**AIDS Activism and the Politics of Women’s Health in South Africa[[1]](#endnote-1)**

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**Introduction**

This paper describes how the *Agenda* journal special issue on “The Politics of Women’s Health in South Africa” came out of my research for my book – it presents material from both projects which use ethnographic and historical research methods. Throughout this paper I refer to the experiences of one of my key informants – Sethembiso ‘Promise’ Mthembu – who is now co-guest editing the journal issue with me. Mthembu told me in an interview in 2003 that she was diagnosed as HIV-positive at the age of twenty in 1995 (Interview 29/08/03). She hails from Umlazi township in Durban. In her first year at university, Mthembu became pregnant. She went to a clinic and tested positive for tuberculosis, a result which meant that she was also encouraged to give a blood sample to be tested for HIV. As a woman in a ‘committed relationship’ with a man, Mthembu did not expect to be diagnosed as HIV-positive. And she felt very angry ‘with myself’ and ‘with the system.’ Her whole outlook on life changed and ‘this whole new world suddenly opened up to me like, oh my goodness. Now I had HIV and I mean surely there are loads of other people that have HIV. Where are they? Why are the issues not on the agenda?’, she wondered?

After her diagnosis she received counseling which helped her adjust to living with HIV. She also began attending meetings of the National Association of People living with HIV/AIDS (NAPWA), where she began talking about living with HIV five months after her diagnosis. In 1996, she started volunteering with the National AIDS Convention of South Africa. But this work had adverse consequences for her relationship, experiences which NAPWA did not prepare her for or help her deal with, and which informed her gender-based critique of the mixed-gender organization. Her HIV-infection – in the absence of access to antiretrovirals, or ARVs -- resulted in her second child being still-born. This tragedy compounded the problems her HIV-diagnosis had caused and her partner began assaulting her. Despite this she decided to marry him because he had paid *ilobolo* (bride-price) for her, but

Marriage changed nothing. He became more and more angry with me for attending AIDS meetings and giving talks about my personal story. He was jealous of my meeting other people who were HIV-positive, saying that I cared for and supported other people at his expense. My life became an endless circle of beatings and unprotected sex, especially if he was drunk. I could not take it any longer and I left him, despite the cultural disgrace and shame that it caused.[[2]](#endnote-2)

In 1996, Mthembu went to work at Durban’s AIDS Testing, Training and Information Centre (ATTIC) with feminist Vicci Tallis. Mthembu began to frame her personal experiences as related to societal sexism and were also influential on her later decision to leave NAPWA and join the TAC and she became its first KZN provincial coordinator. But women like Mthembu and Prudence Mabele’s early feminist AIDS activism was not then significantly influenced by organizations which could be said to be pillars of the women’s movement in this period, such as the National Network on Violence Against Women (NNVAW), Reproductive Rights Alliance (RRA) or African National Congress Women’s League (ANC WL). There is a great deal I could say about Mthembu’s life history and work as an activist and I will have to direct you to the entry I wrote in the Oxford Dictionary of African Biography for a fuller account (Mbali 2011).

This paper focuses on how women’s AIDS activism has developed, politically, since 1994, and it emphasizes how women AIDS activists such as Mthembu have highlighted both the gendered, redistributive limitations of the post-apartheid state and the shortcomings of the women’s movement in our country. Women’s AIDS activism has mattered in terms of development and governance in South Africa because it has shed light on the gap between women’s constitutional rights and poor women’s lived experiences of suboptimal health-related service delivery. This poor health service delivery has stemmed from successive post-apartheid governments’ limited political will to improve the health system and has been expressed in the state’s ongoing, constrained administrative capacity.

In the first three quarters of my paper I share material from the third chapter of my book – *South African AIDS Activism and Global Health Politics* (which will be published by Palgrave Macmillan in early 2013) -- which deals with South African women’s AIDS activism in the 1990s. These first sections of the paper describe the social and political marginalization of women living with HIV (including within the women’s movement). The final quarter of my paper touches on more recent trends in women’s AIDS and sexual and reproductive health activism, which are outlined in papers which we have selected for publication in the special issue.

As I argue in my book, I believe it is important to examine the political dimensions of women’s AIDS activism in South Africa’s past, which has been under-examined in existing literature on the phenomenon which has mostly been contemporaneous and ethnographic in nature and has tended to focus on their intimate relationships and roles as care-givers and support group members (Akintola 2004; Susser 2009; MacGregor and Mills 2011). Our Agenda special issue also points to an emerging literature on trends in women’s health activism, more broadly, in the post-Mbeki era.

**Understanding “The Politics of Women’s Health in South Africa”**

One of the core concepts I will be referring to in this paper is that of ‘the politics of women’s health’. I fully recognize that ‘women’s health’ could encompass many things. When we concretized our ideas for the special issue of the journal, we decided to focus on women’s experiences of service-delivery in relation to their sexual and reproductive health. We chose this focus for two reasons. Firstly, because South Africa is living through a serious and entrenched AIDS epidemic which disproportionately affects women. And, secondly, because women in this country cannot routinely implement their reproductive decisions in a safe manner, even when they attend state health facilities. The contemporary, international norm of a rights-based approach to sexual and reproductive health dates back to the Cairo Conference on Population and Development of 1994. Whereas, previously a number of governments and international agencies had emphasized ‘family planning’ and ‘population control’, women’s rights in relation to their sexuality and reproductive capacities took center stage in relation to population policy, at least rhetorically.

Reproductive rights are interwoven into South African law – including the socio-economic right to access to health care in our Constitution —as a consequence of direct feminist political lobbying in our legislature and at our Constitutional deliberations. In this respect it can be differentiated from, for instance, American ‘pro-choice’ activism which has drawn on libertarian rhetoric and rested on court-based methods (Smith 2005; West 2009). In this sense, South African reproductive rights activism can be understood as moving beyond a narrow definition of the realization of reproductive rights as merely consisting women’s abilities to ‘choose’ abortions, to a wider notion of reproductive justice: a concept which recognizes that the progressive realization of women (and men’s) reproductive rights in the fullest sense – access to free contraception, abortions, free child care; adequate social grants – steps which require a significant redistribution of state resources.

As a consequence of the RRA’s activism South Africa’s Constitution refers to sexual and reproductive rights in three places:-

* The equality clause (s.9.3), which forbids discrimination on grounds of sex, gender and sexual orientation;
* Section 27. 1. A, which states that the **“**Everyone has the right to have access to ­ health care services, including reproductive health care…; and
* Section 12 dealing with “freedom and security of the person”

These rights in relation to sexual and reproductive health include the rights to access to information (frequently manifest in health professionals obtaining informed consent for medical procedures following adequate counseling), education, dignity, and for our bodily integrity to be respected. Our Constitution means that we all have the rights to choose to engage in pleasurable safer sexual experiences free from violence and to choose whether we would like to reproduce and if so, the number of offspring we would like to have. This is also the Department of Health’s formal understanding of the concept, as outlined in its 2011 policy framework document “Sexual and Reproductive Health: Fulfilling Our Commitments, 2011—2021 and Beyond.”

The suboptimal delivery of women’s health services has had profound implications in terms of development in post-apartheid South Africa. Since the 1990s, AIDS has been a demographic, health, socio-economic and cultural catastrophe for South African women. HIV is the leading cause of maternal mortality in South Africa, according to the government’s own statistics (Ramagale et al 2007).

This is extremely relevant to those of us concerned with social justice and the anthropology of development, not least because in 2000 world leaders committed to **8** Millennium Development Goals, which express the global consensus on poverty. One of these was to reduce maternal mortality by three-quarters by 2015 (MDG 5). The South African Health Review (Blauw and Penn-Kekanna 2010, p. 3) stated that “South Africa is definitely not on track to achieve MDG 5 and that maternal mortality has actually doubled since 1990”. Some commentators have argued that South Africa has taken two steps back in this regard with the maternal mortality ratio standing “at an astounding 400 per 100 000 live births (compared with, say, 210 for Ghana, 160 for Brazil)” (Ncayiyana, 2010, p.689). We would have to reduce that rate to 100 per 100 000 live births by 2015 to reach that rate.

Right, so we’ve explored what we mean by ‘women’s health’, now I would like to clarify what I mean by the *politics* of women’s health. When we use the term politics in this phrase, we do so in the feminist sense, to imply that the private sphere of the family, the home and our intimate relationships are infused with power. Moreover, we do so to indicate our affinity with the thinking of feminists who have argued for state intervention into this ‘private space’ to combat problems such as intimate partner violence and defend women’s rights to make autonomous sexual and reproductive choices. Denise Walsh has also usefully pointed out that women’s participation in activism and trade unionism in South Africa has been circumscribed by their disproportionate obligations in terms of domestic chores and child-rearing (2009). Conversely, it would be meaningless to talk about the politics of women’s health divorced from public contestations for control of the state, or policy-making, or budgetary allocation. So, we, therefore, decided to use the term politics in both senses, that it to describe how power is distributed and contested in both the public and private sphere and the implications for women’s rights and activist organizing around them.

**AIDS Activism and the South African Women’s Movement in the 1990s**

Mthembu’s story demonstrates that early male-dominated, mixed-gender AIDS organizations such as NAPWA neglected the gender-specific needs of women living with and vulnerable to HIV infection. It also points to the fact that established women’s Non-Governmental Organizations (such as those NGOs in the violence against women sector) and political organizations (such as the ANC Women’s League) offered almost no social support to women living with HIV and conducted almost no advocacy on their behalf.

I am not the first South African feminist to note that our country’s women’s movement was slow to address the intersections between AIDS and gender inequality in a systematic manner. As I have argued elsewhere, this partly related to sexism in South African epidemiology, and the country’s mainstream media in the early-to-mid-1990s: the overwhelming stereotype was that AIDS was a disease of prostitutes which did not affect ‘ordinary women’ (Mbali 2008). Even speeches by women’s movement activists and articles in feminist magazines and journals, which did cover the issue, did not demonstrate a shared understanding of which groups of women were at risk of HIV infection.

When the ANC swept to power with an overwhelming majority in 1994, the new parliamentary system of proportional representation enabled it to handily implement a gender quota system where 30% of its members were women. Several women also joined the cabinet, including Nkosasana Zuma, the Minister of Health. The new government adopted a ‘gender mainstreaming’ approach to advancing women’s rights. Gender mainstreaming refers to the principle that all government policies should entrench women’s rights to equality with men. As political scientist Amanda Gouws has pointed out, since 1994, an elaborate matrix of South African state institutions has also evolved to promote gender mainstreaming, including the Commission for Gender Equality (Gouws 2005a).

But some feminists have also been critical of gender mainstreaming. Gouws has contended that it has replaced state-engagement with women’s concrete, lived experiences of oppression *as women* with technocratic, abstract readings of gender (2005b). She has also persuasively made the case that because mainstreaming has placed gender policy everywhere in the South African state, it has become no-one’s responsibility (2005b, p.78).

In the post-1994 period, South African women also attended the Fourth World Conference on Women in Beijing, China in 1995. The Beijing Platform for Action committed governments – including South Africa’s – to develop policies to promote gender equality and women’s empowerment. South African women’s participation at the Beijing conference was an important domestic badge of honour. But such activists’ participation in prominent transnational meetings was reflective of hierarchies within the country’s women’s movement. Deborah Mindy avers that ‘Politically savvy women…knew that Beijing was the place to be, to network, and to credential oneself as a leader in the South African local and national arenas’ (2001: 1191). While some women activists engaged in power-brokering in Beijing, ‘young women [SUCH AS MTHEMBU] were left out of women’s organizing [back in South Africa] or, at best, were marginal and silent (and silenced) in women’s organizations’ (Mindy 2001: 1206). Moreover, young women living with HIV were among the ranks of those who were excluded from such global networking opportunities.

In assessing the post-apartheid accomplishments of the women’s movement it is also worth noting that two important pieces of gender legislation were passed: the Choice on Termination of Pregnancy Act of 1996 and the Domestic Violence Act of 1998. The drafting and passage of these two laws must be viewed in the context of the women’s movement’s reconfiguration into a set of sector, or issue-based, networks. In the 1990s the most influential of these networks were the National Network on Violence Against Women (NNVAW) and the Reproductive Rights Alliance (RRA) (Hassim 2006). Unsurprisingly, these two important pieces of women’s legislation (listed above) passed in the 1990s – expressed their issue-specific demands.

But powerful women in government and influential NGOs did not always represent *all women* – especially poor women – in this respect, those living with HIV were by far from the only group of females who had a limited voice in the women’s movement. The economic empowerment of poor women – which Hassim has referred to as ‘substantive gender equality’ – has, therefore, proved to be elusive in post-apartheid South Africa (Hassim 2006). Hassim’s assertion of the interwoven nature of women’s economic marginalization and their low social status is far from an outlier in feminist thinking. Indeed, feminist philosopher Nancy Fraser, has argued that gender is a ‘hybrid category simultaneously rooted in the economic structure and status order of society’ (2003: 19). For Fraser, ‘redressing gender injustice, therefore, requires attending to both distribution and recognition.’ (2003:19).

Some South African feminists, concerned about what Fraser has referred to as the ‘class-like dimension of gender’ (2003:21) have critiqued the government’s 1996 adoption of neoliberal policies under the rubric of the Growth Employment and Redistribution (GEAR) strategy. In particular, they have criticized policies such as the privatization of essential services, associated aggressive cost recovery, and reductions in social spending.[[3]](#endnote-3) They have also characterized these policies has having rested on the sexist assumption that poor women would (and should) have ‘naturally’ undertaken additional, unpaid reproductive labour such as wood/paraffin/water collection and care of children and sick/disabled relatives (including those who were AIDS-ill) (Gouws 2005; Benjamin 2007). Such critiques were pronounced at the time when the policy was passed: for instance, the Women’s Budget Initiative argued that ‘the [GEAR] policy contained elements which had been detrimental to women in other countries’ (Budlender 2001, p.337-8).

Another feminist critic of the GEAR policy at the time it was adopted was ANC Member of Parliament (MP) Pregs Govender (2007). Govender cut a lonely figure in parliament in her feminist opposition to the macroeconomic policy and she was also the only ANC parliamentarian to vote against the multi-billion rand arms deal. Her singular feminist opposition to both policies showed that party loyalty and the disciplinary procedures associated with the proportional representation system hindered many ANC women MPs from taking independent, feminist positions.

South African women’s subordinate economic status was multifaceted. They were more likely than men to be unemployed or employed in the informal sector and, therefore, to be first to lose their jobs when economic conditions worsened (Budlender 1996; Gouws 2005b). Women also faced a gendered disadvantage in education, a major route out of poverty, as the schooling of girl children and young women was disproportionately harmed by teenage pregnancy, their additional share of domestic labour, and their disproportionate victimization through sexual violence in schools (Gouws 2005b). This was relevant to the spread of HIV because many women’s economic subordination prevented them from leaving abusive relationships with wealthier male partners (Abdool Karim 2000).

Another relevant feminist critique of the women’s movement in this period is that NGOs which focused on intimate partner violence and sexual assault seldom engaged with how the issue interlocked with HIV transmission and, when they did, such efforts were not prolonged. For instance, in 1995, the National Conference Against Violence Against Women, NGOs called the compulsory testing of rape suspects and for district surgeons to be trained to offer counselling to women who had been raped both before and after they were tested for HIV but there is little evidence of sustained campaigning subsequent to this call (The Citizen 27/11/95).

A further crucial, if isolated, initiative was an AIDS-related special edition of *Agenda* journal which was published in late 1998. The overall idea behind the edition – compiled by feminist AIDS activist Vicci Tallis – was to showcase the small, but growing, number of studies demonstrating how gender inequality was shaping the AIDS epidemic. As was customary for the journal, the edition included articles which were both academic and activist in tone and content. Abdool Karim published a research-based article showing that the root of women’s greater vulnerability to infection lay ‘in the imbalance in power between men and women’ (1998: 18). By contrast, Mthembu offered personal testimony of her experiences of intimate partner violence as a consequence of her involvement in AIDS activism (1998). The special edition of the feminist journal also included a report on a seminar on violence against women and HIV transmission which was attended by representatives from thirty NGOs which was held at the offices of the Commission for Gender Equality in Johannesburg on 12 August 1998 (Pendry 1998).

But as late as 2001, Lisa Vetten and Kailash Bhana conducted a review of the academic literature and NGO activism around violence against women and AIDS in South Africa and concluded that ‘current responses to HIV/AIDS and violence against women remain split from one another and typically exist as parallel rather than complimentary initiatives’ (Vetten and Bhana 2001). As they argued, the link was eventually brought to the public’s attention in 1999 when journalist Charlene Smith wrote about her experiences as a rape survivor. Smith used her articles about her ordeal to lament rape survivors’ limited access to counselling and PEP with ARVs (Smith 2001). But as Vetten and Bhana contended, the limited epidemiological research and information available at the time made it harder for women’s organizations to develop ‘comprehensive responses’ to address the connections between rape, intimate-partner violence and HIV (Vetten and Bhana 2001, p.1).

Feminist writers did, on occasion, publish articles on AIDS and a few activists affiliated with the health NGOs and women’s movements sometimes spoke out on the issue at conferences, but they lacked a common understanding of the problem AIDS posed for the country’s women – a critical first step to developing effective policy-advocacy around the issue. The women’s movement’s collective inability to develop a shared vision of the problem meant that it was relatively inactive on the sexism behind AIDS, especially as compared to its work on other sexual and reproductive health issues – such as abortion -- or the gay rights movement’s response to the epidemic.

Barbara Klugman has also noted that reproductive rights activists were slow to address HIV in the transition era (2011). For a variety of reasons we can discuss in question time, she has concurred that there was a disconnect between reproductive rights and AIDS activists in the 1990s. Shortly after the Treatment Action Campaign (TAC) was formed, the right to access to HIV treatment came to eclipse an emphasis on the sexual and reproductive issues which underlay the spread of the virus, at least in terms of public consciousness, partly because of this disconnect between the two movements – TAC and the women’s movement.

In the 1990s, the women’s movement was very effective in empowering certain groups of women – NGO-leaders and politicians and civil servants who moved in government – and obtaining significant legal reform. But certain groups of women were also marginalized within the movement – young women, poor women, women living with HIV – which meant that it did not represent their interests in either domestic or international policy forums. Certain groups of women’s lack of representation in the movement partially accounts for many women in government’s immobility around the ‘class-like’ aspects of gender oppression, discrimination which certainly shaped female vulnerability to HIV infection. Moreover, after 1994, the women’s movement slowly lost its former unity of purpose and a disconnect developed between women NGO leaders, those in government and those living with HIV. While some women in government such as Govender took independent feminist positions on issues affecting women who were poor and/or living with HIV, this was very rare given the reality of strict party discipline within the ANC. One of several female AIDS activists who has lamented the failure of the ANCWL to address HIV in this period is Lihle Dlamini, the TAC’s Women’s Rights Representative, who told me in an interview in 2008 that “I think that the women’s league has so much to do (08/04/08). It can also lead other campaigns that we as women want to take forward on HIV issues, for instance, the PMTCT campaign for pregnant mothers, gender-based violence and access to justice for women who have been raped and have been assaulted and also access to post-exposure prophylaxis for women who have been raped and access to pap smears for women”

Of course, this ‘broken telephone’ in the women’s movement was far from the only dimension of the political marginalization of those living with HIV. Mixed gender AIDS NGOs like NAPWA must also feature in a fair account of the social isolation and political marginalization of women AIDS activists living with HIV.

But it is a tragic irony that two female health ministers (Nkosasana Zuma and Manto Tshabalala-Msimang) who had participated in the women’s movement – including in the latter’s case, specifically, women’s health activism – in the early 1990s refused to act to substantially widen access to ARVs from 1998-2002, despite the fact that by the early 2000s AIDS had become the leading killer of young women. While such an ARV roll-out was rendered complex due to substantial patent-related cost and human resource capacity issues, it is important to remember that Brazil – another middle-income, developing country – started rolling out ARVs in 1996 and by the late 1990s already had a thriving generic HIV drug industry – which produced ARVs costing less than a quarter of the patented versions. As I and other colleagues have argued elsewhere, the main reason for the state’s delay in providing antiretroviral drugs was the deficit in political will exhibited by the administrations of Thabo Mbeki – something women in government had neither the power nor political independence to address in an effective way.

There is a lot I could say about the TAC’s campaigning on women’s health issues, but there is one document in particular I would like to discuss and that is one affidavit in the movement’s Constitutional litigation for the government to roll-out Nevirapine to prevent paediatric AIDS. I think it’s worth revisiting this document because it points to the humanitarian implications of the Mbeki government’s refusal to roll-out ARVs, but is also reveals ongoing problems in women’s health service delivery for reasons I will discuss in a minute.

In August 2001, Busiswe Maqungo was a TAC activist who shared her story in court papers submitted by the South African AIDS movement in *TAC v. Minister of Health and others*.[[4]](#endnote-4) She told the court that she was a twenty-nine year old woman who lived in Mfuleni township in the Western Cape. The young mother discovered that she was living with the virus which caused AIDS after taking an HIV test at Conradie Hospital in Pinelands in May 1999, where she had taken her one-month old daughter Nomazizi after she became ‘very sick’ – indeed, her baby suffered from pneumonia, diarrhea and dehydration.[[5]](#endnote-5) The TAC activist said that she felt ‘hurt for my child’ when she found out that her baby girl was HIV-positive because she had unknowingly passed the virus on to her; prior to her own diagnosis she had never suspected that she could be living with the disease.[[6]](#endnote-6) While pregnant, she knew that AZT could be used to prevent Mother-to-Child-Transmission (MTCT) of the virus and recalled that, ‘I gave birth to a[n] HIV positive child and wondered why, if she could be treated with AZT’.[[7]](#endnote-7) The grieving mother was plagued by thoughts of how easily things could have turned out differently. What if all South African hospitals, including the one she attended, had asked pregnant women if they would like to be tested for HIV? Then she would have taken the test and wanted adequate counseling on her results. And what if her doctors had then told her that she could use Nevirapine to reduce MTCT of HIV? Then she would have tried to have obtained it ‘for the sake of my baby’.[[8]](#endnote-8) Her baby daughter who was ‘always sick’ died at nine months of age.[[9]](#endnote-9) She pleaded with the South African government to ‘implement MTCTP [MTCT prevention] nationally so that women can be given a chance and children can be saved’.[[10]](#endnote-10)

**Postscript: Old Problems, New Developments**

So, what sort of advocacy are women AIDS activists such as Mthembu engaging in today? They are still highlighting the gendered, redistributive limitations of the post-apartheid state, but there some exciting green-shoots in the country’s women’s movement which I would like to discuss. For our Agenda special issue we have gathered a number of papers showing that there is still a chasm between our constitutional values and the women’s experiences of health service delivery. We have papers on:-

* Women activists’ unsuccessful struggle to have decriminalization of sex work included as a goal in the 2012—16 National Strategic Plan for HIV/AIDS, TB and STIs;
* Women prisoners’ experiences of changes in HIV-related health-services since the roll-out of ARVs at Westville Prison;
* Young women shackdwellers’ accounts of poor sexual and reproductive health service-delivery in public sector health facilities;
* The implications of gender discrimination and stigmatization for the mental health of widows in rural areas;
* Coercive sterilization of women living with HIV

I can’t talk about all of them, so I will rather talk about two.

One of the papers is a report of a project of Her Rights Initiative (HRI), an NGO led by Mthembu, based in Durban, which represents women living with HIV. HRI conducted workshops with females living with the virus in KwaZulu-Natal, the Eastern Cape, the Western Cape and Gauteng. The women who participated in the workshops did not know that women living with HIV are at an elevated risk of cervical cancer, the commonest form of cancer in South African women, which should be considered an opportunistic infection. Their health providers had mostly talked about ARVs, they were generally not encouraged to get pap smears, which current policy allows each woman to have 3 of over the course of her lifetime (which is out of keeping with Centers for Disease Control recommendations that women living with HIV should have them more frequently). The report points to the need for additional training for health workers on the intersections between cervical cancer and its predecessors and HIV and more frequent provision of pap smears for women living with HIV. Some women said they had been offered hysterectomies as first-line treatment but there are other options such as cone biopsy (localized surgery) which are less likely to damage a woman’s fertility. Women who had had hysterectomies had not been counseled on the hormonal problems, infertility and lack of menstruation which follow a hysterectomy.

Two areas of continuity for me in terms of women’s health delivery are that, yet again, as in Maqungo’s story cited above, women are not being counseled correctly on their options in terms of medical tests and procedures which could protect their health and, secondly, that they are not being routinely offered procedures which could prevent further disease and keep as wide as possible a range of healthy reproductive choices at their disposal.

But before we all get too depressed about women’s health policies in this country, I would also like to quickly describe some new initiatives which may be precursors to the revival of a national sexual and reproductive health movement. The special issue of the journal will also include an article by Khathaso Mokoetle and Barbara Klugman which describes the formation of a new organization – the Sexual Health and Rights Initiative – South Africa (SHARISA). It was formed following a civil society consultation process, which explored the decline of activism around sexual and reproductive health and rights in the past decade. What Mokoetle and Klugman found was that while there are many different groups in civil society working on various aspects of sexual and reproductive health and rights including:-

* Violence against women
* Abortion
* Sexuality education
* Sexual orientation
* Gender identity
* Gender issues

However, as of 2011, there was no mechanism to unite them around shared goals, something which, the authors argue, is necessary to hold government accountable, build a new layer of young activists in a context of the declining quality of services, and shift public opinion in favor of Sexual and Reproductive Health and Rights, or SHRH -- which has not occurred with exception of HIV. It is still early days for the initiative, but they have appointed a director, Betsi Pendry and have some funding from International Planned Parenthood Federation (IPPF). A critical question for me is whether this new network will be able to obtain the political influence that the RRA had at its height?

There is much I could say on women’s health and the NHI scheme. The release of the Green Paper on an NHI scheme presents an important opportunity for civil society to give input to health policy. There is a need for detailed SRH costing exercises and ring-fencing of funds for relevant human resources, equipment and drugs and vaccinations: for instance, how much would it cost to change pap smear guidelines for women with HIV in-line with international best practices? Would it represent a cost saving in terms of hysterectomies prevented and reduced hospitalizations?

I think a large part of whether NHI will improve women’s health is going to depend upon whether feminist health activists in civil society can forge a joint agenda with women in the ANC WL and in government. There is one very encouraging sign in this regard. According to media reports, the league has authored a discussion document on gender which makes the case for decriminalization of sex work in preparation for the ANC’s conference in Mangaung in December. The league has argued that the current laws on sex work criminalize only the (mostly female) sellers but not the men who pay for sex. They apparently want to obtain a resolution in support of decriminalizing sex work and are using the advocacy around abortion legalization as a template for how to go about this.

It is unclear where such initiatives might lead, but the status quo of multiple advocacy organizations lacking a common sexual and reproductive health policy agenda means that they are still largely politically ineffectual. A strong civil society coalition with a list of common demands could certainly assist in ensuring that the South African government is held accountable in terms of the progressive realization of health services which uphold women’s dignity and rights. This is all the more important at a time when the government is fundamentally reconfiguring our health system.

**Notes**

1. Material presented in this paper will be published shortly as follows: (Mbali and Mthembu 2012; Mbali, forthcoming). [↑](#endnote-ref-1)
2. Promise Mthembu, ‘Testimonials Project on HIV/AIDS-related Stigma and Discrimination: Young Women Living with HIV/AIDS Have Rights Too,’ Available at <http://www.abanet.org/AIDS/testimonials/mthembu.html> , Accessed 11 November 2009. [↑](#endnote-ref-2)
3. The strategy has also been critiqued by ‘independent’ left academics because if promoted such policies (Bond 2000; Klein 2007). [↑](#endnote-ref-3)
4. Busisiwe Maqungo, “Affidavit of Busisiwe Maqungo, Submitted in Support of the Applicants” *Minister of Health & Others v. Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.) (Aug. 2001) [hereinafter Maqungo Aff.], Available at <http://www.law-lib.utoronto.ca/Diana/TAC_case_study/AffidavitMAQUNGO.html>, accessed August 18, 2011. [↑](#endnote-ref-4)
5. Ibid. [↑](#endnote-ref-5)
6. Ibid. [↑](#endnote-ref-6)
7. Ibid. [↑](#endnote-ref-7)
8. Ibid. [↑](#endnote-ref-8)
9. Ibid. [↑](#endnote-ref-9)
10. Ibid.

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