UNHOLY ALLIANCE

Empowering women at the heart of the pandemic is vital to ending HIV/AIDS

BY JEANNE CLARK

It started around a kitchen table.

HIV and AIDS were sweeping the globe, with near-pandemic conditions in sub-Saharan Africa, where 70 percent of new HIV infections were occurring. One of the fastest-growing HIV-positive populations was in South Africa, where the disease was threatening to derail the new democratic government and the nation’s recovery from apartheid. By 2000, HIV and AIDS had orphaned more than 10 million African children. And while AIDS in the United States was quickly changing from a certain death sentence to a chronic disease, thanks to widespread availability of antiretroviral (ARV) drugs, the outlook was far different overseas: Less than 1 percent of AIDS drugs were sold in African nations south of the Sahara Desert.

The need for action, particularly by the United States, was clear. And three remarkable people came together around that kitchen table in Washington, D.C., to create a U.S. response—U.S. Rep. Ron Dellums; Barbara Lee, Dellums’ former chief of staff and now his successor; and Dr. Allen Herman, founding dean of South Africa’s National School of Public Health.

Together they developed the idea for an “AIDS Marshall Plan for Africa” that would be partially funded by a trust set up at the World Bank. This eventually transformed into the Global Fund to Fight AIDS, Tuberculosis and Malaria, which led in 2003 to the creation of the President’s Emergency Plan for AIDS Relief (PEPFAR) and its reauthorization in 2008. In addition their work led to legislation enacted in 2005 to provide assistance to orphans and vulnerable children in developing countries affected by HIV/AIDS.

The trio’s combination of knowledge, strategy and commitment was remarkable. In Congress for 27 years, Rep. Dellums propelled many initiatives, including the fight for sanctions against South Africa’s apartheid regime, as well as working to rescue Africa from HIV/AIDS. Rep. Lee came to Congress from a distinguished career fighting for civil rights, women’s rights and health care, and as founding cochair of the Congressional HIV/AIDS Caucus she doggedly and strategically pursued other members of Congress to take up the cause of eradicating AIDS worldwide.

Finally, Dr. Herman, who worked with South African anti-apartheid leader Stephen Biko and is married to women’s health-care expert Dr. Deborah Smith of Washington, D.C.’s famed Whitman-Walker Health Center, had unparalleled understanding of U.S. and South African health-care delivery systems, as well as how government funding is distributed.

Their brainstorming session around the kitchen table has had great results worldwide: As of June 2013, 1 million babies have been born HIV-free thanks to PEPFAR, and PEPFAR directly supports more than 5.1 million people with lifesaving antiretroviral treatment—up from 1.7 million in 2008. From 2001 to 2011, PEPFAR also supported more than 1 million voluntary medical male circumcisions (which lower the chances of contracting and spreading HIV), and the program provided HIV testing and counseling for more than 46 million people. In sub-Saharan Africa from 2005 to 2011, AIDS-related deaths decreased 32 percent, and new HIV infections fell 33 percent between 2001 and 2011.

Researchers from Stanford estimate that PEPFAR saved 630,000 lives because of its efforts to reduce HIV/AIDS in nine of its targeted countries (including South Africa) between 2004 and 2008. Moreover, the study found a spillover health effect that reduced mortality by another 110,000 lives in those years.

But along with these good outcomes from PEPFAR, the magnitude of HIV/AIDS in Africa is still staggering.

Nineteen African countries lead the world with more than 24.5 million in reported infections—more than 60 percent of the global HIV-infected population. South Africa has the largest number of people living with HIV—some 5.7 million—with a 17.8 percent prevalence rate among adults (ages 15 to 49).

And the pandemic in this region has hit women even harder than men.

Six out of 10 South Africans living with HIV/AIDS are women. According to PEPFAR’s 2011 South Africa Operational Plan Report, women have the largest number of people living with HIV. And the pandemic has hit women hardest.


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between the ages of 25 and 29 have the highest prevalence rate at 32.7 percent, with the next highest rate among women 30 to 34 (25.8 percent).

One of the problems initially hindering HIV/AIDS treatment in Africa was that U.S. and European pharmaceutical companies were charging top dollar for the essential ARV drugs so desperately needed to keep people alive. During the first three years of the PEPFAR program, there was a requirement that its funding for drug treatment could only be used to purchase FDA-approved ARV drugs, provided mostly by major American and European drug companies, effectively excluding lower-cost generics.

The major pharmaceutical companies (Big Pharma) received millions of dollars of funding in those first three to four years. And today, some Western biotechnology and pharmaceutical companies are still benefiting from clinical trials being conducted in South Africa. They are cheaper to conduct there, principally because subjects may be recruited from a wider segment of the public (since the rate of HIV/AIDS is so high). There is also no requirement that patients be supplied the drug cost-free beyond the life of the clinical trial. In the U.S., some drug companies provide ongoing treatment at no cost to those subjects who are responding positively to a drug.

After significant protests, though, especially those led by South African advocacy groups such as the Treatment Action Campaign of South Africa, the FDA accelerated the approval of generic ARV drugs. Since 2009, 95 percent of the ARV drugs being used are low-cost generics, mainly supplied by Indian pharmaceutical companies. Today some 2 million South Africans are on ARV treatment, meeting 80 percent of the need.

But research by the Feminist Majority Foundation shows that another problem in the global HIV/AIDS response under the Bush administration is that little money went to women-led service organizations. Instead, it was more often funneled to faith-based organizations, some of which are hostile to comprehensive women’s reproductive services. Abstinence-until-marriage and being-faithful (AB) programs too often ruled the day, and too often the focus was on children or addressing the health and birth of an “unborn child” as opposed to meeting the needs of women.

“Early in its implementation, women (unless pregnant) received fewer prevention services,” says Dazon Dixon Diallo, founder and president of SisterLove Inc., the first women’s HIV/AIDS organization in the southeastern U.S. Diallo has also done work in South Africa for 13 years. “You didn’t have a prevention program [for women], except for transmission to the baby.”

South African women’s health-care leader Marion Stevens, coordinator of Women in Sexual and Reproductive Health (WISH), further describes the impact of the Bush-era policies and a continuing bias against funding women-controlled organizations by saying, “We have seen the complete decimation of women’s groups and community groups. The major women’s groups in South Africa are struggling to survive and many have closed—for example, the Women’s Health Project and the Reproductive Rights Alliance. As a result it is difficult to recruit folks into positions or campaigns that are feminist or clear on issues of reproductive justice, given the unreliability of funding or that one has to pledge not to advocate for abortion access.”

When Congress passed PEPFAR in 2003, it directed that “Abstinence, Be faithful in marriage, and (selective) Condom use” (ABC) be the emphasized HIV-prevention approach, which Rep. Lee opposed. Those receiving funds were required to spend 33 percent of all prevention funding on abstinence and faithfulness (AB) programs. In 2008, that requirement was dropped, but the global AIDS coordinator still had to let Congress know if less than half of funding to prevent sexual transmission of HIV in countries with widespread HIV/AIDS was spent on AB programs.

Even though current PEPFAR guidance has shifted to support comprehensive reproductive and sexual-health programs, the abstinence programs still have a lingering effect, leading some providers to de-emphasize condom education and other comprehensive prevention strategies. On Dec. 1, 2009, PEPFAR released its five-year strategy, which indicated that a key goal is to expand integration of HIV prevention, care, support and treatment services with family planning and other reproductive-health services. Yet the Fiscal Year 2013 Country Operational Plan...
UNDER THE BUSH ADMINISTRATION, LITTLE MONEY WENT TO WOMEN-LED ORGANIZATIONS...INSTEAD IT WAS FUNNELED TO FAITH-BASED ORGANIZATIONS.

Women in breakthrough study to lower HIV risk meet in Vlindela, South Africa, in 2010 (left); counselor in Port Elizabeth, South Africa speaks with young woman getting an HIV test (right).

Guidance states in no uncertain terms that “PEPFAR funds may not be used to purchase family-planning commodities.” That means that women cannot get contraceptives at the same site where they receive HIV/AIDS testing, counseling, treatment, and care.

Also, as in Bangladesh (see “Unholy Alliance,” Spring 2013 issue of Ms.), HIV/AIDS and family-planning money is still going to religious organizations. In total, some 25 percent of USAID partners were and are faith-based, many of which are hostile to comprehensive sexual and reproductive health and rights.

Prime partners, faith-based and not, receive the U.S. funds and distribute them to sub-partners (nonprofit, profit-making, and governmental agencies). But Feminist Majority Foundation research shows that there is inadequate transparency as to where the money ultimately goes and what it is used for, since PEPFAR does not audit sub-partner spending. The PEPFAR data that is available to the public is inadequate for following or tracking dollars spent.

Some South African feminists, however, are worried that money is still going to anti-reproductive-rights, anti-gay, Catholic and fundamentalist organizations. They believe this money has helped fuel a South African anti-abortion and anti-family-planning movement. Some even believe South African right-wing groups getting PEPFAR money are apparently collaborating and being trained in the U.S. by other anti-reproductive-rights groups. Moreover, PEPFAR allows any provider to invoke a “conscience clause” and carry out prevention programs based on its own philosophy, even if it is in conflict with human rights and science.

The second-class citizenship status of women in South Africa has also had a major impact on the spread of HIV/AIDS and sexually transmitted infections (STIs) in the country. Young women are often stigmatized if they refuse to have sex. Polygamous marriages are still part of the rural landscape, and women’s lack of access to education and jobs leads to transactional sex from a young age.

In addition, women are often victims of rape and violence. The rate of sexual violence in South Africa is among the highest in the world: A 2010 survey found that a South African woman was raped every 17 seconds. Women born in South Africa have more chance of being raped than learning how to read. When saying “no” is not an option for too many South African women, policies of abstinence and faithfulness in marriage, rather than comprehensive strategies, are more than a waste of money and time: They endanger women’s lives.

This all points to the need of PEPFAR and USAID to fully incorporate women’s rights and women’s needs into all their work. Earlier this year, President Obama signed a presidential memorandum which ensures that advancing the rights of women and girls remains central to U.S. diplomacy and development efforts. PEPFAR has also expressed a commitment to this approach, focusing on five key strategies in its attempt to ensure access to quality services and reduce the consequences of HIV:

- Increasing gender equity in HIV/AIDS programs and services, including reproductive-health services
- Preventing and responding to gender-based violence
- Engaging men and boys to address norms and behaviors
- Increasing women’s and girls’ legal protection
- Increasing women’s and girls’ access to income and productive resources, including education.

These are great goals, but they are dependent on having a presidential administration that will enforce them, and on having providers that will abide by the new policies and not the previous rules.

And there’s the rub. While PEPFAR’s latest five-year strategy does not include any language about abstinence—stating that PEPFAR’s prevention programs will focus on prevention approaches that include male and female condom distribution, safer-sex education and family planning—money is still being given to organizations and medical providers hostile to women’s reproductive rights and who support ineffective and discredited abstinence-only approaches. And agencies can still refuse to provide comprehensive services by invoking the “conscience clause.”

Moving forward, we must fund and invigorate women’s organizations in South Africa and defund those opposed to gender equity. Experience and research across the globe make the path to a healthy and prosperous nation clear: empower women. Without such empowerment, the dream of ending AIDS in our lifetime, launched around a kitchen table, will never be reality.

This is Part 2 of a series on how U.S. efforts to fight HIV/AIDS globally have been hindered by, among other things, conservative religious ideologies and a lack of funding to women’s health-care groups.

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