

# The lack of social recognition...

## Enabling legal and social environments in the context of HIV and AIDS

### Introduction

In South Africa, the equal enjoyment of all rights and freedoms is constitutionally guaranteed to everyone and yet, people continue to encounter numerous problems in claiming their rights. The national response to HIV and AIDS has human rights at its centre, and yet, people's access to available HIV prevention, testing, treatment, care and support programmes is often limited, if not denied, due to prevailing stigma, discrimination and violation of rights, based on a person's sex, gender, sexual orientation, age and/or HIV status.

It is within this context that this article will explore the legal and social environments of women, examine the extent to which especially women, are in the position to enjoy their rights and freedoms, and raise the question as to whether or not the social environment is conducive for women to access and benefit from HIV prevention, testing, treatment, care and support.<sup>1</sup>

### An enabling legal environment

A supportive and enabling environment for women, children and other vulnerable groups is one of the recognised indicators<sup>2</sup> to measure the adequacy of a human rights-based response to HIV and AIDS.

The right to equality and non-discrimination, the right to life, the right to dignity, the right to freedom and security of a person, including the right to autonomy and to be free from all forms of violence, as well as children's rights, are but some of the constitutional provisions promoting and protecting the rights of women, children and other vulnerable groups. The Constitution also explicitly prohibits discrimination on a number of grounds, including a person's sex, gender, sexual orientation and/or age. In addition, various pieces of legislation are in place, such as the Equality Act, the Domestic Violence Act, Maintenance Act and the Children's Act; to further protect and promote the rights of women, children and other vulnerable groups.

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## Editorial...

*...reduce the vulnerability, stigmatisation and discrimination that surround HIV/AIDS and promote a supportive and enabling environment, by addressing underlying prejudices and inequalities within societies, and a social environment conducive to positive behaviour change...an essential part of this enabling environment involves the empowerment of women, youth and other vulnerable groups to deal with HIV/AIDS by taking measures to improve their social and legal status...* [International Guidelines on HIV/AIDS and Human Rights, Commentary on Guideline 8]

It is within the above context that this edition of the *ALQ* is focusing on the social environment and its impact on women's risks and vulnerabilities to both HIV and violence and abuse. The various articles in this edition examine different aspects of women's social environment, and raise the question as to whether or not these environments are in fact conducive for women to claim their rights, and thus to claim their right to access and benefit from available HIV prevention, testing, treatment, care and support services. The gendered societal context perpetuating women's lack of social recognition; masculine norms and identities furthering the 'culture of violence'; social norms and values heightening women's risk to gender violence and HIV; gender discrimination within the 'world of sports'; as well as potential risks associated with male circumcision are some of the issues explored in this edition.

This issue also provides information on a recent study on intimate partner abuse and HIV; introduces challenges of HIV-related stigma in KwaMakhuta, KwaZulu Natal, as well as rights-based responses to HIV and AIDS in Zambia, and is 'making a point' on farm workers' risks and vulnerabilities to HIV.

In this edition, **Johanna Kehler** explores the legal and social environments of women raising the question as to whether or not these environments are 'enabling'. Examining the enabling legal environment, as well as realities of gender violence and challenges encountered by 'invisible' women, such as sex workers and lesbian women, she argues that without transforming the gendered, unequal, normative and discriminatory societal context in which rights are

claimed, women will continue to have limited 'ability' to claim their rights, and to access and benefit from available HIV prevention, treatment, testing, care and support services.

Recognising the impact of the concept of masculinity on the spread of HIV, **Eric Axelrod** examines the link of masculinity and gender violence. He discusses masculine norms, as well as the role of entertainment media in shaping masculine identities; explores the prevalent 'culture' of discrimination, disrespect and mistreatment; and argues that social norms need to be challenged, when they prove to be detrimental to society, and that laws must become social norms so as to be effective.

Highlighting the need for effective HIV prevention strategies, **Betsi Pendry** looks at male circumcision and potential challenges for its successful implementation. Exploring community perceptions about male circumcision and potential gender implications, she argues that in order to ensure that this new HIV prevention strategy becomes effective for women and men, the gender implications of this new HIV prevention strategy need to be thoroughly examined, especially as there are many 'unknown' implications of male circumcision on women and women's risk to HIV.

**Erica Kessie** explores various factors leading to women's risks of violence and HIV infection. Discussing the extent to which gendered roles and expectations and society's norms and values impact on women's lack of social recognition, as well as women's 'ability' to make informed choices, and HIV-related stigma and discrimination, she argues that women will continue to be denied their rightful place, and thus, remain at risk of violence and HIV, until such time that 'social norms and values' are replaced by 'constitutional norms'.

Barriers encountered by women in the 'world of sport' are introduced by **Johanna Arendse**. Exploring the rewards and benefits of sport, its potential as a 'powerful communication tool' for HIV messages, and the particular sporting environment for women and girl children, she argues that while sports have many benefits, without sport itself becoming a vehicle of social change addressing gender discrimination and violence within both society and the 'industry', women will remain largely excluded from the 'industry' and its benefits.

Within the context of promoting male circumcision as a means of reducing the risk of HIV infection, **Sandy Okkers** introduces some of the challenges and risks associated with male circumcision. Providing a

While the legislative and policy framework, arguably, promotes a supportive and enabling legal environment, reality is largely defined by the lack of social recognition of, and respect for, the rights of women, children and other vulnerable groups. The gendered context of society, including gendered power relations and gendered prescriptions of behaviour; and prevailing discriminatory attitudes, beliefs and practices are some of the factors indicating the lack of a supportive and enabling environment – often maintained and justified by social, cultural and religious value, norm and belief systems. Subsequently, women, children and vulnerable groups remain to have lesser ‘power’ to claim their rights, to access available resources, and to make informed decisions about their lives.

*...women will continue to engage in ‘risky sexual behaviour’, as the potential personal, social, cultural, and economic costs of ‘risk avoiding behaviour’ are often too high...*

Gendered inequalities, imbalances and injustices, as well as prevailing stigma, discrimination and violation of rights based on, and in the context of, HIV and AIDS have been widely recognised as underlying factors not only fuelling, but also exacerbating the impact of the HIV and AIDS pandemics. Research further suggests that women’s vulnerability and ‘inability’ to negotiate sexual relations are premised on multiple and intersecting levels of gendered inequality, underpinned by social, cultural and religious norms of sexual behaviour and often ‘enforced’ through violence. Thus, women will continue to engage in ‘risky sexual behaviour’, as the potential personal, social, cultural, and economic costs of ‘risk avoiding behaviour’ are often too high.<sup>3</sup>

Recognising these underlying factors seem to also highlight that, without transforming the societal context, the adequacy and effectiveness of HIV prevention, testing, treatment, care and support efforts will remain limited, with little or no impact on the lives of women, children

and vulnerable groups<sup>4</sup>. Thus, without ‘social recognition’, women will remain to be not only disproportionately infected with HIV, but also disproportionately affected by the impact of HIV and AIDS at a family, household and community level, as women are the ‘carers’, as well as the ‘implementing agents’ of many HIV initiatives, programmes, and interventions; children will remain to be largely ‘disempowered’ and ‘invisible’; and ‘vulnerable groups’, such as sex workers and lesbian and gay people, will continue to be marginalised, stigmatised, and subjected to violence and abuse.

### Gender violence

Gender violence is, arguably, another factor impacting not only on the extent to which fundamental rights and freedoms can be accessed, but also on the adequacy and effectiveness of a human rights-based response to HIV and AIDS. As gender violence has reached pandemic proportions, the impact of violence, especially sexual violence, on the risk of HIV infection has become widely recognised. It is within the context of gendered power relations that high levels of violence and abuse, including sexual violence, compound especially women’s ‘inability’ to make sexual choices, and to reduce the risk of HIV infection. Violence and abuse, or the threat thereof, heighten women’s risk of HIV infection, as women are seldom in the position to negotiate conditions of sex, whilst sexual violence and/or coercive sex exacerbate the risk of HIV infection, as a direct consequence of physical trauma. High incidences of rape and sexual violence, mostly committed against females, and the increasing number of women living with HIV; as well as common challenges of stigma, blame and shame faced by survivors of sexual violence and by people living with HIV, are, arguably, indicating the links between sexual violence and HIV. There also seem to be common factors, such as lack of an integrated approach to respond to the realities and needs of survivors of rape and of people living with HIV, as well as the apparent failure to effectively address the lived realities of women, who are disproportionately affected by both sexual violence and HIV.<sup>5</sup>

However, despite the acknowledgment of the links

broad overview of male circumcision as a prevention tool and discussing some of the challenges and risks associated with male circumcision, she argues that for male circumcision to become a 'successful' means of HIV prevention, it has to be promoted as an integral part of a whole range of HIV prevention methods, and not as a 'stand alone' prevention tool, as men cannot rely on circumcision alone.

Recent experiences of HIV-related stigma and related violence from KwaMakhuta, KwaZulu Natal, are introduced by **Thabisile Khuzwayo**. Emphasising that it is people's mindsets towards HIV and AIDS, and not HIV itself, which is the real 'problem', she argues that the 'attack' on service providers in the area was 'shocking and disturbing', as well as a 'wake up' call, as it not only highlights the 'danger' of inaccurate information, but also raises the question as to the effectiveness of current programmes in the area.

The **Zambian AIDS Law Research and Advocacy Network (ZARAN)**, an organisation promoting the rights of people living with, and/or affected by, HIV and AIDS, is introduced by **Malala Mwondela**. Highlighting some of Zambia's HIV and AIDS realities and challenges, she discusses ZARAN's challenges in trying to promote a rights-based response to HIV, and argues that human rights are to be incorporated into every aspect of the response to HIV and AIDS – because the day we stop promoting human rights, will be the day we begin to lose the struggle.

Looking at the farming communities in the Overberg district, **Keith August** is 'making a point' about farm workers' realities in the context of HIV and AIDS. He provides an overview of historical, economic and social challenges of the farming community; explores workplace challenges, such as farm workers' vulnerability to stigmatisation and ostracism, and possible solutions for a response to farm workers' HIV and AIDS realities, and argues that programmes for farm workers can no longer be seen as a luxury, but as a necessity, so as to reduce farm workers' risks to HIV infection and their vulnerabilities to discrimination and abuses.

Examining these various facets of the environment as to the extent to which these realities impact on people's abilities to claim and enjoy fundamental rights and freedoms, there seems to be the common conclusion that the 'social environment' is neither conducive nor enabling for women to realise their rights, make informed choices about matters concerning their lives, and access available HIV prevention, testing, treatment, care and support services. There also seems to be the common acknowledgement that 'social

*norms and values*' and a 'culture of discrimination and disrespect', as compared to 'constitutional norms' and a 'culture of human rights', are the very foundation of these 'social environments', which not only cause and maintain, but also 'reinforce' gendered discrimination and violence, as well as risks and vulnerabilities to HIV infection. Thus, while the legal environment is 'supportive and enabling', it is the lack of an 'enabling social environment' that defines women's realities, risks and vulnerabilities.

If we are to agree that even the most progressive 'legal environment' is only as 'good' as it impacts on people's lives, then we are to agree that the 'social environment', in which women live their lives, does not 'promote a supportive and enabling environment', since women continue to lack 'social recognition', despite the enabling legal environment. If we are further to agree that it is the 'social norms and values' which are the main obstacles to an enabling social environment, then we are to agree that these 'social norms and values' are in dire need of transformation, as they 'prove detrimental' to women and women's lives. And finally, if we are in agreement that creating an enabling legal and social environment is key to an effective human rights-based response to HIV and AIDS, then we are to concur that key to creating the 'environment' is a 'social environment' affording everyone equal access, enjoyment, and benefit of the law, and services, irrespective of a person's sex, gender, sexual orientation and/or HIV status.

Thus, any intervention aimed at 'addressing' women's risks and vulnerabilities has, arguably, to be premised on challenging and transforming the very same 'social norms and values' that create, maintain, and 'reinforce' women's greater risks and vulnerabilities. Only as and when steps are taken to 'support and enable' human rights to become the foundation for 'social norms and values', will interventions carry the potential to 'empower' women to take 'their rightful places'. Indeed, as long as women's social environment fails to comply with the 'rule of law', but instead remains 'ruled' by 'social norms and values', perpetuating the gendered and discriminatory societal context, women will remain the ones most vulnerable to, and at risk of, HIV infection; more likely to be subjected to violence and abuse; and thus, least in the position to access, and benefit from, HIV prevention, testing, treatment, care and support services – and 'a supportive and enabling environment' will continue to be 'luxury'...reserved for a few.

**Johanna Kehler**

between sexual violence and HIV risk, HIV prevention services available to people who have been raped, such as post-exposure prophylaxis (PEP), are often inadequate and inaccessible.<sup>6</sup> Moreover, the lack of adequate sexual offences legislation, combined with the inadequate implementation and application of existing legislative provisions are, arguably, further denying access to justice for rape survivors. The various effects of the failure to provide access to justice are well evidenced, most notably by the fact that only one in nine women who have been raped will report the incident<sup>7</sup>. In light of an estimated 500 000 women who experience sexual violence every year, conviction rates of only 5% and common secondary victimisation and abuse of rape survivors by the justice system, further compound the lack of protection for rape survivors.

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The Sexual Offence Bill will undoubtedly improve the legislative framework pertaining to sexual offences and thus, potentially increase access to justice for rape survivors. However, the extent to which this new legislation can create a supportive and enabling environment for rape survivors to access justice, has its limitations. Despite recommendations made by the South African Law Reform Commission, the Bill does not include provisions addressing the psycho-social needs of rape survivors, or allowing broader access to protective measures while testifying, such as the use of CCTV. In addition, the potential of the Bill to enhance access to justice for rape survivors is also limited by the fact that the much needed transformation of attitudes, prejudices and stereotypes within the criminal justice system cannot be legislated. Thus, ensuring adequate implementation of the Bill implies

not only training and ongoing monitoring of its impact, but also addressing the prejudices and beliefs amongst the implementing agents of the legislation.<sup>8</sup>

While there have been numerous efforts to address gender violence, as well as HIV and AIDS, responses to the co-pandemics of gender violence and HIV and AIDS continue to have little impact, as inadequate attention is given to the fact that gender violence and HIV and AIDS are intersecting and mutually reinforcing human rights crises.<sup>9</sup> Violence and abuse not only impact on women's and girl children's vulnerability to HIV infection, but also on the extent to which available HIV prevention, testing, treatment, care and support services are accessible. Women living with HIV or AIDS are often subjected to violence and abuse, denied access to available services; and are least in the position to claim their rights, due to prevailing HIV-related stigma and discrimination. As a result, women's choices whether or not to access treatment, care and support, and/or to disclose their HIV positive status to their partners and families, are often limited, due to fear of rejection and blame, and subsequent violence and abuse. Within this context, violence is as much a cause of increased risk of HIV infection, as it is a consequence.

It also has to be recognised that women are often violated in the context of HIV prevention and testing services provision. Coerced and/or forced HIV testing during pregnancy; prevention of mother to child transmission programmes often failing to recognise women in their own right; as well as limited, and even denied, access to HIV prevention based on a person's sex, gender, sexuality, age and/or HIV status are but some of the realities highlighting the various layers of gender violence in the context of HIV and AIDS. As violence is often condoned and sanctioned by the societal context in which it occurs, women and girl children are the ones most likely to be denied access to, and thus, benefit from, available services.

### **'Invisible' women**

The largely '*non-visibility*' of women belonging to marginalised communities, such as sex workers and lesbian, gay, bisexual and transgender people, further exacerbates the risk to both violence and HIV infection. While available

services are inaccessible, and often even denied, violations and human rights abuses are often unrecognised and thus, afforded limited legal protection.

Within a normative societal context of gendered prescriptions of ‘appropriate’ sex and sexuality, sex work remains to be commonly perceived as ‘immoral’, ‘wrong’, and ‘sinful’ and thus, society’s response to sex workers is mostly defined by stigma, discrimination and violence. The fact that sex work remains to be illegal in South Africa seems to not only facilitate the violation and abuse of sex workers, but also manifest sex workers’ increased vulnerability to HIV.

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The criminalised environment in which sex workers live their lives and work, leads to a situation in which sex workers are often exploited and discriminated against by landlords charging excessive high rentals, as well as by managers and owners of agencies imposing unfair working conditions. Sex workers are also extremely vulnerable to violence and abuse from clients, with no access to legal recourse or police protection, as police officers often refuse to take complaints from sex workers seriously. In addition, while sex workers have limited access to adequate healthcare services, including HIV prevention services, due to the stigma associated with sex work, available protective legislative measures remain inaccessible, as sex workers are considered to be ‘criminals’.<sup>10</sup>

Recognising sex workers’ experience of stigma, discrimination and violence, as well as the subsequent vulnerability to HIV and AIDS, clearly highlights the importance of decriminalising sex work. Decriminalisation

of sex work would enhance sex workers’ ‘ability’ to claim their rights, while affording legal protection, and thus, access to justice. Thus, an effective human rights-based response to HIV and AIDS has to not only acknowledge sex workers’ vulnerabilities, but also create the necessary enabling legal environment to adequately address these vulnerabilities.

The rights of lesbian, gay, bisexual and transgender (LGBT) people are recognised and protected in South Africa, as the constitutional and legislative framework explicitly prohibits discrimination based on a person’s sexual orientation<sup>11</sup>. Yet, LGBT people continue to be subjected to stigma, discrimination and violence in all spheres of society, including at schools and workplaces, as well as at various levels of service provision. As a result, the extent to which lesbian, gay, bisexual and transgender people are in the position to claim their rights and to access available services, remains severely limited, despite the constitutional guarantee to equality and non-discrimination.

Ridicule, rejection and subsequent violence at a family and community level; punishment, detention and suspension from schools; exclusion from religious institutions; as well as prejudice and discrimination within police and healthcare services and, at times, denial of services, are some of the violations commonly experienced by lesbian and gay people, often worsened by the general lack of access to adequate legal services and redress. These violations, combined with a general lack of information and resources, applicable to the realities and needs of LGBT people, are not only greatly impacting on people’s ‘ability’ to claim their rights, but also seem to determine lesbian and gay people’s vulnerabilities to HIV and violence.<sup>12</sup>

In addition, it is argued that available HIV prevention services are inaccessible to lesbian and gay people, as messages and programmes to reduce the risk of HIV infection are primarily premised on the assumption that sex is heterosexual. Thus, people who have same-sex sexual relationships are excluded from, and denied access to, HIV prevention information and services. The assumed minimal risk of HIV infection for women, who have sex with women, seem to not only create an additional barrier to information and services, but also

perpetuate the lack of visibility of lesbian women in the response to HIV and AIDS.

As violence, including sexual violence, is one of the means to maintain and *'reinforce'* gendered norms of sex and sexuality, lesbian women are extremely vulnerable to violence, including rape, and are often *'targeted'* for *'curative rape'*. However, lesbian women, who have been raped, often experience severe difficulties in accessing healthcare services, including post-exposure prophylaxis treatment, largely due to prevailing prejudices and homophobic attitudes amongst healthcare providers. Moreover, there seems to be limited to no access to justice, for LGBT people, as the same prejudices and attitudes are to be found within police services and the justice system. Thus, many lesbian and gay people *'choose'* rather not to access services, than to be subjected to further violation and abuse by service providers.<sup>13</sup>

Increasing incidences of lesbian hate crimes are, arguably, a clear indicator that the constitutional and legal protection of rights remains meaningless, if situated in a societal context of prejudice and homophobic attitudes. Thus, as long as the societal context fails to recognise the rights of lesbian, gay, bisexual and transgender people, human rights abuses based on a person's sexual orientation will continue to be a reality, despite the enabling legal environment. Moreover, the lack of an enabling social environment will not only perpetuate prevailing stigma and discrimination, but also maintain lesbian and gay people's vulnerability to HIV and violence.

### Remaining challenges

While the various links between gender violence and HIV and AIDS may receive greater recognition, programmes and interventions often fail to adequately address these correlations and thus, responses to gender violence and HIV and AIDS continue to be largely fragmented. Similarly, the gendered context of society, including gendered power relations and prescriptions of behaviour, are recognised as the common underlying factor for both gender violence and the feminisation of the HIV and AIDS pandemics and yet, there are few programmes and interventions aimed at transforming the gendered

context of society. Thus, acknowledging the gendered context of society and its core beliefs as the *'driver'* of both pandemics seem to highlight that effective programmes and interventions need to not only develop an integrated approach to gender violence and HIV and AIDS, but also challenge and transform the societal context in which both pandemics thrive.<sup>14</sup>

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The lack of women's autonomy, and thus, women's limited *'ability'* to make informed choices, including sexual choices, are closely linked to social, cultural and religious practices, mostly premised on female's *'subordination'* to male *'authority'*. Within this context, cultural practices, such as virginity testing, and cultural and religious beliefs and *'laws'* sanctioning polygamous relationships are as much heightening the risk of HIV infection and violence, as they perpetuate human rights violations of women and girl children. Considering that South Africa's constitutional framework provides for the right to equality and non-discrimination, dignity and respect, and security in and control over one's body, as well as for the freedom of religion, belief and opinion, the challenge seems to be to *'balance'* these constitutional guarantees. While it is important to respect and protect the freedom of religious and cultural beliefs and practices, it is, arguably, equally important to ensure that women's and girl children's risks of HIV, violence and human rights abuses are not perpetuated, and/or even *'justified'*, by this *'freedom'*.

Legislation, such as the Children's Act, prohibiting virginity testing of girl children under the age of 16 years<sup>15</sup>, and the Recognition of Customary Marriages Act,

protecting the rights of women in customary marriages<sup>16</sup>, could be seen as legislative responses to ensure that fundamental rights and freedoms of women and girl children are protected, whilst recognising the freedom to culture and religion. In reality, however, most women living in polygamous marriages have rather limited access to the ‘protection’ of the law, due to a variety of reasons, including the inadequate implementation and application of the law, as well as a general lack of knowledge about the provisions of the Recognition of Customary Marriages Act. Taking into account that ‘multiple concurrent partners’ are recognised to increase the risk of HIV infection<sup>17</sup>, seem to further highlight the ‘risk’ of legally recognising polygamous marriages.

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Since the Children’s Act has only been enacted in July of 2007, there is very little evidence as to its impact. Nonetheless, there is much evidence as to the general lack of understanding of the ‘inalienable nature’ of children’s rights in all spheres of society, as well as to the violation of rights, and the increased risk of HIV and violence, inherent to virginity testing. Thus, for legislation, prohibiting virginity testing of girl children, to carry the potential to indeed protect the rights of children, it seems essential to not only ensure adequate implementation of the law, but also to challenge the underlying issues of ownership, power and control implicit to the concept of virginity testing.<sup>18</sup>

The ‘progressive’ legislative and policy framework promoting the rights of women, children and other vulnerable groups, as well as proposed legislation and law reform recommendations, are, arguably, indicators of a supportive and enabling environment. However, it seems imperative to acknowledge that without transforming the gendered, unequal, normative and discriminatory societal context in which people live their lives, constitutional guarantees, laws and policies will remain to have little impact on the lived realities of most women, children and vulnerable groups. Thus, an effective human rights-based

response to HIV and AIDS has to be equally premised on addressing the ‘socio-cultural driver’ of entrenched patriarchal values, norms and beliefs, upholding male privilege, gender violence, intergenerational and transsexual sex, as well as stigma and the lack of openness about sex, sexuality and HIV<sup>19</sup> – so as to create a supportive and enabling environment, in which women, children and other vulnerable groups are ‘able’ to claim their rights, and to access and benefit from the national response to HIV and AIDS.

#### FOOTNOTES:

1. This article is a shortened version of chapter in one of the NSP publications produced by the AIDS Legal Network (ALN). See also Kehler, J. 2007. Creating a social environment: The National Strategic Plan and human rights. Cape Town: AIDS Legal Network.
2. Guideline 8 of the **International Guidelines on HIV/AIDS and Human Rights**. See also Strode, A. et al. 2006. HIV/AIDS and Human Rights in SADC: An evaluation of the steps by countries within the Southern African Development Community (SADC) region to implement the International Guidelines on HIV/AIDS and Human Rights. Windhoek: ARASA. [www.arasa.info]
3. Albertyn, C. 2003. ‘Contesting democracy: HIV/AIDS and the achievement of gender equality in South Africa’. In: *Feminist Studies*, 29(3), pp595-615.
4. Kehler, J. 2006. ‘Gendered realities: The underlying factor?’. In *ALQ*, June 2006, pp1-6.
5. Biggs, M. 2006. ‘Sexual Violence and HIV: Can we ignore the link?’. In: *ALQ*, June 2006, pp10-14.
6. A critical analysis of post-exposure prophylaxis as part of HIV prevention is provided in ‘Part One’ of this series of publications. See Kehler, J. 2007. A responsibility for all: The National Strategic Plan and HIV Prevention. Cape Town: AIDS Legal Network, pp34-36.
7. Report published by the Medical Research Council in 2002, as cited in www.oneinnine.org.za.
8. National Working Group on Sexual Offences, Press Release 22 May 2007.
9. Fried, S. 2007. ‘Rights are too often overlooked: HIV and AIDS and gender-based violence – intersection health and human rights crises’. In: *ALQ*, March 2007, pp14-23.
10. Fick, N. 2005. *Coping with stigma, discrimination and violence: Sex workers talk about their experience*. Cape Town: SWEAT.
11. **Section 9(3) of the Constitution**.
12. Mkhize, N. 2005. ‘Homophobia is supposed to have no place’. In: *ALQ*, June 2005, pp10-13.
13. Vilakazi, F. 2006. ‘There is no mention of sexual minorities: HIV prevention challenges for lesbian and gay people in South Africa’. In: *ALQ*, November 2006, pp10-12.
14. Biggs, M. 2006. ‘Sexual Violence and HIV: Can we ignore the link?’. In: *ALQ*, June 2006, pp10-14.
15. Section 12(4) of the Children’s Act (No 38 of 2005).
16. No 120 of 1998.
17. **National Strategic Plan**, p37.
18. Bower, C. 2005. ‘Virginity Testing: In whose interest?’. In: *ALQ*, November 2005, pp.7-9.
19. Leclerc-Madlala, S. 2006. ‘What really drives HIV and AIDS in Southern Africa’. In: *ALQ*, June 2006, pp29-32.

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Eric Axelrod

# Laws must become social norms...

## A personal view on masculinity and the spread of HIV

Call me a pessimist, but I truly believe that masculinity, in its current form, is doing a great amount of damage to the world. Wars are not battles between people, they are battles between men. They are battles of masculine egoism which exhibit a seemingly limitless desire for power, land, and resources. They are battles of 'who has the largest bomb' and 'who can fire the most powerful gun', two phallic obsessions most certainly related to the masculine desire to have a large and highly effective sexual organ. It is unlikely that South Africa will be involved in a full scale war any time soon, but masculinity has been playing a significant role as a different destructive force – the spread of HIV.

### *Masculinity and the spread of HIV*

It is about time that men stop conforming to the current accepted form of masculinity, one which often contributes to hurting our communities, and start changing what it means to be a man. Mass media and society often send the message that men should have certain attributes and take certain actions, including to have a tendency and eagerness to solve problems using violence; to have multiple sexual partners; to be ready and willing to have sex at all times, irrespective of whether or not a condom is available; to drive excessively fast; and to drink alcohol.

In South Africa, the pressure on men to conform to this kind of masculinity is directly related to men contracting and spreading HIV. Morrell [2005:273] argues that 'In South Africa, violent masculinities have been more in evidence...than in most countries around the world'. It is this very masculinity that has helped to build a culture of violence against and disrespect for women. The alarmingly

high rates of rape and sexual assault in South Africa also raises the question as to what is going on in the minds of so many South African men, which makes them think that such behaviour is at all acceptable. Statistics indicate that for the period 2005/2006, 54 926 cases of rape have been reported to the police<sup>1</sup>, while research suggests that only one in nine women who have been raped will report the incident to the police.<sup>2</sup> Regardless of the exact statistic, the estimates are frighteningly high and calls not only for a more reliable system of punishment, but also an entire societal change as to the way men view women and women's rights. It goes without saying that, in a country with such high rates of HIV infection, rape has become more than just the ultimate invasion of a woman's personal privacy; it has become the potential carrier of a 'lethal virus'.

Highlighting the connection between masculinity and HIV, Courtenay [2003:1388] argues that:

*...health-related beliefs and behaviours that can be used in the demonstration of hegemonic masculinity include the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behaviour and physical dominance.*

If a man's fear of appearing 'vulnerable', or his tendency to 'dismiss the need of help', prevents him from getting tested for HIV, or seeking treatment if infected, then he not only puts his own health at risk, but he also puts at risk all the women he has sexual relations with. One study has also found that traditional men's gender roles lead to 'more negative condom attitudes and less consistent condom use' and promote 'beliefs that sexual relationships are adversarial'<sup>3</sup>.

But there is hope. If the research showing a connection between a socially accepted form of masculinity and poor

health practices is in fact true, then one important health prevention strategy most definitely could be to change the form of masculinity into a social construct which promotes men's and women's health.<sup>4</sup> Campell and Mac Phail [2006:334] further argue that HIV prevention education should provide youth with a means of understanding '*the way in which socially constructed norms of masculinity and femininity place their sexual health at risk, as well as a belief in the possibility of alternative gender relations*'. However, the question remains as to how these '*alternative gender relations*' can come about?

*...a law can make it a legal offence to physically abuse a woman, but unless it becomes a socially accepted norm that hitting a woman is wrong, the law will not be followed...*

### Masculine norms

Clearly, it is against the law to commit rape, or to physically or emotionally abuse anyone, including women. South Africa's Constitution<sup>5</sup> clearly states that all South Africans are equal before the law, and that every person has the right to be treated with respect and dignity, regardless of their sex or gender. How then can such a culture of gender violence and discrimination against women exist so prominently? Although the answer to this question is very complex, one part of the answer is clear – laws must become social norms in order to be effective. That is, a law can make it a legal offence to physically abuse a woman, but unless it becomes a socially accepted norm that hitting a woman is wrong, the law will not be followed and the abuse will persist. Laws cannot dictate the culture and norms of a society, unless laws are adequately enforced, and crimes are met with appropriate legal responses. While law reform can

provide the necessary legal framework to respond to gender violence, and even propose harsher sentences for rapists, it is the adequate enforcement of the law that will ultimately help to change the '*culture of violence*' against women.

One reason why it is very difficult for men to discuss the concept of masculinity and the way it affects the lives of women, is that this very discussion itself is considered to be '*non-masculine*', as it is a discussion of one's own feelings. It is almost part of an unwritten '*code of manhood*' to accept one's masculine duties, as well as to accept masculine norms unquestioningly. But, if change is going to be made, and alternate gender relations are to be achieved, then men will have to be '*brave*' and risk to be seen as '*un-masculine*'. This will be the only way for society to actively change the definition of masculinity for the betterment of the broader community. As one male activist, with strong beliefs in promoting women's rights, has mentioned: '*some people are saying horrible things against me and my wife [because I am a public activist], [but] I have to take a stand so the society can see that change is inevitable.*' [Peacock & Levack, 2004:186]

### Entertainment media and masculinity

The attempt to change the current perception of masculinity, to one which helps to better protect the rights of women, is by no means an easy one. There are enormous obstacles associated with this potential change, one of which is entertainment media. Movies and television shows regularly portray women as being no more than objects of male pleasure. Male heroes are often entrenched in the negative masculine stereotypes, which in turn are absorbed by male viewers and come to be understood as ideal masculine identities.

American '*hip hop*', which has become increasingly popular in South Africa, is a form of music filled with messages of empowerment and discussion of the hardships involved with living in poor areas. But at the same time, hip hop conveys messages of negative masculinity, such as

solving one's problems with violence, and treating women with disrespect as a means of feeling powerful. 'Hip hop' in effect popularises these 'ideal male characteristics'. Again, 'hip hop' has many positive aspects, but when language barriers potentially limit the understanding of all the lyrics of a song, some of which do promote a more female-friendly masculinity, all that remains is the popular image of 'hip hop'. It is an image defined by men wielding guns, while being touched on their bodies by gorgeous women in skimpy clothing, women with completely blank and subservient expressions on their faces. Are these the images of success, which young South African men are to aspire to? It is clear that many forms of media entertainment help to promote these negative masculine stereotypes.

American wrestling has also become enormously popular in South Africa and also portrays men entrenched in negative masculine stereotypes. World Wrestling Entertainment (WWE) television shows feature men whose job it is to beat up as many other men as possible, using brute force and violence in order to achieve their goals. When women are featured on wrestling shows, they are often portrayed as no more than 'skimpy sidekicks' to the male wrestlers, as if they are the male wrestlers' property, and when women do something, which the crowd does not like, chants of 'slut' are screamed out in unison.

*...messages, that using violence to achieve your goals, and that treating women as property is acceptable, are not healthy messages for men to be receiving...*

These messages, that using violence to achieve your goals, and that treating women as property is acceptable, are not healthy messages for men to be receiving. While these shows do have a lot of entertainment value, many South African boys do not have the adult guidance to

explain that these negative-masculine values are a part of wrestling, to entertain people, and not to 'teach' how to live one's own life. On its own, idolising wrestlers, who are often caricatures of negative masculine stereotypes, does not ensure that a young boy will grow up to share the values these forms of entertainment embody. But, if a young boy lacks adult male role models, who teach that women are to be treated with respect, and problems are to be solved without using violence, then it is likely that the values, which the entertainers impart on the viewers, will have a strong influence on their ideas of masculinity.

What can be done in order to ensure that more television shows and movies are sending positive messages to men about what it means to have a 'healthy masculinity'? This is not an easy question to answer, since television and movie producers often 'sell sex', and in the process sell the image of negative masculine identity, in order to get high ratings. People like to be fed concepts of social normality and conformity through media entertainment. People do not like to turn on the TV to have their ideas and concepts of normality challenged. But, challenging audiences is exactly what television and movies need to be doing in order to change socially accepted concepts of masculinity, which are often detrimental to men's and women's health. And as long as there is no discussion about masculinity in public media, disrespecting and abusing women will remain a social norm.

### South African 'legacy'

Given South Africa's history of overcoming racial discrimination, it is very disconcerting that gender discrimination is so enshrined in South Africa's reality today. How can a nation with such a progressive and democratic constitution, resulting from decades of social injustice, be the home of so much domestic violence against women, general disrespect for women and their rights, and rape?

It was questions like these that led to the creation of an

organisation called 'Men As Partners' (MAP). MAP is an organisation 'designed to engage men to reduce gender-based violence and to promote men's constructive role in sexual and reproductive health, including HIV/AIDS' [Peacock & Levack, 2004:173]. The organisation also aims to '*transform the behaviours of men and the norms of masculinity*'.<sup>6</sup>

*...how can a nation with such a progressive and democratic constitution, resulting from decades of social injustice, be the home of so much domestic violence against women, general disrespect for women and their rights, and rape?..*

One of MAP's goals is to use a human rights framework to enable men to 'recognize the ways in which contemporary gender roles mirror the oppressive relations of power characteristic of apartheid. [Peacock & Andrews, 2004:176] Since many men would not even consider women's rights to be an important issue, this strategy is key to making men understand the importance of respecting women's rights, by relating the challenges women face in today's gender-biased society to the challenges faced in a racially-biased apartheid ruled society. In 2005, activist Mbuyiselo Botha of the South African Men's Forum stated that

*...it would be very hypocritical to talk of liberation when you know that a large section of the society is still in bondage. They still face violence, still face death, they still face rape on a daily basis, as if it is business as usual. [Peacock & Andrews, 2004:177]*

The scary part of Botha's comment is that all of the violence committed against women goes on in South Africa '*as if it is business as usual*'. It has become so commonplace that most people don't even notice it any more. On an almost daily basis, tabloids, such as the

Daily Voice, feature headlines about the rape and violence against women, often attached to graphic imagery. This is not so much news reporting, as it is exploitation of other people's suffering to sell newspapers. It has not only the effect of desensitising people to the crimes committed against women, which happen all around on a daily basis, but also adds to the general feeling amongst many South Africans that there is just too much rape and violence against women to stop it from happening.

It is easy to be complacent and not to take action to stop an injustice when someone else's suffering does not directly hurt oneself, and even easier to be complacent when one in fact benefits from someone else's suffering. Of course it is ridiculous to think that violence against women won't affect men personally, considering that men have sisters, mothers, female partners, and female friends, and men would be very directly hurt, if these women were seriously disrespected or raped. This is one of the reasons why it is surprising and saddening that not more men take an active role in promoting women's rights. In some situations, men even benefit from social discrimination against women, even if they do so only subconsciously. This current '*culture*' of discrimination, disrespect and mistreatment allows men to sexually exploit women for their own pleasure, without real fear of punishment. It allows men to order women to take care of domestic duties, such as cooking, cleaning, and taking care of children, leaving more free time for men to indulge in their own pleasures, while women are left to do all the work. It also denies girls to have the same educational opportunities as boys, and gives men a disproportionate amount of high paying jobs. Men in South Africa must wake up and recognise discrimination, disrespect and mistreatment of women for what is, and take actions to the unfair and unlawful treatment of women.

### Concluding remarks

As the old saying goes, '*don't try to re-invent the wheel*'. In the same light, it is difficult for some to believe

that something like masculinity, a social construct, which has been centuries in the making, could be at all changed or altered. It has been argued that ‘*too much is at stake to have HIV prevention resting solely on the entire transformation of social realities*’ [Walsh & Mitchell, 2006:66] – which is an excellent point. As one cannot expect to completely change the social realities that masculinity encompasses, other forms of HIV prevention must continue to be pursued.

*...men in South Africa must wake up and recognise discrimination, disrespect and mistreatment of women for what is...*

But, to simply give up and say that masculine identities cannot be changed at all, to make them more health friendly for men and women, would be a terrible mistake. After all, social norms need to be challenged and changed, when they prove detrimental to the societies in which they exist.

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# Not intended to replace condoms, but...

## Gender implications of male circumcision: Initial thoughts and questions

There has been an important scientific advance in the response to HIV and AIDS, as three study results have shown that male circumcision can help reduce HIV transmission from women to men. The studies indicate a reduction from anywhere between 65% in the Orange Farm study , to a reduction of 53% in the Kenya trial , to a 48% reduction in the Uganda trial .

### Introduction

This news is something to be both welcomed and to be further interrogated and investigated, at a community level – particularly with regard to the implications for women, and for broader HIV prevention strategies. Further investigations are especially important given the attention that male circumcision has received, as this HIV prevention strategy is, at times, regarded as the most effective, and cost effective, prevention strategy, even when male circumcision has low coverage<sup>2</sup>, fails to address HIV prevention and protection concerns for women, and the results of male circumcision trials can easily be misinterpreted and simplified, when they are communicated to the general public<sup>3</sup>. As many donors, governments, South Africa included, NGOs, and international agencies have responded with programmes to roll out male circumcision, the greater the need to explore these programmes with attention to the people, who will be on the receiving end of these initiatives, in order to ensure the successful roll-out and implementation of male circumcision interventions for women and men.

Medical research is a critical component of the global response to HIV and AIDS. However, medical research conducted in highly controlled settings is not designed, nor necessarily equipped, to address the challenges of translating medical advances into viable interventions that happen in the ‘*real world*’, with ‘*ordinary people*’ in community settings with relational dynamics that are

seldom equal or equitable. In South Africa, this ‘*real world*’ includes poverty, gender inequality, inadequate healthcare and medical infrastructure, including an inadequate number of trained healthcare personnel, a limited level of medical understanding at a community level, gendered cultural beliefs, attitudes and practices, and an NGO sector, that is already overwhelmed with its role in responding to HIV and AIDS. South Africa is also the country that has the highest rate of rape and sexual assault, and the highest incidence of HIV in the world. Moreover, it is important to note that South Africa experiences enormous challenges in providing adequate HIV prevention, treatment, care and support services, including ARV treatment services to people, who are in need of treatment.

In light of these realities, it seems crucial to ask whether or not, and how, these concerns are to be addressed, so as to advance male circumcision as a prevention strategy. All of these factors deserve particular attention as they speak especially to the social environment of women, and illustrate some of the challenges that the large scale implementation of male circumcision will encounter. Bearing in mind the gap between male circumcision research and implementation, as well as a number of significant issues within the concept of male circumcision, this article intends to begin to identify some of the remaining questions and challenges posed by male circumcision, so as to advance the dialogue on male circumcision, including its implementation, as an effective prevention strategy for women and men.

Because there is such an enormous need, accompanied

by enormous effort, to address the high rate of transmission of HIV throughout the world, and there is, as of today, no successful vaccine, or other available preventative technology outside of female and male condoms, the news about the male circumcision trials, is particularly important. Just as the scientific findings are to be welcomed, the many questions – particularly with respect to women, affected communities, and scale-up implications – that need to be further investigated before the intervention of male circumcision is scaled-up and implemented, are to be recognised. Furthermore, male circumcision must be considered in light of the lessons learned from the nearly thirty years of the AIDS epidemic, and placed within the continuum of HIV prevention, treatment, care and support strategies that currently exist.

*...the messaging ignores the fact that there continues to be the need to use condoms, with male circumcision as only an additional preventative technology, and not the elusive 'magic bullet' that would mean that men no longer need to use a condom...*

### Community perceptions

Community interpretations and related to that – media messaging – will play a key role in the success, or failure, of male circumcision as an HIV prevention tool. It is, thus, critically important to explore both the interpretation of male circumcision as an intervention, and an HIV prevention tool, at the community level, and how this is communicated through the media. Most of the headline news conveys the message that male circumcision reduces the rate of HIV transmission, with no mention of the fact that male circumcision only reduces the instance of female to male transmission of HIV. Moreover, the messaging

ignores the fact that there continues to be the need to use condoms, with male circumcision as only an additional preventative technology, and not the elusive 'magic bullet' that would mean that men no longer need to use a condom.

The impact of these messaging on community perceptions about male circumcision and HIV risks are critical issues that need to be explored, especially as these media messages are conveyed at a time where there has been no government public health messaging on the issue of male circumcision. Furthermore, the messaging occurs at a time where condom usage, and trust for condom use, is at an all time low, particularly since there have been reports that inferior and 'unsafe' condoms were produced and distributed, and are now being recalled. What all of these mean for women and for men, and for the future success or failure of HIV prevention strategies, is not yet clear.

It is, therefore, a critical moment to examine community preparedness for male circumcision, and to pursue a gendered analysis of the intervention, so as to advance effective prevention strategies for women and men, as well as strengthen the implementation of male circumcision, as one of the HIV prevention strategies, in South Africa.

### Gender implications

In response to the male circumcision trial results, a number of issues have been raised, including responses that caution about the potential risks, as well as the thus far 'unknown' implications of male circumcision. While many of these responses deserve consideration and engagement, this article will highlight some the concerns raised about the potential implications of male circumcision on women and women's risk to HIV.

A report, supported by the Ford Foundation<sup>4</sup>, identified

*...that there is substantial evidence demonstrating that condom use drops significantly at the initiation of emotional, intimate or long term relationships demonstrating that women, especially in resource poor countries are at risk for HIV and other sexually*

*transmitted diseases from their regular, not their secondary or casual partners. The search for other prevention strategies is not intended to replace condoms but to rather add to the armoury of available HIV prevention strategies.* [Sawires et al, 2007:10]

The AVAC report<sup>5</sup> also raised a number of concerns about the gender implications of male circumcision, including that

*...the programs must stress what is known and what is not known about male circumcision with particular emphasis on impact on women in a predominantly heterosexual epidemic.* [AVAC, 2007:3]

The study further revealed that there was an increased risk of HIV transmission, if HIV infected men, who had undergone male circumcision, had unprotected sex too soon in the healing process<sup>6</sup>, and because of this, the report cautioned that male circumcision programmes need to be accompanied by adequate counselling to ensure that men understand the increased risk of HIV transmission, if they have sex too soon after the circumcision. In addition, the report identified the need that

*...programs develop clear and accurate approaches to addressing the current state of knowledge on male circumcision, in order to reduce potential stigmatization of uncircumcised men, while also minimizing risk to sexual partners.* [AVAC, 2007:5]

In the context of male circumcision and HIV prevention, Berer [2007:47] argues that

*...there is no technical shortcut to the social transformation needed in how men and women confront and act on their own sexuality and in sexual relationships. Safer sex is a state of mind, and a way of thinking and relating to others sexually and it is only safer sex that will defeat the epidemics of HIV and others STIs.*

Given the above indicators about condom use, together with highlighting the challenges that women face in negotiating with their partners to use condoms; and the concerns about the need for appropriate counselling and for the appropriate messaging about what male circumcision can and cannot do, the question arises as to the 'role' of

male circumcision in the context of women's realities. Will male circumcision be understood to replace condom use? Will male circumcision fuel a common understanding that it is women, who 'bring HIV into to the home', thus further stigmatising women? Ethically, should we prioritise male circumcision as a prevention tool, when it is monogamous married women, who are at a high risk of HIV infection from their husbands? These are all critical questions to ask, and issues to engage with, at all levels of society, especially as the social, cultural, religious, and political environment, in which male circumcision is to be implemented, is already fraught.

*...how can it be prevented that male circumcision becomes equated with being HIV negative, and from the thinking by extension, that if one is circumcised it means, therefore, that one is both invulnerable to HIV, and also HIV negative, and so does not need to use a condom?..*

Another crucial question to ask is whether or not the roll-out of male circumcision will appropriately and adequately respond to, and prioritise, the concerns of women, or will there be a more narrow medical focus on men, isolated from the relational, social, and cultural implications of male circumcision for men and their women partners. Will the male circumcision roll-out continue to relate to HIV transmission as only a medical challenge, rather than as a relational, social and cultural challenge? Will a roll-out of male circumcision isolate men from their relationships, thus, referencing individual responses over relational and social responses, which are inclusive of women and men as a sexual-relational unit, and hence, fuelling already difficult and unequal gender dynamics?

In the context of the lives of women, how will male

circumcision affect women's ability to negotiate safer sex, whether or not it is with a casual partner, or a long-term partner, given the unequal gendered context of society? How will male circumcision, which is protective of men, not enable or not encourage men to say that they do not need to use a condom, because they are circumcised? How can it be prevented that male circumcision becomes equated with being HIV negative, and from the thinking by extension, that if one is circumcised it means, therefore, that one is both invulnerable to HIV, and also HIV negative, and so does not need to use a condom? In an environment in which there is a lot of misunderstanding around HIV, and where women already lack the ability to have their male sexual partners use a condom, how can it be prevented that the development of an over-simplified message puts women more at risk and misleads men as to their own vulnerability for both transmission to others, and becoming infected with HIV?

*...how can it be prevented that the development of an over-simplified message puts women more at risk and misleads men as to their own vulnerability...*

### Concluding comments

These are but some of the questions that need to be raised, so as to ensure that male circumcision will become an effective HIV strategy for both women and men, instead of an HIV prevention tool that decreases women's ability to negotiate conditions of sex and thus, increases women's risk of HIV infection. Recognising the lack of data evidencing the gendered impact of male circumcision, as well as the lack of accurate information and community perceptions about male circumcision, it seems crucial that we – as activists, researchers, advocates, community members, and individuals infected and affected by HIV

– raise these questions and explore all the implications of male circumcision at an individual, relationship and community level.

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# Women are denied their rightful place...

## Women's risks of violence and HIV

Women are the most vulnerable and at risk population group in society. Women bear not only the brunt of assaults, battery and rape, but also are mostly infected and affected by the HIV and AIDS pandemics. Their socio-economic status further perpetuates women's vulnerabilities, including women's risk to HIV infection. The rights of women are promoted and constitutionally guaranteed, yet women are violated and abused on a daily basis.

### Introduction

Statistics indicate that women are disproportionately affected by sexual violence and by HIV and AIDS. According to data released in the South African Police Services Annual Report, 54 926 cases of rape have been reported during the period 2005/2006<sup>1</sup>. It is important to bear in mind that these statistics only reflect the number of reported cases of rape, even more so, as only one in nine women, who have been raped, will report the incident to the police. In addition, statistics also indicate that the HIV prevalence rate amongst adult women (20 – 64 years) is 20.4%, with a national rate of 11.2%. Furthermore, it is estimated that young women between the ages of 15 to 24 years are three to four times more likely to be infected with HIV, than young men of the same age.<sup>2</sup>

Negotiating conditions of sex, including 'safer sex', is almost impossible for women. Male dominance, gender roles and financial dependency give women limited power and resources to negotiate sex, to access information and services, and to claim their right to be treated with respect and dignity.

Abuse of any kind, occurring privately or in public, is a violation of human rights. While women have the right to be free from all forms of violence, coercion, stigma and

discrimination, societal 'tolerance' of violence and abuse often prevents women from reporting such cases to the police, due to fear of being stigmatised and discriminated against. Public perceptions, such as 'going to the police and being on trial, is like being raped again', further deter women from laying a charge against the abuser.

Intimidation and economic disempowerment, depending on the man for food and shelter, further impact on women's 'ability' to leave an abusive relationship, or to access services, including healthcare services. Often, the fear of losing custody over their children deters women to report abuse. Thus, women are silenced and voiceless – a reality strengthened by cultural beliefs and expectations that women are to be seen, but not heard. If a woman speaks out, she is not a 'good' woman, and 'speaking out' often 'initiates' further abuse and violence against her. Cultural and gendered beliefs are thus, largely defining women's vulnerabilities, including the violation and abuse of women as and when women 'speak out'. 'Many people were brought up in the old fashion way, they believe the man is the roof of the house and the woman is the floor they walk on'. [Strebel, 2006:523]

Gendered roles and expectations also define sexual behaviours and norms. As a result, women are 'prone' to be at greater risk to HIV infection, and are most

vulnerable to violence and abuse whilst claiming sexual rights. While it is ‘acceptable’, and often even expected, behaviour for a man to have multiple sex partners, a woman will be branded as promiscuous and the carrier of HIV, if she has multiple sex partners. A man’s social status may even rise, based on the amount of sex partners, while at the same time a woman may risk her safety, if she expresses her sexual needs and desires. A woman has to be ready to please a man’s needs, whenever he wants to have sex. Since men feel they have a right over women and are entitled to women’s bodies, women become objects of men’s sexual desires, leaving women at a risk of violence and abuse. As a result, women may feel powerless and opt not to negotiate conditions of sex, including condom use, due to the imminent fear of violence and abuse. Thus, women’s ‘ability’ to make informed choices, including sexual choices, is compromised, as their right to have autonomy over their bodies is violated.

Women, especially married women, are expected to have children. If a woman chooses to have children at a later stage, or not to have children, women are stigmatised, violated and abused, because they choose not to have children. In addition, women who choose not to have children are often assumed to be infected with HIV and therefore, at risk of violence and abuse. At the same time, women, who are infected with HIV and choose to have children, are violated and abused, because they choose to have children.

**...‘many people were brought up in the old fashion way, they believe the man is the roof of the house and the woman is the floor they walk on’...**

In addition to violence and abuse, and the heightened risk of HIV infection, women are also faced with stigma

and discrimination at a family, household, and community level. Since women are often the first one in a relationship to get tested for HIV, women are the ones to be blamed and shamed for ‘bringing the virus home’, further impacting on women’s risk to violence and abuse.

**...since women are often the first one in a relationship to get tested for HIV, women are the ones to be blamed and shamed for ‘bringing the virus home’, further impacting on women’s risk to violence and abuse...**

*...when I was diagnosed, I had a partner...the relationship became more violent...he said I brought a new problem into the family...the violence became more, he had other relationships...<sup>3</sup>*

The fear of stigma, discrimination and subsequent violence not only prevents women from accessing services, including HIV prevention services, but also impacts greatly on women’s choices whether or not to disclose their HIV status. Similarly, the fear of being perceived to be infected with HIV may lead to a situation in which women ‘refuse’ to negotiate safer sex, use safer feeding methods, join support groups, and seek treatment, which is detrimental to their health. Thus, stigma and discrimination combined with the lack of assured confidentiality, not only limit women’s access to available services, but also increase women’s risk to violence and abuse.

HIV disclosure should be the norm and not the reason for violence and abuse. A person’s readiness to disclose her or his HIV status should not be defined by the fear of stigma and violence, but instead by the assurance of ‘safety’ and the knowledge that there is no threat to one’s

dignity and life. However, the 'norm' of HIV disclosure is one of fear of judgement. When a man discloses his HIV status, the response often is 'ag shame', but when a woman discloses her HIV status, a common response is, 'she must have been sleeping around'. As women are often the first in a relationship to know her HIV positive status, the 'pressure' to disclose is put on women – despite the risk associated with HIV disclosure. While the law is clear on the right to choose whether or not and when to disclose one's HIV status, women are often pressurised with the 'need to disclose' and/or the 'moral obligation to disclose', since it is the 'right thing to do'. In reality, however, 'doing the right thing' often results in violence and abuse, and even death of women, who have disclosed their HIV positive status. And while service providers, including counsellors, are aware of the law and the reality, it is often service providers who strongly suggest to women to disclose their HIV status to their partners, instead of providing factual information about the advantages and disadvantages of HIV disclosure.

*...these beliefs and norms, which increase women's risks and vulnerabilities, are further strengthened by religious and cultural leaders, who reinforce the importance of women's respect for their husbands and thus, the notion of a 'good woman'...*

Everyone has the right to make informed decisions and the right to access accurate and factual information, which enables informed decision-making. But, since information is often influenced by social, cultural and religious beliefs, choices and decisions are influenced

by beliefs and norms of society. In addition, information for women often differs to the information for men, as the information reflects the different expectations put upon women. Thus, the ability to make informed choices greatly differs between the sexes, and so does society's responses to the choices made – leading, amongst other things, to social tolerance of violence against women and social acceptance of women's greater risk to HIV infection.

*...choices, and the responses thereto, are defined by society's norms and morals, which are judgemental and discriminatory against women...*

Choices, and the responses thereto, are defined by society's norms and morals, which are judgemental and discriminatory against women. The moment a woman's behaviour is perceived to be 'wrong', she will be judged and 'punished'. A 'good woman' is faithful, trusts and obeys her husband, and does not question him or his whereabouts. The moment a woman tries to negotiate safer sex, suspicion of promiscuity will fall on her and with it the blame and risk of violence. As a result, women may choose to 'respect and obey' in order to avoid violence and abuse – and in turn, increase the risk of HIV infection. At the same time, women who are infected with HIV are at higher risk of violence and abuse, as their HIV positive status is perceived to be a sign of women's 'promiscuity'. And these beliefs and norms, which increase women's risks and vulnerabilities, are further strengthened by religious and cultural leaders, who reinforce the importance of women's respect for their husbands and thus, the notion of a 'good woman'.

Society's norms and values continue to place women at risk of violence and abuse and at risk of HIV infection,

despite numerous efforts promoting women's rights, as well as studies indicating the links between women's unequal status and high risk of HIV infection. South Africa's history, culture and religion are often blamed for the continued violation of women's rights, and at times it is used to excuse and/or justify men's behaviour, which place women at risk of higher HIV infection; and then discriminate, stigmatise and blame women for 'bringing the virus home'. The same history, culture and religion are often used to excuse the continued stigma, discrimination and subsequent violation of women, especially women who are perceived to be 'non-conforming' to the roles and responsibilities assigned by society's norms. Whatever the 'excuses' might be, what remains is the social acceptance of violating women. And as long as the rights of women are violated, women will be at high risk of HIV infection and of violence and abuse. Similarly, as long as women are marginalised and prevented from taking their rightful place in society, women will continue to be vulnerable and at risk.

*...behaviours and attitudes need to change, to not only 'allow' women to make choices about their bodies and lives, but also to take their rightful place in society...*

So, for women to be 'able' to make choices, to access resources, and to claim their rights, the norms and values defining women's spaces need to change. Behaviours and attitudes need to change, to not only 'allow' women to make choices about their bodies and lives, but also to take their rightful place in society. Society's perception of women and women's rights need to change to reduce women's risks and vulnerabilities. Religious and cultural

leaders need to 'preach' about the importance of respect for women and women's rights, and not about the need of women to respect their husbands. Women need to be recognised as human beings, as people in their own right, and not be predefined by social, religious and cultural beliefs and so-called norms. Thus, 'social norms and values', which deny women their rights need to change and be replaced by 'constitutional values', which guarantee everyone, including women, the right to equality, non-discrimination, autonomy and to be free from all forms of violence.

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# A vehicle of social change...

## Women in sport

Sport has many benefits. Sports can also teach children skills, such as fair play and respect for others. It is argued that:

*...the skills and values learned through sport are especially important for girls, given that they have fewer opportunities than boys for social interaction outside the home and beyond the family network.<sup>1</sup>*

When girls participate in sports, it provides the opportunity to connect with others socially, something which is at times denied, since girls are often expected to do housework. Sports can also be a tool to increase respect for girls and women, as the rules of sport are the same for everyone, and everyone speaks the same language, the language of sports.

There are many rewards for participating in sports activities, including better health, self-confidence, leadership skills, and discipline. If started at an early age, sport *'leads to greater participation in school work, which improves school performance and enhances productivity and earnings in adulthood'* [Moutawakel, 2007]. Sport also develops and increases self-confidence in girls, since girls, who pursue sports, will feel stronger both physically and psychologically. *'Because sport increases self-confidence, girls are better able to stand up for themselves'*. [Moutawakel, 2007]

While sport may have many rewards for women and girls, it also has many challenges. The potential of developing self-confidence and leadership skills through sports will only be realised, if women and girls are given the opportunity to also display these skills in their homes and communities. And this opportunity is often denied to females.

Many girls often do not have the freedom to pursue sport as a career, but instead are expected to prepare themselves for marriage and motherhood. Beliefs, such as girls, who

participate in sport, will not be able to bare children, which are common in many communities, pose a further challenge to women and girls wanting to pursue sport as a career.

Although participation in sport will develop a healthy body, this has become one of the greatest challenges for women in sports, since exercise also changes the shape of the body. If this happens, women athletes often fear being labelled lesbians and may change exercise, training and healthy eating habits, which are vital for their performance. *'Because of existing homo-negativism in sport, some girls will drop out of sport'*, or will select a socially accepted or *'feminine'* sport. [Barber & Krane, 2005:2]. This kind of experience could also result in the athlete developing a low self-esteem and confidence, and eventually leaving the sport.

### Physical education

It is also argued that sport has to be seen as an integral part of education.

*...physical education is an essential component of quality education and an integral part of lifelong learning. The neglect of physical education reduces the quality of education...physical education is the only subject in the curriculum that focuses specially on the body.<sup>2</sup>*

If physical education is in fact such *'an essential component of quality education'*, then sports at schools should be taken seriously and be given the necessary attention by government departments and educators alike. This would include developing sport facilities and structures in all schools, so that every learner can equally participate in sports activities. Female learners' access to available sports activities is additionally challenged by the fact that there is not a sufficient number of qualified women

coaches and trainers, and that sport activity programmes are often designed by men, which, at times, make it difficult for girls to participate in these programmes.

*...beliefs, such as girls who participate in sport will not be able to bare children, which are common in many communities...*

Sport can only develop in schools, if there is a direct link between school and sport clubs. It is important to note that sport clubs, or federations, have the necessary infrastructure and skills to assist with the development of sport in schools, but there is, currently, very little or no contact between the two. Sport clubs would also be the next step for the learner, who, after leaving school, wishes to continue participating in sport.

In addition, participating in sport does have financial implications at a family and household level. Although sport activity might seem ‘cheap’, sport can become an expensive exercise, especially if the athlete excels in the code of sport of their choice. Finances can also become a challenge, when the playing venues are far away from home.

#### *Sports environment for women and girls*

The 2006 Declaration on the Elimination of all Forms of Discrimination and Violence Against the Girl Child [2006:26] states that:

*...supporting the empowerment of girls entails the elimination of all barriers that prevent them from developing their full potential, including through the provision of equal access to, and full participation in, education and training, health services, community activities, and girl-friendly spaces for interaction with their peers could become a challenge if the playing venues are far away from home.*

While there are often not enough resources allocated to the development of women and girls in sports, there are

also structural barriers, such as training venues that are not accessible to everyone, and a lack of safety, especially for women and girls who travel to these training venues. At the same time, most programmes start at a time when women need to attend to their families, whilst in addition, there is a general lack of childcare provisions for women during the time of the training programme. These are some of the barriers which need to be addressed urgently so as to create an enabling environment for women and girls to excel at their chosen sport.

The South African Constitution guarantees everyone the right to be treated equally and not to be discriminated against, irrespective of a person’s sex or gender. There are also numerous laws and policies promoting women’s rights and prohibiting gender-based discrimination. However, despite all of these efforts, gender inequalities and injustices seem to prevail in all spheres of society – and sport is no exception.

*...if sport is to become a tool to build a nation, everyone must be equally in the position to participate in sports activities in whatever chosen form, irrespective of their sex, gender and/or socio-economic status...*

Sport in South Africa is still largely inaccessible to most people, and thus, as argued by Keim [2005:1], peoples’

*...relationship to sport is reduced to being a spectator – not even spectators in the stand, but due to their socio - economic situation standing outside shops and café’s that have television sets, watching from the street and not allowed to enter.*

However, if sport is to become a tool to build a nation, everyone must be equally in the position to participate in sports activities in whatever chosen form, irrespective of their sex, gender and/or socio-economic status.

Many studies have indicated the benefits of sports and the impact that sport can have on the development of personal skills, such as discipline, self-awareness, self-confidence, teamwork, and negotiating skills, as well as how to deal with winning or losing. These are valuable lessons, which, if applied, could benefit especially girls and women. Thus, sport could become a means of women's empowerment, provided that there is equal access to resources and opportunities for women and girls; there is societal acceptance of females' choices pertaining to sport; and that families and communities are supportive of women and girls, who want to actively participate, and excel, in the sport of their choice. On the contrary, if women are not given equal access to resources and opportunities, women will remain marginalised and largely excluded from sports activities, which *'will have diverse effects on women in sport'*.<sup>3</sup>

*...women are generally seen as 'emotional' and 'incapable of making tough decisions', women are seldom elected as presidents of clubs, federations, and international sports organisations...*

It also has to be acknowledged that the challenges of *'women in sport'* are often worsened by the social, cultural and religious beliefs and values, which define women's spaces within the sphere of home, family and *'feminine'* responsibilities and, therefore, women have limited opportunities to participate in activities outside the home, including sport activities. Similarly, girl children, wanting to participate in the sport of their choice are often given very limited space to choose and/or to excel in the sport of their choice, as girls are commonly expected to develop in *'feminine'* activities, which do not include sports.

The same beliefs and values about women's roles, and their 'limitations', are reflected in the fact that there is an enormous lack of women in leadership positions within the structures of the sport *'industry'*. As women are generally

seen as *'emotional'* and *'incapable of making tough decisions'*, women are seldom elected as presidents of clubs, federations, and international sports organisations, and thus, women are generally excluded in the decision-making processes, including decisions affecting the role of women in sport.

*...the sport environment is potentially a 'safe space' to address issues such as sex, sexuality and HIV and AIDS, as athletes feel free to participate in discussions in this setting...*

#### Sport and HIV messages

As *'sport is one of the world's most powerful communication'*,<sup>4</sup> sport has the potential to communicate messages to a wide audience, drawn together from diverse groups and cultures at a national and international event, which are carried by athletes, who become spokespersons on a variety of issues. In light of this, *'...sport can be a vehicle to help mitigate the spread and impact of HIV/AIDS'*.<sup>5</sup>

Coaches and trainers have a trusting relationship with their teams. Therefore, the sport environment is potentially a *'safe space'* to address issues such as sex, sexuality and HIV and AIDS, as athletes feel free to participate in discussions in this setting. It is also argued that well-designed programmes disseminating essential information and teaching *'life skills'*, can also impact on HIV prevention, because *'girls participate in sport...develop a sense of ownership and respect for their bodies'*<sup>6</sup>.

Despite the potential of sport to further raise awareness and knowledge about HIV and AIDS, the HIV and AIDS pandemics also impact on the *'sporting world'*, as many athletes, coaches and administrators are living with, and are affected by, HIV and AIDS, and athletes may have to leave a successful sporting career, due to their HIV infection. It

is, therefore, important for the 'sporting world' to actively participate in the response to HIV and AIDS.

*...the required education and empowerment potentially leading to social change, is to create an enabling environment and equal opportunities for women and girls – starting at the community level...*

## Conclusion

The challenge experienced by women and girls in sport cannot be addressed if the 'sporting world' is seen as a stand alone and separate part of society. Since 'education and empowerment drive social change' [Goslin, 2006:7], the required education and empowerment potentially leading to social change, is to create an enabling environment and equal opportunities for women and girls – starting at the community level.

*Gender equality produces the 'double dividend' of benefiting both women and children and is pivotal to the health and development of families, communities and nations. When women are empowered to lead full and productive lives, children and families prosper.<sup>7</sup> Thus, if sport is to become a vehicle to bring about social change, then sport has to address both gender discrimination and violence at a community level and within the 'sporting world'.*

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# Intimate partner abuse and HIV

## Findings will emerge from a study conducted

South Africa has one of the highest levels of intimate partner abuse (physical and emotional) against women in the world.<sup>2</sup> South Africa also has one of the highest HIV infection rates in the world, disproportionately affecting women between 15 to 49 years. Statistics estimate a 29.1% national antenatal HIV prevalence rate, which peaks at 38.7% in the age group 25 to 29 years, and females between the ages of 15 to 29 years to be three times more likely to be infected with HIV, as compared to their male counterparts in the same age group.

There is evidence of links between intimate physical partner abuse and HIV infection. A study in antenatal clinics in Soweto, for example, found that women, who had experienced physical abuse, were two-thirds more likely to be at risk of HIV infection, than women who had no experiences of physical abuse.<sup>3</sup> Evidence is less clear on whether or not intimate partner abuse is higher among women living with HIV and AIDS. Some studies, internationally, suggest an increase in risk of intimate partner violence among HIV-infected women<sup>4</sup>, while others suggest similar levels of intimate partner violence among women, with similar backgrounds, who are uninfected with HIV<sup>5</sup>. One study in Rwanda, Africa, showed that men were much more likely to become angry when refused sex by the intimate partner (46%), than men, whose partners were uninfected with HIV<sup>6</sup>.

Very few studies have compared intimate partner abuse among women before and after being infected with HIV. While there is growing evidence that an HIV diagnosis may trigger intimate partner abuse at the time of disclosure<sup>7</sup>, it is unclear whether or not increased abuse occurs on an

ongoing basis, due to HIV-related factors. A study by the World Health Organisation in several countries showed that a pattern of abuse tended to exist. Where women experience abuse before becoming infected with HIV, this was likely to continue after being infected, possibly related to HIV. However, where women did not experience intimate partner abuse before infection with HIV, their risk of intimate partner abuse did not increase.

Research has been conducted on reasons for intimate partner abuse among the general population of women elsewhere in Africa. These reasons were related to men exerting power over women. For example, a Ugandan study found that men tended to act violently, when discovering that women had gone for HIV testing, disclosed HIV results, or requested to use condoms.<sup>8</sup> Another Ugandan study found that the most commonly reported reasons for physical intimate partner abuse in the 12 months before the study were: a wife's neglect of household chores (29%), women's refusal to have sex (17%), arguments over money (14%), and a husband being suspicious of unfaithfulness (13%).<sup>9</sup>

However, there has been little research in developed and developing countries on reasons for intimate partner abuse among women living with HIV and AIDS, as there is almost no information on intimate partner abuse among heterosexual HIV-positive men from their female partners.

*...a study in antenatal clinics in Soweto, for example, found that women, who had experienced physical abuse, were two-thirds more likely to be at risk of HIV infection, than women who had no experiences of physical abuse...*

Recently the Women's Health Research Unit conducted a service-based survey among people living with HIV and AIDS in the greater Cape Town area. The main aim of the study was to examine people living with HIV and AIDS' intentions and choices about having children, and factors influencing these, as well as their experiences of sexual and reproductive services. As part of this study, information was collected on women and men's reported experiences of abuse before their HIV diagnosis, after their HIV diagnosis, and the reasons for the abuse, irrespective of whether or not the abuse was HIV-related.

The survey was conducted by trained female and male interviewers between May and September 2006. Face-to-face interviews were conducted in the participants' first language, using the same standardised questionnaire for all participants. Respondents were

selected randomly (by chance) from among female and male clients attending HIV care services at public sector healthcare facilities, in a community with high levels of HIV.<sup>10</sup> All participants were informed about the study and after that gave consent if they were willing to be interviewed. All information from individual participants has been kept confidential and only overall results will be reported. Ethical approval was obtained from the Research and Ethics Committees at the University of Cape Town and the World Health Organisation. The response rate for male and female respondents were 90% and 88% respectively. Ninety percent of men and 88% of women clients attending HIV care and antiretroviral (ARV) treatment, who were approached, were willing to be interviewed. The main reasons for refusal included feeling too ill to be interviewed and having to hurry to work, or some other activity.

*...the most commonly reported reasons for physical intimate partner abuse...were: a wife's neglect of household chores (29%), women's refusal to have sex (17%), arguments over money (14%), and a husband being suspicious of unfaithfulness (13%)...*

The information collected has been entered into a computer programme and the analysis of the information on intimate partner abuse is currently being analysed.

### Future findings

Evidence in this area can contribute towards a better understanding of intimate partner abuse among women and men living with HIV and AIDS. Currently, counselling and service interventions for sexual and reproductive health needs, based on clients' personal situations, are being developed. These will be implemented and evaluated as to whether or not these interventions better meet the reproductive healthcare needs of HIV-infected clients within public sector HIV care services.

*...there is almost no information on intimate partner abuse among heterosexual HIV-positive men from their female partners...*

The information gained from our study analysis will also help develop guidelines to be incorporated into this intervention for healthcare providers. Moreover, the information will help providers to anticipate and counsel regarding potential abuse among people living with HIV and AIDS, and to screen, counsel and refer to appropriate services people, who experience intimate partner abuse related to their HIV-positive status. This can help inform healthcare delivery nationally for people living with HIV and AIDS in South Africa, and health programme development and service delivery for people infected with HIV in other countries, with emerging AIDS epidemics.

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1. We are indebted to the Western Cape and City of Cape Town Health Departments, the Desmond Tutu HIV/AIDS Centre at the University of Cape Town and the health centres where this research was conducted for their permission and cooperation in conducting the study. Sheila Cishe, Penny Mgwigwi and Ntobeko Nywagi conducted the interviews. Joanne Mantell and Zena Stein of Columbia University in the United States, and Lesley Doyal of Bristol University in England were consultants on this study. We are grateful to the participants who gave generously of their time while being interviewed. The study was funded by the World Health Organisation and the Medical Research Council of South Africa.
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Sandy Okkers

# Men cannot rely on circumcision alone...

## Male circumcision as an HIV prevention tool

There have been a number of intervention strategies developed aimed at reducing the risk of HIV infection. One of the most commonly used strategies for HIV prevention is the 'ABC' approach (**A**bstain, **B**e faithful, **C**ondom use). However, this approach to HIV prevention has not proven to be the most effective way of reducing the seemingly ever increasing number of HIV infections.

The number of new HIV infections has increased to 4.3 million in 2006 (400 000 more than in 2004). Sub-Saharan Africa remains to be the most affected region in the world, with two thirds of all people infected with HIV living in this region (24.7 million people in 2006), and almost three quarters of all adult and child deaths due to AIDS occurred in sub-Saharan Africa (2.1 million of the global 2.9 million deaths).<sup>1</sup>

Recognising the importance of effective HIV prevention strategies, this article will provide a broad overview of male circumcision as one of the means to prevent HIV infection, and explore some of the potential risks of male circumcision programmes.

### Male circumcision: An overview

Male circumcision, or the removal of the foreskin of the penis, is practiced across countries, religions and cultures. For over 20 years, observational studies have suggested that male circumcision may prevent HIV infection, and recent research provided additional

evidence in the support of the efficacy of the procedure of male circumcision as an HIV prevention tool.<sup>2</sup>

The biological explanations why male circumcision may reduce the risk of HIV infection for men have been well documented, including that:

- By removing the foreskin, circumcision reduces the ability of HIV to enter the skin of the penis
- Ulcers, which are characteristic of some sexually transmitted infections and which can facilitate HIV transmission, often occur on the foreskin. By removing the foreskin, the likelihood of acquiring these infections is reduced.
- The foreskin may suffer abrasions or inflammation during sex, which could enable HIV to enter the skin.<sup>3</sup>

In December 2006, the trials on male circumcision in Uganda and Kenya were stopped early, as '*an interim review of trial data revealed that medically performed circumcision significantly reduces a man's risk of acquiring HIV through heterosexual intercourse*'<sup>4</sup>. While the trial in Kisumu, Kenya, showed a 53% reduction of HIV acquisition in circumcised men relative to uncircumcised men, the Rikai, Uganda, trial showed that HIV acquisition was reduced by 48% in circumcised men.<sup>5</sup>

Many studies conducted around the world have suggested that male circumcision can protect men from HIV to some degree, but the South African trial in Orange Farm, Johannesburg, was the first randomised, controlled study which demonstrated the extent of protection.<sup>6</sup> This trial, also referred to as the Orange Farm study found

that more than half the number of circumcised men participating in the study, were less likely to be infected with HIV, compared to men, who were not circumcised. In addition, the study results identified a direct link between removing the foreskin and the reduction in becoming infected with HIV; similar to the findings in the Uganda and Kenya trial.<sup>7</sup>

*...Sub-Saharan Africa remains to be the most affected region in the world, with two thirds of all people infected with HIV living in this region...*

The results of the Orange Farm study in South Africa have been widely publicised in the region, and discussed by leaders, members of parliaments, health workers, the press and general public. Subsequently, there are indications of an increasing demand for male circumcision in, especially, traditionally non-circumcising societies in Southern Africa. At the University Teaching Hospital in Zambia, it has been reported that the demand for male circumcision has grown from 1 to 15 per month, with a three-month waiting list. Similarly, the demand for male circumcision at one Swaziland hospital is reported to have risen from less than one per month to 40 a month.<sup>8</sup>

In addition, parliamentarians in various Southern African countries have publicly supported male circumcision programmes. In Swaziland, for example, Marwick Khumalo, a Member of Parliament (MP) for Lobamba, announced to the press that *'All male children should be circumcised. To show my seriousness, I have taken all my sons for circumcision'*; while Kenyan MP, Jimmy Angweni, said that *'in order to stop the spread of HIV/AIDS male circumcision should be made mandatory by the government'*.<sup>9</sup>

In March 2007, the World Health Organisation (WHO) and the Joint United Nations programme on HIV/AIDS (UNAIDS) recommended for male circumcision to be recognised as an additional, important strategy to prevent men from acquiring HIV from infected female partners and thus, to include male circumcision into HIV prevention programmes and policies.<sup>10</sup>

After the global calls for safe male circumcision to be integrated into national HIV-prevention strategies, several African countries have acted, based on the results of the South African study. Zambia and Swaziland both launched national male circumcision programmes, while a report by the member states of the Southern African Development Community (SADC) described male circumcision as a *'one-off intervention conferring lifelong reduced biological risk'*.<sup>11</sup>

In South Africa, male circumcision programmes are part of the national response to HIV and AIDS. One of the interventions identified in the National Strategic Plan (2007-2011) is to convene a multidisciplinary expert group, including traditional healers and private practitioners, to review the WHO male circumcision policy and make policy and programme recommendations. By 2011 policy recommendations from the expert group should be adopted by the NHC and implemented in 80% of districts.<sup>12</sup>

*...study results identified a direct link between removing the foreskin and the reduction in becoming infected with HIV...*

Within the context of promoting male circumcision as a means of reducing the risk of HIV infection, it is however, also important to emphasise that male circumcision alone cannot prevent men from becoming infected with HIV during sexual intercourse, as circumcision is only part of

a broader HIV prevention strategy that includes limiting the number of sexual partners and using condoms during intercourse.<sup>13</sup>

### Male Circumcision: Challenges

While many reports highlight the importance of male circumcision as an HIV prevention tool, there are also reports indicating the challenges and potential risks associated with male circumcision. The lack of adequate initiatives to address the risks of existing male circumcision practices; the risk of a perceived sense of safety and low risk of HIV infection; and limited information focusing on the impact of male circumcision on the gendered nature of the HIV and AIDS pandemics are but some of the concerns.

*...it is however, also important to emphasise that male circumcision alone cannot prevent men from becoming infected with HIV...*

The call to integrate male circumcision programmes into HIV prevention strategies is based on the understanding that circumcision is ‘*provided safely, in sanitary settings, with adequate equipment and with appropriate counselling and other services*’.<sup>14</sup> However, it is crucial to distinguish between ‘*male circumcision programmes*’, as described above, and ‘*male circumcision reality*’, as experienced by many across cultures. The impact of ‘*male circumcision*’, as a cultural practice, on HIV risk, especially if circumcision is performed in non-sterile conditions, has been well documented.

In reality, male circumcision is often performed in non-sterile conditions, and thus, often associated with

many health risks, as circumcision can lead to infections, bleeding and permanent injury, and possible death, if appropriate treatment is not provided. In addition, there is a high risk of HIV infection through the use of non-sterilised ‘*instruments*’. In South Africa, every year, young ‘*abakweba*’<sup>15</sup> enter circumcision schools, which is an integral part of the ‘*rite to manhood*’. And every year, there are reports of young men who are hospitalised, and/or die, as a result of ‘*botched*’ circumcisions performed in initiation schools across the Eastern Cape Province.

*...male circumcision is often performed in non-sterile conditions, and thus, often associated with many health risks, as circumcision can lead to infections, bleeding and permanent injury, and possible death, if appropriate treatment is not provided...*

It is within the context of acknowledging the risks of existing circumcision practices that it seems essential to not only promote male circumcision as an HIV prevention tool, but also to effectively address circumcision practices, which potentially increase the risk of HIV infection.

In addition, it is also important to bear in mind that sexually active men are likely to be at higher risk of HIV infection during the healing period after circumcision. It is, therefore, suggested that men should refrain from sexual activity during this time, approximately three to four weeks.<sup>16</sup>

However, as suggested in many reports and studies, perhaps the largest potential problem with male circumcision is the false perception of safety and low risk to HIV infection. It is argued that if circumcision is perceived

as the ‘*tool*’ to prevent HIV infection, this could also lead to a decrease in condom use, as well as an increase in risky sexual behaviour, amongst circumcised men.<sup>17</sup> Since men, who have been circumcised, may consider themselves immune to HIV infection and as no risk to their partners; a programme of mass male circumcision may further impact on already low condom usage and thus, have an adverse effect on overall HIV infection rates.<sup>18</sup>

Similar concerns have been raised by a number of other reports highlighting that circumcision, if promoted as a ‘*stand alone*’ method to reduce the risk of HIV infection, may be perceived as full protection from HIV infection and a ‘*free pass*’ to have unprotected sex – creating a situation in which male circumcision actually increases the risk of HIV infection.<sup>19</sup> Thus, it is crucial to recognise that while male circumcision reduces the biological risk of HIV infection, it does not prevent HIV infection.

*...perhaps the largest potential problem with male circumcision is the false perception of safety and low risk to HIV infection...*

Taking these concerns into account and responding to the potential ‘*danger that men will see circumcision as an invisible condom and take part in more risky sexual behaviour*’<sup>20</sup>, clearly indicate that male circumcision cannot be promoted as an HIV prevention tool by itself, but instead has to strongly be promoted as part of a range of HIV prevention methods, including avoidance of unprotected penetrative sex, reduction in the number of sexual partners, and correct and consistent condom use.<sup>21</sup> As condoms have shown to be effective in preventing HIV transmission, it is crucial to emphasise that the use of condoms remains a necessary tool to

prevent HIV infection, irrespective of whether or not the male is circumcised.<sup>22</sup>

Although many studies have proven male circumcision to be an effective HIV prevention tool for the prevention of female to male transmission, very few studies have thus far analysed the benefits of male circumcision for women and its impact on women’s risk to HIV infection.

*...the potential ‘danger that men will see circumcision as an invisible condom and take part in more risky sexual behaviour’, clearly indicate that male circumcision cannot be promoted as a HIV prevention tool by itself...*

Due to the overwhelming evidence of the efficacy of circumcision as a prevention tool, the United Nations, in December 2006, supported the urgency of a large scale implementation of male circumcision programmes, in Southern African countries, highly affected by HIV and AIDS. However, it is important to note that the UN also cautioned that male circumcision has, thus far, not proven to have direct benefits for women, or for men who have sex with men.<sup>23</sup>

The apparent lack of evidence as to the impact of male circumcision on female’s risk of HIV infection is of great concern, especially as women are recognised to be at higher risk of HIV infection and to be most affected by the impact of HIV and AIDS. Moreover, it is well documented and recognised that HIV prevention strategies and programmes largely fail women, as women are least in the position to negotiate the conditions of sex and are least in ‘*control*’ of existing HIV prevention methods. And yet, there seems little effort to establish the extent to

which male circumcision may impact on women's risk to HIV infection.

*...it is important to note that the UN also cautioned that male circumcision has, thus far, not proven to have direct benefits for women, or for men who have sex with men...*

### Conclusion

Evidence suggests that male circumcision is an effective HIV prevention strategy. However, evidence also suggests that male circumcision programmes will only be effective, and thus, potentially reduce the risk HIV infection, as and when male circumcision is promoted as an integral part of a range of HIV prevention methods – and not as a stand alone tool to prevent HIV infection. Thus, *'men cannot rely on circumcision alone if they expect to remain free of HIV'*<sup>24</sup>.

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18. Doctors Opposing Circumcision. 2007. The use of Male Circumcision to prevent HIV infection. [www.doctorsopposingcircumcision.org/info/HIVstatement.html]
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Thabisile Khuzwayo

# Shocking and disturbing...

## Stigma and discrimination in KwaMakhuta

We, the KwaMakhuta Community Resource Centre, are situated in KwaZulu Natal. As a legal advice office, our main aim is to facilitate access to justice for people living in, and around KwaMakhuta.

Recently, we conducted an assessment on stigma and discrimination at a community level in preparation for an event, we will be hosting on 29 November 2007, celebrating World Aids Day. Though it was not something formal, this mini research will assist us in ensuring that the information, given at the event, will be relevant.

From our work with, and involvement in, the communities in and around KwaMakhuta, we have observed that HIV and AIDS is no longer a problem, but instead it is people's mindset towards HIV and AIDS, people's attitudes and beliefs, which is the problem. The underlying factors and reasons behind HIV-related stigma and discrimination – that is where the problem lies.

Because of existing stigma and discrimination, people, and their rights, are violated and abused. Even though, HIV-related stigma and discrimination are mostly directed at people who are known to live, or believed to live, with HIV, stigma and discrimination also affect service providers.

As an organisation, we work closely with the Umkomaas Hospice. A recent incident involving members of the hospice clearly highlights how HIV-related stigma and discrimination can affect the safety of service providers. Members of the hospice,

while on their way to one of their clients in one of the surrounding areas, were attacked, in their vehicle, because the community believes that it is the hospice which is carrying the virus and infecting the community with HIV. While it is fortunate that no one was reported to be harmed in the incident, it is unfortunate that no arrests have been made. The lack of an arrest may also be an indication of the difficulty to address these kinds of incidences by means of the law. Thus, we would need to be creative, as it will be difficult to respond to this kind of violence and abuse.

Needless to say, this news was very shocking and disturbing, as it highlights not only the 'danger' of lack of accurate information about HIV and AIDS, including people living with HIV and AIDS, at the community level, but also brought to the fore the 'risk' for the safety of people, who are perceived to be associated with HIV. This news is also disturbing, as the statistics show that there is an increasing number of people infected with HIV in that particular area, as compared to other areas, which utilise the services of the KwaMakhutha clinic.

And finally, this news poses challenges for us, as KwaMakhutha Community Resource Centre, in that we may have to re-evaluate and possibly change our plans and strategies, so as to be in the position to more effectively respond to the current situation

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# Our efforts are not in vain...

## HIV and AIDS Realities and Challenges in Zambia

**The HIV and AIDS pandemic has brought with it many challenges. One of the major challenges is to ensure, in the midst of the many interventions, a rights-based response.**

**This is necessary to mitigate the impact of HIV and AIDS, reduce vulnerability to infection, and empower communities to respond. The promotion and protection of rights in the context of HIV and AIDS are particularly important, as HIV affects adversely people in marginalised groups, and people who already experience a lack of human rights protection, such as women, children, and the poor.**

The Zambia AIDS Law Research and Advocacy Network (ZARAN) exists to champion the rights of people living with, and/or affected by, HIV and AIDS, through advocacy, education, research and law and policy development. ZARAN has conducted work in many priority areas, including employment, healthcare and children's rights. In its six years of operation, ZARAN has carried out many projects, funded by a variety of national and international donors.

Some of the organisation's most important achievements include the establishment of an AIDS Law Clinic to support people living with HIV and AIDS, who have experienced discrimination in the workplace; a review of Zambian legislation with a bearing on HIV; the provision of various training sessions and workshops to diverse groups, such

as police officers and members of the judiciary; the development of relevant materials, such as an AIDS Law Manual and, Advocacy Toolkit, as well as a study on children and HIV and AIDS, and a study on HIV testing & treatment in Zambia.

The work of ZARAN is divided into five main areas, namely research; advocacy; information, education and communication; training; and law and policy development. The basis for what we do at ZARAN is research – without the solid evidence base provided by research, effective advocacy and information, education and communication (IEC) activities are impossible. Advocacy and IEC are essential in order to both influence the policy (and as such, the human rights) environment in Zambia, and to educate and inform society on HIV and AIDS issues. In addition, ZARAN shares its expertise through training aimed at building the capacity of people living with HIV and organisations to integrate the rights-based approach to HIV and AIDS into their programming.

### *HIV and AIDS in Zambia*

The HIV and AIDS epidemic in Zambia is one of the worst in the world – a fact which is supported by shocking statistics, such as one in six adults live with HIV, and that the life expectancy at birth has fallen below 40 years. In 2007, one million Zambians

are estimated to be infected with HIV, and about 370,000 to 380,000 people, including 35,000 to 40,000 children, require antiretroviral medicines (ARVs).— Since ARVs are a priority health care need of the population, they are on the essential medicines list in Zambia.

While there has been a sustained increase in the number of people accessing ART, there are many challenges around equity and sustainability. In terms of the roll-out of ARV treatment, there are various challenges, including a lack of infrastructure, a lack of personnel, and poor nutrition. Much more needs to be done, particularly as the country strives to achieve universal access to treatment.

Like many other African countries, HIV in Zambia is driven and exacerbated by gender inequality and poverty. The feminisation of HIV is also very visible, with women and girls bearing the brunt of caring for the sick.

Over the years, it has become more and more evident that in order to address these challenges, it is critical to promote human rights, which entails calling for an appropriate legal and policy environment.

### *Human rights*

In advocating for human rights of people living with HIV and AIDS, ZARAN has been demanding that the dignity of all people be respected. HIV and AIDS intersect with human rights in a number of ways. Firstly, HIV can be spread through human rights violations, such as sexual violence or coercion, as

well as denying the right to information on HIV transmission. Secondly, human rights are often violated on the basis of a person being infected or affected by HIV and AIDS – orphaned and vulnerable children are often denied their right to basic needs, information and health; women losing their husbands to AIDS are denied their right to property; and many people living with HIV and AIDS, and their families, are subjected to widespread stigma and discrimination.

### *Rights-based approaches to HIV and AIDS*

Given the intersections between human rights and HIV and AIDS, ZARAN strongly believes in promoting and practising a human rights-based approach to HIV and AIDS programming. While there is no single definition of a rights-based approach, ZARAN believes that rights-based approaches guarantee the basic human rights of all people living with HIV or AIDS, as well as incorporate mechanisms for full participation and decision-making of infected and affected individuals and communities. A rights-based approach implies being guided by the needs and rights of a community, while simultaneously empowering communities to broaden their participation; to strengthen their relationships with law, policy makers and partner organisations; and to address the social, economic and political factors that drive the epidemic. Essentially, human rights must be the foundation that defines the objectives of the response to HIV and AIDS, guides the formulation of policies, programmes and other strategies, and human rights are to be incorporated into every stage of the response to HIV and AIDS.

### *HIV-related stigma and discrimination in Zambia*

Stigma is a complex phenomenon which is deep-rooted and presents an enormous challenge. Addressing stigma requires the use of approaches that are focussing on changing attitudes and beliefs. ZARAN has attempted to de-stigmatise HIV by providing education around the need for individuals and communities to eradicate stigma, as it is fuelling the spread of HIV. ZARAN does this through a quarterly newsletter, brochures, posters, radio programmes, documentaries and training.

Stigma against people living with HIV and AIDS often leads to discrimination based on actual or perceived HIV status. Many people with HIV in Zambia have encountered discrimination in their families, communities, health facilities and workplaces. Discrimination is particularly rife in the workplace, perhaps because of the challenge of the employer to remain profitable.

#### *ZARAN AIDSLaw Clinic*

ZARAN has established an AIDSLaw Clinic that provides free legal support to people who, based on their actual or perceived HIV status, have experienced discrimination in the workplace. The focus of the AIDSLaw Clinic on the workplace is a direct response to the many complaints that have come through. Many of the cases involve unfair dismissal and non-payment of benefits. In some of the cases, ZARAN has been able to secure the person's re-instatement, and in others, the payment of benefits.

The following are some of the challenges that

we have encountered in addressing discrimination at the workplace:

- Evidence that the discrimination or the perceived discriminatory act was based on HIV status, as most employers will not make an explicit statement
- Weak legal environment vis-à-vis HIV
- Stigma preventing people, in middle and senior management positions, from making complaints
- Lack of regulation of domestic work

ZARAN has been looking forward to a landmark judgement that will set a precedent for dealing with HIV-based discrimination. ZARAN is only just beginning to take matters to court, due to some of the challenges highlighted above. Also, ZARAN is registered under the Societies Act and thus, cannot represent a client in court. However, ZARAN is able to prepare all the legal documents and conduct research and prepare clients for court. One example of this is that one of our clients is representing himself in the Industrial & Labour Relations Court, and the ZARAN Legal Officer has been there to prepare all the necessary documentation, as well as to prepare the client for cross-examination.

ZARAN has also signed a Memorandum of Understanding with the Legal Resources Foundation (LRF). LRF is an organisation that is involved in public interest litigation. Since the memorandum was effected early 2007, there are two cases referred from ZARAN, for which documents have been filed in court. The outcome of these two cases is critical.

## Case Study

*Our client was working as a security guard for one of the security firms attached to a prominent hotel in Lusaka. He was dismissed from employment on grounds of 'unsatisfactory work performance'. This occurred two days after his colleague told him that he was going to be dismissed from employment, because the supervisors were aware that he was infected with HIV, and that they were looking for every possible reason to dismiss him.*

*The client wanted to be re-instated in employment and his friends advised him to come to ZARAN for help.*

*Upon examination of the case, it was noted that the dismissal was 'null and void', because his work contract did not indicate any form of breach on his part. Our client was not awarded the opportunity to be heard, which is contrary to Section 26A of the Employment Act, providing for an employee to be heard on charges laid against him or her, before dismissal. In addition, it was an infringement of our client's right to freedom, liberty and protection from any form of discrimination, and it was against the rules of natural justice.*

*The AIDS Law clinic staff wrote a letter to his employers, challenging the dismissal and demanding that our client be re-instated with all payments accrued to him, failure to which they would proceed to take appropriate action within 14 days. The employers called the AIDS Law clinic a week later to apologise for their action and to confirm that they were willing to settle the matter.*

*We, however, requested the employers to put everything in writing, which they did, and a meeting was arranged with the client's employers to discuss the working conditions for our client, before he could be re-instated. We demanded that our client be treated like any other employee, regardless of his HIV status and that all the monies, owed to him for the two months that he was out of employment, be paid to our client, failure to which we would proceed to take appropriate action against the employers.*

*His employers agreed to all the conditions, our client was re-instated, and all the monies owed to him were paid.*

ZARAN is also pursuing the option of interested private legal practitioners to take up some of the cases on a pro bono basis. It is hoped that through these initiatives, people living with HIV and AIDS can be more effectively protected from discrimination.

### Law Reform

ZARAN has also been working on a law reform project to advocate for legislation that promotes the

rights of people living with, and affected by, HIV and AIDS in Zambia. On this project, ZARAN has partnered with the Zambia Law Development Commission (ZLDC), Support to the HIV/AIDS Response in Zambia (SHARe) and other organisations. To 'kick start' the project, ZARAN did an analysis of all the pieces of legislation that were thought to have a bearing on HIV and AIDS. The review of laws was based on the International Guidelines on HIV and Human Rights.

The law review has since been taken through the first round of consultations. Further consultations are planned, along with meetings with members of parliament and traditional and other leaders. It is hoped that in 2008, there will be some draft bills for submission to the Ministry of Justice.

The grounds mentioned in the Discrimination Clause in the *Zambian Constitution* do not cover 'health or other status', and as such do not provide protection for people living with HIV and AIDS. The Industrial and Labour Relations Act refers to discrimination based on 'social status', although the definition of 'social status' is restricted to economic status. Again this does not offer sufficient protection.

Through the Constitutional Review Process that is ongoing, ZARAN made a recommendation for the inclusion of 'health or other status' to the grounds listed in the discrimination clause. It is hoped that this proposal will be adopted in the new constitution.

### *Working with the Judiciary*

In a further attempt to address HIV-based discrimination, ZARAN has made efforts to work with Supreme & High Court Judges, as well as Magistrates, to raise awareness of the challenge that HIV poses to the law, but also to determine the role that the judiciary can play in setting precedents, through the 'judge made law' approach. ZARAN has so far hosted two 'Judges Workshops' with Judge Edwin Cameron of the Supreme Court of Appeal in South Africa, and Judge Michael Kirby from Australia, as keynote speakers at these events. The Judiciary has been positive toward this work and it is hoped that

through further interaction, our jurisprudence can be sufficiently provoked.

### *Conclusion*

ZARAN has encountered many challenges in trying to promote a rights-based response to HIV in Zambia. It is, however, exciting to note that we are beginning to affect lives, and that our efforts are not in vain. It is clear that we must continue to promote rights, because the day that we decide to stop promoting human rights, will be the day that we begin to lose the struggle.

#### **FOOTNOTES:**

1. Presentation by Dr. Simpungwe the Director Clinical Care & Diagnostic Services at MOH at the launch of the children's ART guidelines (September 2007).

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Keith August

# Programmes are not a luxury, but a necessity...

## Migrant workers and HIV and AIDS challenges:

### *Introduction*

South Africa, with its turbulent past has inherited a legacy, which remains conducive to the spread of HIV and AIDS. The Deciduous Fruit Industry in the Overberg district can lay claim to its fair share of people infected and affected by HIV and AIDS. Many of these individuals are co-infected with Tuberculosis. The more severe form of TB, identified as multi drug resistant TB (MDR-TB), poses a very real and serious threat to the well-being of people.

Some of the individuals are living on the fringes of society, in galvanised villages, and others are living as landless tenants in backyards of township landlords. My insight of people's expressions of their experiences often begins after they, or a family member, have been diagnosed positively with HIV, as they come for assistance in a work environment. I have heard some of their stories and, in many instances, I witnessed as some of these stories unfolded. My key interest in this process was the interpretation of their situation, as we looked for solutions to the situations, in my capacity as researcher, human resources manager, and fellow citizen. Being in close proximity to these individuals enabled me to receive constant feedback from them.

This disease has impacted on the lives of thousands of farm workers, including migrant workers. Migrant communities throughout South Africa seem to bear the brunt of this pandemic in terms of their vulnerability. Migrant workers filling the breadbaskets of affluent communities have been

severely infected and affected by HIV and AIDS, and the impact of this malady reaches way beyond a skills shortage. Through this article, I would like to give the reader a better understanding of the lives of 'ordinary' farm workers, who have been affected this epidemic.

### *Historical, economic and social challenges of this community*

During the last decade, dynamics such as globalisation, as well as shifting employment conditions in the commercial agricultural sector, have led to an increase in the export of produce. Strategically, farmers used off-farm and seasonal contract labour, and, in this way, minimised their responsibility towards this non-permanent work force. HIV and AIDS were left unchecked, while the disease silently gained a foothold in the Western Cape, due to paralysis from within government circles. This inaction prevented proper HIV education, as well as the development of workplace policies. Lasting solutions are plagued by fragmentation, due to the nature of the various sectors, resulting in a lack of clear leadership.

Farm worker mobility, as a result of shifting employment patterns, could have led to an escalation and subsequent spread of the disease. The seasonality of labour also disguised the actual situation, as many workers returned to the Eastern Cape Province, when they became ill, or at the end of a season. This could be one of the reasons, why many employers in this

sector remained ignorant to the spread of HIV and AIDS. However, the correlation between extreme poverty and high levels of HIV prevalence is an obvious one, and does not excuse a lack of concern from stakeholders. This indifference has led to the creation of skills shortages all over, but in particular in the agricultural sector. The disappearance of a skilled labour force may become chronic in the years ahead.

*...strategically, farmers used off-farm and seasonal contract labour, and, in this way, minimised their responsibility towards this non-permanent work force...*

The Overberg provides a textbook description for the spread of HIV and AIDS among farm workers, which include migrant, off-seasonal and contract workers, as well as permanent employees. Many of the workers speak African languages and their worlds are open doors, through which they have allowed us, to look into their lives. These may be recognised as scenes from hostel rooms and ‘squatter camps’ from the African landscape with its brokenness, alienation and anguish. Severe alcohol abuse is often a catalyst to lowering of inhibitions among individuals. The abuse of alcohol is a major factor in the spread of the disease, and statistics on Alcohol Foetal Syndrome in the Western Cape rate among the highest incidence in the world. It is obvious that not enough has been said about alcohol abuse in the response to HIV and AIDS. The legacy of alcoholism among so many farm workers, who have been exposed to the ‘Dop system’, cannot be overrated, as many employees from the Boland moved to the Overberg.

The Overberg is strategically situated on the

national road, the N2, about 77 kilometres from Cape Town. This community is located within a 100 km radius between five major prisons in the Western Cape Province, and many of the inmates come to Grabouw after serving their sentences. Many former prisoners are infected with HIV, as a result of sexual abuse, which remains a trade mark of the South African Correctional Services. Ex-prisoners, or inmates on parole, are re-introduced into society, without cognisance of their HIV status, or the potential risk to a partner and very often a wife. Presidential amnesty is often embarrassed by the high incidence of atrocities in public, yet, we never stop to consider the effects on a family or a community. The fact that a person’s HIV status remains a secret, might help in the prevention of discrimination, but it does not prevent a partner from being infected by an insensitive lover.

*...the disappearance of a skilled labour force may become chronic in the years ahead...*

The Overberg is also part of a trucker’s route and the nature of the local industry’s export operations involves a lot of travelling to some of the main centres, as well as other markets in South Africa. The high incidence of sexually transmitted diseases in clinics along trucker’s routes is well documented, and statistics at ante-natal clinics in the Overberg are no exception. The Overberg can also boast of large trucking concerns, which create much needed employment. The casualty rate in this industry is often measured by the number of employees the industry has lost. However, the ‘damage on the home front’ is best ignored in the interest of corporate social responsibility. Trucking is seen as a lucrative employment opportunity and for many employees this is part of the ‘boyhood dream’ to drive the

biggest and the best truck in the industry, irrespective of the dangers, which lurk at the truck port and towns, known for their 'prostitution'.

*...the abuse of alcohol is a major factor in the spread of the disease, and statistics on Alcohol Foetal Syndrome in the Western Cape rate among the highest incidence in the world...*

Migrant workers also find themselves challenged as a result of new laws promoting freedom of movement. These empowerment drives to live off the farm have brought some difficulty, as migrant workers moved to self-determination. Poverty, and lack of proper housing and sanitation are among some of the hardships which they face. Many hopeful seasonal workers remain in the Overberg in pursuit of further employment opportunities, resulting in strain on already limited resources. Historically, we also had a hostel community, who settled in informal settlements on the fringes of established municipal areas. There have been attempts by some farmers to encourage accommodation 'off the farm', in order to avoid difficulty with the Tenure Act. This has negative ramifications for the individual, who has not made the mental and financial adjustment to move off the farm. Suddenly, this person is responsible for his or her own security, and there is the added cost of building or renting a home, as well as furnishing it. Under normal circumstances, this private accommodation may seem as a logical progression for any individual, but the migrant worker has his roots in the Eastern Cape. His focus is on building a house close to his family. With the increased pressure, his expenses have doubled.

Economic vulnerability is another factor, that causes extreme hardships, as furniture stores continue to undermine the limited resources of the already embattled communities. Unscrupulous sales staff will engage in 'hire purchase deals' with migrant workers and 'rip them off' with the stroke of a pen, very often doubling the cost of an already inflated product. Many micro lenders are abusing the vulnerability of farm workers, despite legislation to protect the people. Garnishee records in most organisations will reflect, at least, a considerable amount of employees, who cannot cope financially. The high cost of food is another factor impacting on migrant workers. At the time of writing this article, a 10 kg pocket of potatoes is the equivalent of a days wage for migrant workers at the lower end of the scale. Farm workers are also at the bottom of the income scale, just a notch above domestic workers.

*...contractual sex is a reality in the Overberg, where unemployment is rife and mothers have mouths to feed...*

Some migrant workers have also been in a compromising position in terms of sexual gratification, while their partners remained back home. There is a possibility that this scenario created an opportunity in the escalation of HIV infections in this community. For some individuals, the lifelong dream of 'having your partner living with you in the big city', has been tainted by an HIV infection. This issue is a personal one, and even to discuss it, may infringe on the person's right to privacy. However, this single action has been one of the main causes for the rapid spread of the disease. Contractual sex is reality in the Overberg, where unemployment is rife and mothers have mouths to feed. Shebeens and taverns have also been a breeding place for contractual sex.

There is another dark side to HIV and AIDS,

which plays itself behind closed doors in bedrooms, in kitchens and conversations, as partners and family members confront each other with this reality. Some of these broken lives form a tragedy, which has no limits. Meanwhile, the effects of HIV and AIDS are performed, on stages with diverse background scenes, in the lives of men, women and children. The reality is that a bedroom scene at home can become an area of confrontation, as an HIV diagnosis is shared. This could lead to confessions, forgiveness, and sometimes, new beginnings. For others, it would mean the end of a long relationship as a resentful partner refuses to continue with this. Children would listen in dismay, as their worlds are shattered with the news that one or both parents are infected with HIV. Parents may respond in shock and apprehension, as they hear that their children are infected with HIV. The lives of many people are changed in the blink of an eye, while others may nervously, yet inevitably, observe the initial HIV diagnosis developing into full blown AIDS.

*...the reality is that a bedroom scene at home can become an area of confrontation, as an HIV diagnosis is shared....*

We seldom view the ramifications of this disease through the eyes of the aged, despite the fact that some elderly persons are living with HIV. They have to explain to their doctors, ministers and family members that they are HIV infected. A large number of elderly people are also affected, as many of our pensioners are taking care of their grandchildren. Very often the children's parents are chronically ill, or have died, due to AIDS. For the elderly there is no peaceful retirement.

*...children would listen in dismay, as their worlds are shattered with the news that one or both parents are infected with HIV...*

### *Some workplace challenges of HIV and AIDS*

The helplessness of people living with AIDS in the work environment is obvious, and it makes him or her highly vulnerable to stigmatisation and ostracism. The workplace, in this rigorous landscape, lends itself to stigmatisation and exclusion, both from an employer's viewpoint and from the perception of co-labourers, who would gladly identify the less productive individual, who happens to be infected with HIV.

Most of these 'progressive employers' are on the top end of the market, and are bound by ethical trading initiatives. Policy frameworks are in place, but limited to a few organisations. These initiatives should be entrenched in the agricultural sector in order to create space for effective engagement in the workplace. Private partnerships should be developed within the various sectors, such as The Deciduous Fruit Trust, and the wine industry.

Daily, individuals from this rural area are walking through doors, in order to engage with HIV counsellors concerning their HIV test results. Some come out relieved, while others re-appear with their worlds' shattered. The emotional confrontation, as well as indifference about the disease, often leads to enormous stress, which plays itself out in the workplace. Low self-esteem, fear and uncertainty are issues, which the individual have to deal with, often in the face of illiteracy and apathy, with a barrage of cultural unmentionable issues. Thousands of South Africans have had a premature death, because this area has not been dealt with properly, and people are giving up on life because of a lack of assistance in

this area. At present, the only way to stop AIDS is to avert transmission of the HIV virus. This behavioural change has to do with changes in unsafe sexual behaviour, education and life skills, as well as with pre and post-HIV test counselling.

*...at present, the only way to stop  
AIDS is to avert transmission  
of the HIV virus...*

Many individuals who have been infected with HIV may manifest some opportunistic diseases, such as tuberculosis, pneumonia, dermatitis, gastro, and sexually transmitted diseases. The list of ailments is exhaustive and should best be left to the medical fraternity to describe. Evans, as quoted by van Dyk, suggests that

*...the health status of persons infected by HIV will also determine the course of the disease. People who are already chronically ill with illness such as malaria, tuberculosis (TB), and whose health status is poor because of malnutrition, poverty, recurrent infections, repeated pregnancies, or anaemia, will experience a much more rapid deterioration than healthy individuals who became infected with HIV. [van Dyk 2001:16]*

The Overberg's health services are in need of revision. Fast tracking is still a luxury, as many ill migrant workers, who happen to be strangers in the Western Cape, spend hours attempting to consult a medical practitioner. The new divide in South Africa is very evident between South Africans in terms of medical assistance. More affluent individuals will have medical aids and access to private practitioners, while people on the fringes are subjected to long queues, despite their condition. A seasonal worker will pay the equivalent of two days wages, or more, to consult a local General Practitioner. Sadly, our

public health services are overworked, and ill-equipped to deal with the effect of this disease. Other areas of this country may even be worse. Home-based carers are to be acknowledged, even though they are limited in skills and resources. South Africans have shown what they are made of, and despite their limitations, home-based carers assist countless families.

These scenes depicted above have played itself out many times in my association and interaction with migrant and 'ordinary' farm workers. I believe this to be just the beginning of the difficulty which has happened to many people in this era. Coping with new realities does create difficulties, even for a healthy person; however, when infirmity steps in, and resources are reduced, suffering often becomes unbearable for the one infected or affected with HIV and AIDS. Many of the people in this situation do not have the resources, which some South Africans have, because they live on the fringes of society. Some are migrant workers, possibly infected or affected with HIV and AIDS, who are displaced; have no infrastructure, and are often considered as 'aliens' in their new environment, where xenophobia lurks in the shadows of a very intolerant society.

*...the new divide in South Africa is  
very evident between South Africans  
in terms of medical assistance...*

*Legal challenges*

In this andocentric community, female partners are forced to have sexual intercourse with dominate male HIV infected partners, in order to obtain security and a plate of food. This reality is an indication of the vulnerability of women from this district. Many wives and partners are scared to disclose their HIV status to their partners, for fear of reprisal. Government is looking away from it, the legal system ignores it, and

the medical fraternity stands with their heads in the sand, as more and more people become re-infected. Doctors dare not speak to a spouse, even though both partners are patients. Sadly, we are condemning thousands of women to a premature death, out of respect for their male counterparts' privacy. There is a need to shelter women infected and affected by HIV and AIDS against this massacre. The ramifications of this atrocious weakness from the watchdogs of our society will testify against us one day.

*...South Africans have shown what they are made of, and despite of their limitations, home-based carers assist countless families...*

End-of-life issues are not even a factor in many discussions. Adoption of children is an issue, which is conveniently being ignored in the conversations with individuals living with HIV and AIDS. These children are often the victims of greed, as the trustees of countless provident and pension funds, hand out money to relatives without proper investigations or consultation. There is a call to protect children affected by HIV and AIDS from being deprived of their birthright. Foster care should also be monitored more closely, because unfortunately, the Department of Social Services is also stretched to its full capacity, and most of their social workers are reduced to glorified administration clerks.

Monetary relief, as a responsibility of the Department of Labour, happens at a snails pace. Fast tracking is unheard of, and in general, personnel from the department seem to struggle with the system. Persons applying for benefits have to wait, at great frustration, for months to obtain

benefits. Farm workers, travelling long distances to the Department of Labour, very often return disappointed. Financial payouts from provident funds can, at times, exclude partners from the insured benefits of the deceased, through actions by dominant family members in this community. Explanations based on custom and culture have been cited as reasons to justify certain actions. Beneficiary forms for provident and pension's funds, are not filled in correctly, and often exclude the wife, in favour of the partner's relatives. Employees in this community have to learn the value of a will or testament in order to provide for the family, when the 'breadwinner' is not there anymore. Beneficiary forms have very little legal influence upon the trustees. Service providers in this industry are aware of this problem, yet they prefer to ignore their social responsibility to their clients, who are the lifeblood of their industry.

*...sadly, we are condemning thousands of women to a premature death, out of respect for their male counterparts' privacy...*

The scope of this article does not allow me to consider the recourse of individuals for poor treatment at medical institutions in an area, which the Department of Health should take cognisance of, as thousands of citizens are mistreated by impatient and often overworked and under-resourced staff on a daily basis. The Treatment Action Campaign (TAC) has eloquently suggested this shortcoming on a national level. My silence on this matter is out of respect for the many dedicated nurses and doctors, who labour effortlessly in overcrowded hospitals with limited resources. These doctors and nurses are a national treasure and we should commend them.

### *Possible solutions for the response to HIV AIDS*

At the risk of generalising, I have to concur that there are many farmers who produce fruit for local markets. Farmers from this group are often not overly concerned about ethical trading initiatives. They may also not be in a position to access the same resources, as the larger organisations, due to financial constraints. With the possibility of sounding inflammatory, I have to suggest that some farmers simply do the bare minimum to comply, and fall within the scope of the law. Recognising that these areas also have business chambers, where matters of communal interest are dealt with, it is remarkable to see, how little is done on this level. It is also damning when some farmers do not even have an HIV workplace policy at hand.

*...more progressive employers  
have identified the problem and  
have sought to address it through  
Employee Wellness Programmes...*

The labour contractors supply a workforce in return for a nominal fee. Providing the necessary capacity, we find that the more established labour contractor can be perceived as an asset to the industry, in terms of legal compliance. They will source a workforce with no regards for the social or physical well-being of their staff. Their interaction with staff is, at the least, impersonal, and is only focussed on services rendered. Their operation is cold and clinical, and they simply deal with numbers and their overarching concern is profit. A man is measured by how much his labour contributes to their bottom line. They have no regard for relationships. They should, at best, be baned from the industry.

A large number of entrepreneurs from local communities, who function as labour brokers, have

often been guilty of exploiting labourers on the fringes of society, especially women, by paying them less than their male counterparts, and not even providing women with protective clothing, or access to UIF. The rights of people living with HIV and AIDS in employment are not even an issue in this arena. These individuals should be prohibited from employing people, if found guilty in a court of law, since their behaviour borders on criminal. They sustain a vicious cycle of abuse and poverty and hardship.

The abusive practices in the farming industry have been largely curtailed, through the interventions of serious producers, who stepped up efforts to transform and monitor the sector more closely. Efforts, through local community colleges, in VCT programmes, have been in existence for years. Some of these initiatives have been stepped up in this industry. Excellent work has been done with the assistance of WIETA accreditation. Employment equity policies also address HIV and AIDS and this information is available to every CEO, who has to sign off his organisation's Equity Report.

When considering my particular environment, it is heartbreaking to see that most employees do not even remember their company's workplace policies, after an explanation, because of the high turn-over in staff. Low levels of literacy, language barriers, a lack of creativity on the part of some employers are drawbacks which need some attention in order to curb the spread of HIV and AIDS.

*...some farmers simply do the bare  
minimum to comply and fall within  
the scope of the law...*

Importers of South African produce, such as Tesco, have also placed pressure on producers to step up their effort to create better working conditions

for employees. Credit should be given to the Code of Good Practice, presented by the Department of Labour, which forms the bedrock of most company HIV policies. In an attempt to address the HIV pandemic, the Deciduous Fruit Trust has embarked on an HIV and AIDS awareness programme. Similar initiatives would also be found in the wine industry. Countless interventions, presented by NGOs, are implemented during working hours, and include voluntary counselling and testing for HIV. Individuals infected with HIV are then referred to the local medical fraternity for assistance. This action covers only the tip of the iceberg, because of its limitations and exclusivity to larger companies.

*...low levels of literacy, language barriers, a lack of creativity on the part of some employers are drawbacks which need some attention in order to curb the spread of HIV and AIDS...*

### **Concluding remarks**

The problem of HIV and AIDS remains deep rooted and complex. Healthy people are reduced to sick beds. Terminal illness has a new dimension, when mingled with poverty, displacement and illiteracy. Living on the fringes of society, in a strange neighbourhood with limited support systems is 'hair-raising stuff', as some of these situations unfold. This disease is not restricted to any particular generation, or race group, and its host is often marginalised. Denial and HIV and AIDS go hand in hand, as members of different communities use euphemisms to describe HIV and AIDS. This has created a new form of apartheid, with a huge medical divide based on economics. The more affluent can afford access to

proper care, while the poor and illiterate are reduced to government institutions.

Are we back to paternalism? I don't think so. Responding to HIV has to do with service delivery; it should focus on education, prevention, care, medication and support systems. Our South African society has all these elements within its grasp, but we need to connect it. We need to ensure that business becomes a key part of an integrated effective national response to HIV and AIDS. This can only be done through the establishment of sustainable partnerships between the private sector and key stakeholders in the response to HIV and AIDS. Employee assistance and employee wellness programmes for farm workers are not a luxury, but a necessity, in order to reduce HIV infection and improve on care. Companies could introduce voluntary tax to pay for some of these services. National services, as a pre-requisite for graduation in various sectors, should be expanded in order to improve service delivery and minimise costs.

### **Reference**

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# A responsibility of all...

In April 2007, South Africa has launched its new national strategy to respond to HIV and AIDS. The HIV & AIDS and STI National Strategic Plan for South Africa 2007 – 2011 (NSP) has since been applauded for its vision, commitment and ‘ambitious’ targets, as well as the broad consultative process on which the new national response to HIV and AIDS is based.

According to the Deputy President and Chairperson of SANAC, Phumzile Mlambo-Ngcuka:

*...this Strategic Plan defines clearly the nature of the South African HIV and AIDS problem. It identifies relevant key interventions to be carried out in order to reduce, by an ambitious, but realistic magnitude, the rate of new HIV infections. It also recognises the plight of the many people that are living with HIV and AIDS and outlines relevant interventions to mitigate the impact of this disease on individuals, families and communities...however, a sustainable and effective national response to this epidemic is one that has HIV prevention as its fulcrum. The success of prevention interventions depends largely on collective societal commitments that support individual behaviour change, a responsibility of all South Africans.*

The strategic plan also recognises the need for everyone’s involvement in the implementation process of the NSP, so as ‘to reach its desired goals of halving new infections and

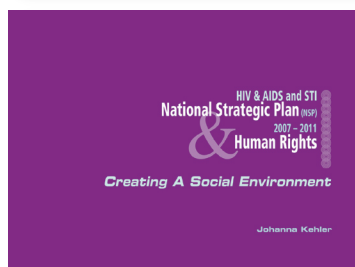
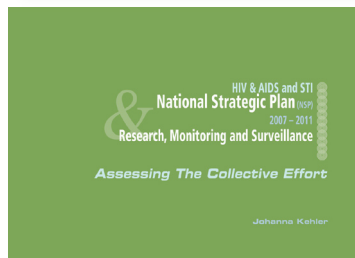
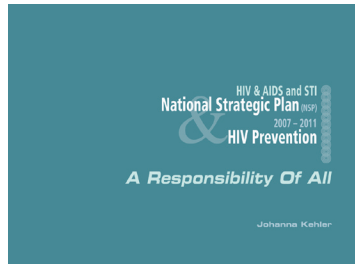
*reducing the impact of HIV and AIDS on individuals, families and society’.*

It is within the context of acknowledging that ‘individuals and communities need to take charge’, that the AIDS Legal Network (ALN) endeavoured on producing a series of publications aimed at enhancing the access to the NSP, and its identified interventions and targets, for ‘everyone’. Thus, with civil society stakeholders in mind, we embarked on the development of four ‘advocacy tools’, each introducing one of the four priority areas of the NSP. Focusing on a particular priority area, each of the publications gives a broad analytical overview of the national response to HIV and AIDS; provides an analysis of various HIV and AIDS realities and challenges, and explores potential mechanisms and strategies aimed to further the timely and adequate implementation of the NSP.

As it is our principled understanding that the ‘success’ of the NSP is as much defined by government’s commitment, as by ‘everyone’s’ knowledge of the national strategic plan and participation in the implementation of the national response to HIV and AIDS, these publications also provide

a useful human rights-based resource for everyone, who is dedicated to achieving the desired goals of the NSP by 2011.

For more information about these publications and/or to receive a copy, please contact the AIDS Legal Network (ALN) at +27 21 447 8435 or at Sandy@aln.org.za.



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