aLQ
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Moving Beyond *'Straight Talk'*…
HIV and AIDS and Non-Conforming Sexualities

…sexuality is not deducible to a body part or a drive; it must be understood as integral to an entire matrix of social, economic, cultural and relational forces: it is constructed rather than given.[1]

Sexual and gendered realities

We live in a world in which gender and sexuality are primarily constructed in dichotomies: male-female, man-woman and gay-straight. Each dichotomous position comes with its prescribed roles, values, expectations and responsibilities, and they provide all who inhabit them with '*socially appropriate*' ways of feeling, thinking and doing.

Accordingly, the powerful social constructs of how to be '*man*', '*woman*', '*gay*' or '*straight*' also craft the social contours between '*right*' and '*wrong*', and '*good*' and '*bad*' sex. Such deeply gendered and sexed social norms and values frame dominant understandings of human sexuality, including who has sex with whom, how and why. These social representations also shape how people think about, talk about, and respond to HIV and AIDS. When it comes to HIV prevention, mainstream responses are mostly engaged in what I will refer to as '*straight talk*'– at the core of which lie the gender dichotomies. And by '*straight*', in this context, I refer to the normative state of '*extending in one direction without turns, bends or curves; or being without influence or interruption*'.[2]

South Africa's generalised HIV epidemic means that infection primarily occurs through heterosexual sex. There are powerful ways in which heterosexuality and heterosexual HIV transmission is socially couched. This comprises highly gendered depictions and representations of male and female (hetero)sexuality, and these stereotypes are (re)presented and reinforced through dominant HIV prevention messages. HIV prevention strategies that

In this issue

• 1 Moving Beyond 'Straight Talk'… HIV and AIDS and Non-Conforming Sexualities • 2 Editorial • 13 More than we bargained for… Transgenders and HIV prevention • 16 Why are we being left out…? Older women and HIV risks • 22 The untold reality… Sexual rights and transgender people in the context of HIV and AIDS • 28 Subjected to preventable HIV infections… Married women and HIV risks• 31 Blowing the whistle on hypocrisy… Markets, Victorian culture, sex work and the 2010 World Cup • 43 Comment/Making a point: 'A conspiracy of silence… Sexual violence in schools • 49 Regional view • 56 Criminalisation harms women… 10 Reasons why criminalisation of HIV exposure or transmission hurts women

Editorial...

The need for '*targeted interventions*' in the response to HIV and AIDS is well recognised; and so the need to increase the focus of '*targeted interventions*' on '*vulnerable and marginalised groups*'. However, despite this recognition, the realities and needs of '*vulnerable and marginalised groups*' remain to be largely '*overlooked*' in the AIDS response; the societal norms and prejudices defining the '*margin*', as compared to '*mainstream*' are not addressed; and there continues to be little '*evidence-based*' knowledge as to the needs of '*vulnerable and marginalised groups*'. Thus, most '*targeted interventions*' not only fail to address HIV risks and vulnerabilities, as well as related service needs, of '*vulnerable and marginalised groups*', but also seem to perpetuate prevailing HIV realities, risks and challenges experienced by '*vulnerable and marginalised groups*'.

It is within this context that this edition of the *ALQ* focuses on specific HIV realities, challenges and needs of '*vulnerable and marginalised groups*'. The extent and impact of excluding '*non-conforming sexualities*' in '*mainstream*' responses to HIV and AIDS; sexual rights of transgender people, as well as the lack of programmes responding to HIV prevention realities and needs of transgender people; implications of the failure to perceive women, aged 50 and older, as a '*target*' for HIV prevention; and the impact of the common misconception that '*marriage is safe*' on especially married women's HIV risks and vulnerabilities, are some of the issues explored in this edition.

In addition, this edition is also discussing the hypocrisy surrounding markets, Victorian culture, sex work and the 2010 World Cup; '*making a comment*' about sexual violence in schools; and introducing the progress and remaining challenges pertaining to HIV and human rights in the SADC Region.

In this edition, **Melanie Judge** analyses the extent to which the mainstream discourse about, and response to, HIV and AIDS is indeed equipped to address non-conforming sexualities. Examining sexual and gendered realities, and the politics of prejudice, including the denial of sexual health and rights of non-conforming sexualities, she argues that, for interventions and programmes to be responsive to all people's realities and needs, the complexities of non-conforming sexualities must become an integral part of the HIV equation, so as to ensure talking beyond the dichotomies, as well as moving beyond the '*straight talk*'.

Highlighting the gap between HIV prevention responses and HIV prevention needs of transgender people, **He-Jin Kim** explores the multiplicity of transgender identities, sexual practices and HIV risks. Recognising the diversity of realities and needs in the transgender communities, she argues that current HIV prevention efforts are inadequately responding to the multiplicity of needs and are thus, perpetuating transgender people's '*high*' HIV risks and vulnerabilities; since, despite the increasing knowledge base, interventions and programmes continue to be largely based on assumptions, as compared to facts, about the bodies and sexual practices of transgender people.

Acknowledging the increasing HIV infection rates in women, 50 years and older, **Martha Qumba** examines the societal context impacting on especially older women's HIV risks. Discussing various influencing factors, including culture, cultural expectations and the concept of '*respect*', she raises concerns about the apparent lack of programmes specifically addressing HIV risks and vulnerabilities of older women, and argues that as long as women of this age group continue to be seen as not sexually active, HIV awareness and prevention programmes will fail older women and thus, perpetuate their HIV risks.

Introducing the realities and challenges of sexual rights of transgender people in the context of HIV and AIDS, **Julius Kaggwa** and **Liesl Theron** raise the question as to the adequacy of programmes and interventions in addressing sexual rights and needs of transgender people. Exploring specific HIV risks and vulnerabilities of transgender people, the article argues that the failure to recognise the sexual rights of all, and the continuing exclusion of transgender people's realities and needs in HIV and AIDS interventions and programmes, constitutes a key opposing factor to the reduction of HIV prevalence.

Raising concerns as to the '*safety of marriage*', **Bongiwe Radebe** explores some of the factors determining HIV risks for married women. Looking at societal expectations of marriage, the gendered context

command the most funding and primacy are male-controlled, such as the male condom and male circumcision. Both of these approaches are rooted in gender norms related to male sexuality and agency. In the case of male condoms, it is men who '*use*' condoms, and women who '*negotiate*' their use. In terms of male circumcision (noting that its impact on prevention is still contested), increased power is potentially invested in men to determine the parameters for safer sex – whilst false perceptions of lower HIV risk amongst men who are circumcised may well undermine the gains made in getting male sexuality to cooperate with condoms use.[3] The extent to which male sexuality *decides* and *acts* is central to both these prevention approaches. This emphasis is not value-free or coincidental, rather it is the result of a confluence of gender politics, gender prejudice and gender priorities that shape dominant discourses of HIV and AIDS, and inform what is rendered important, and consequently what is not rendered as important, in response to it.

…sexuality is fluid, contextual and brings together complex variables of context, power, desire, and control…

HIV prevention

Three decades into the HIV and AIDS pandemics, '*straight talk*' remains largely unchallenged within mainstream programming and policy debates. The fact that women are the most infected and affected world-wide, and vulnerable exactly because of gender social relations, should, as argued, proffer a more logical approach that places women at the centre of the HIV prevention response. And such a response should unhinge, not reinforce, the very patriarchal power dynamics that thwart women's sexual agency and choice. The grim reality, despite how much we know about gender as a vector of transmission and women's social, biological and economic vulnerability to HIV risk, is that we have not prioritised female-controlled barrier methods, such as female condoms and microbicides. The female condom provides a much needed possibility for the locus of HIV prevention control to shift increasingly from men to women. However, their high price and the lacklustre approach to making female condoms available and accessible, as well as negative social perceptions with regard to their usage, have undercut their potential to offer a powerful protective tool for women.

…so that interventions facilitate social change, specifically in arenas where oppressions and marginalisation continue unabated…

It is, thus, not surprising that female condoms are depicted as '*unpopular*' in popular discourse. After all, they offer *women* a barrier method that they can actually *use,* thereby increasing the potential to control safer sex as an option in the sexual act. Perhaps, this is seen to be disruptive of popular gender norms associated with women in the context of heterosexual sex, as a woman who inserts a female condom becomes an active agent in sex, and therefore may be perceived as having increased power to determine the conditions under which that sex takes place. The representation of female sexuality – usually passive in the sexual act – does not conform with gender roles related to male and female sexuality in the context of heterosexual sex. Gender norms would prescribe that men are in control of sex and determine the *how* of sex, whilst women are the more passive recipients of that sex.

There is also promising research[4] on microbicides – a female-controlled barrier method that will be easy to

– prescribing, especially, married women's sexual behaviour – as well as HIV prevention messages, she argues that, the prescriptive '*concept of marriage*' is indeed heightening married women's risks to HIV infection, as married women are least in the position to decide where, when, with whom and how to engage in sex, and thus, *'marriage'* becomes a major obstacle to HIV prevention.

Premised on the need to decriminalise sex work and to protect sex workers' human rights, **Susan Holland-Muter** discusses the correlations between the market, morality, law and sex work, in light of both the latest law reform developments and calls to legalise the sex industry during the upcoming 2010 World Cup. Analysing the various responses and view points in this debate, she argues that it is time to '*blow the whistle on hypocrisy*', to translate international human rights commitments into action, as the decriminalisation of sex work and regulation of the sex industry are essential steps towards the protection of sex workers' human rights.

Recognising the gendered nature of the education system, **Lydia Mavengere** is '*making a comment*' about sexual violence in school. Exploring the extent to which the school environment both facilitates and perpetuates the occurrence of all forms of gender-based violence, she argues that the '*conspiracy of silence*' is one of the major barriers to adequately address sexual violence in schools and thus, create an enabling environment for, especially, female learners to access and realise their right to education.

Based on the 2009 HIV/AIDS and Human Rights in Southern Africa Report, **Nyaradzo Chari-Imbayago** explores some of the key human rights developments in the region. Examining policy and law reform, enforcement mechanisms, as well as human rights protections in the context of HIV prevention, testing and treatment programmes in the various countries, she argues that, despite the progress made, continued advocacy remains crucial, so as to ensure the protection of human rights in the response to HIV and AIDS in the region.

While the specific realities and needs may differ from group to group, what seems common to all the discussed '*vulnerable and marginalised groups*' is the continuing '*exclusion*' from discourses and responses, despite the fact that commitments and calls are made to '*target*', and be responsive to, the realities and needs of '*vulnerable and marginalised groups*' in HIV policy and programme design. Moreover, the patriarchal and heterosexist paradigm, determining both the prevailing HIV risks and vulnerabilities and the continuing failure of interventions and programmes to respond to the realities and needs of '*vulnerable and marginalised groups*', is commonly highlighted as a major obstacle to the effectiveness of HIV prevention efforts.

Recognising the impact of the '*exclusion*' not only on prevailing HIV risks and vulnerabilities, as well as rights violations, but also on the effectiveness of responses to HIV and AIDS, the inclusion of '*all*' realities and needs – and especially the '*marginalised*' realities – while ensuring human rights protections, seems not only an essential factor determining the adequacy of the response, but is also a pre-requisite for a human-rights based response to the pandemics.

Until such time that we are '*brave*' enough, to not only talk '*inclusion*', but think and act '*inclusion*' the '*vulnerable and marginalised*' will remain at risk of HIV infection and rights abuses, and AIDS responses will continue to '*exclude*' and further marginalise '*high risk groups*' identified for '*targeted interventions*'. And so, '*moving beyond dichotomies*' and towards '*respect for all*' seems not only to be '*the key to success*', but also highly overdue in the response to HIV and AIDS – especially if we are to agree that human rights are to be at the centre of our response.

If, however, we continue the '*straight talk*' and '*mainstream*' programming and fail to challenge assumptions and social norms justifying the very same, '*targeted interventions*' will have no impact on the '*target group*', but instead further heighten HIV risks and vulnerabilities, as well as rights abuses, of '*vulnerable and marginalised groups*'. Though, it may be '*uncomfortable*' to include everyone into our discourse and programming, the '*real*' success and effectiveness of interventions and programmes are to be measured by the extent to which HIV risks and vulnerabilities are declining – not for '*mainstream*', but for '*vulnerable and marginalised*' people. And to be '*inclusive*', we need to start translating commitments into actions, knowledge into practice, and '*moving beyond*' our own '*assumptions*' and '*comfort zones*'…

Johanna Kehler

administer and even easier to negotiate, given the fact that the substance may not be visible (possibly making negotiation with male partners a non-essential). However, because microbicides have not been granted the resources and leadership commitment they demand, the discovery for an efficacious product will be slow.

As the failure to prioritise female-controlled barrier methods illustrates, HIV prevention priorities have, for the most part, remained on the '*straight*' path – the normative path – which perpetuates, rather than disrupts, gender inequalities. This presents a lost opportunity for HIV and AIDS responses to radically challenge and transform sexual power relations – which create the very conditions in which both HIV and AIDS flourish. Instead, much of the mainstream responses reveal just how existing gender and sexual relations have been entrenched.

…HIV prevention is both a personal and a political issue…

For instance, the 'ABC' approach, the mainstay of HIV prevention strategy worldwide, is applied into a gendered reality: A married woman is faithful to a husband whom she knows has multiple partners and with whom she dares not negotiate condom use, due to her economic dependency and fear of violence in the relationship. Does 'ABC' talk to her experience, given the contextual dynamics at play? I think not. Perhaps it is more an assumption, or hope, that she will manoeuvre around the circumstantial barriers that stifle her agency and sexual choice. The 'ABC' approach is underpinned by a number of implicit assumptions related to sexuality, monogamy and gender equality, whilst taking on the semblance of being gender free, and as a result, does not speak to women's realities. Rather, de-contextualised HIV prevention messages by-pass the very issues that shape women's risks.

Conditions of sex

The focus on '*sex*' at the centre of HIV risk, with little attention given to the circumstances surrounding that sex, including the precipitating events or contexts and the consequences thereof, is restrictive. There is a general tendency to view sex as an act occurring in a social vacuum between two people (another normative construction), and that sex has a beginning, a middle and an end. A more reality-based approach would be for sex to be engaged with as a process that incorporates the conditions (planned or otherwise; consensual or forced; economic, social and/or political) in which any given sexual act/s take place.

These '*conditions for sex*' are not static, fixed points in time, but are shaped by history, culture, gender expectations and roles. Contextual factors create the setting, across history, generations and locations that will frame a particular sexual encounter. We perform sex, just as we perform gender.[5] This is what makes it more likely for a woman to be raped; for a man in a heterosexual relationship to determine whether or not a condom is used; for a woman to be more likely to sell sex for money and a man more likely to buy it. Sex becomes a way in which we define/perform a sexual and gender identity and communicate that identity to others through sexual acts – be they about desire, power, control, violence or a combination of these.

…both gender and sexuality are about power and politics…

What dominant representations of HIV and AIDS seem to do is close down the space for the myriad ways in which human sexuality is, in reality, expressed. HIV draws into sharp relief the slippage between sanitised, conforming images of sexuality we see on the billboards

and the grittiness and messiness of real life sexuality. HIV is the wake-up pill to the complex factors that render persons in social contexts vulnerable or without power to '*be safe*'. These power constellations directly affect sexual behaviours and choices. But will the wake-up call expand the social discussion on oppressive masculinities; women's subjugation; economic exclusion; stigma and discrimination – all of which serve as social lubricants for HIV? Mostly we gravitate toward the normative paradigm: faithfulness (despite the fact that '*faithful*' women are at risk as a result of the sexual behaviour of their partners[6]); having less sex (despite the fact that it is the '*safety*' of sex, rather than the frequency, that is most critical); promoting moralities to curb sexual expression and freedom (even though this means turning a blind eye to the sexuality of youth, and weakening women's choices and agency).

…social norms are reinforced through homophobic violence…

Beliefs and morals

> [T]*his epidemic has deepened the chasm between those who see religion in decline and those who cling to faith with unrivalled zeal, forcing unfashionable concepts such as morality back into public debate.*[7]

Religious and cultural discourses are foundational pillars to the gender normative paradigm. For example, religious exclusionary perspectives continue to perpetuate the belief that sex is for procreation, not for pleasure or general well-being. Accordingly, non-reproductive sex is stigmatised. In line with this, the Catholic Church's stand on the use of condoms has remained unchanged, despite the fact that condom use saves lives.

The past decade has witnessed a massive increase in global funding for abstinence-only programmes.[8] The emphasis on abstinence strategies, fuelled by conservative religious structures, has become a global priority and results in moralism, rather than scientific information, dictating public policy and global funding priorities.[9] This is unsurprising given the religious fraternities' preoccupation with matters of '*good*' and '*bad*' sex – concepts integral to many national responses to HIV and AIDS. This '*exporting of morality*', facilitated by PEPFAR, reinforces the power dynamics which place women, girls, and stigmatised sexualities, such as lesbian, gay, bisexual and transgender (LGBT), at disproportional risk.

…sexual violence capitalises on the vulnerability of already marginalised groups…

Citizenship

Gender realities are also influenced by a range of other factors, including the extent to which people can claim full citizenship. Citizenship confers upon us those rights and responsibilities that come with equal membership and participation in a community.[10] Such membership is not only framed in relationship to the legal rules established by the state, but also through social relationships between individuals.[11] Marginalised and stigmatised groups that do not fit gender norms and mores are, on paper, full citizens with full claims to resources, recognition and representation. But are they able to realise this promise of citizenship within the confines of dominant representations of sexuality and gender? Mostly not – as society has largely failed to acknowledge the impact of gender and sexual oppression on sexual choices, and, in turn, on the sexual health and rights of individuals.

A lack of sexual rights is in itself a dimension of poverty, producing a whole host of poverty-related outcomes, from social exclusion and physical insecurity to greater vulnerability to disease, hunger and death.[12]

Socio-economic factors

In South Africa, large numbers of people live in abject poverty, and are excluded from the formal economy for structural reasons[13] – thus, likely to be unemployed or underemployed or working in conditions detrimental to health. This also has a *knock on effect* on women not being prioritised for HIV prevention, and not being in the position to access treatment services, due to limited resources and facilities.

Poor quality of care, limited services to meet the demand, lack of adequate training, overcrowding and under-resourcing are all part of more systemic health system failures. Poverty deepens and entrenches these barriers to access. It stands to reason that people who lack social and economic power will feel the might of these failures disproportionately. If class, gender and sexuality undermine a person's social power, their access to health care will be made even more difficult. Here variables of gender, sexuality, race and class coalesce to form very particular forms of marginalisation and resultant HIV risk.

…sexuality is the pivot on which structures of gendered power operate…

It has been argued, thus far, that sex and sexuality cannot be understood in a socio-political vacuum. Paying attention to the social determinants of health illustrates that the ability to access HIV prevention and care is compromised by power dynamics. In tackling these dynamics it is critical to take cognisance of, amongst others, how constructions of gender and sexuality compromise the right to health; and how social prejudices entrench and perpetuate inequality in access to healthcare. These are some of the dimensions of individual and social risk that are most often ignored in the discussion on HIV and AIDS, primarily, because these counter-discourses disrupt or de-stabilise the binaries of the existing social order, as they represent the sexualities that do not fit the proverbial '*straight*' jacket. I want to suggest that non-conforming sexualities offer a lens through which to better understand the complex web of factors that shape the course of the epidemic; and *who* is at risk *when* and *why*.

…hetero-normativity creates the context for discrimination of lesbian and gay and gender non-conforming persons…

The politics of prejudice: non-conforming sexualities[14] and the denial of sexual health and rights

According to the WHO (2004), sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Gender norms provide the framework for women

and men to act as sexual beings in the world. Normative sexualities that conform to the gender dichotomies of female and male are informed by a patriarchal order that maintains a hierarchy of power relations, which places men (who are heterosexual) at the top. Conversely, women (who are not heterosexual) find themselves at the lowest rung of the gender power ladder. As I have argued earlier, HIV risk is a result of individual factors and contextual determinants. When HIV prevention messages are reduced to the '*gender-free*' *ABC*, we de-contextualise human behaviours and silence the social factors that shape individual choice, agency and action.

…HIV risk is a result of individual factors and contextual determinants…

Vulnerability to HIV is also a product of people whose sexualities are silenced; overly policed or directly subjugated. In this regard lesbian and gay sexualities are disproportionately at risk. However, heterosexual sexualities that do not conform to the strict codes of male-female sexual relations also facilitate risk. Non-conforming sexualities include lesbian women; gay men; heterosexuals with multiple partners; people living with HIV, who are sexually active; heterosexual women who refuse to have sex with their husbands; the person who sells sex for money; and all behaviours that disrupt gender norms of how sex should be had, between whom and why.

All the social factors that impact sexuality are mediated through gender norms, values and roles. Sexualities that do not conform to dominant moulds of sexuality are judged and marginalised. Through prejudice and stigma the sexual health and sexual rights of these sexualities are compromised. In this manner, the politics of prejudice applies to all non-conforming sexualities. Whilst non-conforming sexualities cut across all sexual orientations and genders, for the purpose of this paper I focus on lesbian and gay sexualities, as a way to understand how the politics of sexual prejudice impact on HIV risk, and how dominant HIV prevention messages largely ignore these contextual determinants.

> *Social vulnerability of same-sex practicing and gender non-conforming men and women as a result of their sexual and gendered behavior and identity drives an interlocking set of human rights violations and social inequalities. These factors heighten HIV risk and produce disproportionate HIV prevalence, as individuals lack the power to minimize or modulate their risk; and infection with HIV or the perception as being likely to be infected in turn results in legal, social and economic discrimination. Violations of human rights resulting from one area of vulnerability expose individuals to increased risk for the abrogation of rights in others.*[15]

Social inequalities

It is argued that hetero-normativity creates the context for discrimination of lesbian and gay and gender non-conforming persons.[16] Hetero-normativity is the social prescription that renders heterosexuality as the only '*normal*' form of sexuality. Such sexuality hinges on gendered notions of men as '*masculine*' and women as '*feminine*'. In this way, sexuality is the pivot on which structures of gendered power operate.

…dominant HIV prevention messages largely ignore these contextual determinants…

Both gender and sexuality oppressions come into

play for LGBT people in the context of HIV and AIDS, as these are mutually reinforcing systems of power. There is a discord between how people view and name their own sexual behaviour and how it is viewed and labelled by others. This is particularly pertinent when sex between people of the same sex is perceived a social taboo, and this raises specific challenges in relation to HIV prevention. For example, how do we focus, and with what messaging, on men who have sex with men (MSM) who may identify as heterosexual; or lesbian-identified women who are forced into transactional sex with men?

…the politics of prejudice applies to all non-conforming sexualities…

The dynamic between human rights violations and social inequalities presents a '*deadly mix*' that disproportionately impacts on LGBT people and other marginalised groups. There is a complex set of variables that fuel vulnerability of gay and lesbian people to HIV. Sexual desires and expressions that are, as a result of this context, driven underground, are hard to hone in on programmatically. At the social level, this discrimination hinders the availability of adequate HIV and AIDS information and services, and at the psychological level, negatively impacts on individual self-worth, posing obvious sexual health risks. Internalised homophobia and stigma also need to be considered when working towards safer sex behavioural change.

Homophobic attitudes

A recent Human Science Research Council (HSRC) report highlighted clearly the extent to which homophobic sentiments are deeply entrenched within the social attitudes of South Africans. Prejudice towards lesbians and gay men is widespread, with 80% of the population, aged 16 years and above, expressing the view that sex between two men or two women is '*always wrong*'.[17]

…the ability to access HIV prevention and care is compromised by power dynamics…

Sexualities and gender identities that challenge the hetero-normative are silenced, undermined, and, at times, directly attacked.[18] Rape and sexual assault are commonplace for sexual minorities in a heterosexual world, where perceived sexual deviance is quite literally under attack. The so-called '*corrective rape*'[19] of lesbian women and the punitive rape of gay men bear testimony to these realities - which are silenced in mainstream HIV and AIDS programmes. Sexual violence capitalises on the vulnerability of already marginalised groups, and creates new forms of vulnerability.[20] This has particular relevance for people whose sexualities and genders are perceived to challenge and/or undermine hetero-normativity and patriarchal gender roles.[21] Related social norms are reinforced through homophobic violence – which is a form of social control to ensure gender conformity. Sexual violence undermines sexual rights – which then further compromise the sexual and reproductive health of LGBT people.[22] Research indicates that LGBT are reluctant to report such homophobic violence for fear of '*secondary victimisation*' at the hands of criminal justice officials.[23]

Sexual identities also intersect with economic and racial realities, resulting in multiple forms of discriminations on the basis of race, class, gender and sexual orientation.[24] Drawing on research that has been conducted with regard to LGBT people accessing healthcare services, it is clear that one of the systemic barriers to healthcare access is

the homophobic and heterosexist attitudes of healthcare providers themselves. Studies focusing on LGBT experiences in this area highlight the institutionalised homophobia and hetero-sexism that render people at risk of service provider de-prioritisation, neglect and direct victimisation.[25]

…moralism, rather than scientific information, dictating public policy and global funding priorities…

In studies conducted in both Gauteng and KwaZulu-Natal, 6% and 5% of LGBT people, respectively, were refused healthcare because of their sexual orientation.[26] As a result, some people lived with certain medical conditions and had not sought help, because they were afraid of their sexual orientation being discovered. The research indicated that almost half of the healthcare practitioners visited in the preceding two years asked heterosexist questions (49%), or assumed that lesbian women were heterosexual (41%). Fifty five percent of lesbians reported that healthcare providers asked questions which '*made it seem that being heterosexual is the only normal way to be*'.

Such discriminations have a serious impact on health seeking behaviour, the self-perception of health risk, and act as barriers to accessing HIV-related services. Because national HIV and AIDS programmes limit themselves to the '*straight*' notion of human sexual desire and expression, all sexualities that fall outside of this norm are largely overlooked for HIV prevention, treatment and care messaging and services. As such, dental dams and other appropriate barrier methods for lesbian women, as well as lubricants for gay men, are not available in the public sector.

The rendering invisible of lesbian and gay sexualities, precisely because they do not conform, drives people's health concerns underground and results in, amongst other things, an inadequate response in terms of both policy and practice. Changing both the attitudes of healthcare providers to non-conforming sexualities, and addressing the broader heterosexist and misogynist culture are major challenges to the principle of inclusive HIV prevention.

Sexual health and sexual rights

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity.[27] For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

One cannot talk sexual health, without talking sexual rights. The latter, by definition, demands gender equality, freedom from discrimination, sexual abuse, coercion and violence. So, addressing gender and sexual discrimination, hate crimes, and other forms of gender prejudice and injustice, as well as the binaries that keep them in place, should form an integral part of HIV and AIDS programming. This will also ensure that the broader social context, which shapes people's sexual health potential, is also tackled.

…religious and cultural discourses are foundational pillars to the gender normative paradigm…

The freedom to express sexuality differently challenges '*straight talk*' and is fundamental to sexual health and rights. How else can individuals control and protect their lives and bodies – which are so fundamental to sexual well-being? To achieve sexual health, all individuals, including those who fall outside the heterosexual paradigm, must

have access to adequate sexual health information and services. Enjoying the rights to fulfil sexual desires and pleasure can be empowering and can confront deep-seated and learned experiences that teach us to feel ashamed of our bodies and our sexualities, as women, people living with HIV, and LGBT people.

Talking beyond the dichotomies

Both gender and sexuality are about power and politics, as they determine the extent to which basic rights over our bodies and related life choices are made. There is an imperative to confront the dominant discourse of HIV and AIDS and hetero-normative models of prevention. The normative framing of sexuality, upheld in HIV prevention messaging, overlooks sexuality as a continuum - along which a person may be positioned and re-positioned at different points in time and under changing circumstances. HIV prevention is both a personal and a political issue and remains limited in its reach, because it fails to challenge the politics of powerlessness and the systems that maintain the limits to power for women, and people with stigmatised sexualities. Instead, the 'ABC' masks these realities and perpetuates the silencing of the range of sexualities that make up the human experience, as well as the social power dynamics that mediate their expression. It also obscures the social and cultural context that largely defines how sexual choice is manifested in the lives of individuals, in their social, economic and cultural reality.

Effective and context-based HIV prevention education has to ensure openness about sexual practices, and the breaking of taboos around sexuality in society. Healthcare service providers need to interrogate their own perceptions of sexuality and challenge heterosexist and patriarchal assumptions about sex. This includes taking cognisance of the structural elements that fuel HIV risk, such as poverty, gender inequality and lack of access to basic healthcare. As a development issue, HIV and AIDS demands to confront institutionalised discriminations and systemic exclusion so that interventions facilitate social change, specifically in arenas where oppressions and marginalisation continue unabated.

…perpetuates, rather than disrupts gender inequalities…

There is, I believe, also a shroud of secrecy around the assumptions underpinning heterosexual HIV transmission, which can and should be confronted through our discussions about diverse and non-conforming sexualities. Societal responses to HIV and AIDS remain a given trajectory: one that is hetero-normative and patriarchal and where social inclusion and exclusion still determine who gets access to health and whose rights are protected. Of course, it is much easier and safer for a heterosexist culture to name and blame so-called '*sexual deviants*', rather than to confront the sensitive arena of sexual desire and the politics of prejudice.

…unhinge, not reinforce, the very patriarchal power dynamics that thwart women's sexual agency and choice…

However, if we want interventions to be reality-based and to respond to people's needs – however discomforting we may find that place – the complexities of non-conforming sexualities must be factored into the HIV equation. In generalised epidemics there is a need for both general and targeted prevention strategies that speak to the specific social risks facing lesbians, gay men, heterosexual women, sex workers, people living with HIV, and other

stigmatised sexualities. This necessitates challenging mainstream attempts to de-sexualise HIV and AIDS and the oversimplification of the national responses to a 3-lettered catch phrase that has little social relevance.

The purists want us to understand human sexuality in the form of neat categories. However, sexuality is fluid, contextual and brings together the intersecting dynamics of context, power, desire, and control. What is needed is an engagement with the '*nitty-gritty*' of who has sex with whom, why and how. Drawing on the sexual and human rights frameworks, there is a need to advocate for non-discriminatory health services and treatment programmes that address the diverse range of sexualities and behaviours that make up the human experience. This includes demands for increased resource allocation and research to be directed to HIV prevention and treatment for people who do not uphold the '*straight*' mould. By looking at sexualities that are considered social taboo, HIV and AIDS programming can enhance the understandings of gender and sexuality in shaping the course and impact of the pandemics.

We need a radical change to address this pandemic. This change must be about dignity – not divinity; autonomy – not accusations; freedom – not feted moralities; sexual pleasure – not preaching; rights – not restrictions.

FOOTNOTES:

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11. Lister, R. 1997. *Citizenship: Feminist Perspectives*. MacMillan: Basingstoke.
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13. Terreblanche, S. 2003. *A History of Inequality in South Africa: 1652-2002*. University of KwaZulu-Natal Press.
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16. International Gay and Lesbian Human Rights Commission input memo to the UN Secretary-General's Study on Violence Against Women. Prepared by Susana T. Fried and Alex Teixeira. [www.un.org/womenwatch/daw/vaw/ngocontribute/International%20Gay%20and%20Lesbian%20Human%20Rights%20Commission.pdf]
17. HSRC. 2008. 'Pride and Prejudice: Public attitudes toward homosexuality'. In: *HRSC Review*, November 2008, Volume 6, No 4.
18. Nel, J.A. & Judge, M. 2008. 'Exploring homophobic victimization in Gauteng, South Africa: Issues, Impacts and Responses'. In: *Acta Criminologica*, 21(3), pp19-36.
19. '*Corrective rape*' is the prejudiced notion that a lesbian woman can be raped to '*make her straight*': i.e., to '*correct*' her lesbian sexuality. '*Corrective rape*' seeks to justify the rape of people, who are perceived to not conform – or to disrupt – expected gender roles, behaviour and/or presentation. Misogyny and homophobia underpin the prejudice associated with '*corrective rape*'. [Fact sheet on 'corrective rape', OUT LGBT Well-being, 2008]
20. Judge, M. 2008. 'Invisibility in plain sight: Lesbian women and HIV'. In: *ALQ*, March 2008, pp10-14.
21. Nel, J.A. & Judge, M. 2008. 'Exploring homophobic victimization in Gauteng, South Africa: Issues, Impacts and Responses'. In: *Acta Criminologica*, 21(3), pp19-36.
22. *Ibid*.
23. See Polders, L. & Wells, H. 2004. Overall Research Findings on Levels of Empowerment among LGBT people in Gauteng, South Africa. Unpublished Report. Pretoria: Out LGBT Well-being; also Wells, H. 2006. Levels of Empowerment among LGBT people in KwaZulu-Natal, South Africa. Unpublished Report. Pretoria: Out LGBT Well-being.
24. Nel, J.A. & Judge, M. 2008. 'Exploring homophobic victimization in Gauteng, South Africa: Issues, Impacts and Responses'. In: *Acta Criminologica*, 21(3), pp19-36.
25. See Polders, L. & Wells, H. 2004. Overall Research Findings on Levels of Empowerment among LGBT people in Gauteng, South Africa. Unpublished Report. Pretoria: Out LGBT Well-being; also Wells, H. 2006. Levels of Empowerment among LGBT people in KwaZulu-Natal, South Africa. Unpublished Report. Pretoria: Out LGBT Well-being.
26. *Ibid*.
27. The World Health Organization's (WHO) working definition of sexual rights includes the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life. [www.worldsexology.org/who_def.asp]

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He-Jin Kim

More than we bargained for…
Transgenders and HIV prevention

Transgender people are a diverse group, ranging from female to male identified, female to male '*bodied*', or even bodies and identities that do not fit in either the female or male categories.

While the exact definition of the word '*transgender*' is often still a point of discussion, as well as culturally specific, most often '*transgender*' is used as an umbrella term to refer to people whose gender does not conform to their assigned '*sex*' at birth. In this sense it can thus include: transsexual women (pre-or post-operative)[1]; transsexual men (pre-or post-operative); transgenders who do not identify as either male or female; or transgenders who do identify as male or female, but do not choose to pursue surgical or hormonal treatment or both[2].

Terminologies

The language transgenders use to refer to themselves is even more diverse: *transgender, transsexual, transwoman/man, genderqueer, trannie, t-girl/boy, ts-girl/boy, XXboys, XYgirls, boi, pangender, androgyne* – to mention a few. None of these words have a coherent definition that would state which genital they were born with, which ones they pursue to have, or which ones they have now. The words only state, to a certain extent, the identity of the person in question. Also, there are transgender people who refer to themselves as men/women and pass[3] to the extent that it is unknown to any that they are transgender, whether or not they had any surgeries, thus, leaving it uncertain which genital they have and which sexual practices they make their own. The opposite is also true, in that transgender people who are not '*out*' in a certain situation, might identify as a different gender, than the one they portray.

Furthermore, there are culturally specific constructs that refer to what, in western terms, can be called '*transgenders*', such as *Kathoey* (Thailand), *Hijra* (South-Asia), and *Fa'afafine* (Samoa). However, these rarely fit the definition of '*transgender*' perfectly. Some of these groups include other queer people who are not transgender; others might have a tighter definition that might be limited to a small group within transgender communities. Sometimes, these groups exist next to transgender communities, more conforming to western definitions of transgenders that dominate internationally.

Sexual practices and HIV risks

As diverse their gender is, likewise transgenders' sexual practices vary significantly within the group. A transgender woman who has had sex-reassignment-surgery (SRS) might engage in '*heterosexual practices*' with another man or in '*lesbian sex*' with a woman. A transgender man could be *gay*, *straight* or *bi*, yet, his sexual practices might vary depending on whether he is pre-, post-, or non-operative.

Furthermore, the language that individual transgender people use to refer to their sexual activities, and to body parts involved in these activities, can be far from conventional, when their bodies do not fit their identities. Many transgender men would refer to their enlarged clitoris[4] as a penis; this does not only mean that they prefer to name it as such, but also that they try and experience it in that specific way, in order to make it fit their gender, and their accordingly preferred sexual activity.

The reality of transgenders, as a risk group in terms of HIV, is as diverse as the community itself. For example, a *straight* transgender male, thus choosing to have sex with a woman, will have risks according to the sexual activities he engages in with this woman, which in turn is dependent on the body he has, and thus, whether or not he had any surgeries. A *gay* transgender male, who engages

in sex with men, has a completely different situation, similar to another '*cisgender*'[5] male, but with the added complication that his body might not conform to what is defined as the '*male sex*'; he might have a vagina, he might use it, he might call it a vagina and vaginal sex. But often transgender men, engaging in this activity, would not call it '*vaginal sex*', but instead would use alternative terms, such as '*frontal sex*'.

HIV prevention

The complexity of language, bodies and sexual practices creates a problem when '*mainstream*' HIV prevention is applied to transgender communities. In contrast to the reality, current HIV prevention responding to transgenders, too often unifies them into one coherent group. More often than not, this group is implied and interpreted to mean '*transgender women*'. This is evident in the fact that too often transgender women are conceptualised either as Men Who Have Sex With Men (MSM), or alongside it as '*MSM and transgenders*'. However, categories such as MSM (and WSW[6]) cannot be used to describe transgender communities. When the words '*men*' and '*women*' prop up, the question has to be asked: '*what is meant by men and women*?'. In the case of transgender people, this can either refer to the body they have, partially have (genitals), or were born with. It might also refer to their identity, which can be equally, if not more, complex. It is clear that applying descriptions, such as '*men who have sex with men*' or '*women who have sex with women*', in order to contextualise HIV prevention, does not work, as it assumes transgenders to have a specifically gendered body, as well as a specific sexual practice which they might exclusively engage in, which is not the case.

Realities and needs versus HIV prevention responses

Currently many organisations, as well as the UN and governments, will only acknowledge the '*sex*' of a person they are assigned at birth, or, in the best scenarios, the one they legally hold. This has led to the inclusion of transgender women into the MSM category, which turns transgender women invisible or leads to misrepresentation in statistics. While services thus cater for '*MSM*', or for '*MSM and transgenders*', an effective definition is placed onto transgender women, as to what their bodies are, what sexual practices they engage in, and with whom. The result is that their specific needs are lost, and that access to services is often limited to services that primarily are focused on, and tailored to '*cisgender*' men.

…the majority of crimes directed at transgenders are 'discovery crimes'…

While transgender women are '*lumped together*' with MSM, transgender men, however, are far more invisible. There is little to no research done in terms of the specific risks and needs that transgender men face within the current HIV pandemic. Often, the risks they face are not considered, since transgender men do not fit the stereotypical risk groups, such as gay men and sex workers.

However, transgender men's sexual preferences are as diverse as those of '*cisgender*' men. They clearly do inhabit high-risk groups, and thus, face many of the same risks, while having very specific needs on top of that. It is unquestionable that many transgender men, regardless of whether or not they have undergone any surgical and/or hormonal treatment, engage in sexual activities with other men (both trans- and *cisgender*) in- and outside (*cisgender*) gay male communities. On top of that, their specific bodies warrant additional concerns, such as pregnancy, due to vaginal sex they might engage in.

It is also safe to say that transgender men are present in the sex industry as sex workers[7], despite often not being recognisable as such. Within the sex industry, workers mostly present themselves as they perceive is commercially viable – '*cisgender*' men might pose as pre-op transgender men, if they can pass as such, post-operative transgender women might hide the fact they are transgender women, and transgender men will seek to position themselves in a place that is useful for them. There are transgender men, who work as '*cisgender*' women, while they can still

pass as one, or as transgender women, when they can no longer pass as one. And there are those, while not a very visible group, that do advertise as transgender men, with whatever body they have. Considering the discrimination that transgender people can face, as well as the costs of seeking hormonal and surgical treatments, their presence in the sex industry should not be a surprise.

The absence of transgender men in HIV prevention is based on the unquestioned assumption that transgender men do not engage in '*high risk activities*', something that, arguably, is based on the stereotype that transgender men are not '*men*' per se, because they do not have the body to engage in the sexual practices that men can engage in. Their sexual practices are discarded in similar ways as sexual practices of lesbians are.

…there is little to no research done in terms of the specific risks and needs that transgender men face within the current HIV pandemic…

Related risks

The risks transgenders face should also not only be understood purely in the context of their bodies and sexual practices, but also in a social context. As a social minority, transgenders find themselves facing stigmatisation and discrimination. Sexual violence towards transgenders is high, many of this violence is directly related to their gender, as the majority of crimes directed at transgenders are '*discovery crimes*', sometimes committed by former or current (sexual) partners. Transgender men are at risk of '*rape to cure*', like lesbian women are. Economically, discrimination against transgenders renders option for work scarce, and thus, many enter the sex industry. Other considerations include drug-use and other substance abuse, as well as migration[7]

Remaining challenges

As assumptions regarding to the bodies and sexual practices of transgenders continue, HIV prevention will only succeed to be effective for the group of people that finds themselves fortunate to fit the definitions of men and women that are unmistakably implied in current language used within HIV prevention efforts. Nowadays, there is extensive, both academic and anecdotal, knowledge concerning language and sexual practices within the transgender/queer/gay and lesbian communities, and in the fields of transgender/queer/gay and lesbian studies. However, this knowledge is mostly absent in policy and practice dealing with transgenders and HIV prevention, and other health practices – partially, because transgenders are still awarded only a place as recipients of such prevention efforts and practices. The clear gap between what policy dictates and what is practically efficient shows the urgent need for community involvement on all levels in the response to HIV in order to make services efficient, accessible and friendly for transgenders.

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FOOTNOTES:

1. When I use the words '*men*' and '*women*' when refer to transgender individuals, I always do it according to which gender they identify with, regardless of chromosomes, body, etc.
2. '*Pre-operative*' refers to whether or not someone is planning to have surgery to alter their primary sexual characteristics (specifically genitals) to conform to their gender identity. '*Post-operative*' and '*non-operative*' thus refers to either, already having had such surgery or not planning/wanting to have it.
3. '*Surgical treatment*' refers to either bottom surgery (genitals) or top surgery (breasts). Someone can have had one and not the other or both.
4. '*Passing*' refers to being able to '*pass*' as a certain gender, in other words, people do not realise one is transgender at first sight.
5. Enlarged as the result of hormone treatment (testosterone in transgender men's case).
6. '*Cisgender*' is a neologism meaning the opposite of transgender.
7. 'Women Who Have Sex With Women'.
8. This is from personal observance of transgender men, I am acquainted with, who work, or have worked, as sex workers.
9. Especially in terms of transgender sex workers, who are a considerable part of migrant sex worker communities in Europe.

ALQ | June 2009

Martha Qumba

Why are we being left out…?
Older women and HIV risks

The increasing rate of HIV infections amongst the elderly, particularly from the 'less fortunate' communities, is alarming, especially since there is a lot of awareness raising happening in these communities. It almost seems like this group has been forgotten.

An elderly woman, Constance Macozoma, an AIDS activists and the deputy chairwoman of the Health Committee in Langa, said:

> *…the 70 year olds and upwards are the most infected by HIV, because they are scared of talking about it. They are also scared of how their children would react, when they disclose their status.*[1]

Culture and expectations

Women, 50 years and older, are not expected to be sexually active, especially when their husbands are dead, because of the patriarchal system, defining that women have to be under men's control. The patriarchal system '*tells*' women to behave in a certain way, and that '*way*' should satisfy men. This widespread system has affected the lives of women in general, and it has also influenced women's bodies. Women are taught to be with men, and do what men want them to do. A woman is expected to get married and stay with her husband till he dies. When the husband dies, the woman is not to engage in sexual intercourse, because her husband is dead. Once a widow '*jolls*' (has an affair), the woman is often seen as a '*whore*', or a '*bad woman*', who sets a '*bad example*' to her children, and to the community at large.

I agree with Ma Constance, in that women do not want to be seen as being sexually active in their communities, thus, they will rather be quiet about their HIV status. However, this raises a lot of questions. Does it mean women do not have any sexual needs? Does culture mean people have to suppress their feelings in order for them to be real humans? Is there anything '*wrong*' when these women are in relationships, if they want to be? What does culture say to men? Who is the interpreter of culture?

These are some of the questions that came into my mind, when writing this article. I think it is important to ask these questions, so that we have an understanding of what women are going through in most communities. One thing that the culture, or '*culturalists*' need to understand is the fact that culture cannot change one's feelings; but it seems to be good in suppressing them. Also, culture cannot change something that is natural, because culture itself is not natural – culture changes. Clearly, women, widows or not, have sexual feelings, which are natural. Yet, culture attempts to suppress these feelings. So, how can culture and something that is natural be balanced? I am not arguing against culture here, I am arguing against culture that oppresses and suppresses women.

It is because of culture that women cannot be free to express their sexuality or sexual feelings. In that regard, culture is not doing any good to elderly women or women in general, because culture seems to completely ignore the needs of women, and places women in risky situations. For instance, cultural expectations do not make women immune to HIV risks. As such, there is a great need for HIV and AIDS programmes not to sideline women, aged 50 and older, but instead to ensure that programmes do cater for their needs. Programmes need to tackle and unpack the issues of culture, stereotypes about women in general, and their impact on women's lives. Also, the programmes must

make sure that women have choices in life, and that no one can impede on them. At the end of the day, women must understand that there is nothing '*wrong*' in being involved in sex, see sex as natural, and as a human need.

> *…there is a widespread belief that elderly people, women in particular, are not sexually active, because many of them are widows…*

…seems like this group has been forgotten…

In most HIV and AIDS programmes, elderly women are ignored and forgotten, because they are perceived to be safe, since they are widows – a very dangerous assumption. This assumption has indeed placed women's lives in danger of contracting HIV, and some have died as a result.

> *You know, there's still a lot of stigma attached to HIV and AIDS. Some people still think that when one is infected one is actually sleeping around, or a 'whore'. Most women are being called by derogatory terms. Then it would become very worse, when a 70 year old woman is infected.*[2]

To add more to cultural or societal assumptions, my friend told me that one day she met a 60 year old woman, but she looked as if she was in her 40s, because of her beautiful body. The woman shared her experiences of being admired, or proposed, by young men, and how some of these young men '*go crazy*' for her. My friend told me that she looked to the other side of the road, because she felt so embarrassed and uncomfortable in engaging with the woman on that kind of a subject. According to her, she did not expect a woman of that age to be sexually active or '*jolling*', because of what women are expected to behave like, once they are single, or the husband had died. My friend did not even respond to the conversation, because of her shock and embarrassment. She said in Xhosa '*haybo, umama ongaka angathini ukuthetha ngezonto kum*' ['*haybo, how could such an old woman talk about those things to me*'].

She later confessed to me that she is still trapped in societal conventions that say women of that age are not at all supposed to be sexually active, or engage in sexual intercourse. And these beliefs reinforce stereotypes about women in general. In the eyes of the society, women can only engage in sex with their husbands, and once they die, women cannot be involved in sex, as that is seen to be against culture.

'Cultural bondages' *and respect*

My friend's assumption really shows the '*cultural bondages*' that women in general are living under, and are facing on a daily basis, and that these '*cultural bondages*' have, in one way or another, worsened the lives of women.

> *I understand why the elderly don't want to talk about it. Some young people are looking up to us as old people and some respect us. I understand this is a very difficult thing for them.*[3]

'*Cultural bondages*' have not only made women's lives worse, but also the relationship between young and old women is in tatters. The young women cannot share their love affairs, or sex matters, with older women, because of their age – it is culturally not allowed. Young women are told that it is a sign of respect not to talk about sex matters in the presence of older women. This is how '*respect/ looking up to*' has been defined by culture.

…in order to have a healthy and progressive society...women cannot be neglected and forgotten…

So, my friend expected the younger woman to have '*respect*', and not to talk about those matters to her. There

is no doubt in my mind that my friend's understanding of '*respect*' is based on how society defines '*respectful*', and how society expects women to lead by example.

Many children are, undoubtedly, being brought up with these kinds of '*bad*' influences. Also, young people are expected to use a language that is suitable for old people, when in their presence. In some cultures, talking about sex is seen as '*rude*', and disrespectful – no matter the age. However, it seems even worse, when young people do it.

…without addressing the root causes of older women's risks, HIV programmes… will continue to fail…

Ma Constance remembered that at an HIV awareness programme, she attended in Langa, the facilitator reminded the youth to be mindful of the language they use, because there were old people in the room. Reflecting back, she said:

> *There is nothing wrong speaking openly about HIV and AIDS. These kids have to speak about sex matters openly in order for them to understand. Some felt the youth was rude, but they were not. How will they learn, if some things are not spoken about? Those are the kinds of problems we need to consider.*[4]

If the definition of '*looking up/respect*' implies that women, 50 and older, cannot talk about HIV, because HIV is about sex, I would strongly argue that this definition is dangerous and misleading. I also want to challenge all, who are '*culturalists*' to look at their definition of '*respect/looking up*' and '*culture*', and see if it does any good to people who are infected with HIV. According to my understanding of culture, I would argue that these definitions are '*killing people*', and do not offer any good for the betterment of society. The challenge of HIV and AIDS programmes would be how to close these cultural gaps between the two generations, and actually to convince the elderly women that there is nothing '*wrong*' in talking about sex in the presence of young people, and vice versa.

Knowledge transfer

Women, 50 years and older, are also seen as the '*source of knowledge*' and expected to transfer their knowledge to younger women – knowledge about cultural life in general. As such, older women are playing an important role, not only in young people's lives, but also in the community as a whole. So, if older women are regarded as '*useful*' in terms of knowledge, why are they excluded from accessing knowledge about HIV and related risks? If women are being excluded from this particular knowledge, how then can they fulfil their role and transfer knowledge to younger women?

…it not only excludes older women, but also places their lives into a situation of greater risk of contracting HIV…

While writing this article, these are the types of questions that I keep on asking myself, as I am trying to understand if the definition of '*respect*' is indeed relevant to nowadays realities, or if it is something that causes more harm to people, as it seems to increase women's risks of being infected with HIV. In short, elderly women's knowledge transferral would seem useless, if their '*plight*' continues to be ignored, since more young women would '*struggle*' in dealing with life issues in general, because they would not have any particular knowledge pertaining to HIV and AIDS. In this case, young women won't have the necessary tools to deal with HIV-related issues. This, in turn, could also impact on the knowledge transfer regarding HIV care-giving tasks.

HIV risks

You see, elderly women are infected. It happens like this: an old married man sleeps with young girls, without a condom, and comes back home and sleeps with his wife without a condom. And a woman can't refuse or ask him to use a condom – or maybe we trust our men too much; I don't know. Men, in general, don't want to use condoms and you know that. They want flesh to flesh. Some believe that putting a plastic on a penis it's not at all natural, and women have to satisfy their husbands. Thus, they shouldn't ask anything, or refuse to have sex with their husbands. Some of the young girls like old people and they call them 'sugar daddies', because they give them money or they are the providers.

…HIV programmes must come up with innovative ways of introducing the 'sex subject'…

Culturally, a woman is expected to satisfy a man and she cannot say '*no*'. If a man refuses to use a condom, a woman cannot refuse to have sex. The heterosexual society puts men first and women second, thus women cannot challenge anything a man does or says. This system makes women '*dependent*', '*victims*', '*incapable*', '*lesser human beings*', and '*subservient*' to men. Some religious fundamentalists are also advocating for this by using the bible, the so-called '*holy book*', to push their agenda, and to ensure that the '*status quo*' remains the same.

Ma Constance, talking about various ways in which older women get infected with HIV, continues in saying:

What happens is that some of these elderly women got infected, while they were younger and when their husbands were still alive. The virus can stay in one's body for many years, before one realises that one is HIV positive … Sometimes, these old women look after their sick children and most don't use gloves, when they bath them. Some don't know that a person can be infected through blood transmission.[5]

HIV programming

Reflecting further on the realities and needs of older women in communities, Ma Constance points out that:

…we are being excluded from the HIV and AIDS programmes, because of the perception about us. There's a need for us as elderly to be involved, and to be educated around these issues.[6]

Expressing her anger about the lack of HIV and AIDS programmes catering for the elderly, she concludes in saying:

…everything focuses on the youth. Why we are being left out? There's no way that you can leave us behind, because we are affected and infected.[7]

There is a great need to better understand the '*plight*' and needs of women aged 50 and above, so that strategies could be developed to effectively address their realities and needs. There is also a need for HIV and AIDS programmes that specifically focus on elderly women, so that women can be empowered when it comes to HIV-related issues. These programmes would assist women to respond to HIV and AIDS issues, including to freely talk about issues of HIV and sex. These programmes should also be designed to challenge and question the stereotypes about older women, so that, at the end of the day, women can live in a harmonious society, where not their age matters, but their existence. Ultimately, who women have sex with would no longer be a matter of concern, but instead how women engage in sex. However, if these programmes are not being developed, elderly women will continue to be infected with HIV, and continue to die.

HIV testing

…I know most elderly don't go for HIV testing, because there's no emphasis on them to do so.[8]

Although Ma Constance stresses the importance of HIV testing programmes, I believe that these programmes will not have any impact, without addressing the assumptions about older women – thus, before HIV testing programmes are put in place, stereotypes about women, aged 50 and above, need to be challenged and changed. There also need to be programmes in place, which are educating and talking about their '*plight*' and the challenges women are facing in society. In addition, society must understand that older women do have sexual needs, and that there is absolutely nothing '*wrong*' with women of any age to have sexual desires and needs.

…assist women to respond to HIV and AIDS issues, including to freely talk about issues of HIV and sex…

Recognising that HIV is about sex, it is important that HIV programmes come up with innovative ways of introducing the '*sex subject*'. Also, HIV programmes need to bridge the big gap between young people and old people, by creating some new ways of communication between the generations, so that the two can use one language to address HIV and AIDS.

A woman from Gugulethu, who refused to be named, shared her experience about an elderly family member:

She was bedridden for two years. She couldn't eat nor go to the toilet. She was doing everything in bed. One day, while lying in hospital, she confessed to one of our neighbours that she was HIV positive. And she was scared to disclose it, because most people don't expect the old people to be infected with HIV. She was also scared of how many people would react towards her. She was in her seventies, and so, I understand her concern or fears. I really never thought a person of her age could die because of AIDS. I now understand that it doesn't matter how young or old a person is; anyone can be infected. People must be careful, because HIV and AIDS is here to stay, and we can't run away from it.[9]

Talking about the need for HIV programmes focusing on elderly women, she agreed that there should be separate programmes, and that the elderly must be encouraged to go for HIV testing, so that they can know their HIV status.

Activist Responses

Riza Gahru, an activist from Langa, highlighted that women in general are still oppressed, and that is why more women are infected with HIV. She further mentioned that:

There are women, who are still sexually abused by their husbands. These women can't say 'no', because they are scared of being beaten up. And elderly women are not immune to this crisis. We have a long way to go as women, but we need not to give up.[10]

Lihle Dlamini, TAC KwaZulu-Natal provincial coordinator confirmed that HIV infections are increasing amongst elderly women.

Some of the elderly women got infected by looking after their sick children, because some women bath their children without gloves on – and they may have sores or cuts on their hands. Also, some of their husbands sleep around with young girls, without a condom, and get infected. (…) Our programmes at TAC involve everybody. We don't have a specific programme for the elderly. TAC can assist them with regards to training. We do see a need for older women to have their own programmes, but we do not offer such programmes, because of the lack of financial resources to do so.[11]

There are arguably two key and dangerous points that emanate from Lihle's assumptions – the fact that women,

aged 50 and older, only get infected with HIV by looking after their sick children, because some do not use gloves, and the fact that women get infected with HIV through their husbands. Since she does not emphasise the point of older women being sexually active, it seems to indicate that Lihle believes that women, 50 years and older, are not sexually active. Maybe she also grew up with an understanding that older women are not supposed to be involved in sex anymore, because they are widows, or because they do not have sexual needs. Here I am trying to show, what cultural influences can do to some people, who are seen as activists and, as challenging, informed and educated.

…the relationship between young and old women is in tatters…

Again, this is a very dangerous assumption to make, because it not only excludes older women, but also places their lives into a situation of greater risk of contracting HIV. If, for example, AIDS activists, like Lihle, continue to ignore the real risks of older women and, thus, help to spread the myths about them, then AIDS activists are likely to fail women, aged 50 and older – making them more vulnerable, without any mechanisms or remedies available to prevent the problem.

Let alone the challenge of older women perceived to be not sexually active, but they are also care givers in their communities, which means that they are already exposed to HIV risks. Are there programmes in place to assist women care givers? If, the answer is '*no*', then older women are not taken care of, even though they are doing a great job in their communities caring for people living with HIV. How can older women's needs be neglected, while they are saving many lives in communities? There is no doubt in my mind, that this neglect is as a result of how older women are being viewed, resulting in the fact that their role has been largely undermined.

Concluding remarks

Special HIV and AIDS programmes, designed specifically for women aged 50 and older, should be put in place to prevent HIV infections in this age group, and to respond to many of the challenges raised above. Also, programmes need to be designed in such a way that challenges some of the perceptions about women. My fear, however, is, that these '*special programmes*' will be looking at the issue of HIV in isolation and fail to show all the other issues, that place older women at risk. Such a narrow approach to HIV programming for older women would exclude many pertinent and important issues, and will not be in the position to address the societal problems that women are facing, including negative attitudes about women who are sexually active. Without addressing the root causes of older women's risks, HIV programmes – even if designed to focus specifically on the needs of women aged 50 and older – will continue to fail women, and thus, have little or no impact on women's lives and HIV risks.

In order to have a healthy and progressive society with effective HIV and AIDS responses, women cannot be neglected and forgotten, and their realities and needs need to be taken into account, when designing HIV and AIDS programmes addressing older women's HIV risks.

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FOOTNOTES:

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3. *Ibid*.
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Julius Kaggwa and Liesl Theron

The untold reality…

Sexual rights and transgender people in the context of HIV and AIDS

Sexual rights are still a subject of contention in many parts of Africa. The subject draws an even greater debate, when considered in light of the equally contentious issue of HIV and AIDS. Sexual rights refer to the freedom of sexual expression for any and/or every individual and the right to access related sexual health information and care. It is an established fact that the commonest means of contracting HIV and AIDS is through sexual activity, which justifies the many intervention and prevention strategies, the world over, focussing on behaviour and attitude change, especially in the area of sexual activity and expression.

Sadly however, these interventions and messages are exclusive to the conventional sexual expressions and relations, such as heterosexual sex – which is the sexual activity between a woman and a man – and do not embrace the minority sexual relations, such as sexual activity among transgender and intersex people – which is a sexual activity between gender variant people – and none, or extremely few, of these interventions have focused on these most vulnerable and high risk populations.

The question we, therefore, need to address is this: Should HIV and AIDS interventions be further tailored to address the sexual rights of all people? This article attempts to address the subject of sexual rights of transgender people in relation to HIV and AIDS, and to explore references to particular parts of the world, where sexual rights barely exist, or are just ignored, but where the incidence of HIV and AIDS is catastrophic.

Realities and needs: An overview

Over two decades into the HIV epidemic, most African countries have adopted strategies and developed programmes to prevent and/or control the epidemic. In many countries in Africa, bold messages targeting the general hetero-normative populations have been communicated through radio, television, roadside bill boards, and numerous public educational materials and seminars. The messages are clear in that HIV infection progresses into AIDS, and they are clear on how HIV is transmitted and how to avoid transmission. In many African countries, enormous resources have been, and are still being, spent to establish HIV prevention organisations and to address HIV-related social and health problems. However, gender and sexual variance is still a key social determinant of health inequalities in Africa. High sero-prevalence rates, among transgender people in Africa, are

a direct consequence of stigma and discrimination against this population based on public health practices and policies in most African countries.

…refusal to recognise sexual rights… constitutes a key opposing factor to the reduction of HIV prevalence…

Limitations in education and employment have made most transgender people in Africa economically incapacitated and, therefore, unable to afford basic life necessities, such as housing and access to private healthcare services. As a result, a large percentage of biologically male individuals who are transgender have resorted to sex work as a source of livelihood, while biologically female transgender people are victims of '*curative*' rape, which makes them highly vulnerable to HIV infection.

Sex work

According to a review[1] from a reference centre in Rome, reported at the International Conference on AIDS, held in 1998, an increasing number of foreign transsexual sex workers went through the centre for HIV testing and treatment. The data collected suggested that HIV prevalence among transsexual sex workers from Africa accounted for two thirds of the clients at the centre, over a period of six years.

According to Plus News, 21 August 2007[2],

> *...in many parts of the world, men who have sex with men often hide their sexual preferences for fear of being harassed by police, ostracized by their families or discriminated against by their communities. But transgender people, who do not identify with the sexuality they were born with ...are less likely to hide their sexual orientation, and face even higher levels of stigma and discrimination than men who have sex with men (MSM)...The result, according to presenters at a special session on transgenderism at the 8th International Congress on AIDS...is to push them further underground, making them extremely hard to reach with HIV prevention, care and treatment.*
>
> *They often suffer from depression as a result of rejection by family and friends, which can lead to substance abuse and other risk-taking behaviors, making them particularly vulnerable to HIV infection.*

In '*Off the Map*', a report by the International Gay and Lesbian Human Rights Commission (IGLHRC) on HIV programming in Africa and its relevance to same-sex practicing people[3], it is reported that a small but growing number of LGBT interventions are now focusing on same-sex practicing people. However, that there is no evidence relating to HIV strategies and interventions, for transgender people and their HIV risks in Africa, is tragic. In addition, efforts to secure funding to cater for HIV programmes for transgender people are still fruitless.

A study analysing sex work and HIV status among transgender women[4], conducted in June 2008, which involved 6,405 participants from 14 countries, confirmed that

> *Transgender women are a key risk group for HIV, and epidemiologic studies have attributed high rates of HIV infection to behaviors associated with sex work in this population...* [The review] *compared HIV*

prevalence among transgender female sex workers (TFSWs) with prevalence among transgender women who do not engage in sex work, male sex workers and biologically female sex workers.[5]

…transgender people face lifelong health risks and shortened lives…

The study further showed that, compared to other groups, biologically female sex workers had the lowest HIV prevalence of 4.5%, and transgender female sex workers had the highest HIV prevalence at 27.3%.

One of the recommendations from the review was to reduce reliance on sex work for survival among transgender people, as a direct means to reduce HIV prevalence among this population.

Health information and treatment

Regardless of evidence that transgender people in Africa represent one of the most critical HIV high risk groups, most African countries are still disinclined to address the health and psychosocial disparities in HIV interventions for transgender people. In fact, the public health policies of most African countries are either hostile to, or at best, silent about the needs of this minority or vulnerable population.

Culturally and politically, non-heterosexual sex is considered immoral and is not just discouraged, but also criminalised in most African countries. This compels transgender people to refrain from seeking health services. Sexually risky behaviour resulting from lack of appropriate information and interventions for this population has fuelled the incidence of STIs and HIV and AIDS in most of Africa.

However, there has been increasing publicity and evidence that many people, from all walks of life, practice and express themselves through non-heterosexual sexual activity. There are many people who engage in sex, which is anal and penetrative and still some engage in oral and other kinds of sexual activity for pleasure, and for survival, while others are forced into it. The subject of debate is usually whether or not these people – heterosexual and transgender – have rights to protective health information and treatment in their chosen, preferred, forced, or intrinsic sexual expression.

…did not include or address the alarmingly 'sorry state' of sexual and gender non-conforming people in Africa…

In many instances, policy makers and medical practitioners are sceptical and scornful of the nature and sexual expressions of these people and are, therefore, not prepared to develop any supportive strategies to enable this population to deal with HIV and AIDS. Whereas many organisations are doing credible work with the youth, women and men living with HIV and AIDS, there is, undeniably, little being done to address the sexual rights of transgender people.

In addition, most transgender people either undergo, or contemplate undergoing, sex re-assignment hormone

treatment. This treatment – most of which is intravenously injected – is both unavailable and illegal in most African countries. Therefore, transgender people who take hormone medication in these countries, do so without proper medical advice and supervision, and without crucial information on its side effects for HIV positive people, or its interactions with anti-retroviral (ARV) drugs. For example, an article by Future Treatment for HIV 2007[6], states that

> *…recently published clinical trials have concluded that the risks associated with prolonged hormone-replacement therapy (HRT) exceed the potential benefits of such treatment* [although] *…there are no data describing drug interactions between ART and HRT.*[7]

…there is, undeniably, little being done to address the sexual rights of transgender people…

However, a case study done by the University of Washington between 2004 – 2008 reveals that, while the risk of HIV transmission through injection hormone use varies from region to region, many

> *…transgender women harbor the misconception that the neovagina is resistant to HIV, but dilation and sexual activity can cause micro-tears in the neovagina, creating ideal conditions for HIV transmission. Moreover, a thorough sexual history should be taken at each visit, and sexually transmitted diseases screening should be carried out… Thus, recommendations regarding the timing of initiation of antiretroviral therapy do not differ for transgender individuals.*[8]

…rights to protective health information and treatment in their chosen, preferred, forced, or intrinsic sexual expression…

The article further states that sex hormones, especially oestrogen, have potential drug-to-drug interactions with antiretroviral drugs, although the effect of oestrogen on antiretroviral medication levels seems limited to a few antiretroviral medications. Although there is no known significant contra-indication between sex hormone therapy and HIV medication, it is important that transgender people are advised on which sex hormones should not be co-administered with antiretroviral drugs.

At the 14th International AIDS Conference in Barcelona, the HIV situation in Africa was described in heartrending precision, revealing very high rates of infection with millions dying each year, due to lack of HIV prevention information and affordable treatment, while huge numbers of orphans infected and affected by HIV are left behind. This, however, was still a representation of the general hetero-normative population in most of Africa, and did not include or address the alarmingly '*sorry state*' of sexual and gender non-conforming people in Africa. The untold reality of transgender people, who do not have the option of either establishing committed relationships or engaging in gainful economic activity other than sex work, and who are not provided with relevant HIV prevention information and treatment, is that the more sexual partners

they have, the greater the exposure to HIV infection; and more exposure may mean first time infection for some and multiple infections for others, leading to greater susceptibility to numerous opportunistic diseases and earlier deaths.

...compels transgender people to refrain from seeking health services...

While it has been argued over the years that fear is not the best way to motivate safer behaviour, the behaviour of transgender people in Africa is constantly driven by fear, as they evade arrests, detentions, harassment, and numerous other hate crimes, as grave as murder, from both state and non-state agents. Since HIV, and some other sexually transmitted illnesses, are lifelong infections, which result in early deaths, transgender people face lifelong health risks and shortened lives, if they are not included in both national and global HIV strategies and policies. African governments need to realise that absolute health cannot be a reality, unless health programmes focusing on high risk minority groups, such as transgender people, are in place.

Owing to the severity of the matter, many transgender people have – at the risk of being further victimised – come out openly to tell their respective governments and civil society to consider their sexual rights, because they are part of the general population, and have demanded that their constituency should also be included, when designing and implementing HIV and AIDS interventions and messages.

Commitments and progress

Some African countries, such as Tanzania, Swaziland, and South Africa have showed commitment to improving its HIV and AIDS response to include vulnerable groups in HIV and AIDS programming. Firmer steps in this direction have also been taken by regional institutions, such as ACT Africa[9], which hosted workshops in Anglo and Francophone Africa on vulnerable groups in HIV and AIDS programming in Africa. The vulnerable groups considered in the workshops included transgender and intersex people, commercial sex workers, refugees, women, men who have sex with men, women who have sex with women, long-distance truck drivers, youth, and prisoners.

The *2007 AIDS epidemic update*[10] reported that

> *Every day, over 6800 persons become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services. The HIV pandemic remains the most serious of infectious disease challenges to public health...Examination of global and regional trends suggests the pandemic has formed two broad patterns: generalized epidemics sustained in the general populations of many sub-Saharan African countries, especially in the southern part of the continent; and epidemics in the rest of the world that are primarily concentrated among populations most at risk, such as men who have sex with men, injecting drug users, sex workers and their sexual partners. Sub-Saharan Africa remains the most seriously affected region, with AIDS remaining the leading cause of death there.*

HIV and AIDS interventions cannot achieve the desired results, when isolating minorities, who are key and sexually active groups, such as transgender people.

Inclusion of these groups necessitates appreciation of their sexual rights. Obstinate refusal to recognise sexual rights, as an integral part of universal human rights in HIV prevention policies and strategies, constitutes a key opposing factor to the reduction of HIV prevalence.

…that there is no evidence relating to HIV strategies and interventions, for transgender people and their HIV risks in Africa, is tragic…

Social and cultural issues, just like science, are always evolving. Change and the ability to adapt to it are the ingredients of a dynamic and progressive society. Any society can resolve to adapt to any necessary changes within its social and cultural moulds in order to ensure that all freedoms of its people are protected. In the era of searching for best practices and responses to HIV and AIDS, it is a matter of urgency to recognise the sexual rights of minority groups, such as transgender people, in order to guide successful HIV and AIDS programming.

As stated in the International Guidelines on HIV/AIDS and Human Rights, and stipulated in the Commission on Human Rights (CHR) Resolutions,

> *…the protection of human rights is essential to safeguard human dignity and ensure an effective, rights-based response to HIV & AIDS…We recognize that preventing the transmission of HIV is complex and requires the creation of an environment in which people are free to acknowledge their sexual identity, to seek information and get information, to experience the support of peers and role models, to receive services that fit (rather than exclude) their experiences, to see themselves written into (rather than out of) culture, knowledge, and society. For gays, lesbians, bisexuals, and transgendered people, preventing HIV transmission requires eliminating discrimination based on orientation and gender identity.*[11]

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Bongiwe Radebe

Subjected to preventable HIV infections…

Married women and HIV risks

Marriage is a contract, which, like any other contract, depends on an agreement (consensus) between the parties concerned. According to this understanding, the consenting parties must have the capacity to act, and be willing, to enter into a '*contract of marriage*'. As such, a '*contract of marriage*' is not a union to immunise couples against HIV.

Statistics indicate that 60% to 80% of all women infected with HIV had only one sex partner in their life, and 80% of all new HIV infections in women occur in marriages and/or long-term relationships.[1] In some places, the main HIV risk factor for a woman is the fact that she is faithful to a husband with previous or current other sex partners. Among sexually active young women, aged 15-19 years, in the cities of Kisumu (Kenya) and Ndola (Zambia), a multi-centre study reported that HIV infection levels were 10% higher for married women, than for sexually active unmarried women.[2] In rural Uganda, among HIV infected women, aged 15-19 years, 88% were married.[3] These statistics reflect especially young women's risks, as young women often marry men significantly older than they are, and these men are the ones more likely to have had other partners, and, therefore, are more likely to have been exposed to HIV prior to the marriage.[4]

This high possibility of exposure to HIV is not discussed by both parties involved prior to getting married. It is up to a man to decide if he wants to use a condom or not. Women have limited opportunity to exercise and enjoy their rights and freedoms, especially their sexual and reproductive rights. Also, existing socio-economic inequalities and imbalances further limit women's '*ability*' to make decisions, as in most cases women depend on men for financial and economic support. In addition, the patriarchal societal context limits women in negotiating safer sex, because of prescriptive behavioural expectations placed on women in general, and married in particular.

Marriage and societal expectations

The '*concept of marriage*' extends to societal expectations that a married woman should bear children, if she wants to maintain her status as a '*good wife*'. This expectation means that women must subject themselves to unprotected, and, thus, unsafe sex. Automatically, women cannot negotiate condom usage, as it would be contrary to the societal expectation that women must bear children, irrespective of whether or not women want to have children.

If a woman should refuse to conform to these societal norms, or try to insist on condom use within the marriage, she will most likely be subjected to domestic violence, gender-based violence, and rape, and be rejected by her family. To initiate condom use will be perceived like a woman is unfaithful to her husband, or does not trust her husband. It is very seldom that a woman will get support even from the community. Should it happen that she is living with HIV; a woman will face stigma and discrimination, combined with limited access to treatment, care and support. Seemingly, there is no easy way out for married women. The reality, however, shows that HIV infection rates amongst people 50 years and older are climbing – and self-reported condom use is declining from 51.9% outside/before marriage to 17% within marriage.[5]

Even if a woman forces herself to conform to societal

expectations and gets pregnant, the consequences of an HIV positive status are vested on her. If she is pregnant and gives birth to an HIV infected child, she will be blamed and seen as the one who brought the disease home. Even if she gives birth to an HIV negative child, but uses a formula feeding method, she will have to explain why she is not using the ideal breast feeding method. Either way, she will be subjected to stigma and discrimination; and not only does she lose her right to make reproductive decisions, but she also loses her right to privacy, as she will be forced to disclose her HIV status, both to her husband and to her in-laws, with the hope that they will have mercy on her.

…there is no easy way out for married women…

Marriage, violence and HIV risks

Married monogamous women are highly vulnerable to HIV infection, due to the lack of rights within the marriage; difficulties negotiating safer sex; extended partner abuse; and domestic violence.[6] Moreover, due to existing gender imbalances, women often find themselves less in the position to negotiate safer sex practices with their husbands, and thus, placing themselves at greater risk of HIV infection.

Both married women and women in long-term heterosexual relationships are also often subjected to sexual violence. Some men and women do not regard marital rape as a rape, despite the fact, that marital or spousal rape is a criminal offence, because sex without consent is by law regarded as rape. There is also the societal misconception that a marriage certificate means the right to sex. Sex is another way of exercising power over women. Some women are sexually violated by their spouses and are not even aware that their rights have been violated. Sex within marriage is perceived as a right and, thereby, rape as a crime seems not to be applicable to married couples. Some families regard violence, such as rape, as a personal issue that should be left alone, which further perpetuates married women's risks to sexual violence and HIV infection.

Moreover, even when women are aware of the risks of exposure to HIV, they will rather stay in a relationship in order to prevent further abuse. Studies have indicated that married women would often risk HIV infection, rather than ask their husbands to use a condom[7] – highlighting how gender imbalance and inequality of power contribute to the spread of HIV.

Human rights versus HIV prevention

From a human rights perspective, we are all equal before the law, by virtue of being human, regardless of marital status, age, sex and pregnancy. It is, therefore, argued that HIV prevention messages are to be accessible, factual, include a realistic societal context that women find themselves in, and be human-rights based.

…not a union to immunise couples against HIV…

The 'ABC' prevention approach, promoted largely through the media, allows for different interpretations, questions, myths and misconceptions – as the messages are largely based on the concept of normative prescriptive behaviour.

A = Abstain: As there has been no time frame allocated to the 'A', it is commonly interpreted as do not engage in sex until married; implying that once married, sex is safe. Also, little attention has been paid to the production of educational material and messages, which are factual, accurate and clearly outline what to expect when one finally makes a decision to engage in sex, and the consequences thereof. In most cases, little is mentioned about the fact that the environment to make sexual and reproductive decisions must be conducive for such choices to be made.

B = Be faithful: Here, it has not been clearly defined who should be faithful to whom. Also, the right to decide

when, where, with whom, and how to engage in sex was seemingly forgotten, when the '*be faithful*' approach was created. The focus surely should be the protection from contracting HIV, and not the number of sexual partners; especially in a context in which culture, religion and society accept polygamy and multiple partner practices. '*Safety*' is, therefore, not about objecting to these practices, but instead about promoting safer sex practices.

C = Condomise: The target group selected for condoms has mostly been young people, with all publications, materials, and media campaigns emphasising young people as the vulnerable group to HIV infection, thus leaving the impression that HIV only affects young unmarried people. Moreover, the connotation of this approach has also been that condoms are for people who cannot abstain from sex before marriage, or who are unfaithful to their partners.

…leaving the impression that HIV only affects young unmarried people…

Millions of people followed this approach, but were not protected from the risks of contracting HIV, mainly because this prevention approach is directive and authoritarian; it prescribes '*acceptable*' sexual behaviour, without giving people a choice to make decisions about their sexual lives, which would, in turn, instil responsibility, and prevent '*excuses*' for not taking care of one's sexual and reproductive health – an approach that could avoid the new **ABC** approach: **A**ccuse, **B**lame, and **C**riticise.

Gender should not be overlooked

Gender imbalances, as an additional tool to women's abuse and excessive exposure to the risk of HIV cannot be dismissed. As indicated above, it is within the gendered context of society that women find themselves with limited power to decide whether or not to access medical care, including PEP, HIV testing, treatment, care and support, including counselling. Gender violence is one of the major obstacles in providing women with a safe environment to make informed decisions regarding their sexual and reproductive health. As long as gendered prescriptions of '*acceptable*' and '*unacceptable*' sexual behaviour prevail, women, married or not, will continue to have limited access to resources, and available prevention methods will not be successful, unless women feel free and safe to exercise their rights, including the right to decide where, when, with whom and how to engage in sex.

…implying that once married, sex is safe…

Concluding Remarks

Gender inequalities and imbalances as well as the prescriptive '*concept of marriage*', are to be understood as obstacles to HIV prevention, especially since women in heterosexual marriages continue to be subjected to preventable HIV infection. Whether we hide behind religion, culture, or societal norms, HIV, and married women's risks to HIV infection, are a reality, and women will continue to bear the consequences of HIV, and its impact. And while there are '*workable*' HIV prevention methods, such as condom use, marriage is certainly not one of them.

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Susan Holland-Muter

Blowing the whistle on hypocrisy…

Markets, Victorian culture, sex work and the 2010 World Cup

Calls, from various sectors of the ANC, for the legalisation or tolerance of the sex industry during the upcoming 2010 World Cup, have led to much debate amongst policy makers, human rights activists, sex workers, and the general public.

During discussions in 2006 on how to make the 2010 World Cup a success for South Africa, ANC parliamentarian George Lekgetho proposed that South Africa legalises sex work for the duration of the 2010 World Cup. His motivations, however, were nothing short of ludicrous; hypothesising that it would prevent rape and bring in revenue for government to help the unemployed. He argued that '*we hear of many rapes, because people don't have access to them*', and went on to say:

> *…if sex work is legalised people would not do things in the dark. That would bring us tax and would improve the lives of those who are not working.*[1]

In March 2007, the legalisation or tolerance of sex work was once again proposed, this time by former police commissioner Jackie Selebi. Concerned with the lack of personnel to enforce the ban on public drinking and sex work, he asked the Parliamentary Committee on Safety and Security:

> *…I want you to apply your minds to my dilemma of what to do with the thousands of soccer hooligans expected to imbibe in public spaces and those who would feel the urge to try out other more exotic pastimes both currently illegal in South Africa?*[2]

Authorities in Durban also proposed legalising adult entertainment venues during the tournament, arguing that similar facilities existed during the 2006 World Cup in Germany.[3]

The decriminalisation of sex work has in fact been one of the rallying calls of feminists around the world. In South Africa, feminists, human rights, and sex worker organisations alike, have long made the call to decriminalise sex work in order to prevent unnecessary arrests and harassment of (mainly female and under-resourced) sex workers, and to regulate the industry in order to improve their exploitative and dangerous working conditions in the sector. '*Official*' discussions, however, do not seem to respond to these calls, but instead to the needs of an expected influx of predominantly male football supporters during the World Cup.

At the same time, child and human rights organisations have warned that human trafficking could worsen in South Africa ahead of the World Cup, with trafficked women and children being forced into the sex industry.[4] While these issues are related, in that women are trafficked against their will into the sex industry, which constitute a human rights violation, the trafficking debate needs to be separated from the debate of de-criminalisation of sex workers, who are choosing to do this work as a means of survival.

However, what seems to be clear is that the South African government's focus is not on the plight of South African sex workers, or the violation of their right to work, or how their current illegal status makes it difficult to combat the exploitation they suffer. Government's focus is not on the plight of South African and foreign women

and children who could be trafficked into South Africa. Instead, government's focus is on being a '*good host*' and boosting South Africa's international image. What is clear is that the 2010 World Cup is about '*big money*' and about men's pleasure and interests.

...the decriminalisation of sex work has in fact been one of the rallying calls of feminists around the world...

What is the 2010 World Cup worth?

It has been estimated that the 2010 World Cup will contribute R21 billion to South Africa's gross domestic product (GDP); generate another R7.2-billion in government taxes; and the anticipated 500 000 visitors to South Africa are projected to spend some R9.8-billion in the country during the tournament.[5]

Nine South African cities (Johannesburg, Cape Town, Durban, Pretoria, Port Elizabeth, Bloemfontein, Rustenburg, Nelspruit and Polokwane) will host the 64 matches in the ten stadiums, which will seat more than 570 000 people during the course of tournament. People who will not be so lucky to watch the matches at the stadiums are being promised public viewing areas with giant screens, or are encouraged to watch the tournament and '*to get to know the locals at our numerous pubs, restaurants and sports bars*'[6]

Money will not only be coming in from the three million ticket sales, but also broadcasting rights, advertising revenue, hotels and other accommodation, transport, tourism and the entertainment industry.

With the influx of football tourists, there is also the assumption that there will be an increased demand on sexual services. The sex industry is part of the entertainment industry, as it uses the same hotels, bars, transport networks, and tourism industry. However, due to the illegal status of the sex industry, only parts of its profits will go into state coffers.

What is sex work?

Adult consensual sex work can be defined as '*the exchange of sexual services for financial reward*'[7], or, as defined more extensively by Arnott and Macquene [2002:11], as

> *...the negotiation and performance of sexual services for remuneration:*
>
> - *with or without intervention by a third party*
> - *where those services are advertised or generally recognized as available from a specific location*
> - *where the price of services reflects the pressures of supply and demand.*[8]

...child and human rights organisations have warned that human trafficking could worsen in South Africa ahead of the World Cup...

Who are sex workers?

Due to the illegal status of sex work in South Africa it is difficult to provide an accurate picture of the sex work industry. What is clear, however, is that the industry is diverse, highly mobile and largely invisible. Richter (2008)[9] points out that much of the published information on sex work draws on research done in Johannesburg, Cape Town, Durban, or on the mines. The human rights NGO, Sex Worker Education and Advocacy Taskforce (SWEAT), provides a broad stroke picture, outlining that the majority of sex workers are between the ages of 18 – 35 years, and approximately 90 – 95% of sex workers are women, the remainder being men and transgender persons. In terms

of place of work, the biggest distinction is between indoor and outdoor sex work. Indoor work is conducted from private homes, in brothels, hotels, bars and clubs, whereas outdoor work is conducted from the streets, national roads, from truck stops, and border posts. Sex work is also conducted via the phone, the internet or from adverts in daily newspapers.[10]

A survey of 200 sex workers in Cape Town, conducted by SWEAT in 2005, revealed a racial profile that mirrored the racial composition of the province; with 31% of sex workers Black, 54% Coloured, 14% White and 1% Indian[11]. A later study by SWEAT and the Institute of Security Studies pointed out that foreign nationals accounted for only about five percent of sex workers in Cape Town. A 2001 survey of 202 women sex workers in Johannesburg, conducted by the Reproductive Health Research Unit (RHRU), the Sociology of Work Programme from Wits University, and the Vrije Universiteit of Amsterdam, found that 11% of respondents were foreign nationals[12].

Morality, law and sex work

Like elsewhere in the world, sex work is highly stigmatised in South Africa. However, it is the (mainly female) sex worker who faces the brunt of social censure and stigmatisation, arguably, due to the fact that society's views on sex work are deeply rooted in a double standard of sexual morality for women and men. In this context, the (male) client is assumed to be merely satisfying his sexual needs. There is a tacit acceptance that '*men will be men*'. In the classic division of women's sexuality into Eve and Mary, it is sex workers who become the fallen women, who, in the public morality, become no more than '*sluts*', '*whores*', and '*deviants*'. The women sex workers become what Richter (2008) describes as the '*vendor of vice*', '*vectors of disease*', '*potential hazard to society*', and '*a core reservoir of STIs and HIV*'[13]. Subsequently, for the general public, it is the women sex worker who is popularly associated with drugs, disease, crime and moral degeneration.

The criminalisation of sex work in South Africa is rooted in the context of an Apartheid state, which inherited a legal framework based on Victorian morality, coupled with its own Aryan notions that sought to criminalise conduct which it considered immoral – homosexual sex, inter-racial sex and sex work.[14] In this context, sex outside of (heterosexual) marriage is a sin; sex without love is a sin; sex for financial gain is a sin; and sex for a women's financial gain is a heresy.

...the South African government's focus is not on the plight of South African sex workers ... Instead, government's focus is on being a 'good host' and boosting South Africa's international image...

The 1957 Sexual Offences Act (SOA) began as the Immorality Act 5 of 1927 that also outlawed '*carnal intercourse between Europeans and Natives and other acts in relation thereto*'. In 1957, the Act was amended to consolidate the laws related to brothels and unlawful carnal intercourse, as well as consolidating sexual offences previously contained in provincial laws and ordinances.[15] In 1988, the Sexual Offences Act was further amended, and Section 20(1)(aA) was included, criminalising the person who repeatedly sold sex for reward. At that point, all aspects of sex work were criminally sanctioned, except the buyer of services. Unlike brothels, running or owning an escort agency was allowed, provided the manager only arranged an introduction between the client and sex worker, which was not for the purposes of sex work. Most escort agencies were therefore illegal, but owners and managers were rarely arrested or prosecuted.[16] Further amendments to the law, Section 11 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007, extended criminalisation to the client of sex workers[17].

Even though sex work is illegal under criminal law, it is mainly the municipal by-laws that are used to arrest, fine and/or prosecute sex workers in South Africa. By-laws differ from municipality to municipality and across provinces. There is a loitering by-law that makes specific reference to sex workers that is used extensively. The most common by-laws are loitering in general, public indecency, and causing a disturbance.[18]

...with the influx of football tourists, there is also the assumption that there will be an increased demand on sexual services...

The state has argued that the purpose of the limitation is to eradicate sex work, because of its perceived association with organised crime, the exploitation of women, and the moral decline of society.[19]

In reality, however, Arnott and Macquene (2002) point out that a system of de facto decriminalisation exists in South Africa, in that the sex industry is left largely undisturbed by the police and law enforcement.[20] The majority of interventions are in response to public and community complaints. The targets of police action are the more visible street-based or outdoor sex workers, who are mostly arrested under the municipal by-laws. Sex workers are hardly ever prosecuted after arrest, but released once they have paid an admission of guilt fine or spent the night/weekend in jail. Continual arrests and fines have led sex workers to have to work more and longer hours, establishing a cycle of '*arrest, fine and back on the streets*' to pay off the fine. Street-based sex workers have charged that they suffer continual harassment and brutality at the hands of the police, including being exhorted for money or being raped and assaulted[21]. A court judgment, obtained by SWEAT against the Department of Safety and Security in April 2009, interdicted the police from continuing their practice of unlawful arrests, as it was argued that there is no intention to prosecute.

Richter (2008) argues that following 1994 there was some movement at government level to officially decriminalise sex work in line with South Africa's commitment to human rights. However, few of these initiatives went beyond internal discussions and lost momentum in 1998, arguably, because the ANC felt that sex work was too '*sensitive*' an issue.[22]

It is also interesting to note that following 1994 many of the laws violating people's right to exercise their sexuality were challenged and changed, including the Choice on Termination of Pregnancy Act, 1996 (providing females access to legal and safe '*abortion*'); the Domestic Violence Act, 1998 (outlawing marital rape); the Recognition of Customary Marriages Act, 1998 (affording legal recognition to women married under customary law); the 2001 Adolescent and Youth Health Policy Guidelines (promoting adolescents' access to sexual and reproductive health services); the Sexual Offences Act, 2007 (extending the definition of rape); and the Civil Union Act, 2006 (providing for same-sex marriages and civil unions).

...the sex industry is part of the entertainment industry, as it uses the same hotels, bars, transport networks, and tourism industry...

Calls for the decriminalisation of sex work and the need to protect sex workers' human rights, however, has continued to be clouded by arguments of immorality. Human and women's rights activists, including sex workers, have brought various challenges to the courts, such as the Jordan case and the Kylie case.[23] However, all court judgments on sex work are commonly followed by a resurgence of police activity, increased arrests and

harassment of sex workers. As this is not sustainable, there is often a return to de facto decriminalisation, except for street-based sex workers.

...due to the illegal status of the sex industry, only parts of its profits will go into state coffers...

Tasked with providing *'workable legal solutions for the problems surrounding adult prostitution'*, the South African Law Commission (SALC) released an Issue Paper in July 2002, which listed the following three options:

- criminalise all aspects of prostitution as criminal offences;
- legalise adult prostitution within narrowly circumscribed conditions;
- decriminalise adult prostitution, which will remove all laws that criminalise prostitution.[24]

A number of civil society organisations gave submissions on the Issue Paper, arguing for the decriminalisation of sex work on the basis of sex workers' rights to dignity, equality, freedom and security of the person, and the right to engage in economic activity and to pursue a livelihood.[25]

Organisations further argued that criminalisation leads to increased marginalisation and stigmatisation of sex workers. Criminalisation also leads to a lack of state protection and increased lack of social control over their lives, making sex workers more vulnerable to violence from clients and police, with little possibility of redress before the law. Their illegal status also left sex workers with decreased ability and social power to negotiate safer sex, including condom use, which increased their vulnerability to infections with STIs and HIV. Demanding condom usage was also undermined by competition between sex workers and their fear of losing a potential client. This cycle of vulnerability is worsened by sex workers' lack of access to health services, due to discriminatory attitudes and practices of healthcare workers, aggravated by the illegal status of sex work. Foreign sex workers were often in a more vulnerable position, due to their precarious social position in the country.[26]

Demonstrating the government's lack of priority in dealing with the rights and health of sex workers, it has taken a further seven years for the Law Commission to release its Discussion Paper on sex work, which was finally released in May 2009. One has to wonder at the timing of the Discussion Paper and whether it is not being prioritised now in view of '*preparing*' South Africa for the 2010 World Cup.

...the majority of sex workers are between the ages of 18 – 35 years, and approximately 90 – 95% of sex workers are women, the remainder being men and transgender persons...

The 2009 Discussion Paper [SALRC, 2009:4] presents four law reform options:

1) Total criminalization of adult prostitutes (status quo). Proposal that the legislature enact a new Adult Prostitution Reform Act to criminalize prostitution and prostitution related acts.
2) Partial criminalization of some forms of adult prostitution and prostitution related acts. Proposal that the legislature enacts a new Adult Prostitution Reform Act to criminalize specific acts related to unlawful prostitution.
3) Non-criminalization of adult prostitution. Proposal that the legislature enacts a new Adult Prostitution Reform Act after consulting with prostitutes, prostitution organizations and other role players.
4) Regulation of adult prostitution and prostitution related acts. In this model prostitution is legal

but state-regulated, and outdoor prostitution is restricted to prostitution zones. Proposal is that the legislature enacts a new Adult Prostitution Reform Act to regulate specific aspects of prostitution and restrict outdoor prostitution to prostitution zones.[27]

The difference between sex work and human trafficking

Many people, both at the level of society and the state (law enforcement, policy makers, social workers etc) conflate human trafficking for sexual exploitation with voluntary adult sex work. However, it is important to note that voluntary adult sex work is different to trafficking, and public policies and laws need to take these differences into account when drafting a response.

The Palermo Protocol[28] provides for the first internationally agreed-upon definition of human trafficking, stating that:

Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.[29]

The International Organization for Migration (IOM) further states that human trafficking is now considered the third largest source of profits for organised crime worldwide, estimated at $7-billion to $12-billion (R58-billion to R100-billion) a year. Only drug trafficking and the weapons trade are more lucrative.[30] South Africa has been characterised as both a transit and destination point for trafficking of women. Intra-country trafficking of women takes place mostly from rural to urban areas.

...it is the (mainly female) sex worker who faces the brunt of social censure and stigmatisation...

The IOM has recently completed a six-month study into trafficking within South Africa's borders. The research interviewed 224 people, 108 of which stated that they were directly aware of trafficking in their communities. The report found that Black and Coloured women, younger than 20, followed by women aged between 21 and 30 years were at the greatest risk to trafficking in South Africa. All forms of trafficking occur within the country, with Pretoria and Bloemfontein ranking high on the list of destination points when it comes to the trafficking of sex slaves. The Eastern Cape was the greatest target of trafficking syndicates. Most recruiters are known to the victims and are either friends or relatives. Organised crime is the biggest driving force behind trafficking, with money and the need for cheap labour as the primary motivating factor behind trafficking. Most crime syndicates operate out of Johannesburg, Pretoria, Cape Town, Durban, Bloemfontein and Port Elizabeth.[31]

A recently released study by the United Nation's office on drugs and crime shows that between 2005 and 2006, the International Organization for Migration sheltered close to 100 victims of human trafficking in South Africa. Sixty of them were from Thailand. Experts have warned, however, that the figures might be higher, as South Africa does not keep reliable statistics on trafficked persons.[32]

The South African Law Reform Commission (SALRC) is proposing comprehensive legislation to address trafficking in persons. This Bill[33] defines trafficking as:

…the recruitment, sale, supply, procurement, capture, removal, transportation, transfer, harbouring or

receipt of persons, within or across the borders of the Republic

(a) by any means, including the use of threat, force, intimidation or other forms of coercion, abduction, fraud, deception, abuse of power or the giving or receiving of payments or benefits to achieve the consent of a person having control or authority over another person;

(b) or by abusing vulnerability, for the purpose of exploitation.

...criminalisation... is rooted in the context of an Apartheid state... with its own Aryan notions that sought to criminalise conduct which it considered immoral – homosexual sex, inter-racial sex and sex work...

The proposed anti-trafficking legislation might be enacted before the end of the year. The draft bill before parliament would enable authorities to prosecute all forms of human trafficking. The absence of specific legislation on trafficking has undermined both efforts to protect women and children, who are being trafficked, and the capture and prosecution of offenders[34].

Football, sex, money and men

In all times, the sex industry is considered '*big money*'. However, it is commonly believed that major international sporting events, like the World Cup, increase the demand for sexual services, with the corresponding increase in profits. As Atemis, the owner of a German brothel, points out, '*football and sex belong together*'[35].

The connection between football, male spectators, and money to be made from sex has not been lost in certain sectors of the industry in South Africa. Despite the illegality of sex work, and the human rights violations associated with human trafficking, one 2010 official was quick to recognise the commercial value of the sex industry in the context of the 2010 World Cup. The Deputy Director-General for 2010 in Mpumalanga, Desmond Golding, told delegates at an event promoting 2010 business opportunities, that prostitution and human trafficking were lucrative businesses.

> *…Prostitution is an economic opportunity, but it is illegal and immoral. Human trafficking, as well, is an economic opportunity, but it is illegal and immoral.*[36]

He pointed out, however, that it was still a debate whether or not to legalise the trade for the duration of the 2010 World Cup.

The opportunity to promote escort agencies as a business venture has also been taken up by the Mbombela local municipality in Nelspruit, a host city of the 2010 World Cup. It placed an advert calling on people, who intend to provide escort services during the tournament, to apply for a business license and to register their services. However, the Mayor has denied any knowledge of professional escort services being wanted for the event.[37]

...all aspects of sex work were criminally sanctioned, except the buyer of services...

Other officials are more concerned about managing the '*problem*' of the sex industry from the perspective of managing crime. The parliamentary sports committee outlined how the issue not only involves sex workers, but also human trafficking. The chair of the committee, Butana Komphela, questioned what the Tshwane 2010 committee was going to do about the '*inevitable influx of prostitutes*', and how it presented a particular problem for South Africa, as prostitution was illegal here. Nkwane, the Tshwane 2010 coordinator, replied that

> *…this was not only a South African problem but an international problem and that it involved not only sex workers but also human trafficking.*[38]

He went on, pointing out that it is a national problem, it was part of the national agenda of the safety and security cluster of ministries.[39]

...all court judgments on sex work are commonly followed by a resurgence of police activity, increased arrests and harassment of sex workers...

In a similar vein to concerns before and during the 2006 World Cup in Germany, international and local NGOs that work with the victims of human trafficking are also predicting a spike in the number of people trafficked into and within South Africa, in the run-up to 2010.[40] It is argued that conditions like the high unemployment rate and widespread poverty make people easy pickings to the traffickers' offer of fancy jobs and a better life.

Recognising the distinction between voluntary adult sex work and forced human trafficking for sexual exploitation, advocates for sex worker rights have long called for the decriminalisation of sex work in order to recognise and protect sex workers' rights. In a press interview, SWEAT advocacy coordinator Vivienne Lalu said:

> *…We would like to see the government use 2010 to reform the law governing sex work… And the government should do it in consultation with sex workers and advocacy groups.*[41]

Referring to Selebi's comments on tolerating or legalising sex work for the duration of the 2010 World Cup, Lalu said:

> *…we don't see it possible to change the law for a month and then return to arresting sex workers thereafter. It does not make sense.*[42]

During an interview with the AIDS Legal Network (ALN), a sex worker, responding to Selebi's proposal with absolute amazement, stated that '*it can't be only for one month, because we are sex workers all the time!*'[43]. Another sex worker asked:

> *…if we can only work for one month, what are we going to do the rest of the time? How are we going to pay for our food, our house, our children, our clothes?*[44]

In complete agreement, Lalu from SWEAT argued:

> *…surely we would want to address sex work more permanently in South Africa? This is an excellent opportunity to raise the issue of sex work again. But to suggest that you can change the law for a month and a half to cater for the needs of beer drinking tourists, and not to consider the needs and interests of women and sex workers in the country makes me angry.*[45]

...one has to wonder at the timing of the Discussion Paper and whether it is not being prioritised now in view of 'preparing' South Africa for the 2010 World Cup...

In an attempt to ensure that sex workers' rights and interests are considered in the debate around sex work and 2010, SWEAT has made several presentations to differing forums, including the Western Cape 2010 planning committee and police forums. Director of the organisation, Eric Harper, outlines, in an interview with ALN[46], that SWEAT is calling for the establishment of a working group, with the participation of sex workers, to manage the issue of sex work during 2010. Harper painted several scenarios to planners of 2010 to back-up the call for the establishment of a working group. Scenarios included:

a) Some tourist wants to have sex; and because it is criminalised, he might end-up in a dubious part of town and ends up shot. This will make front page news.

b) Sex workers see a 14 year old boy being used for sex work. They are too afraid to report it, due to their own illegal status and relationship with the police.

c) A whole group of male tourists arrive, and the sex worker could become a victim of gang rape. She is too afraid to report it.

d) The current criminalised status of sex work creates a golden opportunity for criminals to capitalise on sex work, and sex workers become perceived as criminals, because they are criminals under the existing law. There is no way of monitoring the situation.

Harper indicated that he was trying to warn officials that in a context of criminalisation of sex work, something is going to go wrong during 2010. He argued that the current practice of fining sex workers is actually a way of taxing sex workers, and instead of playing games and causing distress, the state should decriminalise sex work and charge tax, and go after the real criminals.[47]

If one considers the arguments of the 2010 coordinators during discussions in the parliamentary sports committee, that the police of host cities and the South African Police Services were going to be involved to '*ensure the problem was contained*', and how this translates into raids, arrests and fines of sex workers, one can only imagine that 2010 will see an increase in the cycle of arrests, fines and back-on-the-streets to pay the fines. A sex worker, commenting on the police and treatment by the police commented:

> *…they think we come from trash and so they treat us like trash. The police need to respect us*.[48]

Harper argues that sex work provides many women with the opportunity of putting food on the table. He added that state victimisation of sex workers undermines her economic choice: albeit a constrained choice considering that sex work is often a response to poverty. Harper further argued that police arresting sex workers is a complete waste of state resources, because

> *…you will have less time and resources to deal with issues of trafficking and other cases of exploitation of sex workers*.[49]

...human trafficking is now considered the third largest source of profits for organised crime worldwide...only drug trafficking and the weapons trade are more lucrative.

SWEAT argues that criminalising voluntary sex work actually aids and abets trafficking for sexual exploitation. If police treat all sex workers as criminals, without first finding out if they are working voluntarily or being coerced or trafficked, this makes it difficult to provide assistance to victims of trafficking, or to find and prosecute traffickers. Criminalisation sends the adult sex industry underground, where traffickers can work with more leverage and ease, than in an above-ground legal industry. People, who are trafficked into the industry, are less likely to be in the position to access assistance, and neither will service providers be in the position to access the people under a criminalised situation[50].

In the context of the recently released South African Law Commission's discussion paper on sex work and the continued discussion of how South Africa should deal with the issue of criminalisation of sex work, the Gauteng Premier, Mokonyane, recently made headlines when speaking to journalists. She stated that she would '*keep an open mind*' about recognising sex work. In addition, recognising the '*big money*' behind sex work and the need to move away from a focus on morality to the needs of sex workers, she said that

> *…we must begin to appreciate that commercial sex work is an industry here in Gauteng; we must deal with it objectively and with an open mind… The best is to recognise commercial sex work, make sure it has different support systems...have a designated area, register people, let them be subjected to periodic health tests, and also let them be subjected to what me and you are subjected to – tax.*[51]

Mokonyane went on to say that the government should not wait until 2010 and the World Cup in South Africa as '*pressing issues*' are facing prostitutes now.[52]

...to suggest that you can change the law for a month and a half to cater for the needs of beer drinking tourists, and not to consider the needs and interests of women and sex workers in the country makes me angry...

Although Mokonyane's argument is contradictory in that she advocates for recognition and protection of sex workers, while at the same time arguing for legalisation (i.e., the establishment of designated areas, mandatory health checks, registration), which violates sex workers' rights, she is one of the few senior public officials who has publicly come out in support of sex workers, and who is calling to deal with the '*pressing issues*' that sex workers face.

A sex worker acknowledging the direct link between criminalisation and stigmatisation and of the positive effects of government officials publicly supporting sex worker rights stated:

> *…if government tells everyone on the TV, I promote them, they must be treated normally… if they say, you beat her, you sex her without paying then I will punish you. All clients will hear this and will treat us better. We want respect from everybody in the country.*[53]

The benefit of protection under the law was spelt out by another sex worker who said:

> *…we need all people to respect us. Because even the client abuses us because they know we can't report them and open a case, even if we are raped. If government understands us, even the client, they will be charged and punished.*[54]

In relation to the legal status of sex workers, a sex worker stated:

> *…I don't want to be legalised. A red light district is dangerous for us girls. We want to be decriminalised.*[55]

She was supported by another sex worker who said: '*we are not doing crime, we are doing our job*'.[56]

In a public statement by a senior government official, the head of the National Prosecuting Authority, arguably, abused his position and overstepped the mark by stating that he was not in favour of recognising sex workers, as it was a question of morality. Maybe he should have listened to the sex workers interviewed who demanded that '*we need government to come here to listen to our needs*'.

In a sharp comment on relations between the sexes, a sex worker argued that:

> *…we are just like them (any other women). The only thing that is different is that we get paid every time. Every wife is a sex worker. We are all sex workers, some for cash and some for credit!*[57]

Another sex worker, quite clear about her rights, as well as the morality that exists in society, stated that:

> *…this is my body and I can do with it what I please. But selling sex is supposed to be a sin.*[58]

What does this debate mean?

So what can we say about the debate around sex work in South Africa – before, during and after the 2010 World Cup? How it is managed all depends on one's framework and perspective. Is it a question of business opportunities,

'*big money*' and capitalising on the sex industry? Is it a question of managing crime or of '*stamping out*' increasing numbers of sex workers with increased police raids on women who are choosing to be sex workers? Is it a question of morals? Is it a question of the rights of sex workers, who choose sex work as a means of providing for their families; and of the need to deal with sex workers' exploitative working conditions and harassment at the hands of the police and conservative elements in society? Is it a question of dealing with a crisis of major proportions in the shape of a possible increase in human trafficking?

...fining sex workers is actually a way of taxing sex workers, and instead of playing games and causing distress, the state should decriminalise sex work and charge tax, and go after the real criminals...

Although it might be true that South Africa should be preparing itself for a thriving sex industry during the event, the legal and social issues surrounding sex work and human trafficking for forced sexual exploitation are quite different. One needs to separate the response to voluntary adult sex work from the response to trafficking of children, women and men for sexual or other exploitation.

South African parliamentarians need to speedily enact the legislation on trafficking. Training programmes need to be implemented, for the police to ensure they can identify trafficked women and girls; support systems and shelters for women, who are being trafficked, need to be established; public media campaigns, alerting the public to be aware of trafficking, need to be mounted; and help lines, to alert police and officials to trafficking, need to be established.

South African parliamentarians need to decriminalise sex work and regulate the sex industry. This means that labour legislation becomes applicable, and owners and managers of brothels have a duty to set working standards, and to comply with employment practices. Furthermore, the state has a duty to inspect and monitor labour practices. Decriminalisation of sex work, and regulation of the sex industry, is essential to ensure civil, political, economic, social and cultural rights of the women and men involved.

...if we want to ensure our standing in the international community, apart from putting on a good show at 2010, let us live up to our international human rights commitments...

South Africa needs to be brave. Politicians need to be brave. Healthcare workers need to be brave. The South African Police Services (SAPS) need to be brave. If we want to ensure our standing in the international community, apart from putting on a good show at 2010, let us live up to our international human rights commitments. Let us apply the values and principles of our Constitution. Let us take advantage of the opportunity that 2010 gives us, by breathing life into this debate, and blowing the final whistle on hypocrisy.

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FOOTNOTES:

1. Herborn, M. 2008. 'South African Politician: Legalize prostitution to combat rape and human trafficking at World Cup'. [www.playthegame.org/news/detailed/south-african-politician-legalise-prostitution-to-cut-world-cup-rapes.html]
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5. Project 2010. [www.project2010.co.za/2010_World_Cup_QandA.asp]
6. *Ibid*.
7. Gould, C. & Fick, N. 2008. *Selling Sex in Cape Town: Sex work and human trafficking in a South African city*. Institute for Security Studies (ISS): Pretoria. p5.
8. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town.
9. Richter, M. 2009. *Human Rights Are For Everyone: Why sex work should be decriminalized in South Africa*. AIDS Legal Network, SWEAT, SANAC Women's Sector Task Team: Cape Town & Johannesburg.
10. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town. p21.
11. Gould, C. & Fick, N. 2008. *Selling Sex in Cape Town: Sex work and human trafficking in a South African city*. Institute for Security Studies (ISS): Pretoria. p27.
12. Richter, M. 2008. *Erotic Labour in Hillbrow: Sex work, Johannesburg's 'Den of Iniquity' and HIV/AIDS*. Steve Biko Centre for Bioethics: Johannesburg.
13. Richter, M. 2009. *Human Rights Are For Everyone: Why sex work should be decriminalized in South Africa*. AIDS Legal Network, SWEAT, SANAC Women's Sector Task Team: Cape Town & Johannesburg.
14. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town.
15. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town. p4.
16. *Ibid*.
17. Richter, M. 2008. *Erotic Labour in Hillbrow: Sex work, Johannesburg's 'Den of Iniquity' and HIV/AIDS*. Steve Biko Centre for Bioethics: Johannesburg.
18. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town. p5.
19. SWEAT. 2006. *Fact Sheet: Sex Work and Human Rights in South Africa*. Sex Worker Education and Advocacy Taskforce: Cape Town.
20. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town.
21. Arnott, J. & Macquene, A. 2002. *Submission to the South African Law Commission Project 107 Sexual Offences Act, Issue Paper 19*. Sex Worker Education and Advocacy Taskforce (SWEAT): Cape Town; Richter, M. 2008. *Erotic Labour in Hillbrow: Sex work, Johannesburg's 'Den of Iniquity' and HIV/AIDS*. Steve Biko Centre for Bioethics: Johannesburg; Gould, C. & Fick, N. 2008. *Selling Sex in Cape Town: Sex work and human trafficking in a South African city*. Institute for Security Studies (ISS): Pretoria.
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23. In the case of Jordan v State 2002 (6) SA 642 (CC), a brothel owner, Ellen Jordan, challenged the constitutionality of the provisions of the Sexual Offences Act that criminalised sex work and brothel-keeping. The High Court found that the section criminalising sex work was unconstitutional. However, due to the fact that its findings pertained to the Constitution, it had to be confirmed by the Constitutional Court. In a surprising turn of events, the Constitutional Court reversed the decision of the High Court on sex work and declared that the criminalisation of brothel-keeping was constitutionally justifiable. The Kylie case saw the Women's Legal Centre take a case of unfair dismissal of a sex worker from a brothel in Cape Town to the Commission for Conciliation, Mediation and Arbitration (CCMA). However, the CCMA held that it could not adjudicate a case that included an illegal contract, due to the fact that sex work is illegal.
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Lydia Mavengere

A conspiracy of silence…
Sexual violence in schools

As we countdown towards 2011, the HIV & AIDS and STI National Strategic Plan for South Africa 2007 – 2011 (NSP) whose two primary goals are to reduce the rate of new HIV infections by 50% by 2011; and to reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011[1], do not appear to be any nearer to being achieved. The road still looks long and tenuous.

This paper asserts that, despite much research into the area of HIV and AIDS and despite many provisions within the South African Constitution guaranteeing equality; conditions prevailing in certain public institutions still work towards disadvantaging women. Section 9 of the South African Constitution[2] recognises everyone as equal before the law, with rights to equal protection and benefits of the law. Section 12 of the Constitution notes that

> *Everyone has the right to freedom and security of the person; this includes freedom from all forms of violence from either public or private sources.*

The state, therefore, has an obligation to provide protection for all people from all forms of violence in all spheres of society.

At an international level, Article 3 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[3] notes:

> *States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.*

This paper argues that the gendered nature of the education system, including conditions that condone violence against girl children within the school environment, predisposes women to violence in later life, and, therefore, to contracting HIV.

The NSP recognises the link between sexual violence and risks of HIV infection, including reduced capacity to make decisions, or to respond appropriately to HIV prevention campaigns,[4] and places as an intervention to:

> *Develop communication strategies, including leadership messages, which address the unacceptability of coercive sex, gender power stereotypes and the stigmatisation of rape survivors*[5].

This paper further argues that the violence perpetrated against women throughout South Africa is reinforced in the classroom, where children are taught and socialised into a position where gender-based violence seems not only accepted, but also condoned; and that the education system reinforces gender-based violence – the apparent slow approach in dealing with current cases of violence in schools is but one proof of this assertion.

Within the same frame, while the NSP does recognise the need to make schools a safer place[6], this paper will attempt to explain why the intervention will not be effective in its present state, given current levels of violence in South African schools and current patterns of responses to such violence.

Gender-based violence and HIV

Statistics indicate that an estimated 370,000 children, younger than 15 years old, were infected with HIV in 2007, representing an increase in infections from 1.6 million in 2001 to the current two million globally. Moreover, of all the HIV infections in this age group, 90% are currently occurring in Sub-Saharan Africa.[7]

It is further estimated that more than 30% of girl children are raped at school. The situation in South Africa regarding HIV and AIDS is currently at epidemic proportions, with the incidence rate among South African youth at 22.9%. The incidence rate amongst girl children and young women is more than three to four times higher, than that of boys and men[8].

…schools send an implied message of tolerating and condoning violence…

The eight nations that constitute the majority of Southern Africa, namely Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, account for an estimated 35% of total HIV infections globally. Unlike in the rest of the world, where new HIV infections are distributed evenly between the sexes, in these countries 90% of new infections occur in women and girl children between the ages of 15 and 24, with 67% of the total population living with HIV being female.[9]

According to the South African Police Services (SAPS) Annual Report for 2006/07, a total of 52,617 rapes were reported in South Africa in 2007, noting that an inadequate security climate and societal attitudes condoning sexual violence against women contributed to the problem.[10] In addition, it is estimated that, in South Africa, the number of reported cases of sexual violence represents only one out of nine, thus, 8 cases go unreported.

The gendered nature of the education system

In attempting to address sexual violence in schools, it is important to understand that despite laws being in place, society still has a different perception of factors, such as rape, sexual harassment and discrimination against women. Society's gendered nature tends to determine how people will be treated. According to Kehler [2006:1]:

> *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.*[11]

Such gender disparities are consistently reinforced within the school environment. These include teaching power structures, in which males are more important than females; apparent school tolerance of sexual harassment of female learners; and the seemingly avoidance of responding to issues, such as rape.[12] Historically, school-based gender disparities extended further to the subjects that were taught in schools. Today, however, learners have the option of making their own choices of subjects; yet the argument is that where gender-based violence exists, certain '*male dominated subjects (such as maths and sciences)*'[13] often work to disadvantage the female learner, as female learners tend to avoid certain classes in order to '*keep the peace*'.

…teaching learners the meaning and importance of respect and dignity…

In addition, reports say that a large majority of cases of sexual violence in schools are not being reported. The argument, however, is that patriarchy and the dominance of males in the education system is the main reason behind the '*non-reporting*' of sexual abuse is schools, often leading to girl children dropping out of school. All, arguably, founded in cultural norms that socialise males to be '*aggressive*', '*powerful*', '*unemotional*', and '*controlling*', and contributing to a social acceptance of '*men as dominant*'. Similarly, societal expectations of females as '*passive*', '*nurturing*', '*submissive*', and

'*emotional*' also reinforce women's role as '*weak*', '*powerless*', and '*dependent upon men*'.[14]

In a study on perceptions of boys in South Africa pertaining to gender, sex and violence, Elfenbein [2006:21] notes that

> *…overall, 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.*[15]

The NSP notes that:

> *Based on the premise that young people represent the main focus for altering the course of this epidemic, the NSP emphasises the need for continued investment in, and expansion of, carefully targeted evidence-based programmes and services for young people, as imperative for an effective national response to HIV and AIDS.*[16]

The argument, however, is that, in spite of this recognition, responses to issues of sexual violence in schools, which is an indicator of later adult behaviour, has yet to be dealt with within the institutions in which they occur. Additionally, given current opinion, the responses need to include an awareness raising format, recognising, that gender-based violence is a social ill occurring in all spheres of society, thus, requiring a national response.

The combination of various forms of sexual violence, including rape, sexual harassment, sexual abuse and assault, is rife in our schools – a factor that only further predisposes women to the risk of HIV infection. Although girl children in South Africa have far better access to schools, than girl children in other sub-Saharan African countries, the prevalence of sexual violence mitigates many of their education rights, as either their performance in school drops, or they dropout of school altogether.[17]

Dropping out of school often leads to further limited developments for girl children, as education is a precondition for exercising fundamental human rights, forming the foundation for the understanding and practice of rights. Thus, the enjoyment of a number of civil and political rights, such as freedom of access to information and the right to vote, depend on a minimum level of education, including literacy, so as to be in the position to effectively exercise these rights. Economic, social and cultural rights, such as the right to choose work or to take part in cultural life, can only be exercised meaningfully, once a minimum level of education has been achieved.[18]

…what, thus, prevails is a 'conspiracy of silence'…

Similarly, the same imbalances place women at greater risk of exposure to HIV. Kehler [2006:5] argues that

> *Engaging in transactional sex, and 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.*[19]

In fact, Mohlahlane [2006:34] notes that

> *…women experienced violence at two levels; a localised level of intimate relationship, family and community and a more structural level of external re-victimisation within the healthcare and justice delivery system.*[20]

What then prevails is a pattern of apparent apathy, mainly driven by the fact that women do not see any justice in public institutions, including the education system. Once girl children drop-out of the education system, they will lack the education to fully participate in civic affairs. In essence, by condoning sexual violence in schools, women are systematically denied their right to equality. Thus, by not addressing the issue of sexual violence in schools, women and girl children are systematically denied the right to fully participate in society as equal citizens.

The conspiracy of silence

It is indeed a shame that in a democratic South Africa, where equal opportunities are offered to all who would work for them, the attrition rate for female learners is said to be very high. Even though the female share of enrolment in higher education institutions has increased over the years, from 44.1% in 1993 to 51% in 1999 and about 54% in 2001[21], there is still a significant gap between male and female learners.

…systematically denied the right to fully participate in society as equal citizens…

Sexual violence in schools is a definite contributor to the smaller number of female learners entering higher education. As noted in the 2006 School Realities Report:

> *…a number of factors, including unplanned pregnancies, domestic responsibilities (particularly in rural areas), and gender stereotypes, contributed to higher drop-out rates and lower secondary school pass rates for girls.*[22]

Despite the law requiring schools to disclose incidences of sexual abuse to the authorities; administrators have often concealed reports of sexual violence or delayed disciplinary action. Reports by girl learners have been discounted and authorities failed to respond with any degree of seriousness. School officials offered hostile and indifferent responses to learner reports of sexual violence. In many instances, schools actively discouraged victims of school-based gender violence from alerting anyone outside the school or accessing the justice system.[23] At the same time, the level of sexual violence in schools has also increased the risk for girl children of contracting HIV, or other sexually transmitted diseases, as well as unwanted pregnancies.[24]

Outside of the school environment, societal perceptions regarding abuse, motivators of perpetrators and the role of family honour, as well as gender roles need to be understood in order to reduce the prevalence of sexual abuse against school children in South Africa.[25] In the same way that Naylor acknowledges that sometimes school officials appear to have failed to respond adequately, or ignored the problem, because they simply did not know what to do[26]; it could be argued that reports of sexual violence are silenced in the name of preserving *'family honour'*, and not wanting to bring the school into disrepute. What, thus, prevails is a '*conspiracy of silence*', in that girl children find themselves in a situation in which they have no one to report to, when faced with sexual violence.

…sexual violence mitigates many of their education rights…

According to UNICEF (2001),

> *Schooling equips children with the skills and confidence needed to meet life's challenges and lead productive lives, the absence of justice in the schools, the apparent silence on cases of rape and sexual violence, perpetuate the denial of children, particularly girl children, and later women from accessing resources that lead to a better life.*[27]

As a result, women fail to take decisive action against sexual abuse later in life, as both the school system and the community support system have basically '*taught*' women that such abuse is a '*normal*' component of life.

Responses, such as safe schools programmes, where the school is turned into a virtual '*detention camp*' with CCTV, perimeter fence, metal detectors and alarm systems, clearly highlight not only the severity of violence in schools, but also can be seen as proof that the school system is not a safe environment for the girl child. Recognising the potential impact of these kinds of '*safety measures*' on learners, in that it instils fear in learners, it is argued that what would be required as a solution is a human rights approach to education,

teaching learners the meaning and importance of respect and dignity.

By not dealing with the violence against female learners within schools, and during school activities, schools send an implied message of tolerating and condoning violence. Given the already documented incidence of abuse and violence in adolescents' lives, the avoidance of these issues reinforces the message that violence, including sexual violence, is a private and individual matter, rather than a societal problem that needs to be addressed as such. This attitude only serves to further cover-up the extent of abuse, and perpetuates the shame that such silence promotes.[28]

The way forward

It is largely noted that a lack of coordinated and comprehensive strategies to deal with violent crimes in schools has continued to impede the delivery of needed services to young victims.[29] It is in this regard only fair to argue that this is one of the factors that will always work against the successful implementation of the NSP goals, unless a more nationally coordinated approach at responding to violence in schools is adopted.

…gender-based violence is a social ill… requiring a national response…

What is required, first and foremost, is to raise awareness that gender-based violence is socially unacceptable. Mohlahlane [2006:37] argues that

> *…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 unequal power relations.*[30]

And the best place to start understanding seems, arguably, to be with a mind that is still forming.

Moreover, addressing gender-based violence as an intervention measure for HIV risks need to focus on two levels – the level of the prosecuting authorities, so as to ensure an adequate judicial response to incidences of violence, and the level of education, ensuring greater knowledge and understanding amongst learners and young adults. Increased awareness of the rights of the child within the school environment, including the fact that '*blocking*' reports in an effort to protect fellow educators constitutes a violation of the child's constitutionally guaranteed rights, is, arguably, key to the response.

...a large majority of cases of sexual violence in schools are not being reported…

As Elfenbein [2006:22] notes:

> *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.*[31]

Conclusion

The right to education has its foundation in the recognition of fundamental human rights and, thus, imposes a positive obligation on the state to make education available and accessible to everyone.[32] It is high time, that these cases of violence in schools are not seen as isolated incidents; but instead as a societal problem that needs urgent attention, especially as school violence translates into a systematic denial of generations of female learners to access the education system.

The need to deal with gender-based violence is undoubtedly urgent. What is required are sustainable intervention programmes, placed within the education system, and focusing on learners and young adults.

Such a measure would certainly be one step towards addressing the status quo, which not only reinforce social perceptions, but also facilitates the occurrence of violence within the school environment.

…the gendered nature of the education system…predisposes women to violence…

More recently, Murray and Burnham (2009) commented that:

> *…to date health programmes have largely avoided the needs of children who have been sexually abused as such programs seek wider focus in reproductive health and gender based violence in adults. A shift in focus to include children is even more urgent in areas with high seropresence of HIV. This persistent global tragedy for children is too large to continue ignoring. Murray and Burnham suggest that local and national initiatives need to focus more on the prevention of perpetration by men of violence against girls.*[33]

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FOOTNOTES:

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Nyaradzo Chari Imbayago

Law reform is crucial...

HIV/AIDS and Human Rights in Southern Africa in 2009

Ongoing from 2007, is the recognition that developing a human rights response is complicated by the large number of competing human rights concerns in the region as well as continuing state repression. In the absence of a completely protective environment, stigma and discrimination against people living with HIV and AIDS also continues. [Gerntholz, 2009][1]

Background

In 2007, ARASA published the *HIV/AIDS and Human Rights in Southern Africa Report* to mark the 10th anniversary of the *HIV/AIDS and Human Rights International Guidelines*, and to evaluate the extent to which the International Guidelines have been implemented in Southern Africa.

On 1 April 2009, coinciding with the 4th SA AIDS Conference, the AIDS and Rights Alliance for Southern Africa (ARASA) launched the 2009 update of this Report, which seeks to provide a barometer on HIV and AIDS and human rights in the SADC region. It also describes good legal, policy and human rights practices in relation to HIV and AIDS, in addition to outlining key human rights challenges facing people living with HIV in the SADC region.

The report explores key human rights developments in the region since the publication of 2007 report, and compares regional progress not only in terms of the International Guidelines on HIV/AIDS and Human Rights, but also in terms of the new Model Law on HIV/AIDS adopted by the SADC Plenary Assembly in 2008.

This article provides an overview of some of the key findings of the Report.[2]

Methodology

Three consultants – Anne Strode, Kitty Grant and Liesl Gerntholz – were commissioned to work on the report together with ARASA staff and partners. In 2008, questionnaires were sent to key informants, including ARASA partners, other NGO's and government officials working on HIV and human rights in SADC. The same questionnaires were used as a basis for key informant interviews, which included face-to-face interviews with, amongst others, key staff in ARASA partner organisations in Southern Africa. Desk and web review of relevant laws and policies in Southern Africa, such as copies of HIV and AIDS, health, and other relevant laws and policies; UNGASS country reports and other research reports, including UNDP and other research on HIV and AIDS-related laws in Southern Africa, were also consulted.

Key findings

Models of HIV/AIDS Law and Policy Reform

Although the International Guidelines do not prescribe any law or policy reform model, they provide for steps that must be taken in certain areas of the law in order to protect the rights of people infected and affected by HIV. In 2008, the SADC Plenary Assembly adopted a model law on HIV/AIDS as a guide for law reform in the region. As of January 2009, 14 SADC states had taken steps on law and policy reform on HIV and AIDS and human rights. 40% of the SADC countries had developed HIV and AIDS legislation and 35% had reviewed existing laws to include HIV and AIDS issues. All of the countries in the region have developed a national plan on HIV

and AIDS. However, two of the countries made no explicit reference to human rights in their plans.

Law reform is crucial in the response to the epidemic, mainly because unless human rights are enshrined in law, there is limited protection for people affected and infected by HIV. It may take the form of developing HIV-specific legislation or of integrating HIV provisions into existing laws. Although the latter approach may be preferable, in that it reflects a more multi-sectoral response to HIV, the incorporation of HIV-related provisions into existing laws may slow down the law reform process. The adoption of HIV and AIDS public health legislation is an effective and expedient legislative strategy for ensuring a wide range of protections for people affected and infected by HIV. There have been significant developments in HIV-related law reform in the region. However, continued law reform is needed and should be based on comprehensive legal audits, which examine existing relevant laws, the nature of their enforcement, the impact of these laws on the HIV and AIDS response, and the need for law reform.

…lack of trained personnel is a key barrier to universal access to treatment, care and support…

Reform of Criminal Law

It is heartening that the SADC model law does not provide for the criminalisation of HIV transmission. Disturbing, however, is that, despite this fact, three countries have, since 2007, introduced new legislation providing for offences related to the transmission of HIV.

Using the criminal law to respond to HIV transmission is problematic and it is for this reason that the SADC model law does not provide for the creation of a specific offence to address HIV transmission. Applying the criminal law to HIV exposure or transmission does nothing to reduce the spread of HIV and can actually undermine HIV prevention efforts, not least by deterring people from seeking HIV testing. Whilst often promoted as a tool to protect women against HIV infection, the use of criminal law to address transmission has the opposite effect. All SADC countries have existing broad common law or penal law crimes in place which could be used to prosecute persons who deliberately infect others and there is, hence, no need to create new HIV-specific offences to address transmission or exposure. It is, thus, recommended that countries that have adopted laws containing HIV-specific crimes to address transmission or exposure should repeal these laws.

…PITC carries a real risk of HIV testing being carried out without informed consent…

Botswana, DRC, Lesotho, Namibia, South Africa and Zimbabwe have introduced legislation requiring courts to impose harsher sentences on HIV positive sexual offenders. Of these, the legislation in Botswana, Lesotho and the DRC provides for the imposition of a harsher sentence even where the accused is unaware of the HIV status at the time of the commission of the offence. This approach is inappropriate, since the results of an HIV test cannot establish whether or not the offender was aware of their HIV status at the time of the offence, or whether or not the offender intended to infect the complainant with HIV. If HIV testing of sexual offenders is to take place, it should only take place on the basis of a court order, in a way that protects the rights of all parties and that facilitates access to

post-exposure prophylaxis (PEP) or other significant health decisions for the survivor of a sexual offence.

…children remain at a significant risk of HIV infection, until the service gap is narrowed…

Reform of Anti -Discrimination Measures

Significant progress has been made in ensuring legal protection for people living with HIV in SADC, with 50% of the countries having laws specifically prohibiting discrimination on the basis of HIV and AIDS. Six countries have HIV-specific anti-discrimination legislation and one country protects people living with HIV from discrimination through general equality legislation. The remaining 50% of the countries protect people living with HIV from discrimination in national policy rather than law. All countries have taken steps to protect the rights of employees with HIV and all but one country have done so through the enactment of laws.

Despite the adoption of these anti-discrimination provisions, a disturbingly high level of discrimination on the basis of HIV status is reported, as people find other ways to discriminate once an HIV status is known. In addition, HIV anti-discrimination laws tend to focus only on discrimination based on real or perceived HIV status and fail to recognise that people vulnerable to HIV may also be marginalised for other reasons, for example because of sexual orientation. Without broader equality laws, people living with HIV continue to face discrimination.

Certain categories of employees, notably in the military, are also often excluded from anti-discrimination provisions in employment related laws.

It is, therefore, crucial that countries that do not have HIV-specific anti-discrimination laws in place adopt the same and that anti-discrimination laws be broadened to provide equal protection for all persons vulnerable to HIV and AIDS on a range of grounds, including race, gender, sex, pregnancy, marital status, disability, sexual orientation, religion, culture, language and birth. The adoption of employment legislation that protects employees living with HIV, including the armed forces, from discrimination and required pre-employment HIV testing.

Enforcement Mechanisms

Of the six SADC countries, which have adopted HIV-specific legislation, only one adopted a specific HIV dispute resolution process. However, all six countries have provided for the courts to impose fines, and with the exception of one country, imprisonment as a possible punishment for infringing the rights of people living with HIV. The advantage of giving jurisdiction to the ordinary courts to hear contraventions of the legislation is that it does not stigmatise people living with HIV by creating a separate dispute resolution mechanism for them. It does, however, require the judiciary to be aware of HIV-related issues, such as the need for in-camera proceedings or the suppression of the identity of the plaintiff.

…placing greater emphasis on the scale-up of testing, potentially at the expense of human rights protections…

In Tanzania, a special HIV dispute resolution process has been created in terms of the HIV and AIDS (Prevention and Control) Act of 2008, which provides that any complaint about a contravention

of the legislation may be lodged with the secretary of the village, a police station, a person in charge of a health facility, or an employer. The advantage of this approach is that it extends access to justice, as the persons given the power to hear disputes are easily accessible. To be effective however, these persons will have to have specialised skills to deal with these disputes and it is important to ensure that these persons are so skilled. This is not currently provided for in the legislation.

…public health provisions…must strive towards creating a balance between public health and human rights…

Existing enforcement mechanisms, such as the courts, should continue to deal with HIV-related disputes. It is, however, critical that judicial and law enforcement officers receive training on HIV and human rights, so as to increase capacity to hear HIV-related disputes and to enforce HIV-related laws. Where alternative dispute resolution mechanisms are used, clear policies for their utilisation must be put in place, and staff must be equipped with the necessary skills.

In order for people living with HIV and members of vulnerable and marginalised groups to access justice, it is crucial that legal services are provided for these groups, as well as campaigns that empower people affected by HIV to know their rights in the context of the epidemic and know how to demand their rights and their effective enforcement.

HIV Testing and Discrimination in the Military

90% of the countries surveyed have compulsory HIV testing in the military as a prerequisite for employment, and in four of the countries the practice of HIV testing of military personnel is legally permissible, because soldiers are excluded from protective employment laws. This practice is unacceptable given that physical fitness should be the determining factor for employment and HIV testing alone is not a good indicator of physical fitness.

There is a need for continued advocacy for legal protection of the armed forces personnel from discrimination, as well as lobbying for the extension of existing anti-discrimination laws to cover the military.

Criminalisation of Same-Sex Relationships

Almost two thirds of the SADC countries have laws that criminalise sex between men. A number of negative consequences flow from criminalisation of same-sex relationships and men who have sex with men. The illegal nature of same-sex relationships makes it difficult for service providers to provide HIV prevention and treatment services for people in these relationships. Governments also use the illegal status of the relationships as a justification for refusing to supply condoms in prisons. The vulnerability of people in same-sex relationships is, thus, heightened by the continued criminalisation of these relationships.

Continued advocacy for the decriminalisation of same-sex relationships is, therefore, essential.

Inadequate Legal Protection for Women from Gender-Based Violence

Two thirds of the SADC countries have legislation protecting women against gender-based violence and over 64% have new anti-rape laws, or domestic violence laws, or both. Despite an increasingly protective legal framework, women remain highly vulnerable to gender-based violence. Reasons for this include inadequate implementation

and enforcement of the laws, societal attitudes towards women, and dualistic legal systems, which recognise discriminatory cultural laws and practices.

Violence against women remains a major concern. There is a need for continued advocacy around customary laws that discriminate against women, and broader advocacy for gender equality, in order to reverse the impact of gender-based violence. In addition, research is needed on the use and limits of existing laws and more resources must be allocated to support the implementation of these laws, as well as of programmes to increase women's awareness of their rights.

Reform of Public Health Laws

50% of the SADC countries have introduced HIV-specific public health legislation and 42% have existing public health legislation that is broad enough to use in the context of HIV and AIDS. Much of the new public health legislation that has been introduced purports to be based on human rights principles. They all, however, to a greater or lesser extent, contain provisions that potentially violate human rights principles. NGO's advocacy efforts to remove offending provisions have, however, had some success. For example, in Mauritius, some of the more coercive elements of the draft bill, relating to criminalisation and needle exchange programmes, were removed.

Harmful HIV-related behaviour appears to be a major issue for legislators in SADC and many countries have included criminal provisions in public health laws. Whilst the use of public health law, rather than criminal law, to deal with harmful HIV-related behaviour is to be supported, public health provisions to address this behaviour must strive towards creating a balance between public health and human rights. Those that require, for example, mandatory disclosure, fail to recognise the gender implications of disclosure and in fact deter, rather than facilitate, HIV prevention efforts. Advocacy for continued law reform to develop HIV-specific public health laws that adequately protect the rights of people living with HIV and strike the necessary balance between public health and human rights is, thus, required.

…the vulnerability of people in same-sex relationships is, thus, heightened by the continued criminalisation of these relationships…

HIV Testing

All of the 14 SADC countries reviewed have regulated the provision of HIV testing. Over 50% of the countries have done so through legislation and the remaining countries through HIV policies. Over 85% of countries have laws or policies that promote informed consent before HIV testing. Despite the laws and policies which promote voluntary counselling and testing (VCT), there is a move in the region towards the implementation of provider-initiated testing and counselling (PITC) in accordance with WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling (2007). At least five countries use provider-initiated *'opt out'* testing for pregnant women.

While the PITC model provides for informed consent in theory, there are concerns about the fact that the lack of pre-test counselling, as envisaged by this model, undermines the ability of patients to, in fact, give informed consent. In addition, the *'opt-out'* PITC model also raises the possibility of coercive testing, as some patients may either not be aware that they are entitled to decline the test, or feel unable to decline the test should they not wish to be tested.

…without broader equality laws, people living with HIV continue to face discrimination…

In an attempt to make HIV testing more universally accessible, several countries are placing greater emphasis on the scale-up of testing, potentially at the expense of human rights protections. Whilst universal access to HIV testing is desirable, care must be taken that human rights are protected and that appropriate linkages between testing and treatment are in place.

There is, thus, a need for continued advocacy for legal regulation of HIV testing with informed consent, together with pre- and post-test counselling. Where PITC is provided, measures must be put in place, such as the provision of accessible information about the right to *'opt-out'* and adequate pre-test counselling, to ensure that informed consent is obtained. It is also essential that training, support and supervision is provided to people delivering HIV testing services, to ensure the quality of these services and to ensure that the rights of people who are tested are not violated. Specific monitoring of the implementation of *'opt-out'* testing for pregnant women is needed, as they may be particularly vulnerable to coercive testing.

Confidentiality

There has been an increase in the number of countries that explicitly protect the right to confidentiality. 60% of the countries have a constitutional right to privacy and over 80% of the countries have a law or policy on HIV and privacy. Of concern, however, is the fact that a number of new laws are making disclosure of HIV status mandatory by creating criminal offences for non-disclosure.

There is, thus, a need for continued advocacy for the adoption of laws that explicitly protect the right to confidentiality, that limit the circumstances of disclosure without consent, that clearly specify circumstances in which disclosure is lawful and that create offences for breaches of confidentiality. It is crucial that healthcare workers are adequately trained on the right to confidentiality and that mechanisms be created to address breaches of confidentiality in HIV testing.

Access to Antiretroviral Therapy

Eleven countries have national ARV policies. SADC countries have reported a rapid increase in the number of people receiving ART treatment. However, the overall accessibility of ART treatment for people in need of it is still very low, with 35% of the countries not even reaching up to a quarter of the people in need. Vulnerable groups, such as rural populations, children, as well as mobile and migrant populations, continue to face barriers to accessing treatment. Lack of trained personnel is a key barrier to universal access to treatment, care and support, and distances to health facilities is a major obstacle to accessing treatment, especially for rural populations.

There is, thus, a need to continue to advocate for the roll-out of ARV programmes with a special focus on identifying barriers to accessing treatment and prioritising vulnerable populations with limited access to programmes. States must be called upon to increase available resources, to ensure adequate and skilled healthcare workers in HIV programmes.

HIV Prevention

All SADC countries now have prevention of mother to child transmission (PMTCT) programmes, to prevent HIV transmission from mother to child, in place. Unfortunately, the existence of PMTCT

programmes has not guaranteed universal access for all pregnant women with HIV. Only 60% of the SADC countries are providing access to half of the women who need access. This means that children remain at a significant risk of HIV infection, until the service gap is narrowed.

…countries that have adopted laws containing HIV-specific crimes to address transmission or exposure should repeal these laws…

The criminalisation of sex between men continues to act as a barrier to providing HIV prevention programmes in prisons, with authorities refusing to provide condoms to inmates, whilst men having sex with men remains illegal in most countries.

Some countries have taken significant steps by passing laws recognising the emerging autonomy of children, and allowing children under the age of 18 to consent independently to HIV testing. It is, however, still difficult for many children under the age of 18 to access HIV testing services. Requiring parental consent for HIV testing creates a number of barriers for adolescents accessing HIV prevention services, as many do not want their parents to know that they are sexually active, and others may not have parents or guardians, as they have been orphaned.

There is, thus, a need for continued advocacy for the expansion of PMTCT programmes, for the decriminalisation of sex between men, for access to condoms in prisons, and for continued law reform to provide for independent consent by adolescents to HIV testing.

Access to VCT Services and Move Towards Routine HIV Testing

The slow uptake of HIV testing continues to pose challenges for the SADC region. A large number of people living with HIV in the most affected region in the world are unaware of their HIV status and, therefore, unlikely to access treatment, care and support services when they need them most.

While there is agreement on the need for HIV testing to be widely available to all who seek it, concerns have been expressed from a human rights perspective that the practical implementation of PITC carries a real risk of HIV testing being carried out without informed consent. Not only does HIV testing without informed consent violate human rights, including the right to health, the right to privacy, and the right to bodily integrity and autonomy, but it is also likely to dissuade people from accessing health services, thus constituting a barrier to accessing treatment.

There is, thus, a need for advocacy for the continued expansion of VCT services, as well as for the monitoring of the provision of PITC, to ensure that it is consistent with human rights.

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FOOTNOTES:

1. Liesl Gerntholz, a consultant who worked on the 2009 ARASA HIV/AIDS and Human Rights in Southern Africa Report, during the launch of the report at the 4th SA AIDS Conference in April.
2. To obtain a copy of the full report, please contact ARASA [www.arasa.info]

Criminalisation harms women…

10 Reasons why criminalisation of HIV exposure or transmission *hurts* women

Legislative trends towards the criminalisation of HIV transmission or exposure continue in many parts of the world. More than 20 countries in sub-Saharan Africa alone have recently passed HIV-specific legislation with clauses ranging from mandatory HIV testing and disclosure to criminalising the exposure to, or transmission of, HIV. Recognising that laws criminalising HIV exposure or transmission are unjust and ineffective public policy, a threat to human rights, and have an adverse impact on especially women, these trends have been criticised by many human rights and AIDS activists globally.

Further expanding on the *10 Reasons to Oppose the Criminalisation of HIV Exposure or Transmission*, a document released by a broad coalition of human rights and AIDS organisations in December 2008, the ALN and ARASA, in partnership with the ATHENA Network, drafted the ***10 Reasons why criminalisation of HIV exposure or transmission* hurts *women***.

The identified '*10 Reasons*' are designed to point out how applying criminal law to HIV exposure and transmission increases women's vulnerabilities, endangers women and women's lives, and further oppresses women. The '*10 Reasons*' also highlight how the criminalisation of HIV transmission or exposure is likely to heighten the risk of violence and abuse women face; strengthen prevailing gendered inequalities in healthcare and family settings; further promote fear and stigma; increase women's risks and vulnerabilities to HIV and HIV-related violation of rights; and have other negative outcomes for women.

The draft 10 reasons why criminalisation of HIV exposure or transmission is bad for women are:

1. Women are more likely to know their HIV status, than their male partners
   …to avoid the risk of being prosecuted for exposing their partner to HIV, women who test HIV positive must disclose their HIV status to their partners, refuse to have sex, or insist on condom use…
2. Women are more likely to be blamed for HIV infection
   …and this can result in eviction, ostracism, loss of property and inheritance, and loss of child custody…
3. Women will be at greater risk of HIV-related violence and abuse
   …likely to increase incidences of violence and abuse against positive women, as women are forced to disclose their status to avoid prosecution, and thus, often to face violence and abuse…
4. Women will be deterred from accessing prevention, treatment and care
   …fear of an HIV positive diagnosis and the potential of subsequent prosecution is already discouraging pregnant women from accessing antenatal care, for fear that they will test positive and be exposed to abuse…
5. Criminalisation of HIV exposure or transmission does not protect women from coercion or violence
   …it will increase women's risks of 'secondary victimisation', as rape survivors who have been infected with HIV are now potentially liable for prosecution of HIV exposure and transmission…
6. Women will be more vulnerable to HIV infection
   …existing barriers limiting women's access to information, resources and services…will be compounded by the fear of prosecution for HIV exposure or transmission…
7. Women are more likely to be prosecuted
   …since women are more likely to know their HIV status… [and] knowledge of *one's HIV status is often a necessary element for prosecution…*
8. Some women might be prosecuted for mother-to-child transmission
   …this effectively makes pregnancy, wanted or not, a criminal offence…
9. The most '*vulnerable and marginalised*' women will be most affected
   …posing a threat for double prosecution – prosecution for engaging in 'criminal behaviour' and for HIV exposure or transmission…
10. Women's rights to make informed sexual and reproductive choices will be further compromised
    …may further limit women's ability to choose whether or not, how, when and with whom to engage in sex – as well as to choose whether or not to have children – due to the risk of being prosecuted for exposing and/or infecting a partner and/or child with HIV…

**** The full document is available at www.aln.org.za and at www.athenanetwork.org. For comments and/or inputs, please contact the AIDS Legal Network at alncpt@mweb.co.za.***

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