aLQ AIDS LEGAL NETWORK

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Shaun Mellors

Cry my Infected Country

The International Guidelines on HIV/AIDS and Human Rights: What real impact in South Africa?

The HIV/AIDS epidemic is the most important challenge facing South Africa since the birth of our new democracy. This challenge, therefore, comes at a time when the country is faced with many other competing needs; redressing the imbalances of the past, transformation of society, as well as integrating our country in the global economy are some of the challenges.

> Failure to respond to this epidemic however will reverse the developmental gains made in the last five years. The Government has therefore made the fight against this scourge a top priority. In so doing, it has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic....
>
> South Africans have fought and won many difficult wars before. We have the ability as a country to do the same with the epidemic...
>
> *[Msimang, Foreword to the HIV/AIDS and STD Strategic Plan for South Africa 2000 – 2005]*

INTRODUCTION

As a person living with HIV, I cannot help to wonder why we are seemingly loosing this war against HIV and AIDS. What has happened to have such a negative impact on our ability as a country, a society and a people to have a meaningful and sustainable impact on the tide of the epidemic? South Africa is once again at a cross roads in our history. There are critical questions that have to be answered and our responses and actions are going to define and determine what kind of future we are going to live in. We are at a time where we have the opportunity to ensure that the extensive knowledge we have gained over the last 20 years of trying to respond to this epidemic, and where the commitment that is undoubtedly needed, can be turned into effective action and response to the many challenges that face us in our daily lives as we all try to live with, and respond to, HIV. South Africa is celebrating 10 years of democracy in 2004, and there is no greater threat to this young democracy than HIV/AIDS – leading some politicians and community leaders to refer to HIV and AIDS in South Africa as the ***'new struggle'***.

This article forms part of a project that was initiated by the AIDS Legal Network (ALN), and focuses primarily on where we are now in South Africa with regards to the implementation of the International Guidelines on HIV/AIDS and Human Rights. The ALN initiated a similar project in 1999, and this project is a follow-up to the 1999 project. The article, therefore, looks back at how far South Africa has come, since the first ALQ articles on this issue were published in 'How South Africa Stacks up?' in 1999. A number of surveys (n=42)[1] have also helped to inform the article and to understand how community groups understand, use and apply the guidelines in their daily work[2].

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Editorial

Human rights are more than principles to guide the national and global response to AIDS: they are among the most powerful tools to ensure its success.

Peter Piot, Executive Director, UNAIDS

South Africa is celebrating 10 years of democracy and the fundamental human rights principles of human dignity, equality and freedom as the cornerstone of its democracy. It is also the respect, protection, promotion and fulfilment of the principle of equality and non-discrimination, the principle of human dignity and respect, and the principle of not only equal entitlement, but equal enjoyment of all rights and freedoms that we are celebrating.

HIV and AIDS realities, however, seem to indicate that these principles and fundamental human rights appear to remain but a concept with little or no impact on people's lives. Prevailing socio-economic imbalances and inequalities, discriminatory attitudes and practices, persistent stigmatisation, discrimination and violation of people living with, and affected by, HIV and AIDS, as well as the gendered nature of HIV and AIDS are but a few of the reflections that these principles and fundamental human rights do not coincide with the lived realities of most South Africans.

It is within this context that this edition of the ALQ focuses on the International Guidelines on HIV/AIDS and Human Rights and the extent to which the Guideline can be used as an advocacy tool to ensure a more effective human rights-based response to HIV and AIDS. The various articles in this issue examine the Guidelines as to their impact on South Africa's response to HIV and AIDS, and explore the applicability and implementation of the principles contained in the Guidelines as they relate to draft legislation proposing the criminalisation of non-disclosure of one's HIV status. This issue also explores aspects of women's realities and HIV, as well as sex work and the challenges sex workers are faced with in the context of HIV and AIDS. This newsletter further reflects on the correlation between gender-based violence and HIV and AIDS. And finally, this edition includes feedback from the provincial networks and an organisational update.

In this issue, Shaun Mellors explores the extent to which the International Guidelines on HIV/AIDS and Human Rights impact the South African response to HIV and AIDS. Reflecting on the progress made since 1999 and analysing the impact of various responses to HIV and AIDS, he argues that we are seemingly loosing the war against HIV and AIDS. His analysis indicates that in order to ensure effective responses, realistic strategies and a difference in the lives of people infected and affected by HIV and AIDS, it is not enough to only place HIV within the human rights discourse, but to use human rights as a practical tool to respond to HIV and AIDS.

The impact of women's realities, including existing imbalances between women and men, on women's vulnerability to HIV is assessed by Vicci Tallis. She argues that women are facing a crisis, since it is the gendered inequalities and imbalances in all spheres of society that lead to women's greater vulnerability to HIV and AIDS. Thus, as argued further, addressing women's inequality and vulnerability implies both to addressing women's realities and needs and to challenging and transforming prevailing gender relations.

Draft legislation proposing the criminalisation of the non-disclosure of one's HIV status to one's sexual partner as a sexual offence, is dealt with in an article by Nikki Naylor. She explores the role of the criminal law pertaining to people's sexual behaviour and conduct, the potential difficulty of proving such an offence beyond a reasonable doubt, as well as the risk of further stigmatisation and violation of people living with HIV and AIDS and argues that adequate public health measures offer a better alternative to the criminalisation of sexual conduct.

Vivienne Lalu looks at sex work and various challenges sex workers are faced with due to the criminalisation of sex work in South Africa. The need for law reform and the decriminalisation of sex work is pertinent not only to ensure the protection of the rights of sex workers, but also to maximise the impact of HIV and AIDS awareness raising, education and prevention amongst sex workers. She argues that as long as sex work is criminalised, sex workers will remain one of the most vulnerable groups to HIV infection, the impact of HIV prevention efforts will continue to be limited and the rights of sex workers will remain to be violated and discriminated against.

In this edition, Johanna Kehler reflects on the correlation between gender-based violence and HIV and AIDS in the context of fundamental principles of human dignity, equality and freedom, arguing that while the legislative and policy framework is in place, it is the prevailing inequalities and imbalances, the persistent gendered context of society and discriminatory attitudes and practices that illustrates as much the common determinants as the extent to which fundamental rights and freedoms can be realised. She argues that only a holistic, integrative and human rights based approach can begin to create an enabling environment in which both gender-based violence and HIV and AIDS realities can be adequately addressed and responded to.

While the constitutional and human rights framework is in place and premised on fundamental human rights principles of equality, human dignity and freedom, the recurring challenge appears to be the translation of these principles into a practical human-rights response to HIV and AIDS realities that impacts and makes a difference in the lives of people living with, and affected by, HIV and AIDS. It is the challenge of creating a society in which human rights coincide with human realities. It is the persistent challenge of creating a reality that is in fact, and not on theory, based on equality and non-discrimination, on human dignity and respect and the equal enjoyment of all rights and freedoms.

JOHANNA KEHLER

In any democracy, it is important to hold those in positions of elected power accountable, and South Africa is no exception. This article, therefore, focuses on the impact that the role played by the elected government has had, as well as the role of civil society in applying the International Guidelines on HIV/AIDS and Human Rights and what progress, or lack thereof, has been made with regards to both its implementation and the use of the Guidelines as an advocacy tool.

It is not intended, nor should it be seen, as 'government bashing', since the progress, or lack thereof, is based in reality, a reality one hopes would move beyond rhetoric and simple politics. As it is people's lives that we are talking about, a critical analysis has been provided. The Guidelines are after all

...designed to provide a tool to assist states in creating a positive response to the pandemic based on human rights, and its primary target audience is states (including legislators; policy makers; officials working in national AIDS programs; and officials working in other relevant ministries). The Secondary target audiences include the private sector; professional associations; the media; NGOs; networks of PLWHIV/AIDS etc[3].

We also have to ask questions as to the impact of the ALN project, and what progress they, have made, as an organisation that initiated a similar process 5 years ago? What have been the challenges experienced by the AIDS Legal Network and the reasons for re-introducing the project again.

What is abundantly clear from the surveys and the 5 provincial workshops that were facilitated by the ALN is that the International Guidelines as a tool or document are not known, let alone used, by the NGOs interviewed[4]. This certainly does not imply that NGOs are not working within a human rights framework in their communities, or do not apply the principles stated in the Guidelines. However, in many instances NGOs do in fact link the principles to those set out in the Constitution[5]. The fact that the Guidelines as a tool or document have not been heard of is perhaps indicative of a lack of accountability, or the perceived need for accountability. It is also perhaps a weakness or lack of interest on behalf of civil society, and organisations that are 'custodians' or channels of information and understanding around these international tools.

There is still a huge divide between public policy and public practice that leaves many people infected and affected by HIV and AIDS vulnerable to human rights abuses and HIV infection.

The response to HIV, since the first cases were diagnosed in 1982, has been a turbulent one, one characterised by lethargy, commitment, hope, despair and fatigue. The political commitment and action that is required for a strong and effective response many of us thought, would, as many of us thought, be implemented after the first South African AIDS Conference, held in October 1992 under the theme *'South Africa United Against AIDS'*. This conference also saw the formation of the National AIDS Convention of South Africa (NACOSA). We eagerly anticipated the rapid implementation of the National Plan and had imagined that the National AIDS Programme would be placed in the Office of the President. Sadly though, although it had been endorsed by Cabinet as a multi-sectoral plan and HIV/AIDS was designated a 'Presidential Lead Project' in the RDP, it was situated within the Department of Health, where it still is today.

In the preliminary response to the South African Government Report, highlighted in the ALQ of 1999, most of the concerns centred around the lack of implementation of existing policies and programs.

THE FOLLOWING CONCERNS PERTAINING TO THE GUIDELINES WERE HIGHLIGHTED:

Guideline 1:

The focus for the government response remained a Department of Health response; there was no forum or committee within Parliament driving the commitment by and action of Ministers and Members of Parliament; and great concern was expressed about the lack of governmental action in establishing the HIV/AIDS/STD Advisory Group.

Guideline 2:

There was concern expressed that consultations had occurred mainly on the national level with provincial consultations almost non-existent; that there was a marked decrease in funding, particularly to the provinces; and a tendency of government to interfere with programme implementation of government funded organisations.

Guideline 3:

There was a hindrance of the effective implementation of the operational plan as resources were stretched in order to support the IMC. This misallocation of resources was most clearly seen and felt in the provinces where there was a lack of delivery and services. Notification of AIDS disease and death was noted as a problem area.

Guideline 4:

There was a request that the Ministry of Health and the Ministry of Justice research and provide clear guidelines regarding the provision of the Criminal Procedure Second Amendment Act and the Criminal Law Amendment Act; and, although, the strategies developed to manage HIV and AIDS in prisons conformed to international standards, there was a challenge of effective implementation.

Guideline 5:

Progress on the adoption and implementation of the schools policy was outstanding; and concerns were raised that the policy excluded private schools, as well as concerns as to the future of the Gender Task Team, and how it was going to link up with other initiatives.

Guideline 6:

There was no real commitment on the part

of the government to provide AZT to pregnant women; there was a lack of barrier methods for the protection against transmission of HIV for women; the emphasis on the response to the epidemic was on prevention with little focus on care and access to affordable treatment was still limited.

Guideline 7:

Public institutions must be more proactive regarding the promotion and protection of the rights of PLWAs.

Guideline 8:

More information was needed about the status of the Gender Task Team and there was a need to investigate the suitability of initiatives like the Women in Partnership Against AIDS Programme.

Guideline 9:

There is a need for an intensive programme of public education on the human and legal rights of PLWAs.

Guideline 10:

The South African Defence Force was noted as an agency that was still having unresolved problems related to HIV and AIDS; and that people with HIV and AIDS were still experiencing problems related to life and health insurance.

A ROAD LESS TRAVELLED

June 1999 saw the second democratic elections, which brought with it a change in President, and a new Health Minister. Minister Tshabalala-Msimang started well and met with a number of civil society organizations, the pharmaceutical industry and visited Uganda to learn more about that country's response to HIV and in particular about the MTCT Program. The minister said soon after her trip that she was *'inspired'*, but the inspiration came to an abrupt end, as the South African response to HIV entered a mystifying and exasperating era. It has been one that has undoubtedly set the progress made back many years, has resulted in many more people being vulnerable to and infected with HIV, and one that has placed the International Guidelines on HIV/AIDS and Human Rights (IGHAHR) on a dusty shelf, or available only to the one's who are privileged to have access and to understand the broader context and framework in which they were developed.

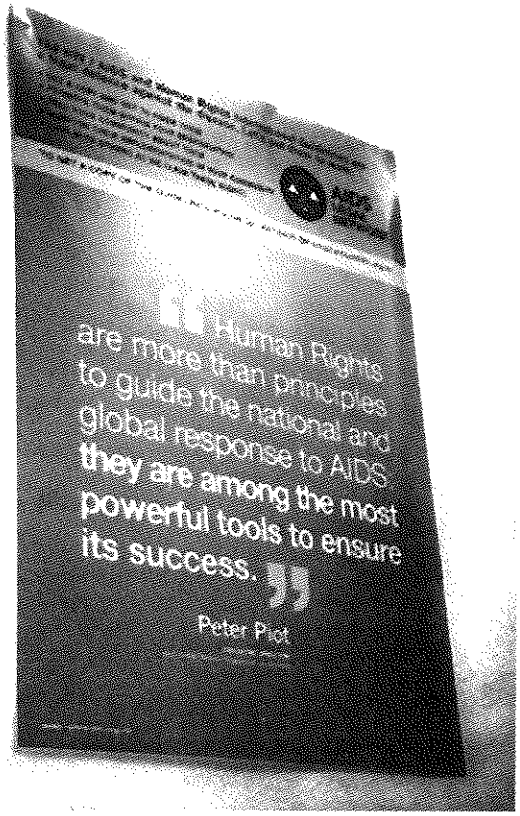
January 2000 saw the launch of the South African National AIDS Council (SANAC), that was met by outcry from members of civil society, as there had been advocacy campaigns and intensive lobbying for a multi-sectoral AIDS Committee (similar to the one in Uganda). Instead, SANAC became a Ministerial super weight structure, with little effective representation from civil society. Many of us were dismayed at the exclusion of representation from the Treatment Action Campaign, scientists or medical practitioners in this structure. SANAC was to be a great disappointment, a body that was unable to take control of the AIDS crisis that we were facing, and still are facing in the country. SANAC did, however, have representation of people living with HIV, and the representation on the SANAC structure has improved since its inception, but it still largely remains a toothless monster, with little strategic leadership or accountability. Who can forget the complete dismay and sense of pain, anger, helplessness and frustration we all felt when President Thabo Mbeki set up the 'Presidential International Panel of Scientists on HIV/AIDS in Africa' in early 2000? The purpose of the panel was to 'establish' the facts and to ascertain the link between HIV and AIDS.[6]

The XIII International AIDS Conference was only a few months away, and a number of international activists and organisations called for a boycott of the conference as a result of the Presidential Panel. However, people arrived in their droves and we all hoped that the rocky road travelled was behind us when Nelson Mandela spoke in the closing ceremony and encouraged us all *'to rise above our differences and combine our efforts to save our people. History would judge us harshly if we fail to do so right now'*. He went on to say that *'the time had come to move from rhetoric to action, to mobilise all of our resources and alliances, and to sustain this effort until this war is won'*.

A joyous victory was to be celebrated a few months later, when the Treatment Action Campaign (TAC) and the Government 'won' their case against the Pharmaceuticals Manufactures Association of South Africa (PMASA), which would allow South Africa to use parallel imports and compulsory licensing to access cheap HIV/AIDS drugs. The PMASA withdrew its case on the 19 April 2001. This led to a glimmer of hope that South Africa would have a national treatment plan in place by 1 December 2001 and would roll out anti-retroviral in the public sector at the beginning of 2002.[7]

A reality one hopes would move beyond rhetoric and simple politics

But once again, the rocky bumpy road that South Africa was travelling on was to continue. There were constant roadblocks, and for every few steps that were taken forward, we had to take a number of steps back. Most notably of these roadblocks was the issue of preventing mother to child infection. The TAC and its allies was once again at the forefront of this campaign, that saw many months of protests, effective national and international awareness campaigns and a stubborn reaction from those in power, including the Medicines Control Council that took more than a year to register the drug.[8] The Department of Health was then supposed to implement pilot sites in each of South Africa's provinces in April 2001, but this program was once again stalled. After constant negotiation and advocacy from civil society (led by the TAC), to implement a MTCT program, the TAC had



no choice but to take the government to court on the issue. The application was filed in the Pretoria High Court on 22 August 2001. When Judge Botha finally delivered his landmark judgment on the 14 December 2001 he said *'About one thing, there must be no misunderstanding; a countrywide MTCT prevention programme is an ineluctable obligation of the state'*.[9] The Government decided to take the case on appeal to the constitutional court, where the court denied the governments leave to appeal on the 5 July 2002.

The judgment had no doubt led to a more invigorated, mobilized and effective civil society leading Geoff Budlender, a lawyer from the Legal Resource Centre, representing the TAC, to say that the judgment had represented a *'new depth and maturity in our new democracy'* [Mail&Guardian, July 2002]. There was a string of high level gaffs and confusing statements from the Minister and Government officials, that have left civil society exasperated, confused and angry, not least of which was the stalling of the grant from the Global Fund to fight AIDS, TB and Malaria, and the Ministers constant promotion of garlic, olive oil, lemon and lately beetroot. No one can deny the importance that nutrition plays in building a strong and healthy immune system, but to have these issues constantly thrown in our faces as the best way to 'treat' HIV, and the only option available to us has been at best frustrating, and at worst an insult.

THE GUIDELINES: GUIDELINES ON PAPER, ABSENT IN REALITY?

The late Jonathan Mann was one of the pioneers in advocating for the importance of protecting and promoting human rights in relation to HIV and AIDS. Since then, the human rights discourse has become integrated in the response to HIV, which has seen a number of international treaties, documents and instruments being developed over the years. Countries that sign and ratify these international documents are obligated to bring domestic legislation in line with the principles stated. South Africa has a strong framework to work from as the South African Bill of Rights lays a strong foundation that *'enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom'* (Constitution, Section 7(1)).

THE INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

...are designed to provide a tool to assist states in creating a positive response to the pandemic based on human rights, a response that is effective in reducing the transmission and impact of HIV/AIDS. The guidelines attempt to take existing human rights norms and mould them into a series of practical, concrete measures states can adopt to fight the epidemic[10].

Although a few organisations in South Africa have referenced the International Guidelines (i.e., the South African Human Rights Commission became the first commission to publicly endorse the Guidelines in 1997, and the South African Law Commission referenced the Guidelines in drafting legislation that prohibits pre-employment testing), the Guidelines on the ground seem to be treaties without teeth. In order for the Guidelines to be used effectively by civil society that are at the forefront of responding to this epidemic, they need to be understood, placed into reality and empower civil society to understand that accountability is a key requirements for a strong and flourishing democracy, accountability and responsibility lead to more effective responses, realistic strategies and a difference in the lives of people infected and affected by HIV and AIDS.

According to Miriam Maluwa of UNAIDS[11] the International Guidelines can be used in a variety of ways, including:

- As a guide for interpreting laws to provide basic protection for people living with HIV/AIDS (PLWAS)
- To assist national non-governmental organisations and governments to develop a strategy for incorporating the Guideline principles into the national response to HIV/AIDS
- To facilitate the formation of strategic partnerships with other national bodies or public institutions
- To monitor an effective and non discriminatory response to the epidemic.
- To raise awareness of rights; assist in the enforcements of rights; assist in

developing strategies for redress where rights have been violated; to act as a framework for social mobilisation; and to ensure changes of attitudes and act as an indicator for monitoring human rights violations.

The HIV/AIDS and STD Strategic Plan for South Africa 2000 – 2005 states in Section 7.4 that:

The HIV/AIDS and STD Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the national, provincial and district levels with input from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

It is difficult to sustain and make a meaningful impact if there are constant contradictions, confusion and set backs, even more so if these come from the very core of policy making.

The Strategic Plan further states:

The HIV/AIDS Strategic Plan must be reviewed every 12 months at national and provincial levels, with quarterly reports to be submitted to provincial and national structures.

Little interaction and opportunity for review of the national plan has taken place. Interaction and relations with key civil society organisations are at an all time low, and however collaborative, energized and focused the efforts from civil society are – and there have been many – it is difficult to sustain and make a meaningful impact if there are constant contradictions, confusion and set backs, even more so if these come from the very core of policy making. All the international frameworks and treaties that have been provided or developed, and which South Africa is signatory to, cannot and will not make a difference if our *'political commitment is not turned into effective and coordinated political action'*.

In many ways, HIV has transformed the human rights discourse. The right to health is not disputable and a relationship between health and human rights is now taken for granted or at the very least acknowledged not only by public health specialists, but also by the one's who generally adhere to classical notions of civil and political rights. It is, however, not enough to think of the human rights framework in a simply functional way, as a good public health practice, but rather as a way to achieve social equity, justice and access to health for all.

It is, therefore, essential that human rights become *'the common language of humanity'*, the fundamental principles of all governance; the cornerstone of democracy. In other words, human rights are an essential element of good governance and not an optional extra. Such an intrinsic understanding of human rights will surely have a bearing on all the processes for the establishment of a culture of human rights in society.

South Africa has a highly developed* rhetoric *of rights, as there is a national tendency to develop sophisticated tables and frameworks, but very little real effort in translating this into action. There is very little on the ground that supports what is in the constitution…
[Prof. Charles Ngwena, Law Faculty UKZN]

FOOTNOTES:

1 Part of the project, initiated by the ALN in 2004, in which member NGOs, who participated in provincial workshops on the International Guidelines in 5 provinces (Eastern Cape, Free State, KwaZulu Natal, Limpopo and Mpumulanga), were surveyed as to their level of knowledge and implementation of the Guidelines.

2 The surveys received from the provincial workshops (n=42) were incorporated into a paper presented at the ALN Consultation on the guidelines. (March 2004). Unfortunately, the surveys have not provided substantive information to provide a critical analysis of where we are at with regards to the guidelines.

3 ICASO (1999). An Advocate's Guide to the International Guidelines on HIV/AIDS and Human Rights.

4 Please refer to survey results that can be obtained from the ALN offices.

5 The Constitution of South Africa, Act 108 of 1996.

6 The National Ministry of Health circulated an explanatory pamphlet 'What did you hear about AIDS today' in national newspapers in April/May 2000.

7 Agence France-Presse, 20 April 2001.

8 The Medicines Control Council finally registered Nevirapine for the use of mother to child transmission in April 2001.

9 The full judgment is available on the TAC website (www.tac.org.za).

10 ICASO (1999). An advocates guide to the International Guidelines on HIV/AIDS and Human Rights.

11 Advocate Miriam Maluwa was in 1999 the Human Rights Advisor to UNAIDS and commissioner with the UNHCR. She now works for UNAIDS.

REFERENCES

AIDS Legal Quarterly, 1999. 'HIV & AIDS – The International Guidelines. How South Africa Stacks up'

ICASO. 1999. *An Advocates Guide to the International Guidelines on HIV/AIDS and Human Rights.* International Council of AIDS Service Organizations.

ICASO. (1999). *An NGO Guide to the International Guidelines on HIV/AIDS and Human Rights.* International Council of AIDS Service Organizations.

HIV/AIDS & STD Strategic Plan for South Africa 2000 – 2005.

United Nation. 1998. International Guidelines on HIV/AIDS and Human Rights. Office of the United Nations High Commissioner for Human Rights & the Joint United Nations Programme on HIV/AIDS. New York & Geneva: United Nations.

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Vicci Tallis

Women's realities and HIV/AIDS

Women are facing a crisis that requires urgent attention. The response to HIV and AIDS must be two-fold: a short-term strategy that needs to, as much as possible, reduce the spread of HIV amongst women and lessen the impact of HIV and AIDS on women. However the long-term goal must be to challenge the complexities and inequalities of power relations between men and women in society leading to the transformation of society.

Agenda 39, 1998:13

Guideline 8 of the International Guidelines on HIV/AIDS and Human Rights provides government and civil society with an opportunity to ensure that the issues facing women [and girls] that both impact on their experience of, and vulnerability to, HIV and AIDS are understood, analysed and addressed. The 12 Guidelines are meant to assist in designing policies and programmes which are sensitive to the context of the HIV and AIDS epidemics and which protect and promote human rights. The guidelines are comprehensive and provide a broad framework in which to develop progressive responses to HIV and AIDS, however, they are largely gender neutral. Whilst the focus on the realities of women in relation to HIV and AIDS is essential, it is not sufficient to only address women's issues in relation to one guideline, but to ensure that a gendered understanding and approach is integrated into all 12 Guidelines.

HIV AND AIDS AND WOMEN IN SOUTH AFRICA

Based on the country's latest national round of antenatal clinic-based surveillance, it is estimated that 5.3 million South Africans were living with HIV at the end of 2002. More than half are women. Because of South Africa's relatively recent epidemic, and given current trends, AIDS deaths will continue to increase rapidly over the next five years at least; in short, the worst still lies ahead. [UNAIDS, 2003]

The Government's *'The National Strategic Plan on HIV/AIDS; 2000 – 2005'*, acknowledges that *'the low status of women,'* is one of the factors under-lying the HIV and AIDS epidemic in South Africa. There are two primary foci of the national strategy. The first is to reduce new infections, especially amongst young people. The second is to reduce the impact of HIV and AIDS on individuals, families and communities. However, when it comes to the actual substance of addressing women's realities little is actually done.

WOMEN'S DAILY REALITIES

Women and girls in South Africa are faced with daily hardship on a physical, social, emotional and economic level. The unequal power relations between women and men are a key factor in the deepening impact of HIV and AIDS. Since 1994, with the transition to democracy, progressive policies have been drafted to advance and improve the position of women and girls in the country. Some women have benefited from policy change. There are, for example, greater numbers of women in key institutions of democracy and in the private sector – increasing the voice and visibility in the public arena. However, the actual realities of most ordinary women's lives have not improved significantly. South Africa remains a country of high statistics of violence against women. Given the context of HIV and AIDS, and an already massive burden of poverty, the status of women and girls is declining. There are already indications that gains made in narrowing the gap between women and men, girls and boys, are being eroded, in that women's additional caretaking responsibilities impact not only on girls' position in the family, but also on their access to education.

POWER AS PROBLEM

The core problem is that women and men are not equal in society. Men have *power over* women – both on a broader political level, as well as in the home, family, workplace and in sexual relationships. The power imbalance ensures that men are more privileged than women, that men have more and greater opportunities. Men have access to, and control over, most of the resources; men are in decision-making and leadership positions and their time is valued more and so on. Men's

power over women is also enforced through the stated or un-stated threat of withholding resources, recognition or support. In this context of men's *power over* women, oppression leads to inequality, which leads to women being dependant on men. This further leads to an inability by women to take charge of their own health and well-being and to protect themselves from HIV. Hence, this creates greater vulnerability to HIV and AIDS.

REALITIES THAT UNDERSCORE THE SITUATION FACING WOMEN IN SOUTH AFRICA:

Access to political, economic resources and access to services

Women have less access to health, social support and education. Women often have less information about HIV and STI's and are less likely to seek treatment for sexually transmitted infections. This makes them more vulnerable to infection.

Less is known about HIV and AIDS in women than in men

Treatment issues for women living with HIV and AIDS have not been prioritised. There is not enough attention paid to the specific women related signs and symptoms which are often easily detected and treated.

Women often have lack of control over their body

Women have little or no control over when, with whom and how they have sex and are not even seen as having their own sexual needs. In the absence of female controlled prevention methods such as female condoms or Microbicides, women find it even more difficult to protect themselves from HIV and other STI's.

Married women have been identified as a group of women who are extremely vulnerable to HIV infection. Whilst emphasis is on younger women, the vulnerability of older women must not be discounted as they are equally bound by the gendered power within their relationships, which is often mediated through marriage. Emerging epidemics are occurring amongst older women in many countries [UNAIDS, 2001]. Globally, the condoning of multiple partner relationships for men is a social norm that increases women's vulnerability. In many cultures, both women and men believe that a variety of sexual partners are acceptable and essential for men, but not appropriate for women.

There is growing evidence that young women and girls' are having transactional sex – for money or favours. Closely linked to the issue of transactional sex, is the problem of intergenerational sex and that older men and younger women – in many cases teenage girls – are often in sexual relationships. Anecdotal evidence points to the fact that whilst this is seen as a problem, it is more or less accepted in many communities – particularly since, even where families do not like it; older men are seen as providing much needed material support in the form of school fees, transport money, groceries and so on. For example, in rural area in KZN – parents turn a blind eye as girls have sex with teachers as form of income – R100 – R 150 per month.

Survival sex

The context of most sex work in Africa is survival sex, and sex work is about making money for women and their families to remain alive. In this way, survival sex is a form of small-scale informal money making. Some women in the informal sector are simply extending their existing capabilities and livelihoods and doing work that is typified as women's work. They are seldom, as is usually the case with women's work, well paid for their efforts. Sex work that is poverty driven is more likely to foster behaviours that are risk-taking.

Reproductive rights

Reproductive rights refer to rights that focus on, and relate to, the potential and ability to procreate. This includes issues such as fertility, family planning and termination of pregnancy. Reproductive rights take on another dimension in relation to HIV and AIDS, as hard-fought battles of the feminist movement are being eroded. An example of this is the control often exerted by health care workers over the reproductive choices of women living with HIV/AIDS. Incidents of women living with HIV requesting termination of pregnancy and being 'forced' into sterilisation have been noted [Mthembu, 1998]. Often, women living with HIV/AIDS are not given accurate information regarding pregnancy and breastfeeding [Seidel and Tallis, 1998]. Women often face difficult decisions regarding breastfeeding as a culturally preferred option. A decision to not breastfeed can lead to a forced disclosure of women's HIV status [Paxton, 2001]. Women have also reported judgmental and hostile attitudes from service providers, including testing without consent and refusal of services [Manchester and Mthembu, 2002].

Violence against women

Men's power over is often enforced through violence or the threat of violence against women – and we know that there are high incidence of rape and domestic violence in South Africa. Gender-based violence is both a cause and consequence of HIV infection:

- Girls and women who are raped may be infected with HIV as a result of the rape;
- Most women who are raped have no access to post-exposure pro phylaxis and live with the fear of possible sero–conversion;
- The fear of violence may prevent women insisting on the use of condoms or other safer sex methods';
- Myths such as having sex with a virgin will cure you of HIV result in rape and sexual abuse.

The gender division of labour

The gender division of labour ensures that women remain the principal caregivers in formal settings, such as hospitals, as well as 'informally' in the community and in the home. May [2000] refers to the *'time poverty'* experienced by women, being a result of the long hours women spend on their reproductive roles – collecting fire-wood, water, child care, cooking and cleaning – to the detriment of their own well-being. Many women living with HIV also have the added pressure of being ill themselves and having to provide care for their partner and/or sick child. For a woman living with HIV, such an increase in workload often means that she does not have time to adequately care for herself and attend to her own needs [Panos, 1990; Loeweneson and Whiteside, 1998]. As noted, home-based care is a middle-class concept as it assumes that the resources [including human] are available in the home. However, this is not always the case [Crewe, 2002].

Women are often viewed as mothers first, and women in their own right second, or not at all. When women are viewed as mothers the focus of care, treatment and support is for their children. Many women find out their HIV status through a child's illness. Previous treatment activism focusing on ARV's to prevent mother-to-child-transmission did not consider the negative effects of such treatment on women's health.

IMPERATIVES TO ACT

- In order to address women's inequality and vulnerability we must address in the short term realities and in the long term women's strategic interests.
- Re-define prevention messages that are appropriate to the lives and realities of women and men, girls and boys. ABC does not work for women and girls.
- Women need prevention methods that they can control. Increase access to female condoms [male condoms 220 million in 2002 compared to 1 million female]. Advocate for increased commitment to and development of a Microbicides that will be widely and freely distributed - ensure that *a safe, ethically developed afford able Microbicides is available and accessible to women so that they may protect themselves from infection, or re-infection whilst still exercising their reproductive and sexual rights.*
- Promote a sexual rights framework.
- Increase access and control over financial resources – traditional income generating projects often do not empower women financially.
- Appropriate counselling care and support that is accessible to women and girls
- Access to appropriate treatment for opportunistic infections, ARV's and other women's health issues based on women's bodies.
- Disclosure of HIV test results must remain the decision of the women. Reduce pressure on women to disclose recognising the realities of disclosure to partner, family, children and in the workplace.
- Address stigma and discrimination: Analyse the different ways stigma and discrimination is experienced by women.
- Create awareness amongst communities, leaders and policy makers of the hidden impacts on women affected.
- Advocate for increased access to quality counselling and support group services that are sensitive to the realities of women affected by HIV and AIDS.
- Lobby government to stop the shifting of the responsibility for care onto women.
- Ensure meaningful participation of women living with HIV and AIDS in policy and practice by all institutions, including civil society and government.
- The transformation of gender relations leading to gender equality is the key objective, and must happen at a personal, organisational, programmatic and societal level.

REFERENCES

Crewe, M. 2002. Presentation at Barcelona Conference, July 2002.

Manchester, J & Mthembu, P. 2002. 'Positive Women: Voices and Choices', In: *BRIDGE* No. 11, Brighton: Institute of Development Studies.

Mthembu, P. 1998, 'A positive view', *Agenda* No 39.

Paxton, S. 2001. 'Parent-To-Child Transmission: Breaking Down the Barriers to Implementing Effective Models'. Paper presented at the 6th ICAAP Plenary 8th October 2001, The Key Centre for Women's Health in Society, The University of Melbourne.

Seidel, G. & Tallis, V. 1999. *Reconceptualising the issues surrounding HIV and breastfeeding and the information given to women by health workers:* Findings from sociological research in KwaZulu-Natal, South Africa.

Tallis, V. 2001. 'Treatment issues for women', Paper prepared for Treatment Action Campaign, South Africa.

Tallis, V. 1998. 'AIDS is a crisis for women', *Agenda* No. 39.

Tallis, V. 2002. *Gender and HIV/AIDS : Cutting Edge Pack – Overview report.* Brighton. Institute of Development Studies.

UNAIDS, 2002. *Report on the Global HIV/AIDS Epidemic,* Geneva: UNAIDS.
www.unaids.org/barcelona/presskit/barcelona%20report/contents.html

UNAIDS, 2003. *Report on the Global HIV/AIDS Epidemic,* Geneva: UNAIDS.

Vetten, L. & Kailash, B. 2001. *Violence, Vengeance and Gender: a Preliminary Investigation into the Links Between Violence Against Women and HIV/AIDS in South Africa.* Research Report, Johannesburg and Cape Town: Centre for the Study of Violence and Reconciliation
www.wits.ac.za/csvr/papers/paplv&kb.pdf

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Nikki Naylor

Prosecuting Bedroom Offences

The criminalization of harmful HIV-related behaviour

Those who would amend the criminal law to prohibit, for example, sexual intercourse without disclosure of one's HIV status are in one sense trying to identify the 'sheep-killing wolf' rather than asking where the flock is wandering.

Criminal Law & HIV/AIDS, 1996

In 2001, the South African Law Commission identified a need to reform the law relating to sexual offences. A culmination of this process has been the draft Sexual Offences Bill, dated July 2003. It was with shock and disbelief that women's groups found that the draft Bill also included in the definition of rape, the offence of intentionally infecting someone with a life-threatening sexually transmitted disease or HIV. Intentionally infecting someone with HIV has now been brought squarely within the criminal law context of rape.

SO HOW DO WE, AS ACTIVISTS AND LAWYERS, RESPOND TO THIS CHALLENGE?

It is important that we realise that before one invokes the rough instrument of the criminal law, we must be sure that it will have some impact. Criminal law must not be counter-productive or do more harm than good. It is submitted that the existing criminal offences are sufficient to deal with issues of intentional infection. The offences of attempted murder, murder and assault, all exist. Perhaps, they need to be re-contextualised in the HIV and AIDS era, but we should guard against creating a new separate offence, particularly, when one considers what the purpose of criminal law is.

THE ROLE OF THE CRIMINAL LAW

Each of the usual rationales for the criminal law (retribution, incapacitation and deterrence) appears ill-suited to deal with HIV and AIDS [Gostin, 1996]. Statutes outlawing sodomy, prostitution, drug abuse and transmission of venereal disease did not and have not deterred these activities and thus, there is little reason to believe that another statute targeting *consensual sex* for criminal penalties would change this. It is highly unlikely that criminal penalties will stop people in South Africa from engaging in potential risky sexual behaviour. Furthermore, threatening people with criminal penalties where they expose others to HIV may create a false sense of security among HIV-negative people.

The criminal law should not police the most intimate details of people's sexual lives and sexual histories based on only *a risk* that someone may or may not be HIV-positive. Sexual activity with any partner **always** carries some risk of lesser or greater harm. Criminal law should, therefore, only deal with high-risk activity and coercive sexual acts (rape) which result in HIV-infection, whilst exercising caution and restraint when dealing with consensual sexual acts bearing in mind that unprotected sex **always** carries a significant risk of harm to both parties.

If we have an offence that says, as long as you don't know your status you cannot be charged with an offence, this is problematic.

Should one create a criminal offence of the kind envisaged by the legislature, one would in effect be criminalizing mere silence and a failure to disclose where there is no legal duty to disclose one's status. Furthermore, it should be borne in mind that persons fearing criminal action will self-exclude from the health system and not be tested or approach the health care system for treatment. Whilst a person has no knowledge of his/her status it will be impossible for the prosecution to prove the element of intent. The offence thus runs counter to every attempt being made for people to disclose their status, get tested and take responsibility. If we have an offence that says, as long as you don't know your status you cannot be charged with an offence, this is problematic.

Flowing from the foregoing, it is also clear that women are often the only parties who get tested for HIV when attending at antenatal clinics and thus, have knowledge and may be liable for prosecution, notwithstanding that their partners may have infected them. It is then impossible to assess who is the infecting partner.

The process of legislating may create a hostile environment and lead to the social stigmatisation of all people living with HIV and AIDS who will now all be regarded as 'potential criminals'. The South African reality at the moment is that people fear disclosing their status as this may result in abandonment, eviction, domestic violence, loss of employment and being shunned by the community. Contrary to creating an enabling environment for individuals to gain access to health care services, it is more likely that criminalizing consensual sexual conduct will create an unsafe, insecure, threatening and ultimately *disabling* environment for individuals to protect themselves from transmission and to access health care services.

THE INTERNATIONAL CONTEXT

In support of the above contentions, UNAIDS and the WHO have noted:

In particular, people will not seek HIV-related counselling, testing, treatment and support if this would mean facing discrimination, lack of confidentiality and other negative consequences. Therefore, it is evident that coercive public health measures ***drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support.*** [Emphasis by author] [Second International Consultation on HIV/AIDS and Human Rights, Report of the Secretary-General, Geneva (1996), page 19.]

Furthermore, in the International Guidelines on HIV/AIDS and Human Rights published by UNAIDS and OHCHR, Guideline 4 stipulates that:

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

It goes on to recommend that:

Criminal and/or public health legislation should ***not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases.*** *Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.* [Emphasis by author]

Coercive use of public health powers against someone based solely on their HIV-positive status is not only unsound public health practice, it is also unethical and a violation of internationally recognized human rights (Ibid).

THE SOUTH AFRICAN CONTEXT

The Southern African Development Community (SADC), like the UN, has endorsed a multi-sectoral approach promoting positive behavioural change and responsible sexual behaviour, as opposed to criminalization. It is my submission that the current attempt at criminalizing harmful HIV-related behaviour flies in the face of the declarations of intent endorsed by the South African government at SADC.

The Justice and Constitutional Development Parliamentary Portfolio Committee has raised arguments in relation to the need to simplify and alleviate evidentiary hurdles currently faced by the state in relation to proving the elements of the crimes of murder, attempted murder and assault. These arguments cannot be sustained for the following reasons.

In terms of this new offence the legislature has failed to consider that it has not simplified or alleviated the evidentiary hurdles. There will now be a need to clearly establish the degree of mental culpability required for liability and the issue of the reasonable possibility of infection and what constitutes significant risk of transmission will have to be explored. In particular, the South African government has not considered issues such as:

- When will conduct be considered significantly risky?
- What degree of risk is unjustifiable?
- What role does gross negligence play?
- What about the situation where an accused without disclosing his/her HIV status explains that he/she has had more than 20 sexual partners and never practiced safe sex with any of these partners? Is this sufficient disclosure to place a duty on the other partner to enquire about HIV status or to demand condom usage to limit the risk?
- What about the difficulties around negotiating safe sex and condom usage, particularly for women?
- What about an accused person who has no knowledge regarding the ways in which HIV and AIDS is transmitted and thereby has no or limited knowledge that the sexual conduct carries a risk of harm to another, even though he/she is aware of his/her HIV status?

The state has to prove all crimes beyond a reasonable doubt, and not every difficulty of proof faced by the prosecution justifies new legislation to circumvent an evidentiary requirement. Difficulties in proving a causal link between an accused person's conduct and the HIV infection of a complainant will not be alleviated. Even if all other factors are proved an accused who has engaged in criminal conduct can avoid liability simply because the nature of the infection is such that the State will have difficulties proving beyond a reasonable doubt that it was this particular accused who was responsible for the infection of the complainant, particularly where an accused disputes that he/she infected or even had sexual intercourse with the complainant. Here previous sexual history becomes relevant and all the inherent bias and victimisation around testifying in this regard has already been recognised by the legislature.

Furthermore, proving the accused had knowledge of his/her status will be particularly difficult to prove conclusively. An HIV test only establishes an accused person's status **at the time of the test** and **not at the time of the sexual act.** It will often be impossible to prove beyond a reasonable doubt that the complainant was HIV negative prior to and at the time of sexual intercourse with the accused. Window periods and a false-negative test in relation to infection also pose problems, as will anonymous testing and confidential medical records.

Every single individual has a responsibility to engage in safe sex and prevent the transmission of HIV and AIDS, thus not only the 'infector' has this responsibility. Bearing in mind the statistics in relation to the number of South Africans infected, any person who engages in unsafe sex can be said to have assumed the risk. The assumption of risk doctrine or tacit consent will then be applicable. The cost of prosecuting and proving the offence with expert medical evidence will be great. The state could channel this money toward anti-retroviral treatment or education programs. At the same time a number of public policy considerations suggest that invoking the criminal law should only be done with restraint. Where criminal law is invoked and a separate new offence created, the guidelines proposed in the UNAIDS Policy Paper [Elliot, 2002] should be borne in mind:

- if resort is criminal law, then preventing HIV transmission must be the single most important objective of doing so. HIV prevention should not be sacrificed in the pursuit of other goals such as retribution;
- the parameters on the use of criminal law should be set out to avoid over-extension;
- prosecutorial guidelines/regulations should be formulated bearing in mind that selective prosecution will not be desirable and could result in bias and discrimination;
- safeguards to prevent adverse consequences for vulnerable groups, such as women have to be implemented;
- the confidentiality of medical/counselling information should be dealt with;
- only the most serious, harmful conduct should be punished bearing in mind however that coercive measures will be of limited utility in responding to HIV transmission as in most instances of transmission/exposure consensual sexual intercourse takes place rather than coercive sexual intercourse;
- where coercive measures are utilized they should be done on the principle that the least intrusive measures possible is always preferred, so as to minimally impair valuable rights and interests.
- a policy will need to be developed considering the bigger, broader social context of HIV and AIDS.

It will often be impossible to prove beyond a reasonable doubt that the complainant was HIV negative prior to and at the time of sexual intercourse with the accused.

CONCLUSION

The above submissions were all put before the Justice and Constitutional Development Parliamentary Portfolio Committee urging the Committee to delete the clause in question. The Committee has accepted that an offence of intentional infection cannot amount to rape and that the new offence should not target vulnerable groups. They have however, stubbornly, maintained that there is a real need for a new offence of 'intentional infection' and have re-worded the clause to protect vulnerable groups to read as follows:

Criminal non-disclosure of HIV or AIDS

(1) A person ("A") who engages in intimate contact with another person ("B") and who intentionally does not disclose to B that he or she has HIV or AIDS is guilty of an offence of criminal non-dis closure of HIV or AIDS.

(2) "Intimate contact" means contact of a sexual nature that exposes the body of one person to a bodily fluid of another person.

(3) It is a defence to a charge under subsection (1), if B was aware that A was infected with HIV or AIDS and consented to intimate contact with that knowledge.

(4) (a) The institution of a prosecution for an offence referred to in subsection (1) must be authorised in writing by the National Director of Public Prosecutions and may only be instituted if such prosecution is in the interests of justice with due regard to the following—

(i) the nature and duration of the relationship between A and B;

(ii) whether A is financially dependent on B;
(iii) the likelihood of retaliation, whether emotional, financial, physical or otherwise against A or his or her family by B or his or her family if A disclosed that he or she has HIV or AIDS;
(iv) the attitude prevailing in the community in which A and B reside towards persons who have HIV or AIDS, with specific reference to previous incidents of violence towards or discrimination against such persons; and
(v) the likelihood of loss of employment or accommodation resulting from disclosure of the fact that A has HIV or AIDS.

(b) The National Director of Public Prosecutions may not delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.

It has been argued by some, that this new offence adequately deals with the problems around vulnerable groups. In my view the problem around stigmatisation and discrimination remains. The criminal law should be a measure of last resort; it is not, and cannot be, a sufficient response to a public health and social welfare issue. In the final instance the unjustifiable invasion of one's dignity, privacy and equality rights should be paramount. There are existing less restrictive means to achieve the purpose of the Bill without stigmatising the HIV positive individual (such as the existing criminal law measures). Co-ordinated social and public responses are what is needed here and not the blind promise of the law and the criminal law.

It is hoped that the words of Honourable Justice Michael Kirby of the High Court of Australia, will echo in the corridors of our Parliament when the Bill is introduced before the National Assembly:

We have a responsibility to guard against the proliferation of a new virus – HUL – highly useless laws!

REFERENCES

Canadian HIV/AIDS Legal Network & Canadian Aids Society. 1996. *Criminal Law & HIV/AIDS: Final Report.* Canadian HIV/AIDS Legal Network and Canadian Aids Society, Montreal.

Elliot, R. 2002. *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper.* (Prepared for UNAIDS).

Gostin, L. 1998. 'The politics of AIDS: compulsory state powers, public health and civil liberties.' In *Ohio State Law Journal,* Issue 49, pp 1017 – 1056.

United Nations. 1998. *International Guidelines on HIV/AIDS and Human Rights.* Office of the United Nations High Commissioner for Human Rights & the Joint United Nations Programme on HIV/AIDS. New York & Geneva: United Nations.

Second International Consultation on HIV/AIDS and Human Rights, Report of the Secretary-General, Geneva (1996).

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Organisational Update...

The AIDS Legal Network, facing quite a number of organisational challenges, engaged in extensive processes of evaluation, strategic planning and restructuring during 2003. Subsequently, the AIDS Legal Network was in the position to re-affirm its goal and commitment to the promotion, protection and realisation of fundamental human rights and freedoms of people living with, and affected by HIV and AIDS. We seek to achieve this through our capacity building, education and training, research, networking, lobbying and advocacy activities at local, provincial and national level. The ALN focuses primarily on the promotion and advancement of the principles of equality, non-discrimination, human dignity and the equal enjoyment of all rights and freedoms. It is our main goal to address discriminatory practices and attitudes, to promote behavioural change and to facilitate a holistic human rights-based response to HIV and AIDS.

Recognising and responding to the general lack of awareness and knowledge that greatly impacts on the extent to which people living with, and affected by, HIV and AIDS are in the position to claim and enjoy fundamental rights and freedoms, the AIDS Legal Network will strengthen its human rights education and training programme.

The ALN will also endeavour on social policy research aiming to not only identify, and increase awareness of, the gaps and obstacles in implementing existing legislative and policy measures pertaining to HIV and AIDS, but also to promote and lobby for the adequate implementation and application of these measures.

We will continue our networking, lobbying and advocacy activities at a local, provincial and national level. These activities are purposed to develop and enhance the capacity of civil society enabling an effective human rights-based response to HIV and AIDS.

For further information please contact Sandy Okkers at the ALN Office on 021 447 8435 or at Sandy@aln.org.za.

Vivienne Lalu

Sex Work, Human Rights and HIV/AIDS

The International Guidelines on HIV/AIDS and Human Rights promote the establishment of a supportive and enabling environment. Guideline Eight states that it is the duty of the state to address underlying prejudices and inequalities facing women, children and other vulnerable groups through, and with, community collaboration and specially designed social and health services. The Guideline, however, relegates its recommendation for vulnerable groups to the last point (j) and does not, it seems, attempt to integrate recommendations for vulnerable groups.

Interrogating the Guidelines, SWEAT[1] is of the opinion that South Africa has failed sex workers[2]. In holding to a policy that criminalises sex work, the state effectively diminishes the opportunity to consider the rights, both health and labour rights, of sex workers.

The discussion paper, expected later this year from the South African Law Reform Commission, will consider decriminalisation of the adult commercial sex industry as an option for law reform. This process of law reform coincides in significant ways with work around HIV prevention amongst sex workers. Without law reform, HIV preventive work will continue to be confronted by numerous obstacles. SWEAT, a non-profit organisation based in Cape Town, is committed to linking the question of the rights of sex workers to the struggle against HIV and has enjoyed some success at a broad mobilisation of sex workers for decriminalisation.

Alongside the campaign for decriminalisation, SWEAT has continued to offer safer sex education to sex workers in the Western Cape. This approach is premised on the belief that health issues and human rights are integrally linked. Ivan Wolffers [2001], the editor of *Research for Sex Work* argues that:

As long as sex workers live in an insecure economic and social position they cannot afford the luxury to pay special attention to some of the health risks they are facing, isolate these specific risks and pay extra attention to them. The continuous threat of violence, repression and intimidation leads sex workers to making different assessments of the risks they are taking.

The safer sex component of SWEAT's work has included the distribution of male and female condoms, safer sex workshops with sex workers, distribution of pamphlets and other educational materials. Part of this process of advocating for law reform has been involving sex workers in making submissions to the South African Law Reform Commission. This campaign has resulted in two major conferences with women and men who work in the industry where questions of sex worker rights were addressed. While the first conference produced a sex workers charter of basic rights, the second saw the launch of a movement, Sisonke, aimed at mobilising sex workers. In both instances, the initiatives could have considerable outcomes for HIV prevention work amongst sex workers.

Sex workers from the Sonagachi Project[3] support the view that preventative work is inextricably linked to human rights:

We the sex workers have been reclaiming our rightful space in our communities and our country as human beings, citizens and workers. We cannot wage an effective battle against HIV/AIDS and other STDs unless we are viewed as whole human beings.

Given the illegality of sex work, initiatives targeting sex workers, especially around their health and well-being, are generally hampered. These obstacles relate to the circumstances within which sex work is conducted. The continued criminalisation of sex workers has contributed to the stigma, isolation and violation of human rights of sex workers. Sex workers are forced to work in isolated and remote areas. These working conditions not only make them vulnerable to violence and abuse, but also make it very difficult for intervention projects to locate them to do prevention work. Increased police harassment often leads to fining. This forces sex workers to increase the sale of their labour to pay off fines. More importantly, criminalisation forces sex work underground hampering sex workers' ability to organise themselves in any significant way to address their human rights needs.

Condoms have been seen as the most effective way of reducing HIV transmission. The illegal nature of sex work, however, makes it extremely difficult for sex workers to negotiate condom use with their clients. In some instances, insisting on condom use has resulted in increased levels of violence against sex workers. Police actions, like the confiscating of condoms as evidence of an illegal activity, further impact on sex workers ability to use condoms. The lack of unity and organisation amongst sex workers ultimately means that some clients

will resort to finding sex workers who do not insist on condom use. Therefore, it is clear that in the current climate of criminalisation of sex work, possible HIV infection is just one of the many risks sex workers have to contend with.

SWEAT's position is not to focus too narrowly on HIV, but to broadly consider the rights issues that sex workers confront. Targeted intervention amongst so-called high- risk groups seems an appropriate course of action, since one of the major modes of transmission of the virus is through sexual intercourse. However, the focus seems inadequate when considered in relation to the sense of powerlessness that most sex workers experience. Sex workers have very little control over their working conditions largely as a result of insufficient recognition of the presence of sex workers by the state and by society in general.

Furthermore, the focus of HIV prevention work with high-risk groups are often aimed at preventing the spread of HIV amongst the general population and not necessarily on risks faced by sex workers. This is largely a consequence of viewing sex workers as vectors of disease and preventing them from infecting their clients. Increasingly questions regarding clients' responsibility for practicing safer sex and the protection of sex workers against infection have been raised.

The majority of sex workers in South Africa, we might assume, are young women between the ages of twenty and thirty. As a result of their particular and marginalised status in society, they are often more vulnerable to acts of violence than is generally admitted to. Therefore, issues facing sex workers are inextricably related to the fight against violence against women, struggles for basic human rights and for decent working conditions, particularly for the poor who work in informal sectors [Distiller, 2000].

In conclusion, SWEAT believes that decriminalising adult sex work will enable change in focus for state interventions. Rather than investing large amounts of resources in criminalising sex workers by policing and prosecuting these workers, the state will achieve more if it concentrates on the health needs of sex workers. This requires a commitment to decriminalisation as a necessary step to securing the rights of sex workers.

FOOTNOTES:

1 Sex Workers' Education & Advocacy Taskforce (SWEAT).

2 In using the term sex worker, SWEAT means adults who voluntarily choose to provide sexual services in return for money. We thus exclude from this definition those who have been forced into the industry for sexual exploitation such as children and trafficked individuals.

3 Sonagachi is a sex worker led project based in Calcutta, India. The project has evolved into a multi-faceted community effort to empower sex workers, not only to protect themselves from HIV, but to fulfill their broader needs.

REFERENCES:

Distiller, N. 2000. Sex Work, Health and Human Rights. In: *Women's health news and views*, 35, pp. 1-4.

Wolffers, I. 2001. Violence, repression and other health threats. In: *Research for sex work*, June Issue, pp. 1-2.

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Education and training...

The AIDS Legal Network (ALN) offers a wide range of education and training workshops. The workshops focus primarily on fundamental rights and freedoms, HIV and AIDS and the relevant legislative and policy framework and aim to enhance the knowledge/understanding about these rights and how to access them. All our education and training activities are rights-based and participatory in nature and are aimed at communities, the youth, civil society, service providers and legal advice offices. We also seek to reach the public and private sector. In addition, the ALN offers Train-the-Trainer workshops.

We offer One-Day and Two-Day Workshops on a variety of issues pertaining to *HIV/AIDS and the Law*, as well as on *Gender-Based Violence and HIV/AIDS.*

The workshop on *HIV/AIDS and the Law* explores the concept/understanding of HIV and AIDS, its transmission, prevention, and realities, the concept/understanding of the fundamental human rights and constitutional framework, its accessibility and realisation in the context of HIV and AIDS, as well as the relevant legislative and policy measures and the extent to which these are adequately applied and implemented.

The workshop entitled *Gender, HIV/AIDS and the Law* explores the concept/understanding of gender versus sex, of gender roles and gender stereotypes, of the gendered context of society, the extent to which the gendered context of society defines prevailing gender inequalities and imbalances and greatly impact on HIV and AIDS realities, as well as the concept/understanding of the correlation between the gendered context of society, HIV and AIDS realities and the extent to which rights and freedoms can be accessed and realised.

For further information on our education and training programme and/or for workshop dates please contact Sandy Okkers at the ALN Office on 021 447 8435 or at Sandy@aln.org.za.

making a point

Gender-based violence and HIV - Reflection on a human rights response[1]

Johanna Kehler

Introduction: Celebration versus acknowledgment

While we are celebrating 10 years of democracy in South Africa, we are also celebrating the progress that has been made in providing a legislative and policy framework that is based on fundamental principles of human dignity, equality and freedom. We are celebrating the constitutionally guaranteed right to not only equal entitlement, but equal enjoyment of all rights and freedoms. And we are also celebrating the right to be free from all forms of violence and abuse. However, celebrating these achievements also demands the acknowledgment of all the challenges that still lie ahead.

While there has been significant progress, we need to acknowledge that South Africa's reality is also marked by seemingly ever-increasing levels of poverty and unemployment, an alarming increase in the number of people living with, and affected by, HIV and AIDS, high incidences of sexual violence and abuse, as well as prevailing gendered inequalities and growing disparities. And these are the realities that largely define the extent to which fundamental human rights enshrined in our Constitution can be accessed, claimed and enjoyed. Furthermore, the response to gender-based violence and to HIV and AIDS seems to be more defined by a lack of political will and, thus, inadequate resource allocation, than by the legislative and human rights framework. Subsequently, it appears to be the reality of prevailing inequalities and injustices, as well as existing discriminatory attitudes and behaviours, that define the extent to which equal enjoyment of all rights and freedoms can be realised.

Promoting and realising principles of equality and non-discrimination, human dignity and the enjoyment of all rights and freedoms, arguably, implies to not only identify, but also to address and respond to the apparent gap between constitutional guarantees and lived realities, between theory and practice, as well as the barriers and challenges that especially women are faced with while trying to claim and enjoy their rights and freedoms.

Reality and Facts

While the right to equality and non-discrimination (Constitution[2], Section 9), the right to have one's human dignity respected and protected (Constitution, Section 10), the right to life (Constitution, Section 11) and the right to be free from all forms of violence (Constitution, Section 12) are constitutionally guaranteed to everyone, the reality is marked by high incidences of sexual violence and abuse, as well as by discriminatory practices and attitudes experienced by people living with, and affected by, HIV and AIDS. While the legislative and policy framework provides for protective measures, such as legislation dealing with the protection of victims/survivors of domestic violence[3] and sexual offences[4], it is the inadequate implementation and application of these existing legislative measures that limits the extent to which they can be accessed and, thus, provide protection.

Statistics, illustrating not only the gendered nature of HIV and AIDS, but also of sexual violence, is but one of the indicators of the link between gender-based violence and HIV.

It is estimated that 5.3 million people in South Africa are living with HIV and AIDS, the majority of whom are women and girl children. The adult prevalence rate is 21.5%. It is young people, age 15 to 24, who are most at risk of HIV infection[5]. The prevalence rate amongst people 15 to 24 is 10.2%. Amongst women, the prevalence rate is much higher (15.5%) than amongst men (4.8%)[6]. Furthermore, four times as many young women age 15 to 24 are living with HIV and AIDS as compared to their male counterparts in the same age group[7].

Simultaneously, young women in the same age group are reportedly more likely to be subjected to sexual violence and abuse. In addition, police statistics indicate that over 40% of rape survivors who reported their case between Feb 2002 and Mar 2003 were girls under the age of 18, with 14% 12 years and younger[8].

These statistics clearly indicate that

it is young women and girl children who are not only the ones at the highest risk of HIV infection, but also the ones at the highest risk of sexual abuse and violence.[9] Research[10] also suggests that especially young women and girl children's vulnerability to sexual violence and hence, HIV infection, increases not only due to the myth that having sex with a virgin cures a person of HIV, but also due to the perception that younger women are less likely to be infected with HIV.

Links between gender-based violence and HIV/AIDS

It is the gendered context of society, as well as the prevailing gendered inequalities and imbalances that largely define the limited extent to which women and girl children are in the position to claim and enjoy their rights and freedoms. The combined realities of women and girl children as the ones who are mostly subjected to gender-based violence, including sexual violence, and of women and girl children as the ones who are more vulnerable to HIV, seems to be a reflection of the shared determinants between gender-based violence and HIV and AIDS.

Based on the principled understanding that sexual violence and abuse is a gendered phenomenon, it could be argued, that the nature and extent of sexual violence and abuse is a reflection of existing social, cultural and economic imbalances and disparities between women and men. Hence, sexual violence and abuse mirrors not only prevailing gender inequalities, but also all other forms of social inequalities and imbalances.[11] And it is within this context that gender-based violence is as much a cause for women's increased vulnerability to HIV, as it is a consequence. Subsequently, women are not only prone to be 'victims' of gender-based violence and, thus, more vulnerable to contracting HIV, they are also often subjected to violence due to being infected with the virus.

It is further argued, that while HIV and AIDS exacerbates women's economic and social insecurity, it is the very same economic and social insecurity of women that increases their vulnerability to HIV infection.[12] Not only are women mostly affected by prevailing socio-economic inequalities and imbalances, but these very same imbalances also place women at greater risk of exposure to HIV. Engaging in transactional sex and the perceived inability to leave abusive relationships due to economic dependency are but two of the indicators illustrating women's greater vulnerability to contracting HIV due to gendered socio-economic inequalities and imbalances.

In addition, it is women and girl children who are not only carrying the increased burden of care, but also who increasingly taken out of education and spheres of paid employment so as to care for the sick and dying family, household and community members [Kistner, 2003].

Some of the other factors defining women's greater vulnerability to, and the link between, gender-based violence and HIV and AIDS are:

- Women are seldom in the position to negotiate safer sex. Women living in abusive relationships are even less in the position to negotiate safer sex, since violence or the threat of violence further limits their ability to negotiate.
- Women who are subjected to sexual violence and/or coercive sex are at greater risk of contracting HIV as a direct consequence of physical trauma, injuries and bleeding.
- Women who are living with HIV are often subjected to violence and abuse by partners, families and communities. Subsequently, disclosing one's HIV status to one's partner, as well as seeking counselling and treatment is often limited due to fear. For women, this fear is not only related to stigma and discrimination, but also to violence and destitution.[13]
- Lack of access to protective measures and services, including PEP, increase women's vulnerability and further perpetuates the status quo.

Challenges

In the context of gender-based violence and HIV and AIDS, the challenge seems to be not only the gendered context of society defining women's inequalities and, thus, greater vulnerabilities to violence and HIV, but also the inadequate application and implementation of existing legislative and policy measures meant to 'protect' from and against violence, meant to 'protect' from discrimination and violation. Prevailing discriminatory practices and attitudes and the seemingly societal acceptance of gendered violence combined with a resistance to change further perpetuates the status quo of women and girl children's greater vulnerability to not only violence and abuse, but also to HIV and AIDS. Furthermore, it is a lack of adequate resources and services, as well as the limited access to existing resources and services, including shelters and care facilities, that largely defines the realities and challenges a vast majority of survivors of violence and of people living with, and affected by, HIV and AIDS are faced with.

It is also the persistent gender stereotypes and beliefs that seem to justify not only the occurrence of violence and abuse, but also women's greater vulnerability to violence and thus HIV. Subsequent stigmatisation and discrimination further limit the extent to which survivors, as well as people living with, and affected by, HIV and AIDS are in the position to claim their fundamental human rights and to access services.

If the principled understanding is that women are both more vulnerable to be subjected to violence and abuse and are at greater risk to contract HIV, then, as can be argued within a human rights framework, HIV and AIDS is as imperative to the gender-based violence response, as gender-based violence is imperative to the HIV and AIDS response. It is within that context that HIV and AIDS demands as much a human rights-based response, as gender-based violence. Furthermore, it is women and girl children's greater vulnerability to sexual violence and to HIV and AIDS that should be seen and responded to as a violation of their fundamental human rights.

Recognising the limited access to protective measures and services for both survivors and people living with, and affected by, HIV and AIDS, arguably, demands acknowledging that the 'HIV positive survivor' will experience even greater obstacles and barriers and be at greater risk of stigmatisation, discrimination and violation. While there is a need to respond holistically to survivors of sexual violence and abuse, it raises the question as to the extent to which existing services take the multiple realities of survivors into account. Acknowledging the lack of adequate resources and services for survivors, arguably, places additional burdens on the survivor who is also HIV positive. Similarly, the lack of adequate resources and services for people living with HIV places an additional challenge on the person living with HIV who is also a survivor.

The question could be raised as to whether or not available services are equipped to cater for survivors who are infected with, and affected by HIV and AIDS. In this context, some of the recurring questions seem to be whether or not prevention strategies are holistic enough in their approach to raise the intrinsic link between gender-based violence and HIV and AIDS? Whether or not available services and treatments are in the position to adequately respond to the 'HIV positive survivor'? And whether or not prevention, treatment, support and care structures should focus primarily on either the need of the survivor or the need of a person living with HIV and AIDS?

The recurring answer seems to be that only a holistic human rights-based response involving all sectors and acknowledging the link between gender-based violence and HIV and AIDS in all aspects of prevention, treatment and care, as well as in policy and law making can begin to provide an adequate response to survivors of sexual violence and abuse and to people living with, and affected by, HIV and AIDS.

If gender-based violence and HIV are to be addressed, and responded to, from a human rights perspective, then gender-based violence and HIV can neither be seen in isolation from one another, nor can gender-based violence and HIV be adequately addressed and responded to in isolation from other fundamental human rights, such as reproductive and sexual health rights and/or socio-economic rights.

Thus, the challenge seems to be to not only respond to gender-based violence **or** to HIV and AIDS from a human rights perspective and framework, but also to develop a holistic approach and response to gender-based violence **and** HIV and AIDS based on fundamental human rights principles of human dignity, equality and non-discrimination. This also demands integrating the gendered context of society, as well as the gendered nature of reproductive and sexual health rights, and of socio-economic rights, as much into the theoretical discourse as into the practical response to gender-based violence and to HIV and AIDS realities. Adopting a holistic integrative approach would further imply to acknowledge and address the apparent lack to adequately respond to the realities and needs of the LGBT community as it pertains to violence and abuse, as well as to HIV and AIDS.

Finally, it can be argued, that as long as the response to gender-based violence and HIV and AIDS remains fragmented, the inadequate implementation and application of existing legislative and policy measures prevail and resource allocations continue to be limited, the extent to which survivors and people living with HIV are in the position to claim and enjoy their rights will remain limited accordingly. Only a holistic, integrative and human rights-based response to the link between gender-based violence and HIV and AIDS will create an enabling environment in which equal entitlement and enjoyment of all rights and freedoms can become a reality, irrespective of one's gender and/or HIV status.

FOOTNOTES:

1 An earlier version of this paper was presented at the Imbiza Intersect Coalition First Provincial Conference, 22 June 2004, East London, South Africa.
2 The Constitution of South Africa, Act 108 of 1996.
3 Domestic Violence Act (No 116 of 1998).
4 Sexual Offences Act (No 23 of 1957).
5 UNAIDS. 2004 Report in the Global AIDS Epidemic: July 2004.
6 RHRU. 2004. HIV and Sexual Behaviour Among Young South African: A national survey of 15 – 24 year old.
7 Dorrington R et al. 2002. HIV/AIDS Profiles in the Provinces of South Africa.
8 SAPS. 2003. Annual Report of the National Commissioner of the South African Police Service 1 April 2002 to 31 March 2003. See also Human Rights Watch Report 2004.
9 Kistner U. 2003. Gender-based violence and HIV/AIDS in South Africa. CADRE.
10 See Human Rights Watch Report 2004. Deadly Delay: South Africa's efforts to prevent HIV in survivors of sexual violence.
11 Gordon & Crehan. 'Dying of Sadness: Gender, sexual violence and the HIV epidemic.
12 Kistner U. 2003. Gender-based violence and HIV/AIDS in South Africa. pp. 18-19.
13 Fox, S. 2003.Gender-based violence and HIV/AIDS

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Feedback...

In preparation for the consultation on the International Guidelines n HIV/AIDS and Human Rights held in March 2004, the AIDS Legal Network facilitated capacity building workshops with our provincial partners and affiliates in 5 provinces, namely Kwa-Zulu Natal, Eastern Cape, Mpumalanga, Limpopo and the Free State. The aim of these workshops was to introduce the Guidelines and to share experiences of how the Guidelines have been, and could be, used as an advocacy tool.

While the responses to, and feedback from, the various provinces varied in accordance with specific provincial needs and realities, there were a number of common issues and concerns raised, including:

- Lack of involvement, consultation, accountability and transparency amongst stakeholders in developing, implementing and evaluating policies
- Lack of gender awareness to protect and ensure women's rights in clinical research and in access to treatment
- Lack of a holistic approach to prevention, treatment, care and support
- Limited access to, and information on, female condoms
- High levels of stigma and discriminatory attitudes and behaviours towards people living with HIV and AIDS

These workshops clearly indicated not only a general lack of knowledge of the Guidelines, but also the need for further awareness raising and capacity building on the principles outlines in the Guidelines, as well as the mechanisms on how to use the Guidelines as an effective advocacy tool.

...most of us did not even have a clue about the guidelines, but now we will be able to teach others... [Limpopo Participant]

...this workshop is not spread as widely as it should be. We are a drop in the ocean... [Mpumalanga Participant]

...ALN should follow up on the how to lobby and on advocacy strategies... [Free State Participant]

...keep up doing the good job, organise more meetings and workshops, especially training of these guidelines, as for most of us it is a new thing... [Limpopo Participant]

...I require ALN to give follow up support in the form of training... [Eastern Cape Participant]

...a report of today's workshop will be useful to the training I need to provide to the community that I serve... [Kwa Zulu Natal]

In addition, participants highlighted the need for accessible and translated information and material pertaining to the Guidelines.

...I require ALN to follow up with booklets that are easy to carry and that are in translated language... [Eastern Cape Participant]

...translation of the guidelines into other languages is needed... [Mpumalanga Participant]

the fact that there are international guidelines gives hope and encouragement

...the presentation was very theoretical, more so because of the subject matter as opposed to the presenter... [Kwa Zulu Natal Participant]

...the format of the workshop was fine...although there is a need for language simplicity... [Free State Participant]

From these provincial meetings and debates we learnt that even though the majority of organisations had not heard of, or seen, the Guidelines, there is an understanding of the principles contained in the Guidelines. However, we also learnt in these meetings that there is a general lack of comprehension and understanding of issues pertaining to the LGBT community, microbicides, sex workers and prison population and thus, a need for more capacity building on these issues.

...the fact that there are international guidelines gives hope and encouragement... [Limpopo Participant]