YOUTH EDITION

SEXUAL & REPRODUCTIVE HEALTH & RIGHTS

+ LIVING POSITIVELY + QUEER FOLK + SEX WORK + SHE CONQUERS & DREAMS + CONTRACEPTION +

on the state of health in South Africa

incorporating the NSP Review Edition #5 – March 2018
In this issue

**The Needs of Queer Folk in South Africa**
Where are we with the implementation of the LGBTQIA+ HIV Plan 2017-2022?
Page 11

**Access Denied**
Access to abortion services remains a dream to young women, as a large number of them still opt for backstreet abortion services.
Page 55

**The Dangers of Vaginal Doucheing**
STIs continue to be a huge health hazard among young women. Many people walk around with untreated STIs because some of them are asymptomatic. It is important to get screened regularly.
Page 20

**The Million Men Drive**
Voluntary medical male circumcision remains one of the most important practices, as it reduces the chances of HIV acquisition by 60 per cent and helps prevent STI infections.
Page 32

**Cutting Edge Youth Services**
The Desmond Tutu HIV Foundation has mastered the art of providing youth-friendly services in Mitchells Plain in Cape Town.
Page 35

**The Contraceptive Implant**
Following the huge uptake of the implant after it was introduced in the public health sector, thousands of women went back to health facilities to get it removed.
Page 49
Contents

SRHR VOCABULARY
The A-Z of SRHR ................................................................. 2

EDITORIAL
We are failing young women in South Africa ................................................... 5

VOX POPS
What young people think about sexual and reproductive health ...................... 8

LGBTQIA
The needs of queer folk in SA .......................................................... 11
Improving SRHR access for queers in South Africa ......................................... 13

YOUNG WOMEN
Menstrual and reproductive myths still persist .............................................. 14
The cost of liberation .................................................................................. 17
Period-shaming must fall ........................................................................... 18
The dangers of vaginal douching ............................................................... 20
DREAMS and She Conquers ................................................................ 22
She decides whether, when and with whom............................................. 26
Hope for young women amid a sea of despair .......................................... 28
Emancipate the female condom .............................................................. 30

YOUNG MEN
The Million Man Drive .............................................................................. 32

SRHR SERVICES
Cutting-edge youth services ...................................................................... 35

SEX WORK
Sex work is work .................................................................................... 39

CONTRACEPTION
The ABCs of contraception ....................................................................... 44
DBE Draft Policy on the Prevention and Management of Learner Pregnancy ...... 46
‘F’ for Fail ............................................................................................... 47
Young researcher sheds light on contraceptive implant ................................. 49

ABORTION
Bill would roll back right to choose .......................................................... 52
Abortion in Khayelitsha .......................................................................... 54
Access denied .......................................................................................... 55

LIVING POSITIVELY
Young and living with HIV ...................................................................... 57
Shakira Namwanje, Uganda ...................................................................... 59
Tshepo Ngoato, Midrand, Gauteng ........................................................... 61
Saidy Brown, Mafikeng ........................................................................... 63
Make Love Safe ..................................................................................... 64
Bonolo’s Story ....................................................................................... 65
Lack of PrEP for young women is a rights violation .................................... 67

TEST YOUR KNOWLEDGE
Crossword puzzle ..................................................................................... 68
Find the word ......................................................................................... 69

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The opinions expressed in Spotlight do not always reflect the views of TAC or SECTION27.

The Treatment Action Campaign (TAC) advocates for increased access to treatment, care and support services for people living with HIV, and campaigns to reduce new HIV infections. Learn more about the TAC’s work at www.tac.org.za.

SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights, particularly the right to health. Learn more about SECTION27’s work at www.section27.org.za.
SRHR stands for Sexual and Reproductive Health and Rights. It is the concept of human rights applied to sexuality and reproduction.

SRHR encompasses all of the rights and issues surrounding a person’s sexual and reproductive life. These rights are closely linked with other internationally recognised human rights, such as the right to privacy, the right to education and information, the right to equality and freedom from violence and all forms of discrimination, the right to the highest attainable standard of health, etc.

The term SRHR combines four separate but interrelated concepts: Sexual Health (SH), Reproductive Health (RH), Sexual Rights (SR), and Reproductive Rights (RR). ‘Sexual and Reproductive Health’ covers the right to decide if, when and how often to have children, the right to live free from disease, the right to have access to accurate, comprehensive and confidential information, etc; while ‘Sexual and Reproductive Rights’ covers the right to sexual pleasure, the right to sexual privacy, the right to have access to the full range of contraceptives, the right to choose your partner, etc.

**ABORTION** is ending a pregnancy by removing a foetus or embryo before it can survive outside the uterus. Abortion is the premature expulsion of the foetus or embryo, and is done either by surgical procedure, with chemicals, or with a suction or vacuum device.

**ACTIVIST** is a person who campaigns to bring about political or social change.

**ADVOCACY** is mostly public activity by an individual or group aimed at influencing decisions within political, economic, and social systems and institutions.

**ANAL SEX** is any form of sexual activity where the anus is penetrated by fingers, sex toys or the penis.

**ANOVA HEALTH INSTITUTE** is an NGO for who provide healthcare solutions and support for those who need it most. With a specific focus on HIV, they do research ad run various community programmes.

**ASEXUAL** refers to a person who doesn’t have sexual feelings or sexual associations.

**BISEXUAL** refers to people who are sexually attracted to both men and women.

**CONTRACEPTION** is the deliberate prevention of conception or impregnation by any of various drugs, devices, techniques or birth control.

**DENTAL DAM** is a thin square of latex that can be used to prevent the spread of STIs during oral sex. It is placed over any part of the body that is receiving oral sex to create a barrier between the mouth and the body part receiving oral sex.

**DEPO PROVERA** is a contraceptive injection for women that contains the hormone progesterin.

**DOMESTIC VIOLENCE** is violent or aggressive behaviour within the home, typically involving the violent abuse of a spouse or partner.

**EMERGENCY CONTRACEPTIVE** is a birth control method used by women after engaging in unprotected sex within a specified period.

**FAMILY PLANNING** is the practice of controlling the number of children you want to have; also how long you want to wait before having another baby, and the **CONTRACEPTIVE** options you have, including voluntary sterilisation.

**FEMALE CONDOM** is a contraceptive device made of thin rubber, inserted into a woman’s vagina before sexual intercourse.

**FINGER COT** is a latex cover which rolls down to fit snugly over a finger. It is used to reduce the risk of infections during oral sex i.e. fingering, hand jobs or any kind of anal play with the hands.

**GAY** refers to a homosexual of any gender – in many cases male homosexuals, but not exclusively.

**GBV** stands for gender-based violence, and is generally understood to be when females are targeted for violence. GBV is characterised by unequal power relationships between men and women, and includes domestic violence, violation of women in conflict situations, systematic rape and sexual slavery of women. While most commonly referring to violence against women, GBV can also refer to violence against any person, if that violence is based on the person’s gender identity – for example, violence against gay men or lesbians.

**GENDER** refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for boys and men or girls and women. These influence the ways in which people act, interact, and feel about themselves. While aspects of biological sex are similar across different cultures, aspects of gender may differ.

**GENDER EXPRESSION** refers to the way a person communicates gender identity to others, through behaviour, clothing, hairstyle, voice or body characteristics.

**GENDER IDENTITY** refers to a person’s internal sense of being male, female or something else.

**GENDERQUEER** also termed non-binary, is a category for gender identities that are not exclusively masculine or feminine.
feminine – identities outside the gender binary and cisnormativity. Genderqueer people may express a combination of masculinity and femininity, or neither, in their gender expression.

INTERSEX is a person born with any of several variations in sex characteristics including chromosomes, gonads, sex hormones, or genitals.

INTRA-UTERINE DEVICE (IUD) is a small, T-shaped device that is inserted in a woman’s uterus to prevent pregnancy.

LESBIAN is a homosexual female.

LGBTQIA+ is an inclusive term representing Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual people. It also includes other group terms relating to sexual orientation and gender identity, including Asexual, Non-Binary and Queer. Many variants are in use, including LGBTQ.

MALE CONDOM is a thin sheath placed over the erect penis. When left in place during sexual intercourse, oral sex or anal sex, male condoms are an effective way to protect yourself and your partner from sexually transmitted infections (STIs). Male condoms are also an effective way to prevent pregnancy.

MENSTRUATION is the shedding of the lining of the uterus otherwise known as periods. It is the monthly process of washing or flushing the vagina with water or a mixture of fluids.

PATRIARCHY is a cultural heritage where males hold power and privilege in society, especially in key roles of political, economic and social power. In this system men are unfairly privileged and given control over things such as property, land rights, status, employment, abortion rights, or social rights at the expense of women.

POST EXPOSURE PROPHYLAXIS (PEP) is an antiretroviral drug taken by HIV negative people after being exposed to HIV.

PRE-EXPOSURE PROPHYLAXIS (PREP) is an Antiretroviral drug taken daily by HIV negative people at high risk of contracting HIV to prevent infection.

RECTAL SWAB is a cotton swab placed in to the rectum. It is used to collect a smear in the rectum that will be tested for rectal cancer.

REPRODUCTIVE HEALTH refers to the diseases, disorders and conditions that affect the functioning of the male and female reproductive systems during all stages of life. It includes looking at such things as fertility problems, impotence and menstrual problems, as well as birth defects and developmental disorders in babiess.

REPRODUCTIVE RIGHTS are your rights to decide whether or not you want to have a baby. Individuals have the right to plan a family, terminate a pregnancy, use contraceptives, learn about sex education in public schools, and have access to reproductive health services.

SERO-DISCORDANT refers to a couple in a romantic relationship between an HIV positive partner and an uninfected person.

SEX EDUCATION is the instruction and information that’s given on a range of issues including human sexuality, and the emotional relationships and responsibilities between partners who engage in sex or sex acts. Education should cover human sexual anatomy, understanding different kinds of sexual activity, reproduction, the age of consent, reproductive health, reproductive rights, safe sex, birth control, and sexual abstinence.

SEX can refer to either sexual intercourse or the gender assigned to a person at birth. The latter refers to one’s biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy.

SEX WORKER is a woman, man or transgendered person who receives money or goods in exchange for sexual services. Sexual services are a way of generating income.

SEXUAL HEALTH is the ability to embrace and enjoy our sexuality throughout our lives. Sexual health is part of our physical and emotional health. It’s also accepting that feeling sexual is a natural part of life, and normal sexual behaviour.

SEXUAL RIGHTS are your human rights in terms of choices over your body and your sexuality. People should be free from being forced, bullied, intimidated or discriminated against because of what they choose in their sexual lives. They should have access to reproductive health care, information and services as part of these rights.

SEXUALLY TRANSMITTED INFECTIONS (STIs) are infections that are passed on from one person to another through sexual contact.

TRANSGENDER is an umbrella term for persons whose gender identity, gender expression or behaviour does not conform to that typically associated with the sex to which they were assigned at birth. ‘Trans’ is sometimes used as shorthand for ‘transgender’. While transgender is generally a good term to use, not everyone whose appearance or behaviour is gender-nonconforming will identify as a transgender person. The ways that transgender people are spoken about in popular culture, academia and science are constantly changing, particularly as individuals’ awareness, knowledge and openness about transgender people and their experiences grow.

UNWANTED PREGNANCY is a pregnancy that is mistimed, unplanned or unwanted at the time of conception. Unintended pregnancies may also result from rape, incest or other forms of forced or unwanted sex.

VAGINAL DOUCHING is the process of washing or flushing the vagina with water or a mixture of fluids.

VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) is the complete removal of the foreskin of a penis by surgical means.
Thuthukile Mbatha, guest editor on this special youth edition of Spotlight.
We are failing young women in South Africa

Thuthukile Mbatha, Guest Editor, Spotlight

Every week in South Africa, around two thousand young women and girls between the ages of 15 and 24 become HIV positive. More than one in ten women and girls in this age group are living with HIV.

On the back of these shocking statistics, many targeted programmes have been launched in South Africa. Whether these programmes are what is needed, and whether the state is fulfilling its duties to young women and girls, are key questions we discuss in this youth-focused and youth-edited issue of Spotlight.

On paper, the rights of women and girls in South Africa – or that subset of rights we call sexual and reproductive health and rights (SRHR) – are relatively well protected. The Constitution enshrines the right to bodily integrity, the right to access healthcare services, the right to education, the right to dignity, and the right not to be discriminated against. Specific laws such as the Sexual Offences Act and the Choice on Termination of Pregnancy Act provide specific protections and affirm specific rights. Policies such as the Department of Basic Education National Policy on HIV, STIs and TB, and strategies such as the National Strategic Plan on HIV, TB and STIs 2017-2022 further guide the implementation of state programmes aimed at the realisation of these rights.

And yet, despite this generally enabling legal framework, the reality in South Africa is that most young women – and young men, for that matter – grow up poor, and with limited education. Only around 40% of young people matriculate by age 20. Around two thirds of youth 25 and younger are unemployed (under the expanded definition that includes people who have stopped looking for work).

Most girls grow up in highly patriarchal communities, often communities with high rates of gender-based violence. The criminal justice system is often unresponsive and downright dysfunctional when it comes to prosecuting gender-based violence.

Doctors without Borders (MSF) estimates that one in four women in the Rustenburg area has been raped at least once in their lives, and that the vast majority of them did not tell a healthcare worker about the rape. Reliable national figures are hard to find, but it seems many rapes are not reported; and even when they are, dockets often go missing, or police bungle the investigation.

The 2014 Khayelitsha Commission of Inquiry, led by Advocate Vusi Pikoli and Judge Kate O’Regan, grew out of frustration with exactly this kind of dysfunction. Despite the excellent

It is within this dire socio-economic context that we should consider that many women and girls struggle to access the tools that may protect them against unwanted pregnancy and HIV infection.
work of the commission and its impressive report, four years later the criminal justice system remains severely dysfunctional in areas where mainly poor people live.

It is within this dire socio-economic context that we should consider that many women and girls struggle to access the tools that may protect them against unwanted pregnancy and HIV infection. Making condoms and other contraceptives easily available to learners remains taboo in many schools.

Youth-friendly healthcare services remain the exception to the rule. While we know that young women at high risk of becoming HIV positive can benefit from oral pre-exposure prophylaxis (PrEP), the rollout of PrEP to young women has been stalled by a lack of political will, and an overly cautious public-health approach that pays scant regard to the rights of young women.

It is not surprising that in such socio-economic conditions, and with such limited access to available prevention methods, as many as six per cent of girls aged 15 to 19 fall pregnant every year – according to one report, that amounted to around 15 000 pregnancies among girls in school in 2015. The two thousand new HIV infections in girls aged 15 to 24 every week are also not all that surprising, given the context sketched above.

Though the personal cost to young women is clearly very high, there is surely also a high societal cost. While most women living with HIV can live perfectly normal lives thanks to antiretroviral therapy, the infection does still require lifelong treatment and care – which come at significant cost, either to the state or to individuals. The minority of women who develop serious secondary infections such as tuberculosis or crypto will face additional costs. Possibly even more disruptive to a young woman’s prospects is an unwanted pregnancy – something that could mean an end to one’s formal education, or which could make it harder to hold down a job.

Together, unwanted pregnancies and HIV infection constitute a kind of poverty trap: poor people are more likely to experience unwanted pregnancies and to contract HIV, and this then makes them and their children more likely to be poor in future. The struggle for SRHR is not a struggle for some abstract ideal, but a struggle to help women break out of this cycle of poverty and disease.

Faced with such a complex set of socio-economic factors, one should be sceptical of supposed quick fixes for the dual problems of HIV and unwanted pregnancy. For example, while anti-sugar daddy campaigns might provide convenient scapegoats, there are real questions as to whether such campaigns will make any difference without addressing the underlying social and economic realities.

Fortunately, however, we do have programmes that are approaching these complex issues with seriousness, and a more sophisticated understanding of the complexities involved. Perhaps foremost among youth-focused interventions is the innovative work done by the Desmond Tutu Foundation in and around Cape Town – see our article on page 35 about their youth-friendly clinics, the Tutu truck, and their trial of conditional cash transfers.

Confirming what works in programmes such as that of the Desmond Tutu Foundation and then scaling that up, as well as addressing the ongoing crisis of South Africa’s dysfunctional education system, must be a national priority in the coming years. In his response to replies to the State of the Nation Address in February, new South African President Cyril Ramaphosa said that “we must confront the social and economic factors that prevent young women from completing school, entering higher education and graduating”, and that “we must all work together to tackle the chauvinism experienced by women in the workplace and other social settings”.

The president identified the She Conquers campaign as government’s key programme in this regard (see our article on DREAMS and She Conquers on page 22). While such big programmes are welcome, as are the donor dollars that often fund them, there are questions to be asked as to whether these programmes really meet the needs of young women.

But along with these longer-term and overarching solutions, there are things that can be done right now – such as ensuring that condoms are freely available at all schools, and dramatically expanding access to PrEP. Whether these interventions will be implemented is mainly a question of political will. And whether the political will is there to
Follow through on President Ramaphosa’s welcome words on the role of women in our society remains an open question. Ultimately, we can measure the state and President Ramaphosa’s response to the dual crises of HIV and unwanted pregnancy by the answers to a few simple questions:

1. Do all young women and girls in South Africa have easy access to comprehensive sex education?
2. Do all young women and girls in South Africa have easy access to condoms and other forms of contraception?
3. Do all young women and girls in South Africa have easy access to professional termination of pregnancy services?
4. Do all young women and girls in South Africa at significant risk of contracting HIV have easy access to pre-exposure prophylaxis (PrEP)?
5. Do all young women and girls in South Africa have access to high-quality secondary and tertiary education?
6. Do all young women and girls in South Africa have safe and easy access to appropriate police and medical services in cases of rape or other forms of sexual violence?

At present, the state is failing abysmally at most of these measures. Look at the lives of young women in Khayelitsha, in Rustenburg, in Lusikisiki, in Ermelo. It is there in our dilapidated schools and in our dangerous and poorly-lit streets, for all to see.

While this remains the case, all the positive rhetoric and advertising campaigns about empowering young women will ring hollow. The large-scale infringement of the sexual and reproductive rights of young women and girls in South Africa will continue; and the poverty trap fuelled by HIV and unwanted pregnancy will ride roughshod over our futures.

Thuthukile Mbatha has been a researcher at SECTION27 since 8 January 2014.
What young people think about sexual and reproductive health

Thuthukile Mbatha, Spotlight

The streets of Winterveld, Mabopane are buzzing with traffic, as people heading home after work try to make up for lost time after a massive thunderstorm. In a nearby building there’s another buzz, as The Victorious Girls and Empire Rise Women’s clubs are about to have their weekly meeting. These are groups of young women who meet every week to discuss social matters that affect young women in the community. Among the topics discussed are issues of access to sexual and reproductive health services in the public health sector.

This programme falls under one of the Soul City projects. The majority of these club members are unemployed. The Spotlight team had short interviews with some of the girls, to test their knowledge on some of the sexual and reproductive health issues. It is important to note that the responses were purely individual perspectives on the various matters.

What are Sexually Transmitted Diseases (STIs)?

Ruth Mthombeni (25) “Sexually Transmitted Diseases are contracted through sexual intercourse. Their symptoms include a burning feeling in the vagina, fishy smell, yellowish discharge, and an itchy rash on the vagina. They are caused by sleeping with multiple partners without protection. Also, if your boyfriend has an STI you can be infected as well, when engaging in condom-less sex.”

Millicent Kubheka (25) “STIs are diseases that you get through unprotected sex. They can lead to infections of the bladder or cervix. But they are treatable. One has to visit a doctor or a clinic to get them treated.”

Note: Some sexually transmitted diseases do have visible symptoms such as the ones described above. Others are asymptomatic, meaning they do not show any symptoms. That is why it is important to screen for STIs frequently, so that they are treated early – before they pose a health risk. Please turn to page 22 for more information about STIs.

What is abortion?

Charlotte Sibeko (21) “Abortion means stopping a pregnancy from going further. Anyone who wants to get an abortion can do so at a public clinic, because it is safe and legal to do it there before 21 weeks. However, I personally disagree with the act of abortion, because it means killing an innocent child based on what happened to the mother. I usually advise people to keep the pregnancy, and give the child away for adoption when it is born, to people who cannot have children of their own.”
Lebohang Malungani (20)

“Abortion is the termination of pregnancy. It is done by teenagers over the age of 18 and adult women who do not want to have a child at that moment. It is safe and legal to do at the clinic, not at the backstreet abortion facilities. People who usually get an abortion are those who do not know what to do with the pregnancy – because they might not know the father of the child, or want to go back to school, and their families would not be able to help them support the child.”

Note: A young girl can get an abortion without parental consent from the age of 12 years. Abortion is allowed within the first 12 weeks of pregnancy. Any abortion performed after 12 weeks can only be done in special cases, such as pregnancy due to rape, or when the pregnancy poses a risk to the health of the pregnant woman. Please see page 52 for more information on abortion.

Name the HIV-prevention tools we have in South Africa.

Petronela Mathebula (20)

“There are four HIV-prevention tools that I know. There is a pill that I just learnt about from the Rise Women’s Club called PrEP. It is taken daily by HIV-negative people to prevent HIV. Abstinence, be faithful to your partner, and condomise are the other three.”

Masabatha Konope (25)

“I am a UNISA student studying toward a degree in teaching. I am also a Zakheni project field worker. My job entails recruiting girls out of school between the ages of 19 to 24 years to form clubs, where we discuss social issues such as issues that affect our communities. I know of four HIV-prevention tools: condoms; PrEP, which is taken before intercourse with an HIV-positive person; and PEP, which is given to rape victims after they have been exposed to the virus – it is taken within 72 hours, which is three days. Abstinence is the last tool.”

Sipho Komane (24)

“HIV-prevention tools can be accessed from clinics, for those who cannot afford to pay for them from the private sector. There are female and male condoms. These condoms come in different flavours, and can be bought from pharmacies like Dis-Chem and Clicks. The government recently launched flavoured condoms in the public sector, so they can now be accessed through clinics, hospitals, schools, and pharmacies. Basically they can be found everywhere, including the toilets in the nightclubs.

“The male condoms are more accessible, compared to female condoms. There is a bit of controversy with female condoms’ availability on public platforms, I hope the government is working on addressing that. Also, abstinence is an HIV-prevention tool, although it is subjective whether people will follow it, and not really feasible.

“The most important tool is sexual education, which should be given to children in schools, in how to conduct themselves and protect themselves from contracting HIV during intercourse. Sexual education is key to HIV prevention.”

Note: There are five physical tools to prevent HIV in South Africa. These are male and female condoms; Treatment as Prevention (refers to people in sero-discordant relationships, with the HIV-positive partner being virally suppressed and having minimal chances of transmitting the virus); Pre-Exposure Prophylaxis, or PrEP (taken before exposure to the virus); Post-Exposure Prophylaxis, or PEP (taken after exposure to the virus); and Voluntary Medical Male Circumcision (which offers men about a 60 per cent chance of protection against the virus).”
Luckyboy Mkhondwana, National Training Co-ordinator at the Treatment Action Campaign.
The needs of queer folk in SA

Thuthukile Mbatha, Spotlight

June 2017 saw the launch of South Africa’s first Lesbian Gay Bisexual Transgender Queer Intersex Asexual Plus (LGBTQIA+) HIV Plan 2017-2022. The plan, which was launched under the banner of the South African National AIDS Council, seeks to address some of the many issues affecting the various communities that are part of the LGBTQIA+ community, with all their varied and unique needs. However, nine months have passed, and still there has been no meaningful attempt to implement the plan.

Luckyboy Mkhondwana is the National Training Co-ordinator at the Treatment Action Campaign, and a long-time campaigner and advocate for the rights of the LGBTQIA+ community. He took Spotlight through the gaps that exist in the policy and its implementation.

Do you think that the Sexual and Reproductive Health Rights (SRHR) needs of queer folk are addressed in the public health sector?

No, there are a lot of gaps that need to be addressed. For instance, if a lesbian woman misses her period and goes to a public clinic to find out about the possible cause of the delay, she will be asked about the last time she had sex, and a pregnancy test would be done on her. This is unfair, and disrespectful to her sexual orientation.

Moreover, the judgement received by gay men when they go to public health clinics for screening and treatment of sexually transmitted diseases (STIs) discourages them from going back to the clinic when sick. For instance, if a gay man has warts on the anus, it is not easy to seek medical help, because some healthcare providers will judge him – especially since they are used to seeing warts on the genitals, not on the anus. This has led to many gay men living with untreated STIs. The only clinics that are sensitised to offer non-judgmental health services are the facilities that work with organisations such as the Anova Health Institute; which are not accessible to all gay men, due to where they are located.

Would you say the LGBTQIA+ HIV Plan 2017-2022 addresses the needs of queer folk?

I think the plan is a good document, full of promise – but there is no implementation. It has been nine months, but we have not seen anything on the ground. I am curious to know what they will report on, when it is time for review.

What should be the specific SRHR priorities for queer folk?

The LGBTQIA+ HIV Plan seeks to offer a core package of health services, and it includes confidentiality. However, that is not practised on the ground. If a trans woman visits a clinic, the healthcare providers usually call their peers to stare at the trans woman. They look at her as if she is in a circus, because she is wearing female clothes. There is a good chance that the nurse assisting the trans woman would disclose to his or her colleagues the reason for her visit.

The plan further suggests that the LGBTQIA+ community should have access to HIV-prevention tools; whereas in reality, only a few have access to tools such as Pre-Exposure Prophylaxis (PrEP). If one lives far from the Anova Health Institute centres, one cannot access such services.

There are no lubricants for the trans women and men who have sex with men (MSM) communities. These should be freely available in public health facilities, just as male condoms are easily accessible. A 500ml bottle of lubricant costs R85 or more in a pharmacy, and not all can afford to buy it.

One of the goals of the plan is to reduce HIV prevalence and incidence rates. It continues to highlight the importance of increased access to HIV prevention tools. However, it is very difficult to gain access to dental dams, finger cots and PrEP in the public sector, to protect against new HIV infections.

A dental dam, like a condom, is a barrier method. It is a thin, square piece of rubber which is placed over the labia or anus during oral-vaginal or oral-anal intercourse. Dental dams are most often made of thin latex rubber;
however, for those allergic to latex, they are also available in silicone. A finger cot is a ‘glove’ that covers only one finger. It is basically a ‘finger condom’. Finger cots are often recommended as a safer sex device for fingering.

Access to Human Papilloma Virus and cervical cancer screening is difficult for some lesbian women and trans men who have not gone for gender reassignment. When they go for a Pap smear test, they are asked why they require such services, because they are men. Healthcare providers judge them based on how they look. You may find that some had previously engaged in sexual intercourse with heterosexual men, meaning they too are at risk of contracting the two diseases.

In general, all service providers must be sensitised and taught how to address queer folk. The assumption that we are all either women or men is offensive. Gender non-binary groups are usually the victims of that offense.

An investment in mental health is key to the provision of SRHR, because the two are linked. There is a great demand for psychosocial support among queer folk, since they endure much discrimination at home, in their workplaces, and in their societies in general. A number of them engage in reckless behaviour, including substance abuse and casual sex, to numb the pain. This kind of behaviour poses a threat to their health, since it exposes them to the risk of HIV infection.

Lastly, the plan stresses the importance of recruiting LGBTQIA+ communities through peer educators. However, no recruitment has happened on the ground. Even when it comes to HIV testing, only the non-profit organisations visit LGBTQIA+ spaces to offer the services to them.

Can we say that all queer folk would have similar SRHR needs?

No, (the solutions to) our needs need to be tailor-made to suit each individual. Not every woman wants contraception; queer women need dental dams or finger cots, whereas a trans woman may need a lubricant. Also, the SRHR needs of one trans woman could differ from those of another trans woman, just as heterosexual women may have different preferred contraceptives.

What are the biggest challenges for queer folk trying to access health care in clinics and hospitals?

Stigma and discrimination prevent a lot of people from accessing healthcare services. This is the major barrier for queer folk.

What would you change tomorrow if you had the power, in terms of SRHR for queer folk?

I would ensure that the individual SRHR needs of queer folk are prioritised – I wouldn’t assume that a one-size-fits-all approach will work. I would ensure that healthcare providers are properly sensitised, and that I would be able to go to a clinic and get everything that I need, without fear of being judged.

What is TAC doing to address the SRHR needs of queer folk?

We have an LGBTQIA+ sector in seven provinces. We have been struggling to get funding for LGBTQIA+ advocacy work; however, we have incorporated LGBTQIA+ work in most of our work and campaigns, including treatment literacy programmes. Funders prefer funding service-provider organisations, because they can quantify how many queer folk they have reached, recruited and assisted; whereas advocacy is hard to quantify.

A dental dam, like a condom, is a barrier method. It is a thin, square piece of rubber which is placed over the labia or anus during oral-vaginal or oral-anal intercourse.
Improving SRHR access for queers in South Africa

Melusi Dlamini shares his take on the state of play when it comes to the Sexual and Reproductive Health Rights (SRHR) of the LGBTQIA+ community.

The overlaps between our progressive constitution and SRHR policies should enable a more effective realisation of SRHR rights for LGBTQIA+ persons; however, we are far from achieving this. There remain glaring gaps between policy and the lived realities of homosexual, bisexual and gender-nonconforming persons. While more than half (51%) of South Africans agree that human rights and inherent protections should be for all, seven out of 10 (72%) still believe that same-sex relations are ‘wrong’.

This is according to a survey by The Other Foundation titled Progressve Prudes – A survey of attitudes towards homosexuality & gender nonconformity in South Africa. South Africa remains a divided society on many fronts, and these divisions are reflected in the treatment and quality of services most queer persons receive. I use the word ‘queer’ here as an inclusive term, to signify the sexual orientations and gender identities that are normally encompassed by LGBTQIA+.

Instances of queer folk being victimised in public institutions are a dime a dozen. The trauma and humiliation suffered by queer persons demonstrates that accessing services is not a given. As a result, most of the queer persons I have encountered through my work usually have to think of all these possibilities before even approaching any public institution. This can have very serious repercussions if it relates to one’s health.

The National Strategic Plan and Accessing SRHR

Sexual and reproductive health rights (SRHR) are about the intersecting issues and concerns that affect the lives of all individuals. Most importantly, these rights – like any others – are legally recognised and protected.

Many queer persons depend on the public healthcare system; even so, access is not automatic. Factors such as gender and income inequality, unemployment, and living in a rural or urban setting have a profound effect on how or whether queer persons are able to access SRHR.

In addition, many queer persons struggle with issues such as mental wellness, owing to the internal and external pressures they experience. For queer persons, SRHR means having service providers who are not only ‘sensitised’, but also able to competently provide access to comprehensive services.

As a result, the role of public institutions is important, and the implementation of the National LGBTQIA+ HIV Plan is central.

The LGBTQIA+ plan is a great example of how South Africa is showing the intention to realise SRHR for queer persons. While the plan acknowledges the importance of reducing HIV infections among ‘key populations’, it is also important to expand psychosocial support and empowerment. The experiences of queer persons are not limited to sexual and reproductive concerns, and the range of services that offer inclusive and comprehensive information should reflect this.

Melusi Dlamini is the Sexual and Reproductive Health Rights Training Officer at the AIDS Foundation of South Africa. His interests include improving access to sexual and reproductive health rights for young people, as well as issues of social justice. Melusi has also worked with queer youth in Durban on creating safe spaces and access to healthcare. He is also a PhD candidate at the University of KwaZulu-Natal, with a specific interest in young masculinities in South Africa.

... the role of public institutions is important, and the implementation of the National LGBTQIA+ HIV Plan is central.
Menstrual and reproductive myths still persist

Lerato Makate, Spotlight

Sexual and reproductive health education being taught in South African schools has left some female learners and young women feeling less confident about the right time to engage in sexual activity, about what to do when their menstrual cycle comes, and even about understanding how contraceptives should be used.

This is according to nursing sister Anna Moloi, the acting head of Department of the Campus Health Clinic Services at the University of the Witwatersrand.

Moloi says the clinic has had several encounters and consultations with female students – mostly in their first year of tertiary education – who were experiencing their menstrual cycle for the first time, and did not understand what was happening or what they needed to do.

She says that as a result, the clinic has seen the need to conduct thorough consultations, including one-on-one sessions, explaining to these young women the process their bodies are undergoing.

“A lot of them, especially the young ones [students], will come with menstrual pains. What we normally do is to advise them on what menstruation is; because in high school, they do not get a lot of [reproductive health] education,” Moloi says.

Menstruation, or having periods, is normal vaginal bleeding that occurs as part of a woman’s monthly cycle. Every month, the female body prepares for pregnancy. If no pregnancy occurs, the uterus, or womb, sheds its lining. The menstrual blood is partly blood and partly tissue from inside the uterus. It passes out of the body through the vagina.

Periods usually start between the ages of 11 and 14, and continue until menopause at about age 51. They usually last from three to five days. Besides bleeding from the vagina, there may be:

- Abdominal or pelvic cramping pain
- Lower back pain
- Bloating and sore breasts
- Food cravings
- Mood swings and irritability
- Headache and fatigue

Explaining the persistent myths concerning women’s menstrual cycles, Moloi says there are still many young women who need accurate information on and a thorough explanation of sexual activity and how it can affect the menstrual cycle. Despite the sexual and reproductive health education taught in South Africa’s schools, many young women continue to believe these myths about menstruation.

Here are seven menstruation and sexual reproductive health myths:

1. **YOU WILL NOT GET PREGNANT IF YOU ‘DOUCHE’ AFTER SEX.** Many people wonder if douching with either regular douching fluid or bubbly cool drink (such as Coca-Cola) can get all the sperm out after sex, effectively preventing pregnancy.

   The truth is that it won’t. Biologically, women’s vaginal muscles contract during orgasm as the body’s way of bringing the semen toward her eggs; so even if you douche immediately after sex, some of the sperm will already be too deep to be flushed out. Plus, douching with soda or other liquids not meant for that purpose can cause irritation and infection, which is also not a good thing.

2. **IF YOU DO NOT HAVE A CONDOM, YOU CAN USE A BALLOON.** No plastic baggie/rubber band or balloon/twist-tie combination will provide the protection of a traditional, approved condom. And it may not even stay on. The ones you’ll find on shop shelves are electronically tested to meet strict standards of strength, reliability, and resistance to tearing. Frankly, it costs about the same amount of money to buy the real thing, which offers far more reliable protection. Also, many clinics will give you free condoms.

3. **YOU WILL NOT FALL PREGNANT IF YOU HAVE SEX WHILE STANDING UP, or if the woman is on top during sexual activity.** If you have vaginal intercourse, it doesn’t matter if you’re up, down, sideways or even under water; the woman can still get pregnant. The one ‘position’ that won’t cause pregnancy is oral sex, because
no semen enters the woman's vagina – though oral sex does have its own set of health risks, including STD transmission.

4. **YOU WILL NOT FALL PREGNANT IF YOU HAVE SEX DURING 'SAFE TIMES',** i.e. various periods during the menstrual cycle and ovulation cycle. While the average female's monthly cycle may be 29 days, others may have a cycle that varies from 20 to 40 days, or even longer.

A woman's likelihood of falling pregnant rises and falls throughout her ovulation cycle; the likelihood that a woman will fall pregnant one to two days after she starts bleeding is nearly zero. But the likelihood increases with each successive day, even though she's still bleeding. At roughly day 13 after starting her period, her chance of pregnancy is an estimated 9 per cent.

While these numbers may be low, it means a woman can never be 100 per cent assured that she won't fall pregnant during her period.

5. **YOU WILL NOT FALL PREGNANT THE FIRST TIME YOU HAVE SEX.** It is thought by many people that sex for the first time will not get a woman pregnant. This is far from the truth; having sex without the use of contraception can get a woman pregnant, irrespective of whether she is having sex for the first time or has had it plenty of times before.

Pregnancy depends on fertility, which can be a very irregular thing. It might take months or even years of desperate trying for some women to conceive, while others might conceive whenever they have sex, even if it is their first time and they have no desire to be pregnant.

Pregnancy is a possibility every time a woman and a man engage in intercourse. The only requirement is that a sperm must reach an egg.

6. **BECAUSE YOU HAVE STARTED USING THE PILL, YOU WILL NOT FALL PREGNANT.** This is a myth; it is incorrect information. The pill is 99 per cent effective in preventing pregnancy. Even so, every year between two and eight per cent of women who use it become pregnant.

7. **IF YOU URINATE AFTER SEX, YOU WILL NOT FALL PREGNANT.** This is a myth, and a misconception about or misunderstanding of female anatomy, by both men and women. For people with vaginas, the tube you urinate through (the urethra) is not the same tube a penis ejaculates into during sex (the vagina). Many people don’t realize these are two separate holes, because the urethra is often very tiny, and right next to the vaginal opening. Urinating after sex won't rinse sperm out of the vagina, because you don't urinate out of your vagina.

Lesedi Mashinini, a first-year film and television student, shared her experience. "In primary school, they taught us about menstruation, sex, and all that. But in high school, I don't remember them teaching us. I don't remember a lot of details from when I learned about having my periods," Mashinini says.

“I know how to take care of myself during my period because of help from my sister and my mom, about what I had to do the first time I had it. So now, I'm more confident about what I need to do.”

Marona Seekane, a postgraduate student, says that menstruation as a topic was only covered properly and thoroughly in Life Sciences from about Grade 10 in high school; and it was only then that she started feeling as though she knew what was happening in her body.

“I don't think that sex education was done properly, because almost all the knowledge that I have, I read up on by myself. The basics were covered in Life Orientation, where we were told that sex without protection would lead to STIs, pregnancy and HIV," Seekane says.

“Things like HPV I only learned about when I got to varsity. I only started feeling confident about sexual health after I had done some research of my own.”

Periods usually start between the ages of 11 and 14, and continue until menopause at about age 51.
Activists demand free sanitary pads for school girls at the 2016 AIDS conference in Durban during Minister of Health Aaron Motsoaledi’s speech.
A moment of true liberation came for Thembi Mahlathi when she was standing at a supermarket check-out queue. In her shopping basket, for the first time, were sanitary pads that she could afford.

“I was so happy that I could finally afford sanitary pads – I think I bought four packs,” says the 28-year-old paralegal, remembering the day she was finally earning enough to pay for her own pads. It was a moment of empowerment, says Mahlathi – the direct opposite to how she felt as a nine-year-old girl, when her cycle started. She remembers her confusion, and not knowing what was happening to her body. She didn’t tell her mother though; she couldn’t.

“I always heard my mother and her friends saying things like, ‘If a girl starts menstruating young, then she’s messing around with boys’; so I was too scared to tell my mom,” she says.

She sneaked the odd sanitary pad from her mother; but because pads were a luxury in the home, she knew her mom would notice eventually. Mahlathi resorted to cutting up a few old T-shirts, folding them into the shape of pads, and jamming them into her panties.

“I had one for the morning and one for the afternoon, and I carried a plastic bag with me so I could take the dirty one home to wash,” she says.

When Mahlathi was 13, her mother found out by chance that she was menstruating. Even then, Mahlathi never told her mom she had been menstruating for years already. Her mother gave her some pads, but there were never enough; and when her mom lost her job and they only had her father’s wages, pads became a luxury item again.

“We both had to use T-shirt pads then, or sometimes we used a stack of tissues. I don’t think my dad understood that pads were something we needed, and that sometimes I needed more than one pack a month, because I have a heavy flow.”

The T-shirt pads were a nightmare. She couldn’t concentrate in class, worrying about an accident that could soil her yellow uniform, and the humiliation and mocking that was in store for girls who did have accidents. The thought of perhaps being called up to write something on the blackboard while she was having her period was pure terror.

“I really wanted to play netball, but I couldn’t; because that pad would move around, and the players wore mini-skirts,” says Mahlathi, who went to a school in Tembisa, east of Johannesburg.

Fear of embarrassment, lack of information, having no one to turn to for answers about her changing body, and the grinding realisation that there was no money for basics in her home marked much of her growing-up years.

“Poverty – I don’t want to go back there,” she says.

Mahlathi says she’s now able to speak openly about menstruation and poverty because as a mom to two daughters, aged 11 and six, she wants better for them.

“I don’t want any girl to go through what I went through. And I want my 11-year-old to be prepared, and to know that what is happening to her body is normal,” she says.

Mahlathi believes schools need better education programmes to teach girls and boys about menstruation, and that myths and superstition must be dispelled. She says schools should also be making pads available to girls, so that girls don’t have to resort to making ineffective alternatives like her T-shirt pads, or feel embarrassed about not being able to afford pads.

Nowadays, Mahlathi never forgets to pack a pad in her daughter’s schoolbag. She also never forgets that liberation, for a poor girl-child, can cost as little as R20 or R30 a month.
Statistics about menstruation and girls’ missed school days in South Africa have been guesstimates at best, and range wildly – between two and seven million girls affected.

Numbers can be a distraction, though; whatever the numbers, in the end they still speak to the massive challenge of ending period poverty, bringing dignity to more schoolgirls who are on their cycle, and shattering the stigma of and myths about menstruation.

For Sharon Gordon, CEO of Dignity Dreams, what struck her most in working with girls and schools in need has been a small reality that has little to do with startling numbers, but has been just as revealing.

Dignity Dreams is an NGO, started in 2013 with a mission to distribute free sanitary products to schoolgirls in need. Together with their various donors they distribute reusable cloth pads to schoolgirls who cannot afford them. In five years, the organisation has been able to distribute 67 000 packs of these reusable pads, to girls in South Africa and even to the Democratic Republic of Congo.

“Plumbers were being called out less to schools to unblock toilets, because girls were no longer throwing disposable pads and homemade sanitary towels into them,” says Gordon.

Items that used to be flushed down toilets included everything.

VAT ON MENSTRUATION
The one-percentage-point VAT increase announced in February has been bad news for many, especially those campaigning for zero VAT on sanitary products.

In November last year, national treasury announced that tax exemption on sanitary towels would be put on hold – despite lobbying by activists and some members of Parliament for over a year. Instead, treasury urged individual departments to reallocate budgets in order to find funds to support subsidies or free pad-distribution initiatives.

The pressure from activists – and even from some in Parliament – was a direct response to growing evidence that girls who cannot afford sanitary pads and are then forced to use makeshift pads are compromised, in their learning and school and sports activities. They are not able to concentrate as well, and some even miss school days entirely as a result.

The number of girls in South Africa affected may not be the routinely quoted seven million, but could still be as high as around 2.6 million girls, according to fact-checking organisation Africa Check. They also found that absenteeism as a result of not having sanitary products was also not as high as the figures used for attention-grabbing headlines.

In the same fact-checking exercise Africa Check published in August 2016, they highlighted former President Jacob Zuma’s promise in 2011 that government would provide sanitary pads to indigent girls and women.

In February last year, through its social enrichment programme, the KwaZulu-Natal (KZN) Department of Education became the first province to roll out a free sanitary pad programme, to around 2 950 quintile 1 to 4 schools. One year on, information and updates on the success and sustainability of this programme – launched with a R50 million budget – are still to be disclosed by the KZN Department of Education. Spotlight has tried several times to access updates on the programme, but has not received an informative response.
from disposable sanitary towels to pads made of newspaper, rags, and socks filled with sand. With the reusable pads, the girls were taking soiled pads home to be washed, dried and reused.

For Gordon, it bought home sharply the impact of positive intervention.

Dignity Dreams has also teamed up with a women’s upliftment collective employed to make the cloth pads for them. The packs contain six pads that can last four years, and they are distributed to Grade 8 pupils. The packs cost R200 each, and donors can also add panties to the packs that are distributed.

“We have focused on cloth pads because they have proved to be the product most acceptable to the girls, and the most sustainable. We also only have to visit a school once a year to distribute to every new Grade 8 class, rather than making monthly deliveries,” Gordon says.

Importantly, she adds, each delivery is an opportunity for outreach and education. The sessions are used to dispel myths and superstitions about periods – nonsense such as that washing your hair when you’re menstruating is unhealthy, or that periods are a sign of contamination.

Gordon is also pushing for men and boys to be informed about menstruation, so that period-shaming can stop; and so that society can let go of its discomfort about talking about periods, and be part of the solution to period poverty.

“We still hear things on distribution days, from teachers and principals,” she says, “saying things like ‘it’s wonderful that you have these pads, girls – now, hide them away.’

“Periods are a bodily function, like blowing your nose, or having a wee – that’s the message we must get across.”

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**THE MENSTRUAL CUP**

“I never thought it would happen to me,” Nonhlanhla Phume (25) told Spotlight. A few years ago, while menstruating, she noticed blood had leaked through and stained her pants while she was studying in a computer laboratory at Wits University.

“I was so embarrassed. I had to literally walk out with the chair I was sitting on, and take it to the bathroom and clean it. I was so self-conscious whenever I was menstruating after that,” she said.

But the worry around her menstrual period vanished after she started using a menstrual cup last year, given to her by the Maternal Adolescent and Child Health Research Unit as part of a DREAMS research project.

A menstrual cup is a small silicone cup-shaped device inserted into the vagina, which traps menstrual blood. According to lead researcher Mags Beksinska the cup, which lasts five years, saves young women a significant amount of money. This is particularly relevant for poor school-going girls who have been reported to stay at home when menstruating, due to the unaffordability of sanitary products.

Beksinska said they are distributing 6 000 free cups to young women, primarily in all the institutions of higher education in three KwaZulu-Natal districts. Five hundred will be followed up for the study to find out what their sanitary challenges are, and what their experiences have been using the cup.

School-going girls are not being targeted in this project because the provincial government provides sanitary assistance in schools; also, there were cultural concerns about virginity testing in relation to the use of the cup.

Phume, who is a project assistant for the menstrual cup study, said the product has not only saved her money, but also a lot of anxiety.

“Even though I had never even used a tampon before, I hardly notice the cup when it’s in. It never leaks, and I’m not stressed about that happening to me ever again.”
The dangers of vaginal douching

Dr Sindi van Zyl, General Practitioner

Ever heard of using plain yoghurt, or a mixture of Stoney and Lemon Twist, or cinnamon and milk? Well, these are some of the ‘remedies’ that have been recommended to help women douche and get their vaginas to be ‘tight and clean’.

Some people might be shocked by this; but these are just some of the extremes that people go to. Let’s start off by understanding what douching is.

According to WomensHealth.gov, the word ‘douche’ means to wash or soak. Douching is washing or cleaning out the inside of the vagina with water or other fluids. Most women make their own douching concoctions using water, vinegar, baking soda, yoghurt, cinnamon or iodine.

This last is commonly used by gynaecologists after major surgery.

**Douching can lead to infection**
The vagina is a self-cleaning organ – it doesn’t need anything to be done to assist it in the cleaning process. When you start douching, you strip the vagina of the bacteria that help it to clean. This leads to infections, the most common being bacterial vaginosis. The symptoms of bacterial vaginosis are a watery/milky vaginal discharge with a very fishy smell. It smells like tinned pilchards; it’s unmistakeable.

The other infections associated with this practice include vaginal thrush and pelvic inflammatory disease. Women who douche regularly may also have difficulty falling pregnant.

**Infections linked to douching**

**Vaginal Thrush**

Vaginal thrush is a common infection caused by an overgrowth of Candida albicans yeast. The yeast lives naturally in the bowel, and in small numbers in the vagina. It is mostly harmless, but symptoms can develop if yeast numbers increase. About 75% of women will have vaginal thrush in their lifetime.

**Pelvic Inflammatory Disease**
Pelvic inflammatory disease (PID) is an infection of the female reproductive organs. It usually occurs when sexually transmitted bacteria spread from your vagina to your uterus, fallopian tubes or ovaries. The pelvic inflammatory disease often causes no signs or symptoms. As a result, you might not realise you have the condition, and will not get the treatment needed. The condition might only be detected later if you have trouble getting pregnant, or if you develop chronic pelvic pain.

There are a lot of myths regarding vaginal ‘freshness’, and they are passed down from the elders to us. But oh my word, they are not true. Stay away from douching and ‘intimate washes’ – your vagina does not need them. Water will do the trick: yes, the one we get from the tap.

**STIs**

Moving on, to another important topic: Sexually Transmitted Infections (STIs). (These were previously called Sexually Transmitted Diseases.) There are different categories of STIs. The trick with STIs is that they must be detected early, and treated accordingly; you need to know what those categories are, so that you can seek treatment timeously. Failure to do so increases the risk of HIV infection. This is why we treat them aggressively. STIs are passed from one person to another through unprotected sex or genital contact.
Common STIs that affect women in South Africa:

**Human papillomavirus**

Human papillomavirus (HPV) is a viral infection that is passed between people through skin-to-skin contact. There are more than 100 varieties of HPV, 40 of which are passed through sexual contact and can affect your genitals, mouth, or throat.

**Genital herpes**

Genital herpes is a common infection caused by the herpes simplex virus (HSV), which is the same virus that causes cold sores. There are two types of HSV: type 1 and 2. Type 1 causes cold sores on the lip. Type 2 causes genital lesions. Some people develop symptoms of HSV a few days after coming into contact with the virus. Small, painful blisters or sores usually develop, which may cause itching or tingling, or make it painful to urinate.

**Gonorrhoea**

Gonorrhoea is a bacterial STI easily passed on during sex. About half of women and one in 10 men don’t experience any symptoms, and are unaware that they’re infected. In women, gonorrhoea can cause pain or a burning sensation when urinating, vaginal discharge, pain in the lower abdomen during or after sex, and bleeding during or after sex or between periods. It can also cause heavy periods.

These are just a few of the STIs that exist. The World Health Organisation (WHO) estimates that more than one million people get an STI every day. The danger is that most people with sexually transmitted infections do not have any symptoms, and are therefore often unaware of their ability to pass infections on to their sexual partners.

Regular check-ups enable you to know what you have and how best to treat it. There are many risks posed by STIs. If left untreated, they can cause serious health problems including cervical cancer, liver disease, pelvic inflammatory disease (PID), infertility, and pregnancy problems.

The Well Project (thewellproject.org) says having some STIs (such as chancroid, herpes, syphilis, and trichomoniasis) can increase the risk of getting HIV if you are HIV-negative and are exposed to HIV. People living with HIV may also be at greater risk of getting or passing on other STIs.

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**Chlamydia**

Chlamydia is passed on during sex. Most people don’t experience any symptoms, so they are unaware they’re infected. In women, chlamydia can cause pain or a burning sensation when urinating, vaginal discharge, pain in the lower abdomen during or after sex, and bleeding during or after sex or between periods. It can also cause heavy periods.

• Screening: testing for a disease in someone who doesn’t have symptoms is called screening. Most of the time, STI screening is not a routine part of health care; but there are exceptions:
  • It is advisable for women who are sexually active to test regularly. Once you are sexually active, you must go for PAP smear screening. The PAP smear screens for cervical abnormalities, including inflammation, pre-cancerous changes and cancer, which is often caused by certain strains of human papillomavirus (HPV).
  • All sexually active women should be tested for chlamydia infection. The chlamydia test uses a sample of urine or vaginal fluid you can collect yourself. Some experts recommend repeating the chlamydia test three months after you’ve had a positive test and been treated; the second test is needed to confirm that the infection is cured, as re-infection by an untreated or undertreated partner is common. A bout of chlamydia doesn’t protect you from future exposure; you can catch the infection again and again, so get retested if you have a new partner.

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Going to the clinic can be daunting. Remember that your health comes first! Keep that in mind when you go to seek assistance at any clinic.
An estimated 2 000 new HIV infections occur in young women and girls every week in South Africa. Two high-profile programmes are aiming to address this crisis. In this joint Spotlight/Health-e News Service special investigation, we go beyond the bells and whistles and ask what difference these programmes are really making.

Roughly 40km outside Durban lies the small town of Molweni. This is where a young woman, Nontokozo Zakwe – now 26 – grew up.

“One of the things I noticed growing up was that gender-based violence (GBV) was the norm,” she says. “And the mentality was: if it happens to you, get over it. If it didn’t kill you, you’re going to be okay.”

The first time it happened to Zakwe, she was just 11 years old.

“We had two options on our walk back home from school: the road, or the short cut past the river,” she says. Most days she took the road; but one day, after staying late after school, she decided to use the short cut, because it was getting dark.

“Then this man, he raped me.”

Zakwe survived the attack and made her way home, where she lived with a number of cousins and siblings. Her mother worked in another province, she didn’t know her father at that point, and her grandmother could only afford to come home one weekend a month from her job as a domestic worker on the other side of the country.

“But being from the kind of community I was from, when I got home I decided to sleep. I cried myself to sleep,” she remembers.

A visiting aunt woke Zakwe up that evening, pulled back the covers, noticed blood, and asked the young girl what had happened.

“When I told her, she told me everything was going to be okay. I could tell in her eyes she was sorry for me and wished it hadn’t happened, but that she felt there was nothing she could do except tell me I was going to be okay,” Zakwe says.

“We were forced not to talk about things. Talking that could help us heal. One can imagine, these experiences – experienced by many young girls, around the country – can leave you vulnerable to HIV, teen pregnancy and other problems.”

At the age of 11, not even a teenager yet, Zakwe was expected to overcome the trauma of that violent experience, stay in school, and avoid early pregnancy, without any support – psycho-social, financial or otherwise – in becoming a successful HIV-negative adult.

### 2 000 infections a week

It is against this backdrop of the lived experiences of many young women in South Africa that a staggering 2 000 new HIV infections occur in young women and girls every week. Over 70 per cent of new HIV infections in people aged 12 to 24 in sub-Saharan Africa occur in young women and girls, who overwhelmingly bear the burden of the epidemic, according to research done by Professor Ayesha Kharsany from the Centre for the AIDS Programme of Research in South Africa.

In South Africa, one third of young women and girls experience abuse, 60 per cent of young people do not have a matric qualification, and about 70 000 babies annually are born to girls under the age of 18, according to the South African National Department of Health (DoH).

It is being increasingly acknowledged that the contexts in which young women and girls live, which are often patriarchal and violent in nature, need to be addressed in order to make any meaningful impact on reducing new infections, and ultimately ending AIDS as a public health threat to the world.

Treatment and prevention campaigns alone, located in the health department, cannot by themselves address all the systemic drivers that make young women and girls more vulnerable to HIV than their male counterparts: poverty and gender inequality, as well as biological factors. These affect every facet of a girl’s life: her ability to stay in school, choose when to have children, her economic opportunities and the gendered and sexual violence experienced by women that is endemic in South Africa.

DREAMS is a global partnership aimed at improving the lives of young women and girls in ten African countries – with the ultimate aim of reducing the rate of new HIV infections in this group.
It is in this context that a number of initiatives, backed by billions in international aid, have been launched in South Africa. On the face of it, they aim to address the contexts in which young women and girls live in order to help them reach their full potential, including changing long-held perceptions in communities that leave them unsafe from violence and HIV.

It was only two years ago, when Zakwe joined the DREAMS partnership as an ambassador, that she began to receive the psycho-social support she needed 15 years ago.

DREAMS is a global partnership aimed at improving the lives of young women and girls in 10 African countries – with the ultimate aim of reducing the rate of new HIV infections in this group.

Another prevention campaign for young women and girls looking to tackle the societal problems driving their vulnerability to HIV is She Conquers, led by the DoH, and most famous for the DoH’s Dr Yogan Pillay, who said that more than R3 billion has been invested in the programme by three major donors: PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the German Development Bank (KFW).

He added that the campaign is being rolled out in three phases, with the first phase being implemented in the 22 districts with the highest HIV burden, “where the need is the greatest”. Based on what is learned in these areas, the tenets the DREAMS name stands for.

Backed by US$385 million (about R4.5 billion), the “ambitious” initiative aims to go “beyond the health sector” to address the social factors that drive young women and girls’ particular vulnerability to HIV, including GBV, poverty, school drop-out, and gender inequality in the form of “economic disadvantage” and “discriminatory cultural norms”.

It was launched in 10 sub-Saharan African countries, with South Africa being allocated US$66 million (about R770 million), when it began operating locally in 2016.

“DREAMS uses multiple evidence-based interventions, including post-violence care, parenting/caregiver programmes, and facilitating access to already available cash transfers and education subsidies,” explained Schneider.

It operates in five districts: eThekwini, uMgungundlovu and uMkhanyakude in KwaZulu-Natal, and Johannesburg and Ekurhuleni in Gauteng, and is facilitated through 20 implementing partners.

**What is DREAMS?**

What are She Conquers and DREAMS exactly? What is happening on the ground to improve the lives of South African girls and young women? Are they reaching their intended audience and achieving their aims? And how can systems of power such as patriarchy, entrenched in society for centuries, be tackled by health-led programmes only in place for a few years?

DREAMS is a global partnership, announced in December 2014, between the United States President’s Emergency Plan for AIDS Relief (PEPFAR), the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare, aimed at reducing new HIV infections in girls and adolescent women by 40 per cent by 2017. But the South African arm of the project started late, and the target has been shifted to 2019.

PEPFAR’s Caroline Schneider told Spotlight/Health-e that to achieve this, the “ultimate goal is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored and Safe women” – the tenets the DREAMS name stands for.

**A grave historical injustice**

In his response to the State of the Nation (SONA) debate on Tuesday 20 February, Ramaphosa, the newly-elected president, said:

“Another grave historical injustice that we need to correct is the economic inequality between men and women.

“It is a task that requires both a deliberate bias in economic policy towards the advancement of women and a fundamental shift in almost every aspect of social life.

“One of the programmes where we have sought to integrate various approaches is the ‘She Conquers’ initiative, which aims to empower adolescent girls and young women to reduce HIV infections, tackle gender-based violence, keep girls in school and increase economic opportunities.

“It recognises how patriarchal attitudes, poverty, social pressures, unemployment and lack of adequate health and other services conspire to reduce the prospects of young women – and then involves these women in overcoming these challenges.

“This is one of the ways we are working to build a nation that is prepared to confront the many different ways in which women are subjugated, marginalised and overlooked – a nation that wages a daily struggle against patriarchy, discrimination and intolerance.”

While Ramaphosa’s words are comforting, as they acknowledge the difficult situations in which young women and girls live, as well as the patriarchal nature of our society, one is left to wonder why so little is known about this important initiative, and how it is working to tackle the multitude of obstacles mentioned.

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Backed by US$385 million (about R4.5 billion), the “ambitious” initiative aims to go “beyond the health sector” to address the social factors that drive young women and girls’ particular vulnerability to HIV, including GBV, poverty, school drop-out, and gender inequality in the form of “economic disadvantage” and “discriminatory cultural norms”.

It was launched in 10 sub-Saharan African countries, with South Africa being allocated US$66 million (about R770 million), when it began operating locally in 2016.

“DREAMS uses multiple evidence-based interventions, including post-violence care, parenting/caregiver programmes, and facilitating access to already available cash transfers and education subsidies,” explained Schneider.

It operates in five districts: eThekwini, uMgungundlovu and uMkhanyakude in KwaZulu-Natal, and Johannesburg and Ekurhuleni in Gauteng, and is facilitated through 20 implementing partners.

**What is She Conquers?**

Also launched in 2016, She Conquers is a government campaign “aimed to reach adolescent girls and young women aged 15-24 in South Africa who have high rates of HIV as well as teen pregnancies”. Like DREAMS, it aims to do this by looking at the problems in society that make this group particularly vulnerable.

This is according to the DoH’s Dr Yogan Pillay, who said that more than R3 billion has been invested in the programme by three major donors: PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the German Development Bank (KFW).

He added that the campaign is being rolled out in three phases, with the first phase being implemented in the 22 districts with the highest HIV burden, “where the need is the greatest”. Based on what is learned in these areas, the
YOUNG WOMEN

interventions will be rolled out nationally. The five targets to be achieved in the 22 priority districts for the three-year-long campaign are ambitious:

1. Decrease new HIV infections in this group by at least 30 per cent, from 90 000 per year to fewer than 60 000 per year;
2. Decrease teen pregnancies, in particular under-18 deliveries, by at least 30 per cent, from 73 000 to 50 000;
3. Increase retention of this group in schools by 20 per cent;
4. Decrease sexual violence and GBV in this group by 10 per cent;
5. Increase economic opportunities for young people, particularly young women, by increasing youth employment by 10 per cent.

It is unclear whether progress against these targets will be measured and reported in a way that allows the public and independent experts to hold these programmes accountable in a meaningful way.

There is also much confusion in the public domain as to what the campaign is, whether it is a communication and awareness initiative, or if it involves practical interventions; and if it is adequately responding to the needs of girls and young women: the people it aims to benefit.

The confusion extends to how these initiatives are linked.

Health minister Dr Aaron Motsoaledi told Spotlight that “She Conquers became the South African expression of how to implement DREAMS.”

Schneider said the $66 million South African DREAMS funding allocation falls under the She Conquers umbrella, but that the money is not directly funding the local campaign.

“DREAMS is contributing to achieving the objectives of She Conquers. The US PEPFAR programs in the DREAMS focus districts are in line with the She Conquers strategy, and support She Conquers initiatives in those districts. We can’t speak to the overall She Conquers budget, as this is a Government of South Africa initiative,” she said.

Pillay said She Conquers is a “combination of awareness and practical projects”. But many activists have questioned, firstly, if the campaign is adequately raising awareness in a nuanced way that speaks to the myriad societal ills preventing girls and women from staying safe; and secondly, whether the other interventions are reaching those affected.

Billboard controversy
She Conquers has been most visible in its communication campaign – particularly in the controversy surrounding two of the billboards it commissioned.

Social media erupted in September last year when a billboard next to the N1 in Johannesburg was erected with the tagline: ‘Who says girls don’t want to be on top?’ In smaller letters underneath it reads: “Complete your matric, study hard and graduate!”

While the DoH rejected claims that the message contained sexual innuendo and therefore failed to address the context of violence and lack of support in which girls are expected to ‘study hard and graduate; many on social media felt the message to be insulting.

Sexual and Reproductive Justice Coalition founder Marion Stevens said that instead of trying to address the circumstances in which young women remain vulnerable, this kind of messaging only perpetuates the status quo: expecting girls themselves to rise above their trying circumstances, be resilient, and somehow succeed.

“With the black girl emoji attached to it and the sexual innuendo, it reinforces the harmful tropes of black women as hyper-sexualised, and places the burden on young black women to overcome obstacles that are out of their control. How can a young woman stay in school when she has to choose to buy food for herself and others in the household instead of paying school fees? Girls drop out because of a range of factors, such as food, security and transport,” she said.

In this type of messaging, Stevens said, there is no mention of the challenges affecting their ability to stay in school or protect themselves from HIV.

Nicknaming the campaign #HeDecides, Stevens questioned who is actually responsible for constructing the She Conquers messaging, because the voices of young women themselves have been left out.

Long-standing HIV activist Yvette Raphael was involved in the initial conceptualisation of the She Conquers campaign, and said that the initial “consultations went well”. “It looked like it was going to be an overarching campaign that would support very successful campaigns on the ground already working with women. But that is not the reality now. I don’t even know what to make of it – it’s very confusing,” she said.

Young women left out?
While the campaign was initially conceived as being youth-led, Raphael said that young women have been left out of campaign decisions on more than one occasion.

“I don’t think enough engaging of the target audience is happening and that’s why we are getting messages that are insulting to young women. Girls want to be on top – which young person would say that, outside of a relationship? Which young person can own that tagline?”

Raphael said that young women were asked to vote on a campaign name, but that name was never used; instead, ‘She Conquers’ was chosen, without an explanation as to why the name chosen by the young women was ignored.

Motsoaledi said a young woman from Limpopo was responsible for the She Conquers name, and suggested it to the DoH through social media.

Raphael said the problem is that “old people are thinking they can think like young women”: “She Conquers can only serve its purpose if it’s led by young people, and comes from them.”

She Conquers has set up a youth advisory committee located within the South African National AIDS Council (SANAC), consisting of nine young woman representatives who were elected at a She Conquers bootcamp.

But members of this committee told Spotlight that they do not have much decision-making power.

The executive secretary for the committee, 23-year-old Koketso Rathumbu, said the committee was not involved in formulating the messaging for the communications campaign, including the controversial billboards.

“The DoH is the one who facilitates and decides on the communication plan; and unfortunately, this was not shared with us, and there no clear reasons as to why – we have made a request,” she said.

While Rathumbu had positive things to say about the campaign – for example, that it is getting people talking about
these issues, and is reaching some young women with beneficial interventions – she said that it is failing in other areas.

“We are advocating for the visibility of the campaign, over and above the media campaigns and billboards. We are fighting for more engagement and inclusivity at grassroots level, but it has been a challenge; many people in rural areas, for example, are not being reached,”

She also said that if every stakeholder, including various government departments, were “synchronised”, then “She Conquers would be a success”.

“The biggest challenge we’ve had is getting different departments to play a role, not just Health – for example, the Department of Basic Education to go into schools with the She Conquers plan. What we need and don’t have is a synchronised system that integrates all stakeholders.”

This could be why She Conquers is so confusing to the public, and even to the people involved in it. Conceived of and led by the DoH, so far it has failed to adequately integrate all sectors.

Who is in charge?
The Medical Research Council’s Dr Fareed Abdullah (a former SANAC CEO) said that SANAC – as a body designed to facilitate multi-sectoral collaboration between various government departments, civil society and other stakeholders – should be responsible for the running of the She Conquers campaign. It should also be the seat responsible for the coordination of various partners working on HIV prevention in young women under the She Conquers banner, including the DREAMS partnership and others.

Pillay admitted that She Conquers is “supposed to be a programme that links various initiatives under one banner”, but that “coordination is not an easy thing to do”. While Ramaphosa was deputy president, he asked that SANAC take on this role – indirectly acknowledging that the DoH cannot fulfil the mandate on its own.

But the confusion around the programme continues. While Pillay said that handling over the running of She Conquers to SANAC had been done as early as last year, SANAC spokesperson Kanya Ndaki told Spotlight a different story.

“SANAC is not responsible for the overall running of the She Conquers campaign, but this is something we are working towards. We are hosting a summit on young women and girls in March, and will be bringing all the partners involved to reflect on what has worked, so that we can coordinate the response better,” she said.

Ndaki said that the She Conquers campaign has been led by the DoH, but “we want to change that. We want it to be a multi-sectoral response, and SANAC is best placed to provide that multi-sectoral coordination.”

She added that while locating the running of She Conquers has been discussed on various platforms, it has not been finalised; but it is expected to be at the March summit.

Moreover, according to Schneider, DREAMS and its funding was intended to spark investment globally in adolescent girls and young women programming, with biomedical, structural, and behavioural interventions, using multi-sectoral approaches.

But when asked if there has been any domestic investment in She Conquers on top of the international aid, Pillay said no – “just the money we have. We have already made it clear from the beginning, from government, the funding will be a reprioritisation of existing funding,” he said.

But Abdullah made the point that the programme – should any impact it makes be sustained – “cannot only be funded by donors, and the South African Government also needs to make significant investments in this programme”.

**Will young women have access to PrEP?**

Abdullah also said that “one of the key weaknesses of the programme is the very limited offering of pre-exposure prophylaxis (PrEP). PrEP consists of a daily dose of antiretroviral medication to prevent HIV infection, and has been shown to be highly effective if taken as indicated.

The World Health Organisation recommends PrEP for young women in areas where the rate of new HIV infections is high; but according to Abdullah, even though this is “one of the most effective interventions” in existence for HIV prevention, “South Africa has limited PrEP to a few pilot sites”.

This is despite the fact that the latest National Strategic Plan (NSP) for HIV, tuberculosis and sexually transmitted infections makes provision for the implementation of PrEP for populations at a high risk of acquiring HIV.

Abdullah has been critical of the NSP, saying it limits PrEP access. The Plan’s targets are that between 2018 and 2022, there should be just over 104 000 new PrEP users. PrEP will be offered to young women, female sex workers, men who have sex with men, and people who inject drugs.

According to Pillay, through She Conquers, PrEP is slowly being rolled out: it was made available to young women at nine university campuses in October 2017. Only 26 people were initiated on PrEP during the first month; after that, the programme was stalled, because universities were closing for the end-of-year holidays. Those who had started PrEP were given a supply for the holidays.

Since February, two more university campus clinics have begun offering PrEP, bringing the total up to 11; but the DoH does not have data on new uptake at these sites for 2018.

Pillay said: “During the next six months, PrEP will be made available at some 20 primary healthcare clinics in the 22 She Conquers priority subdistricts.”

The aim is to offer PrEP to between 5 000 and 8 000 young women over the next year.

There are multiple programmes running under the She Conquers banner that are doing important and effective work. But the success of any HIV-prevention campaign that seeks to solve systemic issues in society such as violence and gender inequality will rely on the successful integration of every actor on every level.

To truly help young women and girls in South Africa, programmes will need to put them and their views, voices and suggestions at the epicentre of decision-making. ‘She’ can only ‘conquer’ when she’s actively engaged and listened to.

In this context, it is important to remember Ramaphosa’s final words on the epidemic of GBV in South Africa during his SONA response:

“It is a social issue that must engage, involve and mobilise the whole of society. We must be prepared, as government, to acknowledge where we have failed our people. Where we have made mistakes, we will correct them.”
She decides whether, when and with whom... to have sex. to fall in love. to have children.

SheDecides was launched at the start of 2017 as a global movement to support the fundamental rights of girls and women to decide freely and for themselves about their sexual lives – including whether, when and with whom, and how many children they have.

It was created as an immediate response to United States (US) President Donald Trump’s reinstatement of the Global Gag Rule – also known as the Mexico City Policy; a policy which has devastating effects on women, girls and their communities around the world. The rule prevents non-governmental organisations (NGOs) outside the US from receiving money from the US government if they provide safe abortions or information about abortion.

This attack on women’s rights resulted in an immediate outcry from many groups, governments and individuals. Initiated by the Dutch Minister of Foreign Trade and International Development, Lilianne Ploumen, SheDecides became a rallying call for leaders to stand up as a matter of urgency to protect the rights, health, safety and livelihoods of millions of girls and women around the world.

**Background on the Gag**

The Global Gag Rule was first introduced by President Ronald Reagan in 1984, under the name of the ‘Mexico City Policy’. Since then, it has been revoked by the Democratic Presidents who have taken office, and re-introduced by all the Republican Presidents.

In January 2017, a dramatically expanded version was signed by President Donald Trump very soon after he took office. Previously, the Global Gag Rule applied to family planning funds only; this version applies to all global health funds provided by the US government.

It bans non-US organisations from receiving any US funds if they give information and referrals for abortion, plead for better abortion legislation, or provide safe abortions (officially, abortion care in the case of rape, incest or endangerment of the life of the woman is allowed under the Global Gag Rule; in reality, the rule tends to be over-interpreted, and all abortion services are affected).

The Global Gag Rule comes on top of the Helms Amendment, a US law (in place since 1973) that already stops any US government funds from being used for abortions. Now, the Global Gag Rule goes further. It stops organisations from using their own or other people’s funds for these purposes. It applies to US funds provided directly to non-US NGOs, or indirectly through US-based NGOs. It does not apply to funds provided by the US government to other governments.

**The Impact**

The impact of the Global Gag Rule will be substantial. Organisations must choose between receiving funds from the US government – to date, the largest funder of programmes for sexual and reproductive health – and providing the full range of programmes, services and care that women and girls need. These are services that are proven, including through independent expert reviews and guidelines provided by the World
Health Organisation, to have the greatest impact on health and well-being.

The Global Gag Rule prevents professionals from giving appropriate medical advice to women or referring them to other services. This means that life-saving medical decisions cannot be made by the trained healthcare providers who are best able to understand the needs of the women and girls they treat. Rather, they are shaped by policymakers in another country.

Organisations can take a stand against this oppressive rule and refuse to sign. But if they cannot find alternative sources of funding, they will need to cut services, fire staff, and close clinics that are often the only source of health care. This hurts the whole community, as well as individual girls and women and their families.

When the Global Gag Rule was in force in previous years, the harm was clear. Research shows that it:
- Prevented women and girls from accessing the contraception and safe abortion that they are legally entitled to in their countries;
- Hampered HIV prevention efforts;
- Contributed to the closing of health clinics;
- Obstructed rural communities’ access to health care;
- Stopped people from speaking out against the laws that prevent women and girls from accessing safe and effective health care.

The Fight Back
On 2 March 2017, the first SheDecides conference was held in Brussels, co-organised by Belgium, Denmark, the Netherlands and Sweden. More than 50 governments attended the conference; the 450 participants included youth leaders, parliamentarians and representatives from United Nations agencies, NGOs, private foundations and the private sector.

This gathering enabled global leaders to raise their voices in support of girls’ and women’s rights, and pledge their commitment to ensure that SheDecides. This outpouring of support included 181 million Euros in new pledges, and a new generation of champions.

The Global Gag Rule prevents professionals from giving appropriate medical advice to women or referring them to other services.
Hope for young women amid a sea of despair

Thuthukile Mbatha, Spotlight

Mitchells Plain is a diverse township with an overwhelming number of social challenges. Many young people in Mitchells Plain suffer from challenges linked to drug abuse, high HIV prevalence rates and teenage pregnancy. The young people have a diverse set of needs; and for those working in the health sector, addressing HIV infection means tackling all the social challenges.

Nabielah Louw is a 21-year-old mother of one. She had her first child at the age of 17 years. Like many other young girls in South Africa, Nabielah has experienced high levels of violence from a young age. At age nine, she was kidnapped by a family friend and held captive for two weeks. During this time, she was drugged, chained, beaten, raped and sexually assaulted.

Her parents did not know where she was until one of her schoolmates came forward and said they had seen her enter her father’s friend’s house. The police found her weak and high on drugs. The perpetrator was arrested and pleaded insanity; he was committed to a mental institution, but released after a short while. Fortunately, her family moved away, so she never saw him again.

Following this incident, Nabielah found it hard to enter into any relationships or to concentrate at school. When she was 17, she finally met a boy who, she said, swept her off her feet. They started a relationship, and that is where she learnt a few things about family planning. The boyfriend introduced condoms, which was something that she had no knowledge of. Like many other young women her age, Nabielah only got to learn about other forms of contraception after giving birth to her son. She has been on Depo-Provera ever since. Depo-Provera is an injectable contraceptive that women get every three months to prevent unwanted pregnancies.

Nabielah joined the Women of Worth study towards the end of 2017. The study is run by the University of Cape Town’s Desmond Tutu HIV Foundation, targeting young women between the ages of 19 and 24. It is offered through the Zimele programme situated in Philippi Village, adjacent to Nyanga township.

The study offers 12 sessions that are aimed at empowering young women out of school. It is targeting 10 000 young women; 5 000 of them will receive a cash incentive as part of the study. This research aims to find out whether these young women's health outcomes will be significantly improved by attending empowerment sessions and receiving a cash incentive. The theory is that providing a care component in the form of the educational empowerment sessions improves health outcomes (HIV, STI, pregnancy etc.); providing a cash incentive improves health outcomes significantly; and cash plus care combined provides the most significant improvement in health outcomes.

Some of the sessions offered include topics such as self-empowerment, sex talks dealing with HIV, STIs and family planning, gender-based violence, personal finance management, and so on.

“I was so excited to go to a place where there would be more young people, since I didn’t have any female friends. I was shy at first, but it turned out to be interesting. I felt welcome – as if I belonged,” said Nabielah.

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Getting to know Nabielah

**What are your hobbies?**

I enjoy recording songs with my friend. I call myself Emosweet. I sing about my life, and things that I have gone through in my life.

**What is your dream job?**

I didn’t finish my schooling due to some personal challenges. However, I would love to become an animation artist. I draw my emotions whenever I feel down. I enjoy it, and it’s very therapeutic.

**What is your favourite song?**

My favourite song is ‘Terrible Love’, by Birdie.

**What is your favourite colour?**

I love the colour black. If I could wear black every day, I’d be very happy.

**What kind of person would you marry?**

I would marry anyone who would show me love and love my child equally. Money and materialistic things shouldn’t matter.

**What is your message to other young people?**

I would like to encourage young people to live their lives to the fullest. Do not make marriage your ultimate goal. Looking at what my mom and sisters went through, I don’t think it’s worth it. Follow your dreams, and then you can get a partner. Being a single mom is not easy.

**If you could meet anyone dead or alive for lunch, who would it be?**

I would love to meet Avril Lavigne. Even my style of clothing is inspired by her.

**What is the biggest challenge facing young women in South Africa, in your view?**

Most young women face a lot of sexual violence. There are so many young women who don’t make it out of such situations. I am one of the few that actually made it out alive, and I’m not on drugs.

**What is your favourite colour?**

I love the colour black. If I could wear black every day, I’d be very happy.

**What is the Women of Worth study?**

The Women of Worth study is an empowerment study for young women living in the Mitchells Plain and Klipfontein areas of Cape Town. It intends to enrol 10 000 young girls between the ages of 19 to 24 years living in this area. Half of the participants will receive a cash incentive every time they finish attending a session; the other half will not receive anything apart from the educational empowerment session. The aim is to establish whether the empowerment sessions and cash incentive provide a protective factor for young women against HIV acquisition, STIs and unwanted pregnancy.
Emancipate the female condom

Zukiswa Pikoli, SECTION27

The female condom (FC) is quite an interesting ‘contraption’ in that it takes quite an invasive form. Firstly, just tracking them down is enough of a trial, as they are not widely accessible; whereas male condoms are readily available. Social messaging and advertising has also not been particularly helpful in this regard as it is limited, which curtails demand, as people cannot ask for what they do not know is accessible.

As women are feeling more liberated to make more empowered sexual choices, it is key that the market is responsive to this rising need. It is reported that female condom use is on the rise, with 27 million condoms having been distributed throughout South Africa in 2016, and South Africa’s National Strategic Plan for HIV, TB and STIs 2017-2022 (NSP) stating that by the year 2022, there are to be 40 million – in stark contrast to the projected 850 million male condoms envisaged for 2022.

While this may sound good, the deeper issue is whether they will be distributed effectively; and specifically, whether adequate training and familiarisation will be implemented alongside the distribution.

According to statistics cited in USAID’s Evaluation of South Africa’s National Female Condom Programme published in July 2017, and in the National Strategic Plan 2017-2022, the use of the FC is lowest among under-20-year-olds – a meagre eight out of every 100 young women. When probed, the main reasons cited for not trying a FC were: not knowing where to obtain them, fear of using the condom, and the resistance of male partners towards their use.

I think it’s important we acknowledge that herein lies the perpetuation of disempowering women. Women feel they would only be able to use the FC with their partners’ direct consent or condoning, which is not the case with male condoms. It is therefore important to emphasise that when one engages in sexual intercourse, one’s agency is exercised without restraint, and that we all have the right to choose when and how we go about this.

The NSP has as one of its goals and focuses the provision of both male and female condoms; and yet, there still is not enough investment in making the FC as readily available as the male condom. If there were dedication to making it a priority, then surely they would be distributed widely and as freely. However, there is also a need to educate and train people about how to use the FC, which would contribute towards making people more comfortable about using them.

As one of its strategic objectives, the NSP states that there will be a focus on “maximised coverage of male and female condoms through distribution in health facilities and non-traditional
outlets, including correctional facilities, mines, airports, malls, shebeens, hotels, schools as part of a broader health package, and tertiary institutions, sex work venues/locations and clubs. This, however, is a practical application that has yet to yield tangible results, as FC are not even available from pharmacy giants such as Clicks or Dis-Chem.

It occurs to me that it is worth exploring why it is that the messaging around FCs is quite sterile, and not presented in the same sexy, empowered and enticing way that we see the Lovers Plus male condom adverts – the ads in which beautiful young people meet at parties and immediately reach for their box of condoms, because they will be hooking up that night. Or the Wet’n Wilds and Rough Riders we see in garage kiosks, with sexy, barely clothed woman on the covers.

No, instead what we have with the FC is very clinical packaging and unimaginative branding. It almost seems as though it’s designed to perpetuate the outdated thinking that a woman’s chastity needs to be protected at all costs – in fact, all the better if she never has sex at all, especially not on her own terms.

Social and societal factors that drive the use and availability of condoms are mostly steeped in the aversion men have towards women taking over their own sexuality, as this means that women are now more in charge in terms of when they do or do not want to have sex. As men traditionally make these decisions, it’s often seen as emasculating.

In a society that tends to lean more to the side of conservatism rather than a progressive realisation of women’s rights and autonomy, it is not entirely unsurprising that our sexual and reproductive rights are contested. The trouble with male condoms is that they are used primarily at the discretion of a man; and if for some reason he decides not to use it, his partner is left vulnerable. A woman can insert the FC ahead of time in anticipation of sexual intercourse, thus taking control of her contraceptive safety and protection against STIs.

However, inserting the FC ahead of time means that women will often be stigmatised for being too eager to have sex, opening them up to all types of verbal and physical abuse. All of this happens in spite of the fact that another danger of the male condom is the timeframe within which it is used, as in the heat of passion it is quite easy for a partner to forgo the condom in order not to ‘ruin the moment’.

In a world where being a woman is a constant battle against gender discrimination and patriarchal rule, for some odd reason sexual and reproductive rights are a much-contested ground. Our bodies are a contested ground because men believe that they own our sexuality, and they will make it as difficult as possible for us to exercise autonomy over our participation. We need to make sure that we are not willing contributors to their doing so, and demand more convenient protection centred on our needs.
As the numbers of voluntary male circumcisions plateau, there’s a new push to convince more men that it’s still the right thing to do.

Good old peer-group pressure was what drove Sduduzo Macwele to get the snip. 

“Nine years ago, everyone was talking about how circumcision was a great way to prevent HIV,” recalls Macwele, who was a 22-year-old student at the University of KwaZulu-Natal at the time. Many of his friends had already undergone male circumcision voluntarily. 

Driving their decision was research at the time that showed that circumcision led to a reduction in female-to-male HIV transmission of 60 per cent.

Like so many considering adult circumcision, Macwele was concerned about the pain. But it was his partner who gave him the final push. “My partner started talking about how having a foreskin was not hygienic for her,” Macwele says.

Now, though – nearly a decade later – voluntary male circumcision has faded from popularity, even as it’s considered one of the best ways to fight HIV infection. Interest has dropped so significantly that government officials and some health researchers worry that circumcision numbers have plateaued.

Studies have shown that to achieve the greatest reduction in the South African HIV/AIDS epidemic, 80% of HIV-negative males aged between 15 and 49 years old will have to be circumcised to prevent 1.1 million new infections by 2025. According to the World Health Organisation, South Africa had met only 54% of its targeted number of circumcisions by 2016.

“I think everyone who wanted to get circumcised has pretty much been circumcised,” says Dr Gavin George, of the Health Economics and HIV/AIDS Research Division (HEARD), at the University of KwaZulu-Natal.

“Now it’s the hard sell, getting those individuals who initially did not want to get circumcised, to be circumcised.”

Last month, in an effort to meet these targets, Sibongiseni Dhlomo, MEC for Health in KwaZulu-Natal, announced that he wanted to have a million men circumcised by April.

When asked by Spotlight, KZN Health spokesperson Ncumisa Mafunda said that her department was confident that they would reach the target of a million circumcisions by the middle of 2018. “The Department is engaged in continuous public awareness campaigns on the benefits of medical male circumcision, and always appreciates assistance from the media in this regard,” she said.

However, according to Mafunda the department is facing challenges in their circumcision drive. “There is sometimes reluctance among some men and boys to undergo medical male circumcision, due to a belief that the procedure is painful. However, medical male circumcision is safe; it is always done under local anaesthesia; and the pain only lasts a few days,” said Mafunda.

“People who have undergone MMC are also given medication to manage the pain. The long-term benefits of MMC far outweigh the temporary pain.”

Mafunda went on to explain that the department would not be pressuring individuals to undergo the procedure. “Consent is always sought for persons under the age of 18 who want to be medically circumcised.”

Circumcising a million men and boys is a tall order; but at least some experts believe it can be done, if the health authorities focus on the youth, and in particular those who are in school. “If you target them at schools, it’s a lot easier to market circumcision, and to provide information to schoolgoing adolescents,” says George.

George and his colleagues at the university recently published an academic paper that provides a peek into what sways pupils into choosing circumcision in rural KwaZulu-Natal.

They used data collected from 750 pupils from 42 secondary schools across the province. In the sample, 251 of the boys were circumcised and 499 were not.

What the researchers found was that learners who saw voluntary medical male circumcision (VMMC) as having a number of health benefits were more likely to have the procedure. These benefits, according to the study, included reduced chances of contracting HIV and other sexually transmitted diseases, increased penile hygiene, and the belief that VMMC allowed them to use condoms less frequently.

“The biggest issue is that there is not much of an incentive to be circumcised for those boys who are not engaging in sexual activity,” says George. “While a lot of the boys would like to be engaging in sexual activity at the ages of 14, 15 and 16, the prevalence of it is simply not that high. So again, there is a
reduced incentive to be circumcised."

A concern that the researchers picked up in their study was that some of the boys who had been circumcised were less likely to use condoms. This finding runs contrary to a number of large studies that found that men who were circumcised were not in fact less likely to use condoms. Says George: “A lot of these kids are asking, ‘if I still have to wear condoms, what is the benefit of being circumcised?’”

George says there must be education at schools that stresses that condoms still need to be used, even after circumcision.

VMMC expert Dr Ronald Ndaba says that he has found that older males are also less likely to consider circumcision. And many low-income earners, he says, are reluctant to be circumcised, as they would have to take unpaid time off work to have the procedure.

“That is why we need to engage with businesses, and make them understand the long-term health benefits of circumcision for the workforce. That this can help reduce the spread of HIV,” says Ndaba.

Another hurdle the authorities still have to face in KwaZulu-Natal is traditional beliefs, according to Ndaba. Current Zulu culture doesn’t have a tradition of circumcision as a rite of passage.

Zulu King Goodwill Zwelithini has previously called on men to be circumcised, explaining that before the reign of King Chaka, it was a part of Zulu custom. The King’s plea, says Ndaba, has helped; but there are still men who say it is not their tradition.

“At the end of the day, it is men who make this decision. And there are men who are not afraid of HIV. They say they will simply take ARVs.”

George says that among pupils, traditional beliefs play less of a role in considering circumcision. The pull factor often comes from peer pressure.

Ndaba says that another problem associated with older men and VMMC is that they often don’t return for follow-up medical check-ups. “It is difficult for males in general outside of schools, because it is more difficult to corral them,” says George.

But one drawcard might just help Heath MEC Dhlomo get his million circumcised men by April: women. Just as when Macwele’s partner gave him the final nudge to get the snip, women continue to play an important role in the circumcision drive. “I think, for men… if they think that woman are keen on circumcised men, you are going to get a greater demand for circumcision,” says George.

Nine years after being circumcised, Macwele has no regrets. At the time, he says, it was painful. But that is long forgotten.

“I am happy, and very proud that I did it; and whenever I talk to people, I tell them to go and get it done,” he says.

THE TARA KLAMP SCANDAL

From 2010 to around 2012, the circumcision roll-out in KZN was highly controversial. In this period, thousands of men in the province were circumcised using an unsafe circumcision device called the Tara KLamp. The device caused some men to suffer severe penile injuries. The Treatment Action Campaign questioned the lawfulness of the Tara KLamp roll-out, and asked the Public Protector to investigate potential irregularities relating to the purchase of the Tara KLamp. The Public Protector investigated, but never produced a report on the matter.
Professor Linda-Gail Bekker, Director at the Desmond Tutu HIV Foundation. (Image: Thom Pierce)
SRHR SERVICES

Cutting-edge youth services

Thuthukile Mbatha, Spotlight

The Desmond Tutu HIV Foundation (DTHF) is implementing a number of innovative youth-focused health services around Cape Town. Others could learn from their approach and successes.

The DTHF Youth Centre was established in 2011; situated in Masiphumelele township, it is at the forefront of trying to find answers to the tough questions regarding young people and access to healthcare services. The foundation is specifically interested in innovative HIV research, and even more so where it intersects with young people’s issues. Simply, they want to find innovative health-delivery mechanisms that keep young people healthy, HIV-free, and without the burden of teenage pregnancy and similar challenges.

The adolescent girls and young women division focuses on sexual and reproductive health rights, mental health, HIV, life skills, and sero-neutral service delivery. ‘Sero-neutral services’ means that everyone is treated the same, irrespective of their HIV status.

The DTHF’s director, Professor Linda-Gail Bekker, has been at the helm for over 10 years, and has led a team trying to figure out how young adolescents can be ethically involved in HIV prevention research. This is because the laws against HIV research on adolescents are very tough, prompted by the assumption that because adolescents are below the age of consent, they are therefore vulnerable. However, the DTHF has made great strides in fighting for adolescents to be included in HIV research trials.

The DTHF has been involved in adolescent PrEP studies, including PlusPills, the 3P project, and the ADAPT study. The Foundation has also conducted HIV vaccine studies (SASHA) and HIV self-testing studies. “Our current range of research (treatment, prevention, socio-behavioural, structural) is vast, but we are always looking to explore and expand the evidence base around what works for adolescents. Permission to conduct research is sought through our ethics committee, and is – rightly – a strict process. We take great measures to adhere to ethical guidelines around adolescent research, and work with our ethics committee and youth advisory board to make sure we go about this in the best way. To best serve adolescents and meet their needs, we need to know what works; so this research is important to do,” says Bekker.

Responding to a question regarding the emphasis on young women, Bekker says: “Young people, particularly young women and girls, are disproportionately affected by the HIV epidemic, and are at high risk for infection. Young people are also undergoing a unique phase of life, characterised by biological and physiological changes, increased risk-taking behaviour, etc.; and so it is important to have services and strategies that are specifically tailored to them.

“The foundation employs a harm-reduction approach, as opposed to a ‘prevent sex from happening’ strategy,” Bekker explains from her office on UCT’s medical campus. In 2005, the foundation conducted a survey at Masiphumelele township in Cape Town’s southern
suburbs, and found that many young women they spoke to were already infected with HIV. One of the outcomes of their survey was information that a contributing factor to the high HIV incidence rates was that young women had no-one to talk to about sex.

The DTHF is now running a number of youth programmes at youth centres, such as the Philippi Village and Hannan Crusaid Youth Clinics (in Philippi and Gugulethu respectively); the Masiphumelele Youth Centre; and the Tutu Teen Truck (mobile service). These include the Health Zone (where young people learn about sexual and reproductive health rights, for example), an Edu Zone (where learners are assisted with school homework), a Fun Zone (where young people participate in sports), the Women of Worth study (see article on page 29), and 18-month internships – offered to youth who have graduated from the Zimele programme, and no longer fit the targeted age category of 10-24 years; these interns run the Zones.

The DTHF delivers youth-friendly sexual and reproductive health services through various platforms, including the Tutu Teen Truck (a mobile clinic delivering health services to young people) and youth-friendly clinics (mobile health facilities providing services that are targeted at and designed for young people). About 4 000 young women use the youth centres, and 300 of those are on Pre-Exposure Prophylaxis (PrEP). This form of PrEP is an antiretroviral drug called TRUVADA, taken daily by HIV-negative people to prevent HIV acquisition.

Innovative reward system

The programme uses some innovative systems to keep track of the young people. Every young person who is part of the youth programme has a unique identifier, logging in using a fingerprint on the biometric machine at the entrance, at which point their medical file is uploaded on the healthcare provider’s computer.

To encourage young people to stay healthy and HIV-free, the foundation has a reward system for all its young members through which they earn points for doing all the vital tests. Undergoing an HIV test gets you double points. This initiative is also aimed at normalising HIV among young people. The ‘currency’ used for the points system is the ‘Tutu’ – three Tutus are equivalent to R1. These can be exchanged for food vouchers. An HIV test is rewarded with 100 Tutus. According to Bekker, “You’ll find a 19-year-old boy asking his friends if they have done an HIV test yet, because he is short of Tutus.” The youth use Tutus to buy a number of items from a local mall or an onsite café.

If someone has a negative test result, they are reminded about the importance of staying HIV-negative, and encouraged to use available HIV-prevention tools. A person who tests positive will receive the same number of Tutu rewards. “We do not penalise mistakes, because that doesn’t work well,” says Bekker. This means that young people get rewards regardless of their HIV status; however, they receive different packages of care. For instance, a person who tests positive would be offered counselling, encouraged to go onto treatment, and advised to encourage their partners to be tested as well.

The Tutu reward system is also aimed at preparing the youth for the grown-up world, and teaching the importance of saving. This is part of positive youth development. The foundation offers 18-month internships to youth who have graduated from the programme, from age 24. The internships involve running the three Zones for younger people, and teaching life skills. There are two interns for each Zone. Most young people relate better to their peers. “What I’m really passionate about doing for this country is to develop a cadre of community healthcare workers who are adolescents,” says Bekker.

The Tutu Teen Truck

According to Bekker, the Youth Centre has been criticised for its perceived inability to be scaled up, as it would not be possible for the government to replicate the same programmes for the entire country. But there are some important elements of the programme that the government could apply, and which are cost effective. The Tutu Teen Truck is one of them. It takes the elements of the sexual and reproductive health services and puts them in a funky-looking truck, which is an “adult-free and adolescent-aware environment”. It is brightly painted, and designed to be attractive to young people. The staff are properly sensitised and trained to be adolescent-friendly.

A range of services is offered to 12- to 24-year-olds. Bekker is trying to get the government to approve the provision of antiretroviral therapy (ART) through the Truck, so that young people – whatever their test results – can get appropriate care and support as part of a combination prevention strategy, without delay.

The Truck travels around Mitchells Plain, Klipfontein and Mfuleni townships, and stops in areas with high HIV prevalence. It draws the attention of young people by playing loud music. It operates every Monday to Friday from 12pm to 6pm, as well as some Saturdays. It offers a range of contraceptives and sexually-transmitted illness (STI) screening interventions, through the use of a GeneXpert machine installed in the truck – a machine mainly used to detect TB, via sputum samples, but which can also be used to test for various other diseases.

A person’s sample is inserted into the GeneXpert, which then conducts an antigen test. “A large number of young people are walking around with untreated gonorrhoea and chlamydia that we are missing, so this offers same-time STI detection and treatment,” says Bekker. The truck also offers tuberculosis (TB) screening to young people suspected of having the infection. Those who require abortion services are referred to health facilities in their neighbourhood that offer such services. “A lot of the young people who use these services just
need to talk to someone who will not judge them in any way,” Bekker adds.

To explore the cost-effectiveness of providing effective youth-friendly services to young people, the same elements of the youth centre and the Tutu Teen Truck are being piloted in some public health facilities. The Global Fund to Fight AIDS, Tuberculosis and Malaria has funded a three-year programme aimed at 22 000 young women and adolescent girls between the ages of 10 and 24 years, in the Klipfontein and Mitchells Plain areas. Alongside the DTHF youth centres, the foundation has identified 24 public health facilities in the Mitchells Plain and Klipfontein health sub-district where they could render the same youth-friendly services to young women and girls. In all of these facilities, they are guided by the National Adolescent and Youth Policy 2017.

Part of the Global Fund grant is used to pay peer navigators at government clinics. A peer navigator is a young person who welcomes young people at the clinic as they arrive at the door, and directs them to the relevant staff. Each clinic also has an adolescent-youth-friendly service champion who has been identified at the clinic. This could be anyone at the clinic: a nurse, a security guard or an administrator, for example. The role of the champion is to ensure that youth-friendly services are rendered to young people without prejudice.

The Foundation is currently developing what is called an ‘adolescent pack’, which outlines how nurses should treat adolescents in clinics. This was prompted by the fact that traditionally, nurses only operate using ‘adult’ and ‘child’ packs; they do not know how to address adolescent health issues, which are largely sexual- and reproductive-health-related. Every clinic staff member – including the security guards, nurses and cleaners – is trained in how to render youth-friendly services.

On top of these programmes, the Foundation has approached all the high schools in the sub-districts to find out from the headmasters what kind of services they would allow to be provided in their schools. Some choose contraception only; others want the comprehensive sexual- and reproductive-health package. Again through the Global Fund grant, the foundation has hired four nurses who visit all the schools that require these services. Some schools only allow counselling to be offered to learners, and nothing else.

### Keeping girls in school

The DTHF has another initiative, called the Keeping Girls in School programme, which targets 15- to 19-year-old girls, with the aim of keeping them in school. Young women and girls are taught about their reproductive organs, and the importance of HIV and pregnancy prevention. This initiative is run by peer educators in schools; through the initiative, the foundation supplies sanitary pads and tampons to female learners.

The DTHF is also conducting a study called Women of Worth, targeting 19- to 24-year-old girls out of school. The study aims to enrol 10 000 young women in order to equip them with self-empowerment skills, in 12 sessions. TheFoundation has approached all the high schools in the sub-districts to find out from the headmasters what kind of services they would allow to be provided in their schools. Some choose contraception only; others want the comprehensive sexual- and reproductive-health package. Again through the Global Fund grant, the foundation has hired four nurses who visit all the schools that require these services. Some schools only allow counselling to be offered to learners, and nothing else.

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The DTHF is also conducting a study called Women of Worth, targeting 19- to 24-year-old girls out of school. The study aims to enrol 10 000 young women in order to equip them with self-empowerment skills, in 12 sessions. The study will assess how well these programmes work. Half of the participants will be randomly selected to receive a cash incentive and the empowerment course, whereas the other half will only receive the empowerment course. The study will establish whether these young women’s health outcomes are significantly improved by them attending empowerment sessions and receiving a cash incentive. The cash incentive is an example of behavioural economics, based on the assumption that a lot of young women get into difficult relationships because they want cash. The cash transfer is dependent on their involvement in the study. After completing the 12 sessions, the young women will graduate, and some will be enrolled in the learnership programme in the DTHF – provided they finish and excel during the two-year period of the programme. The majority of the young women in the study already have a child, and come from very poor backgrounds.

“Unless we try to address the socio-economic challenges that young women face on a daily basis, through equipping them with income-generation skills, we can offer as many contraceptives and HIV-prevention tools as we want; but we will not see any progress,” says Bekker.

The young women who have completed the programme are encouraged to recruit their peers to enrol as well.

There is a parallel programme targeting young men, in which participants discuss men’s issues and how to treat women. The sessions are a ‘woman no-go zone’. Both the Women of Worth programme and the men’s health component include a session on LGBTI needs and issues. Every young person has a tailor-made programme meant to address issues specifically related to them.

“If all these programmes do not work in three years, I will know that we had a fair try,” says Bekker.
Nikita laughing – Diamond Town Girls, from fine arts photographer Robert Hamblin’s InterseXion collection currently on display at the Iziko National Art gallery. (Image: Robert Hamblin)
Sex work is work

In December 2017, the National Conference of the African National Congress resolved that sex work should be decriminalised. A few months earlier, a South African Law Review Commission report had recommended the opposite; that sex work should remain criminalised. What is the state of play in 2018 – and what are the chances that after years of debate and advocacy, sex work will finally be decriminalised?

South Africa is not unique in having to grapple with the legal framework surrounding sex work. In order to evaluate the efficacy of the law reform process, it is critical to evaluate other jurisdictions, the models that they have applied, and the impact that these models have had on sex workers.

**Total criminalisation**
Along with South Africa, the United States of America (USA) and Thailand are examples of total criminalisation, as identified by the South African Legal Resources Centre (SALRC).

The Federal Government of the USA opposes legalised sex work and supports criminalisation, based on the justification that prostitution is inherently harmful and dehumanising, and fuels trafficking in persons.

In Thailand, despite the official approach of full criminalisation, sex work is significantly popular and socially acceptable. The official position, however, is full criminalisation; and this is justified by the Suppression of Prostitution Act of 1996, which seeks to safeguard the welfare of and protect women and children from exploitation.

**Partial criminalisation**
Often referred to as the Swedish model (the model having been conceptualised and implemented in Sweden), partial criminalisation is also the model followed in the United Kingdom (UK).

In Sweden, the clients of the sex worker are criminalised. The justification of the law is to reduce male violence against women and children. The model is based on the presumption that by criminalising the buyer, you reduce the demand for commercial sex and the oppression of sex workers.

In the UK, brothel keeping, pimping and under-age prostitution are illegal; but not the act of sex work itself. The justification for the legislation is the protection of the public from sexual crimes, while at the same time protecting the rights of adults to a private life. The law also contains mechanisms for routes out of sex work, and the prevention and obviation of demand for commercial sex.

Partial criminalisation can therefore take different forms; from the Swedish model that seeks to reduce the demand for commercial sex, to the UK model that is focused on third-party exploitation through commercial sex.

**Non-criminalisation**
Also often referred to as decriminalisation, or just ‘decrim’, non-criminalisation is focused on the repealing of existing laws that criminalise sex work, or not having any laws.

New Zealand has adopted a non-criminalisation model; and in doing so, has stated that although government does not endorse or morally sanction sex work, there is a greater need and obligation to safeguard the rights and safety of sex workers, and to minimise the harm caused by sex work.

**Regulation**
In certain countries, there has been acceptance by government of the age-old practice of commercial sex. To this end, these governments have adopted an approach that seeks to regulate the industry.

The Netherlands accepts sex work and seeks to regulate the industry, in efforts to protect sex workers from exploitation, prevent involuntary sex work, and advance the rights of sex workers. Germany has opted for regulation in order to remove the stigma attached to sex work, and to strengthen the labour rights of sex workers.

**What are those opposed to decrim saying?**
Those opposed to the decriminalisation of sex work often say that it would increase the trafficking of vulnerable people. It is important to note that there is a big difference between trafficking and sex work. Sex work concerns adult, consensual sex. It is a job, a way for people to make a living. Trafficking on the other hand is similar to sexual slavery, and is a gross human rights violation.

The United Nations is clear that for a person to have been the victim of trafficking, the following conditions must be met:

(a) The person must have been moved.
(b) There must have been deception or coercion for the purposes of exploitation.

Sex work concerns adult, consensual sex. It is a job, a way for people to make a living.
Sex workers, photographed in Hillbrow in the run-up to the FIFA World Cup in 2010. (Image: Rowan Miles, Alamy)
Cyril Ramaphosa underlining the last year, with then-Deputy President collaborated in its development. It includes sex workers as peers and as partners, and sex workers collaborated in its development. It also includes the decriminalisation of sex work. It was launched in March last year, with then-Deputy President Cyril Ramaphosa underlining the urgency of its implementation.

**What does the law say currently?**

There are a number of laws in South Africa that criminalise various aspects of sex work. Section 20(1) of the Sexual Offences Act of 1957 states that: “Any person who has unlawful carnal intercourse, or commits an act of indecency, with any other person for reward commits an offence.”

The Sexual Offences Act of 1957 also criminalises a number of acts associated with sex work, such as procurement, brothel keeping, facilitating sex work, and living off the earnings of sex work, among others.

**The impact of the current legislative framework**

The South African government has always made the conscious choice to combat sex work through criminalisation. It is also worth noting that the profession garners its own share of moral reservation and stereotypes from general society.

The impact of this on sex workers, therefore, is objective as well as subjective; in that sex workers may internalise society’s view of them being less than human, or less worthy of protection and of having their rights enforced. Because sex work is criminalised, society seeks to ostracise sex workers from their communities, and the criminalisation contributes to the notion that sex workers are free to be abused and deserv the scorn of society, as they are engaging in an unlawful activity.

All of the above contribute to barriers for sex workers to exercise basic rights.

1. **Violence against sex workers**

Violence against sex workers should be viewed and assessed in the context of the prevalence of gender-based
violence in South African society as a whole. In 2004, a study found that a woman is killed every six hours by an intimate partner. In 2004, 15 per cent of the male respondents participating in a study done by the Medical Research Council admitted to the rape or attempted rape of a partner, wife or girlfriend.

A number of factors have been identified as the cause of the high rate of gender-based violence in South Africa; and although these are relevant to sex workers as well, there is some indication that sex workers, due to the nature of the work and the working conditions, are more likely to experience gender-based and sexual violence.

A Sex Workers Education and Advocacy Taskforce (SWEAT) study conducted in 1998 with 25 participants indicated that 16 of the women interviewed had experienced some form of violence at the hands of clients. Eleven of the participants admitted to being forced into unprotected sex with clients. Violence is not restricted to the outdoor industry; 53 per cent of the women (both indoor and outdoor) interviewed for another SWEAT survey conducted in 2007 revealed that they had been physically hurt or verbally abused while working.

2. Police harassment
The South African Police Service (SAPS) has a long history of violence towards the very people they are sworn to protect. During apartheid, the police were used to violate basic human rights, and violence was the mechanism used to enforce the apartheid regime. In recent post-apartheid years, the police have remained under fire for the violent methods that they use during protest action; a case in point being the shooting of miners at Marikana, North West Province, in 2012.

There have also been a number of delictual claims against the Minister of Police in instances in which members of the SAPS had been found abusing their power and authority to commit acts of rape and assault. In the 2007 SWEAT survey, 41 per cent of the women interviewed reported having experienced physical violence at the hands of members of the SAPS.

In 2010, the Western Cape High Court found that members of the SAPS were indeed unlawfully harassing sex workers. They would arrest and detain sex workers without the intention of bringing them before court to be charged or prosecuted. The judgment in the matter interdicts members of the SAPS from arresting sex workers without having the intention to bring them before court to face prosecution.

Through the SALRC’s engagements with sex workers since the judgment was handed down, all evidence suggests that since 2010, the members of the police have systematically ignored the interdict. Since the judgment, local municipal law enforcement – through an established vice squad – has been profiling sex workers by recording personal details and information and establishing a register of sex workers in the Cape Town CBD. Local law enforcement also systematically makes use of the municipal by-laws to harass sex workers by issuing fines for loitering and disturbing the peace, among other ‘crimes’.

In the instances in which the SALRC has appeared in the Community Court to represent sex workers, these fines are not prosecuted, and our clients were all advised that the State had declined to prosecute. Under these circumstances, where sex workers are legally represented, court processes are often swayed; it remains unclear what the outcome would have been, had the SALRC’s clients not had representation.

Members of the SAPS have also been accused of arresting and then dropping off sex workers kilometres away from where they were arrested or live, often leaving them in remote areas and at risk of serious physical harm. Sex workers report having their genitalia sprayed with pepper spray, and police officials extorting money or sexual favours from them in return for their freedom. Sex workers therefore either do not report incidents of violence or abuse to the SAPS, or they are threatened or threats of arrest are intimated when they do report such incidents. Sex workers do not view the police as individuals who are able to provide them with safety and security.

3. Health and HIV and AIDS
The illegal status of the work directly influences the health of sex workers. Sex workers are very often viewed as a health risk in society, as there is a perception that they carry and transmit sexually transmitted diseases and infections. Due to the physiological factors associated with HIV and AIDS, a woman is more likely to be infected with HIV from a man than to transmit the virus to him. The majority of sex workers in the industry are female; therefore, the reality is that they are more at risk of being infected by their male clients.

Surveys have found rates of HIV infection in sex workers in South Africa ranging from below 30% to over 70%. The very patchy nature of the data on HIV in sex workers is at least in part due to the legal status of sex work, the social stigma relating to sex work, and the related difficulties in involving sex workers in health care and/or research.

The overarching factor in respect of sex work and HIV and AIDS is the issue of consent and control. Sex workers, especially outdoor-based sex workers, have very little to no control over the conditions and circumstances in which they perform their services. They have very little time to negotiate terms and conditions before they get into a car, and have little control over where they are taken once they have been picked up. The lack of control leaves them open to the risk of unprotected sex and HIV and AIDS infection.

Many sex workers are alienated or abused when seeking medical treatment, once they are identified as sex workers by healthcare providers. The stigma (the illegal nature of the work, as well as the moral judgement) attached to the work, therefore, becomes a very real barrier when accessing healthcare services.

In 2014, The Lancet (a highly respected medical journal) published a commission (a special series of articles) on ‘HIV and sex workers’. The commission recommended that countries should decriminalise sex work, stating that: “There is no alternative, if we wish to reduce the environment of risk faced by women, men, and transgender people worldwide.”

“When thinking about the current rhetoric of the end of AIDS, the role of sex work can no longer be dismissed as marginal. Sex workers are central to African HIV epidemics. Their continued exclusion will undermine our goal of creating comprehensive and successful programmes to control HIV.” — The Lancet Commission on HIV and Sex Workers
Paths to decriminalisation

In December 2017, the ANC’s National Conference resolved that sex work should be decriminalised in South Africa. This decision could potentially be a major turning point in South Africa’s path toward decriminalisation. “I was pleasantly surprised at the ANC’s decision to decriminalise sex work, especially since we had been getting a lot of push-back when trying to fight for the decriminalisation of sex work,” says Marlise Richter, the head of policy and advocacy at Sonke Gender Justice. It was a very bold decision, she added, especially since it is against what was suggested in the Law Reform Commission report published last year.

The decriminalisation of sex work in South Africa would require a change to our laws, as described earlier in this article. However, there are a number of ways in which we can get to the point that Parliament amends the law.

The simplest way forward would be if a decriminalisation bill is introduced into Parliament. Legislation is typically developed by government departments. (Individual members of Parliament can also introduce bills, although this does not happen often.) In this case, for example, the Department of Justice and Constitutional Development or the Department of Health could prepare such a bill. Given that the ANC has resolved that sex work should be decriminalised, and given that they have a majority in Parliament, the chances of such a bill being passed in Parliament would be relatively good.

But if a decriminalisation bill is passed, it is very likely that at some point, conservative groups will challenge the bill in court, and the Constitutional Court will have to be the final arbiter on whether the new law is in line with the Constitution.

The courts themselves could provide a route to decriminalisation. If an appropriate case comes along, a court may rule, for example, that certain sections of the law are not in line with the Constitution, and are therefore invalid. However, this is a somewhat more difficult route, given that this kind of strategic litigation failed in 2002 in the Jordan case. A new case would have to be sufficiently different from the Jordan case in order for the Constitutional Court to consider it.

Either way, whether the main thrust comes through the courts or through Parliament, the case for decriminalisation would be much strengthened by greater social awareness and mobilisation in favour of decriminalisation. Parliament and the courts often end up reflecting the norms and values of society, and even with our progressive Constitution, wider societal support will be critical. The ANC’s resolution, at least, is one sign that momentum in South African society may be turning in favour of decriminalisation.

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The ABCs of contraception

Thuthukile Mbatha, Spotlight

You have a right to choose!

The only method proven to reduce the risk of HIV transmission and acquisition is male and female condoms. Whether you are on the pill, the injection, the IUD or the arm implant, it is still recommended that you use a condom during sex – this is referred to as dual protection. If you are HIV-positive it is also recommended that you take antiretroviral treatment, both for your own health and to reduce the chances of transmitting the virus to your sexual partner or partners.

What are my options, bearing in mind that no contraceptive is 100% safe for preventing pregnancy? There are contraceptives that are very effective, such as the intrauterine device and the implant. In approximately every 1,000 women, one may get pregnant while using these methods. Other contraceptives are somewhat effective, such as the pill and the injectable. If 100 women use the pill, typically, nine of those 100 may fall pregnant. If 100 women use the injection, three may fall pregnant.

The methods on the next page are all reversible. There are also methods of contraception that cannot be reversed: sterilisation, for women, and vasectomies for men, although this should be discussed at a clinic. The reversal of vasectomies should only be attempted in exceptional cases.

There is no contraceptive that is 100% effective. They can all fail, but some contraceptives are more effective than others. The implant and the intrauterine device are the most effective reversible contraceptives, because you don’t have to remember to take a pill every day, or to go to the clinic for repeat medication.

You have the right to choose the contraceptive you want to use – you should not feel coerced or forced to use a contraceptive you are not comfortable with. The main focus is that you should make an informed choice; that is, that you understand the method as well as the side effects, and that you believe this will work best for you in preventing pregnancy. You also have the right to be fully informed about your options, and about the benefits and side effects of any medical treatment you receive. Remember, the only method for protecting yourself from getting HIV is to use condoms, in conjunction with any contraceptive you choose to use.

It is your body – you have a right to know, and a right to choose!

(With thanks to Dr Malika Patel, University of Cape Town, for her input.)
**Injection**
There are two types of injection – one you must receive every two months, and the other you receive every three months. They are widely provided in the public healthcare system in South Africa, but it is important to discuss possible side effects with your nurse or doctor. If you do decide to use the injection, it is especially important that you use condoms when having sex, to reduce the risk of HIV transmission.

**IUD**
An intrauterine device (IUD) is a small device that is put into a woman's uterus (womb) by a specially trained healthcare worker – a lack of healthcare workers trained to do this is one factor limiting the availability of this method in the public sector, though this should not be a reason for non-access. It can prevent pregnancy for up to five years. It has the benefit that it does not require you to remember to do anything; this is why it is known as the ‘fit and forget’ method. Once you have an IUD inserted and you have had your follow-up visit to confirm its placement, you only have to return to the clinic if you want it removed, or if you have questions.

The return to fertility is quick after you have the IUD removed. There are no hormones in the copper device, so it is a good method to use if you get side effects from hormones. There are many incorrect assumptions about this method of contraception. Please discuss any issues with your healthcare provider, who will be able to help you with the facts. In the first three months after insertion your period may be a bit heavier, and you may experience some cramping. This should improve with time.

**Implants**
Implanon is a small, matchstick-sized rod that is implanted in the arm, and it lasts for three years. As with the IUD, it is a long-acting, reversible contraceptive, so it is also a ‘fit and forget’ method. For some women the implant may cause excessive and irregular bleeding, as well as headaches; but these are usually short-term issues that should be resolved. It is available at most clinics in the public healthcare system.

**The pill**
There are many different types of contraceptive pill. They all contain hormones, and they should be available at all healthcare facilities.

If you can handle taking a pill at the same time every day, the contraceptive pill may be an option. In addition to preventing pregnancy, there are other medical indications for which your healthcare provider may prescribe a pill – for example, the pill can offer relief from painful menstrual cramps.

Some women may not be able to take the pill, because the hormones may interact with their system; therefore, it is important to speak to your healthcare provider before you start using the pill. Once it is established that the pill is safe for you, you may continue to use it. Some women who use the pill develop side effects – if you do, you should contact your healthcare provider.

**Emergency contraceptives**
Emergency contraceptives can be taken shortly after sex to prevent becoming pregnant, in the event that you are concerned that your contraceptive has not worked – for example, if a condom breaks – or if you have forgotten to take your contraceptive. Most pharmacies and emergency units will have emergency contraceptives, and they should be available at all public-sector facilities.

**Condoms**
Condoms are thin, stretchy pouches that you either wear on your penis or place inside your vagina before sex. Especially male condoms are freely available from shops or health clinics and hospitals. They have a low failure rate when worn correctly, are readily available and completely reversible.
The results of the last Annual School Survey, released in 2017, sent shock waves through the country. According to the survey, an estimated 15 740 learners fell pregnant in the previous academic school year – that’s roughly 43 every day. This was described by Minister of Education Angie Motshekga as a major social, systemic and fiscal challenge – not only for the basic education sector, but crucially, for national development.

Teenage pregnancy among school girls impacts negatively on the girl’s ability to complete her schooling. In many cases, girls who fall pregnant while in school drop out and rarely return to school post-pregnancy, thus ending any prospect of further education or access to the labour market.

It is in this context that the Department of Basic Education introduced the draft Policy on the Prevention and Management of Learner Pregnancy for public comment. The DBE acknowledges its central role in the social sector’s collective response to this challenge, and sets out in this policy its goals, guiding principles and policy themes, to stabilise and reduce the incidence of learner pregnancy and its adverse effects on the education system.

The policy not only seeks to address the high rate of pregnancy among learners, but also the context within which this occurs – the familial and social context. It further seeks to provide options for reducing the number of unintended and unwanted pregnancies, the management of pre- and post-natal implications, the limiting effects of the associated stigma and discrimination, and importantly, the retention and re-enrolment of affected learners into school.

Of significance is that this policy seeks to ensure the accessible provision of information on prevention, choice of termination of pregnancy, care, counselling and support, frameworks for impact mitigation, and guidelines for systematic management and implementation. This it aims to do through the provision of comprehensive, quality sexuality education and access to adolescent and youth-friendly sexual and reproductive health services.

The policy further asserts the constitutional right of pregnant learners to continue and complete their basic education without stigma or discrimination. Specifically, it confirms that there should be no exclusion of pregnant learners, who must be allowed to remain in school during their pregnancy and return as soon after giving birth as is appropriate for both the learner and her child.

For its part, the school is required to accommodate the reasonable needs of the learner to ensure that her right to education is not disrupted or ended by pregnancy or birth. It thus promotes the right of girls to education by ensuring they are not excluded from school as a result of falling pregnant and giving birth, and providing a supportive environment for the continuation of learning.

Comments on the draft policy were due to be submitted by 10 March 2018.
Deadlines came and deadlines went, and still the Department of Basic Education (DBE) failed to respond to Spotlight’s questions regarding their much-touted condom distribution in schools programme.

Eight months have passed since the Department released their national policy on HIV, STIs and TB. In her foreword to the policy document, Minister Angie Motshekga patted her Department on the back, lauding their initiative in making South Africa “the first country in the world to have a policy on HIV and TB emanating from the education sector”.

The policy was widely welcomed, despite the resurfacing of some old moralistic arguments that sex education and condom provision promote sex. In broad terms, the policy recognises the urgent crisis of HIV and unwanted pregnancy in our schools.

Data shows that young women between the ages of 15 and 24 are the group in South Africa worst hit in terms of new infection rates of HIV. Doctors Without Borders believe that in South Africa, around 2 000 girls are infected with HIV every week.

Of equal concern is the incidence of teen pregnancies, which is still high, with Statistics South Africa putting the figure for 2016 at 71 babies born per 1 000 teenagers between the ages of 15 and 19.

The DBE policy was widely seen as an important first step towards making condoms and other contraceptives available to schoolchildren. But in the weeks after the release of the policy, concerns were raised.

The Department said the distribution of condoms would be “dependent on age of consent, inquiry and need”. This was seen as too limiting, and would also not be anonymous or discreet enough to encourage voluntary uptake of the services or the products. In addition, the DBE’s definition of the age of consent, at 16, was seen as excluding younger children who are sexually active.

The Department has also failed to give firm guidelines on implementation, including specifics on how the programme will be rolled out, maintained and measured for effectiveness.

Doctors Without Borders issued a press release calling for “intensified collaboration by the DBE and Department of Health (DoH) to offer annual HIV counselling and testing (HCT), TB and STI screening, and year-round access to stocked condom dispensers in all high schools”. The humanitarian body criticised the DoE for dragging its feet in implementing its own policy; and by their inaction, continuing to restrict pupil access to HIV testing, condoms and other sexual and reproductive health services in high schools.

Now, silence and evasive tactics from the Department of Education in response to Spotlight’s questions continue to raise concerns about government’s commitment, and its capacity to implement the policy.

Department of Basic Education spokesperson Terence Khala acknowledged receipt of Spotlight’s questions, and promised to respond. He has missed deadline after deadline.

Khala has not stated how the policy has been translated into action. Specific enquiries put to the Department include questions on how many schools have been reached; reactions to the project, as it has been rolled out; how many condoms have been delivered; the types of contraceptive made available; the budgets for the programme; the goals for the programme this year; and details of the sex education curriculum to accompany the programme.
Diantha Pillay, Programme Manager in the Implementation Science Portfolio of the Wits Reproductive Health and HIV Institute. Young women need to know the facts about all the available family planning methods in order to make informed choices about their preferred tools. (Image: Lookingroom)
Young researcher sheds light on contraceptive implant

Thuthukile Mbatha, Spotlight

Implanon NXT is a contraceptive method designed in the form of a single, matchstick-sized rod that is inserted on the inner side of a women’s upper arm. A study led by a young local researcher investigated why some women are very satisfied with the implant, while others are not.

Diantha Pillay is a 30-year-old Programme Manager in the Implementation Science Portfolio of the Wits Reproductive Health and HIV Institute. She manages a programme called OPTIONS, which stands for Optimising Prevention Technologies Introduction on Schedule. The OPTIONS programme focuses on providing technical support to the Government and other stakeholders for the roll-out of new HIV-prevention methods, with a particular focus on adolescent girls and young women. At present, the programme is providing support to the National Department of Health in providing oral PrEP exposure prophylaxis (oral PrEP) to populations most at need; such as sex workers, men who have sex with men, and adolescent girls and young women (AGYW). Oral PrEP is a pill taken daily to prevent HIV infection.

Diantha has a basic degree in science, majoring in biomedical sciences; an honours degree in medical science, majoring in medical biochemistry, with a focus on environmental toxicology; and a masters degree in public health, focusing on epidemiology and biostatistics. She has nine years of experience in health research, ranging from laboratory research to clinical trials, research in communities, and research within health programmes.

So who is Diantha out of work? She was raised in a small town south of Durban, and therefore loves being on the coast; she’s a self-confessed bunny hugger, loves to be surrounded by nature, and has a creative mind – so anything artistic catches her eye.

Diantha believes that in order to live a healthy, happy life, one’s mind, body and soul need to be in alignment. As a result she has a passion for health research, and is constantly trying to expand her knowledge in the field; she enjoys regular sessions of Pilates, and is a devout Christian.

Her interest in clinical research started at a young age. When other kids were reading novels, Diantha’s head was buried in her biology books and natural medicine journals, always jotting down her thoughts and ideas. She owes this to her parents, who raised her to

In 2016, Diantha led a study about the contraceptive implant Implanon NXT. Implanon NXT is a contraceptive method designed in the form of a single, matchstick-sized rod that is inserted on the inner side of a women’s upper arm.
Above: A promotional image shows the size and implant position of Implanon NXT. Below: Implant in progress. (Images: Youtube)
have an enquiring mind. She knew from a very young age that the health field was her path. Diantha is a humanitarian at heart and believes that her work needs to have a tangible impact in bettering the lives of those around her, hence her desire to work in the public health field.

In 2016, Diantha led a study about the contraceptive implant Implanon NXT. Implanon NXT is a contraceptive method designed in the form of a single, matchstick-sized rod that is inserted on the inner side of a woman’s upper arm. This method protects from pregnancy for three years, after which women can come back to the clinic to remove and replace it. It is a reversible method, in the sense that women are able to fall pregnant after removal if they so wish. This method was introduced in the public healthcare system in South Africa in 2014.

**Why do some women remove the implant?**
The motivation behind Diantha’s research on the implant stems from talk in the community that women using the implant were removing it before the end of its three-year use period, and that removal was happening in the first six months of insertion. Her study focused on exploring the experiences that women had while on the implant, and determining what nurses thought about providing the implant. To do this, 152 women were surveyed and eight nurses interviewed, in 12 clinics in the City of Johannesburg and the North West Province.

The study found that women started using the implant because they liked the convenience of not having to come to the clinic often for contraception, and because their friends, family and nurses had positive attitudes towards it. When they looked at why women stopped using the implant, on average eight months after use, it was mainly because of the side effects they were experiencing – in particular, bleeding-pattern changes and headaches.

They found that the excessive bleeding that was reported by some women may have affected their sexual lives with their partners, because the women who removed the Implanon rod were mainly married or living with a partner. This showed that women need a bit more support around managing side effects. Rumours and incorrect information about the implant also seemed to be driving down the demand for the implant.

On a positive note, the majority of women who were still on the implant rated their experience on the implant as ‘good’ or ‘very good;’ many did not report side effects, or said that side effects stopped over time.

In terms of counselling women about the implant, they found that counselling on how effective the implant is in preventing pregnancy, and on what side effects could be experienced, could be improved. Nurses felt that they lacked confidence in providing implant services – more particularly, removing an implant; which showed a need for additional training, as well as a need for guidance on counselling about the implant and managing side effects, in order to improve the service.

We are privileged in South Africa that we have a number of choices when it comes to contraception – ranging from pills to injectables and implants, etc. – available to us at public facilities. This enabling environment has been created to empower women to choose what suits them, depending on their stage of life; because women have the right to control their reproductive lives.

When they looked at why women stopped using the implant, on average eight months after use, it was mainly because of the side effects they were experiencing – in particular, bleeding-pattern changes and headaches.
Bill would roll back right to choose

Thabang Pooe, SECTION27

A new Bill threatens the very essence of a woman’s right to bodily integrity and reproductive decision-making, as well as the right to dignity.

Wednesday 31 January 2018 marked the 21st anniversary of the adoption of the Choice on Termination of Pregnancy Act (CTOPA). CTOPA states clearly that every woman, regardless of her age, has the right to a safe abortion. The rationale of the Act is to determine under which circumstances and conditions a woman may terminate a pregnancy. CTOPA sets the context in its preamble:

"Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa; Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies; Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth; … Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm." 

Clearly, the Act places a woman’s agency and autonomy centre stage.

Nevertheless, there are still serious challenges facing the implementation of CTOPA nationwide. According to HEARD’s, South Africa Fact Sheet on Unsafe Abortion, there is an estimated 50% of abortions in South Africa that occur outside of designated health facilities. Healthcare provider objections to providing abortion procedures result in fewer than half of government-designated facilities providing abortion services. The lack of real access to abortion services – due to lack of facilities and equipment required, and widespread ‘conscientious objection’ to abortion on the part of healthcare workers (including outside the legislated perimeters of such objection) – already violate women’s rights.

This points to the need for policy shifts that will enhance access to legal and safe abortion services for women in South Africa – unlike the amendments to CTOPA tabled in Parliament by Member of Parliament (MP) Cheryllyn Dudley in July last year. Dudley, MP for the African Christian Democratic Party, published a draft private member’s Bill, proposing certain amendments to CTOPA.

The stated objects of the draft Bill are to “delete certain circumstances in which a pregnancy may be terminated”; and to “ensure that a pregnant woman has access to ultrasound examinations and sufficient mandatory counselling to enable her to make a fully informed choice regarding the termination of her pregnancy”. This would include providing for mandatory counselling of women seeking abortions, including showing them images of foetuses in wombs.

The draft legislation is also intended to tighten conditions for allowing a woman to have an abortion in the second trimester, by requiring that a social worker must agree with a doctor’s determination that continued pregnancy would significantly affect the woman’s social or economic circumstances. Further, it would scrap provisions that permit a third-trimester abortion if there is a risk of injury to the foetus.

The Bill has been met with fierce opposition; mainly because in reality, the draft Bill aims to limit women’s ability to access safe abortions in health facilities around the country – thereby limiting, without justification, a woman’s constitutional right to equality; dignity; bodily and psychological integrity, which includes the right to make decisions concerning reproduction; privacy; and access to healthcare services, including reproductive health care.
Perhaps it is necessary to look at the proposed provisions more carefully.

1. The Bill eliminates two important circumstances in which women are currently able to terminate a pregnancy:
   - where the continued pregnancy would significantly affect the social or economic circumstances of the woman; and
   - where the continued pregnancy would pose a risk of injury to the foetus.

This is further exacerbated by the Bill requiring that the gestation period calculated is confirmed through an ultrasound examination, and introducing additional requirements for facilities that may provide abortion services – namely that the facilities must give access to ultrasound equipment and ultrasound examinations, and must give counselling.

These provisions are problematic on multiple fronts.

Firstly, our Constitution recognises that women have control over their bodies and reproductive capacities. This is located in a woman’s right to bodily integrity and reproductive decision-making, as well as the right to dignity. Forcing women to carry a foetus to term is an invasion of these rights.

Furthermore: properly understood, these rights ensure that the decision to terminate or not is made within the actual context of women’s lives; the removal of the ability of women to obtain an abortion – for social or economic reasons, or if the continued pregnancy would pose a risk of injury to the foetus – violates women’s rights to equality and bodily integrity.

Secondly, not all public facilities (as designated by CTOPA) will have ultrasound equipment or the expertise to undertake the tests that would be required by the draft Bill. In truth, ultrasound machines and healthcare workers able to operate them are frequently only found in major hospitals – and not at clinics, which is where women often seek (and are entitled to seek) abortion services. The unavailability of equipment or personnel would be an additional and unreasonable barrier to accessing abortion services. The additional restriction would also not improve the health outcomes of women accessing these services.

2. The Bill proposes mandatory counselling that includes showing images of the foetus in the womb.

In reality, the Bill seeks to introduce fear and shame into the counselling process by requiring that women be exposed to images of a foetus, including electronic pictures, diagrams and photographs. This is hidden under the guise of ‘informed consent’. The proposal to force this kind of counselling on a woman who seeks an abortion not only violates the woman’s dignity, but may serve as a barrier to access. This contradicts the rationale of the Act, which is to provide important reproductive health services to women in a way that respects their dignity.

Studies have already shown that currently, the way counselling is conducted amounts more to rhetorical scare-tactics, which construct abortion as firstly, a medical procedure associated with a wide range of extreme consequences; and secondly, as an act that contravenes the accepted purpose of ‘mothers’ (pregnant women) to protect their ‘babies’ (foetuses). The Bill would only serve to add to this, in violation of our legislative framework.

In sum, the proposals in the draft private member’s Bill seek to roll back the advances in sexual and reproductive health rights gained by women in South Africa since our democracy.

This was never an easy battle. The debate we ought to be having should not be around frustrating an already difficult process, but rather on how we may ensure that these services are meaningfully accessible to all women, irrespective of age or social status.
Abortion in Khayelitsha

Thuthukile Mbatha, Spotlight

Young people face many challenges when trying to access sexual and reproductive health services. For years there has been talk about the necessity of providing youth-friendly services at public health facilities. However, very few health facilities are run by healthcare providers who are youth aware; and this poses a barrier for young people needing these important services.

Young people in Khayelitsha are no different. They too have difficulty accessing family planning and abortion, due not only to the unavailability of services, but also to lack of information – and nurses’ attitudes, according to the Treatment Action Campaign (TAC), which has been working in Khayelitsha since the late nineties.

One of the issues identified by the TAC is the high number of backstreet abortion services offered by unqualified ‘healthcare providers’ – in fact, these services are illegal. However, the reason these illegal and often dangerous services continue to exist and flourish is because there is poor access to safe and legal abortion services. “There are so many illegal abortion facilities around Khayelitsha that have led to young women bleeding excessively and eventually dying,” says Amelia Mfiki, the National Youth Sector Representative for the TAC.

For many years, the TAC has been fighting for the abolition of such services, and for more public health facilities to provide abortion services to young women. “When we started the campaign there was only one (government) clinic offering abortion (services), because most healthcare providers felt that it was against their religion and morals,” Mfiki explains. The TAC and other like-minded organisations worked hard to change that; and as a result, five clinics in Khayelitsha now offer abortion services.

“A big issue now is that young women are using abortion services as a contraceptive – we see the same girls coming back to the clinics for abortions, over and over again,” says Mfiki. “As the TAC, we have noted the importance of teaching young women about contraception. The TAC developed a door-to-door campaign that sought to teach young women about family planning, and explained to young people that when it comes to contraception, abortion must be their last option.”
ABORTION

Access denied

Ntsiki Mpulo, Spotlight

Activists blame government for limited access to abortion services in the public sector.

The streets of Hillbrow bustle with morning traffic. Taxis shoot in and out of the wide avenues as the Spotlight team passes through the palisade fencing and glass doors leading to the overcrowded entrance of the Hillbrow Community Health Centre. Patients sit in queues awaiting attention in the reception area and in the casualty ward. There is a din, as traffic noise competes with hundreds of conversations.

The uniformed security guard dispenses directions and acts as a traffic officer, redirecting people to different areas of the clinic in response to questions: where should I go for this ailment, what should I do with this piece of paper? She is a fount of knowledge – of necessity, as there is little signage other than the ‘Reception’ sign at casualty.

When we ask where the area for termination of pregnancy is, she informs us that the facility no longer offers this service. The sister who used to provide the service left some six months ago, and no-one else wishes to provide it.

This is the dominant narrative in many facilities across the country, according to Professor Eddie Mhlanga. Dr Mhlanga, a devout Christian and an obstetrician, is a strong proponent of choice in termination of pregnancy. He was director of the National Health Department’s Maternal, Child and Women’s Health unit from 1995 to 1999. During that time, he spearheaded the development of legislation to legalise abortion.

In his view: though the legislation is in place, in practice, women are being denied the choice to terminate unwanted pregnancies, because the prerogative of choice over women’s bodies is given to health workers. This is an untenable situation.

“Black women have little or no rights over their bodies in this country,” says Dr Mhlanga. “Their autonomy is restricted by patriarchy, in the guise of cultural practices.”

This is a view shared by outspoken sexual and reproductive health activist Dr Tlaleng Mofokeng, who does not pull any punches.

“Patriarchy and misogyny are systematic,” she says. "Power relations are stacked against women; so when they go into facilities, they feel like the healthcare professional is doing them a favour.”

According to a policy brief by Critical Studies in Sexualities and Reproduction, a research programme based at Rhodes University, just over six out of every 10 (63 per cent) young women in Buffalo City Municipality in the Eastern Cape are not aware of their right to obtain a free abortion in the public sector.

“You can’t fight for a right you don’t know you have,” says Dr Mofokeng. “It suits the department not to do a health education drive on abortion.” It seems the department is not interested in upholding the Termination of Pregnancy Act.

“It was reported some five years ago that only 40 per cent of facilities designated for providing this service were operational,” explains Dr Mofokeng. “This means there is a higher risk of women going to clinics in the second trimester, looking for surgical options – where they won’t be helped.”

Every healthcare facility should be able to offer a medical abortion up to 12 weeks, on a woman’s request. But this is not the case; a large number of facilities have insufficient or no trained personnel, and there is no protocol for referring the woman to another facility. In addition, there are often medicine stock-outs, or the drugs required are not listed on the essential drugs list.

According to Dr Mofokeng, the lack of access to abortion services is the result of a lack of care for women on all levels – from the government itself, represented by the Department of Health, to the Ministry, which does not have accurate statistics. They don’t know and can’t quantify the magnitude of the problem; they are disinterested, and disengaged from all the illegal posters advertising medical procedures.

“This is a primary healthcare issue, and it is the Department’s problem to solve,” says Dr Mofokeng.

Approach abortion with compassion

Spotlight attended a termination-of-pregnancy training workshop delivered by venerated sexual and reproductive health rights activist and medical practitioner Professor Eddie Mhlanga. During the workshop, Dr Mhlanga outlined the circumstances under which a woman of any age may obtain a legal abortion in the public sector. He emphasised that a woman does not require consent from anyone to undergo the procedure, but that those under the age of 18 should be counselled to inform their parents or legal guardian.
Circumstances and conditions under which pregnancy may be terminated

<table>
<thead>
<tr>
<th>Gestation Period</th>
<th>Circumstances and Conditions</th>
<th>By Whom</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 12 weeks</td>
<td>On the request of a pregnant woman of any age</td>
<td>• Registered Nurse  • Registered Mid-wife with appropriate training</td>
<td>Informed consent of the pregnant woman</td>
</tr>
<tr>
<td>13 to 20 weeks</td>
<td>• Continued pregnancy poses a risk of injury to a woman's physical or mental health  • Would affect social or economic circumstances  • Severe physical/mental abnormalities in the foetus  • Pregnancy is a result of rape or incest</td>
<td>• Doctor</td>
<td>Informed consent of the pregnant woman</td>
</tr>
<tr>
<td>After 20 weeks</td>
<td>If the pregnancy would:  • Endanger the woman's life  • Result in severe malformation of the foetus  • Pose a risk of injury to the foetus</td>
<td>• Doctor</td>
<td>Informed consent of the pregnant woman; consult 2 doctors, or a doctor and a midwife</td>
</tr>
</tbody>
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Here are some of the questions we posed to Professor Eddie Mhlanga.

Who are the women seeking abortion?

“The majority of women who seek to terminate pregnancies, according to the health professionals Spotlight interviewed, are teenage girls. They report that sometimes girls as young as 14 years of age come to their facilities seeking abortions because this is their second child, and their families had forgiven them for the first ‘mistake’, but would not tolerate another; while others report having relationships with teachers or married men, and are not able to look after a child.

Sometimes it is a married woman who has ‘stepped out’ on her husband, who is perhaps out of the province. “I had a case where a woman came to me pregnant with her eighth child,” says Dr Mhlanga. “She had asked the doctor who delivered her seventh child to tie her tubes, but he failed to do so. She was a poor woman who survived on the grants provided by the state, and she simply could not afford another child. In this instance, the compassionate thing to do was to provide her an abortion.”

How many healthcare facilities offer termination of pregnancy services?

“In Mpumalanga, there are 23 facilities in the public sector that offer termination of pregnancy services. This is up from only five facilities three years ago. It is because we conduct training sessions for health professionals throughout the province, and even offer this training to other provinces. We trained doctors and nurses from Gauteng not too long ago.

In Gauteng there are 25 facilities, the majority of which offer the service only for women in their first trimester. Second-trimester terminations are only available at  • Chris Hani Baragwanath Academic Hospital  • Sebokeng Hospital  • Odi District Hospital  • Tembisa Hospital  • Services have been terminated at Dr George Mukhari Academic Hospital and Hillbrow CHC.”

How many women die as a result of unsafe abortions?

“The Minister of Health has said in a radio advert that a woman dies every eight minutes as a result of unsafe abortions; however, there are no statistics to corroborate this assertion. During my tenure at the National Health Department, we worked on the protocol for confidential inquiry into maternal deaths, which is published every three years. The last report, published in September 2015, looks at 2014 data; which revealed that in all maternal deaths, 57.3% were considered potentially preventable within the health system. However, there is no data specifically on maternal deaths caused by unsafe abortions.”

What do you think about conscientious objection?

“All healthcare professionals have taken an oath to deliver health care to all who live in this country, as stipulated in section 27 of the Constitution. Therefore, they do not have the right to object to offering the service, and the government should not enable this type of intolerance.

Compassion for the pregnant woman’s circumstances should be the primary motivation for any health worker. Currently, there is no provision in the Act for conscientious objection; and so, health workers are using the lack of clarity to deny women their right to health care.

Many health workers do not have a problem completing a botched abortion, irrespective of the cause; but they refuse to perform one at the request of a pregnant woman. This is grossly unjust.”

The ACDP has presented a private member’s bill to amend the Act. What do you think of the provisions they are suggesting?

“They recommend that a woman has an ultrasound. It is not only a coercive strategy to limit women’s ability to choose to terminate a pregnancy, but also impractical. Currently, there is no curriculum for training doctors to perform an ultrasound examination; it is simply not available in the public service. So this would be an additional burden on an already overburdened system.

In addition: in law, a foetus only becomes a life when it takes a breath; and thus, the argument that terminating an unwanted pregnancy is taking a life holds no credence in law.”

Dr Mhlanga is a lifelong advocate for the sexual and reproductive health rights of women, including the decriminalisation of sex work.
Southern and East Africa are the regions of the world hardest hit by HIV. Moreover, women, and particularly young women, are disproportionately affected by HIV. Some young people living with HIV have managed to normalise it, and are doing great things in their communities. This section will be looking at positive living, following three young HIV activists from South Africa and Uganda who refuse to allow HIV to determine the course of their lives.

**HIV PREVENTION TOOLS**

**Female condoms**

**Male condoms**

**Voluntary medical male circumcision**

**Post Exposure Prophylaxis (PEP)**

**Pre-Exposure Prophylaxis (PrEP)**
“At school, children used to say I was HIV positive because I was thin; that used to get to me, but I didn’t know that what they were saying was true.”
Uganda has about 1.4 million people living with HIV, with women – and young women especially – disproportionately affected. According to AVERT, an HIV education organisation, Uganda sees about 52 000 new HIV infections per year.

Young HIV activist Shakira Namwanje (24) has been living with HIV since a very young age, and has become an outspoken and energetic voice in her country. “At school, children used to say I was HIV positive because I was thin; that used to get to me, but I didn’t know that what they were saying was true,” says Shakira.

Shakira was raped at the age of eight, and contracted HIV – not understanding what it was. The rape happened during the school holidays. Shakira’s mom had left Shakira with her uncle, because she had no-one else to look after her while she was at work. “My mother had us at a very young age; both my parents had to work, so they used to send us to different relatives during the holidays, because there was no-one to look after us during the day,” says Shakira.

Shakira enjoyed spending time with her uncle and his wife, who had just given birth to a son. During the holidays, her uncle and his wife had a huge fight, which resulted in the wife moving out of the house and leaving Shakira and the son behind.

Shakira was comfortable staying with her uncle, who was still young, and used to bring them food during lunch and dinner at night. “My uncle used to own a cinema, where people from the community used to pay to watch movies or soccer. A number of his friends used to come to watch television programmes, so I used to call them my uncles as well,” she adds.

One afternoon her uncle had other commitments, and could not bring the food. He asked one of his friends to deliver food to the children. That was the day Shakira was raped; and she remembers it as the day her innocence and peace were ripped away from her.

Her uncle’s friend called Shakira in to the house, under the guise of helping him search for a parcel that her uncle had asked him to take. Shakira followed him into the house, where he raped her. “He told me to go and wash my clothes, which were covered in blood, and to never tell anyone about what had happened, otherwise he would kill me,” she says, with so much sadness and pain in her voice as she relives the experience. The man told her he would kill her should she utter a word to anyone.

When her uncle returned home, he found Shakira ill and feverish. Shakira was taken to hospital for malaria tests, which came back negative. Her condition worsened, and her uncle decided to take her back to her mother. Shakira’s mother also took her to the doctors, who also could not find anything wrong with her. Shakira suffered in silence. “I used to have nightmares every day following the incident,” she adds. She says the words and memory of her rapist haunted her every day.

Three years later, Shakira’s mother arrived at school to tell her that her uncle had died in a car accident. Shakira was sad, as she had loved her uncle. “But when I heard that my uncle was with his friend who raped me, and he had also died, I started laughing uncontrollably. I was sad that my uncle had died, but also relieved that the person who had stripped me of my freedom and happiness was no more,” says Shakira.

Shakira’s older sister told her that it is rude to laugh when someone has died. Shakira then confided in her sister the secret that she had kept for years, and which had led to her health deteriorating. Her sister told her mother, and she was taken to hospital for an HIV test. She was HIV-positive.

“Suddenly I was taking treatment every day, and I did not even know what for,” she says. Her mother did not take it well. “My mother was advised to take me...”
to a children’s counsellor who works with young children living with HIV. For so long she refused, but eventually she introduced me to Madame Ahseah, a counsellor,” Shakira says. Her mother realised that she could not keep this information away from Shakira as she was growing up, and she became more inquisitive about the treatment that she had to take even when she was feeling well.

“After graduating, I decided to disclose my status to more people, with the hope of changing other young girls’ lives,” says Shakira. She used a community radio station as a platform to disclose what had happened to her as a child, and that she had contracted HIV through rape. She then joined the ‘Because I am a girl’ campaign.

This campaign creates awareness about sexual violence, and offers psychosocial support to young girls who have been victims of rape. They visit different schools to talk to both girls and boys, and encourage boys to respect girls and value them as their sisters. The campaign has touched a number of young girls who have had a similar experience to Shakira’s.

The ‘Because I am a girl’ campaign is an international programme that is run in over 51 countries in Africa, Asia and the Americas. It looks at various issues that affect girls by virtue of being born female and being young. The campaign looks at issues of child marriage, teenage pregnancy and sexual violence, among others.

Shakira’s campaign is targeting an area called Kalangala in Uganda, a fishing town that has been in the news in Uganda because of an increase in rape cases. It is alleged that there could be more unreported rape cases in the area.

“I have been sharing my story with these young girls, and that has encouraged them to open up to me about what they are going through in their homes. I have assisted many young girls with getting counselling and sexual health services, and with opening criminal cases against the perpetrators,” says Shakira.

Shakira has not been in many relationships, because her mother was very protective of her following the incident. “I had a boyfriend in university who left me, and to this day I do not know why,” she says. “I never had a chance to disclose my status to him,” she adds.

For most people, finding out that you are HIV-positive is not an easy thing to accept. This is fuelled by the stigma. “The first person that I disclosed to was my best friend, who has been very supportive, and to date is still my rock.”

Shakira does not let her HIV status prevent her from living an active and positive life. “I enjoy sightseeing and touring, swimming, going out with friends, singing; and reading is my favourite. I am actually writing a book about my life,” she says. She is also part of a band called Stigmaless, a group of young people living with HIV. “We sing about HIV prevention, treatment drug resistance, and so on.”

Her message to other young people living with HIV is: “HIV is in you, but it’s not who you are – you can be whoever and whatever you want to be. Taking it one day at a time.”

The ‘Because I am a girl’ campaign is an international programme that is run in over 51 countries in Africa, Asia and the Americas.
Tshepo Ngoato's doctor and aunt sat him down to tell him he was HIV-positive, he felt as if his world had crashed before his eyes – that he had been dealt a death sentence.

Now, this 26 year-old man is a role model for many young people, and a co-founder of the Y+ network, a volunteer group of young people living with HIV (YPLHIV) who have demonstrated a commitment and connection to a constituency of YPLHIV in South Africa. They work to guide parents and healthcare providers on how to address the needs of HIV-positive young people, such as the appropriate age to inform children about their status, and how to support them thereafter. They also offer psychosocial support to HIV-positive youth.

Tshepo is one of thousands of children born with HIV in South Africa. He found out about his HIV status in 2003, after being diagnosed with tuberculosis (TB). His doctor recommended that they do further tests on him, and he tested positive for HIV. He was told to finish his TB treatment first before initiating antiretroviral treatment.

"The media had portrayed HIV as a death sentence – I thought I was going to die soon," says Tshepo. When he disclosed to his family and friends, some of them did not take the news well, and decided to distance themselves from him. "I lost a lot of friends and family when I came out about my HIV status," he adds. This rejection was devastating for the teenager.

Tshepo decided at a young age to be open about his HIV status. "My rule is to tell someone I am (romantically) interested in about my status before we even get into a relationship," he says.

Tshepo has been living with HIV openly for years, and has established a network of young people living with HIV called Y+, represented in all nine provinces. Y+ is currently finalising consultations with YPLHIV in all the provinces to find out the needs of young people living with HIV, because a large number of them find it hard to talk to nurses or their parents. "We have noted that there are a lot of HIV-positive adolescents who have treatment anxiety also, driven by the fact that they do not even know why they are taking this treatment," says Tshepo.

Other than being the founder of Y+, Tshepo is expanding his horizons in other ways too. "I am currently completing a Bachelor of Business Administration degree through Milpark Business College in Johannesburg. I am an outgoing person. I enjoy doing outdoors stuff, such as hiking and mountain climbing."

His message to young people is: "You may see that you are beautiful on the outside; but if you haven't gone for an HIV test yet, you shouldn't be confident about knowing what's beautiful on the inside. You can change this by getting tested, and knowing your health status. That would be a wise decision; you should never be scared of something that involves your health.

"To those already living with HIV, your life is the most important thing; you should value it. Being positive is nothing to fear. Never limit yourself and your strength just because you are positive. Your positivity comes with a lot of reactions; do not change who you are, just change your attitude towards living healthily and taking your pills."
“I read that my teeth and my hair would fall out, and that I’d get a hump on my back. I was so scared, I went into denial.”

Saidy Brown, one of the Y-Plus coordinators who is living positively with HIV.
Saidy Brown shares how she used social media to speak openly about her HIV status.

Doctor Google terrified Saidy Brown. For Saidy, when she was diagnosed with HIV at the age of 14, all the online information sounded like a visitation from hell.

“I read that my teeth and my hair would fall out, and that I'd get a hump on my back. I was so scared, I went into denial,” says Saidy (22), who lives in Mafikeng in the North West Province.

She ignored the results of the random HIV-testing day that she attended as a representative for her school. Denial made her keep her status a secret, even as she continued to Google and the search results continued to freak her out. Eventually – about six months later – she told a teacher, who went with her to tell her aunt.

“I hadn't been intimate with anyone; and that's when we realised that I must have been born with HIV,” she says.

Saidy's dad died when she was nine; her mom, a year later. Her two older siblings, who were tested later, were HIV-negative.

“I was really angry, and I couldn’t relate to anyone. I resented my aunt and my siblings and my parents,” she says.

All the while she stayed silent, keeping the secret to just her immediate family. It wasn't until she turned 18, when sores on her chest spread to her face and neck, that she knew she had to act.

“I was still blaming the sores on the heat, and I would buy umbrellas and shades and hide behind those; but I did know something wasn't right, so I went to the clinic. They had my records from four years earlier, and the counsellor started to talk to me, and told me to stop believing all the stuff I had Googled about antiretrovirals.

“I said I'd only give six months of my life to the drugs. But it turned out I didn't have any side effects, apart from some dizziness – but that was okay, because I took my tablets at night,” says Saidy, who's on a fixed drug combination treatment.

Finding that peace and having the support of her family allowed Saidy to disclose her status; and that’s when she decided to take to Facebook. Her long post, pouring her heart out about everything she had been through over four years, was part of what she calls her personal journey.

And people supported her. There was no judgement, and she didn't lose a single friend after posting her story. In fact, she's gained more followers on social media.

But Saidy admits it hasn't all been plain sailing with her relationships. When she was intimate with a partner for the first time, at 17, she used condoms, but she didn't tell him her HIV status. She remembers being so in love, but being so scared that she was going to infect him.

Two years ago she was rejected by someone she cared for, who told her he couldn’t have a relationship with her because of her HIV-positive status.

“I won't lie; it really broke me that he rejected me because of my status. But I think it made me stronger; because if that ever happens again, I think I will be able to handle it better,” she says now.

Today, Saidy says, she feels healthy and strong, and she continues her advocacy work around awareness and drug adherence. She’s part of a youth network for people living with HIV called SAY+, and she counsels others about the early stages of her own journey.

THE NEWS GETS BETTER
With the roll-out of antiretrovirals in the mid-2000s, we learnt that we can live healthy and productive lives with HIV. Now we also know that if we are stable on antiretrovirals, we can reduce the amount of HIV in our blood so dramatically that we become virtually non-infectious.

If you are living with HIV, you should get at least one viral load test per year. This test tells you how much HIV there is in your blood. If the test result is ‘undetectable’, it means that there is so little HIV in your body that normal tests cannot pick it up. If you stop taking antiretrovirals, however, the virus will start multiplying again, and you will become more infectious as your viral load increases.
Love may be blind; but some things, you shouldn’t ignore – like knowing your and your partner’s HIV status.

South Africa is still considered the world epicentre of the HIV epidemic, with more than 7.1 million people living with HIV in 2016 and around 270,000 new infections that same year, according to Statistics South Africa.

However, as more people gain access to support and improved treatment options for their HIV infection, so they come to live full, healthy lives. They’re also inevitably involved in relationships with people who are not infected with HIV. These mixed HIV-status relationships, where one person is HIV-positive and one is HIV-negative, are called serodiscordant or mixed-serostatus relationships.

Serodiscordant relationships have become part of the ‘new normal’ of our range of relationships. They deserve the right kind of medical advice, management and support to ensure that these sexual relationships don’t come with the risk of HIV transmission.

Researchers join the dots between low knowledge of HIV status and increased risk of transmission between partners. In 2014, Wits RHI researcher Catherine Martin found that up to half of the number of HIV-infected people in her sample group were involved with an HIV-negative partner. Despite this, she found that knowledge of status results was low, with 52.6% of women knowing their status, while only 37.5% of men knew their status.

It makes knowing your status the first step to take in any new sexual relationship. Developing open communication and trust with your partner or partners is also essential. Next, clinicians promote a multi-pronged strategy to manage mixed-serostatus relationships. This entails counselling and good medical advice as a foundation.

Clinicians advocate the ‘Treatment as Prevention’ route. This means that regardless of CD4 count, the HIV-positive partner or partners should start ART as soon as possible after diagnosis. A 2011 study called HPTN 052 found this intervention approach to be 96% effective in reducing transmission of the virus, as viral load can be reduced to be undetectable. Subsequent studies have confirmed that if someone has an undetectable viral load, they are not infectious.

Starting ART as early as possible is not just good for preventing onward transmission of the virus; it is also good for the health of people living with HIV. In 2016, the landmark START trial showed that people who started taking ART earlier were less likely to get tuberculosis or various forms of cancer.

Other critical strategies to manage the sexual relationships of serodiscordant couples and multiple-partner sexual relationships include the use of condoms during sex, as well as undergoing medical male circumcision.

Added to this is the emergence in recent years of pre-exposure prophylaxis (PrEP). PrEP involves people who do not have HIV taking a pill to prevent acquiring HIV. Current PrEP consists of taking a daily pill containing two antiretrovirals: tenofovir and emtricitabine.

It’s also a regime that’s regarded as an appropriate treatment intervention for heterosexual serodiscordant couples who want to conceive naturally. Jennifer Power, a research fellow at the Australian Research Centre for Sex, Health and Society at La Trobe University, writing in The Conversation in April 2015, says that PrEP “re-introduces the possibility of ‘safe’ sex without condoms”, and “allows natural conception with minimal risk. Evidence to date supports the safety and efficacy of PrEP for serodiscordant couples trying to conceive, and it’s seen as a sensible choice”.

The World Health Organisation (WHO) recommendations for serodiscordant couples who want to fall pregnant include ART to suppress viral load; the use of PrEP by the non-infected partner; sexual intercourse without condom use when the woman is at peak fertility; screening and treatment of sexually transmitted infections in both partners; and voluntary medical male circumcision.

It is noteworthy that the WHO acknowledges that serodiscordant couples who would like to have children are “often inadequately supported or face significant barriers to accessing existing sexual and reproductive health services”.

This speaks to the need to challenge stigmas and old societal norms among the general public, as well as among healthcare workers. And along with changing attitudes and behavioural practices, there must also be appropriate policies, legislation, funding, proper implementation and oversight.

This means many layers of responsibility and action coming together for better solutions to minimising the HIV risk for more serodiscordant relationships. It also makes loving whoever you choose that little bit easier to do. ☺

Current PrEP consists of taking a daily pill containing two antiretrovirals: tenofovir and emtricitabine.
Bonolo’s Story

Leonora Mathe, Treatment Action Campaign

Bonolo (not her real name) was born on 22 September 1987 in Cosmo City, in Johannesburg. She became HIV-positive at birth, and started taking ARVs at the age of 10.

“After matriculating from high school, I had my first boyfriend, who I loved so much; sadly, I lost him as soon as I disclosed my status. He blamed me for wanting to infect him. I was very hurt, because being HIV-positive is not a wrong choice I made; I was born with it.

“Actually, it made me lose my confidence and have low self-esteem, in such a way that I doubted I would ever find an intimate partner again who would love me as I am; but things changed when I met my husband of five years.

“We went out for our first and second dates, and as soon as the relationship started getting serious, I told him I was HIV-positive, and asked if he knew about his status. He took a break from the relationship, because he was scared and confused; but after he consulted clinicians and social workers, they taught him more about HIV. We reunited after six months, and we are married now.

“I would love to have children; and although studies have shown that you can have HIV-free children, I always fear that... what if something goes wrong? But my husband assures me that all will be well, and we should consider trying for one soon.”

He took a break from the relationship, because he was scared and confused; but after he consulted clinicians and social workers, they taught him more about HIV.
WHERE TO GET PrEP IN SA

**Gauteng**
- PHRU
- WRHI Ekurhuleni
- WRHI Esselen
- WRHI Tshwane
- NorthStar Pomona
- Health4Men Yeoville
- OUT Ten81
- Health4Men Zola
- Health4Men Chiawelo

**Limpopo**
- NorthStar Musina
- NorthStar Hoedspruit
- University of Limpopo
- University of Venda

**Free State**
- University of the Free State – Bloemfontein
- University of The Free State – Qwaqwa Campus

**Northern Cape**
- NorthStar Upington

**Mpumalanga**
- NorthStar Ngodwana

**Western Cape**
- TB/HIV Care Cape Town
- Health4Men Ivan Toms

**Eastern Cape**
- Rhodes University
- Nelson Mandela University – North Campus
- Nelson Mandela University – Second Avenue Campus
- Nelson Mandela University – South Campus
- Nelson Mandela University – Missionvale Campus

**KwaZulu-Natal**
- TB/HIV Care eThekwini
- TB/HIV Care uMgungundlovu
- TB/HIV Care uMkhanyakude
- University of Zululand – Main Campus
- University of Zululand – Richards Bay Campus
Lack of PrEP for young women is a rights violation

Thuthukile Mbatha, Spotlight

With around 2,000 new HIV infections every week in young women and girls aged 15 to 24, South Africa is facing an urgent HIV crisis in young women. Given the scale of this crisis, we need to use all the tools at our disposal to help young women stay HIV-free. And yet, uptake of one of the most exciting new tools is happening at a snail’s pace.

Pre-exposure Prophylaxis (PrEP) involves people who are at risk of HIV taking an antiretroviral to avoid becoming HIV-positive. A number of different kinds of PrEP options have been tested, but so far the form of PrEP that has worked best involves taking a daily pill that combines the antiretrovirals tenofovir and emtricitabine. This combination is marketed under various brand names, and when taken as prescribed, it is extremely effective at preventing HIV infection. PrEP in the form of a vaginal ring has also shown some promise, but appears to be less effective than the tenofovir/emtricitabine pill.

So why are we not providing every young woman in South Africa at risk of HIV infection with PrEP? Why, even in 2018, are we talking about providing PrEP to only in the region of ten or twenty thousand young women and girls in the entire country?

One probable reason is that in many of the trials conducted so far, people simply did not take PrEP as regularly and diligently as they should have, i.e. as prescribed. Of course, this difficulty is to be expected – convincing healthy people to take a preventative pill is hard, especially if there might be some minor side effects associated with that pill. Thus there is a worry that pills purchased by the state may go unused, or be used only intermittently.

A second (and related) reason might be that studies and mathematical models suggest that – from a big-picture public health perspective, at least – PrEP is not the game-changer many hoped it would be. Broadly speaking, to roll back the HIV epidemic, prioritising the treatment and retention of treatment of people already living with HIV will have greater impact than a PrEP rollout. From a public health perspective, then, PrEP might have relatively low priority.

A third probable reason is cost. Though a month’s supply of PrEP should cost the state less than R100 per person, there are also the associated costs of counselling, and ongoing care and monitoring.

While the financial and human resource costs of a PrEP rollout would indeed be significant, this should be offset against the economic benefits of preventing HIV infections. Several studies have been done in South Africa to test the cost-effectiveness of rolling out PrEP to young women, and the evidence suggests overwhelmingly that PrEP could be a cost-effective tool to reduce HIV infections among key population groups – especially because it need not be a lifelong drug; it is only taken when one is exposed to a greater risk of contracting HIV.

However, these reasons pay scant regard to individuals and their rights. The statistics clearly tell us that young women are sexually active, and being exposed to the risk of HIV infection – how else would we have 2,000 HIV infections a week?

By dragging its feet with the rollout of PrEP, the state is saying to young women: “This new tool with which you could protect yourselves exists, but we don’t think you should have it. Even if you know you are at high risk of contracting HIV. Even if you have a violent boyfriend who refuses to use a condom. Even then, we will not give you PrEP to help you protect yourself.”

Section 27 of The Bill of Rights in the Constitution of South Africa states that “Everyone has the right to have access to healthcare services, including reproductive health care.” It then goes on to say that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

Every young woman or girl in South Africa at risk of HIV infection has these rights, just like any other individual in the country. Accordingly, the state is obliged to fulfil these rights, as far as is reasonable and within its resources. That PrEP might not be the big game-changer in the HIV epidemic in South Africa does not matter. What matters is that there is a relatively cheap pill that can help young women and girls stay HIV-free, in the midst of a still-raging HIV epidemic.
TEST YOUR KNOWLEDGE

Crossword puzzle

ACROSS
7 The only multipurpose tool that prevents STIs, HIV acquisition and unwanted pregnancies?
10 Compounds that can be applied inside the vagina or rectum to protect against STIs including HIV such as gels, creams, films or suppositories are called?
11 What is name of the combination of ART drugs taken for 72 hours after being exposed to HIV?
12 The abbreviation of National Strategic Plan ______
13 A hormonal contraceptive that looks like a match stick and is inserted in a woman’s arm is called an ________.
14 A person who does not have sexual feelings or sexual associations is called ________.

DOWN
1 ________ cancer is the second biggest cause of cancer-related deaths among women in South Africa, after cervical cancer.
2 The contraceptive that women take once every three months?
3 Many young girls in South Africa miss school during their periods because they do not have ________.
4 This precautionary medical procedure offers men about 60 percent protection from contracting HIV.
5 ________ relationship, also known as or mixed-status, is one in which one partner is infected by HIV and the other is not.
6 What is the age at which young girls are allowed to consent to terminating a pregnancy?
8 What is the name of one of the ARV drugs that is included in the drug combination used as a Pre-Exposure Prophylaxis (PrEP)?
9 Abduction of young girls for forced marriage, most prevalent in rural Eastern Cape and KwaZulu-Natal, is called ________.
Find the word

Find the following words in the puzzle. Words are hidden → ↓ and → ↓.

ABORTION    HEALTH    QUEER
CIRCUMCISION HIV    RIGHTS
CONDOMS MENSTRUATION STIGMA
CONTRACTION PADS    SYPHILIS
DIGNITY PREGNANCY   YOUTH
GOVERNMENT PREP

MN QW E W G S O E R B L F S F E
E C B M X G O V E R N M E N T M R F
N K C O N T R A C T I O N W I R
S H E A L T H F Q P Q Y J M Y Y G Z
T S P R E P Q N R G I O A W O S H Q
R T P R E G N A N C Y M I B U V T U
U I A G A O A B O R T I O N T Q S E
A G D H C Q D C O X O W R A H H E E
T M S C O N D O M S L N S O N I T R
I A P N T X Q S D I G N I T Y V F L
O C R C I R C U M C I S I O N J G M
N J S Y P H I L I S O B S S U F U Z