in group discussions and interviews with women living with HIV and AIDS in Southern Africa.[446]   Multiple oppressions based on multiple identities are evident. It is obvious that current approaches to HIV and AIDS are woefully inadequate to address the issues outlined above.

---

[444] Bride price

[445] Interview 3 for GAF/Ipas study. May 2005.

[446] Interviews GAF/Ipas, study. May 2005. Participants YWD workshops. 2004, 2006.

Women's experiences at clinics

There are policies and/or minimum standards that exist at a national and provincial level that inform training of health care workers as well as how people should be treated but interviews in the clinic settings highlighted that these are not well known and are certainly not implemented.[447]   The overall experience of women attending health care settings is negative, a violation of human rights.

> *"There is a lot of discrimination and no service evaluation. There is no confidentiality, no caring, no respect, no motivation, no constructiveness, compassion, empathy and emotional and physical support. It is all about business, violation of human and reproductive rights".*[448]

The general lack of respect was experienced in many different ways. For example, it was reported that one of the clinics was never opened on time. The behaviour of health care workers towards clients is undermining, rude and dismissive.[449]   One woman related how the health care workers "shout" at patients:

> *"If you are very sick they shout at you and say that you are pretending. They tell you that you are not the only patient who is sick in the clinic, 'so keep quiet and stop making noise.'"* [450]

Women themselves are often deciding not to go to the clinic because of the service received.

> *"Often they treat you very badly in such a way that many people have stopped going to the clinic. Many people are dying through depression stress and stigmatisation".*[451]

---

[447] http://www.doh.gov.za, Interviews GAF/Ipas study. May 2005.

[448] Researcher in the GAF/IPAS study at the analaysis / debriefing workshop on her observations from the clinic.

[449] Interviews GAF/Ipas study. May 2005.

[450] Focus group 2 GAF/Ipas study. May 2005.

[451] Interview 6. GAF/Ipas study. May 2005.

Health care workers do not seem to be aware of the impact of their behaviour and attitudes on clients. One of the clinic nurses interviewed stated that *"you have to be hard on them to get them to obey".*[452]

Lack of knowledge

Despite three decades of the HIV and AIDS epidemic, the women interviewed believed that nurses are not well educated about HIV and AIDS and have insufficient training and experience. Generally it was observed that the information given about prevention, treatment, sexual and reproductive rights and health was basic and not gender sensitive.[453] Through treatment literacy programmes, people living with HIV often have more knowledge than health care providers. One nurse admitted that she did not know much about treatment and other needs of women living with HIV. She noted that the clinic gets little information and skills building on these issues.[454]

Confidentiality

Policy documents assert that confidentiality should be guaranteed from 'testing through to death' – yet this is not the experience of women attending the clinics. Lack of confidentiality was a common theme across the interviews and focus groups. Some examples of breaches in confidentiality include:

- The husband of one of the support group members interviewed was given her HIV status over the telephone by a clinic sister.[455]

---

[452] Interview health care worker clinic 2. GAF/Ipas study. May 2006

[453] Interviews GAF/Ipas study. May 2006

[454] Interview health care worker clinic 1. GAF/Ipas study. May 2005.

[455] Focus Group 1 GAF/Ipas study. May 2005.

- A nurse disclosing to a woman's in-laws before her marriage took place: "this one must not come to your family to marry as she is HIV positive" [456]

Such breaches of confidentiality are clearly violations of human rights, but also point to the attitudes of health care workers and highlight the uncaring, abusive context of health 'care' settings.

Issues of access: Understanding the barriers to services and treatment

Lack of access to services is common.[457] Women recounted their experiences of lack of access to treatment, reproductive services and sexual health services.

> *"Too many women have died because they have no access to treatment and because of the stigma that is associated with HIV and AIDS".[458]*

Attending a specific clinic does not mean that treatment will be accessed. Being known by a health care worker, through a support group, personal relationship, friendship or being a regular at the clinic seems to be a pre-requisite for treatment.[459]

> *"If you need treatment you should find a friend or a relative in the hospital".[460]*

---

[456] Interview 8 GAF/Ipas study. May 2005.

[457] Interviews GAf/Ipas study. May 2005. Workshop participants YWD 2004, 2006.

[458] Focus Group 2 GAF/Ipas study. May 2005.

[459] Interviews and focus groups GAF/Ipas study. May 2006

[460] Interview 2 GAF/Ipas study. May 2005.

"If you cannot establish contacts don't bother to go to the clinic". [461]

There was a general frustration at the processes of accessing treatment. Women interviewed felt that there are too many excuses and space for exclusion when it comes to accessing ante retro viral therapy (ARV's) and treatment for opportunistic infections.

Sexual and reproductive rights

The interviews raised some serious, shocking and even horrific stories of sexual and reproductive rights being withheld, and many instances of abuse at the hands of the health care worker. There is a perception by women living with HIV that nurses are against the idea of HIV positive women being pregnant, and this was verified by the attitudes of the health care workers.[462] Women living with HIV related experiences of nurses abusing them when the nurses discovered that the women were pregnant.

> *"They ask the women why do they fall pregnant because they are HIV positive and are going to give birth to Nkosi Johnson".* [463] [464]

A number of women were aware about the need, especially for young women living with HIV, to have regular pap-smears. Often this knowledge was as a result of NGO treatment literacy programmes rather than from the health care workers. South African government policy is that women over the age of thirty can access three free pap smears in their lifetime.[465] This does not take into account the specific needs of women living with HIV, who are more susceptible to cervical cancer. It also ignores the vulnerability of younger women to HIV and by implication vulnerability to cervical cancer. The reality is that by the time the free

---

[461] Focus Group 1 GAF/Ipas study. May 2005.

[462] Interviews GAF/Ipas study. May 2005.

[463] Focus group 2 GAF/Ipas study. May 2005.

[464] Nkosi Johnson was a young South African activist who was born with HIV and died at the age of 12.

[465] http://www.doh.gov.za

pap smears are available many women have died. The CDC recommends two pap smears per annum for women living with HIV, whilst WHO suggests one per annum.[466] It is clear that South African policy needs to change.

Access to termination of pregnancy

Termination of pregnancy has been legal in South African since 1997. However, accessing this right is not a given, and many women are either denied or 'persuaded against' this option by health care workers.[467] Women spoke of being 'scared' to ask for a termination of pregnancy at the clinics.

> *"If we do access the services we are treated poorly – no respect, health care workers are judgmental and often cruel: this adds to the emotional trauma of having a termination of pregnancy".[468]*

Health care workers still exert a major influence on women regarding their reproductive choices, often through misinformation, withholding of information or through incomplete or poor explanations:

> *"I did try to get information when I was pregnant and I tried to abort and the doctor said that I must be aware that I can die because there might be a lot of bleeding".[469]*

This woman, based on the doctor's advice, was too scared to terminate and went on to have the baby. Another experience was of a nurse refusing termination of pregnancy as an "instruction not an option."[470] Women reported experiences of going to the clinic to request a termination of pregnancy and being sent from clinic

---

[466] http://www.cdc.gov

[467] Interviews, focus groups GAF/Ipas study. May 2005.

[468] Focus Group 3 GAF/Ipas study. May 2005.

[469] Interview 2 GAF/Ipas study. May 2005.

[470] Focus group 2 GAF/Ipas study. May 2005.

to hospital with no explanation as to why.[471] As one women stated, the attitudes of health care workers make women go "*to the streets for an abortion*".[472]

It is ironic that in a country which termination of pregnancy is legal that women are forced to go for unsafe, illegal terminations. One of the worst cases of abuse uncovered in the interviews was of a woman living with HIV who decided to have a termination of pregnancy. Once the procedure was over, she was given the foetus to take home. The nurses told her that they had done that much for her, it was her decision and that she must deal with the foetus because if they did they would have nightmares.[473] Women living with HIV are faced with mixed messages from health care workers: they should not get pregnant but if they do they should not have abortions.

Termination of pregnancy is also linked to forced sterilisation, where women are told they will be given a termination on condition that they agree to being sterilised.[474] The issue of forced sterilisation was reportedly much worse in the rural areas, but more recently it has become apparent that sterilisations are happening in urban areas as well. This will be discussed in further detail below as it is a key issue for ICW Southern Africa.

In summary, women living with HIV and AIDS do not easily access their rights to sexual and reproductive health and services. This is due to a complex set of interrelated factors. Firstly, the oppression of women in intimate relationships and households impacts on her ability to access health. For example, women are often prevented by their male partners from attending health care centres or other places of support, counselling and care or women have their medication taken away from them and either used by their male partners or destroyed or thrown away.[475]

---

[471] Focus Group 3. GAF/Ipas study. May 2005.

[472] Focus group 2 GAF/Ipas study. May 2005.

[473] Interview 6 GAF/Ipas study. May 2005.

[474] Interview ICW SA. September 2008.

[475] Interviews GAF/Ipas study. May 2005.

Secondly, the health care system is regarded by many women living with HIV and AIDS as a place of trauma and degradation. This applies to accessing health in general but more especially when it comes to reproductive and sexual health issues which are always more sensitive, complex and personally invasive. The lack of access by women living with HIV to reproductive and sexual health services is in the first instance an outcome of an undeveloped health care system in general, a people unfriendly culture and a women unfriendly range of services and skills. As women living with HIV live with stigma, blame and discrimination these issues are heightened. There are few reasons for a women living with HIV to want to present herself for "care" to the public health care system. Yet the crucial importance of the ability, opportunity and motivation of women living with HIV as "health seekers" is well understood. Even when women living with HIV become empowered to be actors in their own health, they are insulted for knowing and understanding their needs and the correct options for their treatment.

Over and above this, the culture of the medical profession also seems to reinforce the power of health care workers as they consistently deny women their rights. At the same time, nurses are at the bottom of the pile of a patriarchal medical system and have internalised the norms and values of this system.   The GAF/Ipas study found numerous examples of strong, negative attitudes of health care workers to women in general and women living with HIV in particular. This was expressed as rude, abusive and sometimes cruel behaviour as well as misinformation and ineffective communication. The health care centre should be a place of quality services, in respect of equipment, medication and attitudes of personnel but this is seldom true in the public sector system. The consequences of these attitudes include women often avoid attending health care centres until they are desperate, so remain sick and depressed at home.[476]

Furthermore, health care workers lack of knowledge about HIV and AIDS result in inaccurate, incomplete information being given in a place and context where

---

[476] Focus groups GAF/Ipas study. May 2005.

accuracy and good communication are critical to health and well-being. HIV and AIDS are creating imperatives for women and men to become better informed about medical and treatment issues. An increasing number of women present at health care centres expecting to engage with health care workers on the options for their treatment. Health care workers often don't have this information themselves or are threatened by a treatment literate community. Demonstrating knowledge of drug options as a women living with HIV may have a negative impact on women's ability to access the drugs they need.[477]

The GAF/Ipas study clearly indicates that access to reproductive health and services is poor, uneven and erratic and dependant largely on the will of the health care worker. Even knowing one's rights doesn't guarantee that women are able to demand and access these services. It is obvious that despite AIDS activism to date, including treatment activism has not impacted sufficiently on women's lives; women living with HIV are still unable to access quality care, treatment and support that meet their needs for sexual and reproductive health. There is a necessity for the movement of women living with HIV to be strengthened and for the movement to address the numerous violations and oppressions facing HIV positive women.

6.2.3 Solidarity: fighting for the sexual and reproductive rights of women living with HIV and AIDS

Ryan notes that

> *"for social groups to change their situation there is a need for concerted efforts with multifaceted strategies: political work and disruptive direct actions, national grassroots organizing, mass media events and personal change efforts".[478]*

---

[477] Focus groups and interviews GAF/Ipas study. May 2005.

[478] Ryan, B. 1992. p 59

Sexual and reproductive rights have been a key issue for women living with HIV and AIDS and ICW has been active in various campaigns globally and regionally. I will focus on the most recent campaign which tackles forced and coerced sterilisation of women living with HIV and AIDS. According to Patel[479] coerced sterilization refers to cases where coercion was involved in obtaining the legally required informed consent for the sterilization. Whilst I agree in part with this definition, one needs to question the actual nature of consent – whilst consent may have been obtained it may not be informed. Forced sterilization refers to cases where the women were unaware that they would be undergoing sterilization at the time of the surgery and only learned that they were sterilized after the procedure had been performed.

Women's experiences of coerced and forced sterilisation are diverse. An example in Patel[480] highlights the complex "choices" that women in difficult circumstances are forced to make:

> "A young pregnant woman goes to the local public hospital to give birth. At the hospital she is told by the medical personnel that she has to have a caesarean delivery due to the size of the baby and to ensure her and the baby's health. She is also informed that the hospital will not perform this necessary caesarean section unless she also agrees to be sterilized. She conveys to the medical personnel that she does not want to be sterilized as she would like to have the option of having additional children in the future. The doctor refuses to perform the caesarean unless she agrees. She feels she has no option and in order to maintain her and the baby's health she 'agrees' to be sterilized".[481]

Other experiences of sterilisation documented include medical personnel including a consent form for sterilisation with a number of other consent forms and women

---

[479] Patel, P. 2008.
[480] Patel, P. 2008.
[481] Patel, P 2008 p38

given sterilisation forms to sign while being wheeled to the operating theatre, in one instance while in labour.[482]

One woman attending the YWD Namibia spoke of how she signed 'consent' forms and only later realized she was sterilised when she went to obtain contraceptives at a later date and was told she did not need them.[483]   Another woman related her experience of being informed about the need for sterilisation on the day she received her HIV positive diagnosis.[484]   A Durban women was shown pictures of deformed babies and told this is what would happen to her baby should she fall pregnant; she agreed to sterilisation.[485] These examples demonstrate clearly that health care workers are using a variety of unethical and abusive methods to ensure that they obtain 'informed consent' in order to promote a sterilisation agenda and deny women living with HIV their sexual and reproductive rights.

This issue of the forced and coerced sterilisation of HIV positive women was originally raised in South Africa, in an article by AIDS activist and woman living with HIV, Promise Mthembu.[486]   Stemming from this article, and Mthembu's vociferous advocacy in voicing the issue in various platforms both in South Africa and in the region, it became apparent that this was not an isolated experience, but in fact a fairly common one.   In 2006 ICW Southern Africa held a workshop for South African women living with HIV to mobilise and strategise around the issue.   The organisation began to document the experiences of women living with HIV and forced and coerced sterilisation.   Different strategies were employed to bring the issue to the fore including litigation, advocacy and activism.

After the strategy workshop women went back to their networks to uncover other cases of forced sterilisation, and found alarmingly that the practice was, and still is wide-spread in different contexts.   In Orange Farm, Gauteng, sterilisation of HIV

---

[482] Patel, P. 2008.

[483] Workshop participant YWD Namibia. January 2008.

[484] Workshop participant Durban. December 2006.

[485] Workshop participant Durban. December 2006.

[486] Mthembu, P. 1998.

positive women is linked to accessing termination of pregnancy. An ICW Southern Africa activist identified a fourteen year old girl who had attended the clinic for an abortion, had found out her HIV status at the same time, and who had been forcibly sterilised.[487]

A major hospital in Durban is linking sterilisation to caesarean section deliveries, ensuring that women living with HIV never get pregnant again.[488] An ARV clinic in a large township in KwaZulu Natal 'recommends' that women coming for treatment are also sterilised. The nursing staff are quite open about this, and do not see anything wrong with the practice.[489]

HIV positive women activists are working closely with these structures in an attempt to get access to the women who are being sterilised. This causes a conflict of interest, but access to the women is vital in order to document cases and make interventions. As noted by Promise Mthembu, there is an "assumption that forced sterilisation is happening in other spaces",[490] and women activists are constantly talking to other women living with HIV to try and document as many cases as possible to prepare for further activism and possible litigation if funds become available.

Through strategised actions there have been some successes. These include a professor at one of the hospitals where forced sterilisations are agreeing to reverse the procedure.[491] Unfortunately the courageous women who went back to the hospital to insist on the reversal died before it was she could have the procedure performed. However, the professor has agreed to assist other women. In Gauteng a support group has been set up for women who have been sterilised. Apart from getting support, the women are sharing and documenting the evidence. A growing

---

[487] Interview. ICW SA. September 2008.

[488] Interview ICW SA. September 2008.

[489] Interview ICW SA. September 2008

[490] Interview ICW SA. September 2008.

[491] Interview ICW SA. September 2008.

body of knowledge documented and owned by women living with HIV is emerging which will assist further strategies.[492]

At a meeting of young women in Namibia in January 2008, women discussed their experiences of accessing sexual and reproductive rights, and the issue of sterilisation was raised: four of the women out of the twenty present had experienced forced or coerced sterilisation, resonating with the experience of South African women.   Women in the workshop were understandably angry and on the last day of the workshop when a member of parliament was present at the closing ceremony the issue of sterilisation of HIV positive women was raised. The Member of Parliament asked the women present to investigate and document the cases and then report back to her.[493]

ICW Namibia linked up with the Legal Assistance Centre (LAC), the Southern African Litigation Centre (SALC) and Open Society Initiative of Southern Africa (OSISA) to investigate the cases of sterilisation with a view to litigation. Currently there are over fifty cases documented, fourteen with the potential for litigation[494] and four that are in the litigation process.[495]   The LAC has instituted legal proceedings on behalf of women living with HIV who have been sterilised[496] and are using litigation to compensate particular women who have been subjected to coerced sterilisation and asking the High Court in Namibia to declare the practice unconstitutional.   Specifically, the LAC have alleged that the practice of forced sterilisation is a violation of the women's right to life, liberty, human dignity, freedom from cruel, inhuman and degrading treatment and equality.[497]

---

[492] Interviews ICW SA. September 2008.

[493] YWD Workshop Namibia. January 2008.

[494] According to Patel litigation as an advocacy strategy in this situation has the benefit of raising the public profile of the issue, providing redress for some of its victims, and hopefully providing a deterrent to other medical personnel who may engage in the practice.

[495] Meeting ICW/LAC/OSISA. Namibia. December 2008.

[496] The law in Namibia requires that the harm must have been committed in the previous 3 years to initiate legal action and so some women are unable to proceed with their cases.

[497] Patel, P. 2008.

The ICW, LAC, SALC and OSISA approach in Namibia has been multi-pronged: the aim of the legal action is to ensure redress to the women litigants but also to repeal any legal authority or policy which gives medical personnel the authority to continue this violation of women's fundamental rights. Even when or if the official law prohibits forced and coercive sterilisation, it is not always easy to ensure that such practices cease. The campaign thus has other strategies including on-going advocacy to back up the legal challenge and empowering women living with HIV and AIDS to understand and claim their rights.[498]

Women living with HIV have continued to request and hold meetings with both the Ministry and the Department of Health. At a recent meeting they were reassured that a circular had been sent to all clinics and hospitals outlining the illegality of the practice of sterilising women living with HIV, however, when ICW checked at health care facilities the circular had not been received.[499] Furthermore, due to the mobilisation amongst women living with HIV, more and very recent cases of forced sterilisation are being reported: it is clear that the practice is still very much alive. Women are voluntarily coming forward and requesting to ICW that their cases are monitored.[500]

The power with, that is, mobilising a response through solidarity is very evident in this case. Not only have the issues been used to galvanise women living with HIV and AIDS in Namibia, and brought together those women who have been sterilised as well as those who have not, alliances have also been forged between human rights organisations in Namibia and Southern Africa.

Organising around identity, especially as HIV positive women can be challenging. The high levels of stigma discrimination faced by women living with HIV impact on the ability to mobilise women; often women are too afraid to disclose their status and fear if they are involved in activism their HIV status will become known in the

---

[498] Personal communication with ICW Namibia.

[499] Personal communication with ICW Namibia.

[500] Personal communication with ICW Namibia.

community.[501]   Despite such challenges and barriers, there is a groundswell of voices in Southern Africa that has contributed to the successes achieved by ICW.[502] The organisation has facilitated the consciousness raising of many women living with HIV and in doing so build a core of activists committed to improving their lives and the lives of other HIV positive women.   Although nascent, the movement of women living with HIV in Southern Africa continues to strengthen and increase its presence and voice.

The next case study addresses solidarity around an issue, that is the need for microbicides.

6.2. Case study: Mobilising around an Issue: Global Action for Microbicides

As discussed in earlier, global statistics show a dramatic increase in the number of women living with HIV and AIDS.[503]   Certain groups of women are particularly vulnerable, for example, young women and women who have sex in exchange for goods, services or money. An analysis of the response to HIV and AIDS to date, shows that at national and global level both prevention and care interventions have not been effective. Prevention efforts globally have done little to empower women to reduce their vulnerability to HIV infection or re-infection. AIDS prevention campaigns to date fail women by urging prevention methods that women often have little or no power to apply, such as, condoms, abstinence and mutual fidelity (ABC). The 'ABC' message, which is totally inadequate for addressing women's realities, is still high on the agenda.   "ABC terminology infantilizes the prevention discussion by excluding essential interventions and oversimplifying the prevention challenge facing countries".[504]   Over 28 years into a steadily increasing epidemic

---

[501] Interviews ICW SA. September 2008.

[502] Interviews ICW SA. September 2008.

[503] UNAIDS. 2008.

[504] Collins, C, Coates, T.J., and Curran, J. 2008 p5

prevention methods that do little to reduce women's vulnerability are still widely promoted.

In most heterosexual relationships men are in control of women's sexuality, deciding when and how sex takes place.[505] However, women are expected to take responsibility for their sexual health.[506] The rapid increase of women living with HIV and AIDS highlights the fact that existing prevention methods are not working for women. At present there are two prevention barrier methods available, the male and female condom. The male condom is promoted as the main prevention method for the sexually active population, both for heterosexuals and for men who have sex with men. Millions of dollars world-wide is spent on the purchase and distribution of the male condom, in an effort to increase the access to, and hopefully, the use of the condom. Furthermore, social marketing programmes (subsidised condoms sold at a variety of locations and non-traditional outlets such as *shebeens*[507] and petrol stations) have increased condom accessibility.

Whilst there has been an increase in the number of condoms distributed, distribution alone is not sufficient to promote condom usage. Distribution must go along with promotion including education and training, skills building and the creation of an environment in which condom use is made easier. For example, at traditional outlets, such as clinics, the attitude of some health care workers makes it difficult for men and women, especially youth; to request condoms.[508] It is important to remember that the effectiveness of the male condoms as a prevention strategy relies on men's willingness to use the condom. Studies show limited success of condom prevention programmes with low percentages of people engaging in sustained condom use.[509] Maharaj found widespread disapproval of condom use, with condoms are more likely to be used in non-primary than primary

---

[505] Richardson, D. 1996.

[506] Richardson, D. 1996. Wilton, T. 1997. Baylis C., and Bujra, J. 2000

[507] Township taverns.

[508] Abdool Karim, Q. 1998.

[509] Maharaj, P. 2005.

sexual relationships.[510]   In short, male condoms only offer protection to women if men are prepared to use them, and many men are not prepared to do so. In the absence of sustained male condom use, a female-controlled method is obviously needed. At present, the only female controlled method is the female condom.

The female condom was introduced in 1996 as a new method of prevention and additional prevention tool. The female condom is both safe and effective if used correctly and studies have shown high levels of acceptability among men and women in many countries.[511]   The condom provides protection against unwanted pregnancy, HIV and other STI's. Whilst partially solving the problem of a woman-controlled barrier method, the female condom has certain limitations; it is more expensive than the male condom, governments distribute far fewer female condoms than male condoms, for example in South Africa only 1 million female condoms were distributed in 2002 as opposed to 220 million male condoms.[512]

Over and above the expense, resulting in lack of access to the female condom, there are other barriers to its use. The female condom requires, in most cases, that women have to negotiate its use with their partner. Despite the fact that the condom can be inserted hours prior to sex, it is difficult to hide and most men are aware of it. Other barriers to use of the female condom are issues of acceptability including size and appearance, noise levels of the condom during sex, and discomfort to the user, especially when inserting the condom.   The female condom is for some women a viable option, for others it remains out of reach, financially or due to inaccessibility. Some women are unable to negotiate the use of a female condom with their male partners.

Given that prevention options for women are limited strategies to reduce women's vulnerability to HIV and AIDS and other STI's are needed. The long term strategy must be to challenge gender oppression and transform sexual relations. In the

---

[510] Maharaj. P. 2005.

[511] http://www.femalehealth.com/pdf/ResearchSummary.pdf

[512] Manto Tsbalala Msimang 2003, Presentation 1st National AIDS Conference, Durban

short and medium term there is an urgent need to increase the range of prevention methods available and provide women with some power to either negotiate safer sex or to have protected sex without her partner knowing. Thus, a protection method that is controlled by women (one which does not necessarily involve negotiation with the male partner) is essential to empower women to reduce the risk of HIV and STI infection. One such technology is microbicides.

6.3.1 What is a microbicide

A microbicide is a substance that is inserted in the vagina or rectum that will substantially reduce the transmission of STI's including HIV during penetrative sex. Microbicides have the potential to be a fully controlled female barrier method, which would reduce women's vulnerability to HIV. Despite growing consensus that it is theoretically possible to develop a microbicide(s) that can be used to prevent the transmission of HIV and other STI's a viable microbicide does not exist at present. This is in a large part due to the relatively little investment that is spent on the research and development into a microbicide[513] but is also due to the complexities of the human immune virus.

There is a critical need for the research, development and roll out of microbicides to be placed within a sexual and reproductive rights framework. The location of microbicides within a sexual and reproductive rights framework provides a useful paradigm through which to understand both the need for, and the potential of microbicides to address women's vulnerability.

> *"The microbicide has the potential to challenge sexual preconceptions and behaviours. A sexual and reproductive health rights framework and the*

---

[513] Microbicides are being tested in different formulations including, gels, suppositories, creams, film, sponge and vaginal rings. They work through chemical means or mechanical devices in three key ways:
- Killing the pathogen (virus/bacteria) or creating a barrier to the pathogen.
- Inhibiting fusion of the virus to the host cell that is not allowing the virus or bacteria to infect particular cells.
- Preventing replication of the virus

awareness of women's rights has created a platform for the introduction of microbicides".[514]

It is important that a microbicide is both accessible and acceptable to the women and men who will use it. Research into acceptability show that an ideal microbicide needs to be[515] affordable, have a long duration of action, made of formulations acceptable for women and unnoticeable, to avoid the necessity for negotiation by women who have little or no control over their sexual relations. It is also vital that the product be safe for multiple daily use (for example, if a women used the product one to two times per day), safe for vaginal and rectal use and developed with and without contraceptive properties, to offer women a choice regarding pregnancy. A microbicide without contraceptive properties would provide women wanting to fall pregnant with a safe alternative, while those with contraceptive properties would give women control over reproduction and minimise the risk of HIV/STI infection.

Acceptability is a complex interplay between a woman, a technology and a service delivery environment.[516] Choice of microbicide will vary, depending on personal preferences, the nature of the intimate relationship (for example, whether it is new, established, primary, what are the gender power relations) and reproductive intentions. Understanding women's personal and societal vulnerability is vital. The availability and use of microbicide should help women to take control of their bodies, their lives and their fertility. It is important to ensure that women are satisfied with using a specific method. Research has shown that having more products (spread across mechanisms and within mechanisms) is most desirable – giving women both choice and the chance of finding a contraceptive or HIV prevention method which is most suitable for her needs at any given time.[517] The

---

[514] Tallis, V., Christian, B and Cavanagh, D. 2005. P 7

[515] Tallis, V., Christian, B and Cavanagh, D 2005. Moon, M., Mbizvo, M., Nyamapfeni, P, Heiman, J. and Padian, N. 1998

[516] Heise in Tallis, V., Christian, B and Cavanagh, D 2005

[517] Gready, M, Klugman, B, Xaba, M, Boikango, and Rees, H. 1997

more products that exist the more chance women will try different methods until finding one that is best for health, needs and priorities.[518]

It is important to note that microbicides may have a lower percentage of effectiveness than condoms. If used correctly, and of good quality, a condom can be 100% safe and it is unlikely that any microbicide, in the near future, will offer 100% protection.[519] However, this does not necessarily mean that microbicides will have less impact than the male condom. To assess the potential value of a microbicide it is vital to focus on how well it prevents transmission, how often and with how many sexual partners it will be used. For example, a microbicide may only give half the protection of the male condom but may be used 50% more often thus effectively reducing the vulnerability of women and men to HIV and STI infection.[520]

6.3.2 The politics of microbicide research

Medical research is a profoundly gendered activity which is mostly determined from a male perspective. This includes what topics are chosen, what methods are used and how the data is analysed.[521]   Common problems experienced by women receive little attention if they are not seen as part of women's reproductive role.[522] Gender roles influence the degree of exposure and also the access and control of resources needed to protect women and men from infection. Research highlighting gender differences have focused mainly on women's reproductive lives, assessing the effects of various diseases on fertility and pregnancy outcomes.[523] Furthermore, if the same disease affects both men and women many researchers

---

[518] Talls, V., Christian, B and Cavanagh, D. 2005

[519] http://www.globalcampaign.org

[520] Watts C, Thompson W, Heise . L. 1998

[521] Lorber, J. 1997

[522] Garcia-Moreno, C. 1999

[523] Manderson in Garcia-Moreno:, C. 1999

have ignored possible differences in diagnostic indicators, in symptoms, in prognosis and in the relative effectiveness of different treatments.[524]

Scientists have been trying for about twenty years to develop an inexpensive but effective microbicide. Microbicide research has grown rapidly in the past eight to ten years, with the main focus of research on vaginal microbicides. However, as previously noted, it is also vital to consider rectal microbicides for men who have sex with men as well as heterosexual women who have anal sex. Most research into microbicides is currently being carried out by small biotechnology firms, non-governmental organisations, and academic institutions with funding mainly from public sources. A coalition of organisation called *hivresourcetracking.org* annually track investments into microbicide, vaccine and other prevention methodologies[525] – in their most recent report they note the following:[526]

- In 2007, total global investment in microbicide research and development was approximately US$226.5 million, a 2% increase over 2006 funding levels.
- Annual public and philanthropic research and development funding for microbicides more than tripled from US$65 million in 2000 to US$222 million in 2007.
- In 2007, the public sector provided 90% (US$203 million) of the funds allocated to microbicide research and development. The philanthropic sector provided 8% (US$19 million) and the commercial sector accounted for 2% (US$4.5 million) of investments made in 2007.

The up-surge in interest in microbicides is encouraging but increased public sector investment is vital to accelerate the search for a microbicide. Investment into the research and development of microbicides has been relatively small and more

---

[524] Doyal, L. 1994, Foster, P. 1995

[525] Adult male circumcision, herpes simplex virus type 2 (HSV-2) suppression, cervical barriers and pre-exposure prophylaxis using antiretroviral drugs (PrEP).

[526] Hivresourcetracking.org

money is needed to accelerate the development of microbicides. Big pharmaceuticals have not taken on the microbicide agenda because they believe that their investment in a first or second generation product will not yield adequate profits as the people who need a microbicide the most are poor women living in developing countries with limited government budgets for HIV prevention. In short there is a perception that the microbicide market will not generate large profit margins.[527]

However, research with potential users in both the developed and the developing world suggest that women will use the product and there is an urgent felt need by women for a prevention method that is controlled by women.[528] In both developed and developing countries women say they are willing to pay for the product. Studies show that the US market for vaginal microbicides alone could be around 1 billion US$ per annum and the global market would be at least two times that amount.[529]

Along with funding, it is critical that a coordinated approach to research and development is implemented and that resources are targeted to the most promising products. The process to test a microbicide is both a costly and a lengthy one, which goes through various stages including pre-clinical and clinical trials. Once the pre-clinical studies have been carried out satisfactorily clinical trials can begin. The purpose of clinical studies is to test the safety and effectiveness of microbicides in humans.

Phase I trials are conducted in small numbers of women (ten to fifty) at low risk of STI's to assess initial safety. The trial also assesses how acceptable the product is to those who are using it. The purpose of phase II trials is to further assess safety and acceptability and also to focus on efficacy. The trials are conducted in several hundred women who are potentially at risk for HIV and STI's. Phase III trials enrol

---

[527] www.global-campaign.org.

[528] Tallis, V., Christian, B. and Cavanagh, D. 2005.

[529] www.global-campaign.org.

much larger numbers of women (from hundreds to thousands) who are at risk of HIV and STI's. The purpose of Phase III trials is to provide information about the safety of long-term use, as well as how effective the product is.[530]

The process to research and develop a microbicide is a profoundly political one and microbicide research highlights critical ethical issues. There are issues about the where trials take place; all phase III trials are taking place in the developing world with high prevalence rates and with women are already vulnerable and marginalised. Community involvement in trials is vital but is not always apparent. The next few years will see a growing number of potential topical microbicides entering Phase III trials.   The need to test a new product requires healthy volunteers who are at risk of HIV infection to take part in trials. Informed consent, which at the very least must ensure that participation in trials is voluntary, does not in any way affect the quality of care a person has access to and is based on an understanding of the possible risks and/or benefits of the product being tested, is a critical ethical issue.[531]   Obtaining informed consent, especially from women who are vulnerable, is difficult and efforts made may not be enough.[532] Obtaining informed consent should thus be seen as a long and complex process.

6.3.3 Microbicide activism: different role players, different agenda's?

According to the GCM,[533] advocates have been working to draw attention to the need for new HIV prevention tools to supplement the male condom since 1987. The first leaders came from the field of women's health and contraceptive research and development. They were joined by advocates working on HIV and AIDS, STIs, infectious diseases and international development.   In April 1990, South African epidemiologist and advocate Zena Stein published a paper,[534] widely acknowledged as the first voice to draw widespread public attention to the issue. In the early

---

[530] de Zoysa, I, Elias, C.J, Bentley, M.E. 1998.

[531] Heise, L, McGrory, E.C, and Wood, S,Y. nd

[532] Opening address, Kim Dickson-Tetten. Microbicides 2002,

[533] http://www.globalcampaign.org

[534] The paper was HIV Prevention: The Need for Methods Women Can Use, in the American Journal of Public Health (80:460-462).

1990's the Medical Research Council of the UK decided to establish and fund a programme of microbicides research and with the US National Institutes of Health (NIH) were the first two public funding institutions that put money into microbicide research and development.[535]

Various advocacy efforts were evident in the 1990's attempting to ensure that the research process was ethical and mindful of women's issues. As noted by the Global Campaign the 1990's saw new actors in the microbicide arena with activities shifting from the lab to the field, as different microbicide candidates began to enter clinical trials.[536]   In July 1998 at the XII International AIDS Conference in Geneva, the Global Campaign, was formed and committed itself to focusing world attention on the critical need for new HIV prevention options for women.

The initial aims of the Global Campaign[537] included:

- Generating political pressure for increased investment in microbicides - products that could be used vaginally or rectally to protect women and their partners from HIV and other sexually transmitted infections,
- Ensuring that the public interest was protected and the rights and interests of trial participants, users, and communities were represented and respected throughout every phase of scientific process required to develop these new products.

The present microbicide advocacy landscape is much expanded: there are other international role players such as the International Partnership on Microbicides (IPM) who attempt to bridge the gap between scientist, funder and advocate. A regional body, African Microbicides Advocacy Group (AMAG), initiated by civil society activists, brings together the voices of African scientists, advocates and activists in an attempt to increase the voice of Africans in microbicide research and development.   At a National and local level there are a diverse group of

---

[535] http://www.global campaign.org/mission.htm

[536] http://www.global campaign.org/mission.htm

[537] http://www.global campaign.org/mission.htm

organisations, who have a strong interest in the microbicide agenda. These include community advisory boards (CAB) set up to ensure community participation in microbicide trials, AIDS organisations with a prevention focus and women's organisations who are concerned about women's sexual and reproductive rights.

An analysis of the microbicide movement is interesting: there are many role players all with a common end goal, that is, a viable microbicide. However, the movement is diverse, including women's activists, HIV and AIDS activists, scientists, funders and researchers and the agenda's are not always in synch. Whilst members of the informal movement may be united on the need for funding to develop a microbicide there are points of departure and have been disagreements between various sectors: for example, between scientists and activists, activists from the North and the South, activists and research funders. Solidarity is evident; however there are issues of departure that have the potential to disrupt the unity around the end goal.

There are current debates about microbicides putting added pressure on women, that is, increasing their responsibility from fertility to include HIV prevention. Such arguments are theoretically sound, but are often felt more by academics and researchers than women on the ground. They are also in contradiction with the need to expand options. Such debates fail to address the realities that HIV prevention technologies that are under male control do exist, and the failure of men to use these affect women negatively. The stark reality is in a male dominated society, where efforts at transforming power relations between women and men are underway, microbicides are needed by women.[538] Other areas of contention are the decision of where trials take place, who takes part in trials and the failed Nonoxynol 9 (N9) trial.

---

[538] Tallis, V. 2001 b. Tallis, V., Christian, B and Cavanagh, D. 2005

Where trials take place

As noted previously, the decision where to hold trials is based on HIV prevalence rates; most phase II and III trials target groups of women with relatively high HIV incidence who can maintain follow-up for prolonged periods and who are likely to comply with product use. Scientists select communities where they think it will be easy to recruit the large numbers of HIV negative women needed for the trial that at the same time have a relatively high probability of have sex with an HIV positive man during the trial. Women's rights activists have taken issue with this, and have raised concerns about trials in communities making women even more marginalised and vulnerable.

Anecdotal reports of high prevalence rates amongst women who enrol for trials and who are then 'discarded' indicate that in some communities over 50% of women enrolling are HIV positive.[539] Concern has also been raised at the manner of recruitment, and the fact that trial funders and /or scientists are reluctant to provide any support to women who enrol but are found to be HIV positive at the time of enrolment.[540]

Who takes part in trials

Criteria for inclusion and exclusion are based on age, frequency of sexual intercourse, HIV status, fertility intentions, anal sex practice and vaginal douching. The inclusion of young women's inclusion in is a critical issue. Whilst guidelines suggest that the legal age of informed consent (for trial participation) should be the minimum age for inclusion into clinical trials (that is eighteen years old) there have been advocacy efforts to include adolescents in microbicides due to their increased risk for HIV infection.[541]

---

[539] Personal communication. CAB member. Durban 2005.

[540] Tallis, V., Christian, B and Cavanagh, D. 2005

[541] Gender-aids@hdnet.org

The inclusion of women living with HIV in trials has also been raised. Promise Mthembu, from ICW, outlined the importance of a microbicide for women living with HIV and said that a microbicide will "enable HIV positive women to enjoy sex without fear of negative consequences."[542] This includes the ability to use a prevention method without necessarily having to disclose: the burden of disclosure often being placed on women who face serious consequences including violence. Microbicides will also help HIV positive women who want to have children to conceive safely. Many trials exclude women on the basis of their HIV status and despite a few safety trials little is known about the effects of microbicides on positive women, for example, what will the effect of microbicides be on women who are on ARV therapies. Given that few women actually know their HIV status, many women using microbicides in the future will be HIV positive which adds to the need for understanding how microbicides affect positive women.

The potential benefits of microbicides for sex workers are immense. [543] Sex workers are also at the forefront of advocacy, and have concerns about the fact that whilst they are most likely to use the product, testing products on women who have sex once or twice a day does not indicate that it will be safe for multiple daily use.[544]

Failed trials: The N9 experience

An area of contestation between scientists and activists, and South activists and North activists was around the N9 trials. N9 was an existing spermicide, which was tested for use on its own and in combination with other substances to see it was effective as an anti-HIV agent. The studies, sponsored by UNAIDS and Columbia Laboratories, began in 1996. Participants in the trials were sex workers from Benin, Cote d'Ivoire, South Africa and Thailand. Prior to the phase III trial a number of safety studies (Phase I and II) were conducted which found that the formulation of Nonoxynol-9 did not have any of the side effects, such as genital

---

[542] Promise Mthembu, 2002 Presentation, 14th International AIDS Conference, Barcelona 7 – 12 July.

[543] Ditmore, M. 2006

[544] Personal communication Melissa Ditmore. Network of Sex Work Projects (NSWP). September 2008.

sores and irritation, that were associated with other spermicide formulations. However the safety trials were conducted on women of lower risk and did not include multiple use of the product.[545]

The N-9 trial results were cause for concern and the results although inconclusive according to scientists, showed that higher doses and frequency of N-9 have been linked to increased findings of genital lesions. N-9 was proven to be unsuccessful as an anti-HIV agent and in some instances increases susceptibility to HIV infection. Answers are needed as to why a substance that was said to be 'safe' went so wrong in Phase III trials, putting women, who are already vulnerable, at increased risk of HIV infection.[546]

The N-9 studies are an example of diverging priorities and agenda's. As one researcher noted the "potential drawbacks of N-9 are well known but that had to be balanced against its fast track possibilities."[547] Global organisations such as the GCM were also relatively silent on the issue. GAF launched a campaign entitled "*where are the N9 women*" after numerous attempts to engage scientists on whether women who were made more vulnerable on the trial were to receive any compensation. They urged that it is critical that women's rights are addressed in the context of microbicide trials by "independent" bodies and organisations that are not part of the trial process.[548]

Through intensive advocacy by GAF it was only at the Microbicide conference in Cape Town 2006 that a meeting co-hosted by WHO, AMAG, GCM and GAF brought together different role-players, including the scientists who were part of the N9 trials to discuss what went wrong. As a result of the N9 trials certain changes had been made to trial protocol, and scientists finally acknowledged their culpability, albeit six years later. It was also reported that a fund had been set up to

---

[545] Tallis, V. 2000. Tallis V. 2001 b

[546] Ditmore, M.H. 2006

[547] gender-aids@hdn.org. Posting 706

[548] Interview GAF Microbicide co-ordinator. 2006.

compensate women from the trials and provide treatment, although given the time-lapse it may be too late for some of the women, and others may prove difficult to track down. This highlights the power of solidarity, of agitation and of sustained activism; researchers and scientists are not untouchable and can be challenged.

6.3.4 Microbicide activism at a local level.

The critical role of NGO's and CBOs in HIV and AIDS prevention and care at all levels is evident when one looks at the history of the HIV and AIDS epidemic. Community involvement is an important factor in ensuring that communities are prepared for the introduction of microbicides.[549]

> *Start working at community level. Do not use a top-down approach – this approach will never work with this product.*[550]

> *Talk to community about what we, as civil society, need to do to promote access.* [551]

Community responses often precede government interventions, and civil society is active in service provision, research and advocacy. The role of 'community' in the microbicides agenda has, to date, been defined mainly in relation to the research and development process. This has been contentious as definitions of adequate community participation have been framed by researchers.[552] The result has been narrow definitions of community and participation, including the setting up of CAB's with a focus on the geographical communities where trials have taken or will take place. Taking a broader view of community involvement and participation is more useful. This role should start at the research and development phase, but also acknowledges the invaluable role of NGO's and CBOs in the roll out phase of microbicides.

---

[549] Tallis, V., Christian, B and Cavanagh, D 2005

[550] Tallis, V., Christian, B and Cavanagh, D 2005. p 12

[551] Tallis, V., Christian, B and Cavanagh, D 2005. p 12

[552] Tallis, V., Christian, B and Cavanagh, D 2005.

Whilst the literature does not really acknowledge the role of NGO's and CBOs in ensuring access to contraception and female condoms, treatment activism demonstrates clearly the role and power of community.[553] Women's organisations have played, and should continue to play multiple roles in microbicide research, development and access. This should include increasing community knowledge of microbicides, mobilising a groundswell of voices calling for a microbicide, advocating for microbicides – ensuring buy - in by communities, government, donors and investors to the research and development process and advocating for sustained government commitment to roll out. Furthermore women's organisations should engage with researchers and monitor trials – ensuring they are ethical, and that the rights of women trial participants are upheld. A critical goal of collective community action is to ensure that the product is accessible once it becomes available.

6.4 Summary

The power of working with others in solidarity is evident. Social movements based on identity and/or issue can be effective in raising consciousness, identifying and addressing specific issues, changing policy and transforming practices. The case studies provide two examples of successful organising, mobilising and effecting change.

ICW SA has been successful in identifying and acting on the specific issues facing women, including young women, and raising the voices of HIV positive women both within the women's movement as well as in the broader HIV and AIDS sector. The activism around specific violations such as sterilisation, although in its early stages, has already had an impact through highlighting the practices in South Africa and Namibia and mobilising investigations into the practices in other Southern African countries.

---

[553] Sember, R. 2008

Microbicide advocacy is an example of solidarity around a common goal or issue, that whilst complex, has yielded positive results. There is no doubt that the activism to increase investment has been successful – and that the agenda has been driven by this activism by all role-players. Within the movement, civil society has been able to challenge scientists and funders around failed trials, standards of care packages, etc. Solidarity with treatment and vaccine movements has amplified the issues and voices of civil society who up until the advent of HIV and AIDS treatment and prevention research had been virtually non-existent. Such advocacy has changed the face of clinical research to an extent that the involvement of community and civil society, whilst by no means sufficient, is steadily increasing.

Resistance is a long term process as demonstrated in the case studies and the struggles for ICW SA and the microbicide movement are far from over. Victories may be small but they are steps leading to transformation and change. Such victories demonstrate that solidarity around an issue or identity is an effective form of resistance, especially when the voices of those most affected are at the forefront of the struggle.

Chapter Seven: Power to. Dealing with multiple vulnerabilities. Trafficking, HIV & AIDS in South Asia[554]

7.0 Introduction

HIV and AIDS on the one hand, and trafficking on the other, are both growing global development challenges. Whilst HIV and AIDS and trafficking affect men, women and children globally, the growth of both has disproportionately affected women and girl children. The vulnerability of women and girls to HIV and AIDS and trafficking is largely a product of an inequitable society, the impact of economic policies, global disparities in power, and uneven access to and control of resources. HIV and AIDS and trafficking, as two growing social issues, present communities, nations and regions with huge challenges. The linkages between them create even greater challenges that must firstly, be recognised and secondly, understood, if the design of the response is to facilitate the kind of change needed. These linkages demand a response that makes the best possible use of lessons learned elsewhere to ensure results in the shorter term and clear impacts for those most vulnerable in the medium to longer term.

There is extensive writing on both HIV and AIDS and trafficking, some within a gendered or feminist paradigm. The interface of HIV and AIDS on the one hand and trafficking on the other has, over the last few years, been increasingly articulated by academics and organisations, especially in Asia where there is more activism and advocacy about trafficking, coupled with concern about the growing HIV epidemic that is affecting increasing numbers of women and girls with social, economic and political consequences.   However, despite this acknowledgment, many of the responses to HIV and trafficking do not take into account the gendered nature of the issues.[555]   Women and girls who are either trafficked or are living

---

[554] This chapter is based on research carried out in 5 countries in South Asia (Bangladesh, India, Nepal, Pakistan and Sri Lanka) between October and December 2003 for UNDP REACH Programme

[555] Debabrata, R. 2002.

with HIV and AIDS live on the margins of mainstream society, facing rejection, stigma and discrimination. The vulnerability and marginalisation of women and girls who experience both trafficking and HIV and AIDS is more marked and intense leading to untold hardship and even greater discrimination.

My approach to HIV and AIDS and trafficking focuses on theories of vulnerability and empowerment. Power is central to an understanding of why people are vulnerable to HIV and AIDS and/or trafficking.   Addressing power is critical in approaches that are designed to empower. Power is seen as both a problem leading to girls and women being vulnerable to being trafficking or getting HIV infection and also as a solution in leading to the empowerment of girls and women to reduce vulnerability.   It is taken as a given that the imperative to act against both trafficking and HIV and AIDS is already understood; there are many approaches to trafficking and/or HIV and AIDS in the region and these will be discussed. The purpose of the chapter is to disaggregate the various inter-linkages and differences between HIV and AIDS and trafficking, and to look at addressing power as a possible solution. This chapter puts forward the idea that addressing the power inequalities that drive both trafficking and HIV and AIDS will impact on both issues.

7.1 Understanding Trafficking

> "The trafficking of women is a disturbing reflection of inequality in the world wide pattern of resource development. .. Trafficking in women reflects inequality on a global scale: the transfer of resources from depressed economies to prosperous ones, from periphery to the core and from the rural to the urban". [556]

Whilst the focus for this chapter is Asia as the region with the highest incidence of trafficking it is also important to note that trafficking is also rife in Africa.   South Africa is the hub, and is a source, transit, and destination country for men, women,

---

[556] Olaniyi, R. 2003. p45 - 46

and children trafficked for forced labour, sexual exploitation and organ harvesting.[557] Women are trafficked from Lesotho, Mozambique, Malawi and from refugee-producing countries to various locations in South Africa. South Africa is also a destination country for women from South and South East Asia.[558] Women are recruited by "plausible promises of employment, income, educational opportunities, or shelter and care within adoptive families."[559] Traffickers have been able to exploit the context of historical migration patterns in Southern Africa which is complemented by both the geographical situation of South Africa as well as income disparities.[560] Since the dismantling of *apartheid* borders are more open and trafficking in the region has increased dramatically.

Trafficking is a process, the end result of which is the displacement of people solely for the purpose of exploitation, including commercial sexual exploitation.[561] Since 2000 there has been an internationally agreed upon definition of trafficking which is embodied in the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, Supplementing the UN Convention Against Transnational Organised Crime.

> *"Trafficking in persons refers to the recruitment, transportation, purchase, sale, transfer, harbouring or receipt of persons, by means of threat or use of violence, abduction, fraud, deception, or coercion (including the abuse of authority), or debt bondage, for the purpose of placing or holding such person, whether for pay or not, in forced labour or slavery-like practices, in a community other than which lived at the time of the original act described".[562]*

---

[557] UNESCO. 2007.

[558] IOM in UNESCO 2007

[559] UNESCO 2007 p 4

[560] UNESCO 2007

[561] Thapa, P and Chishti, K. 2003. p5

[562] UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, Supplementing the UN Convention Against Transnational Organised Crime. 2000 p 1

The definition provided by the South Asian Association for Regional Cooperation [563] Convention on Preventing and Combating Trafficking in Women and Children is as follows:

> *"Trafficking is the illegal moving and selling of human beings (men, women, girls and boys) across and within countries and continents in exchange for monetary and / or other compensation."[564]*

Sexual exploitation may be the prime reason for trafficking; however, there are other reasons for the trafficking of women, girls and boys include forced labour, organ transplant, circus work, domestic labour, camel jockeying, adoption and forced marriage. As noted, most people trafficked are women and girls, but boys are also trafficked for camel jockeying, adoption and in some areas as sex workers. Sri Lanka has a thriving market for trafficked and/or commercially exploited children, especially young boys or 'beach boys'. [565] This includes a large proportion of children whose sexual exploitation, commercial or otherwise, creates major vulnerability factors to HIV.[566]

As with HIV and AIDS, the true extent of trafficking globally is not known. This is due in part to the fact that activities are illegal and therefore practised clandestinely. A second reason for the lack of knowledge about the extent of trafficking can be attributed to different understandings of trafficking. It is estimated that between 700,000 and 4 million people are trafficked annually[567] but the reliability of these figures are in question. What is known, throughout the region, is that human trafficking is a growing, lucrative criminal activity for those that control it and that trafficking of girls and women is increasing disproportionately in relation to men and boys.

---

[563] Forum for Women, Law and Development. nd. p 2

[564] South Asian Association for Regional Cooperation Convention on Preventing and Combating Trafficking in Women and Children 2002

[565] Workshop Report Sri Lanka 2003, Interviews Sri Lanka. December 2003

[566] Amarasinghe, S.W. 2002

[567] UNFPA 2003

Whilst accurate statistics do not, and probably will never exist, the socio-economic reasons why trafficking happens are well articulated and includes:[568]

- the oppressed position of women and girl children in the country of origin
- the demand in countries of destination for women and children for different exploitative purposes;
- The profit motive, trafficking is lucrative, and women and children can be sold many times. It is estimated that the industry is worth about US $5-7 billion per annum.[569]
- The relative ease in which trafficking occurs, often with the assistance of certain officials.

It is important to differentiate between 'smuggling of human beings' (which can be for legitimate jobs offers across borders, even though the mode of transfer is illegal) and 'trafficking' (where there are criminal intentions to begin with, leading to false promises and exploitation). This also throws up important issues with regard to the very definition of what constitutes 'trafficking'.

Some of the critical debates in reaching a consensus definition include the need to distinguish between the realities and experiences of women and children (girls and boys), clearly distinguishing between sex work and trafficking for commercial sexual exploitation; identify the distinction between trafficking, migration, human smuggling and defining human trafficking within a gendered human rights paradigm.

---

[568] Akher, F 1997. Ali, S 1999. Ali, S. 2001 Ali, S. 2003
[569] Wennerholm, C.J. 2002

7.1.1 Distinguishing between trafficking and migration

The UN Convention on the Rights of Migrants defines a 'migrant worker' as a "person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national." [570] Migrants are people who make choices about when to leave and where to go, even though these choices are sometimes extremely constrained. This broad definition of migrants reflects the current difficulty in distinguishing between migrants who leave their countries because of political persecution, conflicts, economic problems, environmental degradation or a combination of these reasons and those who do so in search of conditions of survival or well-being that does not exist in their place of origin. It is thus crucial that clear distinctions be made between instances of trafficking and the processes of migration, while also acknowledging the fact that several of those who migrate do so under duress and/or without access to proper information on safe mobility processes/services, are often vulnerable to being trafficked and exploited.

Given the circumstances in the region, where large numbers of women migrate either to cities or other countries in search of employment – often without valid contracts, and/or are expected to do jobs other than the ones that they were promised, the distinction between migration and trafficking may become somewhat blurred. There is a growing trend, as many migrant women and children move illegally across permeable borders, they become vulnerable to being trafficked; that is, during the migration process, either in transit or at the point of destination, migration may develop into trafficking.[571]

Migration can be either voluntary or forced. Unemployment and poverty are factors for indirect forced migration. This highlights the problem of "definition" and "understanding". Once we begin to talk of "forced" migration the links with trafficking become clearer. Methods used to prepare women to migrate for jobs may be similar to those used by traffickers. It is clear that there are issues with

---

[570] http://portal.unesco.org/shs/en/ev.php@URL_ID=3020&URL_DO=DO_TOPIC&URL_SECTION=201.html

[571] Debabrata, R. 2002.

the process of migration: whilst women are choosing to migrate, the methods used and the consequences reflect violence against women. However, as one workshop participant noted, women often choose to migrate despite the potential harm to themselves, because there are no other possibilities for them.[572] Whilst forced migration is not trafficking per se, the impact can be devastating.

A further complication is that measures to curb trafficking often have the effect of actually curbing women's migration. For example, Bangladesh has a law preventing single women moving across borders.[573] If people cannot migrate legally then they resort to illegal mechanisms. Furthermore, laws to regulate movement and migration on mobility, especially from the developing to the developed world, create a context in which traffickers can operate. Such laws may in fact increase trafficking.

> *"Laws that violate the fundamental human right to mobility and discriminate against women, also exacerbate the vulnerability of women to being trafficked: where no legal options are available to them, they must depend on the illicit options offered by traffickers"* [574]

Whilst globalisation has resulted in an increase in the free exchanges of goods and services, this has not necessary extended to movement of people and strong obstacles to movement exist, blocking easy entry into many countries. This provides an opportunity for traffickers to make money. They can 'help' people to enter a country where there is no opening for people to enter.[575]

7.1.2 Distinguishing between trafficking and sex work: no inevitable links

Many women, girls and boys are trafficked for the purpose of commercial sexual

---

[572] Workshop participant Sri Lanka

[573] Jana, S., Bandyopadhyay, N., Dutta, M.K., Saha, A. 2002. Ghaus, K and Broli, N. 1997. Grover. A and Divan, V. 2002

[574] Jana, S., Bandyopadhyay, N., Dutta, M.K., Saha, A. 2002. p 70

[575] Shifman, P. 2003

exploitation but many sex workers are not or, have never been, trafficked.[576] As noted previously, women, girls and boys are trafficked for many other reasons, including domestic servitude (which often includes non commercial sexual exploitation) that is equally disempowering, violent and a violation of human of rights.[577]

A critical debate amongst anti-trafficking organisations extends to whether sex work is a function of personal choice. Many sex workers themselves are forceful in asserting that they have made a choice and contend that sex work should be seen as a legitimate form of work; calling for the legalisation or decriminalisation of sex work.[578] There are a growing number of articulate and empowered women whose demands are for making sex work less exploitative and safer.[579] The call to acknowledge sex work as legitimate work is gaining momentum.[580]

Several researchers state that the notion of choice is not static. "Choice does vary from different parts of the world, in different times of life and also just different economic circumstances"[581] This is demonstrated by Gupta who outlines the trafficking cycle which girls and women go through; the initial period of trafficking, including arrival at the brothel and induction into sex work which is traumatic. Secondly there is a period after a couple of years in the brothel, when the girl/woman may be using drugs and/or alcohol, and is dependent on the brothel owner; at this point the woman can keep some of her earning and may chose to stay on at the brothel. Finally, after the woman has a diminished earning capacity due to her age, or she has severe STI's and / or HIV infection or AIDS, her choice may be to leave sex work and maybe start her own brothel.[582]

---

[576] Guthrie, J. 1995.

[577] Ali, S, Hassan, S and Rahman, Z 1999.

[578] Crago, A.N. and Arnott, J. 2008

[579] Interviews with sex workers in India. October – December. 2003.

[580] Crago, A.N. and Arnott, J. 2008

[581] Olaniyi, R. 2002. P 129

[582] Gupta in Shifman, P. 2003

In the interviews with sex workers,[583] it was obvious that many women chose to stay in sex work, even if they are given alternative options for employment. This may have to do in part with the fact that these alternative options do not provide the same level of income. However, some women do chose other forms of income generation even if it means making a fraction of what she used to, seeing this as a better option in which they have more control over their own and their children's lives. For example, a group of ex-sex workers in Bangladesh preferred to make sanitary pads and earn in a month what they could earn in two days as a sex worker.[584]

The debates about sex work have permeated discussions around definitions of what constitutes trafficking. The Coalition Against Trafficking in Women argues that trafficking should include all forms of recruitment and transportation for prostitution regardless of force and decision.[585] More progressive organisations see sex work as a legitimate form of labour that is distinct from trafficking for commercial sexual exploitation.[586]

Debates that challenge the legitimacy of sex work run the risk of further marginalising sex workers. Sex workers already face high levels of stigma and discrimination as evidenced in the following experience highlighted by a workshop participant from India:

> "A van run by the National AIDS Programme was seen parked outside a local village, and a rumour started spreading thereon that the 35 sex workers living in the village were spreading HIV and AIDS. Persons from neighbouring settlements then got together and razed the entire village. On subsequent investigations, it was found however that HIV testing had not even been carried out in the village".[587]

---

[583] Interviews with sex workers in India and Bangladesh. October – December. 2003

[584] Interviews sex workers Bangladesh. November 2003.

[585] Doezema , J.2002.

[586] Network of Sex Work Projects (NSWP), Sex Worker Education, Advocacy and Training (SWEAT)

[587] Workshop participant India. December 2003.

Trafficking women and girls in to sex work needs to be urgently addressed. However, disempowering sex workers by denying their right and ability to make choices about how they use and control their bodies is counterproductive.

7.2 HIV and AIDS in Asia

As noted previously HIV and AIDS has been characterised by what is often seen as two global epidemics, and a third epidemic, the economic, social and political reaction to HIV and AIDS, which has translated to fear, stigma, discrimination and widespread prejudice.[588] According to UNAIDS,[589] the national adult HIV prevalence is still under 1% in all of South Asia's countries. However, these statistics can be deceptive, given that some countries in the region are so large and populous, and national estimates may obscure more serious epidemics in some provinces and states. Although national adult HIV prevalence in India, for example, is 0.8%, five states have an estimated prevalence of over 1% among adults.

In spite of this low prevalence in India, when translated into absolute numbers, it means 4.58 million people are living with the virus[590]. Several African countries which had prevalence rates below 1% a decade ago are now witnessing two digit infection rates. If the situation in India reaches even 5%, it would mean 35 million people living with HIV and AIDS, more than the total number of people infected in the whole of Africa. This simple calculation based on the experience of other countries reinforces that even low prevalence countries such as those in South Asia cannot afford to be complacent and become high prevalence countries. Moreover, there are increasing warning signals that serious HIV epidemics threaten several countries in South Asia.[591]

---

[588] Panos 1990a

[589] UNAIDS 2007. UNAIDS 2008.

[590] UNAIDS 2007.

[591] UNAIDS 2003.

Given that Asia has a relatively new HIV epidemic, deaths from AIDS related illnesses are still comparatively low. Thus, whilst individuals and their families and households are affected by the loss of one or more family members which often results in increased poverty, AIDS as an issue appears not to have become a visible reality for communities as yet.

The third epidemic moves beyond the medical to the political, social and economic realm. Denial, blame, stigmatisation, prejudice and discrimination are present in every country dealing with HIV and AIDS[592]. Commonalities across the region highlight the relatively early stage of the HIV epidemic characterised by widespread denial, the marginalisation of so called 'high risk groups' – sex workers, men who have sex with men, injecting drug users and migrants, lack of services for people living with HIV and AIDS, lack of access to prevention technologies (male and female condoms, women controlled methods) and extremely high levels of stigma and discrimination by communities and specifically by health care workers.[593]

The HIV and AIDS epidemics are at their worst in regions where poverty and economic inequality is extensive and deep, gender inequality is pervasive and access to public services is weak and uneven.[594] These conditions prevail in South Asia. If the epidemics are not dealt with effectively and comprehensively on a global scale there exists the potential to lose hard won development gains. In South Asia, the impact of HIV and AIDS on development is at present relatively small due to the low prevalence rates in the region. However, the region as a whole has the conditions for a rapidly increasing epidemic, and the impact on development in the future will be significant.

The current response in Asia is not that different from the rest of the world, and is characterised by an overall lack of access to prevention methods (especially ones that are female controlled), appropriate information and materials (based on the

---

[592] Panos. 1999 a.

[593] Workshop participants India, Bangladesh, Pakistan. October – December 2003.

[594] Collins, J. and Rau, B. 2000.

realities of peoples' lives), treatment (including basic health care, treatment of opportunistic infections as well as access to ante-retroviral therapy) and adequate care and support systems.

7.3 Understanding the realities of women and girls lives in South Asia

The realities of women's lives in the region are characterised by multiple exploitation and oppression. Collective reflections at the various workshops indicate that societal attitudes, cultural and traditional values towards women are discriminatory. This is reflected in cultural and religious practices and beliefs such as dowry, bride burning, socially sanctioned violence against women, children being viewed as marketable commodities, women being viewed as financial and social liabilities in several instances, lack of education priorities for women, and large premiums placed on boy children. Women are also viewed negatively and media images of women as sex objects add to an environment that is increasingly intolerant and exploitative.[595]

Gender-related inequalities threaten the right of all people but more particularly women and their human security. This also provides a fertile ground for HIV and trafficking to flourish. There are strong social pressures that ensure women and girls remain ignorant about gender, safer sex, sexuality and relationships as well as HIV and AIDS. They lack access to relevant information, resources and opportunities to develop skills needed to apply that information to avoid HIV infection.

The attitudes of society towards women's sexuality impacts profoundly on how women should look and how they should behave. The female body is a site of male domination, experienced by women and girls on a daily basis with extreme forms of domination being for example, rape, female genital mutilation and trafficking of women and girls for sexual exploitation. Women's vulnerability is both due to actual forms of domination as well as the fear of that domination.

---

[595] Workshop participants Bangladesh, India, Nepal, Pakistan, Sri Lanka. October – December. 2003.

The link between violence, sex and power are reflected in the lives of women and girls who have been trafficked as evident from the experiences of the two young women quoted below.

> "The brothel keeper was only happy if we could attract a long line of customers. If we refused to work we would be beaten and tortured".[596]

> (I) .. "refused to give in to his wishes but he raped (me) mercilessly and I fainted".[597]

Women who have been trafficked speak of forced terminations if they fall pregnant and inadequate care and treatment for sexually transmitted infections. In many cases women and girls who are sex workers are not allowed to use condoms both in brothels where they are kept as 'prisoner' and also because the mere act of carrying a condom can lead to imprisonment should the women be arrested.[598]

Gender stereotyping makes both young women and young men particularly vulnerable to HIV and AIDS. In most communities in South Asia, 'pure/good' women are expected to be ignorant and naïve in sexual matters and knowledge of sex can be seen as a sign of 'lax morals/bad-girl-labelling'.[599] The expression of heterosexuality is an important way of proving masculinity,[600] both globally and in the region. While dominant ideologies of femininity encourage innocence and virginity, dominant versions of masculinity often encourage and even force young men into being sexually adventurous and more experienced than their female partners. Men are thus not encouraged to seek information on safer sex, since it can be construed as a sign of weakness/imperfect masculinity.[601] In the context of

---

[596] Thapa , P. and Chisti, K. 2003 p16

[597] Thapa , P. and Chisti, K. 2003 p16

[598] Interviews with sex workers India, Nepal. October – December. 2003.

[599] Workshop participant India. December 2003.

[600] Connell, R.W. 2005.

[601] Workshop participant Pakistan. November 2003.

HIV and AIDS therefore, gender stereotyping further entrenches existing inequalities and power imbalances.[602] Women and girls have few sexual choices as a result of their social and economic dependence on men; this vulnerability is increased if a woman or girl has been trafficked and has even less negotiating power.

Socio-economic, cultural and legal conditions, lead women to have fewer decision making powers regarding the onset and nature of sexual activity, whether she marries and when and whom she will marry and the nature of her sexual relationships. [603] Furthermore women have little control whether to, when and how often to fall pregnant, decisions regarding keeping girl children and whether and where she receives treatment for reproductive health problems and complications.

Marriage affords women little protection from trafficking and / or being forced into sex work. A common theme in the interviews and workshops were stories of husbands selling wives and daughters. One sex worker from Nepal related her experience of being forced by her husband to become a sex worker.[604] Daughters are often seen as liabilities and families are required to provide dowry on marriage. In low income households, families are often forced to cope by marrying girls off to strangers who make no dowry demands, making them particularly vulnerable to trafficking and HIV.

> *"Marriage at an early age prevents women from acquiring professional skills or from getting higher education. This leads to women being unable to earn their living on their own and are completely dependent on their husbands for survival. Even if women are in extremely abusive relations, divorce is not a socially sanctioned option and in society it is deemed disgraceful for a woman to be a divorcee. If women are divorced they often have no place to go and do not have any access to money. The community blames woman for having*

---

[602] Interviews India, Bangladesh. October – December. 2003.

[603] UNDP HIV and Development Programme. 2001.

[604] Interview Nepal. November 2003.

> *broken up such a sacred relationship and considers her disloyal and a betrayer".[605]*

Forced marriages are common and are a violation of women's human rights.[606] Dowry related violence is also common and included being physically abused, beaten and burned.[607] Threats to women's safety and high incidence of domestic violence and resulting in women and girls leaving home and increase non-consensual sex. Women have been trained to tolerate violence, discrimination and sexual wrongs as "unspeakable crimes" and to put up with them with dignity and pretend as if nothing has happened because this is the sort of behaviour expected from men by our society.[608]

Globally, studies point to the vulnerability of married women: that is married women having been infected by their husband, as their only partner.[609] Simply being married is a major risk for women who have little control over abstinence / condom use in the home, or their husband's sexual activity outside the home. Studies from Bangladesh, India and Nepal highlight the vulnerability of newly married, adolescent girls who have arranged marriages, are not familiar with their husbands and are uninformed about sex.[610] Despite remaining faithful to their husbands, young married women in Asia have emerged as the fastest-growing new group of people with AIDS.

An estimated 1.1 million young people aged 15-24 years – 62% male and 38% female – are living with HIV and AIDS in South Asia.[611] Globally, more than 50% of new HIV infections are in this age group. In order to stop the further spread of HIV among young people, they need knowledge and skills to protect themselves. In

---

[605] Workshop participant Pakistan. November. 2003.

[606] Farouk, S.A., Rahman, Z. and Haque, D.M. 2001.

[607] Interview Pakistan. November. 2003

[608] Workshop participant Pakistan. November. 2003.

[609] UNAIDS. 2002.

[610] http://www.popcouncil.org/pdfs/popsyn/populationsynhesis1.pdf

[611] UNAIDS. 2006.

India, only four out of ten married women are literate and only 18% of illiterate women have ever heard about AIDS. In Bangladesh, 86% of married girls aged 15-19 years don't know how to protect themselves against HIV infection.[612]

During 2004 ICW commissioned a study[613] of the lives of women living with HIV and AIDS in Asia; the experiences and realities recorded mirror the experiences in my interviews in the five countries. It also echo's some of the oppressions experienced by women in Africa; violence, control over women's sexual and reproductive rights, and lack of bodily autonomy.

Marital rape is not being recognised as a crime in any of the countries in South Asia. Multiple partners and sex outside marriage for men are widely culturally accepted whereas women could be killed for such behaviour. Women are expected to have relations with or marry older men, who are more sexually experienced, and more likely to be infected. Arranged marriages, particularly among relatives, are a norm in rural India. In India, 60% of married women become mothers before the age of nineteen. Marriage is strongly associated with reproduction and creating a family, and there is strong pressure on young, newly married women to have children.[614]

When certain situations (such as those of conflict) create a heightened sense of insecurity, the disintegration of community and state support systems combine to prompt women to flee in desperation, sometimes with their children, in search of physical and economic security. In the case of children, it is often the death of care givers (parents, guardians), abuse and marital discord between parents that create emotional vulnerability and heighten trafficking related vulnerabilities.

There is a general lack of tolerance of diversity in the region. This is evident in the laws, lack of resources and attitudes of the state and civil society towards women,

---

[612] http://www.kit.nl/frameset.asp?/ils/exchange_content/html/2003-1_hiv_aids_in_south_asia

[613] Paxton, S. 2004 with Welbourn, A., Kousalya, P., Yuvaraj, A

[614] Paxton, S . et al 2004. Malla, S.P. and Joshi, S. 2003

men who have sex with men, lesbian, gay, bisexual and trans-gendered sector, sex workers, prisoners and injecting drug users.[615] This lack of tolerance manifests in stigmatisation and marginalisation of specific groups, especially sex workers, women and girls who have been trafficked and women living with HIV and AIDS. Stigma and discrimination against people living with HIV and AIDS as well as against women and girls who have been trafficked is prevalent in communities and societies.

> "A 15 yr old HIV+ positive girl who was pregnant was taken to a hospital, where she was made to wait in an empty room. HIV+ was written on her forehead and the staff refused to take care of her". [616]

Trafficked women and girls have always been stigmatised, and are often blamed for the situation in which they find themselves.

> "The men used to tease me, and whenever I went to any village festivals or functions, my friends used to ignore me or tell me I was a bad woman and that I carried disease. I was not even allowed to mix with other people in the village". [617]

Prejudice against trafficked women has intensified as often they are viewed as 'vectors of HIV'. Such labelling is counter-productive to responses to reduce vulnerability to HIV as well as trafficking. Trafficked women and girls are thus doubly stigmatised, regardless of their HIV status.

> "People everywhere look down upon trafficked returnees like us; we are often blamed for the spread of HIV and AIDS. I feel so bad and helpless".[618]

---

[615] Malla, S.P. and Joshi, S. 2003

[616] Workshop participant India. December 2003.

[617] Thapa, P. and Chisht, K. 2003. p29

[618] Thapa, P. and Chishti, K. 2003 p26

The impact of HIV and AIDS on women, men and children helps create conditions of vulnerability in which trafficking thrives. For example, the consequences of HIV and AIDS place a huge financial burden on the household, increasing poverty. Increasingly, younger and younger girls are being trafficked as clients often demand girls that are free of HIV and AIDS. This has also impacted on trafficking routes – for example, clients in India requesting girls from Bangladesh and Nepal – that is countries with a lower prevalence rate than India. Wichterich notes there is preference for the 'one stage model' which refers to young girls who are directly shipped abroad from their native village and initiated into commercial sexual exploitation with an act of rape.[619] Such requests have become more common due to the fear of AIDS. Interestingly, anecdotal reports suggest that in some areas the fear of HIV has become a motivating factor in wanting to rescue daughters who have been sold into sex work.[620]

Trafficking strongly impacts on HIV infection.[621] Women and girls who are trafficked become vulnerable to HIV infection because the conditions in which they live create particular vulnerabilities and exacerbate inequalities that facilitate the spread of HIV and deepen the impact of AIDS. Women and girls who are trafficked often have little access to health services – either for prevention or treatment of STI's, HIV and other health concerns. Trafficked women and girls who are commercially sexually exploited are often coerced into unsafe sex and not allowed to use condoms.[622] They lack the power and/or skills to negotiate safer sex and it has been found that in the first couple of months, they are particularly vulnerable to HIV as a result.[623]

The impact of being trafficked and living with HIV and AIDS exacerbates alienation and further places those women and girls affected even more on the margins of society. Alienation in the context of trafficking and commercial sexual exploitation

---

[619] Wichterich , C. 1998 p 62

[620] Interviews Bangladesh, Nepal. November 2003.

[621] Debabrata, R. 2002

[622] Interviews Nepal. November 2003.

[623] Interviews Nepal. November 2003.

adds an extra rung in women's violation. Women and girls who are trafficked for commercial sexual exploitation are alienated from the economic outcomes of their servitude/enslaved-labour. This feeds directly into the social outcomes of long-term slavery endured by trafficked persons in brothel-situations and the heightened vulnerability to HIV, for example rape, non-negotiation of condoms, a sense of fatality/acceptance/inevitability.[624]

> *"Four hundred girls were recovered from brothels in India, twenty one of them were sent to a Short Stay Home in Kolkata, and out of these eleven were HIV positive. It was decided to keep the HIV positive girls separately, leading to them being kept in a room under lock and key. However, as soon as the other residents of the home came to know about their HIV status, the HIV positive girls were stoned by the other residents of the Home. As an alternative arrangement, the government contacted a local NGO, to accommodate these girls".*[625]

Vulnerability to trafficking is profoundly gendered: given that gender is a system of unequal but shifting, and at times contested power relations between men and women[626] which has relevance for an analysis of vulnerability to trafficking. Societal vulnerability incorporates both, the vulnerability to HIV and/or trafficking, as well as vulnerability to the social and economic impacts of the living with HIV and/or being trafficked.[627]   Existing norms and values differ within societies and communities; they strongly influence societal vulnerability. It is possible that socially and culturally acceptable norms may conflict with universal standards of human rights. The challenge lies in transforming from the grassroots, those norms and values that are oppressive and harnessing the collective energy of communities for resisting socially sanctioned violations. There are two sets of factors impacting on societal vulnerability to trafficking; macro factors including political and

---

[624] Debabrata, R. 2002

[625] Workshop participant India. December 2003.

[626] Connell , R.W. 1987, Connell, R.W. 2005.

[627] Barnett, T. and Grellier, R. 1996.

economic reasons and socio-cultural factors. Micro factors include individual circumstances of poverty and unemployment as well as lack of access to social programmes and services.

The lucrative nature of trafficking, which is the third largest source of profit for organised crime after the selling of drugs and arms,[628] is a major factor in the growth in the numbers of women and girls who have been trafficked. Social constructions of gender relations and sexuality facilitate trafficking for sexual exploitation by undermining women's economic position - "unequal gender relations and patriarchal values (control of labour and sexuality) underlie trafficking".[629] Trafficking represents "profit or revenue-making circuits developed on the backs of the truly disadvantaged".[630] In the context of high unemployment, increasing poverty, shrinking state resources that are unable to meet growing social needs, households and whole communities are increasingly dependent on women. Governments are also dependent on women's earnings.[631]

Gender oppression is evident in the way in which gendered power converges with poverty to drive or lure women and girls into situations where they are subjected to extreme forms of violence, such as trafficking.   Women are vulnerable to trafficking not only because they lack economic opportunities, but also because they wish to escape from the burden of long hours of domestic/unpaid work expected of them. Traffickers also feed into the aspirations of women and girls for a better life. It is not only parents who are forced or coerced into selling their children; often girls and young women who are dissatisfied with life are taken in by traffickers promises for a better, more prosperous and fulfilling life.

Personal characteristics, such as low self-esteem, attitudes towards HIV or trafficking and limited perception of own risk also make women and girls more

---

[628] Amnesty International. 2001.

[629] Olanyi, R. 2003. p 46

[630] Sassen, S. 2002. p92

[631] Workshop participant Sri Lanka. December 2003.

vulnerable.   Personal vulnerability is increased by a lack of access to information and education about trafficking, HIV and AIDS and sexuality.   Many women and girls are not exposed to accurate and relevant information on AIDS; nor are they aware of the methods traffickers use or the realities of being trafficked.   The following was noted by Amnesty International from the experiences of women and girls who are trafficked:

> *"some are completely duped about the nature of the work they will be doing; some are told half truths about the work and then are forced to carry it out; some are aware of the nature of the work but not of the conditions in which they will perform it and see no viable economic alternative".*[632]

Personal skills such as the ability to negotiate safer sex, or the ability to realise when one is being tricked and to deal effectively with that, impact on vulnerability. Personal circumstances also impact on vulnerability; it has been well documented that the reason why many women and girls either leave home or want to leave home is physical and sexual violence in the household.[633] Even when women leave home out of a desire to explore new possibilities and be adventurous (personal choice), existing societal vulnerabilities (for example, lack of information available to women migrants) can make them at risk.   Stigma is decreased and challenged only when the empowerment process starts transforming the realities of those most affected.[634]   The next section will address programmatic vulnerability by highlighting the current responses to trafficking and how they reduce or increase vulnerability.

---

[632] Amnesty International. 2001. p17

[633] Interview Bangladesh. November 2003.

[634] Workshop participant India. December 2003.

7.4 Trafficking, HIV and AIDS: power as problem

At the outset it is important to stress that trafficking does not cause HIV and AIDS or vice versa. There was a concern amongst role-players[635] that the two issues do not become conflated thus causing greater difficulties for women and girls affected by HIV and trafficking. An example cited was the assumption that girls who had been trafficked, rescued and returned, especially from Mumbai, were living with HIV and further cementing the belief that 'trafficking = sex work = HIV'.[636] Given the extent of stigma and discrimination attached to the issues and the increased burden faced by women and girls who had been trafficked and were living with HIV and AIDS, this concern is valid. There exist certain root causes common to both HIV and AIDS and trafficking vulnerabilities, which are discussed below.

The social and economic factors driving trafficking and HIV infection and deepening the impacts are similar, for example, poverty and inequality, lack of access to services, population mobility, sexuality and power and gender-based violence. The factors driving the HIV epidemic are "deep-seated and intransigent, embedded in the very power relations which define male and female roles and positions, both in intimate relations or the wider society." [637] The same applies to trafficking.

> "Trafficking in women reflects inequality on a global scale: transferring of resources from depressed economies to prosperous ones, from the periphery to the core and from rural to urban".[638]

The issues that require particular focus by organisations involved in trafficking and HIV and AIDS include addressing the sexual subordination and oppression whereby women are precluded from a basic means of prevention, safe sex practices, lack of knowledge/bargaining power with sexual partner, addressing the lack of access to means of HIV and AIDS prevention and care mechanisms such as condoms and

---

[635] Workshop participants India, Nepal, Pakistan. October – December. 2003.
[636] Workshop participant India. December 2003.
[637] Baylis, C 2000. p1
[638] Olaniyi , R. 2003. p 46

treatment services and challenging gender discrimination in families and communities - especially in countries with (mainly) patrilineal family systems.

The emotional, social and in some cases physical consequences of living with HIV and AIDS or being trafficked are similar. This is reflected in the individual hardship and pain, and the social impact on the family, household and community. Fear of violence and stigma and even abandonment can dissuade women from learning about their HIV status or wanting to go home if they have been rescued. Impact is greater because of generally lower levels of social and economic power. Impacts for the individual include declining health, social stigma and loss of support, economic hardships and so on. As a result of both trafficking and HIV and AIDS, communities and societies are losing young and productive women. Communities, especially women, are bearing the brunt of care and support.

It has been noted that a feminist analysis of power focuses on understanding the ways in which men dominate women and how some women dominate other women based on gender, race, class, , age, ability, ethnicity and sexual orientation. Power analyses also suggest that both men and women are dominated by existing social and institutional structures that both shape and reinforce existing power inequalities and that our very socialisation into particular gendered behaviour patterns have much to do with the overarching power structures that oppress, on the basis of race, class, caste, and gender. For example, whilst trafficking is a form of gender oppression, a growing number of traffickers are women – including women who have been trafficked. This indicates how the "global economy has been systematically structured to ensure that the exploited replicate patterns of exploitation in order to earn a living."[639] In an ongoing cycle, there are pervasive discriminatory mechanisms that further marginalise and dis-empower the least powerful in society. Power can be easily linked to trafficking: in its most basic level it refers to the power relationship between the trafficker and the person being trafficked. However there is a long and hierarchical chain of power over

---

[639] Olaniyi, R. 2003. p47

relationships in the trafficking process, which includes parents, agents, brothel owners, and trafficking syndicates.

Power refers to both individual acts of force and oppression as well as the structure of power, which is defined as a set of social relations with scope and permanence. Individual acts of power must be seen within the context of the structure of power if they are to make sense. Connell uses the example of rape to explain this concept. Rape is deeply entrenched in power inequalities and male supremacy ideology. Rape is not seen as a deviation of the social order but is very much an enforcement of it.[640]

Trafficking can be analysed in a similar way; trafficking embodies ownership of women's body, their sexuality and their labour. As such, it can also be viewed as a reflection of the social order. Within the structure of power there is a need to constrain those who have power; men are both empowered in gendered relationships and they produce their own limits. For example, the patriarchal (western) gender order emphases monogamous marriage as the hegemonic position. However, the unspoken expectations are that men are and will be polygamous. Adultery can be viewed as a structure that defines women as property and holds men responsible for 'theft'.[641]

All men do not enjoy equal power. The intersection of race, caste, class and sexual orientation are also important. There is a core of male power which is dependent on the dominate male in a particular culture or society. For example this could include high-caste, or fairer skinned ('white men' cannot be contextualised in South Asia), heterosexual, upper-middle class. Whilst all men do not hold the same power as the elite, men do benefit in some way from this the power. For example, not all men control the judiciary, yet they benefit from the legal power given to men in legislation around marriage for example.

---

[640] Connell, R.W. 1987.

[641] Connell, R.W. 1987.

Likewise, women too are not a homogeneous group, and for the most part are oppressed and seen as a subordinate group. However, women have access to more or less power in their different roles and relationships, for example, mother-in-laws are powerful in the South Asian context. Power is currency which the mother-in-law acquires through her son (that is, she ultimately accesses power through a male member), and often uses it to oppress the daughter-in-law. This highlights that women are not always the 'victims', but can be the perpetrators as well. The class and caste dynamics of men and women also poses another dimension worth exploring.

Perceived powerlessness is internalised. When people are systematically denied power and influence in society they internalise the message and believe the message to be true. Women over the ages have internalised the message of patriarchy. Empowerment must undo the negative social constructions so that people come to see themselves as having the capacity and the right to act and influence decisions.[642]

Socially sanctioned violence is the most expressive manifestation of power inequities based on gender, , caste, ethnicity, religion etc. In the study by Thapa and Chishti the majority of women and girls who had been trafficked noted that they had been "severely beaten", "tortured" and "abused" by brothel owners and clients. The violence maybe experienced on a daily basis, although many women interviewed made reference to the fact that their initial introduction to the brothel was the most violent. The relationship between violence and trafficking can be seen as cause and effect: violence in the home often makes girls want to leave making them more susceptible to the operations of the trafficker; and as noted above, violence is an integral part of the lives of trafficked women and girls. The demonstration of power, manifested as violence against women is clearly illustrated in the following quote from a young woman who had been trafficked,

---

[642] Rowlands, J. 1997.

"When I refused to entertain clients I was beaten ruthlessly. I was starved and kept inside a dark room. I cried for help but nobody listened to me. Finally I fell sick. I was so scared and ultimately I agreed to work for them".[643]

For many women, the violence remains the reality of their daily lives either in their homes and relationships and/or in the workplace. They are often unable to leave the relationship due to social and economic factors. Trafficked women may have even less freedom of movement and are frequently locked up. Brown notes that sexual access to women and girls is both a privilege of male power and a symbol of that power.[644]

7.5 Current responses to trafficking

The response to trafficking in the region is NGO led, although governments have developed a legal framework to address the problem. The UN agencies are also involved both at a policy level, as well as providing services, such as a home for the children of sex workers situated in a brothel in Bangladesh.

Figure 7.1 depicts the complexities of responses to HIV and AIDS and trafficking, which cut across two intersecting continuum; the prevention-care continuum and range from a welfarist to a rights based approach.

---

[643] Thapa, P. and Chishti, K. 2003. p21
[644] Brown, L. 2000.

Figure 7.1   Responding to HIV and AIDS and Trafficking
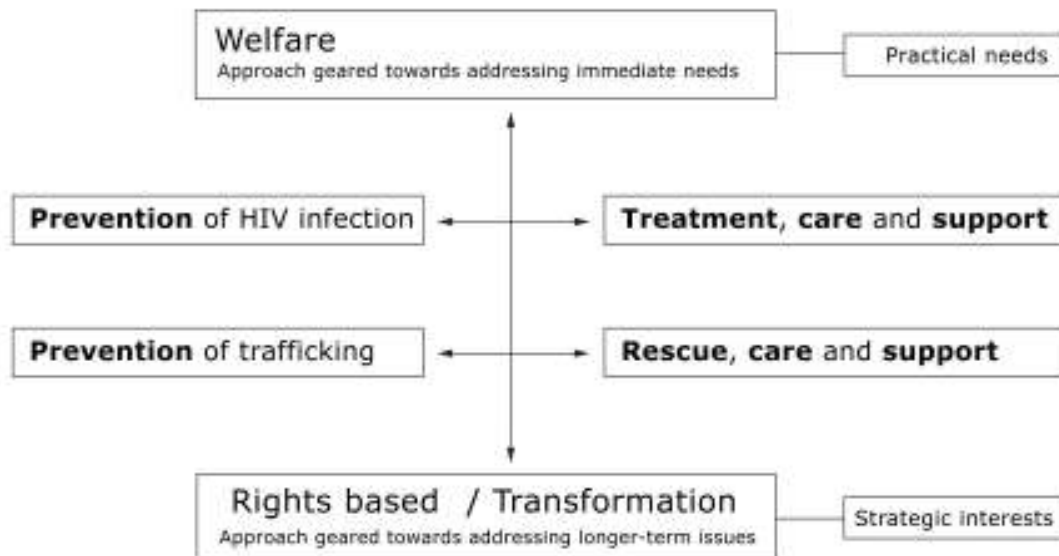
The horizontal axis represents the strategies along the prevention – care continuum, including proactive strategies to prevent trafficking or HIV infection from occurring and reactive strategies dealing with the situation after it has occurred. In the case of HIV and AIDS this means care, treatment and socio – economic support for people living with HIV and AIDS as well as addressing social and economic problems and issues faced by families and communities. Rescue, rehabilitation and reintegration programmes are strategies used to deal with the issue of trafficking.[645]

The vertical axis represents the values and beliefs underpinning the response. The welfare approach focuses on meeting practical needs whereas a transformatory approach addresses the structural causes of HIV and trafficking and deals with strategic interests.   Thus the welfare approach is at a crisis intervention level, whilst the transformatory approach is more political focusing on process and medium to long term goals. The transformatory approach has at the centre the change of the gender social order.

---

[645] ABC Nepal. Nd.

The predominant approach to trafficking has been a welfare/integrationist one; focusing on the immediate issues and reactively dealing with the issues facing women and girls who have been trafficked. Given the urgency of the issue and the impact of trafficking this has been an important approach. However, as has been discussed the ultimate goal is the transformation of society – addressing the core factors accounting for trafficking with the aim of eradicating trafficking. In this regard there has also been some successful advocacy from activist organisations and networks across the region resulting in changes in understanding and legislation. Much more still needs to be done.

7.5.1 Prevention

A few strategic areas, important for developing rights-based and development approaches essential to prevent trafficking have been recognised; effective legal remedies for women and girls, poverty reduction and sustainable livelihood options and safe migration possibilities.[646]

Using national and international legislation to ensure that people at all levels of the chain involved in trafficking are arrested, prosecuted and convicted is an essential prevention strategy. However, most convictions happen to women and men who are recruiters and seldom are the people who gain the most from trafficking ever arrested or convicted. Whilst this method of prevention may protect other women and girls in the future, it is extremely traumatic for the women and girls who have to testify and re-live their experiences in court.[647]

Increasing knowledge and awareness about the realities of trafficking through community and school based education has been effective in some areas.[648] Many women and girls note that they were duped into trafficking. Hearing about the personal experiences of girls and women who have been trafficked, there emerges

---

[646] UNIFEM 2002.

[647] Interview India. October 2003.

[648] Interview India. October 2003.

common ways in which women and girls are tricked: false marriages, taken from the village to the city by someone they know, offered a 'bogus' job in the city.[649] Education is thus vital to equip girls, women and men with knowledge and skills to enable them to identify and avoid potential trafficking situations. Poverty is seen as one of the critical driving factors of trafficking. Poverty reduction programmes that provide families, and especially women and girls with sustainable livelihood options can be an effective prevention strategy in the short term.

7.5.2 Recovery, rehabilitation and reintegration

At the other side of the trafficking continuum is the recovery of women and especially girls from the situation, rehabilitate them – often in institutional care and then to reintegrate them back into their community or failing that into "mainstream" society. There have been many 'success stories' – well documented through the voices of women and girls who have been trafficked. For example:

> "I am proud to say that I am earning my own living. I did spend some years in the centre and whatever I am today is because of the organisation that sheltered me, trained me and helped me to live a dignified and independent life".[650]

Recovery, rehabilitation and re-integration are crucial steps in accessing those who are trafficked and exploited. However, some organisations question whether all rescue attempts are in fact within a human rights framework and believe there is a potential violation of human rights at all three stages of trafficking; during recruitment, during the work on was recruited for, and during rescue, rehabilitation and reintegration.[651]

---

[649] Interviews and workshops India, Bangladesh and Nepal. October- December. 2003.

[650] Thapa, P and Chishti , K. 2003. p43

[651] Interviews India, Nepal. October – December. 2003.

> *"the effectiveness of rescue, rehabilitation and reintegration programmes has been brought into question in terms of capacity to assist the survivors with equal consideration for their human rights and individual dignity. The general principle is that each trafficked returnee should enjoy fundamental human rights, right to privacy, repatriation, proper health care and counselling and other necessary support."[652]*

Potential problems exist at all stages of the recovery, rehabilitation and reintegration process.

Recovery operations discount women's agency in becoming sex workers and overlook women's right to remain in that line of work if they so choose. Women are sometimes brought out of brothels as if they had been waiting there to be rescued.[653] Rescue efforts may also impact negatively on the lives of other sex workers in the brothels; at best this may include police harassment, at worst the closing down of the brothel resulting in the loss of income, as well as loss of food and shelter for the women and their children.   Older sex workers may find it particularly difficult to find another brothel in which to work.[654]

Vulnerability is also increased through legislation which criminalises certain behaviours, for example, sex work, legal discrimination against women and freedom of movement for single women. As noted by the Lawyers Collective rescue and raid operations by law enforcement officials in sex work settings can lead to violation of sex workers, and can also prove to be counter-productive to interventions.[655] Increased disruption caused by raids creates an environment of fear and insecurity, driving sex work underground. To uphold the human rights of sex workers and women and girls who have been trafficked, internal mechanisms such as 'self-regulatory boards' of sex workers themselves that rescue minors and

---

[652] Thapa, P. and Chishti, K 2003 p1

[653] Thapa, P. and Chishti, K 2003 p11

[654] Discussions with brothel based sex workers India. December 2003.

[655] Lawyers Collective. 2003

women who want to be rescued, are essential. In fact sex workers have articulated that it is in their own interests to keep underage girls out to avoid for example, unfair competition, fall in income and insecurity.[656]

'Rehabilitation' centres are either run by state or non-government organisations and differ substantially in the methods they use to rehabilitate. While some are progressive in the way they operate, others are not.[657] For example in the Thapa and Chishti research a volunteer from a renowned rehabilitation centre explained that he/she has witnessed women and girls trying to escape from the centre by hanging their *sarees*[658] from the windows.

> *"There is increasing discontent among them. They feel imprisoned inside the four walls of the shelter homes where they can neither smoke nor drink. They do not want to be reformed and as such do not like all sorts of restrictions that are imposed upon them and their movements"* [659]

A workshop participant from Sri Lanka spoke about the experience of a group of sex workers and homeless women who were arrested and detained indefinitely under the Sri Lankan vagrant laws. Sent to so called "rehabilitation" centres and waiting for family to claim them the women experience awful conditions.

> *…. "sanitary towels have to be shared … there are seventy-five inmates out of the three hundred and fifty that are mentally retarded. About 25% are pregnant and another about 25% are with children".*[660]

Furthermore, the shortages of staff make the conditions even more difficult.

---

[656] Interviews with sex workers India, Nepal, Bangladesh. October – December. 2003.

[657] Interviews Bangladesh, Nepal and visits to rehabilitation sites. October – December 2003.

[658] Traditional Indian/Pakistani dress

[659] Thapa, P and Chishti, K. 2003. p1

[660] Workshop participant Sri Lanka. December 2003.

"There are only twenty staff taking care of the needs of three hundred and fifty detainees, some of whom have children. The staff are overworked and naturally frustrated. Therefore, programmes on awareness, education and motivation are required for both to inmates as well as the staff members but these don't happen".[661]

A complicating issue is that most of the women have been arrested under the Sri Lankan *Vagrancy Ordinance* which allows for indefinite incarceration. Women are not given a date for their release, and are only released if a family member collects them or they are married off to men who are approved by the rehabilitation centre.[662] This encourages further abuse and exploitation of the women who may resort to paying people to act as parents or family in order to be released.[663]

During the rehabilitation, under the guise of medical examinations, which are one of the first requirements when women and girls are rescued, women and girls have to undergo a series of tests, including an HIV antibody test. In many rehabilitation centres such a test is mandatory, whilst others say the test is "voluntary".[664] Workers in rehabilitation centres noted during the interviews and the workshops that women and girls very seldom refuse to take the test. Overall, the compulsory or coerced testing of women and girls for HIV is a violation of human rights.[665]

The universal guidelines on HIV testing are clear that testing should be completely voluntary and performed in the context of pre-test and post-test counselling. The pre-test counselling process is designed to provide accurate information and to enable the person to decide (without any coercion) whether they wish to take an HIV test or not. Even if the person decides to take a test, they can decide not to get the results, should they change their mind. Results need to be given in a post-

---

[661] Workshop participant Sri Lanka. December 2003.

[662] Interviews: Sri Lanka. December 2003.

[663] Workshop Sri Lanka. December 2003.

[664] Interviews Bangladesh, Nepal, Sri Lanka. October – December 2003.

[665] Lawyers Collective. 2003.

test counselling context and follow up counselling is important. Regardless of the result, post-test counselling should be provided.[666]

Two critical issues need addressing: firstly, given the history and experiences of the women and girls who have been rescued it is unlikely that they would be in a position to say no to a test that was being forced on them or 'suggested' to them – especially by people in authority who are providing food and shelter. Secondly, given that the women and girls have been through terrible experiences to get where they are, it is debatable that one of the initial priorities should be an HIV test unless specifically requested by the women or girls themselves.

It is perhaps better to deal with the realities of being recovered before rushing in to HIV testing – given that an HIV positive test result will be devastating and compound the range of emotions the woman and girl will be experiencing coming to terms with being trafficked. Counselling forms one part of the continuum of care that needs to be implemented to provide women and girls living with HIV and AIDS with at least the minimum standards of care which they require. Women and girls need access to health monitoring, access to treatment and support.

Reintegration is a process and many centres have developed sophisticated approaches to ensure that both the family and community are prepared to take back the woman/girl who has been rescued. Part of this process involves assessing whether or not the family will not sell the girl again. Through on-going education, issues of stigma towards trafficked women and girls are addressed. Despite these efforts sometimes the trafficked survivor does not want to return to her home. This should be respected as her right to exercise her own choice. Forced reintegration may lead to girls being re-trafficked.

Despite the serious concerns listed above, rescue, rehabilitation and reintegration remain an essential strategy for those women and girls who want to be rescued and

---

[666] Grover, A. and Divan, V. 2002

return home. However it is noted that an attitudinal change is required to pave the way for ground breaking transformation by re-iterating the fact that trafficking survivors are under no circumstances criminals,[667] and that their human rights considerations are at the forefront of every planned initiative.

The Hawe, Degeling and Hall model outlines six sets of factors influencing trafficking. These are individual factors, including motivation, attitude, knowledge, practices etc; socio-cultural, including social support, gender, ethnicity, religion; economic, including income levels and pressure to work, political focusing on sources of power and influence, policy including legislation, incentives and punishment and existing services, access, scope, appropriateness and quality.[668] Figure 7.2 shows an integrated model of vulnerability combining Mann and Tarantola and Hawe et al.

Figure 7.2. Factors leading to vulnerability to trafficking[669]
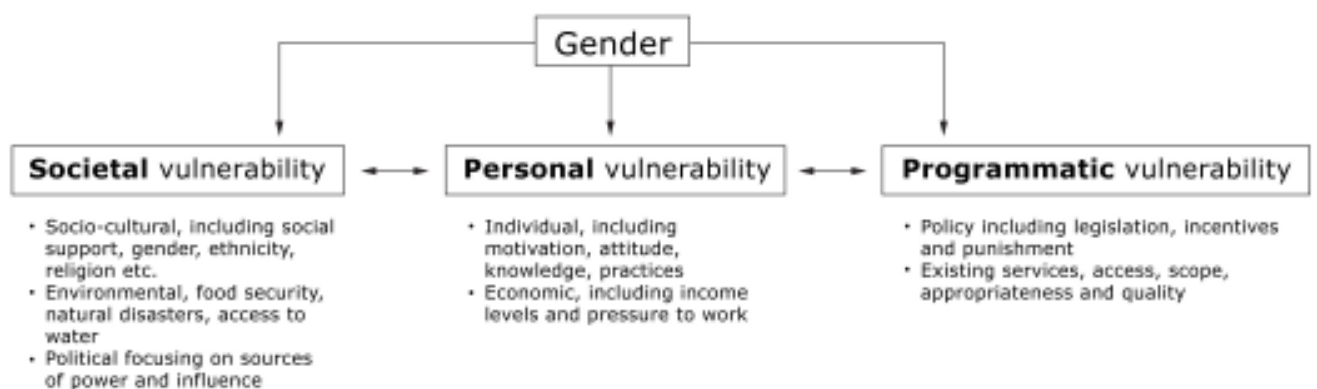
This integrated model is useful in highlighting the role that institutions, policy and programmes play in enhancing or reducing vulnerability. Programmatic / institutional vulnerability is often overlooked when analysing the factors driving the HIV and AIDS and trafficking. Institutions at different levels, be they state, private sector or civil society, can and do increase vulnerability by not taking into account

---

[667] Debabrata, R. 2002.

[668] Hawe, Degeling, and Hall, in Shah, V, and Brar, B, and Rana, S.Y. 2002.

[669] Mann, J. And Tarantola, D. 1996. Hawe et al. in Shah, V, and Brar, B, and Rana, S.Y. 2002.

the realities of peoples' lives. The imbalances in gender power relations is a cross cutting theme across all forms of vulnerabilities.

In short, organisations, both governmental and non-governmental, through their policies and programme implementation, either increase or reduce vulnerability to trafficking. Specific areas of programmatic vulnerability in relation to trafficking include:

- Repressive laws, as responses to trafficking often result in limiting the mobility of women which in turn increases illegal mobility and trafficking
- Limited access to justice for women and girls who have been trafficked. Women and girls are often treated as criminals, the burden of truth lies with them. Given that cases drag on for years women and girls may have to relive the trauma many times over. At the end of the day, there are very few convictions of anyone involved along the complex chain of trafficking.
- Too few holistic prevention programmes are based on an understanding of human rights and gender
- Rescue and rehabilitation programmes that do not promote a human rights framework
- Stigma and discrimination perpetuated by law enforcement officers, health care workers and social services.

International instruments provide guidelines and priorities to address the specific issues of HIV and AIDS and trafficking. Some instruments provide solutions to structural problems such as gender inequality which fuels both trafficking and HIV and AIDS. Furthermore, these instruments present non-governmental organisations a set of indicators with which to monitor governmental progress. Some useful instruments include the Universal Declaration of Human Rights, Convention against Torture, Convention on the Rights of child, Convention for the Elimination of Discrimination against Women, Convention for Suppressions of Trafficking and the 2000 UN Convention against Transnational Organised Crime.

Unfortunately, often the conflicting potential of various national legislation and certain international protocols are being realised. For example, in some instances, governments respond to trafficking fears by legislating to restrict women's freedom of movement. A strategy to implement this is the deportations of sex workers which are common place.[670]

Trafficked women may not have identity documents, or if they do have these are likely to be forged documents. This means women are treated as victims of abuse as well as violators of the law. Protection is only prioritised when women and girls agree to assist in prosecutions.[671] Government and other agencies must develop policies and anti-trafficking measures that will not merely add to harassment or further sexual exploitation of women, for example by police and brothel keepers.

There exists a groundswell of responses to trafficking in the region. This provides an excellent base upon which to build. The welfarist strategies have facilitated quick and immediate responses addressing human rights violations. However, much needed in the medium to long term are strategies that are transformatory, participatory and located firmly within a gendered human rights framework.

7.6 Summary

The analysis presented on the realities of women and girls in South Asia has clearly shown that HIV and AIDS on the one hand and trafficking on the other are acting together to deepen the hardship faced daily by women, girls and boys and act to dramatically increase vulnerability and reduce human well-being. It is important to recognise that HIV and AIDS and trafficking act as co-factors that serve to deepen vulnerability. They also are driven and sustained by a similar set of contextual factors, rather than having a causal link.

Given that both social issues are increasing in the region urgent action is required. The problem of vulnerability created by these twin realities is mediated by power.

---

[670] Lawyers Collective. 2003.

[671] Lawyers Collective. 2003.

The unequal position of women and girls in a range of relations deepens their oppression and disempowerment and their vulnerability to HIV and AIDS and continued exploitation through trafficking. Because of the gendered nature of the problem and the centrality of power in the equation, the most effective, relevant and appropriate responses will be responses that address the contextual political, legal, economic and social factors that drive both HIV and AIDS and trafficking as well as work at a personal level to strengthen self worth and autonomy and facilitate collective action.

Adequate responses must address the current realities and the related practical needs of the women and girls, whilst transforming the existing grossly unequal power relations between trafficked people and the many levels of people benefiting from and actively involved in trafficking. Empowerment is a critical strategy to ensure individual change and collective action. This includes enabling women to collectively take control of their lives, to organise and help each other, to make demands on the state for support and on society for change. The collective empowerment of women leads to a focus on the needs and vision of women.[672] Such a concerted response is necessary if the extreme problems of HIV and trafficking are to be addresses.

It is important to ensure that interventions address the personal level, (where the trafficked women and girls themselves have opportunities to build personal power that includes self worth and a sense of autonomy) coupled with intensive efforts to reform society and challenge the social, legal and economic framework that fuels women's vulnerability.

Despite the incredible challenges in overcoming trafficking examples of resistance have been recorded. Many of the organisations interviewed are vigilant in their approach to reduce trafficking, often at great danger to themselves. Sex workers have begun to organise and are increasingly asserting their own rights whilst being

---

[672] Rowlands, J. 1997

part of the broader anti-trafficking lobby. As has been shown, efforts to subvert the power of those in the trafficking chain may lead to power over the women and girls most vulnerable and at risk; it is thus critical that strategies should empower rather than further oppress.

Chapter Eight: Power within: HIV, rape and lesbian sexuality in the Jacob Zuma trial.

8.0 Introduction

The power within refers to the inner or individual power that, if activated, is inherent in all women. Acknowledging one's own power is vital in ensuring women and girls are able to assert their rights, on an individual and collective level.   Power within is usually harnessed through consciousness raising process, where women begin to articulate their oppression, challenge internalised beliefs about their own subject position and take control of their lives. It is often not easy for women to exercise power within; however, even small acts of defiance in challenging gender inequality in intimate relationships, the household and society in general are important expressions of power within stemming from the belief that 'I am worth more than this'.

This chapter is different from other chapters in that it uses the experience of one woman to underscore issues of power. In November 2005, a young, black, HIV positive lesbian, Khwezi[673] laid a charge of rape against the then Deputy President of South Africa, Jacob Zuma, exercising her personal power on many levels. On the surface, Khwezi could have been viewed as powerless in terms of her position and lack of authority, her age, sexual minority identity, multiple rape survivor, HIV status and her gender. However, her ability to lay the charge, go through the process and at the same time make sure that her personal experience became political through highlighting issues of rape in South Africa is an act of courage and power.

Identity was a critical theme in the State vs Jacob Zuma trial and aspects of the complainant, Khwezi's identity were central issues: she was a young (especially in

---

[673] Named by her supporters from the One in Nine Campaign, an NGO set up by Gender AIDS Forum, Powa and others to provide support for Khwezi and other women who 'speak out'

relation to Zuma), black, Zulu woman, who viewed herself in a father – daughter relationship with Zuma. She was also a woman who was, and had been for years, openly living with HIV. The role-players – defence, prosecution, judge and the media - debated, explored and argued around these identities to prove or disprove that the sexual intercourse which took place on November 2nd 2005 was rape or consensual sex. Less explored in the trial, but and as important to the case, was her self-asserted lesbian identity.[674] I have chosen to explore this expression of 'power within' through the lens of her lesbian identity as it describes her subject position and locates her further in the margins thus underscoring the magnitude of her activism.

This chapter analyses the intersection of power over and power within. Rape in itself is an act of male power over women, and to report rape represents an act of resistance and empowerment. This case presents us with an example of extreme resistance - not only did she challenge male power over women exercised through violence against women, she chose to challenge a man who had extensive political power. Furthermore she chose to use a privileged male system of power, the judiciary, to challenge a privileged male system of rights.[675] The case clearly demonstrates stark differentials in power, and is essentially one woman against the power of politics, the judiciary, and society. It shows how being empowered enables action.

This chapter is based on directly observing the court proceedings, including Khwezi's evidence, cross-examination and the evidence of Jacob Zuma, as well as being present for the judgement. Furthermore transcripts of the trial are used to expand on the intersection of race, class, HIV status and sexual orientation. Finally

---

[674] Although the terms lesbian, bisexual and women who have sex with women are often used interchangeably they do not necessarily mean the same thing. Women who have sex with women, may or may not identify with the label lesbian or bisexual. Studies on lesbian identity show that many women do not self identify as lesbian or bisexual. Morgan and Wieringa 2005 noted that the experience of many women who have sex with women includes having had relationships with men, (in fact they note there is a 'great deal of heterosexuality') for a range of reasons including enforced hetero-sexuality, social pressure to be heterosexual and bear children, personal choice. Some of the women interviewed identified as lesbian whilst others preferred not to label themselves, or used other terminology including bisexual, dyke, and one woman in a lesbian relationship labelled herself as straight.

[675] Faith, K. 1994

the chapter integrates discussions with Khwezi and other activists. The chapter will explore the way that different role-players, the prosecution, defence and judge chose to deal with her sexual orientation. Khwezi's lesbian identity was in no uncertain terms a contested one – by the defense team, the judge, the media and, in some ways by the prosecution. The issue of how Khwezi's sexual identity was used as a strategy by the different role players is outlined. A comment on the verdict and the sidelining of lesbian identity and the personal impact of the trial and judgement on Khwezi and her identity is provided. A critical question to be debated is whether members of the judiciary were adequately equipped to deal with issues of sexuality within the rape trials and the pertinence of sexuality as a factor in the trial.

The trial also raised issues of whether "sisterhood" is universal and whether in fact an injury to one is an injury to all. It was clear in the activism around the trial that Khwezi and her supporters were in the minority. Many women visibly demonstrated their support for Zuma – some even going as far as distributing pamphlets which stated "burn the bitch". The level of anger towards Khwezi was high, and added to the severe stress of the act of resistance. Women have an important role in upholding and entrenching patriarchy – and many women unconsciously may feel they benefit from the status quo. The women who opposed Khwezi and supported Zuma "othered" her by labelling her as different and distanced themselves from her. The sense of injustice at a "sister" being raped was replaced by anger, disbelief and blame – and this was by far the dominant position amongst South African women.

The next section sketches the realities of black lesbian's and their position in post apartheid South Africa.

8.1 Lesbian identity and experiences in post apartheid South Africa

"Lesbian women are often a silent and invisible majority within the broader definition of marginalised sexuality".[676]

A lesbian identity can be defined as "women who chose to direct their energies to other women emotionally, sexually, politically and spiritually among other things."[677] Lesbianism is, in any society, a complex social issue that is determined by social structure and cultural norms and beliefs of a particular society: even in a society which recognises difference and diversity, lesbianism is still often viewed negatively as a rejection of traditional, dominant sexual identity. In fact, a lesbian identity is viewed as a 'counter identity' because it is a direct challenge of what is expected of women by society.

"Society does not give us any space to be ourselves openly, because we are alternative. We are alternative to heterosexuality, which is projected as the norm. We question just by being here many values which are part of heterosexuality".[678]

The African National Congress was the first mass based movement in Africa to formally acknowledge the rights of gay men and lesbian women. This recognition was the result of intensive struggle through organisation, education, advocacy, lobbying and activism by lesbian and gay groups within the anti-apartheid movement.[679] The inclusion of the equality clause in the South African Constitution was seen, globally, as a victory for lesbian, gay, bisexual, transgendered and intersexed (LGBTI) people. However, lesbian issues are not on the agenda of African feminisms.[680]

---

[676] Wells, H, Kruger, T and Judge, M. nd. p 1

[677] Reinfelder, M. 1996. p 4

[678] Ettorre, E.M. 1980. p 15

[679] Gevisser, M., and Cameron, E. 1994. Fine, D., and Nichol, J. 1995.

[680] Aina, M. 1998.

Despite progressive laws and constitution lesbian women face double marginalisation in South Africa: both as women and as women who have sex with women (WSW) living in a patriarchal, heterosexist society. Some lesbian women face deeper marginalisation, for example, because of race, class, ethnicity, HIV status. Multiple marginalisation impacts on different aspects of women's lives including their health. Women's health in general, and the health needs of lesbian women in particular, is not high on the agenda's of neither health service providers nor researchers.

The advent of HIV and AIDS in the late 1970's early 1980's forced LGBTI health issues into the spotlight. Initially conceived of as a 'gay disease' and named accordingly as Gay Related Immune Disease (GRID), lesbian women, or women who have sex with women, were included in the category 'high risk' by virtue of the fact they were having same-sex sex. Once it became apparent that women who have sex with women were not in fact high risk, the focus on lesbian women shifted again and lesbians and HIV in particular, and lesbian health issues in general, once again disappeared from the agenda.

The provision of appropriate health services for lesbian and bisexual women or WSW should be based on adequate knowledge of the complexities and issues. There are huge gaps in knowledge about sexual practices and preferences, including the frequency of same-sex conduct, the number of people who claim same-sex identities, violence against the LGBTI community as well as research into the more positive aspects of LGBTI life.

The advent of HIV and AIDS has resulted in many sex and sexuality studies in different populations and different countries. These studies present golden opportunities for collecting data on LGTI behaviour, experiences and attitudes towards the LGBTI community but such research questions are constantly

neglected.[681] We have limited empirical knowledge about lesbian and bisexual sex and sexuality. There is also little research that has been done on the health issues of WSW including general health issues, HIV and AIDS and the impact of WSW and the community as a whole, and sexual and reproductive health issues. The voices, experiences and issues of lesbian and bisexual women are glaringly absent from the research agenda.

Lesbian health issues have not received great attention from researchers. Lesbian health issues encompass general health, women's health issues as well as sexual and reproductive health issues specific to women who have sex with women. Research for this chapter demonstrated a profound difficulty in finding studies that address the complexities of LGBTI lives in general and lesbian health issues in particular. The absence of such information ensures that such knowledge is not accessible to and not integrated into the work of government and NGO health and HIV and AIDS programmes. Sexual and reproductive health issues are critical for lesbian women with a focus on HIV and AIDS as a major issue facing women in South Africa and globally.

Recent studies that have influenced this chapter include; the Joint Working Group (JWG) study, a collaborative effort between OUT and the Durban Lesbian and Gay Centre, which provides invaluable information on the lives and experiences of lesbians of different ages, races and relationship status in KwaZulu Natal and Gauteng and the International Gay and Lesbian Human Rights Commission (IGLHRC) study on HIV and AIDS and same-sex practicing people in Africa which highlighting many gaps in research, programming and policy negatively influencing the vulnerability of the LGBTI community.

Given the dearth of research it is difficult to get a full picture of the diverse experiences of lesbian lives in post-apartheid South Africa. However, there are obvious worrying trends that need urgent attention. Despite the Constitution

---

[681] Johnson, C.A. 2007

protecting the rights of and asserting equality for the LGBTI community, many lesbians in South Africa still experience oppression on a day to day basis. Homophobic attitudes are still prevalent. In a 1995 survey 48% of the South African public were "anti-gay", [682] for example, over 68% of people were opposed to gay and lesbian people adopting children.[683] In a more recent five year study it appears that homophobia is widespread and rampant; more than 80% of the population over sixteen years of age stated that sex between two men or two women was wrong.[684]

Violence has reached epidemic proportions with murders of lesbian women not uncommon. The Forum for the Empowerment of Women (FEW) working with black lesbians in Gauteng found that women who have sex with women are systematically targeted for abuse such as abduction and murder,[685] for example, the killing of 19 year old Zoliswa Nkonyana in February 2005 by a gang of youths simply because they deemed her behaviour to be too masculine.[686] The murder of two lesbian activists, Sizakele Sigasa and Salome Massoa, on the 7th July 2007, in Meadowlands Soweto, shocked the lesbian community globally, and gave rise to the 07-07-07 campaign against hate crimes.[687] In April 2008, a prominent lesbian and former national soccer player, Eudy Simelane, was gang raped and murdered.

The JWG research on lesbian lives in KwaZulu Natal and Gauteng throws some light on the experiences of almost four hundred lesbian and bisexual women living in a context of inequality. The study highlights the oppressive nature of religion, hetero-sexism, prescribed gender roles, patriarchal norms, resulting in hate crimes, pressure and force being a feature of lesbian life.[688] Multiple unequal power relations experienced by lesbian women which impact on all aspects of existence

---

[682] Cock, J 2003 definition of anti-gay not given

[683] Cock, J. 2003.

[684] Roberts, B. and Reddy, V. 2008.

[685] Johnson, C.A. 2007

[686] Johnson, C.A. 2007

[687] http://www.jwg.org.za

[688] Wells, H, Kruger, T and Judge, M. (nd). p 1

including accessing sexual and reproductive health such as information, knowledge and commitment to address HIV and STI's, assisted pregnancy, and access to basic sexual health prevention technologies such as regular pap smears.

In South Africa, as elsewhere, black lesbians have a different reality to white lesbians. Black lesbians are silenced by patriarchy, culture, social and legal control.[689] Whilst stigma surrounds most lesbians, it can be argued that generally black lesbians experience deeper levels of stigma and homophobia. The increase of 'corrective rape' of black lesbians living in townships illustrates the high levels of violence towards lesbian women as well as highlighting vulnerability to HIV infection. FEW in their work with black lesbians in Gauteng found that women who have sex with women are systematically targeted for abuse such as abduction and murder.[690] Hate crimes are commonly experienced by black lesbians in South Africa. A six country study of female same-sex practices in Africa[691] showed that the rape of lesbian women was more prevalent and violent in South Africa.[692]

8.1.1 Lesbians, HIV and AIDS

Women are more vulnerable to HIV infection than men, partly due to physiology but also due to their often limited ability to protect themselves from infection. This is heightened by a lack of women controlled barrier mechanisms and the socially constructed "rules" of heterosexual sex, where men have the power to decide when, where and how sex takes place. Much of the care that women receive is linked to their reproductive role. Likewise, much of the research into women and AIDS is focused on the prevention of mother to child transmission. We know relatively little about HIV and AIDS in women, even less so in developing countries, and nothing about lesbians and HIV and AIDS. This obviously impacts on prevention, care and treatment issues.

---

[689] Kwesi, B. and Webster, N. 1997

[690] Johnson, C.A. 2007

[691] Morgan, R., and Wieringa, S. 2005

[692] See also Wells, H et al. nd.

"No one knows how many lesbians or bisexual women are infected with HIV or have AIDS."[693]   Based on anecdotal reports, however, it does appear that a substantial number of lesbian women in South Africa are living with HIV. Many women living openly with HIV and AIDS self identify as lesbian.   According to the OUT report the 'high rates of HIV amongst lesbian and bisexual in South Africa can in part be attributed to rape, unsafe transactional sex with men and sexual violence."[694] Obviously more accurate statistics need to be based on women testing, lesbian women are not likely to go for an HIV test, they are also deterred from talking about and seeking sexual health care more generally. The OUT study revealed that just over 50% of the women interviewed had undergone an HIV test, although the reasons for testing were not clear and could have included routine testing.   9% of the women who had tested did not return for their results. Reasons given for not testing included not thinking it was necessary (linking to the myth that lesbians are 'safe') and being afraid to test.[695]

Are lesbians aware of HIV and AIDS? Most of the women interviewed in the various countries in the Morgan and Wieringa study were aware of HIV and AIDS, yet very few of them, apart from the women knowingly living with HIV and AIDS, are practising safer sex.[696]   They explained they have no need to do so as they trust their partners to be monogamous, despite knowing of their sexual history with men. The testing patterns of the women in the OUT study demonstrate that many women have a consciousness about HIV and AIDS although some women are in denial about their risk.

Despite the recent research into the lives and experiences[697] we still do not have a clear picture of the rich and diverse experience of lesbian women in South Africa. It is vital that we make distinctions between lesbian and bisexual women

---

[693] Richardson, D. 2000. p 41

[694] Wells, H, Kruger, T and Judge, M. nd. p 5

[695] Wells, H, Kruger, T and Judge, M. nd.

[696] Morgan, R., and Wieringa, S. 2005

[697] Wells, H, Kruger, T and Judge, M. nd.   Morgan , R., and Wieringa, S. 2005.

understanding that they "occupy different positions socially and historically'"[698] and that different experiences need to be documented, acknowledged, understood and acted upon. Sexuality is complex: there is no simple relationship between behaviour and identity, although sexual behaviour is often equated with sexual identity. It is important to address different elements of sexuality including sexual behaviour, sexual identity and sexual drive and understand that they mean different things and are experienced in multiple ways by women.[699]

The final question is what are the implications of women who have sex with women not being on the agenda. Quite simply the invisibility and marginalisation of lesbian and bisexual is leading to the sexual and reproductive health of women who have sex with women not being adequately met. This is especially true when one looks at HIV and AIDS – there is an urgent need for programmes that address WSW in order to reduce their vulnerability. Safer sex messages should include lesbian women, bisexual women and women who have sex with women and provision should be made for the distribution of prevention technologies for women.

Against this backdrop of promised but not realized rights, extreme levels of violence and a growing HIV epidemic amongst lesbian women it is understandable that the rape trial was conducted in the manner that it was. The next section focuses on how the defense and prosecution dealt with the issue of Khwezi's sexual orientation.

8.2 The Trial

'Coming out' in the context of the Zuma trial was an act of power within. It was an important statement in that it highlighted both the personal choice of identity and its political nature. Khwezi self identified as a lesbian at the beginning of the trial

---

[698] Richardson, D. 2000. p35

[699] Richardson, D. 2000.

in her evidence when being cross-examined by defence attorney, Advocate Kemp:[700]

> *Kemp:* Would you say you are a sexually experienced woman?

> *Complainant:* I have some sexual experience, yes.

> *Kemp:* Have you had sex with a considerable number of men, you could put a sort of estimate on that if you want to.

> *Complainant:* I don't know if I would remember everything but I guess I would say five may be*.*

> *Kemp:* Is that five persons with whom you had sexual relations in your life?

> *Complainant:* Five men yes.

> *Kemp:* Do you qualify that because to put it generally you are bisexual?

> *Complainant:* I have sexually been with men and women; I consider my sexual orientation to be a lesbian.

Although through her disclosure the issue of lesbian sexuality was open in the trial, it was also marginalised, deemed not important and in the final judgement, denied, with Judge van der Merwe pronouncing that Khwezi was not an 'out and out lesbian'. However, it can be argued that her assertion of her lesbian identity should have been a crucial aspect of the trial, and used substantially in the prosecution's case.

---

[700] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05-lks p 222.

Different characteristics combine to influence, and in some cases complicate, identities, for example race, class, sexuality.[701]   Khwezi, as a young, back, Zulu, HIV positive woman, who identifies as a lesbian, experienced layers of stigma in her life as a result of her different and combined identities. These different identities were highlighted and interrogated, to a greater or lesser extent, during the trial.

Rape trials focus on determining whether sexual intercourse was forced, that is whether rape occurred, or whether the sexual intercourse was with informed consent.[702] The central question, around which the case was based, was whether Khwezi had consensual sex with the ex deputy president of South Africa, Jacob Zuma. The judge found that she did have consensual sex and went further to insinuate in his judgement that she even initiated the sex. Whilst it may be a controversial opinion, I believe that once the issue of allowing her sexual history was debated and deemed admissible as 'evidence' and the defence team were given licence to interrogate Khwezi on her previous sexual history, the issue of her lesbianism could have been explored more vigorously in the prosecution's case and possibly could have led to a different verdict: had the issue of her sexuality been explored in a deep, sensitive and meaningful way a different picture would have emerged which could have had a bearing on the outcome of the case.

In reality, the trial itself focused very little on Khwezi's lesbian identity. In an analysis of the language and discourse used by the defence, prosecution and the judge in over one thousand pages of the trial and judgement transcripts, the issue of lesbian identity was raised and discussed very few times. The issue of sexuality was 'used' and dissected in different ways during the trial and the judgement, often demonstrating the value judgements and sometimes overt homophobia of the key role-players. In analysing the different role-players responses to Khwezi's lesbian identity it is necessary at the outset to understand and distinguish between what is legal strategy (for example the defence denial of her sexuality was a key point in their case), and what can be viewed as overt and outright anti-lesbian. In general

---

[701] Muthien, B. 2005.

[702] Reddy, V., and Potgeiter, C., 2006.

the attitudes and understanding of lesbian issues and experiences in the courtroom mirrored those of society, and were in essence prejudicial and stigmatising.

8.2.1 The defence strategy

The defence tactics were to make Khwezi's lesbian identity a non-issue: to show that she was essentially heterosexual (proved through her own "admission" of her heterosexual experiences and witnesses that attested to her having relationships with men) and that her stated lesbian identity in no way prevented her from initiating, or at the very least agreeing, to have sexual intercourse with Mr Zuma. The defence strategy around her sexuality was, from a legal point of view, thorough and effective and certainly coloured the judge's understanding of Khwezi's lesbian identity.

The defence took great pains to focus on the fact that Khwezi initiated discussion about not having a boyfriend (and not using gender neutral partner or lover) to Zuma and about being lonely, as demonstrated in the following leading of evidence:

> *Kemp: …* She testified that during the conversation when it came up as to why she did not have a boyfriend, she amongst other things said something to the effect that today's boys are not men enough. They are not good enough. She says as well that this type of topic was introduced by you and by you asking her about these matters what is your comment about the fact that she says it was you that introduced this type of topic into your conversation.

> *Zuma*: It is not true that I initiated these discussions. She actually introduced these topics and I would only answer what she would ask, but in actual fact she started all these conversations.[703]

Further on in Zuma's testimony the issue was again raised:

---

[703] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 –lr p895

Kemp: The complainant testified that thereafter you had a conversation where the boyfriend issue, that she did not have a boyfriend came up again, and she also testified that was about today's boys, and that you mentioned at a certain stage the fact that she is HIV positive should not stand in the way of her having a boyfriend, and that if there is a need of, if she has sexual needs she must have someone satisfy them, and that would be even if she had to lower her standards, not be so choosy about the boyfriends. And at some stage I think she suggested at the beginning of the conversation that you would also comfort her.

Interpreter: He should comfort her?

Kemp: Ja. …. Who introduced this boyfriend aspect and that whole issue of that she did not have a boyfriend etcetera?

Zuma: She initiated these talks about the fact she did not have a boyfriend.[704]

The strategy of the defence team was to consistently assert that Khwezi's lesbian identity was meaningless and that she was interested in, and raised on more than one occasion, that she in fact wanted a male partner, a 'boyfriend'. This line of defence resonates with public opinion and societal attitudes that all women, including lesbian women, need, is a 'good man', and is in fact the premise upon which 'corrective rape' hangs.   Zuma goes on to state in his evidence that he began to be 'suspicious' about the alleged underlying subtext of the conversation, that Khwezi was in fact not talking generally or hypothetically, about her need for a boyfriend or a good man but was in fact directing her energies to him as the object of her 'desire'.

---

[704] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 – lr p 899

Zuma… Like she said to me that she needed or she was feeling lonely because there was nobody to keep her company and I told her, I advised her to get someone to keep her company. Nevertheless she continued with these discussions up until I became suspicious because the impression I got was that these discussions included me as well.[705]

These discussions between Khwezi and Zuma were not disputed – however the issue of who initiated the conversation and the subtext of the conversation was disputed. This is a critical point which was not interrogated by the prosecution. At no stage was Khwezi asked, why, if she identified as lesbian, she was talking about wanting or needing a boyfriend.

It was important for the defence to cover all bases and establish that even if Khwezi was a lesbian, Zuma had no knowledge of her sexuality at all.

*Kemp***:** Did the complainant ever at any stage tell you that she is either bisexual or lesbian or have any conversations along these lines with you?

*Zuma***:** She has never mentioned such a thing, no discussions before. It was the first time that I heard her mention that.

Kemp: You mean here in court is the first time?

Zuma: Yes in this court.[706]

The fact that Mr Zuma claimed to have no knowledge of Khwezi's lesbian identity was further used to discount her assertion of a father-daughter relationship in Kemp's application to have the case dismissed.

---

[705] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 –lks p 930

[706] High Court of South Africa, Witwatersrand Local Division. 2005.   SS321/05-lr p 894

Kemp **...** one would have thought that if there was that type of relationship between them, this would have been the opportunity to tell him 'no look man, I am not really interested in boyfriends'. The reason is I am actually, as she said in the witness box later, I am a lesbian so I do not really, I am not really interested in boyfriends, what you talk about does not really apply to me. She does not say that my lord, to him and we say it is another indication that the relationship was not exactly as she held it out to be.[707]

They also used the testimony of the prosecution's psychologist, to demonstrate that even if Khwezi was a lesbian she would still be able to understand heterosexual cues and advances. The following extract is from the cross-examination of State psychologist, Dr Friedman, by Advocate Kemp:

Kemp.... you heard the evidence of the complainant doctor that she described herself as a bisexual tending to be a lesbian?

Dr Friedman: M'Lord in fact in her testimony she said she was lesbian, not bisexual.

Kemp: The fact that she describes herself then as a lesbian, let us deal with it in that way, what would the effect thereof be on this what you call the sensitising, would that not have obliterated the normal signs for a woman if she is not reacting the same? Do you understand what I am saying doctor?

Dr Friedman: M'Lord no. Many women that are gay will most certainly see if a man is coming on to them. It is not because their sexual orientation is different that they will not see it.

Kemp: So are you saying it... (intervenes)

---

[707] High Court of South Africa, Witwatersrand Local Division. 2005. Application to have the case dismissed: Defence: SS321/05-lks p727

Dr Friedman Especially if they have had sexual interactions with men.

Kemp:So you are saying that is not a determining factor?

Dr Friedman I am not understanding...

Kemp: The mere factor what sexual orientation is, in sensitising such actions?

Dr Friedman Your sexual orientation definitely does not imply your sensitivity towards somebody else make a sexual advance towards you. Many gay women get sexual advances from men. It does not mean they do not see it. They just do not enjoy it.[708]

The defence strategy was thus: attempt to render her powerless on different levels, and try to break her down. They neutralised any impact Khwezi's sexuality would have on the trial, portray her as heterosexual, lonely, and in need of comfort, denying her perceived father daughter relationship with Zuma, and in doing so made believable that she would initiate sex with him, even knowing her HIV status and when it was discovered that there was no condom present, insist to him that he could not leave her in an aroused state.

Despite all the tactics, Khwezi remained strong and resolute throughout the trial and after the judgement. She noted after the verdict that although deeply disappointed, she was not sorry that she had laid the charge and gone through the process, and she would encourage other women to do the same.[709]

---

[708] High Court of South Africa, Witwatersrand Local Division. 2005. p 412

[709] Personal conversation 8 May 2006

8.2.2 The prosecution strategy

Whilst the defence strategy was to acknowledge and counter any effects that Khwezi's lesbian identity may potentially have on the case, the prosecution, on the other hand, chose to initially ignore the fact that Khwezi was a lesbian and in her testimony (which spanned almost two days) her lesbian identity was not raised at all. It is difficult to understand the strategy of the prosecution not initially raising the issue of Khwezi's sexual orientation during her giving evidence. Some possible reasons could be that they thought it irrelevant to the case, they were under instruction from the complainant not to raise the issue, or that they thought it more strategic to introduce the issue of sexuality at a later stage if deemed necessary. Whatever the initial reasons, when analysing the prosecution's case and how they dealt with the issue of sexual orientation, it is clear that they were often uncomfortable, showed limited understanding of complex issues and had no strategy to counter the defence tactics.

There were critical issues in the defence case that the prosecution chose not to, or did not have the skills to, address. For example, at the outset establishing the reality of a lesbian identity, challenging the stereotypes of lesbian sexuality and providing an argument for why she would not have disclosed her sexual orientation to Zuma.

The prosecution, as did the defence, in the early stages of the trial chose to focus on conversations between Khwezi and Zuma regarding her current relationship status and her discussions around having a boyfriend:

> *Complainant:* So then I jokingly just said to him.. no, *Malume*[710], you are not getting *lobola* anytime soon
>
> *De Beer:* Did he say anything else?

---

[710] Zulu word for uncle.

Complainant: He just then asked me if I had a boyfriend and I said no I don't have a boyfriend.[711]

The prosecution had the option, at this point, to discuss Khwezi's sexuality, question why the focus on boyfriends, explore the common held myth that all a lesbian wants or needs is a good man, and challenge understandings around identity. They chose not to address the issues at this stage. However, when the defence opened up the issue of sexuality, and Khwezi self-identified as a lesbian, the prosecution honed in on it. They attempted to neutralise the issue by trying to get Jacob Zuma to admit that he knew about Khwezi's sexuality, a point that he constantly denied, and then tried to counter this by implying that disclosing ones sexual orientation is difficult and 'embarrassing' and by implication it was understandable that she did not tell him:

De Beer: It was put to the complainant by your counsel that she, to put it generally "you are bisexual", the quote.

Zuma: Yes it was put to her

De Beer: And then she admitted it, not so?

Zuma: Yes

De Beer: It must have been very embarrassing for her to admit that in open court not so?

Zuma: I would not know M'Lord. Yes I remember her M'Lord explaining her position and how she regarded that as well, the sex issue.

---

[711] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 p 14

De Beer: Sorry?

Zuma: Her sexual orientation.

De Beer: Then she even had to admit under oath that she is a lesbian.

Zuma: Yes.

De Beer: And you will agree with me that it is not something that a female from the culture of the complainant would admit lightly.

Zuma: I would not agree M'Lord because now of late so many people come up and declare their sexual orientation. Yes before in the past it was amazing.

De Beer: Did you know that she was one?

Court: That she was?

De Beer: That she was a lesbian, did you know that?

Zuma: No I did not know.

De Beer: So can we take from that, that it was not something that was publicly known about her?

Zuma: Well I do not know M'Lord, I do not have knowledge of that.[712]

This exchange and the use of language clearly shows the prosecution's discomfort with dealing with the issue of sexuality as well as highlighting the attitude of the

---

[712] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/o5 – lr p 962

prosecution: her needing to 'admit' to being a lesbian, the fact that it must have been 'very embarrassing' and noting that it was not something that a Zulu woman would disclose easily. Zuma's response that 'in the past it was amazing' could have been further investigated given that it was common knowledge that his comments about the LGBTI community in the past were homophobic. That could have been a reason in and of itself as to why Khwezi had not disclosed her lesbian sexuality to him, and instead chose to talk to him about 'boyfriends'.

The defence team had made an issue of why Khwezi had not simply disclosed to Zuma that she was a lesbian. This highlights a lack of understanding of the issues surrounding the disclosure of, or 'coming out' as a LGBTI person and provided a good opportunity for the prosecution to counter the argument. The awareness of societal stigma that surrounds gay and lesbian identity impacts negatively on disclosure:[713] and this is often based on shame and secrecy. Other reasons for non disclosure can be linked to confusion around a new or emerging identity. Disclosure to parents or parental figures is difficult, and parents are often not the first people that an LGBTI person will come out to.

Whatever the reason for her non-disclosure to Zuma about her sexual orientation, it was neither questioned nor analysed. Given her openness around her HIV status, it should have been a line of questioning from the prosecution to get the judge to understand the complexities of disclosure, especially in this way the prosecution could have established that the fact she spoke of boyfriends to Zuma, and had not disclosed her sexual orientation in no way indicated that she was not lesbian. This was another instance in which lack of knowledge of the realities and experiences of black lesbian's in South Africa resulted in a shoddy strategy which did little or nothing to counter the defence strategy.

Further on in the cross-examination the issue of whether Zuma knew of her sexual orientation was raised again. Whilst the prosecution once more attempted to get

---

[713] Plumber in Williamson, I. 2000

Zuma to say he was aware of Khwezi's sexuality, he remained adamant that he was unaware.

> *De Beer*: I put it to you that she was not interested in you because, number one, you were a father, a *Malume* figure to her and she is also of a lesbian orientation.

> *Zuma*: That is not true. She did not discuss such things with me and she would not do what she did on that night.[714]

Zuma was also cross examined about his attempts to silence Khwezi by getting two women to discuss with her mother the option of marriage – through *lobola* negotiations:

> *De Beer*: Well I put it to you that she was not interested in *lobola* even if it was mentioned but furthermore she is a lesbian and would not be interested in marrying you.[715]

Whilst specific questions were raised to Zuma about Khwezi's lesbian identity, the prosecution strategy, was, in the final analysis not effective and bordered on inefficient: the defense had already established issues around Khwezi's lesbian identity and the prosecutions questioning and cross examination only helped to cement the defense arguments. In hind sight it may have been a better strategy to explore Khwezi's lesbian identity at the beginning of the trial, take 'ownership' of it and not have allowed the defense to have so successfully neutralise the issue. What is clear is that given the prosecution did not have the expertise and knowledge to deal with the issue of sexuality; they should have called expert testimony to strengthen their case. In an interview with Khwezi the day after the judgment, she demonstrates how, if the prosecution had asked her the right questions, she would have been able to coherently articulate her own identity – and explain how her

---

[714] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 –dd p1025

[715] High Court of South Africa, Witwatersrand Local Division. 2005. SS321/05 –d p 1025

lesbian identity is an emotional, social and political one. This would have been the best strategy of the prosecution – to allow Khwezi to speak for herself.

8.2.3 The media

The trial was closely covered by the media. It is beyond the scope of this chapter to provide a detailed analysis of the extensive print and audio-visual national and international media coverage of the trial.   However, it is important to briefly mention the role of the media.

Whilst some media was sympathetic, critical and analytical most were not, choosing highlighted the stereotypes about rape so prevalent in society. In general, the media's role in the trial in general was problematic: focusing on the sensational, stoking the myths about rape, and being insensitive. The following two examples of reporting highlight the way the issue of Khwezi's lesbian identity was dealt with, either in a neutral way,

> *Zuma's accuser, who considers herself a lesbian, alleged that on November 2 last year, the former deputy president raped her in the guest room of his Johannesburg home while she was staying overnight during a family crisis.[716]*

or in a insensitive way,

> *Inside the court, Judge Willem van der Merwe allowed evidence detailing her turbulent psychological and sexual history, including earlier allegations of rape and lesbian affairs[717].*

This is problematic on two levels, firstly there are inaccuracies in this statement, at no stage in the trial process where the so called 'lesbian affairs' discussed in any detail.   Khwezi simply stated that she had sexual relationships with men and

---

[716] www.mg.co.za 8/05/2006 03:02

[717] http://www.msnbc.msn.com/id/12647411/site/newswee

women. Secondly the juxtaposition of allegations of rape and lesbian affairs and language such as turbulent psychological and sexual history, casts a negative light on her sexuality. There is a need to actively monitor media in its reporting of LGBTI issues and hold them to account for blatant homophobia.

However, despite some negative reporting on the issue of Khwezi's identity, it can be argued that the media coverage of the issue of sexuality was limited and had little impact: in general the media chose to reflect what was happening in the court room and focus on other issues that were given more prominence.

8.3 The Judgement

For the women's movement and those involved in addressing violence against women in general, the judgement was a huge disappointment, not only the finding of not guilty, but the fact that the judge could not even pronounce that the evidence led to 'beyond reasonable doubt'. The judgement was instead a pronouncement on the complainant, highlighting the issue of her contested identity and became a vitriolic attack on the 'victim'. There are also aspects of the judgement that are not a true reflection on the facts presented in the case.

Moffat highlights the legal blurring of Khwezi's sexual history and her previous history of sexual violence and how it was used to discredit her by an 'aggressive' defence strategy. Khwezi's history was used to suggest she was "unstable, emotional and disturbed and therefore could not be trusted".[718] The judgement certainly reflects the points from the defence's case but the judge goes further to discount Khwezi's identity and personality. Her lesbianism was used as a contributing fact to her not being trusted (in that she admitted to having sexual relationships with men, and as such was defined at best as bisexual), but also because she was not trusted it was easy to discount her lesbian identity. This was clear in the judgement. The underlying subtext is that lesbians cannot be trusted.

---

[718] Moffat, H. 2006. p17

"In many respects this is a unique case with unique features. Instead of scaring off unfortunate rape victims it should have been pointed out and emphasised that unfortunate victims of rape will be treated differently because they are different from the complainant in this matter".[719]

Van der Merwe addressed on four separate occasions in his judgement, the issue of Khwezi's sexual orientation:

… *"during the cross-examination of the accused it was on more than one occasion put to him that the complainant is a lesbian. It is clear that the complainant is bi-sexual with a lesbian orientation. She did not testify in chief that she is a lesbian orientated".* [720]

"Though she is not an out and out lesbian, the fact that she is inclined to lesbianism cannot be lost sight of".[721]

"It was put to the accused that the complainant is a lesbian. I have earlier in the discussion of the complainants evidence referred to the fact that she is bisexual and that she regards her orientation as being lesbian. From the evidence it cannot be said that the complainant is a lesbian and only a lesbian".[722]

"It may be asked why the complainant who is inclined to lesbianism would have had consensual sex with the accused. The answer lies in the complainant's history. The complainant regards herself as being bisexual but inclined to lesbianism. She was prepared to have penetrative sex with men on various occasions but also as late as 1996, 1997 and 1998 according to

---

[719] High Court of South Africa Witwatersrand Local Division Judgement 2005 p 171 -172

[720] High Court of South Africa Witwatersrand Local Division Judgement 2005 p49

[721] High Court of South Africa Witwatersrand Local Division Judgement 2005 p93

[722] High Court of South Africa Witwatersrand Local Division Judgement 2005 p 108

the evidence of Mpontshani. According to the complainant herself she had sex with a male in July 2004". [723]

The judge takes great pains to discount Khwezi's sexuality as lesbian and label her as bisexual: he erroneously notes that she did not 'testify in chief that she is of lesbian orientation'. At no point during the trial was Khwezi ever "questioned" about any experiences of being lesbian and her own self identification as lesbian: the pronouncement of her "bisexual" identity was made based on fact she had male lovers in the past, by both the defence team and the judge. It was obvious that the key role players had little or no understanding of the complexities of sexuality, and the bearing that it had on the case. All sexual identities are fluid and contextual; Judge Van der Merwe erred by both incorrectly positioning Khwezi and also defining her as a static sexual identity.

The most insidious oppression faced by lesbians, and evident in this case, is the denial of existence.[724] This invisibility is part of, and compounds, the heterosexism operating at a personal and social level. In many ways, during the trial, Khwezi's lesbian identity was rendered invisible, acknowledged but denied and ridiculed. Judge van der Merwe consistently denied Khwezi's identity and insisted that she had another identity. He denied her identities as a rape survivor, as a lesbian and focused on her strength as an assertive woman who 'could have and should have protected herself'.

The following extracts from an interview with Khwezi on the day after the judgment, by Dawn Cavanagh and Prudence Mabele of the One in Nine campaign highlights the impact of the judgment on Khwezi, and importantly allowed her to speak out about her feelings regarding the pronouncements about her sexuality. It underscores her personal sense of power; despite all the efforts to undermine her she remained strong and powerful.

---

[723] High Court of South Africa Witwatersrand Local Division Judgement 2005 p 170 -171
[724] Reinfielder, M. 1996

"And then there are his pronouncements about my identity. Who I am. It is so strange to be sitting there like an onlooker, to hear someone telling you who you are. And none of it fits, is real for me. And here is this man telling me I am mad, unable to even know what is consensual and not; promiscuous, bisexual and not lesbian".[725]

Khwezi herself highlights many of the crucial issues implied in the homophobia displayed by the judge. For example, the issue of identity is raised; who defines identity, on what grounds and how. Furthermore the issue of lesbian as an identity for women who have sex with men, or who have had sex with men in the past is disputed in the judgment.

"Ja, he questions my identity as a lesbian saying how can I call myself a lesbian when I had had sex with men. He reaches the conclusion that I am not a lesbian! He did this without asking me for the details about my identity as a lesbian. Well that is the nature of identity and this judge didn't get that. He doesn't begin to understand the complexity of sexuality. You live in this heterosexual society. You don't see the options because that's how society works. Then you are raped. And you think well if I am a lesbian, people are going to say I am a lesbian because I was raped and yes, I don't want them to think that. So I have to show that this is not so. Anyway what was the relevance of my sexual identity in this judgment? This was not properly explained as far as I am concerned. Was it a matter of my credibility? I am saying something that is not true? Well how does what we know about sexual identity support the fact that I am a lesbian?"[726]

---

[725] Cavanagh, D., and Mabele, P. 2006 p 2

[726] Interview with Khwezi – Cavanagh, D., and Mabele, P. 2006 p 1

The issue of identity is complex; identities are constructed in a variety of ways according to what is seen as important in a particular context, and in this case is about what is different and not representative of the hegemonic position. It is important to acknowledge that all forms of difference are not viewed as equal: one needs to understand various forms of oppression, understand the historical basis of such oppression, the practices of domination and the specific ways in which it intersects with other forms of oppression. The treatment of lesbian identity and experience in the trial reinforces the oppression of the LGBTI community, regardless of State policy. There is often, and most certainly in this case, a disjuncture between self identity and presumed identity. It is not unusual for there to be a distinction between how an individual perceives herself to be and how she is defined by others.[727] Furthermore, ones' social identity, the identity ascribed by others, is often seen as the dominant identity, and holds more weight than ones' own personal identity. The effects of this, evident in the trial, needs to be further researched.

> *"The denial of same sex behaviour and identities by African political and cultural leadership makes life a struggle for authenticity and belonging for many same-sex attracted African people".*[728]

It can be argued that van der Merwe, in his influential position as a judge, had a political and moral responsibility to tackle the issue of Khwezi's sexuality in a thoughtful, sensitive and informed way. The judgment reflects that he failed to do so and instead propounded biased and uninformed views on sexuality.

---

[727] Ponse, B. 1978

[728] Johnson, C. A. 2007 p 12

8.4 Summary

"The full ire of civil society was invoked against an HIV positive young lesbian who had dared to lay a charge against the second-most powerful citizen in this country".[729]

This case was complex, whilst for many people the key aspects of the case were around the identity of the complainant – an HIV positive, young, lesbian, the defence strategy was to down play issues of identity, the prosecution did nothing to address the issue adequately and the judge blatantly denied the stated sexual identity of Khwezi. It was also an extreme case of an attempt to seek justice by challenging a man in a very powerful position – demonstrating that internalised power / power within is important in enabling women to confront adversity.

At no stage in the Zuma rape trial was it insinuated that the rape occurred because of Khwezi's sexual orientation. However what happened in the courtroom around her sexual orientation can surely be labeled as 'violence'. There is a need to challenge homophobia in the courtroom, and demand that the judiciary have an understanding of diversity and difference, or at the very least understand their limitations and consult expert testimony as they do on other issues.

The impact of the trial and the judgement was felt beyond the experiences of Khwezi, after the verdict; "black lesbians in particular felt they had been marked out as fair game; that rape had been legitimised".[730] Lesbian rape is not uncommon in South Africa, and whether the rape survivor's lesbian orientation is know or not to the rapist is not the central issue. It is obvious that the justice and legal institutions have, in general, little understanding of the complexities of sexuality and are thus unable to deal adequately with the issues. The issue of the

---

[729] Moffat, H. 2006 p 17

[730] Moffat, H. 2006 p 17

rape survivor's sexual orientation may be a key issue in the case, and the sensitive handling of the issue may be pivotal in getting the correct judgement.

In the final analysis Khwezi's act of defiance, utilising her power to challenge the more powerful had both negative and positive effects. The personal affect of the rape, trial, judgement and the aftermath were immense: Khwezi now lives in exile in Europe and is fearful to return to South Africa, especially because of the death-threats that she received. The second negative outcome of the process was the belief that lesbian's are 'fair game' for rape and abuse. The judgement highlighted the many myths about rape, what women do before, during and after in a 'proper rape', the myth that a women can only get raped once and issues around sexuality and rape – especially bisexuality and lesbianism.   He concluded with the sentiment that Khwezi 'got what she asked for'.

On the other hand, the trial opened up the possibility for a resurgence of a women's movement, beyond the traditional violence against women's sector, throughout South Africa, as women and progressive men battled to come to terms with the judgement and its implications. This highlights the power of individuals, backed by others in solidarity, to effect change and push forward various struggles. Rape is common in South Africa, yet this trial, given the complex dynamics of identity and power, provided a pivotal opportunity to mobilise and move forward the women's rights agendas, that are currently only paper rights, and not accessed by the majority of South African women, especially HIV positive lesbian women.

Khewzi's act of resistance demonstrated that one woman could fight powerful societal institutions and individuals and that other women (and men) would stand in solidarity. The strength of Khwezi in laying a charge, going through the trial process and emerging afterwards, battered but still strong in her convictions points to the resilience of women, and that empowerment is possible despite the odds.

Chapter Nine: Power to: Local Action. A feminist response to HIV and AIDS

9.0 Introduction

"Women are facing a crisis that requires urgent attention. The response to HIV and AIDS must be two-fold: a short-term strategy that needs to, as much as possible, reduce the spread of HIV amongst women and lessen the impact of HIV and AIDS on women. However the long term goal must be to challenge the complexities and inequalities of power relations between men and women in society leading to the transformation of society".[731]

The empowerment of women is seen as a critical element of resistance, and is a key step in the transformation of relationships of unequal power. The power to resist and transform comes from a process whereby individuals shift from unconscious to conscious and from inaction to action. Resistance can be an individual or a collective act. Whilst many organisations working in HIV and AIDS focus on addressing immediate, short term needs, such as access to services that tackle practical needs, there are very few organisations that address the longer term and important goal of transformation.

Unequal power is evident in different sites of struggle in women's lives; the body as a fundamental site of struggle, the most basic level where women are oppressed, intimate relationships, the household, community, workplace and community. It is important to note that transforming power relations can take place in any site of struggle depending on the woman's ability to challenge the oppressions she faces. This chapter highlights the application of a feminist approach to HIV and AIDS by a National South African NGO, the Gender AIDS Forum.   My position in the

---

[731] Tallis, V. 1998 p13

organisation enabled me to develop theories of power and put these theories into practice, to test the applicability of the conceptual framework that merges theories of vulnerability at three levels with an analysis of power as problem and solution.

A background to the context of women and girls in South Africa which outlines the country response is provided. The history, structure and strategic focus of GAF is presented. The theory underlying the work of the organisation is discussed and an example is provided of practical application, the Women in Leadership programme. Critical challenges and key lessons learned are discussed.

9.1 Context of women and AIDS in South Africa

Prevalence rates vary within South Africa: at 37.4%, HIV prevalence among antenatal clinic attendees in one of the nine provinces, KwaZulu-Natal is about three times higher than in the Western Cape, the province with the lowest prevalence.[732] A slight decline in prevalence among teenage pregnant women aged between the 15 and 19 years has been offset by consistently high HIV levels among 20 to 24 year-old pregnant women and rising levels among those aged 25 to 34 age group.[733] Because of South Africa's relatively young AIDS epidemic and given current trends, AIDS deaths will continue to increase rapidly over the next five years at least; in short, the worst still lies ahead.[734]

Women and girls in South Africa are faced with daily hardship on a physical, social, emotional and economic level. The unequal power relations between men and women are a key factor in the deepening impact of HIV and AIDS. Since 1994, with the transition to democracy, progressive policies have been drafted over time to advance and improve the position of women and girls in the country. Some women have benefited from policy change: for example, there are greater numbers of women in key institutions of democracy and in the private sector, increasing the

---

[732] http://www.avert.orgsafriastats.htm

[733] National Department of Health. 2008.

[734] UNAIDS.2003. Shisana, O. and Simbayi, L., 2000

voice and visibility in the public arena. However, the actual realities of most ordinary women's lives have not improved significantly. Given the context of HIV and AIDS, and an already massive burden of poverty, the status of women and girls is declining. There is a possibility that gains made in terms of narrowing the gap between women and men, boys and girls will be eroded. There are already examples of this happening, for example, the education of girls is being seen as less important than that of boys, with girls being kept out of school to care for sick and dying parents and relatives.[735]

On the surface, South Africa is a middle-income country with a progressive Constitution that upholds the rights of women and girls.[736] With a Gini Coefficient of 0.58 South Africa is located as one of the most unequal societies in the world.[737] Women's rights were hard fought for during *apartheid*, and over and above the Constitution, mechanisms exist to promote gender equality, for example legislation, policies and institutions such as the Gender Commission. For most women, however, such rights remain on paper – and the realities of women's daily lives have not changed substantially; oppression on the basis of gender remains a factor of women's life. For example, despite changes in sexual and domestic violence legislation, there are extreme levels of violence against women in the country. Another example that underscores women's reality is that since 1994 women have had legal access to termination of pregnancy, however, as noted previously, that women are rather opting for illegal termination than go through the clinic system which is judgemental and discriminatory.[738] This backdrop of extreme inequality, based on gender and class is one of the key driving forces of HIV and AIDS in the country.

---

[735] UNSG Task force on women and girls, HIV and AIDS. 2003.

[736] Tallis, V. 2008.

[737] http://www.dcis.gov.za

[738] Barnabus, L et al. 2006.

9.2 What is the response to women, HIV and AIDS in South Africa?

The response to women, HIV and AIDS has spanned two decades, although the successes are less than apparent. Some critical milestones in the South African response to dealing with women and/or gender and HIV and AIDS include:[739]

1992: First National Meeting on women and AIDS: The Medical Research Council held a meeting focusing on women and AIDS *From sexuality to sero-prevalence, from counselling to care*. This meeting consisted mainly of researchers and a few practitioners. The aim was to identify gaps and develop a research agenda. The central theme was to understand women's lives, especially to define where women have control as well as to analyse men's power. Although the meeting itself was challenging there was little evidence that participants integrated the findings into their work.

1994: The NACOSA Plan: Born out of an extensive provincial and national consultative process the National AIDS Convention of South Africa (NACOSA) Plan cited gender as a key principle in the response to HIV and AIDS and attempted to integrate or mainstream gender into the seven key strategies. This plan was handed to the African National Congress (ANC) government in 1994 to implement. However, the plan was not implemented in its entirety and certain critical principles and strategies, such as gender were lost.

1997: The National Review of the response to HIV and AIDS in South Africa - gender as after thought: The Department of Health commissioned review was conducted by the MRC and involved teams of international 'experts', national and local government and non-governmental role players and people living with HIV and AIDS visiting all 9 provinces to assess the response to date. The teams came up with critical challenges but gender as an issue was not reflected. As a gender consultant to the Department of Health I was requested to write a 'one page' review once the five hundred page report was completed.

---

[739] Tallis, V. and Cavanagh, D. 2004.

South African AIDS organisations and government are increasingly committed to 'do something about gender', whilst women's and gender organisations are addressing HIV and AIDS as a key issue for their constituencies.[740] The HIV and AIDS epidemics in South Africa demand a comprehensive, innovative coordinated response: civil society and government are both important players in the response to HIV and AIDS. Over the years the number of NGO's and CBO's specifically fighting HIV and AIDS has mushroomed. Many CBO's have been established and are led by women, but do not necessarily have a women-focused agenda. The agenda of most organisations focus on women's practical needs filling the service delivery gaps that the health sector does not fulfil. This typically includes home based care, counselling and support groups. As noted, most women engaging in such services do so in a voluntary capacity. Anecdotal evidence suggests that often it is poor women providing services to poor men, women and children, and that women volunteers are getting even poorer through sharing what little they have with people they assess to be more in need than they are. Women volunteers often spend many hours every day providing care and support. More traditional NGO's also play a role in service delivery, and they also engage in capacity building, and or research, and or advocacy to varying degrees.[741]

 AIDS organisations specifically implement 'traditional' HIV and AIDS programmes that fall along the prevention, care, treatment and support continuum. Such programmes may or may not have a women focus. Even those that do focus on women may not necessarily have a women's rights focus and could entrench gender stereotypes. For example, home based care projects do little to challenge the gender division of labour.

Another approach to HIV and AIDS is to address either the structural issues facing women that increase vulnerability, or to focus on specific issues facing women, such as sexual and reproductive rights and health, violence against women or access to

---

[740] Tallis, V. et al 2008

[741] Tallis, V et al. 2008

education. Some organisations address the structural factors whilst focusing on specific issues.

Government's response in to HIV and AIDS is articulated in the National AIDS Strategic Plan 2007 – 2011.[742] Women are noted as a specific vulnerable group in the strategy, due to their biological, economic, social and cultural vulnerability. Women's role in relation to 'community-based HIV and AIDS activities' is acknowledged, with special mention made of women's role in care. There is also some mention made of women needing to be the targets of prevention and mitigation strategies.[743] One of the guiding principles refers to women:

> *"Promoting equality for women and girls: …. Recognize the particular vulnerability for women and girls to HIV and AIDS and its social impact. It commits to prioritising interventions focusing on the causes of gender inequality and the horrific impact that HIV has on many women and girls".*[744]

However, when analyzing the implementation plan it is gender neutral, and only two out of eighteen goals are specifically directed at women:

Goal Seven: Address the special needs of women and children.[745]

Goal Eighteen: Mobilise society to respect and protect human rights of women and girls, including those with disabilities, to eradicate gender based violence and advance equality in sexual relationships[746]

Goal seven is problematic in that it links women and girls as if their special needs are the same. Goals seven and eighteen are obviously an attempt to address the impact of HIV and AIDS on women. However an analysis of the objectives,

---

[742] Department of Health. 2007.

[743] Department of Health. 2007

[744] Department of Health. 2007 p54

[745] Department of Health. 2007 p58

[746] Department of Health. 2007 p59

activities and indicators outlined in the work plan, reveals that the focus on women and the strategies employed become more and more hazy and it is difficult to imagine that the activities proposed will do anything to advance women's rights.

9.3 Case Study: GAF – a feminist response to HIV and AIDS

In 1998, Agenda, a South African feminist journal, was approached by JOHAP to produce an edition of the journal highlighting the critical gender issues in relation to HIV and AIDS. The outcomes of this partnership included the identification of gender issues driving the HIV and AIDS epidemic, a South African analysis of the epidemic focusing on women, and the birth of GAF to take forward the learning and ensure that women's, gender and AIDS organisations work together. The edition of *Agenda* raised many important issues and challenges. These challenges were aimed at government and civil society and were an attempt to get organisations to take seriously the threat of HIV and to see HIV as a crisis for women.

An interim committee was formed at the launch of the *Agenda* journal, *AIDS. Counting the Cost*. It was the vision of the seventy provincial and national organisations present at the launch, that the committee function under the auspices of *Agenda*. The mandate of the committee was to conduct an audit on the extent to which women / gender organisations were engaging with HIV and AIDS, and also to determine whether and HIV and AIDS organisations were engaging with gender. The committee was asked to conduct a needs analysis and develop a plan of action for meeting these needs.

During 1999 both the audit and the needs analysis were carried out. Organisations expressed the need for help and support in working out how to integrate gender and AIDS respectively. At the end of the six month period the committee met and decided that an organisation should be tasked to take forward the needs identified. As *Agenda* could not take this on it was decided that a new organisation be formed and GAF came into being.

Funding was given by JOHAP to implement a gender mainstreaming capacity building process. GAF began to explore how organisations could be supported to respond more effectively to HIV and AIDS through integrating gender, and to gender through integrating HIV and AIDS. The capacity building programme was implemented from 1999 to 2002. Much of the work of GAF was shaped and informed by the board and contracted out to consultants to implement.

Critical issues emerged from the training and capacity building. Firstly, the relevance of a gender mainstreaming approach was questioned and the importance of starting with personal issues before moving to organisational gender mainstreaming was highlighted. Furthermore, the usefulness of gender analysis and planning frameworks and tools were debated, given that such approaches did not lead to the changes that were expected and desired. It was noted that the participants had not been through sufficient personal consciousness raising in order to ensure a sustained commitment to using the tools. There was also an issue on relying on tools which were not developed for the South African context and were not HIV and AIDS specific.

In 2002, GAF reviewed its progress, critically reflecting on its learnings and the impact of its activities up to that point. The outcome was a decision to place women at the centre of its gender and HIV and AIDS focus and to implement this decision through the empowerment of women as activists and actors with agency, rather than as powerless victims. A key strategy that had hitherto been implicit became more clearly articulated: the personal empowerment of women with the goal of affirming and asserting women's autonomy. Based on these decisions GAF began to develop new ways of thinking about the solution to the problem of gender power as it relates to HIV and AIDS.[747]

After the review of the mainstreaming work, GAF needed to develop a more effective approach of how to ensure that gender was effectively tackled. This

---

[747] Gender AIDS Forum. 2003 a.

involved asking specific questions regarding the process of building gender activists. Through a one year process of reflection, implementation and re-reflection to consider the question of what it takes to ensure meaningful, committed and sustained gendered responses three core principles evolved:

- Focusing on power as central to inequality was critical,
- The starting point of any work should highlight the personal and what that means,
- There was a need to identify ways to link the personal to the political context of HIV and AIDS and gender.[748]

9.3.1 Beliefs underpinning the work of GAF

The mission of GAF is to effect change and transform society The ultimate goal is the transformation of gender power relations in all sites of struggle. GAF's approach is based on feminist models and the organisation has tried to ensure that internal and external processes as well as the work done is holistic and is informed by feminist theory and principles. In fact, as an organisation, GAF is very aware of the method being as important as the process.

> *"The future of HIV and AIDS prevention will depend on the ability to understand, at the deepest possible level, the nature of individual and collective vulnerability to HIV and AIDS".[749]*

GAF used, as a starting point, the model developed by Mann and Tarantola, previously discussed, which highlights three levels of separate but interconnected vulnerability: social, programmatic and personal, and developed it to include gender issues. The fundamental cause of women's vulnerability was problematised as oppression and inequality. The Mann and Tarantola model focuses on the

---

[748] Internal planning meeting GAF 3rd March 2003
[749] Mann, J and Tarantola, D 1996. p 463

individual in the context of societal and programmatic issues that impact on or create and deepen vulnerability.

GAF believe that women are not powerless and that change is both possible and necessary. Given that one of the core principles is power as a central concept to understand oppression and liberation, the change the organisation wishes to influence is the distribution and experience of power. The model of change and empowerment used is based on that developed by Young.[750] Four critical parts to enabling change and transformation are identified: access to information, conciseness raising, solidarity and collective action. These four actions are central to the programmes at GAF and form the basis of the Women in Leadership [WIL] programme.[751]

9.3.2 Addressing power

The immediate presenting problems, facing organisations involved in HIV and AIDS reflects the realities of women's lives. GAF's understanding and articulation of the core problem is that women and men are not equal in society. Men have power over women, both on a broader political level as well as in the home, family, workplace and in sexual relationships. The power imbalance ensures that men are more privileged than women, have more and greater opportunities, have access to and control most of the resources, are in decision making and leadership positions, their time is valued more and so on. Men's power over is often enforced through violence or the threat of violence against women as well as the stated or un-stated threat of withholding resources, recognition or support.[752] In this context of men's power over women, oppression leads to inequality, which leads to women being dependant on men, and this leads to an inability by women to take charge of their

---

[750] Young, K. 1997.

[751] Personal communications with GAF staff and board

[752] Gender AIDS Forum. 2005 a.

own health and well-being and to protect themselves from HIV. This creates deeper vulnerability to HIV and AIDS.[753]

A critical challenge facing GAF was defining who to work with. A key decision made in 2003 was to place 'women at the centre' of the response. Deciding who to prioritise was made on the basis of GAF's understanding of the problem, seeing gender oppression as the fundamental cause of HIV and AIDS and other social problems.[754] This has been in the face of increasing pressure and shift for organisations to work with men as the site of power. GAF believe that working with men alone, or even with women, is not enough and that true empowerment and transformation will only happen through the conscientisation of and collective action by women. GAF focus on gender oppression as an entry point – by using methodologies that focus on the lived realities of women's lives other oppressions and identities become evident and exploration of these other oppressions is encouraged.

GAF believe that lack of access to power is at the centre of women and girls vulnerability to HIV and AIDS. Women need to empower themselves, reinvent power and transform society. The HIV and AIDS epidemics clearly flourish in the context of power dynamics that oppress women and add to their vulnerability. The challenge is to change or transform society to create a context where women have equal power and both women and men are less vulnerable. GAF's overall aims are to firstly address the root causes, that is identifying and challenge the 'structural' causes of women's oppression and secondly to address the short term goals or practical interests that will make some difference to the lives of individual women.

GAF has three key programmes, empowerment, advocacy and knowledge creation. The programmes are linked; they aim to provide a personal process of empowerment and work towards action against oppression of women. The organisation has adopted a women centred, consultative, rights based approach to

---

[753] Gender AIDS Forum. 2005 a

[754] Strategic planning meeting 3rd March 2003

advocacy and knowledge creation.[755] The work of the organisation is substantial and complex: for the purposes of this research the women in leadership project of the empowerment programme is analysed as it best describes the practical application of the GAF's work on power.

Empowerment Programme

The aim of the empowerment programme is to build consciousness and skills in women to confront and address issues of power, gender inequality and oppression, and access rights including the including sexual and reproductive rights. A key project of the empowerment programme is the WIL programme. Working with grassroots women, the aim of the programme is to empower grassroots women to begin to challenge oppression within their intimate relationships, households, workplace communities, and society. The programme consists of three phases: phase one, *The Personal is Political*, phase two, *Personal Power*, phase three, *Putting the Political into Practice.* The WIL programme takes a closer look at the different positive types of power and ensures that women are able to access the power within, power with and the power to transform their own lives and transform society through collective action. Focusing on positive power the programme is designed to assist women to dismantle or challenge the oppressive and destructive power over in their lives.[756]

Underpinning the design of the WIL process is Young's[757] model of empowerment, this includes increasing women's access to knowledge through information and building analytical skills, for example, encouraging women to read newspapers and analyse the contents using a gendered lens. The next step is to raise consciousness through getting women to reflect on and share their own life experiences in a way that validates personal experiences whilst at the same time politicising them. Women are encouraged to think of ways that they can change

---

[755] Gender AIDS Forum 2005 a.

[756] Gender AIDS Forum 2005 b.

[757] Young, K. 1997.

their current situation. Building solidarity is the next phase, both as a group, as well as linking in with other women's organisations. Collective action is the final step, for example, the WIL group were an integral part of the solidarity and support that took place on the pavements outside the courts when the Jacob Zuma trial was on.

Participation in the WIL process is based on a written motivation to GAF outlining the reasons for wanting to participate, understandings of gender oppression and ideas of how participation in WIL will impact on the community. Each group chosen is diverse in terms of race, class, education levels, religion, age, sexual orientation, HIV status and relationship status which allows for varied range of experiences and enriches the discussions.[758] The underlying premise of the processes is capacity building. Women's own experiences are used as a starting point to understand gender oppression, links to other oppressions based on race, class, sexual orientation and to determine a common political agenda.

A variety of participatory, empowering methods are used, including: group discussion, individual research into own histories, storytelling and drawing. Participants are encouraged to observe and engage with other women of different generations and identities in their lives and to read around these issues to broaden and deepen their thinking and reflection. Once personal experiences have been explored, the facilitator introduces a conceptual framework, building on the groups understanding of power, within which to locate realities of people's lives. The group then identify the political issues – taking into account women and HIV and AIDS.[759]

According to GAF's Strategic Plan:

> "Strategies for empowerment cannot be taken out of context, including the
> historical context that created male oppression of women as well as the
> current processes that sustain such oppression and vulnerability to HIV and

---

[758] Personal communication with GAF staff in empowerment programme.

[759] Gender AIDS Forum. 2005 b

AIDS. This view of empowerment implies collective, not individual empowerment".[760]

Applying this approach, the WIL programme therefore does not offer welfare relief, or the technical training, that is sometimes associated with development interventions. The circumstances faced by women are not seen as beyond their control, nor are women seen as lacking education or resources. The goal is therefore not to provide technical skills to increase production. Instead the WIL programme posits that women can immediately bring about unaided positive change in any site of struggle or personal situation through an intensive process of conscientisation. The immediate outcome GAF seeks through WIL is a reduction in women's vulnerability to HIV and AIDS, but the systemic longer-term outcome is a transformation of the structural relationships that make women most vulnerable to HIV and AIDS.[761]

How is change measured?

The key aim of the WIL is to effect positive change in all aspects of women's lives. As a learning organisation, the Gender AIDS Forum has mechanisms in place to assess the impact of their work and through these processes review what has been done, identify any changes, and explain why change has happened. Discussions on these questions add to the underpinning theory and learnings are integrated into programme design and planning. GAF staff state that it is important for the organisation to know that what they are doing actually works and that it leads to change and that transformation occurs.[762] GAF have developed a set of "changes" that reflect personal consciousness and empowerment. Success is viewed by any demonstration, indication and expression of change in staff, board, volunteers and participants that relate to transformatory processes. These processes include:[763]

---

[760] Gender AIDS Forum. 2005 a p 2

[761] Gender AIDS Forum. 2005 b

[762] Interview GAF Staff. 2006.

[763] Tallis, V. and Cavanagh, D. 2004..

- Seeing a structural basis for personal and individual problems, conditions, circumstances.
- Feeling a sense of anger and awakening to power information, issues and knowledge.
- Acknowledging and taking appropriate responsibility the perpetuation of gender and other inequalities.
- Knowing others share experiences and feeling a sense of solidarity with others.
- Confronting power at a personal and institutional level.
- Envisioning and believing that change is possible.[764]

Over and above the regular internal review processes that form part of GAF as a learning organisation, two evaluations have been done, both by external consultants: a specific GAF initiated WIL evaluation in 2005 and a donor initiated evaluation of the impact of the organisation, including WIL, carried out in 2006. Both evaluators found the WIL programme to be highly effective in empowering women and getting them to change their own lives. Furthermore an article by Mthetwa-Sommers, based on a focus group with some WIL participants, noted "GAF's leadership training programme achieved its objective to equip grassroots leaders with leadership skills".[765]

Specific questions explored in the donor evaluation were outlined in the terms of reference prepared by the organisation; these questions are indicative of how the organisation views its work in change and transformation:[766]

What significant changes have occurred in women's lives and to what extent are these likely to be sustained?

What changes have women made in the different sites of struggle?

---

[764] Tallis, V. and Cavanagh, D. 2004.

[765] Mthetwa-Sommers, S. 2005. p 65

[766] Gender AIDS Forum 2006. p3

How do women explain the change?

What have been the positive and negative consequences of the change?

**How effectively have women most affected been an integral part of
and benefited from the programmes?**

*What has been the involvement of women, specifically marginalised women
in the programmes?*

*What has been the involvement of women living with HIV in the
organisation?*

*What have been the benefits for women who have participated in the
organisation?*

Interviews were conducted with women who participated in the WIL programme
during 2005 and 2006 to assess the impact of the programme on women's lives.
Women interviewed highlighted a series of changes in their different sites of
struggle, for example, the household, workplace, body, organisation and in the
community. In general, the donor evaluation found that GAF had impacted on the
response to HIV and AIDS through:[767]

- Raising the level of awareness of the gendered nature of HIV and AIDS,
  across civil society organisations.
- Advocacy that has influenced national policy makers to consider strategies to
  prevent and not only treat HIV and AIDS.
- Locating HIV and AIDS as a political process of addressing sexuality and
  gender power.
- Promoting the need to work with various forms of inequality whilst focusing
  on gender power, including issues of class, race and sexual orientation and to
  affirm and advance the rights of marginalised people, especially those who
  are marginalised because they are seen to be in violation of the norms of
  mainstream society.

---

[767] Collingwood, C. 2006

Specifically in relation to the Women in Leadership programme, the donor evaluation found that GAF's programmes have empowered a significant number of grassroots women, for example, members of community based HIV and AIDS support groups, to make changes in their lives that have reduced their vulnerability to HIV and AIDS.[768]   Women interviewed noted that they have become critical thinkers and 'question before agreeing to anything'.[769] They can now see and challenge gender oppression in their lives.[770] The evaluator noted

> *"I consistently heard stories from participants of how they had brought change to their intimate relationships; how they had taken action in their communities as a result of the insights derived from WIL; and how they participated in collective action, such as the One in Nine demonstrations that occurred during the duration of the course".[771]*

Voices from the women of WIL illustrate this:

> *"WIL has raised my consciousness and I am able to articulate the issues and make changes in my life".[772]*

The anecdotal evidence gathered from the interviews on the impact of WIL was rich with examples of actual personal change. The evaluation noted that it was clear that WIL has had observable impact at four of the five sites of struggle on which the programme intends to impact: the body, intimate relationships, household and community.[773] However, to make a causal link between the WIL programme and societal change is too difficult to prove at this stage.

---

[768] Collingwood, C. 2006.

[769] Thabete, T. 2005.

[770] Collingwood, C. 2006.

[771] Collingwood, C. 2006. p 3

[772] Collingwood, C. 2006. p15

[773] Thabete, T. 2005. p7

The following examples of change were articulated by the women interviewed in the evaluation process and are grouped under the different sites of struggle

Body as a site of struggle:

The body as a site of struggle is often the most difficult site to effect change, especially getting women to accept and take ownership of their bodies, in a societal and cultural context where issues about women's bodies are so political.

> *"They taught us all about our bodies and how we can respect them. They gave us a mirror to look at our vagina. When I was growing up I was told this is the bit you wash for your man. But on the course they said 'It's for you! You must love it.' I really liked that. Now I know my body is mine to respect and take care of."*[774]

Women's bodies, more than anything are viewed in terms of male ownership and male desire on the one hand and as baby producing machines on the other. When women are able to articulate and understand this they are able to move on and experience greater bodily autonomy.

Intimate relationships as a site of struggle:

Intimate relationships represent the site of struggle in which women are most aware of their oppression and often most unhappy. It is however not necessarily easy to shift patterns of power in intimate relationships.

> *"From phase one as soon as I went back home, I said, 'This is what I don't like'."*[775]

---

[774] Collingwood, C. 2006. p 17
[775] Collingwood, C. 2006. p 17

"Now I say to men, 'I didn't grow up with a penis, I can get another one. If you want to be with me – wear a condom. This HIV is all around.'"[776]

"Now I know the limits. There's been a big transformation – I didn't realise I was oppressed by my husband. We love each other more now – we just talk. I have now got time for myself."[777]

The WIL programme builds personal power and a sense of self-worth that enables women to take control of their lives. In feedback sessions during the three phases most of the women could relate change they had made in their intimate relationships. The changes differed in significance, from one woman getting her husband to make her a cup of tea when she gets home to work, to being more assertive about sexual rights. However, the feelings of taking power and control were evident in the women regardless of the significance of the change they affected.[778]

Community as a site of struggle

Women who attended the WIL programme were already in leadership positions in the community, either in CBO's or in support groups. However, the WIL programme enhanced their position and instilled a set of beliefs that enabled them to effect greater change.

"Once you become aware of your rights, it is easier to tell the next woman: 'You can do it!' On the course I experienced other women who are having the same experience – women oppression. I'm the Secretary of the national AIDS organisation in my region. Nobody was talking about our oppression. Now the war is on!"[779]

---

[776] Collingwood, C. 2006. p18

[777] Collingwood, C 2006 p 18

[778] Personal observation of WIL process.

[779] Collingwood, C. 2006. p18

"It is somehow hard to influence everyone in the community but the fact that I was able to establish a focus group for lesbians shows that I am able to implement the knowledge I have gained from GAF"[780]

"Before I would suggest that the women stays with her husband and tries to work things out nicely. After Phase 1 I realized that isn't good enough. I accompanied a woman to the police station where she had been five times for protection against her husband. By that stage he was beating her with a gun. I told them about women's rights and Protection Orders. They went with us and now she has a protection order and they took the gun away. I've since met with the MEC for Safety and Security in our province and proposed a Women and Police Indaba. There is now agreement."[781]

It is clear from the quotes above that the women developed a strong gendered and/or feminist consciousness that enabled them to challenge gender oppression, that is, using power to resist.

In short, at the level of the individual impact on grassroots women, their households and communities, WIL participants are able to clearly articulate its impact. They are able to provide examples of how their attitudes towards their bodies have changed and how they are more able to assert their rights. Women spoke of how they have either left abusive intimate relationships or have improved their own quality of life within their intimate relationship, how they have refrained from colluding in undermining other women, how they have incorporated the WIL knowledge into their own workshops with women and how they have challenged oppressive workplace situations and dealt with the backlash. [782]

---

[780] Collingwood, C. 2006. p 19

[781] Collingwood, C. 2006. p 19-20

[782] Thabeti, T. 2005

9.4 Summary

After their experience in tackling HIV and AIDS and challenging gender oppression GAF staff are well aware of the difficulties organisations face in making a difference, and getting to the root of the problem. Whilst as an organisation they have clearly witnessed change through the work they do, the overall global picture is one of increased infections, emerging epidemics and too women who are able to access their rights.[783]

GAF's agenda for action addresses the layers of oppression experienced by women. Three critical lessons are clear in assessing the response of the organisation; the importance of conceptualising the problem of power, ensuring that women and others participating can understand and confront power over and ensuring that values and organisational culture inform, and is informed by, what the organisation does. The experiences of GAF have created sets of linked understandings, knowledge and assumptions which represent some of the major positions that guide both organisational culture and programmes[784].

Oppressive power is at the root of the problem and leads to a world where inequality is the norm and inequality privileges the minority at the expense of the majority. Gender oppression is deeply entrenched and embedded in society through societal arrangements like the family, household, education system (including the media and the socialisation process), religion, culture and sport. Change cannot take place unless women believe that it is both possible and necessary, that is, it is felt and personal. The starting point is consciousness as a state in constant development and evolution; when personal problems are linked to structural arrangements of power in society. Whilst gender transformation is the point of entry, one cannot ignore other oppressions such as race, class, sexual orientation and/or HIV status.

---

[783] Tallis, V. and Cavanagh, D. 2004.

[784] Tallis, V. and Cavanagh, D. 2004.

Based on the internal and external evaluations it is clear that the WIL process leads to visible and demonstrated changes in women and their lives. Indicators include the way participants articulate their positions and viewpoints, and the way they engage and participate in processes. [785] The WIL processes show that subverting power is possible, and women are able to be conscientised to understand and politicise male domination and act on that to improve their lives.

---

[785] Collingwood, C. 2006

Chapter Ten: Power as Solution

10.0 Introduction

HIV and AIDS have disproportionately affected women and girls, and yet there has been relatively little success in reducing vulnerability to, and mitigating the impact of, the pandemics. It is vital to understand the factors that drive women's increasing susceptibility to infection, as well as to analyse the impact that HIV and AIDS is having on individuals, households, communities and society in order to ensure effective responses. In real terms this means that gender inequality must be seen as a driving force in women's oppression, which impacts on the vulnerability of women to HIV as well as increases the impact of HIV and AIDS on the lives of women and girls. As noted previously, there is a fairly sophisticated analysis of the factors driving the pandemics, and why women are vulnerable, not only in regions where they have the highest burden of infection, but also in regions where men are in the majority of those infected.

What has not been done sufficiently, and is the crux of this research, is to translate understanding of the pandemics into solutions: to develop responses to the pandemics that are mindful of the complexities of the HIV and AIDS pandemics and that address women's position and condition. A key aim of this research was to add to theories of power, specifically to identify ways in which subverting power can be instrumental in reducing women's vulnerabilities, and assist in improving women's lives, that is, the knowledge produced should be transferable so that it can be translated into political agendas, actions and inform specific areas for policy change that will benefit women.

This research asserts that confronting power is an appropriate and necessary strategy to reducing women's vulnerability to the impact of HIV and AIDS. Power is a process, which takes different forms: some forms of power are negative and impact on the realities of women's lives, increasing risk and vulnerability and

providing the structural conditions where women and oppressed. Some forms of power are positive and empowering. A key question is how can power be challenged and subverted to reduce the structural, societal and personal circumstances of women in order to lessen vulnerability to HIV specifically and generally improve conditions and position of women's lives. The case studies presented illustrate how in different ways and on different levels power can be re-channelled and re-claimed to empower and transform. Figure 10.1 shows the relationship between power as problem, power as solution.

Figure 10.1. Power as Problem, Power as Solution
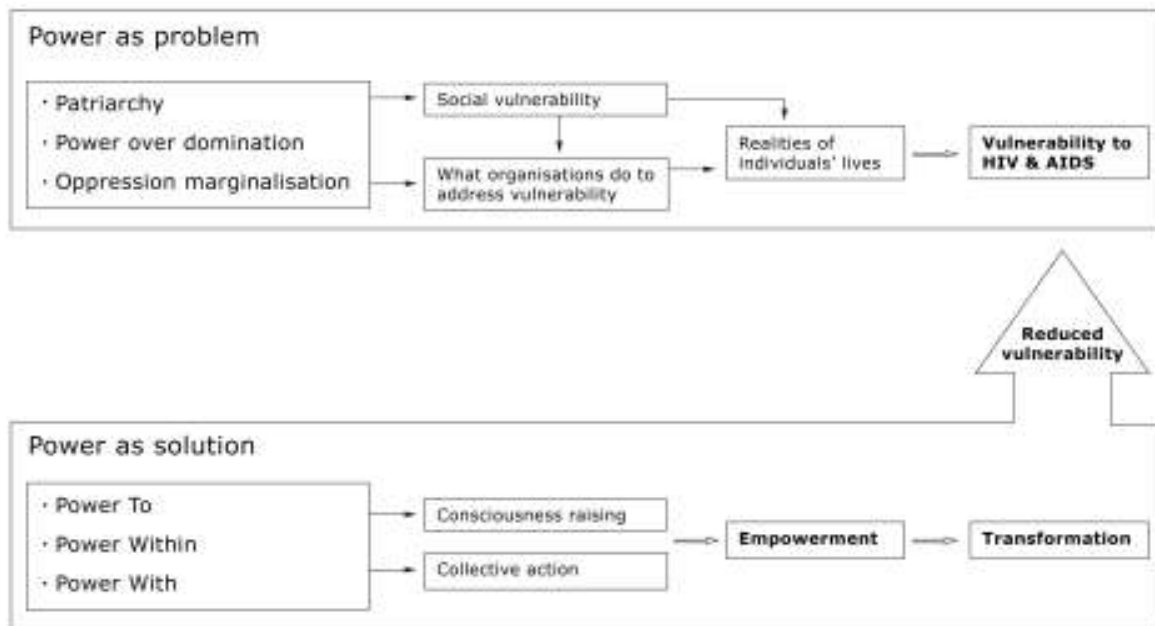
Power as problem or domination is manifested through patriarchy and is maintained through gender oppression and marginalisation. Patriarchy is very clearly linked to the three types of vulnerability which in turn drive the pandemics. This was clear in the case studies which demonstrated how power over at a macro or societal level reflected in the realities of women's lives through systematic violation of rights, on-going violence, poverty and inequality that fuel HIV and AIDS. Furthermore, power over may happen at a micro-level or individual level in intimate relationships and a

277

woman's personal situation may make her more or less vulnerable. Power over at a programmatic level was demonstrated in the relationship between donor and grantee, and whilst in some cases such power over may be trying to influence more admirable agenda's such as the need for a gendered approach, the way the power is exerted can be problematic.

The case studies also provide different examples of how power can be subverted to lead to empowerment and transformation, which in turn reduce women's vulnerability, that is, power as solution. Reclaiming power is possible in different sites of struggle, for example, bodily autonomy, intimate relationships, the household, the community and the workplace. Resistance or power to can be achieved either individually, collectively or a combination of both.

In the case studies it is clear that a personal conscientisation process is vital for women to shift the gendered power relationships they experience. Once women have tapped into the power within they are then able to resist oppression. Challenging rape through the male dominated judiciary system is an extreme example of resistance, however, smaller acts of resistance as demonstrated by the women who underwent the GAF WIL process are just as important. Acts of resistance tend to be cumulative, and women become more and more empowered. Whilst women can subvert power in their individual circumstances and relationships, with larger structural problems there is a need to work in solidarity to effect change. Social movements, through sustained and planned activism, can subvert power over.

10.1 The impact of addressing power to effect change

In keeping with feminist theory, the case studies demonstrate that women are not powerless but instead have the potential to make changes in their lives, or at the very least to fight for changes in their lives. It is important to look at the realities of individual women; individual circumstances make change and transformation more or less difficult. Placing women as powerless victims further marginalises

them, but it is also important to realise that women's lives are filled with struggles and accessing power for some women may require great sacrifice and negative consequences. Figure 10.2 depicts the elements of power as solution discussed in this thesis.

Figure 10.2 Power as solution
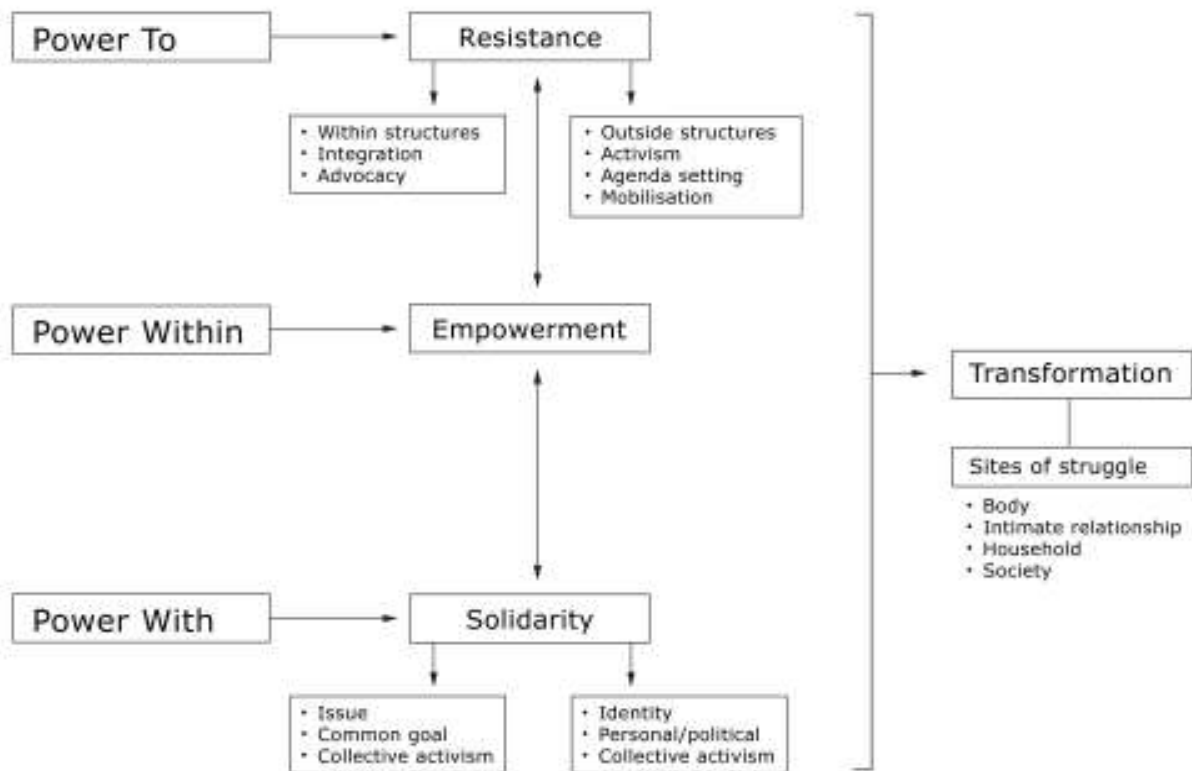
Resistance can occur both within structures as well as outside structures. For example, some of the WIL participants worked in a well know South African AIDS organisation that despite its progressive nature had un-progressive policies and practices around women.   The leadership was male dominated and there were increasing incidents of sexual harassment in the workplace.[786] After attending WIL women went back to the organisation and started a process of addressing gender issues, including developing a gender policy. Sometimes it is impossible to work

---

[786] Thabete, T. 2006

within structures and resistance occurs from the margins. This is demonstrated by the litigation around the forced sterilisation of women living with HIV.

Transformation through the power to or resistance involves extending the power within to move from consciousness towards collective action in the form of activism and advocacy is empowerment in action. Women can, through a deeper level of empowerment, act individually and collectively, to challenge the thing that oppress, take away dignity and result in gender and other forms of inequality. The methodology employed by GAF proves that such consciousness does lead to empowerment and can lead to change at many levels, individually and collectively.

The power within refers to empowerment processes by which women channel their consciousness, into being able to and acting on, the assertion of their rights. The power within is ability to see the invisible, for example patriarchy, which impact so strongly on daily realities. The case study on the Jacob Zuma rape trial highlighted the barriers, experiences and positive implications of harnessing and utilising power to challenge patriarchy using the very systems set up to maintain and perpetuate gender oppression.

Transformation through the power with comes from mobilising together on a common agenda, organising collectively, building relationships and partnerships, and developing a culture where values of dignity, equality and freedom are lived and finding ways to interpret our values into how we live as women and men. Power with confirms that women in general, and specific women in particular are abused, marginalized or oppressed but that through solidarity, the strength of numbers changes can be made.

The women's movement in general was slow to respond to HIV and AIDS; thus women most affected were compelled to act. Through coming together around identity and issues they were able to identifying that their problems were not on any agenda, and were galvanised into action. Working in solidarity, the power with, can effect great change, and be very effective. However, as the two case

studies show, such activism takes time, for example, advocating merely for the concept of women's prevention technologies took years. Addressing an issue such as forced sterilisation through litigation and activism is likely to take years, the benefits though will impact on the individual women litigants, HIV positive women in general in South Africa and Namibia and have an impact on the region as a whole.

Transformation includes radical and fundamental change at personal, relationship, community and societal levels, addressing the systems, mechanisms, policies and practices that are needed to support such genuine change. The focus of transforming society is ending all forms of oppression. Transformation is a long process. Whilst in the short term transformation of individual relationships is possible transformation of society remains a long term goal.

Empowerment can be approached in two ways; either through grassroots initiatives, that is, working with individual women and groups to affect personal and collective empowerment. Collectives of sex workers, women living with HIV, survivors of trafficking are examples of this. Secondly, through creating an enabling environment (through activism, advocacy, legislation etc) which can positively impact 'on the realities of women's lives'. This requires working with existing treaties and conventions, developing policy where there is a vacuum and constantly monitoring the implementation of the policies and conventions that exist. The case studies presented address power through both these ways and demonstrate the power of the grassroots, the collective and of solidarity.

AIDS must be seen in the context of women's oppression. A feminist response to AIDS must challenge medical, social and political assumptions made about the disease and its impact on women. It must provide a theoretical framework for a deeper understanding of women's position in the HIV and AIDS crisis. Furthermore, it must address sexuality as a central concern.[787] The

---

[787] Wilton, T. 1997. Patton, C. 1994.

interrelationship between HIV and women provides information for both gender theory and practice.[788]   The multiple issues of women and HIV and AIDS "disturb accepted ideas and pose challenges to theory and activism" [789]   The focus must be on how HIV and AIDS affects women specifically but also how women's position in society influences risk and experiences of HIV and AIDS.

The current response to HIV and AIDS is to look for evidence based programmes that can be scaled-up and that will make the most possible impact; the bulk of HIV and AIDS funding will be directed to what researchers have shown 'works'. Power and structural transformation are not necessarily part of these debates; and alternative responses, challenging women's oppression are not likely to get funding, especially in the challenging global economic crisis. Feminist and women's rights activists have work to do to influence this agenda.

10.3 Putting the theory into practice

The case studies show that resistance is possible and in many different ways women are challenging their oppression and its link to HIV and AIDS. The image of women in HIV and AIDS is often negative; victim, vector of transmission, powerless.   The case studies do not always show profound transformation; however, what is evident in the case studies is the potential to resist, individually and collectively.

There is diversity in women's resistance, around the issues tackled, the method of engagement and the site of struggle chosen. The case studies are important in that they provide us with stories of hope, show that women are not powerless, provide examples of success and highlight key lessons that will help in the future.

The personal is political is a useful starting point to raise consciousness, or build power within. Consciousness raising can be facilitated; the GAF example shows

---

[788] Roth, L. and Hogan, K. 1998

[789] Roth, L. and Hogan, K. 1998 pxvi

that women can be taken through a process to understand and want to act in their oppression. A raised consciousness is an indicator for action, and is the first step to empowerment. The women whose lives and experiences of activism have been captured in this thesis all have heightened consciousness about their own oppressions and an imperative to act to improve their own situation as well as that of other women.

Women's oppression is so pervasive that change made in any site of struggle can be effective. As shown even small acts of resistance can effect change, especially at the level of intimate relations and the household. Resistance has cumulative effects, and as demonstrated by the WIL programme may intensify with time. Furthermore, the act of resistance, in and of itself, is empowering regardless of the conclusion. Whilst the outcome of the Jacob Zuma rape trial was a disappointment the activism around the trial has led to an upsurge in activism around violence against women. The trial also demonstrated that individual women can and do make a difference

The case studies demonstrate that working effectively to subvert power is process and transformation is a long term goal. For example, for ICW SA to reach the point of litigation around forced sterilisations has taken ten years, and in some ways the battle has just begun. Likewise, work to address the structural effects of trafficking is in its infancy, yet gains have been made. It is important to acknowledge and celebrate victories, however small. Raising awareness about different forms of women's oppression in society is an important first step, and one that make take years to achieve.

In conclusion, the conceptual framework, power as problem, power as solution developed out of the research process provides an agenda for effectively tackling the structural aspects driving HIV and AIDS. It also impacts on other manifestations of gender oppression by using power to tackle personal and programmatic vulnerability and by doing so addressing the practical needs and strategic interests of women and girls vulnerable to HIV and AIDS. This involves

meeting a diverse set of needs including access to basic rights, building self esteem and self worth, provision of support (health, social, legal), increasing livelihoods. It also ensures a balance between initiatives that provide immediate assistance and those that are more long-term. Secondly, addressing societal vulnerability through tackling the strategic interests of all women and girls, especially those most vulnerable to or HIV and AIDS is critical. Thirdly, the impact of programmatic vulnerability cannot be ignored, and theories of power should be integrated so that programmes confront rather than accept the status quo.

Calls for the transformation of society have spanned generations, and whilst gains have been made, progress has been slow. The imperatives of the HIV and AIDS epidemic may provide the catalyst that is needed to recognise, confront and address the inequality of women. This research answers some questions about power and its role in fuelling HIV and AIDS and demonstrates the importance of subverting power in an attempt to impact on the pandemics in a way that positively affects women's lives.

References

ABC Nepal.   nd..   *Programs against girls trafficking*.   Kathmandu: ABC Nepal.

Abdool-Karim, Q.   1998.   Women and AIDS: the imperative for a gendered prognosis and prevention policy.   *Agenda,* 39: pp. 15 – 35.

Aggleton, P. & Parker, R.   2002.   *World AIDS Campaign 2002-2003: a conceptual framework and basis for action – HIV/AIDS stigma and discrimination*.   Geneva: UNAIDS.

Aina, O.   1998.   African women at the grassroots: the silent partners of the women's movement. In Nnaemeka, N. *Sisterhood. feminisms and power: from Africa to the diaspora.*   Asmara. Africa World Press.

Akerkar, S.   2001.   Gender and participation: overview report.   *Bridge Cutting Edge Pack.*   Brighton: Institute of Development Studies.

Akhter, F.   1997.   *Resistance against trafficking in women and children in South Asia*.   Dhaka: Narigrantha Prabartana.

Ali, S., Hassan, S. & Rahman, Z.   1999.   *A research on prostitution: an unresolved social issue due to incomprehensive nature of suppression of Immoral Traffic Act – 1993*.   Dhaka : Bangladesh National Women Lawyers Association.

Ali, S., Coate, K. & wa Goro, W. 2000. *Global feminist politics: identities in a changing world*.   London: Routledge.

Ali, S. 2001. *Special Bulletin: movement against trafficking and sexual exploitation*. Dhaka: Bangladesh National Women Lawyers Association.

Ali, S. 2003. *Violence against women in Bangladesh 2002*. Dhaka: Bangladesh National Women Lawyers Association.

Allen, A. 1999. *The power of feminist theory: domination, resistance and solidarity*. Boulder: USA.

Altman, D. 2007. Rights matter: structural interventions and vulnerable communities. *Inter- American journal of psychology*. 41(1):pp 87-92.

Amarasinghe, S.W. 2002. *Sri Lanka: the commercial sexual exploitation of children - a rapid assessment.* Geneva: International Labour Office.

Amnesty International. 2001. *Broken Bodies, shattered minds: torture and ill-treatment of women*. (ACT40/000/2001). Oxford. Amnesty International Publications.

AusAID. 2002. *Gender and development. GAD lessons and challenges for the Australian Aid programme.* Canberra: Australian Agency for International Development.

Baden, S., & Goetz, A.M. 1998. Who needs (sex) when you can have (gender): conflicting discourses on gender at Beijing. In Jackson, C & Pearson, R. *Feminist visions of development: gender analysis and policy*. London: Routledge.

Baden, S., & Wach, H.   1999.   *Gender, HIV and AIDS transmission and impacts: a review of issues and evidence.*   (BRIDGE Report No. 47). Brighton: Institute of Development Studies.

Bagnol, B. & Marino, E.   2008.   Vaginal practices: eroticism and implications for womens health and condom use in Mozambique. *Culture, health and sexuality*, 10(6): pp 573 – 585.

Barker, Gary.   2001.   'Cool your head, man': preventing gender based violence in fevalas. *Development*, 44(3): pp. 94-98.

Barnabus, l., Cavanagh, D., Madlala, N., Magwaza, T., Maphumulo, T., Mcanyana, N., Mlambo, R., Mpungose, G., Ngidi, C., Tallis V, & Tolofi, T. 2006.   *Things are so bad out there*.   (research paper for IPAS Study.). Durban: Gender AIDS Forum.

Barnett., T., & Grellier., R.   1996.   Societal Vulnerability: Cultures and groups do not crack, they adapt and change.   In Mann., J. & Tarantola, D.J.M. *AIDS in the world II*.   New York: Oxford University Press.

Barnett, T., & Whiteside, A.   2002.   *AIDS in the Twenty-First Century: Disease and Globalization*.   London: Palgrave Macmillan.

Batliwala, S.   1994.   The meaning of women's empowerment: new concepts from action.   In Sen., G., Germain., A. & Chen, L.C.   (eds). *Population policies reconsidered: health, empowerment, and rights*. (Harvard series on population and international health).   Boston: Harvard University Press.

Baylies, C. 2000. Perspectives on gender and AIDS in Africa. In Baylies, C., Bujra, J. & the Gender AIDS Group. (eds.). *AIDS, sexuality and gender in Africa: collective strategies and struggles in Tanzania and Zambia*. (Social aspects of AIDS). London: Routledge.

Baylies, C. & Bujra, J. 1995. Discourses in power and empowerment in the fight against HIV and AIDS in Africa. In Aggleton P, Davis P and Hart G. (eds.), *AIDS. Safety, Sexuality and Risk*. London: Taylor and Francis

Baylies, C., Bujra, J. & the Gender and Aids Group. (eds). 2000. *AIDS, sexuality and gender in Africa: collective strategies and struggles in Tanzania and Zambia*. (Social aspects of AIDS). London: Routledge.

Beetham, G. & Demetiades, J. 2007. Feminist research methodologies and development: overview and practical application. *Gender and Development*. 15(2): pp 199 – 216.

Bell, L. & Nutt, L. 2002. Divided loyalties, divided expectations: research ethics, professional and occupational responsibility. In Mauthner, M.L., Birch, M., Jessop, J. & Miller, T. *Ethics in qualitative research*. Thousand Oaks: Sage.

Bennell, P., Hyde, K. & Swainson, N. 2002. *The Impact of the HIV and AIDS Epidemic on the Education Sector in Sub-Saharan Africa*. Brighton: Centre for International Education.

Berer, M. 2000. *Women and HIV/AIDS, reproductive and sexual health*. London. Spiderweave.

Birdsal,l K. & Kelly, K.   2007.   *Pioneers, partners, providers: the dynamics of civil society and AIDS funding in Southern Africa*.   Johannesburg: CADRE.

Boehmer, U.   2000.   *The personal and the political: women's activism in response to the breast cancer and AIDS epidemics*.   Albany: State University of New York.

Bourdieu, P.   2001.   *Masculine domination*.   Palo Alto: Stanford University Press.

Braig, M. & Wolte, S.   (eds).   2002.   *Common ground or mutual exclusion? : women's movements and international relations*.   London: Zed Books.

Brown, L.   2000.   *Sex slaves: the trafficking of women in Asia*.   New York: Time Warner Book Group.

Brown, W.   2008.   *Power after Foucault*.   In   Dryzek, J.S., Honig, B and Phillips, A. 2008.   The Oxford handbook of political theory. Oxford. Oxford University Press.

Budlender, D. & Kuhn, J.   2007. *Where is the money to address gender-based violence?.*   Funding report written for the Gender-based Violence Programme at the Centre for the Study of Violence and Reconciliation.

Bujra, J.   1999.   *Masculinity and AIDS: discourse and activism in Africa*.   unpublished paper.

Cagatay, N..   1998.   *Gender and poverty*.   (Working Paper Series No. 5). New York: UNDP Social Development and Poverty Elimination Division

Cavangh, D. & Mbele, P. 2006. Interview *with Khwezi.* Viewed on 7 June 2007. Online: www.oneinnine.org.za.

Charles, N. 1996. Feminist practices: identity, difference, power. In Charles, N. & Hughes-Freelann, F. (eds.) *Practicing feminism: identity, difference, power*. London: Routledge.

Charlesworth, H. 1995. Human rights as men's rights. In Peters, J. & Wolper, A. *Women's rights, human rights*. (International feminist perspective series). New York: Routledge.

Clark, C., Sprenger, E., VeneKlasen, L., Alpizar Duran, L. & Kerr, J. 2006. Where is the money for women's rights?: *assessing the resources and the role of donors in the promotion of women's rights and the support of women's rights organizations – an action research project of the Association for Women's Rights in Development*. Toronto: AWID.

Clark, S. 2004. Early marriage and HIV Risks in Sub-Saharan Africa. *Studies in family planning,* 35(3): pp. 149-160.

Cock, J. 2003. Engendering gay and lesbian rights: the equality clause in the South Africa constitution. *Women's studies international forum*, 26(1): pp. 35-40.

Cohen, D. & Reid, E. 1999. *The vulnerability of women: is this a useful construct for policy and programming?.* (Issues paper No. 28). New York: HIV and Development Programme, UNDP.

Collingwood, C.   2006.   *Gender AIDS Forum evaluation* 2002 – 2006. unpublished report.

Collins, C., Coates, T.J. & Curren, J.   2008.   Moving beyond the alphabet soup of HIV prevention. *AIDS*, 22(Supplement 2): S5-S8.

Collins, J., & Rau, B.   2000.   *AIDS in the context of development.* (HIV/AIDS for development paper No. 4).   Geneva: UNAIDS.

Commonwealth Secretariat and the Maritime Centre of Excellence for Women's Health.   2002.   *Gender mainstreaming in HIV and AIDS: taking a multisectoral approach.*   (New gender mainstreaming series on gender issues).   London: Commonwealth Secretariat.

Connell, R.W.   2005.   *Masculinities.*   Cambridge.   Polity Press.

Connell, R.W.   1987.   *Gender and power: society, the person and sexual politics.*   Palo Alto: Stanford University Press.

Cook, R. J.   1995.   International human rights and women's reproductive health.   In Peters, J. & Wolper, A. (eds.).   *Women's Rights, Human Rights: International Feminist Perspectives*.   London: Routledge.

Cornwall, A. & Welbourn, A.   2003.   *Realizing rights: transforming approaches to sexual and reproductive well-being*.   London: Zed Press.

Coy, M.   2006.   This morning I'm a researcher, this afternoon I'm an outreach worker: ethical dilemmas in practical research.   *International journal of social research methodology*, 9(5): pp. 419-431.

Crago, A.N. & Arnott, J.   2008.   Rights not rescue: a report on female, trans and male sex workers' human rights in Botswana, Namibia and South Africa.   New York: Open Society Institute.

Crawford, M. & Kimmel, E.   1999.   Promoting methodological diversity in feminist research.   *Psychology of women quarterly* 23: pp. 1-6.

Crewe, Mary. 2002.   *Rapporteur session*, 14th International AIDS Conference Barcelona, Spain, 7 – 12 July.

Davis, K.   2002.   Critical sociology and gender relations.   In Haugaard, M. (ed.).   *Power: a reader*.   Manchester: Manchester University Press.

De Senillosa, I.   1999.   A new age of social movements: a fifth generation of non-govenmental development organisations in the making.   In Eade, D. (ed.).   *Development and social action*.   Oxford: Oxfam.

Department of Health.   2007.   *National AIDS strategic plan 2007 – 2011*.   Pretoria: Department of Health.

Desmond, C., Michael, K. & Gow, G.   2000.   The hidden battle: HIV and AIDS in the household and community.   *South African Journal of International Affairs*, 7(2): pp. 39 – 58.

DeVault, M.L.   1999.   *Liberating method: feminism and social research*.   Philadelphia: Temple University Press.

De Vogli, R. & Birbeck, G.L.   2005.   Potential impact of adjustment policies of vulnerability of women and children to HIV/AIDS in Sub-Saharan Africa.   *Journal of health, population and nutrition*, 23(2): pp105 – 120.

Ditmore, M.H. 2006. *Encyclopedia of prostitution and sex work.* West point: Greenwood Press.

Doezema, J. 2002. Who gets to choose?: coersion, consent and the UN Trafficking Protocol. *Gender and development*, 10(1): pp. 20 -27.

Doyal, L. 1994. HIV and AIDS: putting women on the global agenda. In Doyal, L., Naidoo, J., & Wilton, T. (eds.). *AIDS: setting a feminist agenda.* London: Taylor and Francis.

Doyal, L. 1995. *What makes women sick: gender and the political economy of health.* Spicataway: Rutgers University Press.

de Zoysa, I., Elias, C.J & Bentley, M.E. 1998. Ethical challenges in efficacy trials of microbicides for HIV prevention. *American journal of public health*, 88(4): pp. 571 – 575.

Debabrata, R. 2002. *Analysing the dimensions: trafficking and HIV and AIDS in South Asia.* Delhi: STOP.

Edwards, R. & Mauthner, M. 2002. Ethics and feminist research: theory and practice. In Mauthner, M.L., Birch, M., Jessop, J., Miller, T. (eds.). *Ethics in qualitative research*. Thousand Oaks: Sage.

Epstein, D., Morrell, R., Moletsane, R., Unterhalter, E. 2004. Gender and HIV/AIDS in Africa south of the Sahara: interventions, activism, identities. *Transformation: critical perspectives on Southern Africa*, 54: pp. 1- 16.

Ettorre, E.M.   1980.   *Lesbians, women and society*.   London. Routledge & Kegan.

Faith, K.   1994.   Resistance: lessons from Foucault and feminism.   In Radtke, H.L & Stam, H.J.   *Power/Gender: Social relations in theory and practice*. Thousand Oaks: Sage.

Fawole, O.I.   2008. Economic violence to women and girls: is it receiving the necessary attention?.   *Trauma, violence and abuse*, 9(3): pp. 167-177.

Fine, D. & Nichol, J.   1995.   The lavender lobby: working for lesbian and gay rights in the liberation movement.   In Gevisser, M. & Cameron, E. *Defiant Desire. Gay and Lesbian lives in South Africa.* London: Routledge.

Foucault, M.   2000.   *Power. essential works of Foucault, 1954 – 1984, Volume III*. New York. Penguin.

Fowler, A.   2001. *Aid pathologies: Why are they and what can be done about them*.   Unpublished paper.

Fraser-Hurt, N., Gorgens-Albino, M., Gelmon, L.J., Whitson, D.W. & Wilson, D.   2008.   *It takes a village": Theoretical considerations and practical suggestions for shifting the focus of HIV prevention in East and Southern Africa to what really works .* Paper presented at UNAIDS/RHRU meeting, June.

Fried, S.   2007.   *Show us the money: Is violence against women on the HIV and AIDS Agenda?*. Washington: Action Aid.

Fraser-Hurt, N., Gorgens-Albino, M., Gelmon, L.J., Whitson, D.W. & Wilson, D. 2008. *It takes a village": Theoretical considerations and practical suggestions for shifting the focus of HIV prevention in East and Southern Africa to what really works .* Paper presented at UNAIDS/RHRU meeting, June.

Geisler, G. 1999. *WID/Gender Units and the experience of gender mainstreaming in multilateral organisations: Knights on white horses?* Report submitted to the Norweigian Ministery of Foreign Affairs by LHR Michelsen institute. Oslo: Ministry of Foreign Affairs.

Gender AIDS Forum. 2003a. *An internal evaluation and strategy review*. Unpublished internal report.

Gender AIDS Forum. 2003b. *Confronting marginalization in the context of AIDS*. Summit Report, Durban, South Africa.

Gender AIDS Forum. 2005a*. A strategy document*. Unpublished internal report.

Gender AIDS Forum. 2005b. *Women in leadership training manual*. GAF

Gender AIDS Forum. 2006. *Novib evaluation: terms of reference*. Unpublished internal document.

Gender AIDS Forum. 2008. *Marginalisation anthology*. OSISA/GAF.

Germain, A. & Woods, Z. 2005. Women's sexual and reproductive health and

rights: a key to ending HIV/AIDS. *Development*, 48(4): pp. 56–60.

Gevisser, M. & Cameron, E. 1994. *Defiant desire. gay and lesbian lives in South Africa.* London: Routledge.

Goetz, A.M. 1997. *Getting institutions right for women in development.* London: Zed Books.

Gordon, P. & Crehan, K. 2000. *Dying of sadness: gender, sexual violence and the HIV epidemic.* (SEPED Conference Paper Series). New York: UNDP.

Gready, M., Klugman, B., Xaba, M., Boikanyo, E. & Rees, H. 1997. South African women's experiences of contraception and contraceptive services. In World Health Organisation. *Beyond acceptability: users' perspectives on contraception*. Geneva: World Health Organisation.

Griffen, V. 2002. *Globalisation and re-inventing the politics of a women's movement*. (Occasional paper No. 6.). Toronto: Association of Women's Rights in Development.

Gupta, G.R. & Weiss, E. 1993. Women's lives and sex: implications for AIDS prevention. *Culture, medicine and psychiatry*, 17(4): pp. 399-412.

Gupta, G.R. 2000. Gender, sexuality, and HIV and AIDS: the what, the why, and the how. Plenary Address, XIIIth International AIDS Conference, Durban, South Africa, July 12.

Farouk, S.A., Rahman, Z., & Haque, D.M.   2001.   *Forced marriages: a blot in women's freedom of expression*.   Dhaka: Bangladesh National Women Lawyers Association.

Forum for Women, Law and Development.   [nd].   *Comments on Convention on Preventing & Combating Trafficking in Women & Children for Prostitution 2002*.   Forum for Women, Law and Development.   Viewed 12 March 2007.   Online: http://www.fwld.org.np/c.html.

Foster, P.   1995.   *Women and the healthcare industry.*   Buckingham: Open University Press.

Garcia-Moreno, C.   1999.   *Gender and health: a technical paper.*   Geneva: World Health Organization.

Ghaus, K. & Brohi, N.   1997.   *Summary report: regional conference on trafficking in women and children in South Asia.*   Karachi: Lawyers For Human Rights and Legal Aid.

Grover, A & Divan, V*.*   2002.   *Colloquium HIV and AIDS: the law and ethics*.   Jangpura: Lawyers Collective HIV and AIDS Unit.

Guthrie, J.   1995.   *Rape for profit: trafficking of Nepali girls and women to India's brothels*.   New York: Human Rights Watch.

Haldar, R.K.   2002.   *Regional consultation on NGO partnership in rescue and rehabilitation of the persons affected by human trafficking in South Asia: report, 24-25 July 2002.*   Tughlakabad: Prayas Juvenile Aid Centre.

Haraway, D. 1988. Situated Knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*, 14 no 3 [Fall 1988]. p 575 - 599

Harding, S. (ed.). 1987. *Feminism and methodology: social science issues*. Bloomington: Indiana University Press.

Haugaard, M. (ed.). 2002. *Power: a reader*. Manchester: Manchester University Press.

Hawe, P., Degeling, D. & Hall, J. 1990. *Evaluating health promotion. a health worker's guide.* Artamon: Maclennan and Pretty.

Heise, L., McGrory, E.C. & Wood, S.Y. 1998. *Practical and ethical dilemmas in the clinical testing of microbicides: a report on a symposium*. Takoma Park: Centre for Health and Gender Equality.

Helzer, J. & Shepard, B. 1997. The feminist agenda in population private voluntary organisations. In Staudt, K. *Women, international development and politics: the bureaucratic mire.* Philadelphia: Tempest University Press.

High Court of South Africa, Witwatersrand Local Division. 2005. *In the matter between the state versus Jacob Gedleyihlekisa Zuma.* Case number JPV2005/0325. Johannesburg: High Court of South Africa.

Himmelstrand, K. 1997. Can an aid bureaucracy empower women. In Staudt, K Women, international development and politics: the bureaucratic mire. Philadelphia. Tempest University Press.

Hivresourcetracking.org. 2008. *Sustaining the HIV prevention agenda: funding for research and development of HIV vaccines, microbicides and other new prevention options 2000 to 2007*. Viewed on 9 September 2008. Online: http://www.hivresourcetracking.org/content/RT_report_August2008.pdf.

Hlatshwayo, Z. & Klugman, B. 2001. A sexual rights approach, *Agenda*, No 47: pp. 14 – 21.

Hulme, D. & Edwards, M. (eds.) 1997. *NGOs, states and donors: too close for comfort?*. London: Macmillan.

Humm, M. 1995. *The dictionary of feminist theory.* 2nd ed. New York: Prentice Hill.

International Center for Research on Women (ICRW). 2002. *Understanding HIV-related stigma and resulting discrimination: emerging trends from early data collection in Ethiopia, Tanzania and Zambia*. Washington: International Centre for Research on Women.

International Council of AIDS Services Organizations. 1999. *NGO summary of the International Guidelines on HIV and AIDS and Human Rights.* Toronto: International Council of AIDS Services Organisation.

International Labour Office New Delhi. 2003. *Socio-economic impact of HIV and AIDS on people living with HIV and AIDS and their families*. Geneva: ILO.

Jackson, C.   1997.   Actor orientation and gender relations at a participatory project initiative.   In Goetz, A.M. *Getting institutions right for women in development.*   London: Zed Books

Jacobs, S.   2003.   Reading politics, reading media.   In Wasserman, H. And Jacobs, S.   2003.   *Shifting Selves: Post-apartheid essays on mass media, culture and identity*.   Cape Town.   Kwela Books.

Jahan, R.   1997.   *The elusive agenda: mainstreaming women in development*.   London. Zed Books.

Jana, S. Bandyopadhyay, N., Dutta, M.K. & Saha, A.   2002.   Tale of two cities shifting the paradigm of anti-trafficking   programmes.   Gender and development, 10(1): pp. 69 – 79.

Janeway, E.   1981.   *The powers of the weak*.   New York: Morrow Quill.

Jewkes, R.   2007.   Comprehensive response to rape needed in conflict settings.   *The lancet*, 369(9580): pp. 2140 – 2141.

JOHAP.   2001.   Strategic plan: phase two

Johnson, C.A. (2007).   *Off the map.   How HIV and AIDS programming is failing same-sex practicing people in Africa*.   New York: International Gay and Lesbian Human Rights Commission.

Kabeer, N.   1997.   *Reversed realities: gender hierarchies in development thought*.   London. Verso.

Kaihuzi, M.T.   1999.   *LDCs in a globalizing world: a strategy for gender*

balanced sustainable development. Paper presented at the Pre-UNCTAD X Expert Workshop on Trade, Sustainable Development and Gender, 12-13 July 1999, Geneva, Switzerland.

Kardam, N. 1994. *Bringing women in: women's issues in international development programs*. Boulder: Lynne Riener Publishers.

Khan, N.S. 2000. The women's movement revisited: areas of concern for the future. In Ali, S., Coate, K. & wa Goro, W. 2000. *Global feminist politics: identities in a changing world*. London: Routledge.

Killian, S., Suliman, S., Fakier, N., & Seedat, S. 2007. Rape survivors and the provision of HIV post-exposure Prophylaxis: *South African Medical Journal*, 97(8): pp. 585-586.

Kodandapani, K. & Alpert, P.T. 2007. AIDS in India: when denial kills. *Home health care, management & practice*, 20(1): pp. 21-26.

Kohler, H.P., Behrman, J.R., Watkins, S.C. 2007. Social networks and HIV/AIDS risk perceptions. *Demography*, 44(1): pp. 1-33.

Kothari, M. (ed.). 1999. *Development and social action*. (Development in Practice Readers series). Oxford. Oxfam Publishing.

Kurtz, S.P., Surratt, H.L., Kiley, M.C. & Incaiardi, J.A. 2005. Barriers to health and social services for street-based sex workers. *Journal of health care for the poor and underserved*. No. 16: pp. 345-361.

Kwesi, B., & Webster, N.   1997.   Black, lesbian and speaking out.   *Agenda*, No. 36: pp. 90 – 94.

Lawyers Collective.   2003.   *Legislating an epidemic.   HIV and AIDS in India*.   New Delhi: Universal Law Publishing.

Leclerc-Madlala. S.   2008.   *Intergenerational/age-disparate sex in Southern Africa: moving HIV between generations*.   Discussion Paper for UNAIDS / RHRU Regional Technical Meeting on Young Women in HIV Hyper-endemic Countries of Southern Africa

Lee, S. & Kroon, A.   2001.   *External evaluation: Joint Oxfam HIV and AIDS Programme (1998 – 2000)*.

Lekas, H.M., Siegel, K & Schrimshaw, E.W.   2006.   Continuities and discontinuities in the experiences of felt and enacted stigma amongst women with HIV/AIDS.   *Quality health research,* No. 16: pp. 1165 – 1190.

Lipman- Bhimen. J.   1994.   The existential bases of power relationship: the gender role case.   In Radke, H.L. & Stam, H.J.   *Power/gender: social relations in theory and practice*.   London: Sage.

Loewenson, R. & Whiteside, A.   1997.   *Social and economic issues of HIV/AIDS in Southern Africa*.   Harare: Southern Africa AIDS Information Dissemination Service.

Lorber, J.   1991.   Dismantling Noahs Ark.   In Lorber, J. & Farrell, S.A. *The social construction of gender*.   New York: Sage.

Lorber, J. 1997. *Gender and the social construction of illness*. New York: Sage.

Lukes, S. 2005. *Power: a radical view*. London: MacMillan.

MacDonald, M. (ed.) 1994. *Gender planning in development agencies: meeting the challenge*. Oxford: Oxfam Publishing.

MacDonald, M., Sprenger, E. & Dubel, I. 1997. *Gender and organisational change: bridging the gap between policy and practice.* Amsterdam: Koninklijk Instituut voor de Tropen Press.

Maharaj, P. 2005. Patterns of condom use: perspectives of men in KwaZulu-Natal, South Africa. *Development Southern Africa*, 22(2): pp187-197.

Malla, S.P. & Joshi, S. 2003. *Report on abuse of commercial sex worker and homosexuals in Nepal*. Kathmandu: Blue Diamond Society Women Acting Together for Change (WATCH) & General Welfare Pratisthan (GWP).

Mama, A. 2001 Subjects, gender and power in African contexts In Daigne, S.B., Mama, A., Melbe, H, and Nyamnjoh, F.B. 2001. *Identity and beyond. Rethinking Africanity*. Discussion paper 12. Upsalla. Nordisk Afrika.

Manchester, J. & Mthembu, P. 2002. Positive women: voices and choices. *BRIDGE in brief*, No. 11. Brighton: Institute of Development Studies

Manchester, J. & Welbourn A. 2001. *Hope, involvement and vision: new*

strategy for HIV in Africa.   Report to agencies of a review on HIV funding, conducted for Comic Relief

Mann J. & Tarantola D.   1996.   *AIDS in the World II.*   Oxford: Oxford University Press.

Maxwell, J.A.   1996.   *Qualitative research design: an interactive approach*. Thousand Oaks: Sage.

May, J.   2000.   *Poverty and inequality in South Africa: meeting the challenge*.   Cape Town: David Phillip.

Mbali, M.   2004.   AIDS Discourses and the South African State: Government denialism and post apartheid AIDS policy making. *Transformation: critical perspectives on Southern Africa,* 54: pp. 104 – 122.

Moffat, H.   2006.   *The political economy of sexual violence in post-apartheid South Africa*.   Presented at the Harold Wolpe Memorial Trust's Tenth Anniversery Colloquium: Engaging silences and unresolved issues in the political economy of South Africa. 21 – 23 September, Cape Town, South Africa.

Moon, M., Mbizvo, M., Nyamapfeni, P., Heiman, J., & Padian, N.   1998. *Acceptability of vaginal microbicides in Zimbabwe is high*.   Poster 33134 presented at the XIIIth International AIDS Conference, Geneva, 28 June – 3 July.

Morgan, R. & Wieringa, S.   2005.   *Tommy boys, lesbian men and ancestral wives. female same-sex practices*.   Johannesburg: Jacana Media.

Morriss, P.   2002.   Power: *a philosophical analysis*.   Manchester: Manchester University Press.

Moser, C.   1995.   *Gender planning and development: theory, practice and training*.   London: Routledge.

Msimang, S. 2002*.   AIDS and the global women's movement*.   Presentation at AWID Forum. Re-investing globalization. October 3-6 2002. Guadalajara. Mexico.

Mthembu, P.   1998.   A positive view.   *Agenda*, 39: pp. 26 -30.

Mthembu, P. 2002 Presentation, 14th International AIDS Conference, Barcelona 7 – 12 July.

Murphy, B.K.   1999.   *Transforming ourselves, transforming the world: an open conspiracy for social change*. London: Zed Books.

Muthien, B.   2005.   Playing on the pavements of identities. In van Zyl, M. & Steyn, M. *Performing queer: shaping sexualities 1994 – 2004*, volume One. Roggebaai: Kwela Books.

Naidu, V., & Harris, G.   2006.   The impact of HIV/AIDS morbidity and mortality on households: review of HIV/AIDS studies. *South Africa Journal of Economics*, 73(s1): pp. 533 – 544.

National Department of Health South Africa. 2008. *The National HIV and Syphilis Prevalence Survey South Africa 2007*. Pretoria. Department of Health.

Ndlovo, B., Masondo, T., Mthembu, P., Barnanbus, N., Silondo, P., Ntombela, A., Telophi, R., and Tallis, V. 2003. *Realities of our lives: an agenda for positive women*. Unpublished paper.

Ndlovu, N. 2006. An exploratory analysis of HIV and AIDS donor funding in South Africa. *Budget Brief No. 155*. Johannesberg: IDASA.

Novib. 1995. *More power, less poverty: policy document*. Amsterdam: NOVIB.

Nkosi, M. 2008. Male circumcision as an HIV prevention strategy and implications for women's sexual and reproductive rights. *Agenda*. No 75. Sexual and Reproductive Rights. pp 141 – 154.

Nugteren, M. 2001. *Aiming gender: evaluation of the Novib gender policy 1995 - 2000.* Amsterdam: Novib.

Ogden, J. & Nyblade, L. 2005. *Common at its core: HIV-related stigma across contexts*. Washington: ICRW.

Olaniyi, R. 2003. *No way out: the trafficking of women in Nigeria*. Agenda, 55: pp. 45-52.

Oxfam Community Aid Abroad. 1998. *Gender and development: a community aid abroad programme policy*. Melbourne: OIAP Section.

Panos Institute. 1990a. *The third epidemic: repercussions of the fear of AIDS.* London: Panos Institute.

Panos Institute. 1990b. *Triple jeopardy: women and AIDS*. London: Panos Institute.

Patel, P. 2008. How did we get here and where to now?: the coerced sterilization of HIV positive women in Namibia. *Agenda*, 75: pp. 38-44.

Patton, C. 1994. *Last served?: gendering the HIV Pandemic*. London: Taylor & Francis.

Paxton, S. 2001. *Parent-to-child transmission: breaking down the barriers to implementing effective models*. Presentation to the 6th ICAAP Plenary 8th October, The Key Centre for Women's Health in Society, University of Melbourne.

Paxton, S., Welbourn, A., Kousalya, P., Yuvaraj, A Malla, S.P, & Seko. M. 2004. *Oh this one is infected!: women, HIV and human rights in the Asia-Pacific region*. Paper prepared for the UN Office of the High Commissioner for Human Rights.

Peltzer, K., Mngqundaniso, N.; Petros, G. 2006. HIV/AIDS/STI/TB knowledge, beliefs and practices of traditional healers in KwaZulu-Natal, South Africa. *AIDS Care*, 18(6): pp. 608-613.

Peters, J. and Wolper, A., 1995, *Women's Rights, Human Rights: International Feminist Perspectives*, London: Routledge.

Pettifor, A. E., van der Straten, A., Dunbar, M.S. Shiboski, S.C.; Padian, N.S. 2004. Early age of first sex: a risk factor for HIV infection among women in Zimbabwe. *AIDS*, 18(10): pp. 1435-1442.

Ponse, B. 1978. *Identities in the lesbian world: the social construction of self.* Westport: Greenwood Press.

Posel, D. 1997. Counting the poor: who gets what in which households. *Agenda,* 33: pp. 49-60.

Preston-Whyte, E., Varga, C., Oosterhuizen, H., Roberts, R., & Blose, F. 2000. Survival sex and HIV and AIDS in an African city. In R.G Parker, R.G., Barbosa, R.M. & Aggleton, P. *Framing the sexual subject: the politics of gender, sexuality and power*. Berkley: University of California.

Radke H.L & Stam, H.J. 1994. *Power/gender: social relations in theory and practice*. London: Sage.

Rao, A. & Kellener, D.   2002.   *Unravelling institutionalised gender inequality.* Occasional paper no 8.   Toronto: Association for Women's Rights in Development (AWID).

Razavi, S. 1998. *Gendered poverty and social change: an issues paper*. (UNRISD Discussion Paper No. 94).   Geneva: United Nations Research Institute for Social Development.

Reddy, V. & Potgieter, C.   2006.   Real men stand up for the truth: discursive meanings in the Jacob Zuma rape trial.   *Southern African linguistics and language studies*, 24(4): pp. 511-521.

Rees, H.   2008.   *Essential interventions for reducing biomedical vulnerability of women to HIV infection in southern Africa*.   Policy Brief for UNAIDS Meeting on Vulnerability of Young women and girls to HIV and AIDS.

Reid, E.   1995.   *HIV and AIDS: the global inter-connections.*   Bloomfield: Kumarian Press.

Reid, E. & Bailey, M.   1992.   *Young women, silence, susceptibility and the HIV Epidemic.   UNDP Issue Paper No.12*.   New York: UNDP.

Reinfelder, M.   1996.   Persecution and resistance.   In Reinfelder, M. *Amazon to Zami: towards a global lesbian feminism*.   London. Cassell.

Reniers, G.   2008.   Marital strategies for regulating exposure to HIV. *Demography*, 45(2): pp. 417-438.

Richardson, D.   1989.   *Women and the AIDS crisis: new edition*.   London: Unwin Hyman.

Richardson, D.   1996.   Contradictions in discourse: gender, sexuality and HIV and AIDS.   In Holland, J. & Adkins, C.   (eds.).   *Sex, sensibility and the gendered body.*   London: Macmillan.

Richardson, D.   2000.   The social construct of immunity: HIV risk perception and prevention among lesbians and bisexual women.   *Culture, health and sexuality*, 2(1): pp. 33-49.

Riley, M.   2001.   *Women's economic agenda in the 21st century*. (Feminist collections: a quarterly of womens resource issues occasional paper series on gender and development*)*.   Women's Project at the Center of Concern and the International Gender and Trade Network.

Roberts, B. and Reddy, V. 2008.   Pride and prejudice: Public attitudes toward homosexuality. *HSRC review*, 6(4). pp. 9 – 13.

Roth, N.L., & Hogan, K.,   1998.   *Gendered epidemic: representations of women in the age of AIDS*.   New York: Routledge.

Rowbotham, S. & Linkogle, S.   (eds).   2001.   *Women resist globalization: mobilizing for livelihoods and rights.*   London: Zed Press.

Rowlands, J.   1997.   *Questioning empowerment: working with women in Honduras.*   Oxford: Oxfam.

Rudd, A. & Taylor, D.   1992.   *Positive women: voices of women living with AIDS*. Toronto. Second Story Press.

Ryan, B.   1992.   *Feminism and the women's movement: dynamics of change in social movement ideology and activism*. New York: Routledge.

Sassen, S.   2002.   Counter-geographies of globalization: feminization of survival.   In Saunders, K. (ed.).   *Feminist post-development thought:*

rethinking modernity, post-colonialism and representation. London: Zed Books.

Saunders, K. (ed.). 2003. *Feminist post-development thought: rethinking modernity, post-colonialism and representation*. London: Zed Books.

Schineller, S.J. 2008. Meeting development goals. *American magazine*, 26 May – 2 June: pp. 5.

Seekings, J. 2001. *The changing nature of donor-funded capacity building in CBO's in South Africa since 1980*. Unpublished paper.

Seidel, G. and Tallis, V. 1999. *Reconceptualising the issues surrounding HIV and breastfeeding and the information given to women by health workers: findings from sociological research in KwaZulu-Natal*, South Africa unpublished

Sember, R. 2008. The social construction of ARV's in South Africa. *Global public health*, 3(1): pp. 58 – 75.

Shah, V, and Brar, B, and Rana, S.Y. 2002. *Layers of silence: links between women's vulnerability, trafficking and HIV/AIDS in Bangladesh, India and Nepal*. Draft paper prepared for the UNRISD project HIV/AIDS and Development March 2002

Shifman, P. 2003. Trafficking and women's human rights in a globalised world: an interview. *Gender and development*, 11(1): 125 -132.

Shilts, R.   2007.   *And the band played on: politics, people, and the AIDS epidemic*.   New York: St Martin's Press.

Shisana, O. & Simbayi, L.   2002.   *Nelson Mandela/HSRC study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media household survey 2002.*   Cape Town: HSRC Press.

Singh, A. & Zammit, A.   2000.   International capital flows: identifying the gender dimension.   *World development*, 28(7): pp. 1249-68.

Smith, T. & Bornstein, L.   2001.   *Northern NGO's in South Africa: programmes and partnerships.*   Durban: School of Development Studies, University of Kwazulu Natal.

Smith, T.   2006.   *Questioning the crisis: international donors and the reconfiguration of the South African NGO sector*.   (Advocado Working Paper series, No. 4).   Durban: Olive OD&T.

Sogge, D.   2002.   *Give and take: what's the matter with foreign aid*.   London. Zed Books.

Staudt, K., (ed.).   1997.   *Women, international development and politics: the bureaucratic mire. Philadelphia*. Temple University Press.

Stevens, M.   2008.   Towards treatment guidelines for women of reproductive age: recognising the right to chose. *Agenda,* 75: pp. 67-77.

Stoller, N.   1997.   *Lessons from the damned: queers, whores and junkies respond to AIDS.*   Routledge: New York.

Stover, J. & Bollinger, L.   2006.   The economic impact of AIDS.   In Columbus, F.H., & Wusu, O. (eds.).   *Politics and economies of Africa, volume 5*.   New York: Nova Publishers.

Sweetman, Caroline   (ed.)   1998.   *Gender and migration*.   Oxford: Oxfam.

Tallis, V.A.   1998.   AIDS is a crisis for women.   *Agenda,* 39: pp. 6 – 14.

Tallis, V.A.   2000.   Gendering the response to HIV and AIDS: challenging gender inequality.   *Agenda,* 44: pp. 58 – 67.

Tallis, V.A.   2001a.   *Treatment issues for women*.   Paper prepared for Treatment Action Campaign, South Africa.

Tallis, V.A.   2001b.   *Microbicides*.   Paper prepared for Treatment Action Campaign, South Africa.

Tallis, V.A.   2002a.   *Gender and HIV and AIDS: cutting edge pack – overview report.*   Brighton.   Institute of Development Studies.

Tallis, V.A.   2002b.   *Search for viable microbicide*.   Agenda, 52: pp. 91 – 94.

Tallis, V.A. & Cavanagh, D.   2004.   Equality is not enough: confronting power to reduce women and girls vulnerability to HIV and AIDS.   Paper presented at Learning and empowerment: key issues in strategies for HIV/AIDS preventions seminar, UNESCO, Chaing Mai, Bangkok, Thailand.

Tallis, V.A., Christian, B., & Cavanagh, D. 2005. *Community preparedness: are South African communities ready for Microbicides*.   Durban: Gender AIDS Forum.

Tallis, V.A., Hopenhaym, F & Knab, M.   2008.   *Funding to fight HIV/AIDS through the promotion of women's rights: a case study from South Africa*. Toronto: AWID.

Tarantola, D. 1998. Expanding *the global response to HIV/AIDS through focused action: reducing risk and vulnerability: definitions, rationale and practices*. UNAIDS.   (UNAIDS 98/1).   Geneva: UNAIDS.

Thabeti, T.   2005.   *Internal evaluation: women in leadership*.   Durban: Gender AIDS Forum.

Thapa, P. & Chistini, K.   2003.   *Nepal resisting trafficking in women: auditing testimonies and restoration approaches.*   Kathmandu: Action Aid.

Thapar-Bjorkert, S. & Henry, M.   2004.   Reassessing the research relationship: location, position and power in fieldwork accounts. *International Journal of Social Research Methodology*, 7(5): pp. 363-381.

Tong, R. 1997. *Feminist thought: a comprehensive introduction*. London: Routledge.

Travers, M. & Bennett, L.   1996.   AIDS, women and power.   In Sherr, L., Hankins, C. & Bennett, L.   (eds.).   *AIDS as a gender issue: psychosocial perspectives. (*Social aspects of AIDS series).   London: Taylor and Francis.

UNAIDS. 2000. *Report on the Global HIV and AIDS Epidemic*. Geneva: UNAIDS.

UNAIDS. 2001. *Report on the global HIV and AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2002. *Report on the global HIV and AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2003. *Report on the global HIV and AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2006. *Report on the global HIVAIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2007. *Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2008. *Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNDP. 2003. *Human development report 2002/2003*. Viewed 16 October 2008. Online: http:/hdr.undp.org.

UNDP. 2008. *Human development report 2007/2008*. Viewed 16 October 2008. Online: http:/hdr.undp.org.

UNDP HIV & Development Programme South / South West Asia. 2001. *The nexus of vulnerability: prevention of trafficking of women and girls and HIV and AIDS in South Asia.* Delhi : UNDP.

UNESCO.   2007.   *Human trafficking in South Africa: root causes and recommendations*.   Paris. UNESCO

UNFPA.   2003.   *State of world population 2003: making a billion count - investing in adolescents' health and rights.*   New York: UNFPA.

UNIFEM & AWID.   2002.   *Act now: resource guide for young women on HIV and AIDS.* New York: UNIFEM.

United Nations, Division of the Advancement of Women (DAW), World Health organisation (WHO) & UNAIDS.   2000.   *The HIV and AIDS pandemic and it's gender implications.*   (Report of the expert group meeting, DAW & Department of Economic and Social Affairs, 17th of November 2000).   New York: Division for the Advancement of Women.

UNSG Task Force on Women, Girls and HIV/AIDS in Southern Africa.   2003. *Facing the future together*.   New York: UNICEF.

Urdang, S.   2001.   *Statement to UNGASS first informal consultative meeting*.   New York: UNIFEM.

Varga, C. & Makubalo, L.   1996.   Sexual (non) negotiation among black African
teenagers in Durban.   *Health transition review*, 7(s3): pp. 54 – 67.

Vetten, L. & Bhana, K.   2001.   *Violence, vengeance and gender: a preliminary investigation into the links between violence against women and HIV and AIDS in South Africa.*   Johannesburg: The Centre for the Study of

Violence and Reconciliation.

Vyavaharkar, M.V, Moneyham, L. & Corwin, S.   2008.   Health care utilization: the experiences of rural HIV-positive African-American women. *Journal of Health Care for the Poor and Underserved* 19(1): pp. 294 – 306.

Wasserman, H. And Jacobs, S.   2003.   *Shifting Selves: Post-apartheid essays on mass media, culture and identity*. Cape Town. Kwela Books.

Watney, S.   1997.   *Policing desire: pornography, AIDS and media*. Minnesota. University of Minnesota Press.

Watts, C., Thompson, W. & Heise, L.   1998.   *The effectiveness of microbicides for HIV prevention*.   International Conference on AIDS, 12: 634 (Abstract 33161).

Watts, J.   2006.   The outsider within: dilemmas of qualitative feminist research within a culture of resistance. *Qualitative research*, 6(3): pp. 385 – 402.

Wennerholm, C.J.   2002.   Crossing borders and building bridges: the Baltic Region Networking Project.   In Masika, R.   (ed.).   *Gender, trafficking and slavery*. (Oxfam focus on gender series).   Oxford. Oxfam.

West, G. & Blumberg, R.L.   (eds.).   1990.   *Women and social protest*. Oxford: Oxford University Press.

Wells, H., Kruger, T. & Judge, M.   (nd*).   Experiences and dimensions of power: discussions with lesbian women*.   Pretoria: OUT.

Whelan, D.   1999.   *Gender and HIV and AIDS: taking stock of research and programmes*. (UNAIDS Best Practice Collection*).*   Geneva: UNAIDS.

Whiteside, A & Sunter, C.   2000.   *AIDS: the challenge for South Africa*. Cape Town: Human and Rousseau.

Wichterich, C.   1998.   *The globalized woman: reports from a future of inequality*. London. Zed Books.

Williamson, I.   2000.   Internalised homophobia and health issues affecting lesbian and gay men. *Health education research,* 15(1): pp. 97 – 107.

Wilton, T.   1997.   *Engendering AIDS: deconstructing sex: text and epidemic.*   London: Sage.

Wiseberg, L.S., Hecht, M.E. & Reekie, K.   1998.   Human rights, law, ethics and HIV.   In Human Rights Internet.   *Human rights: effective community responses.*   Ottawa: Human Rights Internet

Woodward, K. 1997. Identity and difference: culture, media and identities. London. Sage.

Young, K.   1997.   Planning from a gendered perspective: making a world of difference.   In Visvanathan N, Duggan L, Nisonoff L & Wiegersma N. (eds.). *The women, gender and development reader.*   Cape Town: David Philip Publishers.

Zegeya, A.   2001.   *Social identities in the new South Africa. After*

apartheid. Volume 1. Cape Town and Maroelana. Kwela Books and SA History on line.