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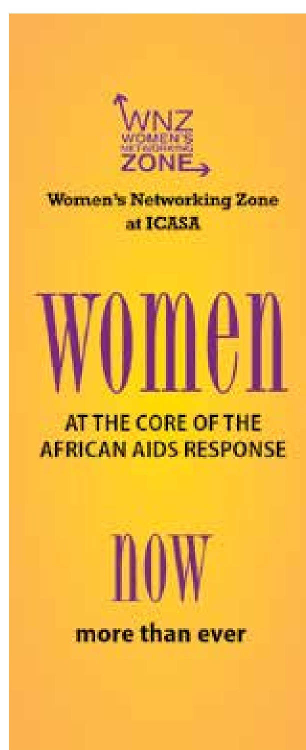
Move discussion and rhetoric into action...

Women's rights *ARE* human rights

Sophie Dilmitis

Over the past thirty years the AIDS response has collectively moved mountains. No other health movement in history has made so much progress in shifting the landscape.[1] The collective global strength and leadership of civil society addressing HIV has become a legacy. Where would we be today without community activists – women and men, living with HIV, and those who stand in solidarity, who have advocated for change in often political agendas around treatment access, research, human rights, social justice and gender equality?



With everything we have been able to achieve, unfortunately key affected women in all our diversity survive and thrive, but only despite the very structures that are there to protect and serve us. In countries most affected by the epidemic, human rights have not been meaningfully integrated into everyday life as a fundamental principle of social and political relations. In fact, human rights and gender equality have often been characterised by many governments as a great imposition, and hence addressed more in the breach than

Mujeres Adelante
A NEWSLETTER ON WOMEN'S RIGHTS AND HIV

Editorial...

Recognising the continuing need for critical discourse on women's rights and HIV, this edition of the ***ALQ/Mujeres Adelante*** examines some of the challenges persistently '*obstructing*' the translation of commitments to women's rights protections into a practice of '*enabling*' social environments for women in all their diversity to claim their rights, to meaningfully engage with and participate in all aspects of the AIDS response, and to move '*from criminalisation to agency*'.

The various articles in this edition explore the progress made in the protection and advancement of the rights of women in all their diversity – in the discourse, policy and practice – based on and in the context of the response to HIV. Some of the issues discussed include the need to '*move beyond women as mothers*' and '*PMTCT as the panacea of gender programming*'; to address and respond to women's health '*across their lifespan*', whilst recognising and transforming the underlying inequalities and power relations defining women's health and access to healthcare; the invisibility of women who have sex with women in sexual health policy, research and service provision; and the realities and risks of migrant women. This edition also includes an opinion on the '*politics of confession*' and '*disclosure*', a civil society call to action in response to the controversial Ugandan HIV/AIDS Prevention and Control Act, and further elaborations on the '*law versus religion*' debate within the context of South Africa's constitutionalism.

The need to place women and human rights at the centre of the AIDS response is well acknowledged, with commitments at a national and global level to protect and advance women's rights in the context of and the response to HIV. Reflecting on the progress made in access to treatment, **Sophie Dilmitis** raises the question of how far we have come in translating the women and human rights policy framework into a practice of protecting and advancing the rights of women in all their diversity. In light of the many rights abuses women experience, she argues that without the integration of human rights as '*a fundamental principle of social and political relations*', and acknowledgement that

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KEY MESSAGES

- Women are not homogenous – we are diverse and our rights should be respected and upheld – women's rights *ARE* human rights
- There has been so much progress yet we are lagging far behind in achieving gender equality and human rights for all – especially people living with HIV
- We must move from policy and rhetoric to action

in respect and accountability, most especially when it comes to women who are marginalised and made vulnerable by the lack of human rights protections. Many of these key affected women include pregnant women; lesbian, bisexual and transgendered women; young people; sex workers; women who use drugs, women who are incarcerated, and migrant women.

…but only despite the very structures that are there to protect and serve us…

ACCESS TO TREATMENT: GAINS AND CHALLENGES

One of the great successes of the AIDS response has been around treatment. We know there has been incredible scale-up. At the end of 2012, 9.7 million people accessed antiretroviral therapy in resource-limited settings.[2] HIV treatment is profoundly affecting the epidemic in countries where it has been brought to scale.

In South Africa, where HIV treatment coverage reached 83% in 2012 under WHO's 2010 treatment guidelines[3] (initiating treatment at a CD4 cell count of 350 cells/mm3), scaling-up treatment is estimated to have reduced the number of people newly infected with HIV by 17–32% in 2011.[4] South Africa's new approach to treatment yielded extraordinary results, resulting in a 53% overall reduction in the cost of antiretroviral medicines, with projected two-year savings of US$640 million.[5] Whilst the progress is impressive, countries need to do more and should not become complacent about turning the tide.

…we must move from policy and rhetoric to action…

I have been living with HIV for 20 years. 12 years ago when I began treatment, I could not afford it and a friend purchased my first supply until I was fortunate enough to enrol in a treatment programme. At over US$20 000 per annum – lifesaving treatment was beyond my reach. At that point – I also never believed that I would ever give birth to a child. Today,

'*women are not homogenous*', we will continue to '*lag far behind*' in achieving gender equality and human rights for all. Concluding with recommendations for women's advocates, she cautions that '*we must not be complacent about the gains we have made*', but instead '*move from policy and rhetoric into action*', and '*seize every opportunity*' to ensure that women in all their diversity are '*central*' in the response to HIV.

The persistent failure to respond to women's realities, risks and needs from a premise of '*moving beyond women as mothers*' has been a key element of the women, human rights and HIV discourse for a while. Within this context, **Ann Strode, Vicci Tallis** and **Sethembiso Mthembu** explore women's health in South Africa today, and identify key challenges facing women in healthcare provision. Notwithstanding the '*enabling*' policy and legal environment, the article argues that the social and cultural environments '*remain hostile*' towards women and that services '*do not adequately address women's needs*'. Based on the need for a '*coordinated and comprehensive*' approach to women's health that responds to women '*across their lifespan*', the article calls for a national policy on women's health, and argues that a '*feminist health agenda*' requires both '*law reform*' and '*redefining the power relations*' impacting as much on women's health, as on women's experience of accessing healthcare.

The benefits (and risks) of '*disclosure*' – both HIV positive status and sexuality – are an essential part of the discourse; with some arguing that '*disclosure*' assists in mitigating stigma, and some questioning the effects of such disclosure on not only peoples' '*safety*', but also the manifestation and perpetuation of the concept of '*otherness*'. Responding to the news about the first '*openly gay cabinet minister*' appointed in South Africa, **Pierre de Vos** raises the question: '*so what's the big deal?*', and elaborates on the meanings and implications of '*confessions*' and disclosure. Taking into account the heteronormative societal context we live in, he argues that the '*ritual of confession*' is one of confirming the perceived '*difference and inherent peculiarity*' of homosexuality and an HIV positive status, and '*yet another discursive tool*' used to justify '*marginalisation and oppression*'. In an '*ideal*' world, he concludes, a person's sexuality and/or HIV positive status would be of no interest or importance to anyone, but '*in the world we live in, it is far from it!*'.

Women who have sex with women is one group frequently '*forgotten*' and '*left out*' in the women and HIV discourse, whilst their risks and vulnerabilities to HIV exposure, transmission and related rights abuses are often questioned. Recognising the implications of such beliefs, **Ingrid Lynch** and **Matthew Clayton** introduce the findings of emerging studies examining HIV risks of lesbian, bisexual women, and other women who have sex with women in Southern Africa. The article demystifies the notion that women who have sex with women are '*virtually immune to HIV*', examines the consequences of '*disclosing their sexual identity*' on accessing healthcare, and argues that '*silence increases the risk*' and '*contributes to isolation*', which in turn further strengthens their risks to stigmatisation, violence and HIV. Given the '*hierarchy of risk*' for women created by the '*current HIV discourse*', the article concludes with recommendations to ensure that women who have sex with women move from being '*generally invisible*' in sexual health policies, research and service provision

my treatment in Zimbabwe (one pill a day) costs me between US$38 – 42 per month, which I can afford – but we need to make sure that this is available to all!

Another great stride has been the increase in access to PMTCT. In 2012, of the estimated 1.5 million pregnant women living with HIV in low- and middle-income countries, 62% received effective antiretroviral drugs (ARVs) to prevent transmission of HIV to their children; increasing from 57% in 2011.[6] Contrary to what I believed about my future at the time of my diagnosis – today, I have a two-year-old son and he is HIV free. This access is not something that we – mothers and fathers take for granted.

Whilst we advocate for the expansion of all four pillars of PMTCT, we also raise the alarm that we are more than mothers. Yet, countries tick the box and say they have addressed '*gender*' by providing PMTCT. Countries choose not to address the four pillars of PMTCT – in fact, they almost always just focus on preventing vertical transmission from mother to child. This is unacceptable! Not enough countries are investing in gender transformative programmes, nor do most countries actually understand what '*gender transformative programming*' is. If we are going to succeed, then we need to move beyond PMTCT as the panacea of gender programming.

…human rights have not been meaningfully integrated into everyday life as a fundamental principle of social and political relations…

HIV POSITIVE DIAGNOSIS REALITIES

Despite the gains and progress in access to treatment – an HIV positive diagnosis is still seen by many as a death

to becoming '*an integral part of*' the discourse, policies and programming on women, human rights and HIV.

Migrant women is yet another one of the '*marginalised populations*' who are not as '*central*' to the discourse on women's rights and HIV, as the intersections of xenophobia, gender inequality, violence, stigma and HIV risks and vulnerability may demand. Based on this premise, **William Bourget** explores the realities and risks of migrant women in the context of and the response to HIV in South Africa – from entering the country to finding employment and accessing healthcare services. Taking cognisance of the '*widespread xenophobia and gender-based violence*' migrant women experience, he underscores that healthcare settings become the '*spaces*' in which these intersections '*intersect most profoundly*', and argues that the potential '*benefits*' of migration become '*virtually inaccessible*' for migrant women. He concludes that without '*centering marginalised populations*' in the discourse on and response to HIV, programmes will remain both '*unresponsive*' to the realities and needs of migrant women, and '*destructive*' to the human rights agenda.

The debate on the law versus religion and '*morality*' seems to be not only never ending, but also more importantly seems to persistently be used to define, manifest, perpetuate and often justify especially women's risks and vulnerabilities to HIV and related rights abuses. Further elaborating on the '*law versus religion*' debate, **Pierre de Vos** emphasises that the '*moral views of the majority*' (even if based on '*religion*') cannot be used to '*infringe on the rights of others*'. Within the context of '*South African constitutionalism*', he argues that the protection of and respect for '*diversity*' and '*human dignity*' as constitutional values are contrary to promoting a religious (or otherwise) '*uniform moral code*', and concludes that the Constitution (not any religion) '*serves as the source of our constitutional morality*', which '*celebrates*' religious and other forms of '*diversity and respect for human dignity*'.

The recurring theme in all the articles seems to be that despite the many commitments and '*rhetoric*' to protect and advance women's rights in all aspects of the response to women, violence and HIV, and to ensure that women in all their diversity are in the position to '*meaningfully*' engage with and participate in the discourse, policy design and programming, we seem to '*lag far behind*' in achieving these '*ambitious goals*'. While some women continue to be '*left out*' and remain '*invisible in the 'discourse*', women who appear to be '*central*' to the discourse and at the '*core*' of the '*rhetoric*' seem to be equally left at the '*margins*' when it comes to translating commitments to actions and policies into practices.

And so, despite all the commitments to women and human rights at the '*centre*', what seems to remain is as much a '*gendered*' as a '*heteronormative*' societal context, filled with '*hostile environments*' for women and perceived notions of '*otherness*' – which without '*drastic transformation*' of the very same environments and contexts will (and cannot) '*move discussion and rhetoric into actions*', or truly '*advance*' the rights of women in all their diversity in '*practice*'. Thus, without *real* '*actions*', there will be no *real* '*movement*', and women's rights protections will remain but a '*commitment*', with little to no impact on women's realities and multiple layers of risks to HIV and rights abuses…

JOHANNA KEHLER

sentence. Many are paralysed by the fear that people might one day discover they have HIV, and that they will have to then defend their lives, their actions, their profession and their sexuality. In many parts of the world this fear is real – it is not just internalised stigma. Many countries, communities and families do not support people living with HIV. HIV continues to amplify the cracks and social challenges in our homes, communities and countries, which is evident through the many countries that ignore numerous human rights and gender equality indicators – from Papua New Guinea, where people with HIV are still buried alive, to Uganda where Lesbian, Gays, Bisexual, Trans people and Intersex (LGBTI) live in fear and can no longer access their medication, because of their sexuality.

…they will have to then defend their lives, their actions, their profession and their sexuality…

Our lack of humanity and compassion shows in how we deal with the non-biomedical aspects of HIV. We know that HIV is more than just a health issue, and that stigma and discrimination continue to be perpetuated – many times by the very people in service provision, who are supposed to protect and serve all people as equals. A good example of this is from Uganda, where Rosemary Namubiru – a 64-year-old nurse, charged with attempted murder, denied bail and sent to jail for three years even though the child she supposedly exposed to HIV continues to test HIV negative. Another example is the dangerous backslide in Uganda's efforts to respond to HIV – the new HIV Prevention and AIDS Control Bill – a law that not only, amongst others, violates the rights of people living with HIV, but also empowers medical workers to disclose a person's HIV status.[7] This makes

pregnant women, who are mandatorily tested for HIV, particularly vulnerable to this gross violation of privacy and confidentiality.

…live in fear and can no longer access their medication, because of their sexuality…

As mentioned in a UNAIDS background paper on criminalisation[8]

> *…at least 63 countries have jurisdictions with HIV-specific criminal statutes, although just 17 of these countries appear to have prosecuted individuals under these laws.[9] At the turn of the 21st century, no country on the African continent had an HIV-specific criminal statute. It is now the region with the most countries with HIV-specific criminal statutes (27), followed by Asia (13), Latin America (11), and Europe (9).*[10]

…our lack of humanity and compassion shows in how we deal with the non-biomedical aspects of HIV…

We see the rights of women continuously violated – especially in developing countries – where women, particularly women from key affected communities, are treated as second class citizens. In countries across continents, women living with HIV continue to be sterilised without their consent and coerced into abortions. Around the world, 1 in 3 women have experienced some form of violence in their lifetime. A recent study of young women in South Africa showed that women who had experienced intimate partner violence or high levels of gender inequality in their relationships with men were 51% more likely to acquire HIV over the next two years; and that women are 55% more likely to be HIV positive, if they have experienced intimate partner violence.[11] Evidence from Rwanda, Bosnia, and the Democratic Republic of Congo (DRC) documents mass rape and military sexual slavery, repeated rapes and gang rapes of women, girls and some men, and women being forced to offer sex for survival or in exchange for food, shelter or protection.[12]

Another major challenge has been that countries need

to better track who is accessing treatment – a systematic review of people who initiated ART across sub-Saharan Africa found that approximately 25% were no longer in care one year after initiation; a figure rising to 40% after 2 years.[13] Countries need to be smarter around data collection and look at overlaps with sex- and age disaggregation, as well as collecting data that speaks to nuances. For example: are there sex workers who use drugs?; women who use drugs?; trans sex workers? who are also young - etc. The data quality should speak to these nuances and not assume that '*key populations*' or '*women and girls*' or '*people who use drugs*' are a static group.

HOPES...

Within all of this chaos – one step in the right direction has been that The Global Fund to Fight HIV, TB and Malaria (the largest donor pertaining to HIV) is becoming smarter, more effective and efficient in how it supports countries, and provides technical assistance to civil society. With the Global Fund New Funding Model (NFM), more communities are engaged and part of the decision-making process. The Global Fund is providing better guidance and support to what countries could be investing in that will make a difference in the lives of women –through their new Gender Equality Strategy Action Plan – which must move from policy to practice.

> ...networks of key affected women are doing great work to fill crucial gaps...

Networks of key affected women are doing great work to fill crucial gaps, taking the lead in addressing the crisis, and providing services for many of their peers. But this needs to happen on a far larger scale. No matter how great the work of civil society organisations and networks, they will remain just a few centres of excellence, and only scratch the surface of what is needed. Until the major challenges, such as criminalisation of HIV transmission, punitive laws, coerced abortions and sterilisations, gender-based violence perpetrated by health staff, extreme levels of stigma and discrimination, are overcome, the

> ...across continents, women living with HIV continue to be sterilised without their consent and coerced into abortions...

prospect of equality for all – irrespective of HIV – is going to be a mirage for most. Sadly, community responses that can – and have – effectively worked to overcome these structural barriers are chronically and severely lacking resources to shift the status quo.

> …they will remain just a few centres of excellence, and only scratch the surface of what is needed…

I am proud to be part of a global movement of activists, from civil society to our friends in the UN, who deeply care about human rights and gender equality. I remain inspired by people who put others before themselves and consider the struggle with regards to HIV, gender equality, human rights and social justice more important than their own lives. Many years ago I was brought back to life – physically, mentally and emotionally – because of access to treatment and care from family and friends. Because of what we have today – I have many life problems and HIV is just one of them.

RECOMMENDATIONS TO WOMEN ADVOCATES!

A couple of points that we must remember when we find ourselves in strategic spaces

1. ***Women are not homogenous – Key affected women are diverse.*** Women in all our diversity must be respected and be meaningfully involved in all aspects of decision-making that affects our lives. We rely on our partners in the UN and amongst the donor community to support us in this participation. We must commit to effectively participating and consulting constituencies of women, and represent women in all our diversity. We must support each other and not to be divided by terms used to define different communities of women – in the end we are not that far removed and we should not allow ourselves to be pitted against each other. Too often we are subject to '*divide and conquer*' strategies that in the end fail all of us.
2. We must continue to advocate that ***countries urgently redress gender inequality*** and implement approaches that re-define women and men's gender roles and relations *(Gender Transformative*), and address the key issues that make women more vulnerable to especially HIV and TB.
3. ***We must not be complacent*** about the gains we have made. We have to ***move discussion and rhetoric into action***. We must advocate for the full implementation

of policy and guidance that respects and promotes the rights of women, and where there are gaps, we must shine light on these. We must seize every opportunity to strategically ensure that women are central to any response to HIV, TB and malaria.

FOOTNOTES:

1. Civil Society Hearing 2011: Revitalizing The HIV Response 2011 And Beyond. [www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110408_CSH_Bgrd_en.pdf]
2. UNAIDS Treatment 2015. [www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2484_treatment-2015_en.pdf]
3. *Ibid*, and also Eaton, J.W. et al. 2012. 'HIV treatment as prevention: systematic comparison of mathematical models of the potential impact of antiretroviral therapy on HIV incidence in South Africa'. In: *PLoS Medicine,* 2012, 9:e1001245.
4. Eaton, J.W. et al. 2012. 'HIV treatment as prevention: systematic comparison of mathematical models of the potential impact of antiretroviral therapy on HIV incidence in South Africa' In: *PLoS Medicine,* 2012, 9:e1001245.
5. UNAIDS Treatment 2015.
6. A focus on women: a key strategy to preventing HIV among children. [www.unaids.org/en/resources/documents/2014/name,93962,en.asp]
7. Clause 21(e): '*where any other person with whom an HIV infected person is in close or continuous contact including but not limited to a sexual partner, if the nature of contact, in the opinion of the sexual medical practitioner, poses a clear and present danger of HIV transmission to that person*'.
8. UNAIDS Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Background and Current Landscape. [www.unaids.org/en/media/unaids/contentassets/documents/document/2012/ackgroundCurrentLandscapeCriminalisationHIV_Final.pdf]
9. Bernard, E.J. 2010. Where HIV is a crime, not just a virus: A global ranking of prosecutions for HIV non-disclosure, exposure and transmission. (THAF0201) XVIII International AIDS Conference, Vienna, July 2010.
10. *Ibid.*
11. Together for Girls Scope of the Problem: Sexual Violence against Girls, Atlanta, U.S. Centers for Disease Control and Prevention. [www.cdc.gov/violencePrevention/sexualviolence/together/index.html]
12. UNAIDS Survey. 2013; WHO, Addressing Violence Against Women in HIV Testing and Counselling: A Meeting Report. 2006.
13. Rosen et al. 2007. Why are antiretroviral treatment patients lost to follow-up? A qualitative study from South Africa. [www.ncbi.nlm.nih.gov/pmc/articles/PMC3060335/]
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16. *Ibid.*
17. Together for Girls Scope of the Problem: Sexual Violence against Girls, Atlanta, U.S. Centers for Disease Control and Prevention. [www.cdc.gov/violencePrevention/sexualviolence/together/index.html]
18. UNAIDS Survey. 2013; WHO, Addressing Violence Against Women in HIV Testing and Counselling: A Meeting Report. 2006.
19. Rosen et al. 2007. Why are antiretroviral treatment patients lost to follow-up? A qualitative study from South Africa. [www.ncbi.nlm.nih.gov/pmc/articles/PMC3060335/]

Sophie Dilmitis has worked for two decades in pioneering grassroots work and top-level policy development focusing on women and young people in developing and developed countries. Born and living in Zimbabwe, Sophie has been HIV-Positive for 20 years. She has become a vocal advocate for policies and programmes that work for all women, human rights and programmes that integrate sexual and reproductive health and rights (SRHR) with HIV.
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A call to action...

Civil society organisations call on the President of the Republic of Uganda to refuse to sign controversial Ugandan HIV/AIDS Prevention and Control Act, 2014

The Uganda Network on Law, Ethics and HIV/AIDS, AIDS and Rights Alliance for Southern Africa, International Community of Women living with HIV Global, Global Network of People living with HIV and the International Treatment Preparedness Coalition, along with the under-signed civil society organisations, working to advance health and human rights in Africa and the world, including members of the Ugandan HIV Bill Coalition, call on you to show leadership by refusing to sign the HIV/AIDS Prevention and Control Act 2014, passed by Parliament on 13 May 2014, into law in its current form and referring it back to parliament for review.

While we commend Your Excellency and the Government of the Republic of Uganda for showing political leadership in attempting to reduce the rates of HIV transmission and increasing domestic funding for HIV, we are concerned by the many problematic provisions in this bill, which along with the recently enacted Anti-Homosexuality Act, 2014 will negate the gains made by Uganda over the past three decades.

The HIV/AIDS Prevention and Control Act, 2014, incorporates provisions which criminalise '*attempted*' and '*wilful*' transmission of HIV with a five year imprisonment term, provide for the mandatory testing of pregnant women and permit healthcare workers to forgo confidentiality and to unilaterally disclose a patient's positive status to an '*at-risk*' partner or household member.

Not only do these provisions violate the rights to equality, autonomy, bodily integrity and privacy guaranteed in the Constitution of the Republic of Uganda but they also go against evidence based effective rights-based approaches to HIV, as embodied in the East African Community HIV and AIDS Prevention and Management Act of 2012.

...the promulgation of laws that criminalise HIV exposure, transmission and non-disclosure is not an effective solution to addressing the HIV epidemic...

From a public health perspective the implementation of these provisions increases the risk of an escalation in the recent surge in the number of new HIV infections, which over the past 5 years have increased from 6.4 to 7.3%. The implementation of the provisions of this Act will not only place a heavy burden on the already burdened state, but will place an onerous task on Uganda's judiciary which will be obliged to adjudicate these matters.

Evidence has shown that the promulgation of laws that criminalise HIV exposure, transmission and non-disclosure is not an effective solution

to addressing the HIV epidemic, as these laws have not proven to prevent new HIV infections or to increase safer sex. On the contrary, laws which criminalise HIV raise serious human rights and public health challenges and present a further barrier to the testing, treatment and anti-stigma efforts of the Ugandan HIV response, as people living with and at higher risk of HIV will shy away from healthcare facilities for fear of prosecution.

Also of concern is that laws that criminalise HIV transmission and exposure have been found to disproportionally affect already marginalised groups, including women, who are often unable to enforce safer sex due to gender inequality, are often the first to know their status through antenatal care and are blamed for bringing HIV home. They are often unable to disclose due to fear of physical harm and eviction due to high levels of gender-based violence and inequality in most African communities.

Therefore, we call on Your Excellency to:

1. Decline to assent to the Act in its current form and to refer it back to Parliament for review of the problematic provisions (amongst others Clause 39 on Attempted Transmission, Clause 41 on Intentional Transmission and Clause 21e on Exceptions to Confidentially) using the East African Community HIV and AIDS Prevention and Management Act of 2012 as a standard;
2. Call for the effective enforcement of existing criminal or public health legislation in the rare cases where there is clear evidence of wilful transmission;
3. Address the root causes that drive the demand for criminalisation such as promoting the equal status of women, protecting women against violence and addressing cultural practices that render women more vulnerable to HIV;
4. Call for the implementation of a rights-based response to HIV, including implementing the recommendations of the Global Commission on HIV and the Law; and
5. Facilitate dialogue between members of parliament, people living with and at higher risk of HIV, researchers, civil society organisations responding to HIV and other stakeholders on this Act.

The Republic of Uganda, which has been heralded as being one of the first African countries to provide widespread access to prevention, treatment and care in the early years of the epidemic, cannot afford to risk backsliding now.

For more information and/or comments, please contact Michaela Clayton at ARASA at Michaela@arasa.org.na.

Moving beyond women as mothers...

Transforming women's health through policy reform in South Africa

Ann Strode, Vicci Tallis, Sethembiso Mthembu

Medicine and the provision of healthcare play a central role in ensuring that individuals have an adequate standard of living. The Preamble to the Constitution of South Africa reflects the importance of socio-economic rights by stating that one of the purposes of the Constitution is to improve quality of life.[1]

INTRODUCTION

Section 27 reflects this principle as a right stating that

(1) Everyone has the right to have access to ... health care services, including reproductive health care;

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.[2]

The right to access healthcare services is intertwined with the constitutional right to equality and dignity. In other words it is not only about a right to certain services, but to such services being provided in a manner that is consistent with the Constitution. In *Government of the Republic of South Africa & Others v Grootboom & Others*, the Constitutional Court held when examining the right to have access to adequate housing that:

> *All the rights in our Bill of Rights are interrelated and mutually supporting. There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter. Affording socio-economic rights to all people therefore enables them to enjoy the other rights enshrined in Chapter 2 (of the Constitution – the Bill of Rights). The realisation of these rights is also key to the advancement of race and gender equality and the evolution of a society in which men and women are equally able to achieve their full potential.*[3]

What is women's health?

Women's health is a holistic approach to women achieving a state of emotional, social, cultural, spiritual and physical well-being. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential.[5] In other words women's health requires the recognition of both their common health needs with men, and their special and specific health needs, as well as social and other structural barriers that may affect their ability to access or use such services.

Why is a focus on women's health important?

Women are a vulnerable population that face distinct healthcare needs. It is affected by the services that they can access, their living conditions and the social, political, cultural and economic contexts of their lives. Unlike men, women's ability to access healthcare is often determined by social factors, such as whether she can make childcare arrangements or delegate household responsibilities to others.

These principles of equality and dignity are particularly important within the context of access to healthcare services for women. Feminists argue that women's health cannot be addressed without the recognition of underlying inequalities and the impact of gender norms that affect the way in which the state responds to women's health and as possible barriers to individual women accessing healthcare.[4] As a result, feminist responses are mindful of both women's position (the extent to which they have access to political power) and condition (the reality of their daily lives), addressing the structural factors driving women's health, as well as ensuring that short-term strategies, such as service provision, understand women's realities and integrate these realities into programming.

…feminist responses are mindful of both women's position (the extent to which they have access to political power) and condition (the reality of their daily lives)…

Her Rights Initiative (HRI), with the support of other organisations, believes that, twenty years into our democracy it is time to demand that the constitutional rights of access to healthcare services, which are provided equally and with respect for everyone's inherent dignity, are translated into the total transformation of women's health in South

Africa. Although there are many ways in which this can be done, we argue that the first step is the adoption of a national policy on women's health.

In this article we briefly describe women's health in South Africa today and identify some of the key issues facing women and healthcare providers. We propose and justify a solution in the form of advocacy for the development of a new, national policy on women's health to address the key conceptual, structural and value-based problems with the current system.

> ...ensuring that short-term strategies, such as service provision, understand women's realities and integrate these realities into programming...

WOMEN'S HEALTH IN SOUTH AFRICA

There has been a radical transformation of the framework for the provision of health care in post-apartheid South Africa. Flowing from the constitutional rights described above, there has been a plethora of new laws and policies introduced that create a legal framework for many of the key rights of women to access healthcare services, including rights in relation to termination of pregnancy[6], sterilisation[7], and sexual and reproductive health services for

adolescents[8], among others. However, despite the lofty principles in the Constitution and these laws, as well as the robustness of our constitutional jurisprudence, we have not seen real change for women's health in post-apartheid South Africa.

Significant health issues include:

1. The health systems fail women

Each year at least 1,600 mothers die, due to complications of pregnancy and childbirth.[9] At least 60% of these deaths are avoidable, and 55% are caused by what is referred to as health systems failures.[10]

Likewise, cervical cancer even though a preventable disease through early diagnosis, results in over 250,000 deaths annually, making it the second most common form of female cancers[11]. It is of great concern that poor black women living in rural areas account for 84% of women diagnosed, and represent between 60 – 70 % of all deaths.[12]

Implementation gaps are also tangible – and even in the presence of good policy the implementation often falls way short. These failures are attributed to health systems failures, such as insufficient sites of service delivery, poor management, insufficient stock and stock management, insufficient trained staff, poor transport infrastructure, and poor infrastructure at health facilities. Research further describes the problem as being:

> ...women's health has not extended much beyond women as mothers, with the focus being on reproductive health...

There is a wide chasm between many women's experiences of public sector health services which are of a poor quality, inaccessible, provided in an

unprofessional manner and the rights enshrined in our country's constitution.[13]

2. Women bear the burden of some diseases, such as HIV

Women between the ages of 15 and 49 are one of the groups in South Africa most vulnerable to HIV infection; women account for over half of adults aged 15 and over estimated to be living with HIV and AIDS in South Africa.[14] Young women are especially vulnerable; those between the ages of 15 and 24 (12.7%) are significantly more likely than men of the same age (4.0%) to be infected.[15] Approximately one third of women between the ages of 25 and 29 are HIV positive, and a total of 3,200,000 women older than 15 are living with HIV.[16] The main cause of premature deaths amongst women is overwhelmingly HIV and AIDS.[17]

> …a major gap in policy and political discourse on women's health heightening the need for a proactive political agenda…

3. Mental health needs of women are side-lined

Women's experiences of mental health differ from that of men. Women may experience increased mental health mortality and morbidity, due to unaddressed issues, such as sexual violence, intimate relationship problems, issues related to fertility, partum depression and general depression.

4. There are barriers to women equitably accessing health care services

Universal health means the provision of accessible and necessary services that do not place an unaffordable burden on the household.[18] Whilst it can be argued that universal access does not exist in South Africa generally, the situation for women is disproportionately worse than that of men. Women's health has not extended much beyond women as mothers, with the focus being on reproductive health,

and even reproductive health services are not adequate to prevent huge numbers of maternal mortality. Recent research has shown the following to be barriers created by uneven social-power relationships:

- Vast distances to healthcare facilities – especially in rural areas – the more sophisticated the health facility the further the distance is likely to be
- The high cost of taxi/transport (often a recurring cost). The cost of transport to these distant facilities is often high, especially for women affected by poverty and unemployment.
- High out-of-pocket payments for initial or continued treatment
- Long queues at clinics that necessitate getting there early, taking a day off work and perhaps not being seen at all
- The negative attitudes of healthcare workers

…the social and cultural environments remain hostile, especially to women's sexual and reproductive rights…

The often less than caring attitudes and practices metered out to people, especially women, in healthcare settings are well documented. Experiences range from rude treatment, breaking and/or lack of confidentiality, being mocked or ridiculed, to withholding treatment or being forced into treatment or procedures. The consequences of such violence have a spin-off effect on women's health in general – as their experience of violence, or fear of such treatment, makes women less likely to go to healthcare settings, waiting until they require urgent treatment – and often until it is then too late.

PROPOSING A SOLUTION: A NATIONAL WOMEN'S HEALTH POLICY

Her Rights Initiative (HRI) argues that there is a major gap in policy and political discourse on women's health heightening the need for a proactive political agenda. An enabling policy and legal environment exists, but the social and cultural environments remain hostile, especially to women's sexual and reproductive rights.[19] Her Rights Initiative (HRI) recommends the introduction of a specific policy that addresses women's health beyond sexual and reproductive rights. We argue that a policy is required as this is the best way to:

- Recognise women's health as a fundamental human rights issue that ought to be addressed by the state
- Hold the state accountable, if they do not meet their constitutional obligations regarding women's health
- Ensure that greater budgetary priority is given to diseases that affect women, such as HIV, mental illness and cervical cancer
- Ensure that there is clarity within the Department of Health on the need for a co-ordinated and comprehensive approach to women's health, which addresses issues across their lifespan and moves beyond women as mothers
- Transform the way in which we approach women's health at service delivery level
- Ensure that structural and other barriers that prevent women from accessing health services are addressed in a gender sensitive manner

HRI argues that such a policy should include reference to:

- Women specific health issues, including violence against women, specific cancers that affect women – breast, cervical, ovarian, reproductive health including maternal health

- Women's experiences of general health issues – for example, heart disease, osteoporosis, other forms of cancer – and how women may experience symptoms, side-affects and need for different treatment, drugs and dosage
- Life-span issues – from adolescent girls to women in old age, and include issues of palliative care, death and dying
- The specific and complex health needs of women living with HIV and how their needs differ from women who are HIV negative – for example, around the issues of prevention and treatment of cervical cancer
- Health issues of diverse women – including, but not limited to women with disabilities, migrant women, transgender women, lesbian and bisexual women

We argue that such a policy is required in terms of the recently passed, but not as yet operationalised, *Women Empowerment and Gender Equality Bill.* The new Gender Equality Bill will probably come into effect in 2015. Health is addressed in Chapter 2, Section 5. This provides that:

Access to health care, including reproductive health

5 (1) Designated public bodies and designated private bodies must, within its available resources, develop and implement a model for delivering women's health, including reproductive health, in order to achieve the progressive realisation of access to health and reproductive rights for women, in compliance with the applicable legislation and international agreements such as the Millennium Declaration and Development Goals.

(2) Designated public bodies and designated private bodies must submit to the Minister their plans and measures in compliance with subsection (1) within one year of being designated, for consideration, review and guidance.

(3) The Minister may at any time after the submission of the plan or measures contemplated in subsection (2) require a designated public body or a designated private body to submit to the Minister a report on its implementation of subsection (1), for consideration, review and guidance.[20]

…a policy on women's health that creates a framework for service delivery…

It is argued that the '*model*' referred to in the Bill could include a policy on women's health that creates a framework for service delivery. We would see this as being operationalised through a national policy that sets the over-arching framework and then local models at an institutional level, to show how individual institutions would operationalise these principles.

CONCLUSION

In conclusion, we argue that there is a patchy recognition and addressing of women's health issues in South Africa, which has resulted in services that do not adequately address women's needs generally, and specifically that the health issues of poor and/or marginalised women are ignored. South Africans in general are not accessing optimal health services, and for women this reality is intensified.

Furthermore, women's differing experiences of healthcare services and the gender barriers that often prevent women from accessing services are not addressed.

…power relations that impact on women's health issues and her experiences of diagnosis, treatment, care and support…

We argue that our framing of health through a feminist, and by definition a human rights lens, cannot be addressed without law or policy reform. If we are to advocate for a feminist health agenda, existing inequalities within health relationships must be addressed. This cannot be done in a piecemeal fashion, as it requires the transformation of both health and healthcare services, as well as redefining the power relations that impact on women's

health issues and her experiences of diagnosis, treatment, care and support.

A woman living with HIV, who was interviewed for the HRI study on forced sterilisation, encapsulated the problem by saying:

> *You know what, she* (the nurse) *snatched something that I wanted, you know? She made up a choice. She made up a choice for me.*[21]

A feminist approach demands that the power inherent in this relationship is transformed. This requires these often unarticulated issues of values, stereotypes and inequalities are addressed in order to truly address emotional, social, cultural, spiritual and physical well-being. We argue, that even if it is only a symbolic victory, a women's health policy provides the best way of articulating women's health issues, and requiring the state to be accountable for addressing them.

...a feminist approach demands that the power inherent in this relationship is transformed...

FOOTNOTES:

1. Constitution of the Republic of South Africa, Act 108 of 1996.
2. *Ibid*, Section 27.
3. *Government of the Republic of South Africa & Others v Grootboom & Others* (11) BCLR 1169 (CC).
4. Tallis, V. 2012. *Feminisms, HIV and AIDS. Subverting power, reducing vulnerability.* Palgrave MacMillan. Basingstoke, London.
5. Phillips, S. 1995. CMAJ [www.med.uottawa.ca/genderequity/eng/what_womens_health.html]
6. Choice of Termination of Pregnancy Act (No 92 of 1996).
7. Sterilisation Act (No 44 of 1998).
8. Children's Act (No 38 of 2005).
9. Human Rights Watch. 2011. "*Stop Making Excuses" Accountability for maternal Health Care in South Africa*. [www.hrw.org/reports/2011/08/08/stop-making-excuses]
10. *Ibid.*
11. Mthembu, S. 2012. 'Cervical cancer and women living with HIV in South Africa: Failure of AIDS treatment policy or gendered exclusions in health care?' *Agenda* 96/26.2.
12. *Ibid.*
13. Mbali, M. & Mthembu, S. 2012. 'The Politics of Women's Health in South Africa'. In: *Agenda* 96/26.2.
14. Human Sciences Research Council. 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. HSRC Press, Cape Town, South Africa.
15. *Ibid.*
16. *Ibid.*
17. *Ibid.*
18. Harris, B. et al. 2011. 'Inequalities in access to care in South Africa'. In: *Journal of Public Health Policy*, (2011) 32, pp5102-5123, Palgrave.
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20. Ministry of Women, Children and People with Disabilities. 2011. Women Empowerment and Gender Equality Bill.
21. Strode, A., Mthembu, P. & Essack, Z. 2012. '"She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces'. In: *Reproductive Health Matters*, 1. Vol 20(39S).

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So what's the big deal..?
Gay cabinet ministers

Pierre de Vos

Several media outlets reported late in May that Lynne Brown became the first openly lesbian cabinet Minister in South Africa after President Jacob Zuma appointed her as Public Enterprises Minister. In an ideal world the sexual orientation of a Cabinet Minister – like that of any other person – would be irrelevant. But we do not live in an ideal world.

I am deeply ambivalent about the ritualised staging of confessions, which require some of us to make public declarations about aspects of our lives that are deemed to be different from a deeply entrenched norm.

If you happen to be gay, lesbian or HIV positive, for example, it is widely expected that at some point you will '*come out of the closet*', which is often equated with making the requisite tearful '*confession*' to your family and friends and, later, an endless set of often nervous, but dry-eyed declarations to members of the larger community.

Sometimes your '*confession*' is rejected out of hand or used to vilify and further marginalise you or to discriminate against you. Sometimes the '*confession*' leads to genuine and heartfelt questions or encouraging comments by well-meaning friends and acquaintances.

It matters not whether those who hear the confession are sympathetic or antagonistic. What matters is that

you are prodded into confessing that you are different from the desired norm, from a supposedly coveted standard of human existence.

Much like a devout Catholic who is expected to confess his or her sins to either a stern or sympathetic, but always elaborately frocked priest in a confession stall, you are expected to go through the ritual that confirms your difference and inherent peculiarity.

This ritual reinforces and perpetuates deeply held assumptions about being gay or lesbian: that your life is potentially difficult or filled with struggle (in my own case this is an assumption that is spectacularly wrong); that you are either a bad person or strangely brave for being able to deal with this loaded deck of cards that fate had dealt you.

...prodded into confessing that you are different from the desired norm, from a supposedly coveted standard of human existence...

When I am required to '*confess*' my homosexuality or HIV positive status, I am required to play a game that results in me having to confirm that heterosexuality and non-HIV status are '*normal*' (or at the very least, the norm).

My confession, then, both signals and reinforces my perceived '*otherness*'. It imbues my invented '*otherness*' with singular meaning and provides yet another discursive tool that can be used by others to justify my marginalisation and oppression.

That is why I now try to avoid making confessions about these aspects of my identity. Instead, if I think it would be politically important to convey this kind of information about myself (or on a personal level, if I think I need to establish a measure of intimacy with someone else) I '*accidentally*' drop facts into a conversation that reveal more about who I am.

Talking about rugby with a colleague or acquaintance? Easy to say that although I am not sure whether he is a good fly half, I do think Kurt Coleman is exceedingly attractive, then telling the person about that time my father took me to watch the Springboks play at Ellis Park. Talking about the coming weekend? Easy to mention my romantic dinner with Lwando, then talk about my favourite restaurants.

Complaining to a colleague about being overworked? Easy to mention my visit to the doctor to do my bi-annual blood work or how my ARVs make me dream the most wonderful but tiring dreams, then talk about my computer screen that seems to be on the blink.

In short, I tend to avoid the '*confessional*' style of talking about my sexual orientation or my HIV status, because I fear that the language of confession tends to erase the singularity of my existence as a human being and sets up a hierarchical opposition between '*normal*' people and poor '*abnormal*' me.

In an ideal world, this would scarcely have mattered. After all, in an ideal world the only normal thing about any human being would be that none of us are truly normal.

But we do not live in an ideal world.

We live in a world in which heterosexuality is deeply embedded in our culture as both normal and desirable. Conversely, the idea that homosexuality is wrong, shameful, strange or undesirable is also deeply embedded in our culture.

Because the notion that heterosexuality is desirable is so deeply entrenched in our culture, the way it permeates and infiltrates our existence becomes invisible. People tend not to notice how heterosexuality are ceaselessly advertised and promoted (almost always as normal, pure, desirable – few people mention that Adolf Hitler was straight and nod knowingly to imply this says anything about heterosexuals as a group), while homosexuality is silenced or erased, except when it is made visible to try and affirm the belief in its abnormality.

…yet another discursive tool that can be used by others to justify my marginalisation and oppression…

…confirm that heterosexuality and non-HIV status are *'normal'* (or at the very least, the norm)…

While gay men and lesbians are often told not to '*flaunt*' their sexuality by, for example, telling others about who they love, who broke their hearts or who they had slept with on the weekend, heterosexuals shamelessly get to '*flaunt*' their sexuality every day and this is called life.

At shopping malls, heterosexual

couples walk hand in hand, proudly advertising their heterosexuality. At the office, colleagues out themselves as straight almost as soon as you meet them for the first time, dropping not-so-subtle hints about their husbands or wives or partners in the tearoom or at other informal gatherings.

Politicians, sports stars and actors parade their heterosexuality for all the world to see, having pictures taken at their weddings (apparently You magazine actually pays '*celebrities*' to have their wedding pictures published) and appearing at the opening of Parliament or a new movie or at an awards ceremony with their different-sex partner on the arm.

This is the world we live in: relentlessly advertising and promoting heterosexuality; relentlessly making the rest of us invisible.

One way of being in the world (one man and one woman in love to the exclusion of all others) is valorised, incessantly promoted and rather optimistically and disingenuously lauded as an ideal that every person should strive for in order to attain eternal or at least temporary happiness.

…in an ideal world the only normal thing about any human being would be that none of us are truly normal…

Other ways of being in the world are vilified or erased through embarrassed or enforced silence, or '*othered*' by well-meaning people, who insist on telling you that they have no problem with homosexuality – thus affirming that they think there is potentially something profoundly disturbing or at least strange about two men or two women loving each other, something that they are broad-minded enough not to have a problem with.

It is exactly because we live in this far from perfect world that it matters profoundly when an openly lesbian politician is appointed to an influential Cabinet position. I am not suggesting that Minister Brown herself should make a big deal out of it.

Because of my ambivalence about the politics of '*confession*', of coming out, anything she says on the subject would have the potential to be counter-productive.

But when openly gay or lesbian individuals (or people living with HIV, for that matter) happen to be powerful politicians, sports stars, actors or other

influential individuals, like judges or business leaders, they become potential role models to others who might have internalised widespread societal prejudices and might previously have believed that being gay, lesbian is somehow shameful, something to hide from others.

...homosexuality is silenced or erased, except when it is made visible to try and affirm the belief in its abnormality...

Moreover, because such individuals have a distinctive presence in public life and are strongly associated with the characteristics that made them well known (their acting talent, their political acumen, their sporting prowess), people who would usually obsess about their sexual orientation might begin to look past this one aspect of their lives and see more of the whole person there.

...relentlessly advertising and promoting heterosexuality; relentlessly making the rest of us invisible...

When gay men, lesbians or bisexuals are appointed to important positions it also signals to the wider society that there is in fact nothing abnormal, shameful, surprising or undesirable about people who happen to love differently from themselves.

For these reasons I think it is more than noteworthy that Minister Brown has been identified as a lesbian. In another world, a world in which a person's sexuality (whether he or she is gay, lesbian, bisexual or heterosexual) would be of no interest or importance to anyone in society, it would have been silly to take note of and report on this fact.

In the world we live in, it is far from it!

FOOTNOTE:

1. An earlier version of this article has been published on 28 May 2014 on the Constitutionally Speaking blog. [http://constitutionallyspeaking.co.za]

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I never thought lesbians can be infected...[1]

Women who have sex with women and HIV risk[2]

Research indicates that a substantial number of lesbian and bisexual women and other women who have sex with women in South Africa are living with HIV, yet this grouping is rarely included in efforts to curb the spread and impact of the epidemic and is generally invisible in sexual health policies, research and service provision.

Ingrid Lynch, Matthew Clayton

This research brief summarises the findings of emerging studies regarding HIV risk among lesbian and bisexual women, and other women who have sex with women in Southern Africa.

'WOMEN WHO HAVE SEX WITH WOMEN' AS A RESEARCH CATEGORY

'*Women who have sex with women*' is a **socially constructed research category** coined in recognition of the fact that sexual behaviour does not necessarily translate into sexual identity; i.e. women who have sex with other women may or may not identify as heterosexual, bisexual or lesbian – or may not identify with any sexual orientation at all. In public health research, this research category is increasingly used to study sexual and reproductive health and rights among diverse women who engage in same-sex sexual activity regardless of self-identification. '*women who have sex with women*' therefore refers to a behavioural dimension of analysis, while '*lesbian*', '*bisexual*' or '*heterosexual*' refer to self-aware social identities.[3]

ARE WOMEN WHO HAVE SEX WITH WOMEN AT RISK FOR HIV?

Accurate HIV prevalence statistics for women who

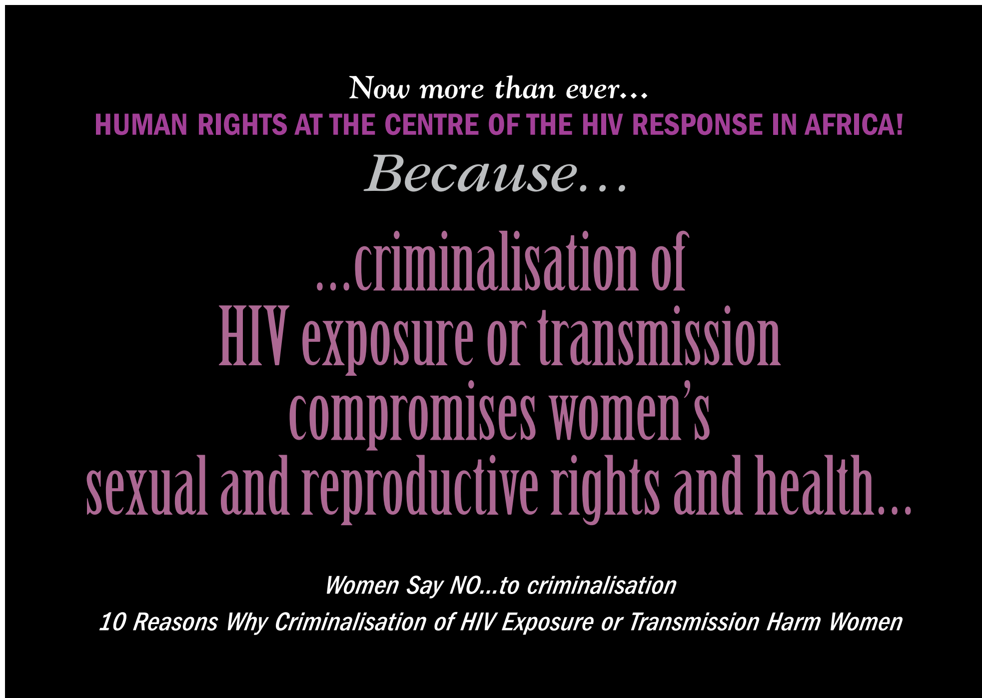
engage in same sex sexual activity are hard to come by, motivating the need for including women who have sex with women in HIV research. The current HIV discourse creates a '*hierarchy of risk*' for women, where sex with men is considered the most risky, while sex with women is rarely considered. This hierarchy means that women who have sex with women become '*epidemiologically unfathomable*' and makes estimating the number of women who have sex with women with HIV almost impossible.[4] Research conducted in South Africa, Zimbabwe, Namibia and Botswana placed the self-reported rate of HIV infection among participating women who have sex with women at 9.6%.[5] In a study focused on a South African sample only, 9% of black women who have sex with women and 5% of white women who have sex with women who were aware of their HIV status reported being HIV positive.[6]

...women who have sex with women become 'epidemiologically unfathomable'...

These studies, while restricted to using self-reported HIV status, point to a high prevalence of HIV among a group generally regarded as not at risk for HIV infection.

WHAT INFLUENCES WOMEN WHO HAVE SEX WITH WOMEN'S VULNERABILITY?

Women's vulnerability to HIV infection is increased by **high levels of sexual violence**. South Africa has one of the highest rates of sexual violence in the world[7] and, compounded by homophobia, has led to lesbian and bisexual women and other women who



have sex with women being targeted for sexual violence motivated by prejudice.[8] Although no specific research has been conducted regarding the relationship between targeted lesbian rape and HIV infection, research[9] found a strong correlation between perpetration of sexual violence and HIV risk behaviour among men who admitted to having raped a woman. The correlation between rape and HIV prevalence in men is relevant to women who have sex with women because 25% of women who have sex with women report being raped by a man in their lifetime. Research[10] also hold that it is not sex with men per se, but rather forced sex with men, that is an important risk factor for HIV among women who have sex with women. This is currently completely invisibilised due to the fact that HIV transmission occurring through rape is classified as '*heterosexual transmission*'.[11]

A second route of HIV transmission among lesbian and bisexual women and other women who have sex with women is that of transactional sex. 10.5% of women who have sex with women have had transactional sex with men and 15.2% have had sex with other women. Also, women who have sex with women who report transactional sex with

either men or women are more likely to be HIV positive than those who do not.[12] Studies also identify transactional sex as an important marker for HIV among women who have sex with women, where a third of HIV positive women who have sex with women in their study had engaged in transactional sex.[13]

A third route of transmission is woman-to-woman transmission. The pervasive idea that women cannot transmit HIV to other women is one that persists even among women who have sex with women, with many responding with disbelief to the idea.[14] HIV is not the only concern for women who have sex with women as other sexually transmitted infections can also be passed on through female same-sex sexual activity.

...heteronormative notions of what is considered *'real'* sex have informed a dominant focus in HIV research and policy on penile-vaginal penetrative sex, rendering woman-to-woman transmission unfathomable...

SEXUAL AND REPRODUCTIVE HEALTH CONCERNS OF WOMEN WHO HAVE SEX WITH WOMEN

Sexually transmitted infections for which women who have sex with women are at risk when engaging in same-sex sexual activity[15] include:

- HIV
- Human papilloma virus (HPV)
- Syphilis
- Trichomoniasis (trich)
- Herpex simplex virus (HSV)
- Bacterial vaginosis

Transmission risk is influenced by the type of sexual practices engaged in and whether barrier methods, such as dental dams or finger cots, are used to prevent contact with vaginal mucosa, cervical secretions or menstrual blood.[16] Bacterial vaginosis occurs more often in lesbian women compared to women who have sex with men only.[17]

WHY ARE WOMEN WHO HAVE SEX WITH WOMEN OVERLOOKED?

Despite indications of HIV risk and vulnerability, there is a widespread silence regarding the sexual and reproductive health of lesbian and bisexual women and other women who have sex with women in research and policy documents. Heteronormative notions of what is considered '*real*' sex have informed a

dominant focus in HIV research and policy on penile-vaginal penetrative sex, rendering woman-to-woman transmission unfathomable. For example, in country reports responding to HIV and AIDS, there is an almost universal lack of reporting on HIV indicators for women who have sex with women[18], and the South African National Strategic Plan on HIV, STIs and TB (2012-2016) excludes women who have sex with women as an at-risk group in the government's response to the epidemic.[19]

Additionally, lesbian and bisexual women and other women who have sex with women are often met with stigmatising and discriminatory responses from health care providers when they attempt to access services such as testing or treatment for HIV or other sexually transmitted infections.[20] 18.7% of women who have sex with women site fear of being discriminated against or embarrassment after disclosing their sexual identity to health care providers as reasons contributing to non-disclosure whilst wishing to avoid further experiences of discrimination and stigmatisation ultimately leads to women who have sex with women avoiding seeking treatment. Women who have sex with women who do not encounter hostility when seeking medical attention or testing are often met with inexperienced or curious healthcare providers who know very little about lesbian sexual health, and healthcare facilities do not supply safe sex aids for women who have sex with women.[21]

SILENCE INCREASES RISK

Of particular concern is how the widespread belief

that HIV risk is minimal for women who have sex with women is internalised by many women who view themselves as virtually immune to HIV and who are generally unconcerned about the use of prevention measures in same-sex sexual practices.[22] A further consequence of stigmatisation is the manner in which it contributes to isolation and consequently increases risk and vulnerability. Lesbian and bisexual women and other women who have sex with women who test HIV positive may be stigmatised especially in contexts of general and ongoing stigmatisation of people living with HIV. Research conducted by Triangle Project in urban and rural settings in the Western Cape indicates that the silence of lesbians around HIV and their HIV status is related not only to a denial of risk or limited information, but also to the possibility of stigmatisation within lesbian social spaces.[23] Furthermore, bisexual women may also be stigmatised as '*AIDS carriers*' by lesbian women which may prevent health and support seeking behaviour.[24]

> …wishing to avoid further experiences of discrimination and stigmatisation ultimately leads to women who have sex with women avoiding seeking treatment…

WHAT SHOULD BE DONE TO ADDRESS HIV RISK AMONG WOMEN WHO HAVE SEX WITH WOMEN?

Recommendations for activists and NGOs:

- Include the sexual and reproductive health and rights of women who have sex with women, including their HIV risk and vulnerability, as a programmatic focus in your own activism and that of your organisation.
- Conduct or facilitate research on the sexual and

reproductive health and rights of women who have sex with women.

Recommendations for researchers and academics:

- Conduct research on the sexual and reproductive health and rights of women who have sex with women, with particular focus on: the prevalence and correlates of HIV among women who have sex with women; the relationship between sexual violence and HIV risk; woman-to-woman transmission as a possible route for HIV infection; experiences of women who have sex with women when accessing health care; and social and structural barriers to sexual health of women who have sex with women.

Recommendations for government and policy makers:

- Ensure that women who have sex with women are included in national reporting indicators, policies and plans to address HIV and AIDS.
- Integrate sexual and reproductive health and rights of women who have sex with women, including their HIV risk and vulnerability, in sensitisation and competency training of health care service providers.
- Ensure the availability of relevant safer sex information and barrier methods for women who have sex with women, such as finger cots and dental dams.

...ensure the availability of relevant safer sex information and barrier methods for women who have sex with women, such as finger cots and dental dams...

Recommendations for donors:

- Fund research on the sexual and reproductive health and rights of women who have sex with women.
- Fund programmes that integrate the sexual and reproductive health and rights of lesbian and bisexual women and other women who have

sex with women into overall HIV advocacy and direct service provision.

- Take into consideration the severe lack of existing services and support targeted programmes that provide services to women who have sex with women in particular until such services become available through mainstream service providers.

FOOTNOTES:

1. A lesbian participant during a focus group discussion. Triangle Project. 2009. *Lesbian women and HIV*. (Unpublished research report; a copy available from info@triangle.org.za).
2. This article has first been published by Triangle Project as as a research brief in March 2014, and is reprinted with permission from the authors. See Lynch, I., & Clayton, M. 2014. 'I never thought lesbians can be infected': Women who have sex with women (WSW) and HIV risk. *Triangle Project Research Brief, March 2014*. Cape Town: Triangle Project.
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6. Wells, H., & Polders, L. 2004. *Levels of empowerment among LGBT people in Gauteng, South Africa*. Pretoria, South Africa: OUT LGBT Wellbeing.
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Benefits virtually inaccessible...

Migrant women and HIV

William Bourget

In the last half century, women have become more and more present in rates of international migration. For Southern Africa, women's migrations started to increase since 1960 from 30% to 42% in 2005.[1] Though South Africa's economy and new democracy is an appealing destination for those searching for a better life in sub-Saharan Africa, widespread xenophobia and gender-based violence make these benefits virtually inaccessible. In addition, South Africa's 6.422 million people living with HIV is the highest in the world.[2]

The intersection of these three subjects – migrant women, xenophobia, and high levels of HIV – offers a sound critique of an incomplete HIV discourse unresponsive to the most marginalised populations. While there is much research to be found on each of these subjects individually, few scholars have addressed the compounding effects of xenophobia, HIV, and migrant women. Beyond suggesting for more research surrounding migrant women living with HIV in South Africa, this report will look at migrant women's experience in migrating, accessing healthcare, and living in South Africa to illustrate the intersection of xenophobia, gender inequality, stigma, and discrimination.

OVERVIEW

Researchers from the Southern African Migration Project (SAMP), and other scholars, have characterised the increasing migration rates of women as the '*'feminisation' of international migration*'.[3] Through their Migrant Voices Project, SAMP conducted interviews with 59 migrant women in hopes of better understanding their experience. While the mining industry's role during apartheid framed Southern African immigration as male-dominated, SAMP's research shows progressive rates of women acting independently for survival. Instead of passive and submissive to their husband's will, interviewees identified their home country's poverty, '*political instability and intolerance, as well as gender inequality*' as driving factors for their migration[4]. For many, migrating to South Africa is a last resort for when times are no longer bearable or survivable:

> *If only* [the South African police] *knew that in Zimbabwe it's difficult, that's the poorest country in the whole world. It's difficult living in Zimbabwe because you can't get a job nor even sell something, but you just sit there and starve to death, but they harass us a lot… Life is tough at home,* [we] *need to survive… We are not here by accident but by design. If life was fine we would not be here (Focus Group 3, Participant 7).*[5]

…widespread xenophobia and gender-based violence make these benefits virtually inaccessible…

The statement above depicts a South African sentiment reserved for migrants; instead of perceiving migrations as an escape from conditions unfit for living, South Africans categorise migrants as a drain on the country's well-being. Ultimately, dominant understandings of migration are xenophobic in their portrayal of migrants as aimless dependents, and gendered in their perception of women's migration as passive and unwarranted.

The effects of xenophobia have been integrated into virtually every aspect of migrants' lives. At the social level, surveys show that 25% of South Africans believe non-South Africans should be deported regardless of their citizenship status.[6] Moreover, SAMP's survey reported that 54.3% of those surveyed believed non-South African's had a negative impact on South Africa by contributing to rising rates in crime, resource consumption, unemployment, and disease; while only 30.5% perceived migrants as having a

positive impact in terms of '*skills*' or '*needed jobs*'.[7] Furthermore, the potency of South Africa's xenophobia has saturated the social sector, and now seems to be integrated into the institutions' delivery, or lack thereof, of a human rights agenda.

Officials in the Department of Home Affairs (DHA), South African Police Service (SAPS), and South African National Defence Force (SANDF) possess xenophobic beliefs and independently act out against institutional procedures to halt or deter non-South Africans from entering the country.[8] Border officials are often unsupervised and will ask for extra fees before letting those they perceive as non-South African cross. In addition, while patrolling the border for undocumented crossers, SANDF officials develop extra-legal relationships with local farmers.[9] The farmers will exploit these informal border crossers' economic and legal vulnerability only to report them back to SANDF when they are no longer of use. To acquire official documentation, migrants must refer to the DHA; however, DHA officials are charging invalid fees and purposefully misguiding migrants from obtaining documentation at an '*endemic*' rate.[10] These service officials' ad-hoc actions are as influenced by xenophobic sentiments as the rest of the population's, and have managed to institutionalise xenophobia. Moreover, the nationwide attacks in 2008 against perceived non-South Africans confirm that xenophobia is a thriving ideology among South Africans. Ultimately, these

…if women do find a source of income it is typically unskilled labour with low pay, long hours and little to no control over when they work…

circumstances force migrants to avoid public spaces and formal employment – away from the hostile public and law enforcement, as well as the clinics, organisations, and other helpful resources.

MIGRANT WOMEN: REALITIES AND RISKS

For migrant women, the effects of xenophobia place them at higher risks of abuse and HIV transmission, than that of their male counterparts. As mentioned earlier, many of the women migrating are looking for economic opportunities and a better way to support their family. As a result, 16 of the women that SAMP interviewed were unable to pay visa fees and had to cross informally.[11] Women crossing alone will commonly use a *malaisha* – a person familiar with the area who brings people across the border in return for payment.[12] Personal accounts recorded in these interviews depict *malaishas* as capable of holding individuals' hostage until more money is paid, as well as raping, or even killing them.[13] A participant from SAMP's study explains the risks of finding a *malaisha*, saying:

> *…you find people who help people to get into South Africa – sometimes they rape you and take your money. Sometimes they shoot you if you don't want them to rape you.*[14]

When women cross the border informally they are not only exposed to sexual abuse by *malaisha*, but immigration officials as well:

> *I went to Beitbridge on foot up to the river. I didn't have any money, any passport, it was through the rural areas that I walked from there to the river and it was at night, at the river we found soldiers who wanted money if we did not have money they demanded sex. I slept with the soldiers because I didn't even have a single cent, then I crossed to the farms next to the Limpopo to work there (Participant 5, Focus Group 5).*[15]

The degree of corruption experienced by women when informally crossing the border is gender specific. Of course, corruption is also evident when men cross the border, but this is usually settled through monetary bribes. Unlike men, women are forced to negotiate with sex and their bodies before knowing whether or not South Africa will even deliver the new life they desire. Unfortunately, for many

> …spaces where the intersections of xenophobia, a stigmatising HIV discourse, and discrimination intersect most profoundly…

migrant women, South Africa will change the scenery, but not the circumstances that lead to sex trading.

SAMP's interviews show that even at the earliest stages of the migrant experience women are at a higher risk of HIV exposure and transmission than their male counterparts. Once past the border posts, women's ability to seek out antiretroviral therapy (ART) is compromised through their inability to find a steady source of income, and the constant threat posed to them by xenophobic law enforcement and citizens. Many migrant women find themselves unemployed when first arriving in South Africa, which forces them to engage in a variety of jobs to get by. Some jobs are reserved for men, as employers believe women are not qualified.[16] In addition, employers will sometimes reject women on the basis of education, which means if women do find a source of income it is typically unskilled labour with low pay, long hours and little to no control over when they work.[17]

Admittedly, migrants are represented in a wide spectrum of jobs, but '*overall, female migrants are less likely to be in formal employment*', than their male counterparts.[18] For migrant women, research shows domestic and sex work as common avenues of income.[19,20] The lack of legal protection for informal workers means higher rates of exploitation; thereby making migrants more likely to live in informal settlements – characterised by poor infrastructure, high rates of violence, and poverty. These socio-economic attributes expose migrant women to an environment more susceptible to HIV. South Africa, as argued by scholars, is a prime example of how social context can have an impact on the prevalence of HIV.

> *…it is critical that the responses to the epidemic recognise and take cognisance of the factors that see HIV vary from 7.3% (Blaauwberg) to 32.5% (Khayelitsha) in a single municipality as is the case in the City of Cape Town.*[21]

The relationship between HIV and poverty is not causal, but the correlation is indicative of how critical it is to engage

social issues in the response to HIV. The combination of poverty, violence, and poor infrastructure reduces accessible resources and limits women's ability to engage in safer sex.

After administering 2,354 questionnaires in Illovo, New Brighton, Beacon Valley, and Tafelsig, the AIDS Legal Network's (ALN) study '*highlight*[s] *a continuum of violence and abuse upon* [women's] *disclosure of their positive HIV status*'.[22] In addition, there were accounts of women '*being forced by their partners to engage in sex without a condom*'.[23] The consequences that follow women's disclosure of a positive HIV status are not confined to the household. Another ALN report shows 72% of the 2,379 community members surveyed in the Northern Cape and North West areas know of people living with HIV who have experienced

> *…'rejection' and 'ill-treatment', as well as 'gossiping' and being 'called names', by partners, families, and community members.*[24]

In short, ALN's studies suggest that women are often not in the position to ask for safer sex and/or disclose a positive HIV status without fear of abuse, isolation, or harassment from their household and community. The threat of xenophobia and economic insecurity that accompanies migrant women heightens their inability to call the police, reach out to community members, or access a health clinic, if they experience violence and discrimination post-disclosure.

The relationship between migrant domestic workers and their employers can often prove problematic, as the relationship between the worker and the employer is not legally regulated and hence often manipulative. Domestic workers are often asked to live on the premises, or '*live-in*'. However, without the legal protection of a formal position, living-in furthers migrant women's vulnerability as it '*reinforce*[s] *workers' dependence on employers to provide basic services*'.[25] Equally concerning is that employers might terminate their employees' position when the workers' positive HIV status becomes known. In addition, the risk of losing all, accommodation and income, discourages domestic workers from taking time off to get tested or attend ART appointments. Finally, irregular working times make domestic workers less likely to attend ART or other health related appointments.

…its ignorance of the social components that dictate whether or not prevention tools are obtainable and/or usable…

When struggling to find economic opportunities, many migrant women will turn to sex work, as a way to generate

> …the rhetoric perpetuated by BCC campaigns further marginalises women and places them at higher risks of infection…

income, until they find a better situation. In fact, out of the 1,653 female sex workers who participated in a study, 758 (46.3%) identified as international migrants.[26] The lack of rights given to sex workers leaves them at an extreme risk of violence, rape, and other forms of abuse. Furthermore, the abuse, policing, and criminalisation experienced by sex workers, and common to migrant sex workers, act as barriers to HIV prevention and other health services, and only perpetuate the vulnerabilities and violence characteristic of their lives.

ACCESS TO SERVICES

Those who are able to access a health clinic are frequently met with a staff's demeaning preconceptions of informal livelihoods, migrants, and HIV. Unfortunately, South African clinics serve as spaces where the intersections of xenophobia, a stigmatising HIV discourse, and discrimination intersect most profoundly. In order to maintain convenience, clinics label folders indicative of the patient's health issue, and designate certain wings of their facilities for people with a positive HIV status. As a result of '*the infrastructure of a health facility*', a service provider told ALN, anyone can '*identify why a person is at the clinic*'.[27]

These organisational policies and structural flaws are relatively simple to change; however, migrants' personal accounts depict public health professionals as equally discriminatory, as those observed in the actions of DHA, SAPS, and SANDF officials. This phenomenon has been

characterised by SAMP as *medical xenophobia*, and refers to

> *…the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job.*[28]

Moreover, medical xenophobia is carried out in a number of different discriminatory methods. Some public health clinics will outright deny treatment, while others will charge an unconstitutional fee. Health clinic staff are also known to implement a form of nationality '*triage*' – prioritising service to anyone who is perceived to be a South African national, scolding migrants who cannot speak a traditional African language, and prohibiting the use of a translator.[29]

The gendered make-up of the dominant HIV discourse tends to overlook the significance of socio-economic context when developing prevention techniques and this has drastic effects on rates of gender-based violence and HIV. The dominant paradigm facing the HIV epidemic revolves around Behaviour Change Communication (BCC). The naivety of this campaign is illustrated through its ignorance of the social components that dictate whether or not prevention tools are obtainable and/or usable. The rhetoric perpetuated by BCC campaigns further marginalises women and places them at higher risks of infection. Women living in informal settlements are often not in the position to use condoms, as they risk their partner perceiving the sudden use of condoms as indicative of an affair, or of the women's positive HIV status. As a result, women are often reluctant to suggest condom use or disclosing a positive HIV status, as their honesty might be met with violence, exclusion, and discrimination. For the migrant women living in informal settlements, the BCC paradigm opens the door to an abusive home life, and an exclusive community.

…alienate migrant women and make them less likely to have access to, or the social capital to suggest, condom use…

Similarly, narrowly interpreting HIV prevention as solely having to do with people with HIV continues to focus efforts on blame, rather than eliminating stigma, building supportive communities, making ART more accessible, and engaging the underlying issues that facilitate the spread of HIV. In this sense, the marriage of xenophobic sentiments linking migrants and the spread of disease in South Africa, along with the stigmatising effects of a behavioural HIV response, marginalises migrant women to a greater extent than those seen by a migrant man, or South African woman.

While some may critique the intersection of xenophobia, gender, and HIV to be purely theoretical, the fact that 39% of South Africans attribute the spread of disease to an influx of migrants is itself informed by a misguided HIV response, and the fear that non-South Africans are responsible for the country's struggles in development.[30] The intersection of xenophobia and gendered HIV risks alienate migrant women and make them less likely to have access to, or the social capital to suggest, condom use.

IN CONCLUSION…

Without centering marginalised populations at the centre of its HIV response, South Africa's efforts will continue to see the informal sector grow, along with the intractable rates of poverty, gender-based violence, and HIV. Preventing xenophobia and its far-reaching impacts – from undermining the South African Constitution to impeding the response to HIV – will require a shift from simple human rights rhetoric towards active supervision over service institution and health clinic employees. Alongside institutional efforts, human rights organisations must further the dialogue surrounding migrant women, violence and HIV, to ensure they are not being ignored in the response to HIV.

> …a shift from simple human rights rhetoric towards active supervision over service institution and health clinic employees…

Failing to do so will reinforce marginalised communities' inability to access clinics, prevention tools, and a safe place to disclose a positive HIV status; fuel stigma, discrimination and violence; and result in programmes that are unresponsive to marginalised communities, and destructive to a human rights agenda.

FOOTNOTES:

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5. *Ibid*, p15.
6. Crush, J., Ramachandran, S., & Pendleton, W. 2013. *Soft Targets: Xenophobia, violence and changing public attitudes to migrants in South Africa after May 2008.* Cape Town: Megadigital Cape Town, p4, 23.
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8. Vigneswaran, D. et al. 2010. 'Criminality or Monopoly? Informal immigration enforcement in South Africa'. In: *Journal of Southern African Studies*, pp471-480.
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16. *Ibid*, p69.
17. Munyewendea, P. et al. 2011. *Exploring Perceptions of HIV Risk and Health Service Access among Zimbabwean Migrant women in Johannesburg: A Gap in Health Policy in South Africa?* Johannesburg: Witwatersrand University.
18. Dodson, B. et al. 2008. *Gender, Migration and Remittances in Southern Africa.* Cape Town: Idasa, pp25-26.
19. *Ibid*.
20. The Dodson et al. pages cited above disclaims that there is no way to generalize an occupation for migrant women as it varies geographically, unlike the vast majority of men who work within the mining industry. However, Crush does acknowledge trade, domestic work, and informal sector production as the three main avenues of income for migrant women.
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Let's try that again...

The law versus religion[1]

Pierre de Vos

The debate sparked by South Africa's Chief Justice Mogoeng Mogoeng after he stated in a speech in Stellenbosch that it would be a good thing if religion influenced 'the laws that govern our daily lives starting with the Constitution', *has been both frustrating and misinformed. Instead of focusing on the veracity and desirability of the arguments advanced by Justice Mogoeng, most commentators focused on the irrelevant question of whether a Chief Justice should express his religious views in public at all.*

Chief Justice Mogoeng Mogoeng was admirably honest and transparent about his personal convictions when he stated – quoting that great freedom fighter and anti-colonialist, Lord Denning – that he believed '*without religion there can be no morality; and without morality there can be no law*'.

Judges are not empty vessels lacking any personal beliefs, values and opinions. Instead, the different life experiences of judges (often focused on their differences in sex, gender, sexual orientation, race, class, religious or non-religious beliefs and other circumstances) may well influence how they view the world and the legal problems they are confronted with and, to some degree, how they will interpret the often open ended provisions of the Constitution in order to solve those legal problems.

Similarly whether a judge is a Pentecostal Christian, an atheist, a cultural Anglican, a Rastafarian, an agnostic, a devout member of the Dutch Reformed Church or a member of the File Sharing Religion may well have some influence on the way in which that judge sees the world and how he or she will resolve the legal problems he or she is called upon to adjudicate on.

Of course, judges need to be impartial. But this does not and – conceptually – cannot mean that a judge is required to have no beliefs or value system on which he or she will inevitably draw to decide complicated constitutional questions raised before him or her.

It only means that a judge must not pre-judge a case and must hear all the arguments before him or her and must consider both the applicable legal text and the relevant binding case law before making a ruling on a specific matter.

…humanism is an attractive non-religious source of morality, given its emphasis on the value and agency of human beings…

I would think it is far better and more honest for a judge to admit to these personal beliefs and to declare them upfront, as the Chief Justice did in his speech. Where judges declare their views openly, it is far easier to engage with the judgments written by that judge and to construct an argument either in support of or critical of the approach taken by a specific judge.

For this reason I have come to the realisation (modifying my previous position) that I have no problem with Chief Justice Mogoeng Mogoeng stating his views on the desired role of religion in law-making and constitutional interpretation in public.

However, I do believe that judges are not beyond criticism and that citizens are entitled to engage critically with the stated beliefs and values of judges.

The far more productive debate about the speech delivered by the Chief Justice would confront the substance of his speech and would construct arguments either in defence of his views or critical of them.

I propose to do the latter. It would enhance democratic debate if others who disagree with me took the time to construct counter arguments.

In this regard I believe the views expressed by Chief Justice Mogoeng on the role of religion in law-making and constitutional interpretation are intellectually incoherent and shallow, nonsensical and (to the extent that one can make any sense out of them) socially and politically reactionary, and hence in direct opposition to my own value system and the norms embedded in the Constitution.

It is of course highly controversial to argue – as the Chief Justice did – that religion can be the only source of morality in any society. This claim ignores (or is ignorant of) developments in both traditional African philosophy and Western philosophy of the past 150 years.

For example, for some of us, humanism is an attractive non-religious source of morality, given its emphasis on the value and agency of human beings, individually and collectively, and its focus on the value of critical thinking and evidence over established doctrine or faith.

Given the fact that the value of human dignity is one of the founding values of our Constitution and given, further, that dignity is closely associated with the moral agency of humans, it is easy to square humanism with South African constitutionalism.

However, it is conceptually difficult if not impossible to square the views of the Chief Justice about morality (as prohibiting human beings from engaging in forms of sexual behaviour outside of state recognised marriage – even when this does not harm others) with the demands of the Constitution to protect the infinite human dignity of every human being.

...religious rules relating to how and with whom we are allowed to have sex function to control and discipline citizens...

If laws were put in place (as the Chief Justice suggest they should) to curtail the freedom of individuals to decide for themselves how they wish to live their lives and how they want to arrange their intimate affairs, such laws would curtail the inherent human dignity of everyone. This would be in direct conflict with one of the founding values of our Constitution, a value, which our Constitutional Court has said, runs like a golden thread throughout the Constitution.

Moreover, anyone familiar with Immanuel Kant's attempts to formulate rules on how to determine right from

wrong through the categorical imperative (the idea that actions can only be considered moral if they could be imitated by anyone else and produce good results) would also be hard-pressed to agree with the Chief Justice that religion is the only possible source of morality in society.

You might not agree with Kant, but at the very least his philosophy – which former Constitutional Court Justice Laurie Ackermann has argued forms the intellectual basis for any understanding of the Constitutional Court's dignity jurisprudence – posits an alternative source of morality not associated with any religious doctrine.

…disrespectful of the freedom of those who do not share your very narrow religious view of morality…

Of course, this idea that religion is the only source of morality for a society is especially common among those who associate morality with sexual behaviour.

Although it is difficult to tell exactly what the Chief Justice means by '*religion*' (there are many different religious traditions and many conflicting moral beliefs even within the Christian tradition, a tradition which the Chief Justice claimed to source his views from) his speech does suggest that he associates religious values with a strand of Pentecostal Christianity that focuses on sex as the root of all evil in the world.

Thus Justice Mogoeng stated in his speech that:

> *…a legal framework that frowns upon adultery, fornication, separation and divorce, subject to appropriate modification, would, idealistic as this may appear to be, help us curb the murders that flow from adultery, help us reduce the number of broken families and the consequential lost and bitter generation that seems to be on the rise, which in turn cause untold harm to society*.

At a press conference called to '*clarify*' his views, he reiterated that he saw a clear link between '*morality*' (as he understands it) and sexual behaviour, stating that:

> *Concerns that cannot be left unattended relate to the effect of religious principles on the right to secure a divorce, the freedom to indulge in adultery and promiscuous fornication*.

I am sure many South Africans will claim to agree with this view of morality as espoused by the Chief Justice (even as they fail to live their lives according to it). But in a pluralistic society the moral views of the majority cannot be used to infringe on the rights of others and to rob those who

do not wish to adhere to the majority view of their dignity and freedom.

Be that as it may, personally I find the views of the Chief Justice on '*promiscuous fornication*' and the need for laws to force people to remain married even if they wish to divorce, deeply conservative and objectionable.

This is because religious rules relating to how and with whom we are allowed to have sex function to control and discipline citizens (especially their bodies) and rob them of the freedom to decide for themselves how they wish to live their lives. It imposes the view of some about how we are allowed to use our bodies for pleasure on all of us and robs people of their right to live according to their own beliefs about how to arrange their intimate affairs.

Suggesting that the law should ideally regulate consensual sexual activity and the freedom to enter into and terminate relationships that have little or no bearing on the material well-being of people is disrespectful of the freedom of those who do not share your very narrow religious view of morality. It has the potential to interfere with the private choices of individuals and requires the church or the state to have a decisive say over our bodies.

This is potentially devastatingly invasive of the right of everyone to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to security in and control over their body guaranteed by Section 12(2) of the Constitution.

It is therefore difficult to see how the views of the Chief Justice can be accommodated within the current constitutional regime.

Moreover, the morality espoused by the Chief Justice, does not seem to focus on the need to respect the inherent human dignity of every person and the idea that each human possesses moral agency to decide for him or herself how to live their life – as long as this does not harm others.

Instead, it seems to lean towards the view that the law, as well as the power and authority of the state, should be deployed to inculcate a specific religiously inspired morality in citizens.

In this regard the argument put forward by the Chief Justice that principles sourced from all religions could be infused into a '*national moral code that could be taught at home and school from a tender age all the way up to adulthood*' is particularly worrying. It is also intellectually incoherent as it directly contradicts other statements made by the Chief Justice in his speech.

In Stellenbosch the Chief Justice referred to the fact that the Constitutional Court has embraced the notion of South Africa as a pluralistic society. He even quoted the Court's judgment in *Prince* where it stated that: '*The protection of diversity is the hallmark of a free and open society*'.

But once you recognise that our Constitution demands protection of this diversity – including diversity related to religious and other beliefs such as the belief not to believe in any God – it is intellectually incoherent to then argue that a very narrow conception of religious morality should influence laws that regulate the private and intimate lives of citizens. It is also incoherent to argue that certain religious values should be infused in a national moral code, which should be used to indoctrinate vulnerable children.

A society that respects diversity cannot enforce or propagate a narrow religiously inspired moral code on society as a whole. Instead, a society that respects diversity will celebrate difference – also different attitudes about morality.

For example, for some a '*moral*' society will be a society which censors and regulates the sexual activities of citizens and emphasises the moral superiority of monogamous marriage between one man and one woman (and maybe two and a half children and a dog) till death do them part.

For others a '*moral*' society may be a society in which individuals are free to decide for themselves (without interference from the state) how to arrange their consensual, private, intimate affairs and in which we all fight to eradicate social injustice and economic inequality.

…a society in which diversity is respected cannot enforce or promote a uniform moral code…

Because of these vastly different

conceptions of what is good and moral, a society in which diversity is respected cannot enforce or promote a uniform moral code as the Chief Justice suggested.

Moreover, the view that religious values should influence laws and the interpretation of the Constitution is also in direct conflict with the precedent developed by the Constitutional Court.

In the *Fourie* judgment (ironically, perhaps, dealing with the need to recognise same-sex marriage), the Constitutional Court in no uncertain terms rejected the argument that religious beliefs should form the basis of legal regulation, stating as follows:

> *It is one thing for the Court to acknowledge the important role that religion plays in our public life. It is quite another to use religious doctrine as a source for interpreting the Constitution. It would be out of order to employ the religious sentiments of some as a guide to the constitutional rights of others. Between and within religions there are vastly different and at times highly disputed views on how to respond to the fact that members of their congregations and clergy are themselves homosexual. Judges would be placed in an intolerable situation if they were called upon to construe religious texts and take sides on issues which have caused deep schisms within religious bodies.*

It is exactly because there is no universally accepted set of moral norms – religious or otherwise – on which any court can rely that the South African Constitution (not any set of religious beliefs) serves as the source of our constitutional morality.

We have a choice: either we amend the Constitution in order to ensure that the religious beliefs of some become the moral loadstar for legislation and constitutional interpretation – thus rejecting any accommodation of diversity – or we stick with the constitutional values which celebrate religious and other forms of diversity and respect for human dignity and prohibit the law from enforcing the narrow religious morally inspired beliefs of some on the whole of society.

If you favour the first route, the Chief Justice is your man. If you favour the second, well, then his speech will make you extremely nervous.

FOOTNOTE:

1. An earlier version of this article has been published on 10 June 2014 on the Constitutionally Speaking blog. [http://constitutionallyspeaking.co.za]

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Nobody left behind...

AIDS 2014: Melbourne Declaration

All human beings are born equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. [Article 1, Universal Declaration of Human Rights, 1948]

We gather in Melbourne, the traditional meeting place of the Wurundjeri, Boonerwrung, Taungurong, Djajawurrung and the Wathaurung people, the original and enduring custodians of the lands that make up the Kulin Nation, to assess progress on the global HIV response and its future direction, at the 20th International AIDS Conference, AIDS 2014.

We, the signatories and endorsers of this Declaration, affirm that non-discrimination is fundamental to an evidence-based, rights-based and gender transformative response to HIV and effective public health programmes.

To defeat HIV and achieve universal access to HIV prevention, treatment, care and support – nobody should be criminalised or discriminated against because of their gender, age, race, ethnicity, disability, religious or spiritual beliefs, country of origin, national status, sexual orientation, gender identity, status as a sex worker, prisoner or detainee, because they use or have used illicit drugs or because they are living with HIV.

We affirm that all women, men, transgender and intersex adults and children are entitled to equal rights and to equal access to HIV prevention, care and treatment information and services. The promotion of gender equity is essential to HIV responses that truly meet the needs of those most affected. Additionally, people who sell or who have sold sex, and people who use, or who have used illicit drugs are entitled to the same rights as everyone else, including non-discrimination and confidentiality in access to HIV care and treatment services.

…non-discrimination is fundamental to an evidence-based, rights-based and gender transformative response to HIV and effective public health programmes…

In over 80 countries, there are unacceptable laws that criminalise people on the basis of sexual orientation. All people, including lesbian, gay, bisexual, transgender and intersex people are entitled to the same rights as everyone else. All people are born free and equal and are equal members of the human family.

Health providers who discriminate against people living with HIV or groups at risk of HIV infection or other health threats, violate their ethical obligations to care for and treat people impartially.

We express our shared and profound concern at the continued enforcement of discriminatory, stigmatising, criminalising and harmful laws which lead to policies and practices that increase vulnerability to HIV. These laws, policies, and practices incite extreme violence towards marginalised populations, reinforce stigma and undermine HIV programmes, and as such are significant steps backward for social justice, equality, human rights and access to health care for both people living with HIV and those people most at risk of acquiring the virus.

We therefore call for the immediate and unified opposition to these discriminatory and stigmatising practices and urge all parties to take a more equitable and effective approach through the following actions:

- Governments must repeal repressive laws and end policies that reinforce discriminatory and stigmatising practices that increase the vulnerability to HIV, while also passing laws that actively promote equality.

- Decision makers must not use international health meetings or conferences as a platform to promote discriminatory laws and policies that undermine health and wellbeing.
- The exclusion of organisations that promote intolerance and discrimination including sexism, homophobia, and transphobia against individuals or groups, from donor funding for HIV programmes.
- All healthcare providers must demonstrate the implementation of non-discriminatory policies as a prerequisite for future HIV programme funding.
- Restrictions on funding, such as the anti-prostitution pledge and the ban on purchasing needles and syringes, must be removed as they actively impede the struggle to combat HIV, sexually transmitted infections, and hepatitis C among sex workers and people who inject drugs.
- Advocacy by all signatories to this Declaration for the principles of inclusion, non-criminalisation, non-discrimination, and tolerance.

...the promotion of gender equity is essential to HIV responses that truly meet the needs of those most affected...

In conclusion we reaffirm our unwavering commitment to fairness, to universal access to health care and treatment services, and to support the inherent dignity and rights of all human beings. All people are entitled to the rights and protections afforded by international human rights frameworks.

An end to AIDS is only possible if we overcome the barriers of criminalisation, stigma and discrimination that remain key drivers of the epidemic.

To sign on and support this declaration, please go to www.aids2014.org/declaration.aspx.

www.aln.org.za

www.ATHENAnetwork.org

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