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AIDS LEGAL NETWORK

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Johanna Kehler

Gendered realities... *The* underlying factor?[1]

In South Africa, legislative and policy measures aiming to protect fundamental rights and freedoms are in place and yet, reality remains to be marked by prevailing gendered inequalities and imbalances, by seemingly ever-increasing levels of poverty and unemployment, by an alarming increase in the number of people living with, and affected by, HIV and AIDS, as well as high incidences of sexual violence and abuse – and disproportionately impacted and affected by these realities are women and girl children.

Reality also remains to be marked by persistent stigmatisation, discrimination and violation of people based on their sex, gender, sexuality and/or HIV status. Education and awareness programmes are in place and yet, the general lack of knowledge about human rights, as well as HIV and AIDS prevails, the number of new infections and the HIV prevalence rates are rising annually, indicating, amongst other things, great disparities between the sexes, between provinces and between the poor and affluent members and sectors of society.

THE LEGISLATIVE FRAMEWORK

While the Constitution[2] of South Africa guarantees everyone the right to equality and non-discrimination (Section 9), the right to have one's dignity protected and respected (Section 10), the right to life (Section 11), the right to bodily integrity and to be free from all forms of violence and abuse (Section 12), the right to privacy (Section 14), and the right to have access to healthcare and social security (Section 27), people continue to encounter numerous obstacles and discrimination based on their sex, gender, sexuality and/or HIV status in claiming their fundamental human rights and freedoms.

Giving effect to the constitutional provisions, legislative and policy measures provide similarly for equality and non-discrimination. Yet, it is the inadequate application and implementation of these measures, as well as a general lack of knowledge, that limits the extent to which they can be accessed, and thus provide protection. In addition, it is the persistence of discriminatory attitudes, beliefs and practices in all spheres of society, including amongst service providers, which often deny people living with, and affected by, HIV and AIDS, the access and thus, benefit from these protective measures. And finally, it seems to be the gendered context of society and the persistent male dominance in all spheres of society that further defines why women and girl children are not only most vulnerable and at risk of HIV, but also why women and girl children are the ones disproportionately affected and impacted by prevailing inequalities and injustices.

As a result, the reality is characterised by continuing stigma, discrimination and violation of rights based on one's sex, gender, sexuality and/or HIV status. On a daily basis, incidences of HIV testing without consent, disclosing

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Editorial

Bringing AIDS under control will require tackling with greater resolve the underlying factors that fuel these epidemics – including social inequalities and injustices … these are extraordinary challenges that demand extraordinary responses. [UNAIDS, 2005]

It is these very same *'underlying factors'* that seem to be the persistent challenge to the effectiveness of current responses to HIV and AIDS realities. Despite the enormous efforts, resources and time spent in addressing the pandemic and its underlying factors, gendered inequalities and injustices, gender violence, and social, cultural and religious belief, value and norm systems, justifying the *'status quo',* prevail – persistently fuelling the pandemic.

It is within the context of *'tackling'* these factors that this edition of the *ALQ* focuses on core beliefs and underlying factors fuelling the HIV pandemic. The various articles in this issue examine a broad range of realities as to the extent to which various core beliefs and/or underlying factors not only fuel the HIV and AIDS pandemics, but also impact on the effectiveness of HIV prevention, treatment, care and support initiatives and programmes. The impact of various gendered realities on the pandemic, the link between sexual violence and HIV, the pandemic in the context of violence, the involvement of men in responses to HIV, the *'region specific'* underlying factors of the pandemic, perceptions of gender and gender violence amongst adolescent boys, as well as the right to be different, the right to make reproductive choices and the *'excuses'* for the violation of rights are some of the issues explored in this edition. The integral features of the *ALQ* introduce experiences with core beliefs from an NGO in Mpumalanga, and experiences from a VCT study site in rural Tanzania. This issue is also *'making a point'* about workplace approaches to HIV and AIDS.

In this edition, Johanna Kehler examines various gendered realities as to their impact on the HIV and AIDS pandemics. Analysing the inherent barriers of the gendered societal context to the effectiveness of current approaches to HIV and AIDS, she argues that as long as gendered inequalities, imbalances and injustices are not addressed and challenged as *'the'* underlying factor, efforts will remain to have little impact and gendered realities will continue to fuel the pandemic.

The meaning and implications of the *'right to be different'* as provided for in the Constitution is explored by Pierre de Vos. Discussing various constitutional provisions and their interpretation by the Constitutional Court, he argues that any views, culture and beliefs used to justify the marginalisation or exclusion of anyone from the benefits of social acceptance, is against the constitutional imperative to respect difference and not to reject it.

Recognising the link between sexual violence and HIV, Meaka Biggs raises the question as to whether or not the relationship between the two is adequately understood and addressed. She examines the various realities, underlying factors and correlations of the two pandemics and argues that only as and when the underlying factors of women's lack of reproductive and sexual autonomy and choice, as well as the gendered nature of power and control in society are taken into account, can prevention strategies and awareness campaigns be effective.

The concept of *'dethroned men'* is introduced by Dumisane Remombo. Acknowledging unequal gender relations as the most serious underlying factor that fuels the HIV pandemic, he explores the impact of the *'new social order'* on men and argues that the success of responses to the pandemic will remain limited, since current HIV strategies and approaches fail to involve men as solution seekers and partners.

Findings of a study exploring the perceptions of adolescent boys pertaining to gender, sex and violence are introduced by Rachel Elfenbein. Based on research data indicating a lack of a critical engagement with issues of gender, sex and violence in the boys' lives, she argues that this very same environmental context could contribute to the perpetuation of gender violence and the spread of HIV, if not addressed by means of human rights-based sex education for children and youth.

Katharina Tangri examines the extent to which women living with HIV and AIDS are in the position to make reproductive choices. Analysing various underlying factors of the pandemics in Botswana, such as gender inequalities, violence and abuse, as well as stigma and discrimination, she argues that it is imperative to make informed reproductive choices, if the fundamental right to found a family is to become a reality for every woman, irrespective of her HIV status.

Recognising the seemingly relentless spread of the HIV pandemic in Southern Africa and the disproportionate impact on women and girl children, Suzanne Leclerc-Madlala raises the question as to the *'real'* underlying factors for the pandemic in the region. She examines the impact of various *'region-specific'* underlying factors and argues that reducing multiple concurrent sexual relationships, introducing male circumcision, and addressing gender inequalities, especially from the perspective of male involvement and responsibility for HIV prevention, are some of the interventions carrying hope for effective and relevant responses to HIV in the region.

Focussing on the context of violence,

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someone's HIV status unlawfully, discrimination and dismissals at the workplace, refusing medical treatment, expelling learners from school based on their, or their parent's, actual and/or perceived HIV status, refusing access to medical schemes, refusing access to credit facilities are reported – and this list seems to be endless, despite constitutional and legislative provisions based on principles of equality, non-discrimination and human dignity.

GENDERED REALITIES

In addition, HIV and AIDS realities seem to be increasingly characterised by the feminisation of HIV and AIDS in that women and girl children remain to be at greater risk of HIV infections and are more affected by HIV and AIDS realities and challenges. It is the gendered context of society, defining females largely as *'inferior'*, as the *'weaker sex'*, as the ones who are socialised to become *'good women'* and who should respect the male *'head of the household'* at all times that creates an environment in which women are not in the position to make choices, let alone informed choices. Hence, women will remain to be more vulnerable to HIV infection.

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Statistics indicating that 60% to 80% of all women infected had only one sex partner in their life and 80% of all new HIV infection in women occur in marriages and/or long-term relationships[3] are but two of the indicators that female socialisation seems to perpetuate women's vulnerability. Furthermore, statistics[4] indicating that abstinence until marriage and faithfulness are not necessarily sufficient in preventing especially women's HIV infection, also seems to question the efficacy of the ABC prevention message. Since this approach to HIV prevention is based within the gendered societal context defining that women and girl children are seldom in the position to make choices, including sexual choices, the ABC prevention message, arguably, fails to *'protect'* the most vulnerable to HIV infection; fails to *'provide'* an environment in which equal decision making about, and participation in, prevention can take place; fails to emphasise the need for everyone to make informed choices; and thus, perpetuates the status quo of who is at greater risk of infection. This seems to indicate that as long as HIV prevention strategies fail to take into account the unequal gendered societal context in which prevention occurs, women will remain to be largely excluded from accessing, controlling and/or benefiting from HIV prevention efforts.[5]

The gendered context of society also defines sex and sexuality for women largely as a means to reproduce, and women as the ones, who are the *'passive recipients'* of sexual choices and decisions of their male counterparts. Subsequently, women are seldom in the position to negotiate conditions of sex, even less so, safer sex, and thus, are seldom in the position to prevent HIV infections.[6]

High incidences of violence and abuse, including sexual violence, further impact on the extent to which especially women are in the position to make sexual choices and to reduce the risk of HIV infection. While violence and abuse, or the threat thereof, limit the ability to negotiate conditions of sex and thus, increase the risk of HIV infection, sexual violence and/or coercive sex exacerbates this risk as a direct consequence of physical trauma, injuries and bleeding. Violence and abuse impact not only on women and girl children's vulnerability to HIV infection, but also the extent to which women who are living with HIV are in the position to access treatment, care and support, as well as to claim their rights. Often, women's choices to access treatment, care and support and/or to disclose their HIV status to their partners and families are limited due to fear of rejection and blame, as well as due to fear of subsequent violence and destitution[7]. It is within this context that violence and abuse is as much a cause for women's increased vulnerability to HIV infection, as it is a consequence.

The above seems to highlight the gendered context of society as one of shared determinants between gender violence and HIV and AIDS. If the nature and extent of gender violence, including sexual violence, is a reflection of existing social, cultural and economic inequalities and injustices between the sexes, then, as could be argued, the gendered context of society determines the extent to which women are *'prone'* to not only be violated and, thus, more vulnerable to HIV infection, but also to be violated based on, and in the context of, HIV and AIDS.

The very same gendered context of society defines females primarily by their caretaking and reproductive responsibilities. Thus, women and girl children are the ones who carry the brunt of the burden of not only taking care of the sick and dying in their families and households, but also in their communities. This is further strengthened by the fact that care and support programmes and interventions, such as home-based care, thrive on the very same caretaking responsibilities of females. In addition, taking care of the sick and dying limits the extent to which women are in the position to generate an income and to participate in paid employment.[8]

Statistics are one of the indicators reflecting the impact of the gendered context of society on local, regional and global HIV and AIDS realities. According to statistics[9], the majority of the estimated 6 million people living with HIV and AIDS in South Africa are female.

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Rakgadi Mohlahlane looks at various factors fuelling the HIV and AIDS pandemic. Analysing various forms of violence, including structural violence, she argues that as long as strategies and approaches to violence and to HIV and AIDS perpetuate, rather than address, the polarised environment of *'men as perpetrators'* and *'women as helpless victims',* responses to either pandemic will remain limited.

Recognising the gap between rights and realities, Emma Harvey reflects on discrimination and the various *'excuses'* for its occurrence. Exploring factors, such as culture, religion, upbringing and *'human nature'* as the common reasons for discrimination, she argues that these very same reasons become *'excuses'* to justify the continued occurrence of discrimination of the *'other'*, despite the fundamental right not to be discriminated against.

Experiences from Nelspruit, Mpumalanga, in responding to the concurrent pandemics of sexual violence and HIV and AIDS are introduced by Barbara Kenyon. She discusses some of the sexual assault realities, including the impact of the *'virgin myth'* and approaches to prevention, and argues that current prevention strategies fail to de-mystify and/or respond to prevailing myths and beliefs fuelling the pandemics.

Project Afiki, a behavioural/social science intervention on HIV incidence is introduced by Laurie Abler, Gad Kilonzo and Jessie Mbwambo. The article highlights realities and challenges of community-based VCT research in rural Tanzania, and discusses some of the experiences and initial findings in affecting motivations and barriers to test from the study site in Kisarawe, Tanzania.

Looking at workplace approaches to HIV and AIDS, Shawn Hattingh is *'making a point'* about the extent to which current HIV workplace policies and programmes are in the position to enable the constitutionally guaranteed right to fair labour practices. He examines the impact of various HIV workplace policies and programmes and argues that current responses to HIV in the workplace will remain to have limited impact, since they fail to address stigma and discrimination in all its forms, and to take into account workers' human rights in the development and implementation of HIV workplace policies and programmes.

Identifying and examining the various underlying factors fuelling the HIV pandemic, seem to highlight the real challenge – how to *'tackle'* the core beliefs apparently *'justifying'* the persistence of the underlying factors. Irrespective of the particular identified *'factor'*, the recurring challenge seems to be *'gender',* which is perpetuating inequalities, injustices, violence in all its forms, and the marginalisation and exclusion of the *'less powerful'* – often reasoned, explained and *'justified'* by core beliefs. However, despite its recognition, it appears that *'gender'* is continuously the *'factor'* least considered and, thus, HIV approaches and strategies remain largely ineffective.

If we are to agree that *'gender'* is the core belief that needs to be addressed and challenged, then we need to agree that this is indeed an *'extraordinary challenge',* since it questions the very same foundation of society, the very same foundation of who we are to be as people and how we are to interact with one another, of what we belief to be *'appropriate'* behaviour and/or treatment of people. It is also the very same foundation that, with persistence, describes who is the *'victim'* and who is the *'perpetrator'*, as it, with the same amount of persistence, resists to change, especially to the much required *'behavioural change'.*

However, if we are to *'tackle with greater resolve the underlying factors'* fuelling pandemics in the context of *'gender',* then one of the *'extraordinary responses'* may have to include the acknowledgement that in the context of current pandemics, people are equally *'at risk'* to be *'helpless victims', 'perpetrators', 'solution seekers'* and/or *'agents of change'*. Similarly, it might need acknowledging that people are equally as *'prone'* to be violated, marginalised, excluded and discriminated against, as they are *'prone'* to violate, marginalise, exclude and discriminate against the *'other'*. Thus, the *'extraordinary response'* required seems to be *'engendering'* society, its various realities, and the various responses, strategies and approaches to society's *'extraordinary challenges'*.

So, if, the *'response'* is to create an enabling environment for *'bringing AIDS under control'*, then the environment needs to be *'engendered'* so as to be *'enabling'* for people to be *'in control'* of the pandemic. If we fail to create such an environment, the underlying factors will remain unchallenged; the gendered nature of society will continue to determine the gendered nature of any pandemic; and the access to, and realisation of, fundamental rights and freedoms will remain gendered and so *'justify'* the marginalisation and exclusion of the *'other'* who is *'less powerful'.* Thus, the extent to which people are in the position to claim and enjoy human rights, and to *'take control'*, will continue to be determined by their *'gender',* rather than their *'humanness'*. Subsequently, the persistent failure and/or resistance to *'engender'* society will manifest itself in *'lack of ability'* to develop and implement effective responses to the 'extraordinary challenges' of the HIV and AIDS pandemics. And so, *'gender'*, if not *'tackled with great resolve',* will remain to be the *'status quo'...*

JOHANNA KEHLER

While the estimated adult prevalence rate in South Africa is 25%, the prevalence rate amongst women attending antenatal clinics is 29.5%. In addition, it is females, aged 15 to 24, who are three times more at risk of HIV infection, than their male counterparts. A further gendered and regional view at statistics reveal that in Sub-Saharan Africa, 75% of all people living with HIV are female; that of all women living with HIV worldwide, 75% are African; that more than 75% of all young people (aged 15 to 24) living with HIV are female; and that of all the ones caring for people living with HIV and AIDS, 75% are women and girl children.[10]

It is argued, that societal, cultural and religious practices, attitudes and beliefs enforcing *'gender appropriate'* behaviour, and the continuous stigmatisation, marginalisation and discrimination against the one who is perceived not to conform are but another determinant perpetuating the gendered nature of the pandemic and its underlying factors.

POVERTY AND HIV: THE GENDERED LINK

It is within the context of underlying factors fuelling pandemics that the link between the feminisation of poverty and the feminisation of HIV and AIDS realities has to be recognised, in that HIV and AIDS contributes to increasing levels of poverty, while simultaneously the increasing levels of poverty reduce the ability to cope and manage the disease. According to statistics[11], 48.5% (21.9 million) of South Africans live in absolute poverty[12], the majority of whom are women (54.4%). And while females are expected to take care, females are the ones least provided with the necessary resources and support to provide the much needed care.

While many households experience loss of income as a result of HIV, there is no social security provision in place. Even though, there is the provision to access a Disability Grant, it is the inadequate application of this grant, as well as its eligibility criteria, which create a situation in which the potential of the grant to improve the well-being and quality of life of people living with HIV and AIDS is rather limited, if not lost.[13] In addition, increasing levels of poverty are related to the fact that larger proportions of the household income are spent on healthcare and treatment, as well as funeral costs.[14]

It is further argued, that while HIV and AIDS exacerbates especially women's economic and social insecurity, it is the very same economic and social insecurity of women that increases their vulnerability to HIV infection.[15] Not only are women mostly affected by prevailing socio-economic inequalities and imbalances, but these very same imbalances also place women at greater risk of exposure to HIV. Engaging in transactional sex and the perceived inability to leave abusive relationships, due to economic dependency, are but two of the indicators illustrating women's greater vulnerability to contracting HIV based on prevailing gendered socio-economic inequalities and imbalances.[16]

In addition, it is women and girl children who are not only carrying the increased burden of care, but also the ones who are increasingly taken out of education and spheres of paid employment, so as to care for the sick and dying family, household and community members.[17]

Acknowledging the correlation between the feminisation of poverty and the feminisation of the HIV and AIDS pandemics is but one of the examples that clearly highlight the common underlying factors of persistent structural and systemic gendered inequalities and injustices that determine, amongst other things, female's greater vulnerability to poverty and to HIV infections. It is female's continuous lack of access to, control over, and benefit from available resources and opportunities that underpins both, the feminisation of poverty and the feminisation of HIV.

CHALLENGES

It has to be acknowledged that a large amount of time, resources and effort has been dedicated to issues of the HIV and AIDS pandemics in an attempt to address various factors underlying HIV and AIDS realities, including the gendered nature of the pandemics. However, it is the efficacy of these efforts that seems to be limited in accordance with not only the prevailing gendered belief, value and norm systems, but also with persistent discriminatory attitudes, beliefs and practices, as well as the seemingly resistance to change behavioural patterns and attitudes. As a result, the gendered societal context, as one of the underlying factors fuelling the HIV and AIDS pandemics, will *'ensure'* that females continue to be disproportionately infected and affected.

As long as HIV prevention efforts, such as the ABC approach, fail to take into account existing societal gendered inequalities, imbalances and injustices, impacting not only on behaviour, but also on choices, HIV prevention efforts will continue to have little impact – since it is the very same gendered realities that define women's greater vulnerability to HIV and the extent of women's choices in negotiating sex. For HIV prevention efforts to carry the potential of reducing the risk of HIV infection, they need to take into account the reality in which prevention is to be applied and implemented; the reality in which existing inequalities and imbalances limit prevention choices and decisions accordingly. Only as and when HIV prevention is available and accessible to everyone, can preventative choices be made and the risk of HIV infection be reduced. Subsequently, challenging the

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...*'reality'* will continue to *'fuel'* the pandemic, despite numerous efforts of HIV prevention...

gendered context of society, including the gendered access to, control over, and benefit from available resources, opportunities and information has to become an integral part of HIV prevention efforts, so as to have the potential to address the underlying factors of the HIV and AIDS realities.

Similarly, as long as HIV support, care and treatment programmes and interventions not only fail to acknowledge that it is the very same gendered context of society that facilitates the implementation of these programmes, but also fail to provide adequate resources and infrastructure for the programme implementation, the effectiveness of these efforts will remain limited. In addition, it is argued that current HIV care, support and treatment strategies will not carry the potential to address underlying factors of the gendered realities, as long as the gendered realities form the very basis of these strategies.

Acknowledging the gendered realities in which responses to HIV and AIDS are developed and implemented, leads, as is argued, to the recognition that it is of utmost importance to not only address the underlying factors of the HIV and AIDS realities, but also to identify mechanisms and build capacity, so as to facilitate a holistic, integrative and human rights-based response to HIV and AIDS. Thus, an adequate human rights response to HIV and AIDS realities needs to encompass as much transfer of knowledge about fundamental rights and freedoms, including the skills and resources to claim them[18], as the challenge and transformation of the underlying value and belief systems that seemingly justify prevailing discrimination, stigmatisation and marginalisation.

Similarly, if we are to acknowledge that the seemingly not only persistent, but societally sanctioned, widespread gendered inequalities are the underlying factor exacerbating women's and girl children's greater vulnerability, then the very same gendered inequalities and imbalances need to be addressed, challenged and transformed.

In other words, in order to address and respond to HIV and AIDS realities from a human rights perspective, the underlying factors, fuelling the pandemic, need to be addressed.[19] This, arguably, includes challenging and transforming the existing inequalities and injustices, as it includes challenging and transforming the newly created inequalities and injustices based on, and in the context of, HIV and AIDS. It also requires acknowledging that the violation of one's fundamental human rights and freedoms is as much a cause of the pandemic as it is a consequence. Hence, the efficacy of responses to HIV and AIDS realities and challenges will remain limited, as long as the violation of fundamental rights and freedoms as the underlying factor fuelling the pandemic, as well as the violation of fundamental rights and freedoms based on, and in the context of, HIV and AIDS are not addressed, challenged and transformed.

In summary, if we are to address the gendered realities as the underlying factor fuelling the HIV and AIDS pandemics, it is the very same societal core beliefs and gendered prescription of behaviour, limiting not only individual choices, but also the access to, and realisation of, fundamental rights and freedoms accordingly, that need to be challenged and transformed into concepts based on the right to equality, non-discrimination and human dignity guaranteed to everyone, irrespective of one's sex, gender, sexuality and/or HIV status. If we fail to challenge, and/or resist to challenge, the gendered inequalities, imbalances and injustices, then the main underlying factor fuelling the pandemic will remain unchallenged and, thus, *'reality'* will continue to *'fuel'* the pandemic, despite numerous efforts of HIV prevention, treatment, care and support.

This means that as long as the gendered nature of society and its lived realities are not taken into account, attempts to *'equalise'* society and to address *'pandemics'* and their underlying factors, will continue to have little or no impact. Hence, the disproportionate impact of *'pandemics'*, such as HIV and AIDS, gender violence and poverty, on people with limited access to available resources, opportunities and information, as well as limited *'ability'* to make choices will continue. And so, if not adequately addressed, the *'feminisation of pandemics'* will continue.

FOOTNOTES:

1. An earlier version of this paper was presented at the *'HIV/AIDS and the struggle for democracy and rights – implications for civil society'* Conference of the Olof Palme International Centre on 16 – 17 January 2006 in Johannesburg.
2. The Constitution of South Africa, Act 108 of 1996.
3. The State of the World Population Report 2005, Chapter Four.
4. The State of the World Population Report 2005. UNAIDS. AIDS Epidemic Update: December 2005.
5. See also Elfenbein, R. 2005. 'ABC: A gendered look at HIV prevention'. In *ALQ*, November 2005 Edition, pp10-13.
6. See also Harvey, E. & Kehler, J. 2005. 'Sex and sexuality in the context of HIV and AIDS'. In *ALQ*, November 2005 Edition, pp1-6.
7. Fox, S. 2003. *Gender-based violence and HIV/AIDS in South Africa: Organizational response*. Johannesburg: CADRE.
8. See also Harvey, E. 2006. 'Home-Based Care: Realities and challenges'. In *ALQ*, March 2006 Edition, pp31-32.
9. UNAIDS. 2005. AIDS Epidemic Update: December 2005; Department of Health. 2005.
10. UNAIDS. 2005. AIDS Epidemic Update: December 2005; and also The State of the World Population 2005.
11. UNDP. 2003. South Africa Human Development Report 2003.
12. Absolute poverty refers to living below the national poverty line, which is calculated to be R354 per month per adult.
13. See also Clark, S. 2006. 'ARVs versus Social Grants: The dilemma of the poor'. In *ALQ*, March 2006 Edition, pp28-30.
14. UNDP. 2003. South Africa Human Development Report 2003.
15. Kistner, U. 2003. *Gender-based violence and HIV/AIDS in South Africa*. Johannesburg: CADRE, pp18-19.
16. UNAIDS. 2004. Women and AIDS.
17. Kistner, 2003:18-19.
18. The State of the World Population 2005:21.
19. UNAIDS. AIDS Epidemic Update: December 2005, p7.

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Pierre de Vos

The right to be different...

When the members of the Constitutional Assembly sat down to draft the South African Constitution just more than ten years ago, they had much on their minds. Every day, thousands of letters, postcards and odd pieces of paper arrived at the Constitutional Assembly with requests from ordinary South Africans about what to include and what to exclude from the brand new Constitution.

In between the hundreds of thousands of agitated submissions supporting the reintroduction of the death penalty and the scrapping of *'rights for criminals'*, there were many thoughtful and heartfelt contributions from groups who saw themselves as marginalised, vilified or forgotten. Members of religious and cultural minorities pleaded for tolerance and acceptance. Gay men and lesbians demanded the right not to be discriminated against. Abused women pleaded for protection from violent men and the patriarchal system that protects the abuser. Many members of traditional African communities wrote to tell about the hardship and indignity visited upon them, because of the lack of respect shown to them, and their culture, during the apartheid era.

The drafters of the Constitution had to come to grips with these concerns in ways that demonstrated the importance of public opinion in the Constitution-making process. But they had to balance this against the duty to create a Bill of Rights that embodied the founding values of the new Constitution, the values of human dignity, equality and freedom. Given the apartheid past, it must come as no surprise that they decided that equality concerns had to be paramount in any discussion of the rights to be included in the Bill of Rights. That is why the Constitutional Assembly decided to include as the first substantial right in the Bill of Rights, the right that guarantees equality for all and prohibits unfair discrimination against anyone on any ground including race, sex, gender, sexual orientation, religion, culture and language.[1]

However, mindful of the need to respect the diversity of views, practices and beliefs in South Africa, the Constitutional Assembly agreed to include a slew of other rights in the Bill of Rights that would emphasise that the new South Africa would be tolerant of diversity and celebrate the uniqueness of every individual. These rights would point towards a society that rejected the dull uniformity that is the aim of fascism or the oppressive normality associated with market liberalism.

The Bill of Rights, therefore, also contains provisions that guarantee freedom of religion, conscience, belief and opinion[2] and the right of people to enjoy their culture and practise their religion, as long as this does not contravene any of the other rights in the Bill of Rights.[3]

At first glance this solution seems rather elegant and politically astute, because it signals that the Bill of Rights will protect the most marginalised, oppressed or vilified individual against discrimination and marginalisation – even from the views and prejudices of the overwhelming majority – while also celebrating and protecting the rights of the majority, or the rights of other dominant groups, to celebrate their cultural, social or religious distinctiveness as a group.

But this matter is rather more complex and politically difficult than the members of the Constitutional Assembly might have realised or might have wanted to admit. It was not too long after the adoption of the Constitution that the Constitutional Court was confronted with the first major difficulty in interpreting all these rights in a harmonious and logical way. The Constitutional Court had to decide whether or not the long standing beliefs or practices of the overwhelming majority of members of the community, which had the effect of discriminating against particularly marginalised and vulnerable groups, were nevertheless acceptable, because they represented the dominant or majority view.

In the case of *National Coalition for Gay and Lesbian Equality v Minister of Justice*[4] the Court decided that the criminal prohibition against same-sex sodomy was unconstitutional, because it discriminated

...no one group should be able to invoke their own views, culture or beliefs to justify the marginalisation or exclusion of any other group ... The most radical aspect of this view is, of course, that it applies to everyone...

against gay men and lesbians on the ground of sexual orientation. Despite the sincerely held beliefs of especially religious groups, who believe homosexuality is an abomination in the eyes of God, the Court found that the Constitution calls everyone to respect the human dignity of others and this requires tolerance beyond one's own world views and beliefs. Although, the Constitution protects the rights of other groups to practice and celebrate their religion, beliefs or culture, they have to do so within the confines of the Constitution, which requires respect for difference. As Justice Sachs stated:

> *Equality means equal concern and respect across difference. It does not presuppose the elimination or suppression of difference. Respect for human rights requires the affirmation of self not the denial of self. Equality therefore does not imply a levelling or homogenisation of behaviour but an acknowledgment and acceptance of difference. At the very least, it affirms that difference should not be the basis for exclusion, marginalisation, stigma and punishment. At best, it celebrates the vitality that difference brings to any society.*[5]

Although, many South Africans may have strong objections against same-sex relationships and sexual activity, the Constitution demands from everyone to accept the right of an individual to form such relationships or engage in such sexual activity. As Justice Sachs astutely remarked, this respect for difference was particularly important in South Africa where group membership (based on race) has been the basis of expressed advantage and disadvantage in the past. As far as homosexuality was concerned, this meant that the very concept of sexual deviance had to be reviewed. According to Justice Sachs, the problem is that in South Africa a heterosexual norm was established and gay men and lesbians were labelled deviant from the norm *'and difference was located in them'*. What the Constitution requires at the very least, is for us to recognise that what is statistically normal, ceases to be the basis for establishing what is legally normative. More broadly speaking, the scope of what is constitutionally normal is expanded to include the widest range of perspectives and to acknowledge, accommodate and accept the largest spread of difference.

> *What becomes normal in an open society, then, is not an imposed and standardised form of behaviour that refuses to acknowledge difference, but the acceptance of the principle of difference itself, which accepts the variability of human behaviour.*[6]

The Constitutional Court's view – which is also applicable in relation to other *'unpopular'* or marginalised groups, such as Rastafarians or the homeless – emphasises the important principle that no one group should be able to invoke their own views, culture or beliefs to justify the marginalisation or exclusion of any other group from the benefits of social acceptance, no matter how strange their beliefs or way of life might appear to people, who see themselves as part of the dominant belief system. According to the

...the government can therefore, not make laws or formulate policy that will perpetuate the marginalisation or oppression of an *'unpopular'* minority group – no matter how popular such a law or policy would be with its voters...

Court, we must all respect each other and respect and celebrate the differences between us, despite the fact that our beliefs, practices and world views might call on us to reject and vilify the *'other'*. The most radical aspect of this view is, of course, that it applies to everyone – from the people whose views are largely shared by society to the smallest minority. In this area, at least, the majority *does not rule.*

This is, of course, not an easy injunction to live by. For example, an acceptance of this respect for difference would seem to mean that fundamentalist Christians would have to respect and accept homosexuals and homosexuality, despite the fact that they might believe sincerely and passionately that homosexuals are *'sinful perverts'*, who must burn in hell – the sooner the better. At the same time it would seem to mean that gay men and lesbians would have to accept the same Christians, who they believe are *'bigots'*, who threaten their very existence and should be resisted at all cost. Viewed thus, this *'right to be different'* can easily be caricatured as the right to anarchy and chaos or the right to allow anything whatsoever.

...if the ... beliefs and practices of one group ... threaten the human dignity ... of others, the government has a duty to curtail such practices...

This is, however, not how the learned judges of the Constitutional Court would see it. They may point out that the right to be different does not mean that anything goes, because the government still has a duty to govern the country in accordance with the Constitution. Government must pass laws and formulate and implement policy, but it must do so in a way that respects the diversity of the community and without endorsing the cultural, religious or other beliefs and practices of the dominant majority. As a general rule, the government can therefore, not make laws or formulate policy that will perpetuate the marginalisation or oppression of an *'unpopular'* minority group – no matter how popular such a law or policy would be with its voters. For example, legislation that would ban same-sex sexual relationships, or sexual intercourse between Hindu's and Christians, or that would ban Rastafarians or former sex workers from becoming school teachers, would not comply with the injunction to respect difference.

At the same time, the judges of the Constitutional Court would point out that the government of the day has a constitutional duty to safeguard the rights protected in the Bill of Rights. If the social, cultural or religious beliefs and practices of one group – especially the dominant group – threaten the human dignity or bodily integrity of others, the government has a duty to curtail such practices. For example, the state would have a duty to forbid a traditional practice, such as the one of female genital mutilation, because it would be harmful to women – even when this practice is widely accepted amongst a particular group.

The constitutionally inspired respect for difference – also for different religious or cultural beliefs and practices – is, thus, limited. Some beliefs or practices may so offend against the founding values of the Constitution – against human dignity, equality and freedom – that they are considered beyond the pale and not worthy of respect. Even when such beliefs or practices are widely shared in the community, or by dominant groups in society, they remain constitutionally unacceptable. When individuals, therefore, justify beliefs or practices that harm others on the basis that it is part of their religious beliefs, culture or tradition, they will only have a valid point, if their beliefs or practices do not reject difference, but respect it.

FOOTNOTES:

1. Constitution of the Republic of South Africa Act 108 of 1996, Section 9.
2. Section 15 of the Constitution.
3. Section 31 of the Constitution.
4. National Coalition of Gay and Lesbian Equality v Minister of Justice, 1998 (12) BCLR 1517.
5. National Coalition of Gay and Lesbian Equality v Minister of Justice, 1998 (12) BCLR 1517. para 129.
6. National Coalition of Gay and Lesbian Equality v Minister of Justice, 1998 (12) BCLR 1517. para 135.

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Meaka Biggs

Sexual Violence and HIV: Can we ignore the links?

Rape and sexual violence are unfortunately a common occurrence and a lived reality for many South Africans. Coping with the violation of rape is difficult enough on its own, adding the possibility of acquiring HIV, as a consequence of rape, represents another trauma, which can be unbearable.

Living with HIV is a challenge that many South Africans face on a daily basis. Combine this challenge with the fact that many women living with HIV are also exposed to rape, sexual and physical violence and the results can, admittedly, be disastrous, as in the case of Lorna Mlofana.[1]

The links between rape, sexual violence and HIV are apparent and increasingly acknowledged. Statistics, even though they are at times problematic, do indicate that while there is an increase in the number of reported rape cases, there is also an increase in the number of HIV infections.

At Rape Crisis Cape Town we assist all survivors of rape and sexual violence who approach us, including survivors who are HIV positive or who have been exposed to HIV as a result of rape. Thus, we are constantly challenged to incorporate the dynamics of HIV and AIDS into the work that we do.

INTRODUCTION

Even though, the links between HIV and sexual violence are receiving greater recognition, the relationship between sexual violence and HIV is not always adequately understood or addressed by the interventions of government, civil society, the community or survivors. This lack of acknowledgement of the intersections between HIV and sexual violence has a number of consequences. For example, for the survivor this could mean not being able to access medication to prevent infection after rape, it could also mean not completing the course of medication and/or not revealing the HIV status to the partner, due to the legitimate fear of violent retribution, even if the partner is the source of infection. For government it could mean inadequate or incorrect allocation of resources and services, a lack of recognition of the multi-faceted nature of the problem and an inability to protect the constitutionally guaranteed rights of all South Africans. For civil society it could mean a challenge to prevention messages and awareness raising, whilst it also represents a challenge to the dichotomised manner in which civil society works and the projects that are initiated in communities.

The prevalence of rape and sexual violence in society, with women largely being the victims of such incidents, and the increase in the number of people living with HIV, with women being the section of the population where the growth has been the greatest over the past few years, indicates that the links between sexual violence and HIV cannot be ignored. The challenges faced by survivors of sexual violence and people infected by HIV are similar in nature. These challenges relate to prevailing gender roles in society and involve stigmas and myths encouraging certain beliefs about HIV and rape. Both issues are linked to sex and beliefs about sex, both issues have also struggled for acknowledgement and commitment from government often resulting in inadequate or inaccessible services and treatment. With regard to both issues, there seems to be a lack of understanding about the psychological and emotional impact on the survivor or the person infected and affected by HIV. The challenge seems to be to debate, research and implement solutions that have a practical and real effect on the daily, lived realities of all South Africans, particularly women who are disproportionately affected by sexual violence and HIV.

SEXUAL VIOLENCE: REALITIES AND FACTS

Rape is a crime of violence that is committed through a sexual act. It is an expression of dominance and control by one person over another, which is humiliating, invasive and dehumanising. It is a crime that is not comparable to any other violent crime, as it violates not only physical safety, but psychological and sexual integrity. Rape is any act of a sexual nature which has been forced onto another person and where sexual behaviour is used as a weapon of domination. It is a violent, traumatic and life changing experience that can happen to anyone, and threats and manipulation are often the method used to secure submission instead of physical violence alone.

Working with survivors, one realises that rape happens anywhere, to anyone at anytime. People tend to think that it only happens to a certain type of person, but the reality is that it is happening everywhere, including in our families, in our homes, in our neighbourhoods and communities, in our places of worship, education and recreation. And it is happening to anybody, including our mothers, sisters, wives, daughters, girlfriends, colleagues, friends and sons.

Rape often relies on an existing relationship to ensure silence and takes many different forms from date, acquaintance and marital rape to child sexual abuse, sexual exploitation and gang rape. '*Stranger rape*' is what many people still consider to be *'real rape'*; the type of rape

...rape is a crime ... that is not comparable to any other ... as it violates not only physical safety, but psychological and sexual integrity...

that society seems to offer the most support to survivors for, and the most prevention messages about. In other words, a woman walking in a parking lot and being attacked by a stranger who grabs her and violently rapes her, leaving physical injuries and scars will receive society's sympathy and support. And, it is this situation that further seems to define rape prevention messages, telling people, especially women and girl children, not to walk alone at night, not to accept lifts from strangers and not to open the door unless they know who is on the other side.

The problem is, however, that in most cases, rape and sexual violence do not happen in this manner and the threat is more likely to be from within the home and/or from someone known and already acquainted with, than someone unknown. Experience shows that society is more likely to believe and support the *'real rape'* scenario, rather than the instance where a woman is raped after going on a date, having a glass of wine, and then inviting the person in for coffee. In this instance, society questions, blames and says that 'she brought it on herself' and is reluctant to offer support, yet, the psychological, emotional and physical impact on the survivor in both scenarios is immense and the reaction of people who are meant to offer support, such as families, communities and society in general, play a major role in the healing process.

Statistics, released by the South African Police Services on rape for the period 2004/2005, revealed 55 114 reported cases of rape in South Africa, which is approximately a 4% increase on the 2003/2004 statistics[2]. Due to the narrow legal definition of rape[3] provided for in current legislation, the cases of indecent assault reported over the same period, 10 123, need to be included in order to get a clearer picture of the reported rape statistics in South Africa.

Research[4] estimates that anywhere between 1 in 9 rapes go unreported, which is an indication that the number of survivors of rape and sexual violence is far larger than the reported figures. Research also indicates that the majority of survivors of rape and sexual violence are women and children. While men are not as vulnerable to rape as women, rape and sexual violence against men is on the increase, however, the vulnerability of women and children presently far outweighs that of men.

HIV AND AIDS: REALITIES AND FACTS

Since 2002, there has been a sharp increase in women living with HIV in sub-Saharan Africa. In earlier years, men had a higher rate of infection than women, but women are presently the fastest growing group of people living with HIV and AIDS. Nearly 50% of adults infected globally are women living in sub-Saharan Africa. In South Africa over 5.6 million adults are infected with HIV and a vast majority of people living with HIV and AIDS are women.[5]

HIV infection is affected by a number of different factors. It is primarily transmitted through sexual intercourse and it is, therefore, linked to the relationship between women and men. It is also recognised that unprotected sexual intercourse and other high risk behaviours create risk for any person irrespective of their sex. However, there are certain psychological and social factors which increase the risk of infection and impact on the care, medication, nutrition and support available to people living with HIV. Sex, gender, race, class and age powerfully influence exposure to, and progress of, the virus. Gender inequality is one of the primary

...in most cases, rape ... is more likely to be from within the home and/or from someone known...

factors linked to the rise of women who are infected with, and are affected by, HIV and AIDS. Gender inequality is also one of the greatest barriers preventing women from protecting themselves from infection, not simply because they are women, but because of the discrimination and inequality that they face as women.

Physiologically, women are at higher risk of infection during intercourse, as they have a larger mucosal surface, which can be exposed to abrasions. Women also have a higher rate of sexually transmitted infections, due to biological factors and the unchallenged

norms of male ownership of women's bodies. This allows for easier transmission of the virus. Unlubricated sexual intercourse increases friction in the vagina and the risk of physical injury, making transmission of the virus easier. In cases of rape and sexual violence, lubrication can be limited and the survivor's muscles are tense, thus increasing the risk of HIV transmission and compounding the trauma suffered. The risk

...physiologically, women are at higher risk of infection ... as they have a larger mucosal surface, which can be exposed to abrasions...

of HIV infection associated with rape and sexual violence is, therefore, much higher than that of a single act of sexual intercourse. Other factors increasing this risk for survivors of rape and sexual violence are that some survivors are exposed to multiple assailants and multiple receptive sites. At Rape Crisis Cape Town we are seeing an increase in survivors of multiple rapes and clients who have been raped orally, anally and vaginally. Women's vulnerability to HIV infection is, therefore, both biological and centrally linked to their status in society and the gender roles assigned by society.

Socially, women are at a greater risk of contracting the virus due to the norms prevailing in society regarding to who has power and control over women's bodies and their sexual lives. Women have limited choice when it comes to negotiating sex. Male ownership of women's bodies and the notion that women should submit to men, be unchallenging of men and not be sexually dominant means that for women exerting control when it comes to sex is not a *'viable'* option. For often, in the attempt to assert control, further violence and injury occur. Hence, the ability to enforce one's constitutionally guaranteed right to bodily and psychological integrity[6] seems not practical, nor safe for a majority of South African women.

These societal norms mean that adhering to the ABC prevention message, as an example, is not a practical solution for limiting the transmission of the virus for many women. For it is the men in their lives that make the sexual choices and when women attempt to challenge these choices, women often face greater harm and violation.

Women also carry the burden of HIV disclosure, due to antenatal testing programmes and the roles of care and support that women fulfil in families and communities. Pregnant women are the most tested group of people when it comes to testing for HIV, which also means women carry the greatest risks associated with disclosure and exposure of their HIV status. Women often experience severe violence and abuse as a result of disclosing their HIV status to their partners and families, or as a result of being exposed in the community as someone who is infected with HIV, which is often due to the violation of the right to confidentiality. In many instances, women have contracted the virus from their partners; yet, women often face retribution from the very partner who infected her. This is but one example of the unintended consequences that programmes and interventions can have, when the links between sexual violence and HIV are not fully explored.

There has also been an increase in female-headed households. Hence, there is greater economic reliance on women, yet, at the same time women continue caring for the sick and dying. With the burden of care falling on young girls within the family, girl children often end up leaving school early in order to take care of the family. This further entrenches the inequality that young girls and women experience in their daily lives.

Current programmes and responses to HIV and AIDS often seem to entrench gender roles and increase the risk of violence against women. For example, calling on women to volunteer as home-based and community-based caregivers, entrenches the concept that women's work is undervalued and unpaid, reinforcing the notion that they do not *'fit into'* the formal economy. Programmes calling on people to disclose their status in a society where the social stigma around HIV is mainly judgmental, blaming and unsupportive, coupled with the high levels of rape and sexual violence, leave women in a vulnerable position. Thus, these programmes will not have the intended effect of

...we are seeing an increase in survivors of multiple rapes and clients who have been raped orally, anally and vaginally...

support and acceptance, as initially anticipated. One reason could be that most of these programmes fail to consider the environment in which people are asked to disclose, as well as the effects that disclosure can have on an individual in a community, which has a particularly antagonistic attitude to HIV and AIDS.

Ambiguous messages from government also play a role in

maintaining certain social stigmas around HIV. A lack of clear direction from government assists in the proliferation of many unfounded beliefs regarding HIV and AIDS. Programmes and interventions need to carefully consider the impact of the intersections between sexual violence and HIV in order to ensure that the impact is one of improving the situation, as opposed to increasing the danger.

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COMMON CORE BELIEFS

Survivors of rape and sexual violence and people living with HIV are labelled, ostracised, rejected, intimidated and blamed by the very people who are supposed to provide support, during the time of need. This often prevents people from speaking out about their situations. It also means that many survivors do not seek the medical, psychological and emotional assistance that they need, and do not receive the correct medication after the rape, so as to reduce the risks of HIV transmission, as well as other sexually transmitted diseases. Because rape survivors are often ignored, dismissed, questioned and shamed, in very much the same way that people living with HIV are, it means that the risk of exposure is heightened, as is the isolation.

In addition, the belief that sexual intercourse with a virgin can cure AIDS could in fact lead to an increase in rape and sexual violation. Or the belief that using a condom undermines manhood and that it is part of one's culture to have numerous partners, could further perpetuate the spread of HIV, the subordination of women and the inability of prevention messages to make a real difference. The links between sexual violence and HIV go beyond the numbers to the very core values and beliefs that many in society hold.

Sexual violence and HIV are both matters that many South Africans are seemingly not prepared to accept as reality. When discussing either rape and sexual violence or HIV and AIDS there appears to be an inability to meaningfully comprehend and acknowledge the devastating impact of both of these issues, as well as of the responses and actions required. It is almost as if people hear the information, but do not make it part of their conscious reality. There seems to be a distancing from the devastating impact for many, and the more that the effects of sexual violence and HIV are pointed out, the greater the denial becomes. People do not want to accept this as part of their lives and it is only as and when people are affected in a very direct and personal manner and they can no longer deny the situation that a shift may occur. As a result, prevention messages are ignored and there is a general lack of knowledge about how, when and where to access services. Subsequently, if services are available, they may not be accessed appropriately or timeously when the need arises.

SERVICE PROVISION

A further challenge regarding services for survivors of sexual violence and people living with HIV is the limited access to information and knowledge of how to access services. In many areas, there are no, or limited, services and information, and accessing services free from judgement and insult can often be a challenge in and of itself. Survivors of rape and sexual violence encounter many problems when trying to access the criminal justice system at the various levels from the health system to the police and the courts. People who are infected with HIV also have problems accessing services, as not all clinics provide testing facilities and the necessary medication and information for treatment.

Services at the various levels are provided by people, who come from communities. So, if stereotypes and judgements prevail in the community, the individual providing the service will bring the same beliefs into the clinic, police station or court. As a result, survivors of sexual violence and people living with HIV encounter the same judgements from within the system of service provision, as they encounter from within the community. Hence, services that are meant to protect and support, are in fact, unsafe and discriminatory.

Experiences highlight that counselling services, offered by social services, are notoriously limited and the huge gaps that government funded services leave, are not able to be filled by civil society, as civil society faces capacity and resource constraints. As a result, a person, who is a survivor of rape and has potentially been exposed to HIV, has little or no access to counselling unless the person is able to pay for this costly service. Or, the woman who reveals her status and as a result thereof is beaten, abused and violated may have to wait for months, before she can obtain an

...women often face retribution from the very partner who infected her...

appointment for appropriate psychological and emotional assistance. This, arguably, indicates that the psychological and emotional impact of rape and sexual violence is not fully understood, nor is the psychological impact of HIV on people who are infected and affected.

Rape and sexual violence, and HIV and AIDS present already significant challenges as separate issues confronting South African society. The challenges in addressing service provision around these issues are further complicated by the complex and often unexamined intersections between these issues. Service provision that does not adequately take cognisance of the intersections, may unintentionally remain ineffective in addressing the needs of survivors and those infected and affected by HIV and AIDS.

In the past, rape and sexual violence and HIV and AIDS have been distinctly separate and dichotomised. Acknowledging that there are links and that these intersections cannot be ignored would mean that the various sectors need to complement each other and work together, rather than remaining in the *'silo'* mentality of operation. For example, to access services, a rape survivor would need to go to an organisation dealing with rape and sexual violence for counselling and support, and then to another organisation for voluntary testing and counselling relating to HIV. Specialisation of services can, therefore, increase the financial and emotional burden

...programmes... need to begin to reshape... *'acceptable'* behaviour...

for an already traumatised survivor. By sticking only to one speciality and not developing a holistic approach, or a well thought out and operational referral system, service providers are not assisting in the overall healing and support of the survivor. The move to an integrated approach is a challenge both at government and civil society level to the manner in which services are provided, and prevention and awareness campaigns are conceptualised.

WAY FORWARD

As sexual violence is increasingly linked to HIV and AIDS, prevention strategies and awareness campaigns need to take women's lack of reproductive and sexual autonomy and choice into account. If such programmes fail to do so, then women will continue to constitute,

...challenging the State to enforce existing legislation and policies, and to enact new legislation, will also assist...

by far, the majority of people at risk of sexual violence and HIV infection. Care strategies should address, challenge and transform the gender roles within the family and community. Treatment strategies need to reach women in their own right, rather than solely in their reproductive roles, as is the case with Prevention-of-Mother-to-Child-Transmission (PMTCT) initiatives; or in cases where women have reported sexual violence. Programmes and responses need to begin to reshape attitudes, beliefs and values and what has come to be understood as *'acceptable'* behaviour or culture.

Prevention, care, support and treatment for HIV are mutually reinforcing and not inseparable and are linked to the gendered nature of power and control in society, as are the constructs involving rape and sexual violence. Initiatives of government and civil society pertaining to sexual violence and HIV need to take cognisance of the links between these two issues and effectively work together to decrease the impact of HIV and sexual violence. To ensure the impact of these concepts in their entirety, arguably, encompasses the need to further develop the understanding of how they intersect; plan and implement programmes and services from the perspective that they are linked; consider the impact of such links; and form partnerships across sectors that recognise and address these intersections successfully.

Challenging the State to enforce existing legislation and policies, and to enact new legislation, will also assist in changing the realities of sexual violence and HIV. Adequate resource allocation and taking the issues faced by many South African women serious, rather than simply paying lip service, will impact on the effectiveness and implementation of programmes that recognise the links between sexual violence and HIV. We cannot ignore the links. We do so at out own peril.

FOOTNOTES:

1. Lorna was a 21 year old HIV activist, who was killed after informing her rapist that she is living with HIV.
2. www.saps.gov.za/statistics/crimestats/2005.
3. The legal definition of rape only includes vaginal penetration by a penis. Other forms of rape are currently trialed as indecent assault.
4. Medical Research Council report, 2002, as cited in www.oneinnine.org.za.
5. UNAIDS. 2005. AIDS Epidemic Update. December 2005. See also 2005 World Population Report.
6. Constitution of South Africa, Act 108 of 1996, Section 12.

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Dumisani Rebombo

'Dethroned men'... an underlying factor fuelling the pandemic?

Introduction

It is a known fact that even before the discovery of HIV, women and girls experienced discrimination and oppression based on well-documented gender related factors. HIV and AIDS merely exacerbated a situation of inequality and injustice that already prevailed in all Southern African countries and many other parts of the world. For example:

- The incidence of all forms of violence against women is an indicator of the status of women. Sexual violence including rape is quite common.
- In most communities, women are less educated and by extension less economically independent than men, though recently there has been a positive shift in this regard.
- Women and girls are disproportionately saddled with household work and responsibilities.
- In most Southern African countries, women are still discriminated against by law and/or through the biased implementation and interpretation of the law. Even in the South African context, with a world acclaimed democratic Constitution, there are still rights that women are not in the position to enjoy.

There has been long standing socio-cultural factors that have made women and girls in Southern Africa more likely to become infected with HIV and less in the position to protect themselves, and/or fight for their rights at all levels. In addition, the extent to which men were, and are, affected by the new social order creates a debate that needs to be included in the equation, so as to closely look into some of the underlying factors that fuel the HIV pandemic.

Inequalities between men and women

As cited above, the question of unequal gender relations is one of the most serious underlying factors that fuel the pandemic. For example, many women are not in the position to either negotiate safer sex or make overall decisions about their reproductive health, which leaves women vulnerable to poverty, dependency to their male counterparts, and sexual violence. Complementing WHO's (2002)[1] report, research on women has shown that women who experience both sexual and physical abuse from intimate partners are significantly more likely to have had sexually transmitted diseases, including HIV. It seems, however, that HIV prevention, care and support strategies address this issue merely in research papers and political talk, without proper and effective programmes on the ground.

Men and the effects of rigid gender roles

Socio-cultural changes affect men as well, even though at a different level. For example, men's health and well-being are seriously jeopardised by rigid gender roles. Indeed, researchers suggest that *'gender is one of the most important determinants of health behavior'*, and that *'men engage in fewer health-seeking and have less healthy lifestyles than women'*[2]. When men are not taught to reform such behaviours, or if excluded from projects, collectively, efforts will be greatly challenged!

Similarly, other studies have documented the effects of *'masculine ideology'* on condom usage, and sexual and reproductive health in general, and indicate that traditional men's gender roles lead to *'more negative condom attitudes and less consistent condom use'* and promote *'beliefs that sexual relationships are adversarial'*[3] .

As is indicated by a number of recent studies[4], these gender roles leave men especially vulnerable to HIV infection, and also decrease the likelihood that men will seek voluntary counselling and testing services, or access medical services, until they are already very ill. A recent study of anti-retroviral treatment in Johannesburg conducted between April and June of 2004[5] reported that women accessing ARVs outnumbered their male counter parts, as many men would only access ARVs by the time they are very sick.

However, most of the current HIV strategies focus mainly on challenging men to stop these types of behaviours, or pointing a finger

of blame to men – which in turn leaves men with a perception of being the alienated gender group. It has to be recognised that men are not a homogenous group and, therefore, it is crucial to heed an inclusive approach, which creates spaces to work with men as solution seekers. This does not suggest that where men have perpetrated any form of violation or practiced injustice, this should be treated with soft gloves, but rather that universal punitive masculine ideology that suggests a narrow definition of masculinity, will miss the underlying factors of certain behaviours.

Men dethroned

Though this might sound cynical, a thought must be shed here in that there is a belief that colonisation has dethroned men, especially African men, as *'head of families'*. Prior to colonisation, men herded cattle and ploughed fields and, therefore, the masculine identity and wealth was built and accepted in this way. In addition, men had to pay lobola (the dowry) to as many wives as they so chose, this dimension giving birth to dictatorship and control of women and reinforced the *'head of the family'* concept. This norm was practiced and accepted for many decades without doubt that many African men enjoyed this privilege

...traditional men's gender roles lead to *'more negative condom attitudes'* ... and promote *'beliefs that sexual relationships are adversarial'*...

(if it is a privilege at all!), without realising or taking stock on how this affected women and children. Colonisation, amongst other things, introduced municipal by-laws (therefore not every man would have big herds of cattle and

...mixed HIV messages can send out negative perceptions and false hopes ... after all there seems to be no need to panic, as HIV is just another health condition...

large plough fields), and paying of taxes. This, combined with industrialisation resulted in many of the *'head of families'* having to migrate to cities in search of work – and though, the men held on to the title, their women counterparts became in reality the new *'head of families'*.

The inevitable new social order

Patriarchy in all its forms had to be challenged and continues to be dismantled. However, currently, as can be argued, only *'enlightened men'* applaud the new dispensation that is spearheaded by the UN's declarations and most heads of state. Similarly to the colonisation era, this was bound to happen, since, unfortunately due to limited transitional processes that are in place, some men, if not most men, see the new order as a continuation of their dethroning.

The new order *'forces'* men to consider sharing household chores; to accept equality with women and the fact that women can be *'above'* men economically – not to mention the rising unemployment figures that *'allow'* women to be *'bread winners'* and, sometimes to be perceived as *'arrogant heads of families'* forced on men by the new social order, which is also misunderstood as a challenge to the wisdom of men (whether from a cultural or religious perspective). Fortunately, these beliefs and perceptions cannot completely stop the progressive development dispensation, even though human development can, in many ways, be seriously challenged by these beliefs and perceptions, especially with regard to the HIV pandemic.

The point, however, is that if there is not a constructive focus on how to allay these fears and perceptions from the masculine centred beliefs, yet another underlying factor that fuels the pandemic, will be missed. A few examples would be:

- When men feel that their dominant powers over women and systems are *'dethroned'*, they may resort to violence, especially sexual violence in the HIV context; due to these misguided misconceptions.
- Sometimes it might not be violence per se, but engaging in casual sex or with multiple sexual partners (with harmful repercussion to HIV awareness and prevention programmes) as a form of retaliation to loss of power. This behaviour can also be viewed as a consolation to the *'hurting male pride'*.

- Men might resent female leadership, because of how they feel inside, coupled with the lack of understanding the changing external environment.
- Mixed messages and expectations, e.g. on what it means to be a man from the order of the past, linked with the little *'know-how'* on the new definition and expectations of who a man should be in the context of the new era. For example, some men are still expected and told to be the *'bread winner'* or *'provider'*, even though this is no longer as practical, failing which could subject these men to direct or indirect ridicule or undermining.

It is, therefore, imperative that such gaps be bridged in order to arrive at workable solutions that will benefit not only specific initiatives and programmes, but all the infected and affected.

Mixed national HIV messages

It is argued, that the more mixed HIV messages are sent out to the nation, the less effective they become. According to Dr. Liz Floyd, director of the provincial ministry of health, more than 80% of the population has been successfully reached with HIV and AIDS messages.[6] The question then is, why does South Africa has the highest number of new infections, even though there is adequate condom distribution? Why are there such high rates of stigma resulting in less behavioural change? Sending out different mixed messages to the nation, as compared to one single message, is what, arguably, can create *'resilience'* and self-belief to ignore certain messages of life and death.

In Uganda, for instance, the central message for the nation, over and above the ABC approach, was that of *'no to zero grazing'*, which means *'no'* to multiple sexual partners, including *'no'* to casual sex. South Africa sends out messages about *'HIV as a killer'* and simultaneously messages of hope.

...the presidential approach to HIV is, arguably, a bit casual – bringing about *'casual approaches'* in some circles...

When one thinks of the different forms in which masculinities get to be performed or identified, these mixed HIV messages can send out negative perceptions and false hopes to some people, since after all there seems to be no need to panic, as HIV is just another health condition. Furthermore, if *'HIV gets you'*, there are monetary grants and anti-retroviral treatment available to assist.

In South Africa, it seems that politically HIV is the sole responsibility of the ministry of health, whereas it is a well-known fact that a comprehensive approach by all government departments, including the presidency, is critical in the response to the pandemic. The presidential approach to HIV is, arguably, a bit casual – bringing about *'casual approaches'* in some circles.

...perceptions in some circles that working with men equals wasting scarce resources and time, as there is a strong belief that patriarchy in all men cannot be changed...

Swaziland, for example, has recently launched centralised HIV messages, one about the need for life and the other about being faithful to one partner and it is believed that this will yield positive responses from the nation. This does not suggest that a holistic approach to HIV prevention and care strategies is not needed, but that there is the need to prioritise and centralise behavioural change messaging for optimum national response and benefit.

Changing HIV strategies and approaches

Whether this is due to current needs, trends or donor driven preferences, there has been changes and/or shifts of priority interest in the response to the HIV pandemic. Where HIV prevention was a strategy of focus, it was soon swallowed by the interest for orphaned and vulnerable children (OVC). This too did not last long as voluntary counselling and testing (VCT) entered the fray. Soon after, treatment took the centre stage and the cycle seems to roll on. However, what is needed is a holistic approach, in which HIV prevention, care and support activities are given equal

attention and are parallel activities at all times, so as to ensure sustainable and effective programmes responding to the pandemic.

Fewer programmes target men

As alluded to in the introduction, men are immensely shaped and challenged by socio-cultural changes and, therefore, working with men is of paramount importance, since leaving men to themselves, whether by default or due to radical feminist ideologies, will hamper most of the good work that is done, even for women and children. There are, however, perceptions in some circles that working with men equals wasting scarce resources and time, as there is a strong belief that patriarchy in all men cannot be changed. This view is, arguably, a dangerous one, since there is an urgent need for a social movement of men and women to respond to the pandemic – so, the exclusion of men (or their inclusion as perpetrators) has, and will continue, to challenge many of existing programmes.

...have more male targeted programmes (that are not setting the agenda for women's emancipation)...

In conclusion, these underlying factors in the response to the pandemic need urgent attention and all efforts are needed to fill in the gaps and to redress harmful beliefs and perceptions that constantly present themselves. Researchers and strategy formulators have done enough in their profession. It is time that efforts to capacitate communities to be HIV and gender competent be exerted, since a competent community is the one that knows, understands, and is able to respond to the issues effectively within the constraints of limited resources. These kinds of communities are in the position to enhance and sustain programmes in their communities, without constant help from experts.

Recommendations

The recommendations listed below are an attempt to provide mechanisms of how to address the issues and to obtain a common understanding.

- Incorporate and increase male involvement in all HIV strategies – e.g., have more male targeted programmes (that are not setting the agenda for women's emancipation), but that support the women's agenda. Men's fears and negative beliefs and perceptions need to be addressed. Safe spaces need to be created for men and women to dialogue on all issues of concern, and women organisations need to unite and work together.
- There is a need to have one or two national HIV messages that the nation can identify with – e.g., everyone in South Africa can identify with the Treatment Action Campaign T-shirt and the Soul City emblem.
- Capacitate communities to be gender and HIV competent – as much as research, monitoring and evaluation, and other strategies are needed to be in place, it is recommended that communities need to be given skills to stand up, and be involved in the planning and implementation of HIV programmes and initiatives in their respective communities.
- Provide community education on policy and the socio-cultural changes by both government and civil society – this should include gender equality, human rights, including a simplified version of the Constitution. Traditional healers and the faith-based organisations are to be included in the process.
- There is a need to strengthen civil society in order to advance policy and advocacy work, especially with government, and to hold government accountable to all its constitutional obligations.

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Rachel Elfenbein

We're not supposed to know about these things...

A call to embed sex education within a human rights framework

High rates of gender-based violence exist in South Africa.[1] Rape and all forms of gender-based violence are telling examples of high levels of gender inequality in the country. Research has revealed and explained the link between gender-based violence and the spread of HIV and AIDS in South Africa.[2] The need to understand what contributes to the perpetration of gender-based violence is, therefore, imperative, because, as argued by UNAIDS [2004]

> *...if HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls.*

Most counselling, advocacy and research initiatives and programmes on issues of gender-based violence in South Africa focus on girl children and women – on responding to their trauma – and not on the prevention of gender-based violence. Furthermore, most gender-based violence counselling, advocacy with and research activities in South Africa, that focus on men, focus on men, who are already sexually active and violent. As such, an '*in-depth understanding of why and how men come to act as they do sexually is absent*'. [Jewkes, Maforah & Wood, 1998:17]. Little work has been accomplished in understanding how boys in South Africa are socialised and come to be perpetrators of gender-based violence.

This article focuses on how adolescent boys in South Africa, who have yet to engage in sexual relationships, come to understand issues of gender-based violence as they develop their own sexual and gender identities. The information presented in this article is based on a study exploring the perceptions of pre-sexually active South African adolescent boys pertaining to gender, sex and violence, and the mechanisms of how these issues are communicated by various role players in their environments. Based on the research results, this article argues that sex education for children and youth must be based on a human rights framework, if it is to be effective in preventing gender-based violence and the spread of HIV.

Research background

A random sample of the population of eighth grade boys at Lowveld High School in Nelspruit, Mpumalanga, was drawn for this research. From this sample, fifteen boys, aged twelve to fifteen, participated in in-depth qualitative interviews in 2004.[3]

Children come to attend Lowveld High School from homes all throughout Mpumalanga and, in some cases, from other provinces and countries. The selected random sample that participated in the interviews, therefore, reflected the various language and cultural groups of the province and the region. Permission to conduct this study was received from the School for International Training, the administration of Lowveld High School, the participants in this study and their parents and/or guardians. Participants were assured of the anonymity of their responses and were offered counselling and information services, if they felt they were needed.

Perceptions of gender, sex, and violence

The research participants were asked a series of questions in order to probe the ways in which they perceived and conceptualised gendered identity. Most of the participants spoke of clear differences between a woman and a man, with a man described in terms of strength, power, and control, while a woman was often described as less powerful and more nurturing and caring.

The research participants had conflicting perceptions of sex, both individually and within their group of male peers. Most of the participants understood sex to serve a reproductive function, while a minority of participants understood sex to be an expression of love. At the same time, most participants viewed men to be in control of the initiation of heterosexual sex, yet, they also said that a couple initiates sex once they have built up a sense of trust and commitment with each other and they have discussed the issue.

The research participants were further asked a series of questions to probe as to how sex and heterosexual relations are broached within their families. A small number reflected on engagement and discussion of these issues. In general, the participants reflected upon a limited amount of discussion within their families about sex, especially with their fathers and other men in their families. Just

...a random sample of the population of eighth grade boys ... fifteen boys, aged twelve to fifteen, participated in in-depth qualitative interviews in 2004...

over half of the participants' parents were talking to their boy children about sex in any way at all. If the participants' parents did talk about sex, it was most often to tell the child to abstain, while a minority of the participants said that they were able to have varying degrees of open dialogue about sex with their mothers.

When asked to describe rape, almost every participant defined rape in terms of unwanted sexual contact, but participants differed in their description of who can be perpetrators and victims of rape. At the same time, almost every participant thought that rape can occur in marital and dating relationships.

Most of the participants thought that men rape in order to cure themselves of loneliness and/or HIV. One-fifth of the participants thought that men rape in order to gain ascendancy amongst their peers, or to have fun. Only one participant perceived men to use rape as an act of power and control over women. He said that men are *'power hungry: they want to be shown respect and prove that they're bigger and stronger than the other sex'*.

Similar to issues involving sex, the participants' mothers and female family members were more willing to talk about rape with the boy child, than their fathers and male family members. Four of the participants reflected that they received explicit messages from members of their families that they should not force sex on women. The same number of participants reflected that their families have never approached the issue of rape.

From the participants' responses, it seems that their families were more likely to approach the issue of rape, if someone within their families is known to have been a victim of the crime.

Most respondents described little tolerance for rape in their communities. Three participants stated that members of their communities do not address the issue of rape at all. The response of four participants, who described a climate of revenge and taking justice into one's own hands within their communities, warrants taking note. In general, these respondents said that community members, either actively or passively, advocate for the death penalty for perpetrators of rape. For example, one boy said that, in his township,

> *...parents don't even want to think about rape: they come down with full force on known rapists, they do anything to get you behind bars.*

He went on to state that members of his community capture and take suspected or known rapists to a cliff and throw them off it. Another of these respondents stated that a woman in his township community was raped and the following day, community members killed the alleged rapist. A similar number stated that various members in their communities do not forgive alleged rapists, including their religious leaders, who say that God does not forgive a rapist.

When questioned how young men in their communities address the issue of rape, half of the participants responded that young men either take an implicitly permissive stance to rape, or they actually commit rape themselves. For example, one participant said of young men in his community: *'They are with rape. They say you can't just rape somebody, that women are most probably willing'*. On a more overt

...most of the participants thought that men rape in order to cure themselves of loneliness and/or HIV...

level, several participants reflected on how young men in their communities openly commit rape. *'They say rape is a kind of hobby for some young men: they don't know what to do with their life, so they start raping and it becomes a process,'* – one participant noted. Another participant answered, similarly to his response as to why men rape, that boys and young men commit rape to gain ascendancy within their male peer groups. *'Gangs want to rape girls and women. They are usually men nineteen years old and out of school, but a few young ones, like my old friend who is twelve years old'*.

At the same time, the participants perceived young women in their communities to be silent about the issue of sexual violence. Overall, their responses indicated that rape is not an issue that they perceived to be dialogued openly and constructively by, and between, various role players in their communities, as only two participants reflected on initiatives in their communities to address issues of sexual violence in a non-violent manner.

In most cases, participants reflected that, if rape was discussed within their classrooms, it was initiated by female teachers and not male teachers. The participants' responses indicated that they received different messages from teachers with regards to issues of sexual assault, if they did receive information at all. At the same time, the participants' responses showed that teachers are not delivering a standardised curriculum or programming that addresses issues of sexual assault.

Conclusions from the research

Although the data in this study do not illustrate any direct examples of gender-based violence perpetrated by the research participants, their responses indicated that most key role players in their environments are not critically engaging issues of gender, sex, and violence with them. Most of the participants described a limited engagement of these issues on interpersonal, family, educational, and community levels, even though many did describe a climate of violence and revenge in these environments. The data presented in this research, therefore, points to the conclusion that the general environmental context that the research participants described could contribute to the perpetration of coercive sex within adolescent sexual relationships.

Related to the general silence around issues of sexual violence in the research participants' lives is their lack of critical engagement and examination of gender roles. Most of the boys' views reflected gender inequalities. The majority of the participants defined men as strong in comparison to women, and some explicitly noted that men are more impulsive and violent, than women. Many of the participants defined women in relation to men, specifically positioning women as subservient and in less powerful roles. Moreover, views on gender influence the roles that people play within their sexual relationships, as the majority of the boys interviewed thought that men were the ones who control sexual activity within heterosexual relationships.

One cannot help but draw the conclusion that the boys who participated in the research did not critically engage with gender roles, because almost all of the adults in their lives do not directly approach gender issues and gender-based violence with the child. Moreover, the participants' responses indicated that the adults in their lives are not linking the incidence of sexual assault to gender roles, and gender inequalities in society at large, and that this crucial connection is, therefore, not communicated to the boys.

The boys noted that, if they received any sort of sex education from adults, it was more often from the women in their lives, whether the women were their teachers or family members or community members. Furthermore, when adults in these boys' lives chose to broach sexual issues, they paid attention to matters, such as abstinence and HIV and AIDS. From the data presented, one can conclude that there is an overall neglect of the issue of rape and, to some extent, tacit condonement of sexual violence in these boys' environments. Moreover, when the adults in their lives chose to address the issue of rape, they often perpetuated myths and stereotypes surrounding the issue.

Furthermore, one cannot help but draw the conclusion that most of the boys who participated in the research did not understand the causes of rape and sexual violence, because of the ways that the adults in their lives choose to address or, more often, not to address the issue of gender-based violence. Overall, the boys did not see rape as a crime that is reflective of gender inequality, in which someone uses sex as a tool to assert their power and control over another person. Participants talked of rape as an issue distant from their lives, because they did not view rape as something that can, and more often does, occur in intimate relationships.

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...there is an overall neglect of the issue of rape and, to some extent, tacit condonement of sexual violence in these boys' environments...

In addition, the research participants' words reflected a general reactionary approach to the issue of rape, to the neglect of a preventative approach. When the boys did speak of disapproval of rape by the adults in their lives, they usually referred to either indirect or direct violent reactions. Moreover, several of the boys' descriptions of men in their communities seeking revenge for crimes committed against community members and,

subsequently, choosing to take the law into their own hands demands urgent notice. Such violent reactions to rape by adult men, as described by the boys, tie back to generally accepted social constructions of gender.

What therefore needs to be examined and questioned is the belief that men have the right to employ violence as a tool to solve interpersonal and community problems. Furthermore, the very construction of gender roles needs to be scrutinised, and, in particular, as the data presented suggest, the absence of dialogue between adult males and adolescent boys about issues of sexual and gender identity development must be addressed. What also needs to be questioned is who is responsible for educating children about sex and why the responsibility is being left to women. The lack of dialogue with older men in these boys' lives limits their opportunities to seek correct and appropriate information and advice regarding issues of sexual health and gender relations. The overall lack of information and resources can effectively place children at risk for unhealthy and violent sexual behaviour in the future.

...the belief that men have the right to employ violence as a tool to solve interpersonal and community problems...

Implications for human rights and sex education

The results produced from this research carry a practical relevance for everyone working with and responsible for providing sex education to children and youth. The Children's Charter of South Africa demands that all child- and youth-related stakeholders

> *…contribute to children's physical and emotional wellbeing. In terms of the Charter, a child has the right to be appropriately educated about sexuality, AIDS, and human rights. All children have a right to sexuality education. [Kelly, Oyosi & Parker, 2002:60]*

Everyone who has a stake in children's well-being, therefore, bears the responsibility to ensure that children's right to sex education is realised.

In addition, sex education that aims to prevent HIV will only be effective, if it addresses issues, such as gender-based violence, that fuel the spread of the pandemic. As UNAIDS [2004] states:

> *In many places, HIV-prevention efforts do not take into account the gender and other inequalities that shape people's behaviours and limit their choices… These factors are not easily dislodged or altered, but until they are, efforts to contain and reverse the AIDS epidemic are unlikely to achieve sustained success.*

In conclusion, the results of the research highlighted in this report indicate that sex education is not grounded within a human rights framework, which demands that everyone has the right to equality (Constitution[4], Section 9), the right to be free from all forms of violence (Constitution, Section 12(1)(c)), the right to make decisions concerning reproduction (Constitution, Section 12(2)(a)), the right to security in and control over their body (Constitution, Section 12(2)(b)), and the right to access any information that is required for the exercise and protection of any rights (Constitution, Section 31(1)(b)). Sex education must, therefore, be based on respect and the promotion and equal enjoyment of human rights, as enshrined in the South African Constitution, if it is to be effective in preventing gender-based violence and the spread of HIV.

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Katharina Tangri

Women's reproductive rights in the context of HIV and AIDS

Experiences from Botswana

'We are normal. We are like everybody else. Why should I stop living, because I tested HIV positive? Why should I stop doing the things I have been doing before?' – says Onie, a woman living with HIV and mother of two children, who are not infected with HIV. *'But when I met a man I wanted to marry and have children with, there was an outcry in his family'*.

Onie's experience is not an uncommon scenario faced by women living with HIV in Botswana. Many of the women want to have children and found a family, a common desire that would not generate opposition under other circumstances.

While women's reproductive rights have always been a subject of discussion and contestation, a new focus has now, however, emerged in this southern African country – the focus on the rights of women living with HIV and AIDS to make reproductive choices.

Every woman has the right to found a family. This is a universally recognised fundamental right. Women living with HIV and AIDS, however, are being systematically discouraged from establishing a family, either because they are not considered *'fit'* to take care of a baby, or because it is believed they will automatically transmit the HI virus to the infant.

In February 2006, a Member of Parliament in Botswana was quoted in the media saying that he was concerned about HIV-positive women who continue to become pregnant and contribute to the spread of HIV and AIDS. This view seems to suggest that women living with HIV, who become pregnant, can be targeted as *'scapegoats'* for the epidemic.

'Many people connect HIV automatically with death. So they assume that if you are HIV positive you are going to die. And your child will also die' – says Onie, explaining the discrimination she experienced when she revealed her wish to have a family of her own.

The broad public perception in Botswana is that HIV infected pregnant women tend to increase the infection rate. This involves moral judgment and, as a result, HIV infected pregnant women face a great deal of discrimination. On the surface it appears that there is a conflict between the individual rights of these women and a societal goal of reducing the spread of HIV and AIDS.

After three workshops with women living with HIV, held in 2006 around the country by the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), it appears that the situation is much more complex than it may seem. BONELA, an NGO centred on human rights issues related to HIV and AIDS, has been engaged in fact-finding missions to determine the ability of women living with HIV in Botswana to actually make decisions as to whether or not to have children.[1]

'We need to fully understand the situation in which HIV positive women are becoming pregnant', says the organisation's director Christine Stegling. She further argues that *'While they have a right to control their reproductive health, they may not always be in the situation where they can make these reproductive choices'*.

Botswana: HIV and AIDS realities

To begin with, Botswana is experiencing one of the most severe HIV and AIDS epidemics in the world. According to UNAIDS[2], Botswana had an adult HIV prevalence rate of 37, 3% in 2005. Severe also are the infection rates amongst pregnant women. According to the 2005 Botswana HIV Sentinel Surveillance Data, the HIV infection rate amongst pregnant women aged 15 to 49 years was 33.4%. Thus, the issue of whether or not women infected with HIV should have children seems to be one deserving serious discussion.

Onie, like other women, already knew her HIV status when she and her husband, whose HIV status is negative, decided to have children. They had always wanted children and it was part of their plan and a personal fulfilment to her and her husband. So, in order to have children and prevent mother-to-child-transmission, she enrolled in a PMTCT Programme.

Botswana is not only the first African country to offer anti-retrovirals (ARVs) through the public healthcare system, but also to implement the first national prevention-of-mother-to-child-transmission (PMTCT) programme on the continent. At the beginning of 2002, the ARV and PMTCT programmes were made available free of charge, to nationals and non-nationals married to a Botswana national, who met the relevant criteria.

Access to the PMTCT programme allows couples, where HIV transmission is a risk, to found families under the safest possible conditions. Such developments, arguably, affect the choices of women who live with HIV, as to how and when to become pregnant, if they so choose.

A year after the ARV and PMTCT programmes were introduced, the uptake by women was only at about 39%. One of the factors why so few women were willing to participate seemed to lie in the fact that HIV still carried a great deal of stigma.[3] However, a recent study[4] on the PMTCT programme in northern Botswana showed that in areas where access to the public ARV programme was available, women were enrolling more and more often. The study also suggested that 76% of the women who agreed to be tested for HIV, possibly as a first step to enter the programme, had known a person who was on anti-retroviral medication and this influenced their decision to get tested.

Infection of an infant by an HIV infected mother around the time of birth is what is referred to as mother-to-child-transmission (MTCT) of HIV, also known as vertical transmission. Without effective medical intervention, there is a 25 to 35% risk of a child born to an HIV infected mother to become infected during pregnancy (in utero), during labour and delivery (intrapartum).

The major mechanism of vertical transmission (60 to 85%) is during labour and delivery. This risk can be reduced if the baby is delivered through a caesarean. The additional risk of transmission during breastfeeding through infected breast milk (postpartum) is estimated to be about 15%, which depends also on the duration of breastfeeding.[5]

PMTCT programmes can reduce the risk of vertical transmission to as low as 1%, if the enrolment with the programme is started on time, when a woman is 28 weeks pregnant. A

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pre-requisite to successful prevention is a mother's knowledge of her HIV positive status, which provides the opportunity for appropriate care. Medical advice may then be offered to the pregnant woman, including information on medication, caesarean section, and breastfeeding. The woman has the chance to look after her own well-being, treatment and health and, thus, it also provides the opportunity to protect the baby from HIV infection.

In short, the knowledge of a woman's HIV status may enable a woman to make informed choices about future pregnancies and will allow more appropriate counselling about delivery and infant feeding practices. Crucial to the process is a supportive environment that can encourage women to enrol in the PMTCT programme. But, in general, people still lament the lack of community participation in such programmes, as well as the specific lack of male involvement.

Clearly, it always takes two to make a pregnancy happen. Women in Botswana do, however, not always have the control over getting pregnant. But, as illustrated by the negative attitudes directed towards women infected with HIV, it is often the case that the blame is placed solely on women.

'In this era of HIV, everyone should be responsible. Men who are impregnating these women are not equally being asked about engaging in unprotected sex', argues Mary Motse, a spokesperson for Bomme Isago Association, a network of women living with HIV and AIDS in Botswana.

In the midst of the social pressure and a hostile environment faced by women living with HIV and AIDS, a clear violation of the right to make a private and freely negotiated decision becomes evident.

Onie argues that while most people have knowledge about how HIV is transmitted, the issue remains hidden.

> *When my husband and I decided to get married, my in-laws begged him not to marry me, an HIV-positive woman. They said that I would give them AIDS and would never be able to bear children. They thought I would bring shame upon the family.*

Gender Inequalities

As is widely recognised, HIV and AIDS is not only a medical problem. Only by considering social, economic, political, as well as cultural factors can the difficulties faced by HIV infected women, when becoming pregnant, be better understood.

It is a concern when, for example, people start asking childless

couples why do they still not have children. A woman might want to have children, but is afraid, due to her HIV status and does not want to disclose her status, because of the stigma attached to the disease. A married woman may feel a lot of pressure from others if she does not have any children, because she is expected to have children. And, if she does not have children, then she is called a *'moopa'*, intended to be an insult directed towards women who are barren. In Botswana, women feel a considerable pressure to have children. These are some of the experiences women living with HIV revealed at the BONELA workshops.

These women's anxieties are, in part, a reflection of gender relations in the Botswana context as they play into HIV infected women's ability, or lack thereof, to exercise their reproductive rights. The choices permitted to individual women are severely limited by strongly held social and cultural values, as well as various legal restrictions. For women living with HIV, who are poor or socially stigmatised – for example, sex workers and women living with disabilities – it is particularly difficult to make decisions about whether or not to have children.[6]

In Botswana, women and girls who live with HIV, face numerous constraints, including social expectations and gender roles, in claiming their reproductive choices. Women in Botswana have traditionally been seen as inferior to men.

> *Botswana is a patriarchal society. And therefore, women are subordinate to men and have historically endured various forms of discrimination and disempowerment on account of their being women, for example, in access to and control of resources such as land, cattle, power, education and business opportunities.*[7]

In Botswana, the position of women within the family is generally one of subordination to their husbands. Social expectations of the role of women continue to be held most strongly in rural areas. Many women are expected to remain in the home, serving primarily as caregivers to children and men. Women are also expected to bear children. These expectations can affect the ability of women to decide whether or not to have children. The inequalities between men and women often translate into disempowerment of women. Because women are often considered to be inferior, they are unable to negotiate, or even discuss, sexual and reproductive matters with their male counterparts.

Botswana has a middle–income country status, but the inequalities in the distribution of income are amongst the highest in the world.[8] This inequality severely affects especially women, because they are disproportionately working in the informal sector. The combination of a patriarchal social inheritance and poverty is a particularly *'deadly'* one for women.[9] The specific context of poverty and gender inequalities also has a great impact on the high infection rates amongst women in Botswana.

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...the combination of a patriarchal social inheritance and poverty is a particularly *'deadly'*...

In many relationships, women are virtually entirely dependent on men for their economic existence. Women have had difficulties in gaining access to resources, such as land, credit, finance, education and information. The resulting financial and economic dependency increases the vulnerability of women to the demands of men, and, especially their husbands. This also makes it difficult for many women to insist on safer sexual practices and to make choices about their own sexual and reproductive health.

A directly related effect is the transactional sexual relationships some young women are involved in. Age difference and economic inequalities within sexual relationships are widespread in Botswana, in that young women date older men and, in return, they receive money and other valuables.

Known as *'sugar daddy'*, *'ghost'* or *'small house'* relationships, this exchange of gifts and financial benefits, which sometimes includes paying the rent for a flat or buying a car, often place young women in a position where they are not able to negotiate the practice of safer sex. While older men, in their strategy to attract younger women, established these forms of transaction, they also enforce the bargain to get something in return, often including unprotected sex.

Older men with relative affluence are more likely to control the conditions of sexual intercourse, including condom and contraceptive use, and the infliction of violence. Young women are not likely to insist on condom use, partly because of social norms (differences in power relations and the perceived lack of need to discuss sexual relationships) and the economic dependency established.[10] Besides the fact that there is a high risk of HIV infection, the outcome is often unintended pregnancy and only a few of these older men take the responsibilities in the aftermath.

...my partner, they say, would take it as an insult and as questioning of his faithfulness, if I asked him to use a condom...

Violence and abuse

In these relationships and others, domestic violence sometimes plays a role. Women who are involved in abusive relationships are often not in the position to negotiate safer sex with their partners, which places women at risk of getting and passing on HIV.

Asking the question as to why it is so difficult to negotiate condom use with their partners, many women respond that they are afraid of being beaten up and suffering other forms of domestic violence, which includes physical, emotional and economic abuse. My partner, they say, would take it as an insult and as questioning of his faithfulness, if I asked him to use a condom.

A great number of women experience a constant threat of rape, sexual assault and domestic violence. While women experience this at the community level, most cases of crime against a woman occur in intimate relationships. Yet, in many instances, immediate police assistance, medical attention, ongoing healthcare, counselling and support services for survivors of sexual violence are widely unavailable or are inaccessible. This includes effective and accessible post-exposure prophylaxis (PEP) – medication which may help reduce the risk of transmission after a sexual encounter where there is a risk of HIV infection. Women who experience such violence in their homes have even less access to these services. The psychological and physical trauma of violence is made even worse by the increased risk of contracting HIV.

Stigma and discrimination

Women living with HIV experience HIV-related social stigma, even more so when making the decision to become pregnant. Because HIV is a sexually transmitted disease, there may be certain assumptions about a person who is tested HIV positive. Even after many years of living with HIV in societies, individuals living with HIV, and women especially, are perceived to have a *'loose lifestyle'* or to be promiscuous.

Stigma creates a great barrier for women infected with HIV to enrol in PMTCT programmes. If an HIV infected woman enrols, other people might take notice and this can lead to discrimination from her social surrounding. Very crucial in this context is the issue of breastfeeding. The enrolment with the PMTCT programme includes the choice to formula feed, instead of breastfeeding.

But in Botswana's society, there is a big social expectation for a woman to breastfeed her child. If a woman does not do so, she will be automatically perceived to be living with HIV, and since women are afraid of stigmatisation and negative assumptions, many women would try to hide the fact that they formula feed and may even *'give in'* to breastfeeding their children, thus, increasing the risk of infecting the child.

As one of many women in Botswana who live with HIV and whose children are not infected with HIV, Onie decided to formula feed her children. From government healthcare facilities, she obtained formula for free, taking turns with her husband picking up the formula. And, contrary to the experience above, they always did it out in the open. She remembers:

> *I carried the formula openly on the streets, so everyone could see it ... When you try to hide the formula you just contribute to the stigmatisation. But there is nothing we have to be ashamed of. If you follow the medical instructions you can have a healthy child. And that is what your primary concern should be.*

Another aspect that fuels the stigmatisation of, and discrimination against, people living with HIV, is the lack of knowledge on the part of some healthcare workers. A recent study[11] on stigma in Botswana suggests that, even after so many years into the epidemic, healthcare workers are still misinformed and lack information on HIV and AIDS. About half of the nurses questioned in the study reported that they were fearful of contracting HIV by handling patients. This sort of fear might be one of the reasons why many patients are treated in a poor way. No doubt, women who are afraid of being stigmatised by people, who are meant to care, may not seek information and are prevented of getting involved in PMTCT programmes.

According to participants of the BONELA workshops, the counselling women receive in PMTCT programmes is not always adequate and responsive to their needs. Women also stated that they feel stigmatised by healthcare workers. In other instances, healthcare workers have not given women the right information, because they thought that it was wrong for a woman infected with HIV to have children. But, if important information is withheld, a woman cannot consider all the options available and, thus, cannot make an informed choice.

...most cases of crime against a woman occur in intimate relationships...

Legislative Framework

In Botswana's legal system, general law and customary law, which represents the traditional authorities, are combined. For example, marriage can be registered under either system. Many believe that both customary law, as well as national law, privilege men.

Customary law is an instrument guaranteeing male authority, especially in the rural areas, where customary authority still holds much sway. But customary law and general law differ in approaches to certain matters, such as legal age of marriage, property and inheritance rights. The dual legal system provides for a choice of law depending on what is easily accessible. The majority of people live in rural, semi-urban, and urban villages where customary courts are more accessible.

In December 2004, Botswana's Parliament passed the Marital Power Bill, which abolishes the power of men as *'heads of household'* and *'sole decision-makers'* in family property and other related issues.

...half of the nurses questioned in the study reported that they were fearful of contracting HIV by handling patients...

It also protects women's equitable sharing of joint property upon separation, divorce or annulment of marriage. But, traditional authorities argued against the Bill, mainly because they thought it stood contrary to cultural practices and beliefs. According to customary law, the traditional role of men is the one of *'head of households'* and *'decision-makers'*.[12]

Because of the differences between general and customary law in regard to gender equality, it is particularly important that women understand their legal and constitutional rights. Women need to be in a position to choose the option which benefits most and that might also empower women in economic matters, enabling women's independence in exercising their rights.

Remaining challenges

Against these challenges, the decision of women to become pregnant should be reached through open and free negotiation, irrespective of her HIV status. This is why education around family planning, HIV, and basic rights are so crucial in responding to the epidemic in Botswana.

The International Guidelines on Human Rights and HIV/AIDS state that universally recognised human rights standards should guide policy makers in formulating the direction and content of HIV and AIDS related policy. Unquestionably, the right to equality is one of the fundamental human rights and prejudicial, customary and other practices that are based on the idea of the inferiority of women are contrary to the concept of equality. In addition, the right to privacy and autonomy includes the right to make autonomous decisions about one's sexual and reproductive life, and to have the privacy to protect it.

International human rights instruments classify the right to have a family as one of the fundamental rights. Article 16 of the Universal Declaration of Human Rights states that:

> *Women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family and the family is the natural and fundamental group unit of society and is entitled to protection by society and the state.*

If every person has the right to have a family, then it follows that hospital services, as well as family planning centres and other healthcare facilities should be accessible to help a woman to make informed choices about continuing and/or terminating a pregnancy, irrespective of the woman's HIV status. Thus, every woman has the right to choose whether or not to bear children and make her own informed choices in all reproductive matters.

BONELA workshops provided a forum to discuss ways forward for women living with HIV to protect their reproductive rights and advocate for appropriate laws and other measures that would ensure women's rights to bodily integrity, autonomy and reproductive choice.

Botswana must address its lack of formal legislation around the topic of HIV and AIDS. It is argued that government should consider developing and implementing legislation specifically pertaining to the protection of the rights of people living with HIV and AIDS.

...customary and other practices that are based on the idea of the inferiority of women are contrary to the concept of equality...

To be effective and comprehensive, the new legislation has to consider the gender aspects of this epidemic, including issues on marital rape, domestic violence, and equal property rights.

While women must be in the position to

make informed choices, irrespective of their HIV status, increasing men's involvement in HIV and AIDS strategies may be an equally useful contribution. In 2006, Botswana had its first *'Mr. HIV-Positive'*, as a counterpart to the winner of the three–year old annual *'Miss Stigma Free'* pageant. The Men's Sector – a national focal group dealing with men's issues and behaviour – has been established and chaired by influential representatives, such as the Botswana Defence Force in its first year, and currently the forum is chaired by the Commissioner of the Botswana Prison Service.

...don't make your status a secret and don't be ashamed of your decision to have children...

Some women believe that it would be helpful to allow men into the maternity wards at hospitals and to be part of counselling sessions, as well as pregnancy preparation classes. This could encourage men to participate in the process of pregnancy and in PMTCT programmes. It could be one step forward to overcome gender prejudices and stereotypes, which are primarily based on stereotyped roles for women and men, and as such a necessity to empower women to exercise more independent decisions in the area of reproductive health.

Women, like Onie, who participated in the workshops, say that a gendered, human rights-based approach to HIV and AIDS and reproductive rights issues should also promote HIV counselling as part of the family planning programme, which should include the options for women living with HIV to bear children. More access to, and awareness of, PMTCT programmes and its benefits should also be enforced, especially in the rural areas.

In addition, access to information about reproductive and sexual health, as well as access to healthcare facilities and medication concerning reproductive health, can increase the knowledge and modify the attitudes on sexual and reproductive health issues and, thus, women, irrespective of their HIV status, will be in the position to make informed choices about whether or not to have children.

Onie, appropriately, will have the last word on this matter.

Women who plan to have children should go for an HIV test ... but you must not go alone. Encourage your partner to go test with you. It holds the family together ... if you are tested positive, get enrolled in an ARV programme and PMTCT programme. Then you can still lead a normal life. Don't make your status a secret and don't be ashamed of your decision to have children ... even though we are HIV-positive, we have the same rights as everybody else. And if we want to have children, we can have healthy ones.

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Suzanne Leclerc-Madlala

What really drives HIV and AIDS in Southern Africa

Across all levels of society, we need to see a deep social revolution that transforms relationships between women and men, so that women will be able to take greater control of their lives – financially as well as physically. [Kofi Annan, 2004]

This statement was made by UN Secretary-General Kofi Annan at the launch of the 2004 Task Force Report on Women & Girls in Southern Africa. In many ways this was a watershed report, marking the realisation in organisations, such as the UN, international donor agencies and NGOs, and governments that efforts to slow the rapid rates of HIV transmission in the region had, thus far, been directed at the symptoms, rather than the deeper social malaise of systematic disregard of the rights of women and girls. While it had been generally recognised for years that gender inequalities underlie and drive the HIV and AIDS epidemic in sub-Saharan Africa, there was a lack of gender analysis in developing national and community prevention strategies and implementation of responses. This deficiency helped to ensure the relentless spread of the epidemic and its disproportionate impact on the region's women and girls.[1]

There are signs that we may be starting to get things right. A growing number of decision makers in Southern Africa are at last acknowledging the need for Dr. Annan's *'deep social revolution'* and are preparing to commit themselves to engaging with the real underlying drivers of HIV and AIDS in this part of the world.

In April 2006, the United Nations, together with the African Union, declared a *'Year of Acceleration of HIV Prevention'*. During this time, key role players are being called upon to closely analyse the evidence on drivers of the epidemic in their particular part of the continent and to develop innovative action plans guaranteeing that the next decade of HIV prevention is not a sorry replication of business as usual. The Southern Africa region, through the Southern Africa Development Community (SADC) Secretariat, responded to this call by requesting UNAIDS to organise an *'Expert Think-Tank Meeting'* on HIV prevention. This meeting took place over several days in Maseru, Lesotho in May 2006. Out of genuine concern for the continued high incidence and prevalence of HIV in the region, known as the epicentre of the global HIV and AIDS epidemic, the meeting drew together a team of experts from UNAIDS, UNFPA, WHO, UNICEF, SIDA, USAID, members of regional national AIDS councils, HIV and AIDS Desk personnel from SADC, and several local HIV and AIDS researchers and resource people.

I was privileged to be invited as a member of the latter group. My brief was to give a summary analysis of common patterns of sexual networking and intergenerational sex in the region and to make recommendations for existing or new approaches to addressing these drivers of HIV. It was a refreshing opportunity for me to be amongst like-minded individuals who were familiar with the research evidence on the nature of high-risk behaviours in the region, and were not there to score political points or argue about historical misrepresentations. The majority of participants at this *'think-tank'* meeting shared a basic assumption that the key to preventing the spread of HIV, especially in epidemics driven mainly by heterosexual transmission, is through changing sexual behaviour. In the context of Southern Africa, that means placing a major focus on the reduction of casual sex and concurrent multiple sexual partnerships.

PRIMARY AND SECONDARY DRIVERS

The think-tank participants agreed that a *'lethal cocktail'* which combined a particular socio-cultural factor with a particular biological factor was the primary driving force behind the exceedingly high rates of HIV and AIDS in the sub-region. The socio-cultural factor was identified as the high level of concurrent multiple partnerships by men and women, together with the biological factor of low rates of male circumcision. Supporting and sustaining these twinned drivers are the secondary drivers of high levels of viral STIs (e.g. Herpes simplex-2) on the biological side[2], and

...it was a refreshing opportunity ... to be amongst like-minded individuals who were familiar with ... high-risk behaviours ... and ... not there to score political points or argue about historical misrepresentations...

the socio-cultural driver of entrenched norms that uphold male privilege and allow for unfaithfulness in relationships (most especially for men), gender-based violence, intergenerational and transactional sex, along with stigma and non-openness about sexuality and the epidemic. Both the primary and secondary drivers are further supported and sustained by another level of drivers that are structural in nature. These include growing wealth differentials, high mobility and migrancy, and high levels of poverty and sexual violence throughout the SADC countries.

Concurrent multiple sexual partners

It is well accepted that people in Africa or Southern Africa in particular, are not any more or any less sexually active, than people in other parts of the world. In terms of numbers of sexual partners over a period of time, the local population is quite average. What is unique, however, and what is now understood to be the 'engine' behind the epidemic, is the pattern of concurrency whereby a person maintains a sexual partnership with more that one person concurrently. Because of the high risk of HIV transmission during the initial acute stage of infection, concurrent multiple partnerships act to disseminate the infection through complex and inclusive sexual networks.[3] This sexual partnership pattern can be contrasted with the pattern of serial monogamy that prevails in other parts of the world for example. HIV infection transmitted in a serial monogamous arrangement would tend to be *'trapped'* between two individuals over months or even years perhaps, and, therefore, its spread would be contained and limited. It is this common pattern of concurrent multiple partnerships in the sub-region that has propelled, and continues to propel HIV throughout urban areas and into rural hinterlands.

Although, condom usage could potentially negate the effects of this sexual partnering pattern, experience from years of efforts in advocating correct and consistent use of this preventive method strongly suggest that condom usage is not likely to increase enough in the future to make any significant difference[4]. UNAIDS estimates only 19% condom coverage in sub-Saharan Africa overall in 2004. If one accepts the idea that the required high rates of consistent and correct use of condoms in the sub-region will never be achieved, then the need to explore other options and strategies to limit HIV transmission becomes a matter of urgency.

In concentrated epidemics, such as those that once raged in San Francisco and Thailand, where infection was primarily limited to specific high-risk groups (homosexuals and commercial sex-workers respectively) condom promotion was an effective preventive strategy and HIV declines have been attributed to high levels of condom usage. In the context of a highly generalised epidemic, such as exists in Southern Africa, where high-risk groups are no longer the main epidemic drivers and longer-term concurrent partnerships are widespread, condom promotion has had very limited success. Strong socio-cultural ideologies militate against condom use in medium to long-term relationships. In many places, marriage is women's primary risk factor, with 60-80% of HIV positive tested women in the sub-region reported to have had sexual relations only with their husbands.[5] Female condoms have yet to be sufficiently programmed to judge their impact, and microbicides are unlikely to be widely available before 2010. After several years of often heated debate over the reasons for HIV incidence declines in Uganda, Kenya and more recently Zimbabwe, there is now a general consensus that reduction of concurrent multiple partners was the most extensive contributing factor.[6]

Male circumcision

Compounding the negative effect of rapid growth in HIV transmission, resulting from the normative pattern of sexual

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partnering, is the fact that levels of male circumcision are extremely low throughout Southern Africa. There is compelling evidence that male circumcision in itself is protective.[7] While we are awaiting the results of two large studies on the correlation between circumcision and HIV transmission, SADC countries have been advised to develop a *'male circumcision preparedness plan'* in the meantime. With a recent local randomised controlled trial in Orange Farm, South Africa, which was stopped early due to the striking finding that male circumcision had a 60-75% protective impact, it is likely that this once-off intervention that confers lifelong reduced risk of HIV will be a major part of a new generation *'roll-out'* throughout the sub-region.

Sexual violence

It is estimated that about 30% of the population in the sub-region has experienced forced sex before the age of 18.[8] Extensive studies in the region demonstrate that survivors of violence have a higher likelihood of many risk factors, such as engagement in anal sex, intergenerational, as well as transactional sex, and higher HIV prevalence rates. In addition, survivors of violence are more likely to become perpetrators themselves, even as young people. One South African clinic that deals with cases of child sexual abuse has reported that some 25% of the offenders are children under the age of 14.[9] Sexual violence is linked to a culture of violence that involves negative attitudes and reduced capacity or disinclination to make positive decisions, or respond appropriately, to HIV prevention campaigns

...the socio-cultural factor ... the high level of concurrent multiple partnerships ... with the biological factor of low rates of male circumcision...

(e.g., wilful intent to spread HIV). Therefore, reducing sexual violence at all levels of society would no doubt contribute to HIV reduction.

Intergenerational sex

Much like the pattern of concurrent multiple sexual partnering, intergenerational sex (with age disparities of 5 years or more) are common throughout the sub-region. Studies indicate that economic transfers are the normative expectation in these and most other non-married relationships, and that there is a direct inverse relationship between the wider age gap and/or larger economic transfer and the likelihood of safer sex practices. Globalisation and the growth of consumer capitalism are adding a new dimension to transactional sex, as a key survival strategy for many of the sub-region's poor women. Sexual exchange for food and clothes is increasingly being replaced by

...what is unique... is the pattern of concurrency ... whereby a person maintains a sexual partnership with more that one person concurrently...

exchanges of cell phones and i-pods.[10] Stereotypically wealthy *'sugar daddies'* are only part of the problem, impoverished men also engage in intergenerational sex with their offers of comfort, cool drink and packets of chips. Where the balance of power is so deeply entrenched in favour of men, as is the case in Southern Africa, differences in age and economic status often result in severe life-or-death implications for women and girls.

WHERE DO WE GO FROM HERE?

As the purpose of the think-tank meeting was to systematically review the evidence and make recommendations for possible exceptional and immediate action, the final day was spent on developing a way forward to include a proposal of three key priority interventions. These included the following recommendations:

1. Significantly **reduce multiple, concurrent partnerships** for both men and women. Explore possibilities for mass campaigns or social movements with strong political, religious and community leadership (both top down and bottom up) and endorsed by the mass media to stigmatise and discourage multiple partnerships as a threat to individual and public health.

2. Prepare for potential national roll-out of **male circumcision** through acceptability, feasibility and costing studies depending on the readiness of individual countries, and/or on the outcome of the Kenya and Uganda randomised controlled trials of male circumcision. Male circumcision should be embedded within a broader context of

...marriage is women's primary risk factor, with 60-80% of HIV positive tested women ...have had sexual relations only with their husbands...

strengthening male sexual and reproductive health: STI treatment, condom use, and counselling and testing for HIV.

3. Address gender inequalities especially from the perspective of **male involvement and responsibility** for sexual and reproductive health and HIV prevention and support. The specific objective should be to reduce multiple, concurrent partnerships, intergenerational/age-disparate sex and sexual violence through multiple channels, including those noted for (1) above.

CAN WE DO IT?

To have issues of gender and the role and responsibility of men in this epidemic squarely placed at the top of the agenda for HIV prevention, is, from my perspective as someone long arguing for a gendered approach to this insidious disease, nothing short of revolutionary. For the first time, I feel hopeful that a more effective and relevant strategy against HIV and AIDS is possible. Now, at least, there is real acknowledgement that the focus of our prevention attentions should be primarily men. For a whole host of reasons that are no doubt linked to deep-seated ways of thinking and doing in Southern Africa that endorse male dominance and foster female vulnerability, most of the past two decades of the HIV and AIDS epidemic were spent focusing the attentions on women. Tremendous efforts and resources have gone into programmes hoping to empower women to negotiate safer sex, to insist on condom use, to increase women's self-esteem, their financial independence, their sense of self-efficacy, and more lately to enhance their abilities to care for the sick, dying and orphaned. Finally, we have come to realise that the failure to focus on men and to engage men in interventions has allowed this virus to reproduce like wildfire across the Southern African landscape.

... the failure to focus on men and to engage men in interventions has allowed this virus to reproduce like wildfire...

There is wide agreement that many of the existing interventions and initiatives need to be sustained and in some cases scaled-up (i.e., promotion of delayed sexual debut for youth, better access to condoms both male and female, voluntary testing and counselling, treatment of bacterial STIs, and the further development of microbicides and vaccines). Yet, it is clear that none of these interventions are likely to be as effective in arresting the spread of HIV as community-driven and community-monitored behavioural change efforts that address the main vectors and primary drivers of our local HIV and AIDS epidemic.

FOOTNOTES:

1. According to the UN Task Force Report on Women and Girls in Southern Africa (2004), women and girls account for 57% of people living with HIV and AIDS in the region. The impact is greatest amongst females aged 15-24 who are three to six times more likely to be infected than young men of the same age.
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Rakgadi Mohlahlane

HIV and AIDS, gender and power relations: A context of violence

More than twenty years into the HIV epidemic, an assumption can be made that generally, there is abundant knowledge about HIV and AIDS infection, transmission and prevention. However, this knowledge is undermined by the interplay of the social, economic, cultural and biological factors that create a barrier to behaviour modification. This paper looks at factors that can be said to drive the HIV and AIDS epidemic, focusing on the context of violence within which the epidemic exists in South Africa. The violence is historical, but also takes place at the level of intimate relationships, family, communities and institutions.[1]

South Africa has high infection rates which, are said to be directly linked to the many reports of violence against women in all sectors of society, including infant rape in recent years, coupled with neglect of women's sexuality. However, interventions have not necessarily focused on gender-based violence in the same way that gender inequality and oppression did not take prominence in the mainstream discourse and politics of struggle against apartheid. The emphasis was on fighting the enemy as a collective force, while the patriarchal status quo remained intact. It was also reported that as late as 1997, the issue of women, gender and AIDS was said to be invisible in the AIDS reviews at national or provincial level. Progress was made however in 1998, when national training of gender trainers was initiated.[2]

The United Nations Commission on the Status of Women defines, in Article 1, violence against women as

> *…any gender-based act which results in or is likely to result in physical, psychological or sexual harm of women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.*

Gender-based violence, which includes rape, domestic violence, mutilation, murder and sexual abuse, has been identified as a profound health problem, particularly in the age of the acute health crisis – the HIV and AIDS epidemic[3]. In South Africa, as elsewhere in the world, sexual violence *'constitutes one of the main threats to the mental and physical integrity of women and children'* [Ford, 2003].

Brief overview of violence in the 70's and 80's

In the 1980's a phenomenon called *'jackrolling'*, where especially young women were abducted, gang raped at gunpoint by young males was prevalent. This was done in public, displaying a sense of entitlement on the sexuality of girls and women.

State sanctioned violence was also common occurrence, including military strikes, which were carried out by the then apartheid government in the front line states, such as Lesotho, Botswana, Mozambique, Swaziland, Namibia (then South West Africa) and Zimbabwe. If it was not military strikes it was providing guns to militia groups in Mozambique, Namibia and Lesotho to fight against the liberation movement.

There were reports during the Truth and Reconciliation Commission (TRC) hearings that it was common practice for Special Branch Police to use the combination of physical and sexual torture on women during detention, including rape. It was interesting, however, that indeed not many men reported any experiences of rape, which could be a reflection of a hegemonic form of masculinity that expects men to be brave, strong and not show any emotions. (One could ask the question how then men deal with traumatic experiences.)

During the run up to the first democratic elections, South African townships, especially the East Rand (where some of the research was carried out) were turned into a 'war zone'. Thousands of people were killed in a conflict which was said to be between Inkatha Freedom Party (IFP) and the African National Congress (ANC), though there were contradicting reports of a third force which was funded by the apartheid government.

Violence post apartheid

After 1994, change was inevitable for all South Africans at all levels and in very different ways. There were expectations, particularly from most black South Africans, of equal opportunities and tangible changes.

A constitution, which has been hailed as one of the most progressive in the world, was put in place. Work was done to put sound policy frameworks in place, including the

Commission on Gender Equality (CGE), whose mandate is to monitor, research, protect and promote gender equality. There was a clear shift in the traditional role of women in society; women were more visible in government, in commerce and education.

Parallel to all these changes, there is an almost 50% unemployment rate, affecting mainly black males, which brought insecurities and resentment, often expressed within intimate relationships. A member of a group called Supporting Unemployed Men argued that

> *…unemployed men should not allow their women to go out and work because when we (men) are at home and the women say they are going out to work, they are simply going to sell their bodies and support their families with prostitution money, the men are in danger of being infected by their female partners.*[4]

A few observations from this statement: there is a sense of hopelessness, blaming women for spreading HIV, and also a sense of entitlement and ownership of women's sexuality. What is rather disturbing is that there is quite a large constituency of males, who think and feel the same way.

South Africa is said to be a *'rape prone society'*. Statistics indicate that:

- In 2001, 21,000 child rapes, and some 37,000 adult rapes, were reported in South Africa. According to the South African Police Service, only one in 35 rapes are actually reported.[5]

...there is a sense of hopelessness, blaming women for spreading HIV, and also a sense of entitlement and ownership of women's sexuality...

- There were 52,000 reported rapes from April 2002 to April 2003. Police estimated that perhaps one in eight assaults is actually brought to their attention. Of the people arrested for rape, 45% tested positive for HIV.
- There are reports of violence, in some cases death, directed at women who disclose their HIV positive status. In 2002, a case of a young AIDS activist Lorna Mlofana, 21, who was gang raped and killed after she disclosed her HIV positive status is poignant. The perpetrators were all young men ranging from age 14 to 21.[6]
- In 2000, 43% of rape cases brought to the attention of Child Line were committed by people under the age of 18.[7]
- In another report, a four year old girl was raped by her 14 year old cousin and his 12 year old friend. In the same report, an 8 year old boy stabbed his 10 year old brother to death; the two had an argument.[8]

In a study[9], that looked at HIV and AIDS and trauma amongst abused women, and the type of violence experienced, it was found that the women experienced violence at two levels; a *'localised'* level of intimate relationship, family and community, and a more *'structural level'* of external revictimisation within the healthcare and justice delivery system.

...unspoken *'rules'* ... around sex that ... violence is often justified as *'culture'*...

At the level of intimate relationships, the violence experienced by the women includes extreme forms of physical and emotional violence, which fits in with what (Johnson, 1995), describes as *'patriarchal terrorism'*, as opposed to common couple violence. In contrast, *'patriarchal terrorism'* tends to be perpetrated by men toward women, shows a pattern of escalation in frequency and severity over time, and includes not only physical violence, but also *'economic subordination, threats, isolation, and other control tactics'*, and *'is rooted deeply in the patriarchal traditions of the Western family'* [Johnson, 1995:284] Some of the statements of the women include:

- *'My husband came out of prison and shot me, I have bullets lodged in my body…'*
- *'My husband, who is a policeman, used to beat me up so much my son would find me in a pool of blood…'*
- *'I was gang raped by a group of unknown men who broke into our house; my husband blamed me for the incident…'*
- *'I was raped by my father's friend (I think my father knew), when I was twelve, I went to the priest to get help, he raped me repeatedly until I decided to run away from home…'*

There were also mentioning of implicit/unspoken *'rules'* and

values around sex that create another form of violence that revictimises survivors within families and communities; this form of violence is often justified as *'culture'*. These cultural dictates and traditional practices endanger both the survivor and the perpetrator, particularly within the context of HIV and AIDS. These *'rules'* and values include that:

- Socialisation into sexuality is characterised by fear or modesty, moral or religious judgment. It is considered inappropriate for women to initiate discussion around sex and express their pleasure related to sex. A woman who contradicts these *'rules'* is looked at as being *'loose'*, a *'slut'* ('letekatse', 'sefebe')[10] and as a potential carrier of sexually transmitted diseases, including HIV and AIDS.
- STI's are transmitted by women.
- Women who have abortions are dangerous as they are carriers of dirty blood that can infect men during sexual contact.
- Men are inherently knowledgeable about sex, they can initiate sex.

Related to the above points is the naming of sexual organs implying concepts of male = power and female = objects. The vagina is called *'kuku'*, *'koek'* which, when translated, means *'cake'*, obviously something that one eats. The penis is commonly known across most languages as *'induku'* or *'molamu'* and *'pipi'*. *'Induku'* or *'molamu'* refer to *'sticks'*, which are used in fighting and to inflict pain, but also representing power and authority. In the era of AIDS, one could argue that this type of language can powerfully influence male perceptions to see a penis as being powerful to a point of being immune to diseases, including HIV and AIDS.

...language can powerfully influence male perceptions to see a penis as being powerful to a point of being immune to diseases...

It is within the family and community that the women suffered a triple form of stigmatisation because of their HIV positive status, for trying to leave the abusive partner and move to a shelter, and for bringing the virus into the family.

Structural revictimisation: Justice delivery system[11]

In dealing with abuse one cannot avoid the role of the justice system, with the police being the first port of call for most women. However, many women reported that accessing justice was difficult, particularly after a traumatic experience, such as rape. In addition to the direct trauma of such a crime, a survivor must undergo the harassment that has come to be associated with the law enforcement agencies, and the medical and legal machinery in the course towards justice.[12]

...perhaps the biggest challenge on the medical fraternity is the absence of a *'cure'* for AIDS, considering a culture where prescribing medicine and providing *'cures'* for illnesses is a big part of medical practice...

Examples of police revictimisation as expressed by the women include:

- The police would encourage the women to go and resolve the problem with their abusive spouses or the in-laws (*'bo mmatsale'*).
- The police took sides with the perpetrators by asking the question: *'what did you do to the person'* (your partner, the stranger who raped you etc). This attitude often rendered the survivor a possible liar and/or devalued the person.
- Some women were told by the clerks at the Maintenance Court to go and find jobs and stop harassing their husbands/partners for money.
- Magistrates openly sided with the perpetrator by questioning the woman's credibility.
- Lack of understanding of the legal process involved in child maintenance, although there is a sound policy framework in place.

Revictimisation within the health delivery system

There is no question that the HIV and AIDS epidemic has imposed new challenges on all human institutions, particularly health

sectors, in most Sub Saharan countries. It has been widely reported that health personnel in these countries are over-stretched. Perhaps the biggest challenge on the medical fraternity is the absence of a *'cure'* for AIDS, considering a culture where prescribing medicine and providing *'cures'* for illnesses is a big part of medical practice.

In terms of sexual violence, as argued by D'Souza [1998]:

> *…the emphasis at the medical facility is on collection of forensic evidence. Scant attention is paid to the emergency and long-term medical and psycho-social needs of the woman.*

Treatment and advice for sexually transmitted diseases and pregnancy takes second place. Often these aspects of medical care are completely overlooked. The examination of survivors of alleged sexual offences is one of the most difficult tasks in forensic medicine. The danger of allowing true offences to go unpunished as well as the injustice of wrong convictions make the responsibility of the examining physician very heavy.[13]

...the context of violence does seem to paint a *'grim picture'* for gender relations ... a sense of a polarised environment of *'men as perpetrators'* and *'women as helpless victims'*...

Whether or not these factors contribute to some of the challenges in dealing with the epidemic is a question that could be interrogated and researched further. What is clear, however, is that healthcare providers (nurses, doctors) have a lot of power over patients, and for many years, the practice is that patients do not question their doctor or nurse.

Some of the experiences of the participants in dealing with the health system included:

- Isolation of women who were diagnosed with HIV in the maternity or labour wards. This approach was in many ways a forced disclosure, but most importantly it stigmatised HIV positive tested people in the hospital or clinic.
- Giving away people's HIV status to third parties without their consent, testing without counselling, as well as providing results in public and without post counselling. A poignant example was of a patient, who nearly killed herself with rat poisoning, after she was told by a health worker that *'my girl you are going to die, just know that you are going to die anytime, you're in big trouble'*.[14] This statement was supposed to be her blood test results; she said she guessed that her HIV test results were positive.
- Diagnosis without a blood test. One of the participants reported that a doctor told her that she was HIV positive without giving her a test; she had been losing a lot of weight but she did not understand why.
- Healthcare providers failing to help a rape survivor, who did not want to keep the pregnancy after the rape.

These case studies are a clear indication that *'gender-based violence is not only about interpersonal relationships but is also reinforced by laws, institutional structures, oppressive customs'* [Wood & Roche, 2001:584]. It is important for interventions, or any strategies on HIV and AIDS, to pay attention to external oppressive conditions and help deconstruct oppressive self-stories internalised by the survivor, to engage in radical listening and not see the person as a problem.[15]

Carlson (2000)[16] points out that these structures can *'thwart'* a person's coping efforts. Furthermore, the dignity and personhood of survivors of gender-based violence is taken away. Kidd et al [1998:73] argues that:

> *…even though there is no omnibus definition of personhood, there is no doubt that both the indigenous and the liberal legal forms confer upon women in a variety of situations the status of social and legal minors thereby diminishing their autonomy and capabilities as persons.*

The context of violence does seem to paint a *'grim picture'* for gender relations in South Africa. It gives a sense of a polarised environment of '*men as perpetrators'* and '*women as helpless victims'*. This position has indeed received a lot of attention in the arena of public debates on gender and received strong counter arguments pointing out, that this approach is limited for a number of reasons, including the way society defines, and links, concepts of gender, masculinity, femininity, sexuality and HIV and AIDS.[17]

Conclusion

In summary, I will raise a few questions, as well as offer a few thoughts regarding the remaining challenges.

An expanded approach should not only address gender ideologies and patterned relations, but also the structural context (barriers) versus

...rather than develop programmes that teach women to protect themselves from men, interventions should strive to work with men to understand and prevent violence...

policies or laws that affect people at high risk of infection, especially vulnerable and marginalised groups. Placing women within the HIV and AIDS crisis is important in exploring, as well as understanding, the implication of gendered power relations and how men are *'endangered'* by certain ideologies of masculinity, with regards to prevention and the spread of HIV and AIDS.

Some pertinent question in dealing with violence should include: how can societies foster identity formation that rejects violence and aggression in men; what is the roles of mothers and fathers, particularly the role of heterosexual women, in recasting male identities. Snider (1998)[18] argues in this context that both mothers and fathers, worry about their sons being *'sissies'* or *'wimps'* and subsequently may send mixed messages, when it comes to aggressive behaviour, such as bullying.

In addition, questions could be raised as to the role of communities in the occurrence and response to gender-based violence, including infant rape; as well as whether or not communities perceive violence solely as a problem of the criminal justice system, or as a problem that can also be addressed by communities.

Rather than develop programmes that teach women to protect themselves from men, interventions should strive to work with men to understand and prevent violence, and to understand masculinities as a key component in addressing gender, HIV and AIDS and unequal power relations. There is much to learn from programmes that seek to challenge and address gender roles and create more gender equitable relations, in which society's attitudes and behaviour in relation to sex is mutually respectful. Working with perpetrators would be one of the options for offering support to women, since, as one woman pointed out:

> *…we (women) have been learning about HIV since it started but no one is teaching our men, it does not help us.*

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FOOTNOTES:

1. The paper draws primarily from a study that worked with abused women in the area of Gauteng; an action research that examined the impact of a rights-based approach to HIV and AIDS at a local level.
2. See also *Agenda*; 'Counting the Costs'. 1998. Issue 39.
3. D'Souza (1998).
4. Participant at the Centre for the Study of AIDS University of Pretoria AIDS Forum Seminar, held in 2004.
5. Earl-Taylor, M. 2002. 'HIV/AIDS, the stats, the virgin cure and infant rape'. In *Science in Africa*, April 2002. www.scienceinafrica.co.za/2002/april/virgin.htm.
6. 'Aids murder suspect in court'. 12 January 2004. www.news24.com/News24/South_Africa/News.
7. Children's Institute. November 2003. *Rapid Assessment: The situation of Children in South Africa.* Children's Institute: University of Cape Town
8. *ThisDay*. February 2004.
9. Collaborative Research Project: Department of Psychology/Psychiatry and Epidemiology and Public Health at Yale University; Centre for the Study of AIDS (CSA), University of Pretoria; and People Opposing Women Abuse (POWA), an NGO that provides training and support services to women who have experienced sexual abuse and violence.
10. These are strong Sesotho terms, whose equivalent in English would be *'whore'*, but more than that the terms are stigmatising and can isolate women who are named as such from mainstream society.
11. Justice delivery system includes services provided by the police, courts and the social welfare system.
12. D'Souza (1998).
14. Focus group discussion with people living with HIV and AIDS; Centre for the Study of AIDS, University of Pretoria: A study to examine the impact of a rights-based approach to HIV and AIDS at a local level.
15. Wood & Roche (2001).
16. Carlson, B.E. 2000. Children exposed to intimate partner violence: research finding and implications for intervention. In *Trauma, Violence and Abuse*. 1(4), pp321-340.
17. For more information on emerging discourses on masculinity see Rao Gupta, G. 2002. 'Gender, sexuality and HIV/AIDS: The what, the why and the how'. Plenary Address at the XII International AIDS Conference in Durban, South Africa. 12 July.; Morell, R. 2001. *Changing men in Southern Africa.* London: Zed Books; and Ford (2003).
18. Snider, L. 1998. 'Towards Safer Societies: Punishment, masculinities and violence against women'. In *British Journal of Criminology,* 38, Winter.

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Emma Harvey

Excuses, Excuses, Excuses...

A facilitator's reflection on discrimination

Human rights in South Africa are constitutionally guaranteed and said to govern not only legislation, but behaviour too. Yet, the principles of the Constitution seem to be rarely translated into reality. This article examines some of the common *'excuses'* used to justify continuing discrimination, both broadly, and specifically in the context of HIV and AIDS.

DEFINING HUMAN RIGHTS AND DISCRIMINATION

> *Human rights are based on respect for the dignity and worth of each and every human being, both as individuals and as members of society as a whole. Human rights capture those qualities of life to which everyone is entitled, regardless of their age, gender, race, religion, nationality, or any other factor. The responsibility for making sure that rights are respected, protected and fulfilled lies primarily with the state, in the form of the national government. But it also has implications for all elements of society from the level of international institutions, through to individuals in the family and community.* [Child Rights Programming, 2005:12]

In other words, human rights are a set of values that in their most basic form set out how a person should be treated, and, treat others. And this is not merely an obligation for the national government and its representatives, but also an obligation for any individual and interpersonal behaviour. Section 9 of the Constitution[1], therefore, states that neither the state (Section 9(3)) nor a person (Section 9(4)) *may unfairly discriminate directly or indirectly against anyone*, thus, no one has the right to discriminate against another person or group of people.

It is important to note that the non-discrimination provisions are contained within the clause on equality. One interpretation of this is that equality is non-discrimination, and that non-discrimination, therefore, means treating each person with the same and/or equal respect, regardless of any differences that may exist between people. Hence, it could be argued that discrimination is treating people differently based on real and/or perceived differences, which are often based not on facts, but on judgements and/or stereotypes of these differences.

DISCRIMINATION REALITIES

Discrimination is not merely treating people differently. Discrimination manifests itself in behaviour, ranging from indirect to direct exclusion of people; in the inability to access services, because of service providers' prejudices[2]; in hate speech, as well as derogatory and exclusionary language, such as *'those AIDS people'*. And, in some cases, discrimination leads to violent behaviour.

Discrimination is also based on stereotypes and/or judgements, and it often occurs on the basis of a perceived difference, rather than a real one. Wetherall [1996:189] argues that

> *...the problem with stereotypes is their partial, biased and inadequate nature…pictures or fictions people carry in their heads which distort or muddy their perception of reality.*

An example of this would be the assumption that thin or skinny people must be infected with HIV, which may result in discrimination based on an incorrect assumption.

Discrimination is often portrayed in language and the way that various groups of people or individuals are spoken about. Van Dyk [2001:95] states:

> *While saying 'He caught AIDS', as opposed to 'He has AIDS' may mean the same thing; the first sentence is loaded with negative meanings that betray the implicit attitudes of the speaker. (Such a negative meaning may be that AIDS is something over which we (the innocent) have no control, something that we 'catch' from 'them' – the contaminated out-group.) People often say 'He is HIV' instead of 'He is HIV positive' or 'He is infected with the HI virus'. A sentence that is constructed like this implies an identity with the virus, i.e. the person is the virus, instead of the person.*

Gender-based violence and violence against people living with HIV and AIDS are only two of the examples of violence based on discrimination, some of which lead to murder.[3] The consequences of belonging to a vulnerable and/or marginalised group, who are often subjected to discrimination, can be dire. While this article focuses primarily on the context of HIV and AIDS, it is important to recognise that discrimination persists based on a variety of factors including HIV and AIDS, gender, race, age, sex, sexual orientation, class, job, status, nationality – to name but a few.

...if ... people are prepared to choose whether or not to obey certain scriptures, then it is quite possible ... to *'choose'* not to continue using religious beliefs as an excuse to discriminate...

'REASONS' FOR DISCRIMINATION

Recognising the gaps between the constitutional guarantee not to be discriminated against and the reality of persistent discrimination, there are, arguably, various questions that need to be raised. Why, in spite of constitutional guarantees, does discrimination continue to take place? Why do people treat people who are different *'unfairly'*? Why is a person who is tested positive for HIV treated differently? Why are women treated differently to men? Why are young people treated differently to older people? While the specific questions could go on, since the factors used to *'reason'* discrimination are so many and varied, there are, however, a number of responses that are common to these questions.

It is due to culture; it is due to tradition; it is part of religious practices or personal beliefs; it is due to how people are brought up; it is natural, human beings do it all the time; it is because of peer pressure; it is just the way society works – are only a few of the recurring *'reasons'*.

Most of these *'reasons'* are raised as absolute and unchanging. Culture, tradition, religion, upbringing, society, nature, and people are presented in the context of justifying discrimination as being static and unchanging. Since things always happened this way, they will continue to happen this way.

REASONS OR EXCUSES?

Culture, tradition, religion and society are not static, change happens constantly, as society adapts to its changing environment. While, for example, culture and tradition govern the way people dress, clothing, as well as the understanding of what is *'acceptable'* to wear changes constantly. Many traditions and cultures call for women to wear skirts and yet, many women are choosing to wear trousers. It is argued, that this is but one of many examples indicating that people seemingly have the tendency to pick and chose which one of the cultural and traditional practices are changeable. Thus, if it is possible for traditional or cultural practices to change, then it is also possible to *'change'* and not to use culture or traditional thoughts as excuses to discriminate against the *'other'*.

Similarly, the wide variety and ever-changing religious inter pretations and practices indicate that religion is not a static concept either, but instead a value, norm and belief system that is constantly modified as to respond to the changing environment. Once again, it can be argued, that if religious practices are open to change, and people are prepared to choose whether or not to obey certain scriptures, then it is quite possible for people to *'choose'* not to continue using religious beliefs as an excuse to discriminate.

Besides, it has to be born in mind that while the South African Constitution provides for freedom of religion, belief and opinion (Section 15), the rights to use the language and participate in the cultural life of one's choice (Section 30), and the freedom of cultural, religious and linguistic communities (Section 31), these rights and freedoms are limited, in that they may not be *exercised in a manner inconsistent with any provision of the Bill of Rights* (Section 31(2)). This means that everyone has the right to practice and enjoy the religious, cultural, linguistic and traditional values of their choice, as long as these beliefs, norms and values do not promote and/or practice discrimination. In addition, everyone has the duty to respect the various belief, norm and value systems that people may hold. Thus, the freedom to choose one's value, norm and belief system does not include the *'freedom to choose'* to exclude, marginalise and discriminate against the one who thinks differently.

Commonly, *'the way a person is brought up'* is also used as a justification for discrimination. Yet, studies show that during a person's growing up or development there are stages in which presented *'moral rules'* are questioned and deliberated on. Subsequently, people start making choices for themselves whether or not certain kinds of behaviour are acceptable.[4] Van Dyk [2001:183] argues that:

> *Once adolescents develop some capacity for principled moral reasoning, they begin to see that absolutes and rules may be questioned because such rules may be based on someone else's subjective point of view – a point of view that is open to various interpretations and (therefore) disagreement.*

Once again, what people learn as part of *'upbringing'* is subject to change, and, therefore, cannot be presented as static, and thus, as a justification for continuing discrimination.

In essence, that means that people have the capacity to decide for themselves whether or not particular kinds of behaviour are acceptable, including the capacity to decide whether or not discriminatory attitudes, beliefs and practices are acceptable. It is

***...'this is the way society works,* ... as if it absolves an individual of any responsibility to treat people equally...**

...as long as individual choices are judged and people are discriminated against ... instead of respected ... the right to equality ... cannot be realised...

within this context that even the notion of *'peer pressure'*, as a justification for discrimination, can, arguably, be invalidated and/or challenged, since people do have the capacity to decide themselves what is and what is not *'acceptable behaviour'*.

And then there is the excuse of *'human nature'* – that it is somehow *'natural'* for people to discriminate. Reynolds[5] looked at the question as to whether or not racism, as a particular form of discrimination, is natural and concluded that *'human behaviour is very obviously also a product of learning and cultural conditioning'*. The author further argued that explanations for racism, using human nature as a basis, cannot explain why racism is an issue for some groups and not others, or that it is a variable phenomenon that takes specific forms. Based on this, the author concluded that racism cannot be all 'natural' human functioning.[6] If, as is argued, racism, as a form of discrimination, is not *'natural'*, then other forms of discrimination are not *'natural'* and can similarly be defined as products of learning and cultural conditioning. Therefore, the argument that discrimination is *'natural'* seems invalid and cannot be used to continue justifying discrimination.

And finally, there is the argument that *'this is the way society works, discrimination happens all the time'*. Especially in the context of South Africa, where *'the way society worked'* for decades was based on institutionalised discrimination, such an argument becomes very questionable. If, for example, services, such as healthcare, are to be delivered to one group of people faster than to another, many would argue that 'society cannot work this way', since services need to be delivered equitably, with no discrimination. Yet, when asked to come up with a *'reason'* why discrimination occurs, the issue of society is raised, as if it absolves an individual of any responsibility to treat people equally. Once again, the Constitution demands that the duty to promote, protect and respect equality and non-discrimination is not only an obligation of the state, but also a constitutional obligation for each and every individual.

The above clearly indicates that the *'reasons'* provided as to why discrimination occurs, become *'excuses'* justifying the very same continuation of discriminatory attitudes, beliefs and practices. In addition, people using the above raised arguments often fail to take into account that within the constitutional and legislative framework of South Africa the principles of equality, non-discrimination and human dignity are clearly laid out, and, thus, unfair discrimination is unconstitutional and against the law.

THE ALTERNATIVE

As long as people hold on to *'excuses'* to justify discriminating against the *'other'*, the violation of fundamental rights and freedoms will continue. Similarly, as long as discrimination based on, and in the context of, HIV and AIDS persists, the access to services, including prevention, treatment, support and care, will remain limited in accordance with the prevailing *'excuses'*. Thus, as long as individual choices are judged and people are discriminated against based on their choice, instead of respected, no matter what their choice, the right to equality and non-discrimination will not, and cannot, be realised.

In essence, what would create a society in which equality and non-discrimination are a reality, is a society based on a *'culture of human rights'*; a society, in which the dignity of each person is promoted, respected and protected; a society in which people's differences and choices are treated with respect. This is not as alien as some may see it, since

> *...the international system of human rights encompasses values that can be found in all cultures and all religious, moral and ethical traditions.*

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FOOTNOTES:

1. The Constitution of South Africa, Act 108 of 1996.
2. See 'Disclosure' on http://www.dayzero.co.za/steps/info/info_disclosure.htm.
3. The AIDS Law Project website highlights three major cases where discrimination based on a persons HIV positive status resulted in murder. 'Why are people with HIV or AIDS victimised?', AIDS Law Project. http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sic=19. See also Isaack, W. 2004. Crimes of hate and prejudice against black lesbians'. In *ALQ*. November 2004 Edition, pp14-16.
4. van Dyk, 2001:163.
5. Cited in Wetherall, 1996:187.
6. Wetherall, 1996:187.
7. Child Rights Programming, 2005:2.

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Barbara Kenyon

Factors fuelling the pandemics – Experiences from Nelspruit, Mpumalanga

HIV and AIDS and domestic and sexual violence are concurrently fuelling, and feeding into, each other. Statistics indicate that South Africa has one of the highest rates of reported domestic violence, femicide and sexual abuse in the world. South Africa also has one of the highest numbers of people living with HIV and AIDS[1]. It is, arguably, one of the dichotomies of South Africa to have, despite all its available resources and infrastructure, as compared to other African nations, the highest statistics in both of the pandemics, sexual violence and HIV and AIDS.

Sadly, these are also the two areas which show the least amount of strong leadership by the South African government. These two areas do not have adequate legislation in place – while the Domestic Violence Act lacks adequate implementation, sexual offences lack adequate legislation. These two areas also have no voice of unison from the political, religious and/or traditional leadership of the country. The Constitution[2], providing for the right to equality and the right not to be discriminated against (Section 9), the right to have one's dignity protected and respected (Section 10), and the right to be free from all forms of violence (Section 12), appears to have little or no impact on the lived realities of most South Africans. This is largely due to the persistent patriarchal norms prevailing in society.

The recent trial of Jacob Zuma is but one of the examples highlighting the challenges, as well as the attitudes towards HIV and AIDS and sexual violence. This case not only highlighted a sample opinion of one of the political leaders on issues of HIV and sexual violence, but also seemed to have strengthened, once again, the notion that the *'word of a man'* is taken over and above the *'word of a woman'*, as well as the notion that the prior sexual history of a woman seems to *'explain'* whether or not the alleged rape took place.

SEXUAL ASSAULT REALITIES: THE GRIP EXPERIENCE

GRIP, an organisation based in Nelspruit, Mpumalanga, is an intervention programme aimed at empowering survivors of trauma and abuse. Prior to 2002, GRIP faced three court cases. The charges were based on the fact that GRIP subsidised and paid for each survivor of sexual assault to access Post-Exposure Prophylaxis (PEP), in an attempt to prevent the transmission of HIV for survivors of sexual assault. Years later, there are still areas in South Africa, where the access to PEP to survivors of sexual assault remains limited.

The increase in children being orphaned or left vulnerable, due to the HIV and AIDS related deaths of parents and caregivers, also impacts on the growing incidences of sexual assault perpetrated against children, as well as on the transference of HIV. This is further exacerbated by the fact that children are more likely to report sexual assault only after the window period for accessing PEP (72 hours) has expired, which is often due to intimidation and the lack of family safety nets. In cases of incest, there is the additional challenge of *'sorting it out'* within the family – by payment of a *'bride price'* – especially, when the perpetrator is also the *'bread winner'.*

The myth that *'cleansing one's blood, by having sex with a virgin/child'* is not an African myth, but actually originated in Scotland, and has been evident with very large scale pandemics over the centuries. In the late 19th Century, it was a common practice that a man could be acquitted of sexual assault, if he proved it was for medicinal reasons. This myth, now said to be *'African'*, is, not surprisingly, predominantly found in areas, in which access to basic resources are limited.

Even though the impact of this myth is hard to prove, or to disprove, GRIP has become aware of a pattern of factors which leads us to suspect that the myth of 'cleansing the blood through virgin sex' does indeed impact on the occurrence of sexual violence. These factors include the perpetrator's relationship, both biological and through relationship of power, to the child; the age of the perpetrator; and the type of access the perpetrator has to the child. These occurrences of sexual assault usually get reported post the window period of accessing PEP and often the child has been sexually violated over a period of time – thus, the increase in children presenting HIV for the baseline HIV test, which is administered when reporting sexual assault.

GRIP has also seen a shift in that the perpetrators becoming younger and younger in age, while concurrently the survivors also becoming younger and younger in age. Some juvenile sexual assault offenders say that they have sex with younger children to *'practice'* for their girlfriends. Some of the offenders are survivors of sexual assault themselves, and some commit sexual assault as a *'revenge'* for being *'dumped'* by their girlfriend. Thus, sexual assault fuels the HIV and AIDS pandemic amongst younger age groups.

Over the past six years, GRIP statistics have shown children between the ages of 11 and 15 years of age to be the highest group of people reporting sexual assault. One of the possible aftermaths for a child, who is raped at this age, is the possibility of becoming sexually promiscuous, due to post rape stress syndrome, which, of course, greatly impacts on the risk of HIV transmission. GRIP statistics further indicate that while in 2001, 59% of sexual assault survivors in the reported cases were children below the age of 18 years, the number of child survivors of sexual assault increased to 60% in 2005.

GRIP has observed a 60% reduction in adult survivors of sexual assault presenting a positive HIV test result at the baseline test from 2001 to 2005. This is encouraging and may also be indicative that HIV prevention messages are impacting on the adult population. However, disconcerting is the simultaneous increase in children presenting baseline HIV positive test results when reporting sexual assault, which has increased by 24% during the same time.

Of all people raped, 25%, or one in four people, will be a child between the ages of 11 and 15 years. This is the same time when a child's body is developing physically and when self esteem and world view is established. To destroy the very being of a healthy body image, especially at this age will have consequences for the rest of their lives.

In an effort to prevent abuse of women and children, GRIP has implemented a three year programme focussing on the boy child to encourage gender sensitivity. In most areas, the programme was successful in that it created some change. However, boy children's understanding of HIV and AIDS, and its consequences, still seemed to be a *'foreign'* concept. Generally, boy children still seemed to question the existence of HIV and AIDS and to not believe that they are at risk of HIV infection. What was also startling to find out is that the boy children often said that it is the *'girlfriend'* who resists using a condom. Furthermore, most of the boy children portrayed the attitude that a 'no' generally means a 'yes', because the girl is trying to play *'hard to get'* and/or is too shy to admit that she wants to have sex.

Consensual sexual coercion is also very evident amongst the *'brand conscience'* youth. This is not

necessarily only due to economic factors. Girl children will 'consent' to have sexual relations with older men – for the *'status'* and *'gifts'* that the man can provide – without demanding the use of condoms. It is argued that even though these sexual relations often qualify as statutory rape, the law, once again, is not applied consistently. A recent trial of a soccer *'star'*, who had a sexual relationship with a minor child and who was acquitted of all charges is but one of the examples of statute failing to protect the *'victim'*. In addition, there is an increase in the phenomenon of *'Taxi Queens'*, usually minor girl children, who *'consent'* to sex in exchange for *'goods'* – without the use of condoms. Too often, these incidences are discounted as sexual assault, since it is seen as an economic transaction.

THE 'DOUBLE-EDGED SWORD'

Women, in the reproductive cycle of their lives, visit the clinics for check-ups during pregnancy and many women choose to be tested for HIV. As a result, women know their HIV status before their partners do. This often leads to a situation, in which women are blamed for the transference of HIV, as well as to violence and abuse by their partners and/or family members. It is then that women are seemingly presented with the *'double-edged sword'* of '*to know or not to know'*.

It is a common perception in communities that the person, who first tests positive for HIV, is the person responsible for the transference of HIV, irrespective of the initial transference, and more often than not, it is the woman who is blamed. This perception not only fuels domestic violence incidences, but also impacts negatively on the extent to which 'infant' PEP is accessed. Similarly, the perception that women who live with HIV choose bottle feeding over breastfeeding, as well as the attached stigma towards women who do not breastfeed their children, often further limits women's choices. Thus, women are often not in the position to make an informed choice, due to prevailing beliefs and perception, as well as the subsequent stigma and discrimination.

CONCLUSION

For GRIP it seems apparent that HIV prevention messages based on the ABC (Abstain, Be Faithful, Condomise) approach, including LoveLife messages, have no real impact on the realities of HIV and AIDS. In addition, it seems that current HIV prevention messages do not, and cannot, adequately de-mystify and/or respond to prevailing myths and beliefs which further the occurrence of sexual assault and, thus, the transference of HIV.

And while GRIP, by no means, claims to have found the answers as to how to provide the necessary information and services for people to make the much needed *'different'* choices and decisions, we will continue to respond to the escalating pandemics of sexual assault and HIV and AIDS.

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Laurie Abler, Gad Kilonzo, Jessie Mbwambo

Community-based VCT research in rural Tanzania

Introduction to Project Afiki (Accept)

Voluntary counselling and testing (VCT) is at the forefront of both prevention and treatment of the HIV epidemic in sub-Saharan Africa and is becoming more available throughout many regions in these countries. Uptake of testing services is increasingly important with the ongoing boost to anti-retroviral therapy (ART) access in many countries throughout the continent. Individuals worldwide have the right to choose to know their HIV status and knowing one's HIV status is necessary to open the way to prevention and ART treatment. Studies have been done to show the benefit of VCT access for individuals in regards to accessing ART, reducing sexual risk behaviour, and increasing disclosure, but little research has been done to show the impact of providing VCT services to communities.

With study sites in Thailand, Zimbabwe, South Africa, and Tanzania, Project Accept is a research project that aims to use evidence-based results to determine the effects of a community-level VCT intervention, building on previous research showing the efficacy of the provision of VCT at the individual level. Reliance on the individual to foment behaviour change is nearly impossible without a concomitant change in the social norms of the community in which the person lives. The design of the study's intervention aims to avoid the pitfalls of an individual level approach to VCT provision – namely that VCT and knowledge of one's status is not normative in communities, that there is stigma attached to HIV and, thus, to HIV testing, and that little support is available to help people deal with the implications of their test result, whether positive or negative. (At this point in time, this study is not equipped to provide or to assess the impact of ART access on these factors.) The assumption that approaches aimed solely at the individual are ultimately less effective lies at the foundation of this community-based VCT intervention and inform the theoretical design of the study's intervention components.

Instead of using a medical intervention – such as anti-retroviral therapy, circumcision or a vaccine – Project Accept will measure a behavioural/social science intervention on HIV incidence, as well as on behavioural and cost effectiveness outcomes. More explicitly, the three objectives of the study are to:

- 1) test the hypothesis that communities receiving 2.5 years of community-based VCT (CBVCT), relative to communities receiving 2.5 years of standard VCT (SVCT), will have significantly lower prevalence of recent HIV infection;
- 2) test the hypothesis that CBVCT communities, relative to SVCT communities, will at the end of the intervention period report significantly less HIV risk behaviour, higher rates of HIV testing, more favourable social norms regarding HIV testing, more frequent discussions about HIV, more frequent disclosure of HIV status, less HIV-related stigma, and fewer HIV-related life events;
- 3) assess whether CBVCT is cost-effective compared to SVCT, in terms of cost per HIV infection averted and disability-adjusted life years.

In terms of implementing the research intervention, what does this mean practically? Whereas typically access to VCT services is in a stationary structure like a clinic – hereafter referred to as *'Standard VCT'* or SVCT – this study aims to look at the effect of bringing HIV testing services into communities by providing free mobile VCT services. Not only does Project Accept provide mobile VCT services, it also works to mobilise communities around accessing VCT services, as well as providing post-test support services.

This combination of mobile VCT, community mobilisation and post-test support services comprise the intervention, hereafter referred to as *'Community-based VCT'* or CBVCT. Project Accept is a Phase III community-randomised control trial, in which the effects of CBVCT provision are compared to SVCT provision; half of the communities in which we work receive CBVCT services, while the other half receive SVCT services for the sake of research comparison.

Description of the study community: Kisarawe, Tanzania

Project Accept works in Tanzania under the local Swahili translation of its name, Project Afiki, a name decided on in partnership with the communities in which the research takes place. These rural, impoverished communities in the Kisarawe district are located from 50 to 150 km away from Dar es Salaam, the largest city in Tanzania. There are approximately 60,000 inhabitants in the communities in Kisarawe in which the study runs, ranging in size from approximately 3500 to 7000 people. The people predominantly live off subsistence level agriculture and/or rely on employed family members in Dar es Salaam to send money back to the rural home. By road, access to Kisarawe is quite remote, but a major transit route – the Trans-Africa railroad heading from Dar es Salaam to Zambia – runs through the centre of Kisarawe.

Ten communities throughout Kisarawe have been selected for the purpose of conducting the research. The leadership in each of the communities have agreed to work with us and have welcomed us into their community. These ten communities were then matched into pairs based on common features, such as population size, access to health and social services, HIV risk behaviours, and social network profiles. Of the five pairs of communities, one of each pair was randomised to receive SVCT, while the other was randomised to receive CBVCT. Prior to the arrival of Project Afiki, VCT services were only available in one Kisarawe location at the district hospital and were typified by a short supply of test kits and testing mainly limited to antenatal women. The district hospital lies on the north border of the district and is quite a long distance away from the majority of the district's residents and access poses quite a considerable financial cost to pay for transport. Regardless of the randomisation results, all communities stand to gain from the additional VCT services that Project Afiki brings.

SVCT facilities are permanently attached to the existing health dispensary in each of the SVCT communities; people must travel to their local health dispensary, a distance ranging from 0 – 7 km. CBVCT is provided in mobile tents that move to each of the sub-villages in the CBVCT communities; testing is brought to the people. In addition to the mobile tents, post-test support services are provided in the CBVCT communities, with a focus on coping-effectiveness training, stigma reduction training, and income generating skills, as well as information sessions for people who are interested in learning more about VCT and referral to other organisations for additional help. CBVCT communities are also actively mobilised to test through community meetings, staff and volunteer door-to-door household visits, and distribution of Information Education and Communication (IEC) materials.

Challenges and considerations of conducting research in Kisarawe[1]

The project in Kisarawe has two and a half years to accomplish a difficult, but not impossible, task, mainly to facilitate changing social norms and behaviours in order to affect HIV infection rates. For the most part, in order for Project Afiki to be as effective as possible, it must be welcomed and respected by the Kisarawe communities, which previously have not been exposed to research studies. The necessary trust to accomplish this has been developed together slowly, and not without setbacks, and there is the need for clarifications between the researchers and the community members. Conducting a pilot study was immensely helpful in elucidating some of the potential trouble spots.

Lessons from the Pilot Study

During the pilot study which was conducted in preparation for the actual research study, mobile VCT services were provided in a similar community just outside of Kisarawe for a period of approximately three months.

Post-test support services were beyond the scope of activities that were offered as part of the pilot. A self-selected group of 300 people voluntarily received testing and counselling during the pilot activities, of which 7.7% tested HIV positive.[2]

Concurrent with the pilot CBVCT activities, community meetings were held in which project staff were informed by various people that the community must be free from HIV. This belief arose and spread in the community because people expected Afiki testers to disclose. Everybody who disclosed said that they tested HIV negative. It is not known whether people who tested HIV positive refrained from disclosing their status at all and remained completely silent, or if they said that they had tested HIV negative instead, for fear of the stigma attached to a positive disclosure. This created the belief in the community that it was free from HIV as rumours spread about all the people who tested HIV negative. The pilot staff and volunteers worked hard to dispel this myth while simultaneously maintaining and fostering respect for testing confidentiality, reinforcing the presence of people living with HIV and AIDS or the existence of HIV in the community, and ensuring people that the project was providing high quality VCT services which informed people of their correct HIV status.

Another challenge that emerged out of the meetings during the pilot activities was community leaders' request that Project Afiki disclose to them all the people who had tested HIV positive, in direct opposition to the confidential nature of the services the project provides. The leadership wanted to know all the people who had tested HIV positive so that they could warn the other people in the community to avoid people living with HIV and AIDS, a highly stigmatising attitude. The desire of the community leadership to publicly identify all the people living with HIV and AIDS who had tested is quite reactionary and would constitute a basic violation of people's rights, but is also understandable in a community going through the process of first dealing with the implications of accepting that people are tested HIV positive without the adequate information to comprehend what this means. The initial fear and misunderstanding of HIV was pervasive, which begat stigma, often stemming from misinformation about the true nature of the virus. Making public judgments about the village leaderships' request at this point in time would not have been helpful for Project Afiki; instead it would have distanced the project from the village leadership and compromised the project's ability to work effectively in the community. Pilot staff worked hard to liaise with the village leaders in order to work through this attitude, by reinforcing the implications of Project Afiki's confidential testing policy, assuaging the fear of people living with HIV and AIDS that their status would never be disclosed by an Afiki staff member, and providing the community with more information about HIV, how it is transmitted, and positive living with HIV.

In regards to both of these challenges, valuable lessons were learned which were then applied to the community preparedness activities prior to the launch of the intervention and ongoing in the community mobilisation activities in the Kisarawe communities, where the actual research study is taking place.

Other considerations for working in Kisarawe

A number of other factors are involved in conducting the VCT research project in Kisarawe, some of which built directly into the study design. With any sort of implementation of a community-based research project, community input is essential. Community here is defined as the collection of study villages that comprise the area of Kisarawe in which we work. To this end, the project needs a number of different community members to work in various capacities with the project. Three levels of formal community involvement help ensure the success of the project and have been essential in helping to build trust and gain entry into the communities. Also, all the members of the following bodies are encouraged to test for HIV. The first body is the Community Working Groups (CWGs) whose role on the study is to give community-level feedback in regards to testing locations and any other aspect of service provision. CWGs help inform Project Afiki about issues in both SVCT and

CBVCT communities, and each community has its own CWG to address issues specific to the community. The second body is the Community-based Outreach Volunteers (CBOVs) who are responsible for helping to mobilise the communities to test for HIV, by providing condoms, IEC, and advertising the CBVCT services. Since they play such a direct role in community mobilisation, CBOVs only work in CBVCT communities. The third body is the District Advisory Council (DAC), which works to provide the project with district level feedback regarding the conduct of the study. Representatives are gathered from each of the ten communities in which the project works and are comprised of a mixture of elected political leadership, people living with HIV and AIDS, youth representatives, and faith-based representatives.

In addition to needing the help from these community-based bodies to adequately liaise with the study communities, Project Afiki aimed to try to recruit and hire a number of people from Kisarawe to work as staff members. Unfortunately, it has been difficult to find qualified people in Kisarawe due to the high education level requirements – a secondary or tertiary degree – for the majority of the project's positions. Many people from Kisarawe who fulfil this requirement have already moved to an urban area to pursue economic activity there. Most of the staff come from Dar es Salaam and only a few from Kisarawe, mostly to fill positions having little or no education requirement. Though, in terms of confidentiality and community level trust in the project's VCT services, having non-Kisarawe staff has proven helpful in that they are seen by the community at being more able to maintain testers' confidentiality. Many people have indicated that they like services provided by Afiki, because of this assurance of confidentiality and maintenance of clients' anonymity.

Affecting client's motivations and barriers to test

Since the launch of VCT services two months ago in March 2006, approximately 800 people have tested at CBVCT sites and 300 at SVCT sites. The study team has been overwhelmed by the large number of villagers who have turned out to be tested and we sometimes have to tell people to return another time when the counsellors can handle the demand. This was especially true when the project first started offering services, but uptake has curtailed recently. Physical proximity to testing facilities alone is not enough to change social norms and convince more people to test. Bringing CBVCT services to the communities in which people live is just the start. Attention must be paid to special, sensitive provisions in terms of the community mobilisation and operations of the VCT tents in order to maximise the accessibility of VCT.

Client-centred approaches to VCT provision

On a most basic level, VCT services are offered using a client-centred approach and adhere to ethical standards. Since it is a research study, informed consent is given to each client accessing services in which the procedures of VCT are explained; the potential risks, discomforts and benefits of participation; and contact details to find study staff if it is necessary to get more information. This study was reviewed and approved by the Institutional Review Boards at Muhimbili University College of Health Sciences and the Tanzanian National Institute of Medical Research, as well as the Committee on Human Research at John Hopkins School of Public Health. The ethical clearance that the project has received from these Institutional Review Boards only allows for informed consent to be given to people who are aged 16 or older, and thus, our intervention services can only be offered to people aged 16 or older. The project collects basic data about gender, age, services received, and test results for each of the clients who come to access SVCT or CBVCT services, but can not be linked back to the client.

In addition to providing confidential services, the project also aims to make the process of testing as accessible as possible. The project uses rapid testing procedures that provide a client with her or his results the same day of testing. Both pre- and post-test counselling are given to the client and uses the client-centred HIV counselling approach,

in which the nurse counsellor guides the client to develop a personal risk reduction plan, instead of focusing on the test results and/or judging the behaviour of the client. Though the exact reason is not clear yet, a number of people like to test in a CBVCT venue which is not in their direct community. To that end, Project Afiki provides VCT services to anyone who accesses the testing tents, regardless of their community of origin.

Gender sensitive approaches to VCT provision

Any HIV intervention hoping to affect community change must actively take gender issues into consideration. Considering the different gender dynamics in all the different Project Accept study countries, each site must actively determine how to be gender sensitive within their particular cultural context, while some gender issues are operationalised study-wide. High quality couples counselling and testing is one such study-wide provision that helps create open disclosure between partners who come together and test. In the Tanzanian context, this means that each member of the partnership is consented and agrees individually to participate in the VCT and that pre- and post-test counselling, following the risk-reduction model, is conducted individually first for each member of the partnership, and if they both agree then they are brought together to be counselled and share their results if they desire. The same model holds true for polygamous families who access counselling together. Each member is individually consented, pre-test counselled, tested and post-test counselled. Members of the polygamous partnership are counselled and share their results together only if they all agreed. Often we have seen that one member of a partnership will come and test, go home and disclose her/his results with the partner, and then return to Project Afiki to test together again with the partner. Promoting couples counselling is especially important for women; it helps to alleviate the blame that is often put on the woman for being the partner responsible for bringing HIV into the relationship, evidence of which we found while conducting in-depth qualitative interviews with women and men in the communities.

Site-specific adaptations relevant to gender issues at the Tanzanian site have also been implemented. Men typically act as the public face and voice of the community and represent the communities' wishes to the project in the community preparedness and community mobilisation meetings. The project staff actively recruit women to attend these meetings and also hold meetings in venues and forums acceptable to women, so as to increase their attendance. They also reinforce with the men in the community the importance of women's active presence in the meetings and work to maintain a meeting environment that coordinates the participation of both women and men in informing the project. Not only does Project Afiki actively work to hear women's voices in community meetings, women are heavily recruited and encouraged to participate in the various community bodies that work together with the study. Of the 14 first-wave CBOVs that have been trained, five are female. Of the 200 CWGs, 59 are women. There are 13 females out of 43 representatives on the DAC which is chaired by the District Commissioner, who is currently a female.

After two and a half months of providing services in the field, it has quickly become apparent that women in Kisarawe have much greater barriers to accessing VCT services than men. Preliminary figures from VCT uptake show this. Of the approximately 1100 people that have tested at both CBVCT and SVCT venues thus far, overall only 36% have been women. When these numbers are broken down between the two testing venues, 32% of testers at CBVCT venues and 45% of testers at SVCT venues are women. Failure to equally avail VCT services to women is problematic, especially considering the low uptake of testing in venues which are brought directly to the communities and are easily (physically) accessible to the women in the communities. Yet other barriers exist for women to access the VCT services, especially in CBVCT venues. It is socially normative for women to leave their homes to visit the health dispensaries where the SVCT services are located. Here, women access antenatal services while they are pregnant and bring in sick children for care. While women are already there, it is easy to get counselling and HIV testing at the same time, while taking care of their other

health needs in a socially acceptable manner. Women do not have as readily an acceptable excuse to visit a CBVCT venue outside of admitting the desire to test, which in Kisarawe may be seen as admitting culpability for HIV risk behaviour.

On some level, Project Afiki is taking a *'wait and see'* approach to increase the number of women who access VCT services, relying on the theory of the intervention that invokes change agents and diffusion of innovation to create a critical mass of people who have tested which affects the community testing norms and the likelihood that non-testers will come forward and test. Alone, it will not be enough for Project Afiki to just wait for the numbers of women testing to increase. The purpose of the community mobilisation component of the study is to mobilise all facets of the community aged 16 and above to come and test. Concerted effort by all project stakeholders must be made to identify and then discourage other factors deterring women from accessing VCT services. This involves not only identifying and dismantling barriers to accessing VCT for women, but also barriers for women to cope with their test result. And outside of the project identifying the problem of gender disparity amongst testing rates, it will ultimately be up to the Kisarawe community itself to take ownership of ways to decrease HIV-related stigma and increase the likelihood that women test. More active engagement with the CBOVs, CWGs and DAC are needed to develop culturally sensitive mechanisms to increase the number of women who test in a way that does not further increase the HIV-related stigma against women in Kisarawe.

What next?

The way the study is designed – with elements of mobile testing, community mobilisation and post-test support services – it aims to reduce the levels of stigma in regards to testing and HIV status with the hope of ultimately affecting infection rates. At this point in time, mobile VCT and community mobilisation services have only been provided for two and a half months, which is a little premature to assess the effects on the social norms in the community. Also, post-test support services will only be rolled out in the next few weeks, so up to this point in time, people who have tested do not have a supportive, semi-public forum in which they can start coping with their test result, be it positive or negative. Once all three components of the intervention are running in the community, it is expected that the predicted changes in social norms affecting stigma will begin to occur.

Project Afiki VCT activities will continue in the SVCT and CBVCT communities through September 2008, at which point all intervention activities will be curtailed for the duration of survey research conducted to measure the research outcomes – the impact of providing VCT services in these communities. After this break in service provision, to afford the opportunity of all the people in our study communities' convenient access to VCT services, CBVCT services – including mobile testing, post-test support services and community mobilisation – will be offered to the previously designated SVCT communities for a duration of six months.

Eventually, policy change – i.e. large-scale uptake of the CBVCT model – needs to be guided by research showing the efficacy of results. Assuming that the hypothesis holds and CBVCT is proved to be more efficacious and cost effective than SVCT, district and national level buy-in is necessary to hand-over the provision of CBVCT services with little to no disruption. The foundation with district and national stakeholders has already begun in regards to creating a district level and a national level community advisory board that have input into the conduct of the study. The on-going relationship with these stakeholders must be continued to hear their input on the study and to ensure an easy hand-over of CBVCT services once the study is finished.

FOOTNOTES:

1. The purpose is to explore some of the actualities and logistics of providing VCT services sensitive to the Kisarawe community members while adhering to a research protocol standardised for implementation across five international study sites.
2. The 2004-2005 Tanzania Ministry of Health data estimates that the HIV prevalence in Kisarawe is 11%.

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making a point

Shawn Hattingh[1]

Workplace approaches to HIV and AIDS: Enabling fair labour practices?

The Constitution[2] of South Africa guarantees everyone the right to equality and non-discrimination (Section 9), the right to dignity (Section 10) and the right to privacy (Section 14). The Constitution also guarantees the right to fair labour practices (Section 23). The Labour Relations Act (No 66 of 1995), the Basic Conditions of Employment Act (No 75 of 1997), and the Employment Equity Act (No 55 of 1998) specifically aim to translate these constitutional provisions into a reality within the workplace in order to ensure fair labour practices for all. Along with the NEDLAC Code of Good Practice on Key Aspects of HIV/AIDS and Employment (2000), this legislation should, theoretically, provide protection to people living with HIV and AIDS in the workplace. However, the question has to be raised as to whether or not this legislation really enables fair labour practices, dignity and non-discrimination within the workplace.

WORKPLACE REALITIES AND RESPONSES TO HIV

The reality is that stigma and discrimination against people living with, and/or perceived to be living with, HIV and AIDS, remains rife within society, including in many workplaces. In fact, a number of studies[3] have demonstrated that HIV is still shrouded in stigma in many workplaces. One study[4], conducted amongst 383 companies, found that approximately 30% of workers and managers in these companies believed that people living with HIV should not be allowed to work, while more than 40% believed that HIV and AIDS was a punishment for immoral behaviour.

Such stigma continues to result in many people who live, and/or are perceived to live with HIV, being subjected to various forms of discrimination from both co-workers and managers. At times, this takes the form of subtle and even overt verbal abuse from both supervisors and co-workers. In companies, where such practices take place, workers living with, and/or perceived to be living with HIV, often face social isolation and an intolerable working environment. In fact, Esu-Williams [2004:9] reported that over 65% of workers interviewed feared that they would be completely socially isolated in their work environment, if they were perceived to be infected with HIV.

Despite provisions in the Employment Equity Act some companies still preclude promoting people on the basis of their HIV status, gender and/or race. This is often done in a subtle manner and, thus, difficult for workers to prove. Power relations within companies mean that employees that have been subjected to such discrimination will rarely take action, largely due to the fear of further victimisation; the fear of losing one's job; as well as the fact that workers are often unaware of their rights.

In reality, workers are still dismissed, because of their actual and/or perceived HIV status, despite

legislation prohibiting discrimination.[5] Versteeg [2004:15], in a study conducted amongst companies and business chambers, found that employers still believe that companies could use various means to essentially dismiss people living with HIV, without getting penalised. Indeed, some employers subject workers living with, and/or perceived to be living with HIV, to unbearable treatment in a bid to force the worker to resign.[6] In this way, employers hope to avoid the legal ramifications of openly firing someone because of their HIV status. Despite legal recourse, many employees, who have been pushed into resigning, select not to take any action. This is due to various reasons: some workers are unaware of their rights[7]; many workers, who are not union members, cannot afford legal advice or a lawyer; some workers select not to go to the CCMA, because, in the case of *'constructive dismissal'*, the burden of proof lies with the worker; some workers are fearful of facing up to someone they believe is powerful; and some workers, because of the experience of being discriminated against, might not even wish to disclose any aspect of their HIV status any further.

In fact, it could be argued that, despite private sector's claim to the contrary, it is still relatively easy to dismiss employees in South Africa – since, in the case of someone, who is ill due to HIV, or any other chronic illness, all that a company has to do is to prove incapacity on the grounds of health. And this can be done quite easy, if the person misses more than 12 days of work a year, and the company has made a token attempt to *'accommodate'* the worker in another position.

In addition, confidentiality around medical information is problematic in some workplaces. Research has revealed that there have been instances, in which supervisors, senior managers and medical aids break the confidentially of workers. Versteeg [2004:15] reported that in one of the companies surveyed, supervisors revealed the identification of workers living with HIV, without their consent. Although, these may be relatively isolated instances in large companies, amongst the most vulnerable workers, such as domestic workers, breaches of medical confidentiality, and even forced HIV testing, are relatively common.[8]

Many employees also fear that confidentiality around their HIV status would be violated, if they were to become involved in HIV programmes or to access voluntary counselling and testing (VCT) services, made available directly by their employers.[9] It could be argued that the low level uptake of many workplace HIV programmes is indicative of the fear of stigma, discrimination and the violation of confidentiality that exists.[10]

Some companies, however, do have a relatively high uptake of VCT by employees. In fact, it has been reported that some companies even regularly schedule VCT sessions for employees.[11] The question is, under such circumstances, how voluntary is VCT? In name it might be voluntary, but many workers would test, essentially against their will, if employers placed pressure on the worker to do so, due to unequal power relations in workplaces, and the fear of the repercussions of refusing the *'suggestion'* to get tested for HIV by someone in a position of power. In such cases, workers' right to security of person and the freedom of choice may be completely violated.

It has been reported that in 2005, approximately a third of large companies are offering ARVs to their employees.[12] The problem is that often ARVs have to be directly accessed through the company, or a clinic affiliated to the company. This means that a person wishing to access ARVs, offered by an employer, might have to disclose their HIV status in order to do so. Hence, some workers essentially have to forego aspects of their right to confidentiality to gain access to treatment. The

reality is that most workplace environments are not conducive to people disclosing their HIV status. Added to this, many workers fear that if their employer knew they are ill, even with a minor illness, they will be retrenched or forced to resign. Part of this fear stems from the reality that over the last 15 years companies have been downsizing their workforces. In such cases, it is often new workers, or workers that are perceived as having weaknesses – including older employees or employees with chronic illnesses – who are the first to be retrenched.

The above clearly indicates that stigma, discrimination and fear of the violation of confidentiality are major concerns in the workplace. Indeed, it seems that the legislation and Codes of Good Practice are filtering into far too few workplaces. Hence, it seems that the majority of workplace approaches to HIV are not creating an environment in which equality, non-discrimination, dignity, and fair labour practices are guaranteed. The question now becomes: Why have workplace responses to HIV not created an environment enabling fair labour practices and an adequate response to stigma, discrimination and issues around confidentiality?

REASONS WHY WORKPLACE RESPONSES TO HIV, IN MOST CASES, HAVE NOT LED TO FAIR LABOUR PRACTICES

Although, private sectors' response to HIV and AIDS has historically been slow, recently, within the last five years, large businesses have, to a greater or lesser extent, started offering a response.[13] In 2005, 90% of large companies have HIV policies in place.[14] However, large companies only form a fraction of the employer community in South Africa. Most employers take the form of small and medium sized enterprises. Unfortunately, only 19% of these smaller companies even have HIV policies in place. This means that the vast majority of workplaces do not have any response to HIV. In such an environment, it is not surprising that discrimination and unfair labour practices towards people living with HIV and AIDS continue. Indeed, it is the most vulnerable workers, who are usually employed by small companies or in the domestic service sector, that are mostly subjected to discriminatory practices. Added to this, more and more established companies are also using brokered labour or casual labour in an attempt to circumvent labour legislation. As a result, workers are subjected to extreme exploitation, receive no medical benefits and are not covered by a company's policies, including HIV policies, because, legally, they are employed by a broker and not the company.

The fact that most large companies and some of the smaller companies have HIV policies does not, however, mean that all of these policies are *'quality'* and/or *'real'* policies. It has been found that many companies simply *'borrow'* HIV policies directly from other companies.[15] Thus, many companies simply have generic policies that have not been developed for the specific dynamics of a particular company. Added to this, many of the policies do not take workers' human rights into account, and far too many of the policies have been developed solely by management, without consulting trade union representatives or workers.[16] In such cases, it seems that managers often disregard the opinions and possible inputs of their employees. This is, arguably, symptomatic of the power relations that exist between employers and workers, and the disregard that many employers have for workers as people. This results in employees feeling that they have no ownership of these policies. Indeed, it has been shown that where top-down approaches are favoured, very few workers will even be aware that an HIV policy exists; let alone what is in it.[17] Many of the policies seem to be nothing more than

pieces of paper that are never implemented and therefore, have no impact on discrimination and stigma in the workplace.

It must be recognised that some companies have gone a step further. There are companies that have developed and implemented HIV prevention and awareness programmes. However, some of these programmes lack adequate costing and quality. In fact, it has been reported that the majority of HIV workplace programmes are under-resourced.[18] Again, the effectiveness of low cost HIV prevention campaigns is questionable; since they only make the company look reasonable, but have very little impact on the lives of workers and their families.[19] Most employers tend to allocate very little working time towards the implementation of these programmes. Indeed, the extent of many HIV prevention programmes does not go beyond a few boxes of condoms and a lecture during the occasional lunch break. Many of the programmes are driven by a limited number of motivated people, and once they leave the company, the quality of the HIV workplace programme often suffer as a result. In addition, very few companies monitor or evaluate the effectiveness of their HIV workplace programme and, thus, have very little data on whether or not programmes in place are indeed effective.

Another issue is that HIV in the workplace has often been seen as a cost-analysis issue, rather than a human rights issue. Many employers choose not to offer their workers benefits, such as medical aid, or access to healthcare, on the basis that it is too costly. Linked to this, some companies, along with medical aids, have started to shift the costs of healthcare and medical aid policies more and more onto the worker, hoping to avoid some of the material costs associated with HIV and AIDS. Even in companies that do offer workers access to medical schemes, it has been found that the workers are often unaware of the healthcare benefits that they are entitled to receive.[20] Hence, many workers, who may be entitled to chronic illness benefits under medical aid schemes, fail to take up such services, while medical aid schemes and employers often do very little to ensure that workers, with medical aids, are fully aware of the benefits they are entitled to receive.

It is further argued that workplace responses to HIV and AIDS will remain to be inadequate and fail to ensure fair labour practices, since the Codes of Good Practice are not legally binding.[21] As a result, companies can choose not to do anything, or very little, about HIV and AIDS in the workplace. However, even if the Codes were legally binding, and companies were legally obliged to develop and implement HIV policies and programmes, it is still not guaranteed that HIV policies and programmes would be adequately applied and implemented.

Perhaps, one of the main problems with HIV workplace policies is that they often solely focus on HIV and people, who live, and/or are perceived to be living, with HIV. Thus, at best, HIV workplace policies aim to address stigma and discrimination based on, and in the context of, HIV and AIDS. Broader issues, such as the fact that most employers have very little regard for workers' rights in general, regardless of workers' HIV status, are not addressed in most of the workplace policies, despite the fact that discrimination in workplaces do not just occur in the context of HIV and AIDS. In reality, workers, whether or not actual or perceived to be infected with HIV, often face discrimination on a number of other grounds, including race, class, gender, sex and/or sexuality. Power relations prevalent in most workplaces mean that the constitutionally guaranteed right to equality cannot be realised.

Hence, it is argued that until workers' human

rights are fully respected and protected, discrimination, stigma and the violation of rights in the workplace will continue and will not be adequately addressed. Similarly, until workplace policies do not address stigma, discrimination and the violation of rights in all forms, HIV workplace policies cannot and will not adequately address stigma and discrimination based on, and in the context of, HIV and AIDS.

SO WHAT IS TO BE DONE?

In summary, it is argued that HIV workplace policies and programmes that exist, have failed to adequately address stigma, discrimination and the violation of rights, and failed to create an enabling environment for fair labour practices, as guaranteed in the Constitution.

As long as companies and their workers do not develop and implement policies that address and respond to all forms of stigma, discrimination and violation of rights in the workplace, workplace policies will continue to create an environment that is neither conducive to fair labour practices nor to the promotion, protection and realisation of fundamental rights and freedoms.

In order to implement policies and programmes aiming to create an environment for fair labour practices, challenging and transforming the societal, cultural and religious belief and value systems, which lead to all forms of discrimination, has to become an integral part of workplace policies and programmes. This includes providing education and training to workers about fundamental human rights and freedoms, as well as equal access to healthcare and other work-related benefits, as much as it includes adequate inspection and monitoring tools for companies, so as to ensure fair labour practices, as well as the equal promotion, protection and realisation of rights, irrespective of employment status, sex, gender, sexuality and/or HIV status.

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FOOTNOTES:

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Gahsiena van der Schaff

Feedback...

Give people informed choices...

Since the beginning of 2005, the AIDS Legal Network (ALN), as part of its ongoing activities at a provincial level, facilitated provincial networking meetings focussing on sex and sexuality in the context of HIV and AIDS (Oct – Nov 2005), as well as meetings exploring core beliefs and underlying factors fuelling the HIV pandemic (April to June 2006). Various social and networking partners participated in these meetings and its lively debates.

As a direct response to common issues raised during the meetings focussing on sex and sexuality in the context of HIV and AIDS, such as religion, culture, socialisation, upbringing and gender as the factors defining why women are disproportionately infected and affected by the HIV pandemic, a decision was taken to explore these *'factors'* more in-depth. Thus, in 2006 the ALN began facilitating provincial networking meetings exploring the very same underlying factors and core beliefs that not only fuel the pandemic, but also, unless adequately addressed and challenged, prevent an effective response to the pandemic. A response, that indeed impacts on HIV infection rates, as well as on discriminatory attitudes, beliefs and practices that seem to constantly limit the *'success'* of HIV prevention, treatment, support and care efforts.

The aim of these meetings was to discuss and analyse the underlying factors and core beliefs that continuously fuel the pandemic and render efforts to address and respond to HIV and AIDS meaningless; to explore the link of the societal context determining choices and the realities and challenges of the pandemic; as well as to collectively identify potential advocacy and lobbying strategies and activities aimed at addressing, challenging and transforming the underlying factors and core beliefs that fuel and perpetuate the pandemic.

Meetings with social and networking partners took place in the Northern Cape (11 April), Mpumalanga (26 April), KwaZulu Natal (3 May), Eastern Cape (10 May), Limpopo (22 May), Free State (14 June) and for the first time in the North West (7 June). The meeting in the Western Cape has not taken place at the time of print, but has been scheduled for the 28 June 06.

The response to, and feedback from, the various provinces on the underlying factors varied in accordance with provincial realities and challenges. However, there were a number of commonly raised issues and concerns amongst all provinces, including:

- Lack of in-depth understanding of the impact of value, norm and belief systems on HIV prevention, treatment, support and care efforts
- Strong resistance to change cultural/religious prescription of behaviour, including sexual behaviour
- Reluctance to take responsibility for own HIV prevention
- Need for follow-up seminar/meeting to include traditional healers and religious leaders in the debate
- Need for strengthening provincial networking activities to address issues collectively

The meeting clearly indicated not only the lack of an in-depth understanding of the various realities, and its correlation, of the prevailing challenges pertaining to the HIV pandemic, but also of the role of prevailing social, cultural and religious value, norm and belief systems on the *'success'* of current HIV prevention, treatment, care and support efforts. In addition, the meetings highlighted a lack of realisation as to how the very same core beliefs and norms limit the access to available services, and, thus, potentially perpetuate the pandemic, including its discriminatory attitudes, beliefs and practices leading to the exclusion, marginalisation, stigmatisation and discrimination of the one, who is actually, and/or perceived to be, living with HIV and AIDS.

Feedback... continued

The meetings also showed the '*capacity',* on an intellectual level, to realise the role of core beliefs in perpetuating the *'status quo'* of prevailing gendered inequalities, imbalances and injustices, as well as the societal acceptance of the constant violation of rights. The meetings, however, highlighted simultaneously the *'lack of capacity,'* and/or preparedness to utilise the *'intellectual capacity,* to challenge, change and transform the *'status quo'.*

…I will remember the cultural beliefs and how these affect people on making choices and on equality… [KZN Participant]

…vigorous and thought provoking discussions with real life scenarios…keep up the good work… [Northern Cape Participant]

…I will remember that we should give facts and not judgements…HIV and AIDS is there…and most of the people are dying, because of wrong education… [North West Participant]

…thank you for giving us the chance to network with others…the workshop was so informative… [KZN Participant]

…the meeting/workshop has enlightened me and I believe I will be able to apply the new approach when giving health education talks in preventing HIV… [Eastern Cape Participant]

…I'll remember the way we spoke and the way questions were asked in a way that we ended up feeling guilty...I thank you guys, cause we will be able to correct our way of thinking and do what is right for a change… [Limpopo Participant]

…I'll remember the dialogues we had as different stakeholders on these issues… [Mpumalanga Participant]

…what is important to remember is the choice that we should afford every human being... [KZN Participant]

…the challenge I found myself faced with regarding education on sex and HIV is my own beliefs and who I am...the workshop was good, because it dealt with our own fears rather than people outside… [North West Participant]

…The workshop was very good because now we can analyse and think broadly before doing things concerning HIV and AIDS… [Limpopo Participant]

An additional challenge raised during these meetings is the expressed need for further human rights education and training; for follow-up sessions; and for similar meetings focussing specifically on the traditional, religious and/or cultural leadership in the various provinces.

…I'd like to see ALN doing these workshops once every month on different topics… [KZN Participant]

…what is needed is a summit addressing challenges in churches, and with traditional leaders and healers, and politicians on issues of HIV and AIDS... [Mpumalanga Participant]

…No one must tell someone what to do or not to do because everybody has the right to choose…may AIDS Legal Network not stop giving us this information every year… [Limpopo Participant]

…the workshop came at the right time and need to be put into practice… [North West Participant]

…I learned so much...the most important thing is that if we change the way we talk and teach people about HIV…people have the choice... [Free State Participant]

…we would like to see some changes by the next 12 months and we hope through the ALN support, we will make it happen… [Mpumalanga Participant]

…thank you for sharing this information with us...I think that if HIV education is non-prescriptive and non-judgmental we can go a long way in trying to reduce infection rates… [North West Participant]

…I remember most how our religion and culture play a role in increasing or decreasing HIV/AIDS...we must not use our culture and religion to hurt others and to ignore HIV… [Free State Participant]

So, after all these meetings the message seems *'clear'*. Until we provide information/education that is *'facts-based'* and not *'judgement-based'*, core beliefs and underlying factors will continue to fuel the HIV pandemic and render our efforts meaningless. What is needed, as stated by one participant in the North West, we need to learn to give people informed choices…

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