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ALQ

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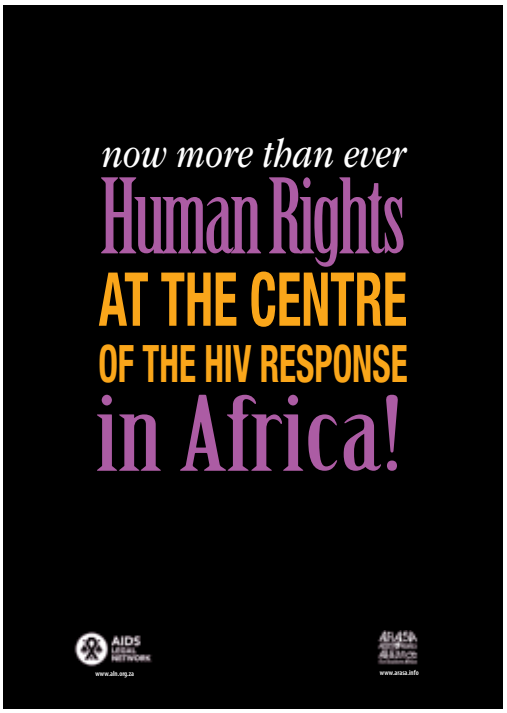
# We need to acknowledge them first...

## Human rights protections versus human rights acknowledgements

***Sierra Mead***

*In a world that is looking to* 'end AIDS' *and create a path towards an* 'AIDS-free generation', *the* 'battle' *for human rights of marginalised populations must be at the forefront to achieve this aspiration. On July 13 2013, the United Nations launched* Treatment 2015, *a framework that focuses responsibility on government to change their approach to healthcare and provide more people with Antiretroviral Treatment (ART). However, no matter how much pressure is placed on any government from an international community, until human rights violations end and the social environment shifts to acknowledge that people living with HIV have the same rights as everyone else, access to ART will remain out of the hands of marginalised populations, the populations that need it the most.*




Numerous countries that are in the international spotlight as needing assistance with the HIV pandemic, like South Africa, are going through the motions of pumping money into the healthcare

# Editorial...

Recognising the continuing need for critical discourse on human rights in the context of and the response to HIV, this edition of the ***ALQ*** explores some of the persistent challenges barring the advancement and protection of human rights for people in all their diversity.

Based on the recognition that human rights protections are to be at the core of all aspects of the AIDS response – in policy and practice – for the response to HIV to be effective, the various articles explore some of the continuing '*threats*' to human rights and its impact on '*goals*' and '*commitments*' made to advance and protect human rights of *all* people.

In the era of treatment scale up and seeking universal coverage, **Sierra Mead** explores the Treatment 2015 Framework and raises the question as to whether or not '*ambitious goals*' like these are indeed achievable with all the many '*barriers*' to access to treatment prevailing the world over. Based on the premise that protecting human rights is a critical step towards increasing access to treatment, the article highlights the impact of '*punitive laws*' on access to HIV-related services and treatment for people with HIV and other '*key populations*' in the current '*political and social environment*', in which too many countries are not just '*stagnant*', but indeed '*regressing*' on their human rights progress. Recognising the '*social climate*' – that perpetuates and nurtures stigma and discrimination against the '*other*' – she argues that the pre-requisite for any form of progress in human rights protections (and access to treatment) is '*human rights acknowledgments*' for *all* people. In order to protect peoples' rights, '*we need to acknowledge them first*'; otherwise treatment goals '*while honourable*' will remain non feasible and a '*wistful fantasy*'.

The need to address the multiple layers and forms of stigma and discrimination, and their effects on peoples' risks to HIV exposure, transmission and subsequent rights abuses, has long been recognised as a key element of effective and rights-based responses to HIV. Elaborating further on the intersections between xenophobia and HIV, **William Bourget** discusses the extent to which '*xenophobia's 'othering*' mixes with stigma, discrimination and other rights abuses based on and in the context of HIV, and '*dictates*' the realities and risks of migrants. The article illustrates the overall '*hostile environment*' in which migrants have to '*navigate*' on a daily basis, and introduces the concept of '*medical xenophobia*' – indicative of migrants' experiences within the healthcare sector. He argues that the '*sheer*' numbers of '*officials*' carrying xenophobic attitudes is '*itself institutionalising xenophobia*'; hence perpetuating human rights violations and deterring access to services, including treatment, for migrants.

Public discourse and opinions on the '*rightfulness*' of court judgements are more likely to be led by '*values*' and '*emotions*', rather than by '*facts*',

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## In this issue

system, yet human rights violations remain as glaring and foreboding as ever. Other nations are not doing anything to improve marginalised population's human rights, in fact, in sub-Saharan Africa, homosexuality is '*illegal*' in 38 countries[1], and Russia has recently passed anti-gay legislation. The challenges that the HIV epidemic poses are unique, for although improved healthcare is of vital importance, human rights acknowledgement and protection is equally critical to ending the epidemic. As Bertrand Audoin, the executive director of the International AIDS Society, rightly states, the '*deprivation of human rights goes beyond mere civil liberties: it is bad public health*[2].

## TREATMENT 2015: THE FRAMEWORK

*Treatment 2015* is a programme that focuses on bringing 15 million people around the globe accessible antiretroviral treatment by 2015.[3] What sets the *Treatment 2015* framework apart from previous goals and proposals set forward to increase universal coverage is its emphasis to call the healthcare systems to adapt to the people who use them, rather than expecting people to adapt to the service system.[4]

> …healthcare systems to adapt to the people who use them, rather than expecting people to adapt to the service system…

> …deprivation of human rights goes beyond mere civil liberties: it is bad public health…

Before we start working on protecting human rights to expand treatment, we must first *acknowledge* that individuals living with HIV *have*

especially with regard to the '*judgement*' on whether or not teenagers should '*by law*' be allowed to engage in sexual activities. Recognising the risks of '*misinterpretations*' and the '*power*' of public opinion, **Sanja Bornman** outlines the '*facts*' of the Teddy Bear judgement, and its implications, so as to shed light on what is '*fact versus fiction*'. She underscores that the '*judgement*' is *not* about non-consensual, forced or coerced sex between teenagers, nor about sex between children and adults – neither should it be seen as an '*encouragement*' for teenagers to be sexually active. Emphasising that the '*judgement*' is instead about protecting teenagers' human rights to dignity, autonomy, and privacy, she argues that the hence '*judgement*' needs to be '*welcomed*' and '*applauded*' for what it is, a '*victory*' for human rights; as society cannot '*abdicate its duty*' to educate teenagers about '*responsible sexual behaviour*', and leave this responsibility to the criminal justice system.

It is well recognised that criminalising consensual '*same-sex sexual and emotional desire*' not only constitutes a gross human rights violation against a '*sizeable section*' of a country's population, but also impedes on the effectiveness of the AIDS response to '*key affected populations*'. Looking at the recent passing of '*anti-gay legislation*' in Uganda and Nigeria, **Pierre de Vos** explores the meaning and implications of '*quiet diplomacy*'. He reflects on the '*power*' of '*silence*' informed by prejudices and homophobia – both at an individual and state level – and highlights the extent to which gay men and lesbians on the continent are '*silenced out of existence*', and '*oppression is made invisible*' through '*silence and negations*'. Noting South Africa's approach of '*silent diplomacy*' to the passing of these repressive laws, he argues that this '*quiet diplomacy*' and '*silence of the closet*' is indeed a '*devastating betrayal*' of gay men and lesbians on the continent, and feels like '*acquiescence with our own oppression*'.

The persistence, occurrence and effects of HIV-related stigma, discrimination and violence on peoples' risks and vulnerabilities are well-documented, leading to amongst others a global '*commitment*' of moving towards '*Zero HIV-related discrimination and violence*'. Assessing the progress made in achieving this ambitious goal from a community perspective, **Ione Wells** provides an insight to the discourse and concerns raised during a Community Dialogue in Atlantis, Western Cape. She introduces some of the '*community voices*', and underlines the many ways in which the laws protecting peoples' rights have not '*yet become social norms*'; '*tradition*', culture and religion are '*manipulated*' to '*justify forged hierarchies*'; and the '*social environment*' that seems to '*obstruct*' the enactment of legal rights. Based on the premise that '*getting to Zero*' requires '*a total paradigmatic shift of attitudes*', she concludes that we have not come '*far enough*', and unless human rights are '*acknowledged and lawfully executed*', and integrated in '*our social environment*', getting to *Zero* remains but an ambitious goal.

While the adverse effects of criminalising HIV exposure, transmission and non-disclosure are well recognised, countries all over the world continue to draft and enact legislation to this effect. Looking at '*a perspective from down under*', **Rhys Larsen** explores the '*law response*' to HIV exposure and transmission in Africa and Australia, raising the question as to the '*role of law*' in responding to and mitigating the effects of HIV. He discusses the various law provisions, emphasising the need to ensure that laws are not written or can be interpreted in ways that '*produce unjust and unethical results*', thus deterring people from accessing services. Conceptualising HIV as a medical condition that '*limits social and legal interaction*', he argues that irrespective of whether or not the law criminalises HIV exposure and transmission, '*the community will*' – which is the actual '*issue*' that needs to be addressed.

The recurring theme in all the articles seems to be '*criminalisation*' – in law and practice – of '*certain behaviours*' and '*populations*', as a '*misguided*' approach to alter '*behaviours*' perceived to be '*non-conforming*' to the '*dominant and oppressive*' social norms and environments, persistently threatening the '*liberty and lives of people*'. Despite the overwhelming evidence to the contrary of the '*law*' deterring '*certain behaviours*' from occurring or '*populations*' from existing, social environments seem to continue to '*nurture*' the notion and yearn for '*the law*' to take its cause and deal with '*the other*'. How far have we come in protecting human rights of people in all their diversity? – '*not far enough*'; as we not only fail '*to acknowledge them first*' and '*silence them out of existence*', but also '*justify*' with and '*manipulate*' social norms and values in such way that further deepen the '*forged hierarchies*' and '*make oppression invisible*'. Thus, '*it is time to rethink our priorities*' and act upon '*our wisdom*' that progress in human rights protections does not happen in a vacuum, but instead in an array of '*hostile environments*', which need transforming to become '*enabling and supportive*' for human rights to be '*real*'…

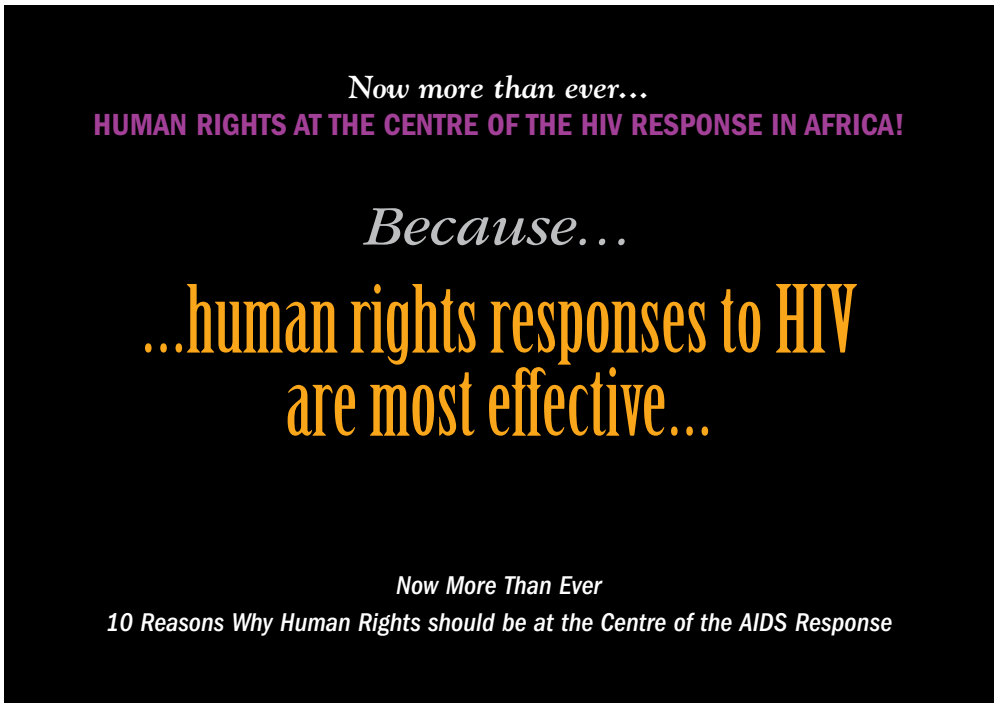
***JOHANNA KEHLER***

human rights. If we expect any work to be done, it will most likely be done from smaller organisations because, in many cases, the government is a hindrance instead of a help. Fortunately, *Treatment 2015* recognises this to an extent,

> *…as non-clinical issues are often the most significant barriers to effective navigation of the HIV treatment continuum, communities are often best placed to provide leadership and support to address these issues. This is especially true for key populations, who often face especially acute challenges in accessing services through mainstream health systems.*[5]

…we must first acknowledge that individuals living with HIV have human rights…

Key populations include intravenous drug users, transgender people, women and girls, men who have sex with men, and sex workers. We have seen countries taking formal steps in the '*right*' direction in terms of public policy to assist people with HIV; for example, South Africa has increased HIV treatment by 75% in the last two years, with a total of 1.9 million people having access to lifesaving



treatment.[6] It cannot be denied that we have at our disposal the science and technology to prevent the transmission of HIV and even to potentially end the epidemic; however,

> *…we cannot apply that science worldwide because so many people at high risk infection fear recrimination and are reluctant to seek help from the organizations that can help them.*[7]

…the population that needs to be acknowledged…

By the end of 2012, 9.7 million people had access to antiretroviral therapy and the UN estimates that 4 million people are alive because of the treatment's accessibility.[8] The *Treatment 2015* framework mentions an important milestone to HIV treatment, when the number of people on HIV treatment exceeds the number of people becoming infected with HIV and claims that, as of December 2011, several countries have accomplished this goal.[9] However, in 2011, 2.5 million people were newly infected with HIV and 1.6 million people sought access to antiretroviral therapy.[10] These statistics are of those who are diagnosed with the virus, and the numbers

do not take into account those living with HIV and do not know it. If the international community sees leaving 900,000 newly infected people (not including those who are infected without their knowledge) without access to treatment encouraging, then it is time to rethink our priorities. Those who cannot access the treatment, those 900,000 newly diagnosed, is exactly the population that needs to be acknowledged.

The *Treatment 2015* proposal states

> *…for the first time since the beginning of the AIDS epidemic, we have an historic opportunity to lay the groundwork to achieve zero new infections, zero discrimination, and zero AIDS-related deaths…a determination to embrace and respect human rights is critical if we are to reach those most vulnerable to HIV infection*.[11]

…before we can protect people's human rights, we need to acknowledge them first…

Protecting human rights is, indeed, a critical step towards bringing more people treatment, because ideally if human rights are protected, then people living with HIV are not living in fear of stigma, violence, or a complete life transformation when they are diagnosed with HIV.

Fortunately, there are thousands of remarkable organisations around the world that focus on protecting the rights of women and men living with HIV, but

…this goal, while honourable, is not feasible in the current international political and social environment…

the protection of human rights by these organisations can only go so far and reach so many people. Every day there is news of violence against people living with HIV and, particularly in Sub Saharan Africa, the stigma against the virus exists in an incredibly real way. In a study done in South Africa, 59% of participants indicated that when a woman's HIV status becomes known within the community she would be '*rejected*', '*treated badly*', and '*discriminated against*'.[12] International policies like *Treatment 2015* is an incredibly noble goal, however, entire communities need to change their impressions of people living with HIV, because before we can protect people's human rights, we need to acknowledge them first.

## BARRIERS AND PUNITIVE LAWS

Governments that have restrictions on gay marriage or any kind of anti-gay rights legislation, are not directly infringing upon the rights of specifically people living with HIV, but rather restricting human rights of key marginalised populations where HIV prevalence is high. The UN recognises that

> *…education campaigns that reach the general population are unlikely to reach these populations, and it is no surprise that in many parts of the world HIV prevalence among men who have sex with men, transgender people, and sex workers is much higher than in other populations*.[13]

In fact, these key populations and their sexual partners account for '*a substantial share of the people newly infected with HIV*' in countries ranging from Nigeria (51%), Kenya (33%), Morocco (80%), and Peru (65%).[14]

The UN further recognises that in order to reach the substantial goal of bringing treatment to 15 million people in less than two years,

> *…we must work together. Only through partnership, beginning with leadership of the countries burdened by HIV…can we reach our common goal*.[15]

...in Russia and parts of sub-Saharan Africa, it is political leaders that are the drivers of discrimination...

What is not acknowledged in this statement is that, in many cases, it is the very leadership of the countries that is increasing the burden of HIV and stripping their most marginalised citizens of human rights. How can the healthcare changes actually make a difference in nations that do not recognise and respect the rights of each citizen? In today's current political climate, there is arguably none more screeching and obvious breach of human rights by elected leadership, than Russia's recent anti-gay legislation.

Let's take a look at Russia and its implications for the expanded access to ART or the '*AIDS free generation*'. Today, one million people in Russia are living with HIV; ten years ago the figure was at a more *manageable* 100,000 people, yet still alarming.[16] The UN is drawing upon governments to help support people living with HIV, but in Russia and parts of sub-Saharan Africa, it is political leaders


that are the drivers of discrimination. In Russia, the human rights breaches span from not just one law, but an entire dung-heap of legislation.

Signed in 2013 by President Vladimir Putin includes legislation that bans Russian-born children from being adopted by gay couples or couples living in any country where marriage equality exists; a law that allows police officers to arrest suspected '*pro-gay*', or homosexual tourists and give them the right to detain them for up to 14 days; and a law that classifies '*homosexual propaganda*' as pornography, a term so vague that anyone making a pro-gay statement to an underage child is subject to fines and arrests.[17] When looking closely at this repressive collection of legislation, technically

...the social climate, that perpetuates stigma and discrimination against people living with HIV and, therefore, discourages many people from getting tested for HIV, is closely linked to the political climate that violates their civil rights...


anyone suspected or accused of being gay can go to jail and

> *...even a judge, lawyer or lawmaker cannot publicly argue for tolerance without the threat of punishment.*[18]

Men who have sex with men, as stated above, is a population at higher risk of HIV. With laws like these being passed in the turbulent political and social environment, how can anyone expect a man who has sex with men to seek out ART treatment in Russia? Russia, with a functioning parliamentary and democratic system, is displaying gross disregard for the LGBTQ community's human rights. Is it thus practical to expect other narrow-minded countries whose citizens do not have the economic and political advantages of Russia, to ever develop a system that helps people living with HIV? Russia's recent anti-gay laws, as the media so

...too many countries and governments are not just stagnant in terms of human rights progress, but are even regressing or obstructing developments to improve the lives of people living with HIV...

eloquently calls them, is a disheartening example of how governments are inadvertently making the UN's goals of 15 million people accessible to ART nothing more than a wistful fantasy.

In 38 Sub-Saharan African countries, homosexuality is '*illegal*' and in some instances, to highlight some of the more gruesome violations to human rights, can result in the death penalty. In Nigeria, there is a 10-year prison term for people publically showing affection, advocating for gay rights, or witnessing or assisting with gay marriage.[19] In Malawi, the law imposes a 14-year prison term against men who engage in same sex conduct, and a 5-year prison term for women.[20] Uganda has a creative spin on exactly how they dismiss their citizen's human rights by introducing a law that makes '*aggravated homosexuality*' (engaging in gay sex three times or while HIV-positive) illegal.[21]

## TREATMENT GOALS: A WISTFUL FANTASY?

The social climate, that perpetuates stigma and discrimination against people living with HIV and, therefore, discourages many people from getting tested for HIV, is closely linked to the political climate that violates their civil rights. The UN recognises that

> *…enhanced support for strengthening community systems is also needed, to broaden awareness of the availability of simple, easily tolerated regimens, increase access to user-friendly testing options and alleviate stigmatizing attitudes that deter many from seeking testing services. Focused, community-centred testing outreach can help reach marginalized populations at elevated risk*.[22]

It is true, change will begin first from the communities and eventually policy will follow.

The UN is making a sensible decision in trying to expand access to antiretroviral therapy, because the treatment not only saves people living with HIV, but also restricts the spreading of the virus.[23] This goal, while honourable, is not feasible in the current international political and social environment; too many countries and governments are not just stagnant in terms of human rights progress, but are even regressing or obstructing developments to improve the lives of people living with HIV.

...it is true, change will begin first from the communities and eventually policy will follow...

*Treatment 2015* fights only half of the battle; just focusing on expanding healthcare treatment is not enough if we, as an international community, are trying to achieve an '*AIDS-free generation*' or reach the most marginalised people in need of ART. Until policies around the world focus on both human rights violations against people living with HIV and expanding opportunities for treatment, it will be difficult to reach 15 million people with antiretroviral by 2015, let alone achieve an '*AIDS-free generation*' in the future.

**FOOTNOTES:**

1. Audoin, B. 2013. 'The AIDS Epidemic Can Be Ended.' In: *New York Times,* 20 Aug. 2013. International Herald Tribune. [www.nytimes.com/2013/08/21/opinion/global/the-aids-epidemic-can-be-ended.html?_r=1&adxnnl=1&adxnnlx=1381862941-2OzXJNFKGyvOmxTlDqT0iQ&]
2. *Ibid*.
3. 'UN Framework to Give 15 Million People Access to HIV Antiretroviral Treatment.' *UN News Center*. UN, 13 July 2013. [www.un.org/apps/news/story.asp?NewsID=45402]
4. Chan, M. et al. 2012. *Treatment 2015*. Rep. UNAIDS, 2012, p5. [www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2484_treatment-2015_en.pdf]
5. *Ibid*, p17.
6. See http://countryoffice.unfpa.org/southafrica/2013/05/03/6675/hiv.
7. Audoin, B. 2013. 'The AIDS Epidemic Can Be Ended.' In: *New York Times,* 20 Aug. 2013. International Herald Tribune.
8. Chan, M. et al. 2012. *Treatment 2015*. Rep. UNAIDS, 2012, p4.
9. *Ibid*, p13.
10. *Ibid*.
11. *Ibid*, p3.
12. Kehler, J. et al. 2012. *Gender Violence & HIV*. Cape Town: AIDS Legal Network, p25.
13. Audoin, B. 2013. 'The AIDS Epidemic Can Be Ended.' In: *New York Times,* 20 Aug. 2013. International Herald Tribune.
14. Chan, M. et al. 2012. *Treatment 2015*. UNAIDS, 2012, p11.
15. *Ibid*, p3.
16. Fierstein, H. 2013. 'Russia's Anti-Gay Crackdown'. In: *New York Times,* 26 July 2013. [www.nytimes.com/2013/07/22/opinion/russias-anti-gay-crackdown.html?_r=0]
17. *Ibid*.
18. *Ibid*.
19. Wong, C. M. 2013. 'Africa's Anti-Gay Laws: A look at Uganda, Malawi and more'. In: *The Huffington Post*. Associated Press, 24 June 2013. [www.huffingtonpost.com/2013/06/24/africa-anti-gay-laws_n_3491565.html]
20. *Ibid*.
21. *Ibid*.
22. Chan, M. et al. 2012. *Treatment 2015*. UNAIDS, 2012, pp17-18.
23. *Ibid*, p5.

*Sierra Mead is a political science major and an intern at the AIDS Legal Network (ALN).*
*For further information and/or comments, please contact her at sierra.mead@gmail.com.*

# Myths versus evidence...
## Xenophobia and HIV

*The period of nation-building that followed the passing of the apartheid regime in South Africa created a discourse that blamed rising rates of crime, unemployment, and HIV on foreigners immigrating to South Africa. Indeed, we still see the effects of xenophobia on migrants at the social, civil, and political level almost twenty years from the fall of apartheid. While many have addressed the rise and development of xenophobia post-apartheid, few have delved deeper to see how xenophobia's 'othering' mixes with the stigma, discrimination, and humiliation experienced by people living with a positive HIV status.*

***William Bourget***


To frame the discussion, xenophobia will be referred to as an unreasonable or irrational dislike of those perceived to be foreign or strange, and will use this understanding throughout the paper.[1] This paper will further deconstruct what xenophobia means for migrants living in South Africa before using the Southern African Migration Project's concept of *medical xenophobia* to delve deeper into the institutionalisation of xenophobia in South African society. After this, the focus of this paper will shift to South Africa's health sector and analyse why institutions have failed to deliver the South African ideals set post-1994. This article argues that the specific intersection of stigma and xenophobia in South Africa, as carried out by *ad hoc* officials, subjects migrants living with HIV to forms of discrimination, violence, and human rights violations that are unparalleled throughout the rest of South Africa.

The South African Immigration Act of 2002 identifies approximately 20 different types of citizenship status. The bulk of these fall under those granted Temporary Residence Permits (TRP). In this report we will discuss migrants generally, but will focus on TRPs and make reference to asylum seekers, refugees, permanent residents, and undocumented immigrants. According to the Immigration Act of 2002, asylum seekers fall under the broader category of TRPs; however, we will recognise asylum seekers separately as they experience forms of discrimination unique to their circumstances. Similarly, while refugees fall under the umbrella of permanent residents, we will address refugees as their own category, due to the politics surrounding asylum. Clearly, South African society grants some forms of migrants higher degrees of privilege than others, but none are exempt from the effects of xenophobia, no matter how subtle.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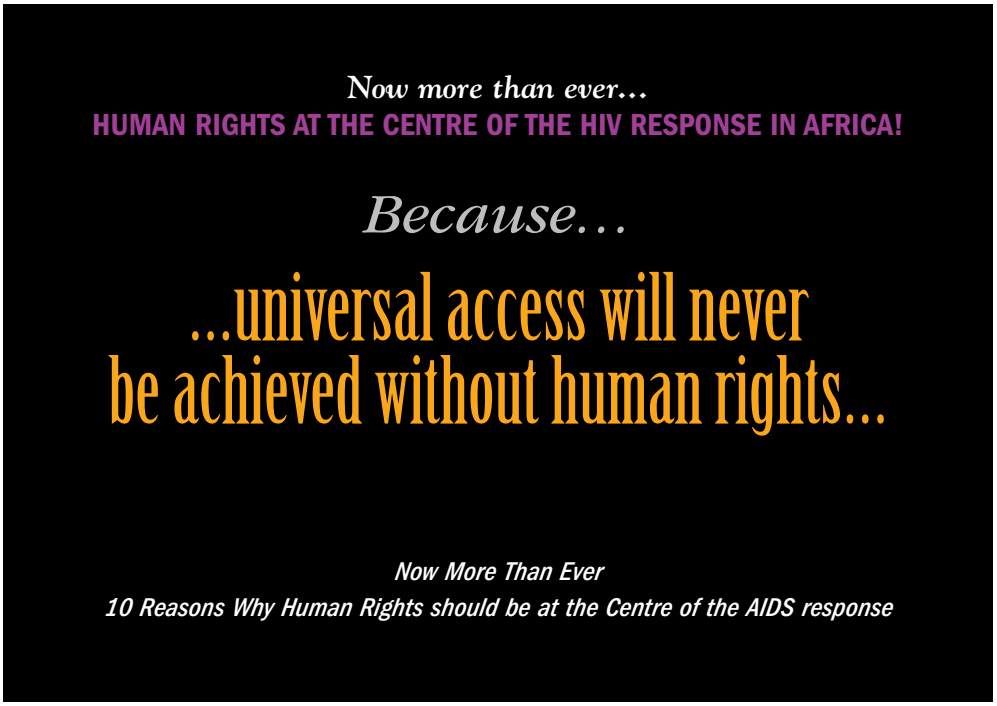



## XENOPHOBIA: AN OVERVIEW

The marriage of nationalism and racial equality left South Africa praised by human rights advocates for its liberal constitution, but plagued by overarching traces of xenophobia. The Southern African Migration Project (SAMP) sought to better illustrate South Africa's xenophobia through a series of surveys. Their research shows that 25% of South Africans believe immigrants, regardless of their citizenship status, are responsible for the rise of crime, unemployment, and disease in South Africa, and should be deported as a result.[2] In 2010, SAMP's studies showed that 54.3% of those surveyed '*perceived impacts of migrants on South Africa*' to be negative, with 30.5% perceiving positive impacts[3].[4] In summarising their findings, SAMP reports:

> *Citizenship and nationality are clearly strong factors shaping public attitudes towards the inclusion and exclusion of various communities living in South Africa. In terms of general attitudes to their own racial group and to migrant groups, the ratings follow a predictable pattern with all of the South African groups receiving much higher positive evaluations.*[5]

Furthermore, SAMP's conclusion shines empirical light on xenophobic sentiments as common and widespread in South Africa, as opposed to radical and isolated.

Formally, the rights outlined in South Africa's Constitution, except those pertaining to voting, are extended to all forms of migrants – apart from undocumented migrants – including the protection from discrimination, right to equality, healthcare, etc. Contrary to these ideals, reality shows us that many policies pertaining to migrants are inconsistently implemented. The National Strategic Plan on HIV, STIs and TB, 2012 – 2016, South Africa's primary document in regards to HIV and AIDS, acknowledges migrants as a population at high risk, but continues the common trend of failing to implement its rhetoric.[6] A wide range of scholars have documented this phenomenon and conclude there is no single source, but rather a multitude of actors responsible for the lack of delivery.

> …preventing the transmission requires a broader lens that shifts the HIV discourse away from blame and towards a better understanding of the factors that increase the prevalence of the disease…

A study that surveyed 1,696 migrant experiences across nine reception offices in Cape Town, Pretoria, Durban, Port Elizabeth, and Johannesburg, and found that *ad hoc* officials – meaning agency employees who diverge from procedures outlined by their institutions – influence virtually every sector of migrants' lives in South Africa: at the border where South African Police Service (SAPS) officers demand fees before allowing people to cross; within the Department of Home Affairs (DHA) '*transform*[ing] *bureaucratic procedures into major obstacles for migrants*'; and in the city where SAPS and the South African National Defence Force (SANDF) target migrants under the façade of crime prevention.[7] The DHA and SAPS departments themselves are not corrupt, but the rate of diverging from procedures by *ad hoc* officials illustrates a degree of persistence that cannot be explained by mere mishap or forgetfulness.[8]

Furthermore, data depicting xenophobia as common can be used to suggest that *ad hoc* officials' decision to independently deter, halt, or minimise immigration is an extension of the xenophobic sentiments recorded at a national level.[9] Ultimately, the sheer number of officials producing xenophobic effects is itself institutionalising xenophobia.

## XENOPHOBIA: MYTHS AND EVIDENCE

Further supporting the impact of xenophobia is the vulnerability, lack of political mobility, and financial insecurity that shapes migrants' lives and heightens the risk of HIV transmission. People working in rural agricultural settings work long hours, receive a low pay, and are often subject to manipulative employers that have standing relationships with local SAPS officials.[10] It is common for border officials to accept bribes from incoming migrants, knowing that once an employer obtains the profit he/she originally sought, they will be calling the SANDF to come repatriate the migrant employee. In the eyes of farmers and border officials this is a win-win situation: the farmer profits off cheap labour without the fear of legal prosecution, and the border officials preserve an exclusive South Africa.

The xenophobic sentiments linking migrants with escalating crime, unemployment, and disease rates are mere rhetoric unsupported by empirical evidence. After interviewing 362 immigrant entrepreneurs in inner city Johannesburg, a study showed that the majority of the people surveyed were making a profit, invested towards future expansion, and that the informal industry as a whole had an employee base that was 45% South African.[11] In terms of crime, the

…the sheer number of officials producing xenophobic effects is itself institutionalising xenophobia…


Human Rights Watch warned South African officials and the media, saying that popularising '*the unfounded perception that migrants are responsible for a variety of social ills*' only perpetuates xenophobic attacks and abuses from '*South African citizens, as well as members of the police, the army, and the Department of Home Affairs*'[12]. The data above shows that the use of non-South Africans as a scapegoat for rises in crime and unemployment is derived from the same xenophobia noted in *ad hoc* officials' actions.

## XENOPHOBIA AND HIV

The conflation of migrants with the spread of disease, is similarly unsupported and has an adverse effect on organisations' intervention responding to HIV, as well as migrants' access to healthcare. In addition, centering the HIV discourse around who is to blame hinders efforts towards preventing future transmissions. Instead of focusing on the source, HIV efforts should complement bio-medical treatments by looking at factors that heighten risks of transmission – poverty, discrimination, and violence.

While there is no causal relationship between

…mere rhetoric unsupported by empirical evidence…

…history of xenophobic attacks and corrupt SANDF officials deter foreigners from seeking treatment at a local clinic…

poverty and HIV, there is a correlation that needs to be acknowledged in order to accurately address the complex intricacies that contribute to the spread of the disease, and what that means for migrants. Research suggests that densely populated areas without sufficient resources, such as townships and other informal settlements, are at a higher risk than areas with stronger infrastructure.[13] Comparing one of Cape Town's touristic suburbs, Blaauwberg, with that of the township Khayelitsha, research further stresses the importance of socio-economic context:

> *…it is critical that the responses to the epidemic recognise and take cognisance of the factors that see HIV/AIDS vary from 7.3% (Blaauwberg) to 32.5% (Khayelitsha) in a single municipality as is the case in the City of Cape Town.*[14]

In other words, a bio-medical approach to HIV is crucial for the treatment of the disease, but preventing the transmission requires a broader lens that shifts the HIV discourse away from blame and towards a better understanding of the factors that increase the prevalence of the disease.

Studies conducted by the African Centre for

…lasting consequences for migrants living with HIV…

Migration and Society and Wits University show '*that less than 5% of international migrants report 'ever bringing a sick relative to join them in the city*' and that if they themselves ever fell sick, they would return to their home country before seeking out a local clinic[15]. Surely, South Africa's history of xenophobic attacks and corrupt SANDF officials deter foreigners from seeking treatment at a local clinic. These events, along with blaming of migrants for the spread of HIV, further ostracise non-South Africans into informal, violence prone, and poverty stricken environments increasing the risk of HIV transmission.

The intersection of stigma and xenophobia makes intervention by organisations focused on migrant rights and/or HIV- related issues extremely difficult.[16] Scholars have noted that simply blaming certain populations or persons for the spread of HIV is not only incorrect, but also irrelevant, as it does nothing to prevent future transmissions. This evidence serves as a counter to misinformed accusations against migrants for the spread of disease and highlights the vulnerability of those migrants working in the informal sector. The troubles migrants face in navigating their positive HIV status does not stop at the clinic doors; in fact, research suggests that health professionals use a similar xenophobic lens as that seen in Department of Home Affairs and border officials.

Compounding the circumstances that come with low wages and manipulative employers, which are characteristic of migrants' work conditions, xenophobia makes migrants living with HIV more susceptible to stigma, refusal of antiretroviral treatment (ART), and unemployment. Around the globe activists are bringing attention to how disclosing one's positive HIV status can mean humiliation and isolation from your community. A 2012 study by the AIDS Legal Network surveying 2379 community members in the Northern Cape and North West area found that '*more than half (57%, 1364) of respondents felt that people would be 'rejected', 'judged', and 'discriminated against' by community members as a result of their positive HIV status*[17]. The intersections of stigma associated with a positive HIV status and the xenophobia targeted at migrants have lasting consequences for migrants living with HIV.

## MEDICAL XENOPHOBIA AND ACCESS TO HEALTHCARE

With 39% of South Africans perceiving migrants as responsible for '*bringing into*' and spreading diseases in South Africa, one can assume that such sentiments are not exactly uncommon.[18] This sentiment results in non-South Africans encountering more barriers when attempting to access public health facilities, than their South African counterparts. The conflation of disease with migrants is an example of the xenophobia surrounding foreigners, and heightens the risk of discrimination and attacks against non-South Africans. Furthermore, after discovering an individual's informal citizenship status, some health professionals may refuse service, due to their personal biases associating immigrants with South Africa's rise in disease. Research also suggests that health professionals based in personal biases might refuse ART to refugees and asylum seekers if they perceive the patient to be unworthy of asylum.[19]

The past few paragraphs have presented information that outlines how the experience of migrants living with HIV is uniquely characterised by both the stigma assigned to a positive HIV status, as well as the xenophobia that haunts foreigners living in South Africa. These circumstances illustrate the effects of institutionalised *medical xenophobia*,


...after discovering an individual's informal citizenship status, some health professionals may refuse service, due to their personal biases...

which the Southern African Migration Project defines as

> *…the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job.*[20]

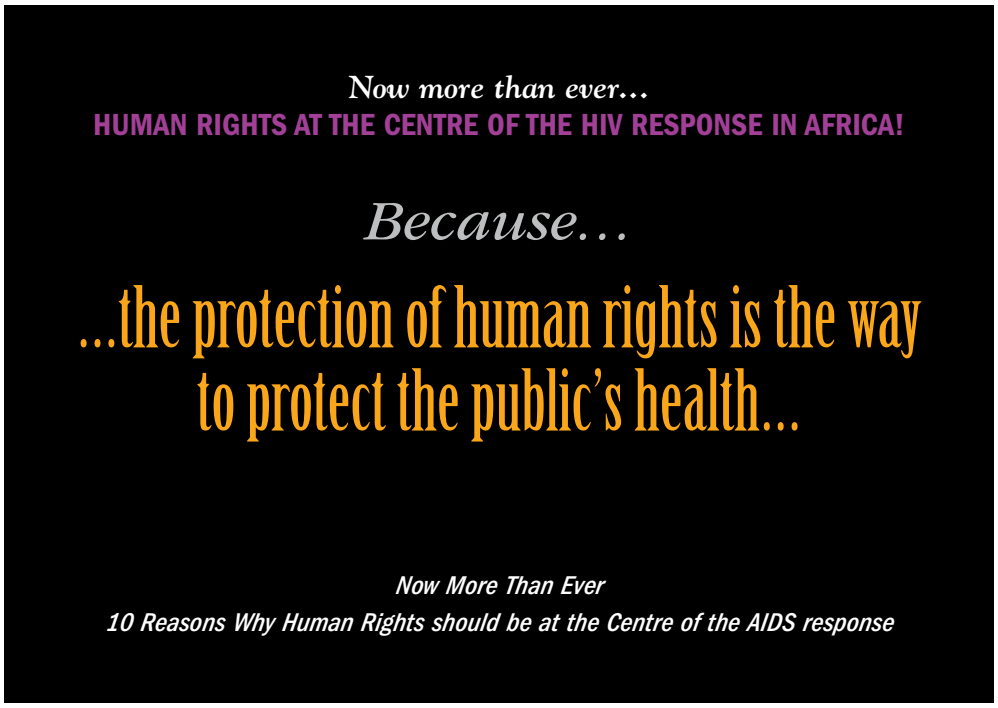
Similar to the concepts discussed earlier with DHA, SANDF, and SAPS, public health officials are also acting independently to implement their personal beliefs surrounding immigration. Health professionals' biases are often coded in false legal jargon to deny foreigners treatment.[21] Though the South African Constitution grants healthcare access to all, with the exception of undocumented migrants, health professionals often get confused by the wide variety of documents ascribed to the different types of citizenships. Confusion then leads to the accidental, and sometimes purposeful, misreading of documents, which can end in health professionals unconstitutionally charging an extra fee or outright denying treatment to the patient.[22]

…indicative of the xenophobia that dictates migrants' experience within the health sector…

…focusing on who carried the virus first is ineffective as it does not cure, prevent, or educate anyone on what to do next…

If a clinic agrees to see a patient with an informal citizenship status employees maintain the feelings of humiliation and discrimination via a language barrier and triage system. Public health employees will often scold and humiliate those who cannot speak Zulu or Xhosa for not knowing the dominant African language.[23] SAMP's research surrounding medical xenophobia not only shows the troubles of communicating in a different language, but also suggests that health employees outright ignore those with English accents, yell at patients for speaking incorrect Zulu or Xhosa, and are reluctant to the use of translators.[24]

The mistreatment of those who cannot speak a local language is supported by data reflecting what South Africans believe makes you a 'true' South African. SAMP's study shows that 64% of South Africans prompted said '*speaking an African language*' was necessary '*for being a 'true South African'*'[25]. Therefore, the consequences that follow not speaking




an African language amplifies the humiliation already engrained with the stigma assigned to a positive HIV status, and can be interpreted in a way that discourages the patient from returning for treatment.

Patients that responded to SAMP's questions described a triage system where locals would be prioritised over those who had accents, certain styles of dress, or other stereotypical images associated with certain nationalities. In this example, we see healthcare employees treating foreigners as though they are truly lesser than the South African nationals. One of SAMP's respondents from Alexandra illustrated the degree of discrimination when saying

> *…There were only four people in front of us… However, it took us almost three and half-hours to be served as some local people just came in and went directly in without queuing.*[26]

The prioritising of certain individuals over others on the basis of nationality is indicative of the xenophobia that dictates migrants' experience within the health sector.

## CONCLUSION

Ultimately, officials within SANDF, SAPS, DHA, and the health sector are nullifying the protection from discrimination, right to equality, and access to healthcare outlined in South Africa's Constitution as a

...South Africans are accusing migrants for the ills of society and their relationships, instead of looking at how the spread of said ills can be prevented...

right to all documented forms of citizenship. The lasting effects of xenophobia are executed by the *ad hoc* officials dispersed throughout every element of migrants' lives, and especially so if they are living with a positive HIV status.

The hostile environment that migrants have to navigate on a daily basis threatens both his/her livelihood, as well as the health of their family who is dependent on their financial support. Moreover, being humiliated for a positive HIV status, a foreign accent, and an informal citizenship status discourages migrants living with HIV from seeking further treatment, and thus increases the risk of them going back home for the simple sake of dying somewhere familiar.[27]

Part of the medical xenophobia phenomenon is linked in an HIV discourse obsessed with finding the source. Instead of implementing an approach that is truly beneficial to all parties involved, pointing the blame stigmatises populations and suppresses migrants' ability to seek treatment and safely disclose a positive HIV status. Focusing on who carried the virus first is ineffective as it does not cure, prevent, or educate anyone on what to do next.

Moving forward does not mean assigning blame, but rather focusing on what steps should be taken to protect people with a positive HIV status, while simultaneously preventing further transmission. This can be done by tougher oversight on border and health officials, more resources for migrant workers, and investment in social infrastructure. The conditions seen in South Africa's response to immigration can be used as a metaphor to highlight the flaws in the current HIV discourse: South Africa has committed to a human rights agenda, and agreed for migrants to be protected under the South African Constitution. However, South Africans are accusing migrants for the *ills* of society and their relationships, instead of looking at how the spread of said *ills* can be prevented (i.e. crime, unemployment, disease, etc.).

**FOOTNOTES:**

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2. Vigneswaran, D. et al. 2010. 'Criminality or Monopoly? Informal immigration enforcement in South Africa'. In: *Journal of Southern African Studies*, pp471-480, pp. 4, 23.
3. 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, p23.
4. *Ibid*, table 12.
5. *Ibid*, p18.
6. Department of Health. 2012. *National Strategic Plan on STIs, HIV, and TB 2012-2016*. [www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf]
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8. 1 in 5 people were denied transit permits by SAPS at an official border crossing site; 23% of those surveyed had to return to DHA six times before being allowed in;1 in 3 stops involving migrants resulted in the police officer '*soliciting a bribe*'; 1 in 4 where the officer accepted money. Vigneswaran, D. et al, 2010, pp471, 474, 478.
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15. Vearey, J. 2011. 'Learning from HIV: Exploring migration and health in South Africa'. In: *Global Public Health*, pp1-13, pp6-7.
16. Williams, B. et al. 2002. *Spaces of Vulnerability: Migration and HIV/AIDS in South Africa.* Cape Town: Idasa. p31.
17. Kehler, J. 2012. *We as people should change our attitudes: Perceptions and experiences of HIV-related stigma and discrimination in the Northern Cape and North West, South Africa.* Cape Town: AIDS Legal Network, p5.
18. Crush, J., Ramachandran, S., & Pendleton, W, 2013, p23.
19. Vearey, J., 2011, p5.
20. Crush, J., & Tawodzera, G. 2011. *Medical Xenophobia: Zimbabwean access to health services in South Africa.* Cape Town: Idasa. P1.
21. Vearey, J., 2011, p6.
22. *Ibid*, p5.
23. *Ibid*.
24. Crush, J., & Tawodzera, G., 2011, pp23-25.
25. Crush, J. 2000. 'The Dark Side of Democracy: Migration, xenophobia, and human rights in South Africa'. In: *International Immigration,* Vol. 38, pp103-133, p19.
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27. Clark, S. et al. 2007. 'Returning Home to Die: Circular labour migration and mortality in South Africa'. In: *Scandinavian Journal of Public Health*, pp35-44, p43.

*William Bourget is a major in Political Science and Ethnic Studies and an intern at the AIDS Legal Network. For more information and/or comments, please contact him at wbourget@gmail.com.*

# Fact versus fiction...

## *An explanation of the Teddy Bear judgment*

*There is a perception that the judgment has the effect of* 'giving the green light' *for teenagers to engage in sexual activity, despite the dangers of teenage pregnancy, sexually transmitted diseases, high levels of sexual abuse in South Africa, and other inherent risks.*

***Sanja Bornman***

### INTRODUCTION

On 3 October 2013 the Constitutional Court handed down judgment in the matter of *Teddy Bear Clinic for Abused Children & Another v Minister of Justice and Constitutional Development and Another* (the judgment).[1]

The judgment confirms an earlier decision of the North Gauteng High Court, which declared Sections 15 and 16 of the Sexual Offences Act[2] (the Act) to be unconstitutional, in so far as these sections criminalise consensual sexual activity between adolescents aged 12 to 15 years. From the date of the judgment, Parliament will have 18 months to redraft the sections, so that teenagers can no longer be prosecuted for consensual sexual activity. During that time, there will be a moratorium on all investigations into, arrests of, prosecutions of, and criminal proceedings against, children under the age of 16 years in relation to Sections 15 and 16 of the Act, pending Parliament's correction. The names of children who have been previously convicted in terms of Sections 15 and 16 also may not be added to the National Register of Sex Offenders.

Although widely hailed by children's and women's rights organisations as a victory for the rights of children, and the rights of girl children in particular, the judgment has come under fire from the South African public, and has been the topic of heated debates in public *fora*. This article seeks to debunk assumptions, by setting out the facts of the matter and the substance of the judgment.

## THE LAW BEFORE THE JUDGMENT

Before the judgment, Sections 15 and 16 of the Act criminalised any form of consensual sexual activity between children aged 12 to 15 – even the kind that is a part of healthy, natural, and normal developmental behaviour. The Act effectively defines sexual conduct so widely that it was not only a crime for children between 12 and 15 to have penetrative sex with each other, but also to hug, kiss, hold hands, cuddle, and engage in petting. Both children would be guilty of this consensual '*crime*', and both would have to be charged, at the discretion of the Director of Public Prosecutions. These children then formally entered the criminal justice system. They could be arrested and brought into a police station. They came into contact with an investigating officer, and a prosecutor. They would have to appear before a magistrate, and be assessed by criminal probation officers. They were required to either participate in diversion programmes, with other sex offenders, or face trial.

In accordance with Section 50(2)(a)(i), if a child was found guilty of a Section 15 or section 16 offence, her or his name would have to be entered into the National Sex Offenders' Register, for life.

Additionally, in terms of Section 54, any person who

…a victory for the rights of children…

…individuals whom we encourage teenagers to trust and seek out for advice…

became aware that a child had committed a Section 15 or 16 offence was legally enjoined to report this offence to the police, or risk a fine or imprisonment. This of course included parents, teachers, nurses, doctors, counsellors, and religious officials – all those individuals whom we encourage teenagers to trust and seek out for advice, and who are tasked with providing teenagers with education, and a safe space in which to discuss their troubles and life challenges.

## WHAT THE JUDGMENT IS *NOT* ABOUT

First and foremost, the judgment is not about non-consensual, forced or coerced sexual activity. In other words, the judgment is not about rape, and it is not about sexual assault. It is not about any other sexual offences contained in the Sexual Offences Act of 2007. The judgment has absolutely no effect on these other sexual offences which the applicants, who have over twenty years' experience in fighting against the sexual abuse of children, and in dealing with its consequences, have a vested interest in upholding. If a teenager finds her/himself in a situation where (s)he is being forced or coerced into sexual activity with a peer, (s)he is outside

the realm and applicability of the impugned Sections 15 and 16 of the Act.

Secondly, the judgment is not about sexual activity between children and adults, however consensual that activity may be. For an adult to have sexual contact with any person under the age of 16,[3] even where that sexual contact is consensual, is and remains the offence known as '*statutory rape*'. The judgment leaves the law against adults preying sexually on children completely intact.

Finally, the judgment is not about the encouragement of sexual activity between teenagers. There is a vast amount of difference between encouraging a particular behaviour, and simply choosing not to enlist the time and resources of the criminal justice system to address that behaviour.

## WHAT THE JUDGMENT *IS* ABOUT

The judgment emphasises from its very start that '*children are precious members of our society*'. The Court makes it clear:

> …difference between encouraging a particular behaviour, and simply choosing not to enlist the time and resources of the criminal justice system to address that behaviour…

> *Rather, we are concerned with a far narrower issue: whether it is constitutionally permissible for children to be subject to criminal sanctions in order to deter early sexual intimacy and combat the risks associated therewith.*

The applicants presented *expert evidence* showing that, as they stood, Sections 15 and 16 did far more harm to children than good. They showed how, together with the reporting obligations contained in Section 54(1)(a) and the provisions regarding the Sexual Offenders Register, the detrimental impact of the sections on children is exacerbated. They demonstrated how the effects of Sections 15 and 16 infringe a range of children's constitutional rights, including children's human dignity, privacy and bodily and psychological integrity, as well as the best-interests principle.[4]

The Court set out the main points of the applicants' expert evidence, which the State did not contradict:

> *First, children charged under sections 15 or 16 will feel a 'mixture of shame, embarrassment, anger, and regret' which will 'have an adverse impact on the individual and his or her development'. These feelings may also lead to the development of a generally negative attitude to sexual relations. Second, these feelings are 'likely to inhibit the individual from seeking help for issues about sex… in order to avoid the emotional distress and interpersonal or social problems, adolescents will avoid seeking help or being open about issues*

*with their sexuality [such that] existing problems will grow and future problems are unlikely to be prevented.' Third, far from achieving the positive outcome of deterring the harmful effects associated with early sexual conduct, the impugned provisions are likely to 'increase adolescents' risk for negative experiences and outcomes... Sections 15 and 16 of the Act contribute more to silencing and isolating adolescents, which makes unhealthy behaviour and poor developmental outcomes more likely.' Finally, children's reticence in seeking assistance will have a corollary effect on the ability of adults to provide the necessary guidance and support.*[5]

…criminalisation simply drives teenage sex underground…

…no research, expert or any other form of evidence that criminalisation was discouraging, regulating, or correcting risky sexual behaviour in teenagers…

The Women's Legal Centre, together with the Tshwaranang Legal Advocacy Centre as friends of the Court, put evidence before the Court showing the discriminatory and disproportionate effects of the sections on girls, who are most often the victims of rape and sexual assault. It was submitted that the sections would make the current under-reporting of sexual offences in South Africa even worse. The judgment recognises the practical manner in which this can occur:

*As the second and third amici submitted, some instances of rape stem from scenarios in which*

*there was consent for the initial, consensual sexual conduct. For instance, if a child of 12 consented to kissing another child of 15, but was subsequently raped by the 15-year old, then, if the 12-year old reported the instance of rape to the police, he or she could be prosecuted for the initial consensual kiss (in terms of section 16 of the Act). In these instances, victims may be discouraged from reporting crimes such as the rape for fear of being investigated and prosecuted for consensual sexual violations they have committed, which is at odds with the statutory purpose of protecting children.*[6]

…the judgment, far from encouraging teenage sexual activity, simply reaches the logical legal conclusions…

The respondents, on the other hand, were unable to provide the court with any evidence whatsoever that criminalising the consensual sexual conduct of teenagers was having a positive practical effect. There was no research, expert or any other form of evidence that criminalisation was discouraging, regulating, or correcting risky sexual behaviour in teenagers.

In response to the State's arguments, the Court accepted that the stated purposes

*…of discouraging adolescents from prematurely engaging in consensual sexual conduct which may harm their development, and from engaging in sexual conduct in a manner that increases the likelihood of the risks associated with sexual conduct materialising, are legitimate and important.*[7]

…the criminal justice system is an inappropriate mechanism for regulating or correcting risky teenage sexual behaviour…

However, in the light of the evidence before it, the nature and extent to which the sections limited children's rights to dignity, privacy and their best interests was simply too great, and the Court could not find a rational link between the limitation of teenagers' rights and '*protection*' that Sections 15 and 16 hoped to achieve.

## CONCLUSION

Instead of protecting teenagers, and discouraging teenage sexual behaviour, criminalisation simply drives

teenage sex underground – away from the services designed to educate and empower teenagers to make responsible sexual choices, away from the protection of the law, and away from the help and guidance of the adults in their lives.

> …society cannot abdicate its duty to teach children responsible sexual behaviour, and leave it up to the criminal justice system…

The judgment, far from encouraging teenage sexual activity, simply reaches the logical legal conclusions, on the basis of the uncontested evidence before it: the impugned sections are harmful to children, especially girl children, and are unconstitutional. There is simply no evidence that criminalisation deters teenage sexual activity, or that it results in the protection of children. In the light of the facts, the Court could not but find that the criminal justice system is an inappropriate mechanism for regulating or correcting risky teenage sexual behaviour.

Importantly, the Court was persuaded '*that there are various methods the State could use that do not involve criminalisation of consensual sexual conduct between adolescents in order to encourage them to lead healthy and responsible sexual lives*',[8] which include open and free parent-child communication about sex.

This amounts to the plain fact that society cannot abdicate its duty to teach children responsible sexual behaviour, and leave it up to the criminal justice system – which experts tell us is entirely the wrong system for the job. We cannot criminally punish our children for our own failure to communicate openly about sex, and to provide the education they need, which has been proven to be a successful way to protect teenagers and help them develop a healthy responsible attitude towards sex.

The judgment is sound, and should be welcomed by all. It finally does away with harmful and irrational provisions that have no place in our children's lives.

**FOOTNOTES:**

1. *Teddy Bear Clinic For Abused Children and Another v Minister of Justice and Constitutional Development and Another*, Case CCT 12/13, (2013) ZACC 35. [www.constitutionalcourt.org.za/site/Teddy.htm]
2. The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No 32 of 2007.
3. The age of 16 is the legal age at which a person can consent to sexual activity.
4. *Teddy Bear Clinic For Abused Children and Another v Minister of Justice and Constitutional Development and Another*, Case CCT 12/13, (2013) ZACC 35, para29.
5. *Ibid,* para47.
6. *Ibid,* para93.
7. *Ibid,* para80.
8. *Ibid,* para98.

*Sanja Bornman is an Attorney at the Women's Legal Centre. For more information and/or comments, please contact her on Sanja@wlce.co.za.*

# Ten myths about the AIDS response

## Myth 1: THE END IS IN SIGHT, WITH A VARIATION THAT AIDS IS OVER

*'I wish it were true, and it should be our goal. I am not saying there hasn't been progress but people's behaviour and societies are not mathematical models and cannot be predicted. Let's stop saying AIDS is over. One day, we will be there, but not yet!'*

## Myth 2: ALL WE NEED IS BETTER COVERAGE OF ART, WHICH WILL WIPE OUT THE EPIDEMIC

*'If we have learned one thing, there is no magic bullet. Yes, there have been studies (such as HPTN052, which showed that ART can prevent HIV transmission) but it is a gigantic leap from these results to the reality of the community and is simply not yet supported by evidence.'*

## Myth 3: BEHAVIOURAL INTERVENTIONS DON'T WORK, WE CAN ONLY RELY ON BIOMEDICAL PREVENTION

*'What we have to remember is that even treatment is a behavioural intervention with its strong emphasis on compliance. We should remember that for example PrEP only works when you take it!"*

## Myth 4: THERE IS NO LONGER A NEED FOR DISTINCT HIV PROGRAMMES, INTEGRATION IS THE ANSWER!

*'Some say all we need is health system strengthening which is ideologically driven, or supported by academic health theories. Whilst there are areas where integration will be beneficial and cost effective, such as PMTCT, we have to know what we can integrate and what not. Particularly whilst stigma and discrimination remain a hallmark of this epidemic.'*

## Myth 5: THE EPIDEMIC IS ON A DOWNWARD TRAJECTORY – LET'S CONTINUE DOING WHAT WE ARE DOING AND IT WILL WIPE OUT HIV

*'Downward yes, but not everywhere. There are many different epidemics with their own dynamics, and these need to be dealt with individually and appropriately.'*

## Myth 6: STIGMA AND DISCRIMINATION HAS DISAPPEARED NOW WE HAVE ART, AND THE PROMOTION OF HUMAN RIGHTS AS PART OF THE AIDS RESPONSE IS AN UNNECESSARY LUXURY WHICH CAN BE HANDLED BY OTHERS

*'Whilst many hoped that the introduction of effective treatment would mean 'normalisation of AIDS, there is absolutely no evidence that this is the case. Everywhere you go you can still see the devastating impact of stigma and discrimination as a result of HIV.'*

## Myth 7: THERE IS NO LONGER A NEED FOR CIVIL SOCIETY, PHYSICIANS WILL FIX THIS FOR YOU

*'Whilst this position may have some rational ground, some of it is also medical hubris.'*

## Myth 8: DOMESTIC FUNDING WILL NOW COVER ALL NECESSARY COSTS OF THE RESPONSE

*'Some countries can definitely afford to do this – India, South Africa – but most can't. And most won't even prioritise health spending, so you can't expect HIV to be prioritised within a bigger context of de-prioritisation. The reality is that many countries for many years will depend on international funding for their AIDS response.'*

## Myth 9: WE CANNOT DO BETTER WITH CURRENT FUNDING, AND MANAGERIAL AND PROGRAMMATIC EFFICIENCY ARE UNNECESSARY BUSINESS CONCEPTS

*'We CAN do better with available funding. In particular, we need to concentrate our resources on where the epidemics are – and then apply the usual cost-saving approaches.'*

## Myth 10: THERE IS NO NEED TO CONTINUE INVESTING IN A VACCINE

*'Ending HIV without a vaccine will simply not be possible.'*

*[This is an excerpt from the key note address by Peter Piot at the International HIV/AIDS Alliance 20th Anniversary Convention on 17 February 2014. For more information: www.aidsalliance.org/NewsDetails.aspx?Id=291690.]*

# Silenced '*out of existence*'...

## Why quiet diplomacy is a devastating betrayal of gay men and lesbians on the continent

***Pierre de Vos***

*The famous (and tragically accurate) slogan which spurred members of ACT-UP on to ever more urgent activism to save their own lives and the lives of their comrades was: SILENCE = DEATH. The absolute silence of politicians like Reagan around HIV and AIDS in the USA was, of course, directly related to the fact that in the USA, at the time, the disease was associated with sex between men, and therefore, with gay men more particularly.*

This silence was informed by prejudice, shame and embarrassment about same-sex love and same-sex sexual desire. This made it difficult for politicians to even mention the disease, let alone to take action to prevent its spread and to find a cure. (Even Ed Koch, who during this period was the closeted gay mayor of New York, remained silent about AIDS.) Despite the fact that there is nothing shameful about consensual same-sex desire (just as there is nothing shameful about different-sex desire), the politicians remained silent, despite the fact that speaking up would have saved hundreds of thousands of lives.

When we are embarrassed, ashamed or disgusted by something or someone, we often choose to remain silent about that person and what he or she has done. This silence protects us from having to confront our own complicated and cowardly feelings and allows us not to feel complicit when members of an unpopular group are discriminated against, physically attacked, raped or murdered.

It also distances us from the person or to act as if we are judging and ensures that we will not be '*tainted*' with that, which we are ashamed, embarrassed or disgusted.

But when we remain silent about the prejudices some people harbour and express about others (for example, if I say nothing when another white person makes a racist statement in my presence) and the often deadly consequences of those prejudices, when we refuse to name the horror of it, when we hide behind euphemisms and generalisations, we are implicated in that prejudice and its perpetuation.

…we are implicated in that prejudice and its perpetuation…

When we are told as gay men and lesbians that we should not '*flaunt*' our sexual orientation (when the '*flaunting*' of heterosexuality permeates our society and culture), it sends a signal that the majority believes that who we are as human beings is inherently shameful. It tells us that we must be disgusted with ourselves and must hate ourselves because of who we love and who we have sex with. We are told that we belong in the closet where we will not prick the conscience of those whose silence help to make our oppression possible.

Because gay men and lesbians are a marginalised minority and because the bigotry against us stems from fear, shame and disgust – including the fear, shame and

…where we will not prick the conscience of those whose silence help to make our oppression possible…

disgust internalised by gay men and lesbians by the silence of others – silence is an extremely effective weapon in the social control and oppression of gay men and lesbians.

'*The closet*' is a powerful mechanism through which gay men and lesbians are silenced '*out of existence*'. In societies where hatred and fear of gay men and lesbians are deeply embedded in political practices and religious beliefs, otherwise sympathetic heterosexuals will often maintain a silence about homophobia or will use other rhetorical devices to distance themselves from those who experience same-sex desire in order to escape what they perceive to be the shame and the so called '*taint*' of homosexuality.

In such societies, when others are vilified, ridiculed, discriminated against, assaulted or murdered, because they are perceived not to conform to gender stereotypes or are suspected of same-sex desire or action, many supposedly

…silence is an extremely effective weapon in the social control and oppression of gay men and lesbians…

'*kind*' and '*good*' people will remain silent. They will do so to protect themselves, perhaps knowing that their failure to speak up for what is right contributes to the oppression of their neighbours, colleagues and friends.

Similarly, those who experience same-sex sexual desire often impose a silence of the closet on themselves out of fear of being ridiculed, marginalised, discriminated against, assaulted, raped or even killed. There is, of course, no reason to be ashamed or disgusted with same-sex love. There is much reason to be disgusted and ashamed of the bigotry of those who, through their actions and silence, promote or acquiesce in homophobia and the often deadly consequences of such homophobia.

Sometimes absolute silence becomes politically impossible. Those who are not prepared to embrace the full humanity of fellow human beings, because of prejudice or self-protection, will then hide behind impersonal statements or will make hollow declarations devoid of any real compassion.

It is the absence of any words or actions that display true solidarity with the oppressed minority that is usually the dead give-away. Such statements impose a different kind of silence – even as it pretends to speak about the love that '*dare not speak its name*' – which can often have equally devastating effects. This silence – which hints at but never names or describes the oppression of gay men and lesbians and its often devastating effects on fellow human beings in full – is the silence of the hypocrite and the closet homophobe.

This, unfortunately, is the quality of the *'half-silence'* of the South African government about the horrors faced by many people who experience same-sex sexual desire in South Africa and elsewhere in the world.

According to a statement by the South African

…hide behind impersonal statements or will make hollow declarations devoid of any real compassion…


government it '*takes note of the recent developments regarding the situation of Lesbians, Gays, Bisexual, Transsexual and Intersex persons (LGBTI) worldwide*' and will be '*seeking clarification*' on these developments from many capitals around the world. Although the statement continued to say that South Africa '*believes that no persons should be subjected to discrimination or violence on any ground, including on the basis of sexual orientation*', it remained silent about the situation in Uganda (and before it, Nigeria and every other country where more repressive laws aimed at discriminating against gay men and lesbians had been passed in recent years).

If South Africa did indeed engage in '*quiet diplomacy*' with the governments of Uganda and Nigeria (and there is no evidence to this effect), this diplomacy must have been a spectacular failure as both countries adopted repressive laws in conflict with International Human Rights standards and the jurisprudence of UN Human Rights bodies, such as that of the UN Committee on Human Rights.

> …the absence of any words or actions that display true solidarity with the oppressed minority…

Millions of gay men and lesbians across our continent must yearn for an African government to break the silence about the way their plight is abused by other African

governments to distract attention of serious governance problems. Unlike the hypocritical and self-righteous bleating of some Western governments on the issue, a statement by the South African government that named and condemned the homophobic bigotry of fellow African governments would have had a powerful symbolic effect.

> …ways in which our oppression is made invisible through silence and negation…

It would have broken the silence. And as the example of ACT-UP reminds us: SILENCE=DEATH.

Instead, South Africa in effect decided to remain quiet, hiding behind vague and general language that spectacularly fails to acknowledge the true effects of the bigoted laws passed in places like Uganda. The half silence is even worse: by stating that '*clarification*' is needed about the oppression of fellow human beings in other parts of the continent our government is hinting that our legitimate outrage may all just be based on a misunderstanding.

For those of us who are attuned to the ways in which our oppression is made invisible through silence and negation, or through the failure to name and confront it in words and deeds, South Africa's '*quiet diplomacy*', and the failure to acknowledge our pain, humiliation and fear, feels like a deadly betrayal.

It may well be that in certain circumstances it would be strategically wise for a government to engage in '*quiet diplomacy*'. But because of the specific ways in which the silence of the closet create, maintain and perpetuate homophobia across the world, and because of how this silence of the closet terrorises those of us who are gay or lesbian, our government's silence in this case feels like acquiescence with our own oppression.

*Pierre de Vos is a constitutional law professor at the Department of Public Law at the University of Cape Town. For more information and/or comments, please contact him at Pierre.DeVos@uct.ac.za.*

# A paradigm shift from us all…

## Moving towards *Zero* HIV-related discrimination and violence

*When the question of* 'how close are we to zero HIV-related discrimination and violence' *was posed to the community of Atlantis in the Western Cape during a Community Dialogue, a significant discrepancy was highlighted between progress on a legal front and progress from a social perspective.*

***Ione Wells***

Answering '*yes*' when asked if every individual has the right to equality and freedom over their choices, sexual endeavours and family planning, but also '*yes*' to the claim that women are increasingly experiencing discrimination, and '*no*' to the proposition that an HIV positive status would turn an abusive partner into a supportive one or give a woman the power to demand protection, illuminated this issue. It was, therefore, intimated that the main obstacle that remains, opposing the achievement of '*zero*', is that the laws protecting an individual's rights have not yet become social norms.

So are we just choosing to ignore that our social environment exists? A recurring theme that explained why this might seem the case was the notion of tradition. A male voice in the audience contributed that *'women are special'* and, yet, our culture has a historical past of male dominance and thus, for some, a world in which women obey their fathers and husbands, regardless of how they are treated, is the only one known. Some argued further that this stemmed from misinterpretations of religious texts; another field of '*tradition*' that has been manipulated over the years to supposedly justify forged hierarchies. Such '*tradition*' results in a vicious circle in which women feel trapped and unable to break-out and become stronger, because *'men will feel challenged'* and consequently resort to violence. Concluding this topic was the argument that if it is largely tradition setting us back, then it is a paradigm shift from us all that will give the social force towards anti-discrimination more muscle, and thus ensure that the legislative measures protecting human rights are acknowledged and lawfully executed.

It became apparent that another branch of tradition that is obstructing women from fleeing abusive relationships is an assumed dependence on men which was, again, indicated to originate from one's upbringing. Opinions demonstrated a belief that women will wait until their children are independent, for example, before seeking help in an abusive marriage for fear of being left to provide for them alone, and it was vocalised that some women even believe such concerns are unpreventable, because men are *'entitled'* to such influence and power. One example raised was concerning a case of a woman who had withdrawn a case filed against her partner for abuse as soon as the partner threatened to divorce her. Such cases exemplify the need for women to gain a stronger awareness of the detrimental consequences that dependency can have on one's conduct, and how we cannot surrender our legal rights as soon as our social life is threatened.

…another field of *'tradition'* that has been manipulated over the years to supposedly justify forged hierarchies…

…the laws protecting an individual's rights have not yet become social norms…

The issue here, however, is that this can leave a woman living with HIV, and possibly with children to care for too, questioning who she can turn to for support. Questions were raised about what one is supposed to do when one's family insists on remaining with a respective partner, regardless of whether abuse is present, leaving individuals with few other options to turn to, and similarly on how to proceed if one wishes to try and fix an abuse problem, because one still loves a partner for other desirable traits. It was asserted, however, that it is excuses like this that ingrain abuse issues and one audience member expressed that she would extend this

…it is a paradigm shift from us all that will give the social force towards anti-discrimination more muscle…

debate as far as to say that she believes domestic violence is on the increase, due to it being progressively *'pushed under the carpet',* because of women wanting to protect and preserve the structure of their families, hence suffering in silence.

Arguably, the most imminent threat to women in society, on top of individual cases of personal threat, is judgement. When it comes to the exposure of an HIV positive status, women face not support, but gossiping neighbours, critical parents accusing individuals of breaking out from *'who they are supposed to be'* and, when such a position results in divorce from a partner, exclusion from religious institutions.

In addition, one of the worst posers of blame and judgement on a woman is often herself. Many women voiced that they had walked into relationships without a sense of interdependence, and furthermore, had blamed themselves when something went wrong, given their partner was viewed as always '*right*' and to be obeyed.

Where this obstructs progress towards '*zero*' on a social front, is when women do not walk out when the abuse starts – walking out instead when it is too late and they have acquired HIV, and been subjected to discrimination. It is clear, therefore, why the unanimous vote was a '*yes*' towards women testing for HIV without coercion, but a '*no*' towards an obligation to disclose one's status. As with the previously raised issue of *'tradition',* it was considered that to hinder judgement we need to shift fundamental attitudes from both men and women. There are too many assumptions still in place in society for us to reach '*zero*'

…unless human rights are acknowledged and lawfully executed…

– that if a woman has had multiple partners she is '*scum*', whereas a man of the same predicament is applauded; that it is the *'mistress'* of a cheating partner, rather than the partner in question, that is to blame for infidelity or the transmission of HIV; and that women cannot even be seen in certain places, such as *'car parts stores'* without being judged, because these are considered a *'man's place'*.

This being the case, it is clear that in answer to the overriding question of '*how far have we come*', the opinions were decisively pointed towards '*not far enough*'. Despite having moved forward from a legal perspective, the implementation of the relevant legislation is insufficient. As a result, the final push of the dialogue was to define the key points that need to be addressed regarding this limitation.

These areas can be collectively categorised under the aforementioned need for a total paradigmatic shift of attitudes. '*Independence*' as a term needs to be thoroughly unpacked, to diminish all exceptions given to '*tradition*' or '*dependence*'. This goes hand in hand with the need for a universal, strong ethic of treating people with the respect that the law demands. A web of education was thus proposed as a requirement. Community members underlined the need for education to not only start from within social communities, but first and foremost amongst people working in social institutions. Young pregnant women should not be turned away from family planning clinics, because of their age, women living with HIV should not be accused of *'sleeping around'* by clinic nurses, to name a few of many outstanding observations by the community. As well as sexual and social education, women can and should embrace partaking in matriculation, whatever their age or occupation. One resident of Atlantis articulated how, at 37, she undertook her matric qualification and it was her first major step towards feeling empowered, and no longer dependent on family or her partner.

Abuse is still very much regarded as being an issue that is escalating in different directions and thus '*zero*' is still not yet on the horizon. The more that individuals remain complacent and push apparent issues aside, neglecting their voice and power to speak out, the more that legal rights are not enacted in the everyday. The analogy to summarise the consensus of this particular community dialogue in Atlantis is thus that of a gift that has been given but not unwrapped and accepted. No matter how close to '*zero*' we are with the rights that we are legally entitled to, this means nothing and is useless unless we all, as a community, act towards integrating them into our social environment.

> …we cannot surrender our legal rights as soon as our social life is threatened…

*Ione Wells is a student of English Literature at the University of Oxford, UK, and an intern at the AIDS Legal Network (ALN). For more information and/or comments, please contact her at ionebwells@gmail.com.*

# A perspective from down under...
# Criminalisation of HIV transmission

**Rhys Larsen**

*Africa and Australia are not so different. We have similar ties in colonisation and racism that are still evident in modern times. Our popular culture is heavily focused on alcohol, socialisation and sport. In addition, our growing economies and populations have turned both countries into epicentres of globalisation, embracing and producing transnational flows in equal measures.*

What sets Africa and Australia apart, are their geo-political boundaries. Where the Australian continent is completely ocean bound, and consists of only one sovereign state in its entirety, Africa is made up of over fifty. This means that South Africa in particular is subject to significantly larger influx of transnational and trans-boundary flows.[1] It is in this way that HIV can continually travel across borders. In Africa, the HIV pandemic is the foundation for a majority of the continent's social issues. HIV is *THE* globalised disease, and is recognised as a '*medical catastrophe*'. But where the African and Australian approaches differ most, is the non-medical impact of the condition. In Australia, it is impossible to determine the HIV status of another, unless they tell you themselves. In most cases, a person will only disclose their condition to someone they deem relevant i.e. family, close friends, sexual partners and their General Practitioner. Aside from this, Australians who are HIV positive will attempt to maintain an element of normality in their lives, while the larger community remains unaware, and without detriment. Any fear associated with HIV is more a result of its negative health impact, but this view does not stretch across the Indian Ocean.

Instead of directing attention to HIV's adverse effects on human health, there is still a strong sentiment in the African public that HIV is '*a deadly, transmissible, disease*'. With this mentality, people with HIV are often treated as subhuman, purely because of their potential for '*spreading*' HIV. What makes this worse is that the discrimination experienced by people living with HIV extends well beyond the medical field. The stigma branches into sexism, racism, domestic violence, sexual abuse, cultural sensitivity and crime. All of these are enormous problems unto-themselves. However, they also all have their foundation in the social perception of HIV. This article aims to address a policy approach to the condition, specifically with regard to the criminalisation of HIV transmission.

## CRIMINALISATION OF HIV TRANSMISSION: THE LAW PROVISIONS

There is a general understanding that people with HIV have a legal and moral obligation to '*make reasonable efforts to ensure that they do not pass on HIV to others*'.[2] To enforce this obligation, laws that criminalise HIV transmission are found in Canada, 37 of 50 USA states, 27 African countries, 13 Asia/Pacific countries, 11 Latin America countries; and 9 European countries.

Australia and South Africa are not found on these '*official*' lists, and for good reason. From all reports, any practices that criminalise and dehumanise populations at high risk of HIV ultimately make these populations more vulnerable to social stigma, in addition to driving them away from HIV '*harm, reduction and health services*'.[3] In most developed countries, populations at risk, include sex workers, injecting drug users (IDUs), men who have sex with men, and youth.[4] This is especially true in Australia, with 91.7% of all people living with HIV falling into these categories.[5]

**METHOD OF TRANSMISSION[6]**

| Country | Male-to-Male Sex | Heterosexual Sex | Injecting Drug Use | Male-to Male Sex AND/OR Injecting Drug Use |
|---|---|---|---|---|
| Australia | 16,322 (66%) | 6,182 (25%) | 1483 (6%) | 744 (3%) |

However, in Africa, it is women who are most at risk from criminalisation legislation. Continued application of cultural customs in addition to the imbalance of social and domestic gender roles leaves African women extremely vulnerable to these laws. This problem is exacerbated when medical clinics enforce mandatory HIV testing prior to being allowed *ANY* other medical procedure. In this system, something as common as seeing a doctor for a general check-up can become a '*self-incriminating step that may provide the state with a key element for prosecution*'.[7] Furthermore, there is no consistency between the severities of criminalisation laws of separate states.

…potentially risking significant personal and legal consequences…

In some legislation, criminal prosecution requires knowledge of the infection. Therefore, one can only be found guilty of transmitting HIV, if they are aware that they are indeed HIV positive. In some other jurisdictions, only '*constructive knowledge*'[8] is required. This application implies that a person '*ought to have known*' that he/she was living with HIV. Another element usually critical in the application

of these laws is the conduction of safer sex. Excluding abstinence, using latex condoms (both male and female) is the most effective way to prevent transmission, infection and re-infection. Many of those who are aware of their HIV status will make an effort to engage in protected sex. Despite this, only a few of the 27 African HIV criminalisation jurisdictions shield those who engage in protected sex from prosecution.[9]

This is an inadvertent promotion of unsafe sex. If a person is to be prosecuted for HIV transmission, regardless of whether they have taken all the necessary precautions, then why should they make the effort at all; especially when condoms are renowned for hindering sexual gratification. So if knowledge and safer sex are not universally valid defences, what of disclosure and consent?

> …the implementation of these laws indicates clear breaches of a number of fundamental human rights…

Disclosure refers to informing one's sexual partner about being diagnosed HIV positive. Consent refers to an informed consent of engaging in an activity that may put one at risk of acquiring HIV. Of the African states, very few exclude liability when consent and disclosure are verified.[10] This again is paradoxical to the states that encourage, and sometimes even require by law, the general disclosure of a positive HIV status. People in these countries are forced to live a lie, avoiding any situation that may force them to discover or disclose their HIV status, potentially risking significant personal and legal consequences.

The final and perhaps most terrifying aspect of HIV criminalisation and transmission is '*how the substances were used or administered*'. When many of these separate jurisdictions employed statutory interpretation, it was decided by some that a mother who transmits HIV to her child through pregnancy or breastfeeding could be prosecuted.[11] This is absolutely outrageous. Most jurisdictions broadly criminalise exposure or transmission in this exact way. Some take it even further by expressly criminalising mother-to-child transmission. The provisions were intended as a form of quarantine, deterring women with HIV from bearing children. This is a blatant violation of reproductive rights, in addition to contributing to the stigmatisation of women as '*vectors of the disease*'. The implementation of these laws indicates clear breaches of a number of fundamental human rights.

## CRIMINAL LAW: THE CASE OF AUSTRALIA

Fortunately, countries like South Africa and Australia have strong constitutions that, so far, forbid the direct implementation of these laws. However, HIV criminalisation has still managed to find a backdoor into Australian legislation. Although criminal law differs amongst Australian states, the '*transmission of deadly diseases*' is expressly

…even if the government does not legislate against HIV transmission, the community will…

included in some form of another across the entire country. In New South Wales (NSW), '*transmission of a deadly disease*' is found under the umbrella of '*grievous bodily harm*':

> *...In which case a reference to the infliction of GBH* [grievous bodily harm] *includes a reference to causing a person to contract a grievous bodily disease*.

Therefore, in NSW, transmission of HIV with or without consent is an indictable offence.[12]

In Australia as a whole, the more relevant question is whether a person intends to transmit HIV. Intent is the only mitigating factor that can be taken into account through sentencing, and is the difference between 2 and 25 years in prison. For example, if a person has no knowledge of being positive for HIV, they cannot possibly be charged for deliberate transmission (constructive knowledge is not applied). Even so, a person would still be guilty to some extent. As for consent and wearing protection, these are all irrelevant. Under Australian law, a person cannot consent to having '*grievous bodily harm*' inflicted upon them. Therefore, if HIV is successfully transmitted, then the employment of protection was obviously ineffective, and immediately becomes irrelevant. Fortunately, Australia is yet to extend this legislation to cover mother-to-child transmission.

Despite being marginally unfair, the application of Australian law carries none of the African stigmata that '*prompts people to act in ways that directly harm others and deny them services or entitlements or any actions that take the form of HIV related discrimination*'.[13] The same cannot be said for South Africa. Despite not providing specific laws governing criminalisation, the social and cultural criminalisation of people affected (specifically women) is still causing enormous problems. It seems that even if the government does not legislate against HIV transmission, the community will.

## THE WAY FORWARD

I can conclude that legislating against the *intentional* transmission of HIV is an effective, and necessary, counter measure against the HIV pandemic. However, there are so many issues when attempting to define the criminal circumstances of *intentional* transmission. How can one establish whether an individual had the requisite state of mind when transmitting via sexual intercourse or pregnancy? Despite this, there is still no clear solution. Eliminating the laws entirely would no longer protect society from those who are attempting to maliciously spread deadly diseases; yet keeping them in place is a constant reminder and threat from society about a *MEDICAL* condition that limits social and legal interaction.

…a *MEDICAL* condition that limits social and legal interaction…

In my opinion, there are some steps that could be taken immediately without completely altering current systems. The first step is improving definitions so as to ensure that legislation cannot be interpreted in ways that produce unjust and unethical results. This coincides with the removal of laws that are already blatant abuses of human rights. The most prevalent example is the conviction of a mother for transmitting HIV to her child through pregnancy or breastfeeding.

…ensure that legislation cannot be interpreted in ways that produce unjust and unethical results…

Not only is this unethical in regard to HIV transmission, but it sets a dangerous precedent for mothers with children who have other medical conditions. If this law continues, what is to stop the scope of this enforcement from including another illness or disability caused due to the action or inaction of the mother? Potentially, it could go as far as to include hereditary genetic defects or conditions.

The damage from this floodgate may be irreparable, if allowed to continue its flow.

**FOOTNOTES:**

1. *'Transnational'* refers to actions that are advanced intentionally across national boarders i.e. terrorism. *'Transboundary'* refers to phenomena that occur across national boundaries without the intent of agents i.e. spread of disease.
2. National Association of People With HIV Australia. 2009. *Criminalisation HIV Transmission.* [http://napwa.org.au/?q=taxonomy/term/521]
3. Global Commission on HIV and the Law. 2013. *How an Epidemic of Bad Laws is Obstructing the Global HIV Response.* [http://hivlawcommission.org/resources/report/HIV&Law-Factsheet-EN.pdf]
4. *Ibid*.
5. AVERT. 2012. *Australia HIV/AIDS Statistics.* [www.avert.org/aids-hiv-australia.htm]
6. *Ibid*.
7. Eba, P. 2008. 'One Size Punishes All: A critical appraisal of the criminalisation of HIV transmission. In: *ALQ*. Cape Town: Aids Legal Network. pp1-10, 8.
8. 'Constructive Knowledge' refers to notice of a fact that a person is presumed to have, regardless of whether or no they actually do. Such knowledge is expected to be obtainable through the exercise of reasonable care.
9. Eba, P. 2008. 'One Size Punishes All: A critical appraisal of the criminalisation of HIV transmission. In: *ALQ*. Cape Town: Aids Legal Network. pp1-10, 8.
10. *Ibid*.
11. Sierra Leone expressly criminalises mother-to-child transmission.
12. This was the decision reached by the New South Wales Supreme Court of Appeal in the case of *R v Aubrey* [2012] NSWCCA 254.
13. Aggleton, P et al. 2005. HIV-Related Stigma, Discrimination and Human Rights Violations. *UNAIDS Best Practice Collection*. 5(1), p4-75.

*Rhys Larsen is a student of Law, and International Relations at Bond University, Australia, and an intern at the AIDS Legal Network (ALN).*
*For more information and/or comments, please contact him at larsenrhys@gmail.com.*

AIDS LEGAL NETWORK
www.aln.org.za

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**Editor & Photographer:** Johanna Kehler (*jkaln@mweb.co.za*) • **DTP Design:** Melissa Smith (*melissas1@telkomsa.net*) • **Printing:** FA Print
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