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IMINYANGO

Welcome to our first edition

This is the first edition of Iminyango, a publication aimed at providing information on the intersections between gender-based violence and HIV/AIDS in southern Africa.

What are these intersections between gender-based violence and HIV/AIDS?

In recent years, there has been an increased recognition of the gendered aspects of the HIV pandemic. At the same time, progress has been made in acknowledging the linkages or intersections between gender-based violence and HIV/AIDS. While these intersections were initially mainly seen in the provision of post-exposure prophylaxis following sexual assault, we now understand it as a much more complex relationship. *We explore the intersections between gender-based violence and HIV/AIDS in more detail on page 2 of this issue.*

Why the focus on Southern Africa?

Southern Africa, which has the highest HIV prevalence in the world, has correctly been described as 'the epicenter of the HIV/AIDS pandemic'. The SADC Heads of State and Government acknowledged in the Maseru Declaration (2003) that HIV/AIDS is currently posing the greatest threat to sustainable development in the subregion. Due to the specific regional dynamics (including migration), insulated national strategies will not contain the pandemic. Although the HIV epidemics across Southern Africa are not homogeneous, there are certain commonalities, such as the fact that women are disproportionately affected. *We look at the most recent statistics on page 4 of this edition.*

Is there only bad news from Southern Africa?

The picture is not all bleak. In sub-Saharan Africa, the number of people receiving treatment increased more than eight-fold (from 100 000 to 810 000) between 2003 and 2005. Most of this trend is due to increased treatment access in Southern African countries (including Botswana, South Africa, and Zambia). The subregion has also seen a number of positive developments, such as the drafting of a *SADC HIV/AIDS Framework and Programme of Action for 2003-2007*, the adoption of the *Maseru Declaration* by the SADC states in 2003, and the appointment by the UN Secretary-General of a *Task Force on Women, Girls and HIV/ AIDS in Southern Africa*. However, these events have yet to be consolidated into tangible and sustainable benefits for persons vulnerable to both gender-based violence and HIV/AIDS.

What will this newsletter focus on?

Because of the fluid and constantly changing nature of the HIV pandemic, responses to HIV/AIDS are also continually shifting. Many organisations in southern Africa are doing work to address the intersections between gender-based violence and HIV/AIDS, and have developed innovative strategies as well as resources such as training manuals, pamphlets, posters and other information material. These are the projects that we would like to write about.

On a broader level, we also aim to provide a platform for debate about contentious issues such as the compulsory HIV testing of sexual offenders (which we discuss on page 3 of this issue), the criminalization of harmful HIV-related behaviour and related topics.

The newsletter is specifically intended to encourage communication and interaction between organisations working in the gender-based violence and the HIV/ AIDS sectors. We hope that this first edition will be the initial step towards an ongoing and vibrant dialogue and information and skills exchange in Southern Africa. Readers are warmly invited to send articles or other contributions for publication. Organisations from outside South Africa are specifically encouraged to contribute.

'Iminyango' is the isiZulu word for 'doors'. This title is derived from the following explanation for the intersection between gender-based violence and HIV/AIDS, given by a survivor of domestic violence (who had also contracted HIV from her abusive partner):

"Gender-based violence happens behind closed doors and HIV is killing women behind those closed doors. The solution is to break down those doors."

The Fatal Connection

Lorenzo Wakefield investigates how violence against women is linked to HIV/AIDS.

The Declaration on the Elimination of Violence Against Women (1993) defines violence against women as any act of gender-based violence that 'results in, or is likely to result in, physical, sexual or psychological harm or suffering, whether occurring in public or private life, in the family, in the community, or perpetuated or condoned by the State'. Given this broad understanding of violence against women, the links between violence against women and HIV/AIDS can be made on many different levels. The UN Special Rapporteur on Violence Against Women devoted her 2005 thematic report to the intersections of violence against women and HIV/AIDS, and highlighted some circumstances where these links can be made. We briefly discuss some examples below.

As a starting point, one must bear in mind that women are more susceptible than men to HIV infection, due to physiological, socio-cultural and economical factors (as explained by Amnesty International in its 2004 report on women, HIV and human rights). These factors also play a role in the examples that we discuss here.

1. Rape and Sexual assault

Considering the fact that HIV/ AIDS is spread most frequently through unprotected heterosexual intercourse, rape and sexual assault are closely linked to women contracting HIV. As the UN Special Rapporteur notes: "Rape and sexual assault take away women's control over when, with whom, and how they have sex, significantly increasing risk of HIV." [Par 28]

2. Domestic and intimate partner violence

The UN Special Rapporteur states that in a domestic setting, physical violence is often accompanied by sexual abuse, making it difficult, if not impossible, to have safer sex. With this in mind, it should also be noted that domestic violence also entails psychological and economic abuse. An example of psychological abuse would be where a wife knows that her husband has multiple sexual partners, but when she asks him to go for a HIV test, he refuses. This can seriously compromise the wife's psychological and emotional wellbeing. An example of economic abuse would be where a husband, who knows that his wife is living with HIV/AIDS and needs ARV [anti-retroviral] treatment, takes away his wife's money so that she is unable to travel to the clinic for her treatment.

3. Violence related to condom usage

Vetten and Bhana (2001) note that women fear that they may encounter some form of violence if they insist on condom usage. Women in such circumstances are often perceived by their partners, as having sexual affairs outside of the relationship. The woman's insistence on condom usage is thus not seen as a mechanism used to prevent both against the transmission of HIV/ AIDS, but is used by the man as an excuse for abuse of the woman.

4. Violence related to commercial sex work

The UN Special Rapporteur states that women's lower socio-economic status is directly connected to their work in the sex industry. Women in the sex industry, with multiple sexual partners, have a higher susceptibility to HIV and violence than most other population groups. For example, surveys in South Africa have shown that sex workers in the "truck route" sex industry faced violent reactions, loss of clients or loss of income for insisting on condom usage.

5. Violence following disclosure of HIV status

Vetten and Bhana found that many women fear the possibility of being attacked once they reveal that they are HIV positive. These attacks may come not only from their partners, but also from the broader community. The fact that stigmatization of people (and specifically women) living with HIV/AIDS continues is confirmed by the UN Special Rapporteur, who notes that across cultures, stereotypes remain that people living with HIV/AIDS contracted the disease through some sort of deviant activity [Par 55].

The examples set out here provide only a few 'snapshots' of how violence against women can be both a cause and a consequence of HIV/AIDS. There are also other areas of intersection that we have not explored here, most notably violence in armed conflict. An issue that has not been spoken about enough in Southern Africa is the potential connection between HIV/AIDS and traditional practices, including early marriage and widow inheritance, as well as harmful sexual practices such as 'dry sex'.

Ultimately, it is important for us to recognize not only the fatal intersections between violence against women and HIV/AIDS, but also the fact that these intersections can be traced back to women's lack of sexual autonomy, their economic disempowerment and the oppressive societal and cultural norms that result from women's inequality. Only then can we begin to address the symptoms.

SOURCES

Amnesty International *Women, HIV/AIDS and Human Rights* (24 November 2004)
AI Index: ACT 77/084/2004
[www.amnesty.org, follow links to 'Library']

L Vetten & K Bhana *Violence, Vengeance and Gender* (2001)
[www.csvr.org.za/papers/paplvkb.pdf]

UN Special Rapporteur on Violence Against Women, Its Causes and Consequences *Intersections of Violence Against Women and HIV/AIDS* (17 January 2005)
Reference: E/CN.4/2005/72
[www.ohchr.org/english/issues/women/rapporteur/annual.htm]

A Victory for Victims' Rights –

Or just a false sense of security?

Helene Combrinck examines the debates around the compulsory HIV testing of alleged sexual offenders in the context of the Sexual Offences Bill currently before parliament.

At the time of writing, the national assembly portfolio committee on Justice and Constitutional Development is in the process of deliberating on the Criminal Law (Sexual Offences and Related Matters) Amendment Bill B50-2003, and although no specific date has been set for completion, it would appear that the committee is in the final stages of its work on the Bill.

One of the more contentious aspects of the Bill is that of compulsory HIV testing of alleged sexual offenders. The provisions currently included in the Bill are mostly derived from the 'Compulsory HIV Testing of Alleged Sexual Offenders Bill' [B10-2003], introduced in parliament in 2003.

The proposed legislation allows for a victim of a sexual offence to make an application to a magistrate within 90 days after the alleged commission of the offence for an order that the alleged offender be tested for HIV.[1] The application must be handed to the investigating officer, who must, as soon as is reasonably possible, submit it to a magistrate. An application may also be brought by 'an interested person' on behalf of a victim, provided that the victim gives his or her written consent. The Bill further provides for the victim to request that the HIV test results, already obtained on application by the investigating officer as explained below, be made available to her.

The results of the HIV test will be disclosed to the victim and to the alleged offender. In practice, the investigating officer will hand to the victim the sealed record of the test results and a notice containing prescribed information on how to deal with the test results, and if necessary, explain the contents of the notice.

A new provision, which was not included in the 2003 Compulsory HIV Testing of Alleged Sexual Offenders Bill, allows for an investigating officer to apply to a magistrate for an order that the alleged offender be tested for HIV or that the HIV test results of the alleged offender, already obtained on application by the victim, be made available to the investigating officer or prosecutor. The purpose of making the results available to the investigating officer is for purposes of investigating the sexual offence and to the prosecutor when he or she needs to know the results for purposes of the prosecution of the matter or any other court proceedings.

The Bill explains that the results of an HIV test may only be used to inform a victim whether or not the alleged offender is infected with HIV with the view to "empowering the victim to make informed medical, lifestyle and personal decisions", or use them as evidence in any ensuing civil proceedings as a result of the sexual offence in question. The result may also be used to enable an investigating officer to gather information with the view to using them as evidence in criminal proceedings.

The Bill further makes provision for a register of applications and orders, for maintaining confidentiality around the outcome of applications and HIV results obtained and creates certain offences, including bringing an application with malicious intent.

Civil society organisations, including victims' rights organizations, have responded to these provisions with strong opposition. The first concern is that the victim's decision whether or not to access post-exposure prophylaxis [PEP] should be taken independently of the alleged perpetrator's s HIV status. As it currently stands, all HIV tests except the polymerase chain reaction (PCR) test can potentially deliver a so-called 'window' period, where the subject may test negative although he or she is in fact HIV positive. This may leave the victim with a false sense of security, and is therefore not useful in assisting her in making medical, lifestyle and personal decisions.

It should further be remembered that the test indicates the alleged offender's status at the time of *testing*, and not necessarily at the time of the alleged incident. The longer the time period between the incident and the test, the more tenuous the inference becomes that the offender's HIV status at the time of the alleged incident was the same as at the time of testing. (Interestingly, at the time when most of the organizations made their written submissions, the draft Bill provided that the victim had to bring her application for testing within 60 days after the incident. This has now been amended to 90 days.)

A further concern is that the results will be disclosed to both the victim and alleged offender without any pre- or post-test counseling (although the portfolio committee intends to overcome this difficulty by means of the notice which will accompany the results).

The National Working Group on the Sexual Offences Bill and other organizations therefore recommended that rather than putting energy and funding into the implementation of compulsory HIV testing provisions, the State should focus on the provision of comprehensive and accessible services for victims of sexual offences.

However, the portfolio committee was not swayed by these arguments, and the provisions have stayed. It remains to be seen how compulsory testing will play out in practice: whether it will serve to empower victims of sexual assault, or whether it will further shift the focus away from these victims and their interests.

Footnotes

1 This discussion is based on the draft Bill dated 10 October 2006. A copy can be accessed via the committee minutes at www.pmg.org.za.

Counting the Cost:

HIV Prevalence in Southern Africa

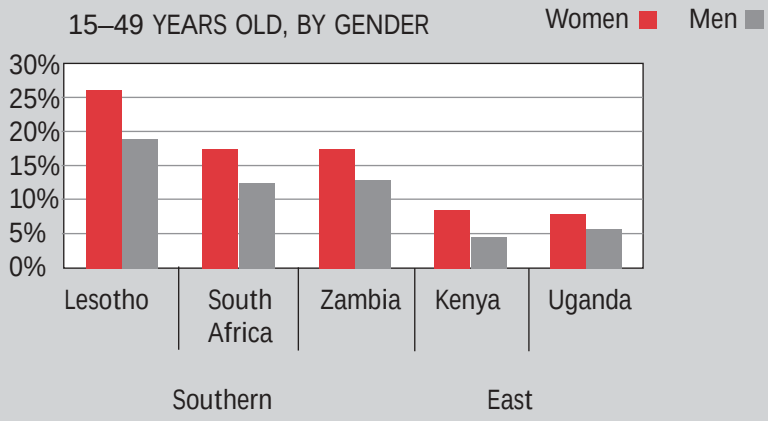
According to the 2006 UNAIDS report on the status of the AIDS epidemic, national infection levels are exceptionally high in all southern African countries except Angola, as shown in the table below. (In Angola's case, it is thought that isolation during the country's prolonged period of conflict may have served to restrict the spread of HIV.) Moreover, infection levels show no signs of leveling off, with the exception of Zimbabwe, where the estimated national adult prevalence of 20.1% is down from 22.1% in 2003. This decline has been attributed to positive behaviour changes (such as increased condom use) as well as to high mortality rates, which implies that the numbers of people being newly infected with HIV roughly match the numbers of people dying of AIDS-related illnesses.

The UNAIDS report notes that in most of the sub-Saharan region, women are disproportionately affected by the AID epidemic, compared with men – "expressions of the often highly unequal social and socioeconomic status of women and men". In this region, on average, three women are infected for every two men. Among young people (15-24 years), this ratio widens considerably: three young women are infected for every young man. Figure 1 shows the difference between women and men in estimated HIV prevalence for the age group 15-49 years for six countries in southern and eastern Africa.

All information for this article obtained from the UNAIDS *2006 Report on the Global AIDS Epidemic* (pp 15-23). This report can be accessed at www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

Country	Estimated national HIV prevalence (%)
Angola	3.7
Botswana	24.1
Democratic Republic of Congo	3.2
Lesotho	23.2
Malawi	14.1
Madagascar	0.5
Mozambique	16.1
Namibia	19.6
South Africa	18.8
Swaziland	33.4
Tanzania	6.5
Zambia	17.0
Zimbabwe	20.1

Figure 1: Estimated national HIV prevalence (%)



[**Source:** UNAIDS *2006 Report on the Global AIDS Epidemic* (2006) at 19.]

Editorial Team: Heléne Combrinck, Lorenzo Wakefield

Contact Details: Gender Project • Community Law Centre • University of the Western Cape • Private Bag X17 • Bellville, 7535

Tel: +27 21 959 3602/ 2353 • Fax: +27 21 959 2411

Email: hcombrinck@uwc.ac.za
www.communitylawcentre.org.za

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COMMUNITY LAW CENTRE
University of the Western Cape

UNIVERSITY of the WESTERN CAPE