

HIV is not for me: A study of African women who have sex with women's perceptions of HIV/AIDS and sexual health

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Summary

Women who have sex with women face a unique, yet under-researched set of HIV/AIDS-related risks in sub-Saharan Africa. The findings of this study highlights a tension that, on the one hand, exists between the heteronormativity of healthcare providers and broader society, and the ways in which this silences lesbians and other women who have sex with women in their healthcare interactions and, on the other, the totalising view of WSW sexualities within this community, which silences conversations about HIV because such conversations may expose or accuse a person of 'not being a real lesbian'. The women within the African lesbian, gay, bi-sexual, transgender and intersex (LGBTI) community who participated in our study had scant access to credible HIV/AIDS and safe-sex information, resulting in various and dangerous (mis)conceptions proliferating. The vulnerability of lesbians and other

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WSW to HIV infection is a complicated public health issue that is perplexing to some and ignored by many, not only on the African continent, but globally. Our research indicates that some WSW engage in high-risk behaviour that places them at an increased risk for HIV transmission. Furthermore, a lack of access to inclusive prevention and healthcare services and an unwillingness to seek treatment are often the consequence of stigma and discrimination and point to distinct inequalities for female-identified LGBTI persons. The study explored the prevailing perceptions of women within the LGBTI community on HIV/AIDS, using various fora, including social media sites, anonymous surveys and anecdotes shared anonymously with the organisation, and which highlights the urgent need for specifically-tailored sexual health and HIV-preventative and coping strategies toward improved health outcomes and an understanding of this vulnerable group. In addition, the experience of our participants demonstrated a strong demand for LGBTI health needs training for healthcare professionals, with a specific focus on the depathologisation of LGBTI identities on the continent. Potential strategies and further research in this community are suggested.

Key words: HIV/AIDS; sexual health; women who have sex with women (WSW); Queer African Women; African Women's Protocol

1 Introduction

In many parts of Africa, rights discourses about gender and sexuality have been most prominent in the post-colonial period. This has meant that the African state mechanism has been assigned distinct obligations for the realisation of the rights of women and sexual minorities – albeit not explicitly with respect to non-discrimination on the basis of sexual orientation. However, the emergence of extreme levels of gender-based violence in this period points to a type of 'patriarchal backlash', resultant from a shift in focus away from essentialised notions of womanhood towards more fluid and varied expressions. Problematic rhetoric about the susceptibility of lesbian and bisexual women to HIV has become dominant; managing to quell the dissemination of scientifically-verifiable, appropriate and relevant information, thereby allowing for problematic notions to become central to thinking on issues of sexual health and safer sexual practices and leaving an already vulnerable group in an even more vulnerable position.

Distinct discursive nodes, shaped by social forces, have emerged as a result of this 'confused state'. Therefore, any attempt to accurately address the challenges women who have sex with women (WSW) face with HIV would identify the ways in which specific 'folk' knowledge is being created within various spaces – particularly online blogs and social media sites, the central objective being to evaluate the discourses on HIV that are emerging online among African women performing non-normative sexualities.

Our research found that young, non-normative African women are using social media tools to create a large number of groups where discussions about gender and sexuality occur and events, focusing on sexual identity and performance, like 'open-mic' nights, are promoted. Some of these groups are extremely vibrant and active, while others 'pop up' for shorter periods of time; usually being organised around a particular concern, such as the controversies that occurred during the 2012 Johannesburg Gay Pride Festival. However, regardless of the permissiveness of the online space, our research has shown that sexual health issues are rarely addressed and, where they are addressed, they are often inaccurate. Therefore, the primary motivation for this study is the high number of problematic statements made on certain social media platforms, pertaining to the sexual health strategies taken up by WSW to mitigate the impact of HIV. Although it must be noted that information on safe(r) sex for African WSW was presented on a few sites, with posts such as 'Unwrap me'¹ and 'On hot safe lesbian sex',² these posts were the exception rather than the rule.

WSW's silence about sexual health mirrors wider societal silences about non-conforming women and their location within the pandemic. Healthcare providers are often under-prepared or unwilling to adequately cater to the needs of WSW, which leads many WSW to believe that they cannot be affected by the illness. Unfortunately, these silences mask the fact that there is indeed a need for equitable access to sexual health information and services; while also hiding a significant social group that is being denied their right to sexual health through state-sanctioned heterosexism.

2 Human rights framework

2.1 Context

HIV has challenged the ways in which African states think about the relationship(s) between public health, sexuality and the law, and has been one of the biggest threats to development and sustainable livelihoods.³ Globally it has been recognised that women comprise one of the more vulnerable groups to the pandemic because of the interaction between their biological and socio-cultural susceptibilities. The marginalisation of women directly impacts their health status and their ability to fully realise their health rights. Therefore, feminist scholars have been arguing for gendered approaches to public health that analyse and address the ways in which structural, social, cultural

1 Miss Pamstar 'Unwrap me, indulge, but cover your tools' 11 September 2012 <http://www.holafrica.org> (accessed 29 June 2013).

2 Lady Mango 'On hot safe lesbian sex' 4 July 2013 <http://www.holafrica.org> (accessed 4 July 2013).

3 KM de Cock *et al* 'Shadow on the continent: Public health and HIV/AIDS in Africa in the 21st century' (2002) 360 *The Lancet* 67-72.

and biological factors interact to promote and/or impede the ability of women to access health care and to secure protection from HIV and other sexually-transmitted infections (STIs).⁴

Utilitarian considerations have traditionally underpinned public health approaches to disease control which, in their most extreme manifestations, focused on isolating affected populations as a means of containing infectious diseases; thereby limiting their spread amongst the general population. The emergence of the HIV pandemic in the post-World War II period has meant that public health has necessarily been subjected to human rights standards. To this extent, utilitarianism, crude cost-benefit analyses and social contract theories have been challenged and subordinated to the principles of social justice⁵ and equality, demonstrated by the application of human rights norms and principles to HIV activism and litigation in South Africa in the early 1990s and 2000s.⁶

2.2 Non-discrimination

It can be said that the defining characteristic of international human rights discourse is the notion of non-discrimination.⁷ This principle is articulated in the African Charter on Human and Peoples' Rights⁸ (African Charter) to mean that 'every individual shall be entitled to the enjoyment of the rights and freedoms guaranteed [with]in the ... Charter without discrimination of any kind'.⁹

Internationally, advocacy for the recognition of the right to non-discrimination for sexual minorities has been framed in terms of the right to privacy. In the seminal case of *Toonen v Australia*,¹⁰ the complainant challenged the criminalisation of same-sex consensual sexual conduct on the grounds that it violated his right to privacy by failing to distinguish between 'sexual activity in private and sexual activity in public', thereby bringing 'private activity into the public

4 V Tallis 'Health for all? Women who have sex with women health needs and issues' in V Reddy *et al* (eds) *From social silence to social science: Same-sex sexuality, HIV/AIDS and gender in South Africa* (2009) 216.

5 S Corrêa *et al* *Sexuality, health and human rights* (2008) 152.

6 M Mbali 'The Treatment Action Campaign and the history of rights-based, patient-driven HIV/AIDS activism in South Africa' Research Report 29, Centre for Civil Society, University of KwaZulu-Natal; P Jones & K Stokke *Democratising development: The politics of socio-economic rights in South Africa* (2005); E Cameron 'Legal and human rights responses to the HIV/AIDS epidemic' (2006) 17 *Stellenbosch Law Review* 47.

7 CE Welch Jr 'Human rights and African women: A comparison of protection under two major treaties' (1993) 15 *Human Rights Quarterly* 549-574.

8 African Charter on Human and Peoples' Rights, Organisation of African Unity 27 June 1981, CAB/LEG/67/3 Rev 5, 21 *ILM* 58 (1982), entry into force 21 October 1986, reprinted in C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2013) 29.

9 Art 2 African Charter.

10 *Toonen v Australia* CCPR/C/50/D/488/1992, UN Human Rights Committee, 4 April 1994.

domain'¹¹ which, it was further argued, would have the undesired effect of enabling unlawful attacks on the 'honour and reputation'¹² of 'suspected' individuals. In elaborating on the content of the right, the Committee held that the right to non-discrimination within the Universal Declaration of Human Rights (Universal Declaration) on the basis of 'sex'¹³ could be 'taken as including sexual orientation'.¹⁴

Within the African regional system, there is no explicit recognition of the right to non-discrimination on the basis of sexual orientation. However, the interpretive provisions of the African Charter state that the African Commission on Human and Peoples' Rights (African Commission) shall 'draw inspiration from international law',¹⁵ especially from the provisions of both international and regional legal instruments. The African Charter further states that 'international norms ... customs generally accepted as law, general principles of law recognised by African states as well as legal precedents and doctrine'¹⁶ shall be taken 'into consideration' for the purposes of interpretation.

Internationally, the right to non-discrimination is codified in a number of instruments. The notion was first articulated in article 2 the Universal Declaration, where it reads: 'Everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind.'¹⁷ A similar expression of the right to non-discrimination is found in the International Covenant on Civil and Political Rights (ICCPR), where state parties are compelled 'to ensure to all individuals' within their territory to enjoy the rights within ICCPR without 'distinction of any kind'.¹⁸ ICCPR further states that 'all persons are equal before the law and are entitled without any discrimination to the equal protection of the law'.¹⁹ The International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees non-discrimination in similar terms to the aforementioned instruments, as it states: 'The rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex ... or other status.'²⁰ The phrase 'or other status' as mentioned in these three treaties indicates that the recognised grounds for non-discrimination are not exhaustive, but can be expanded to accommodate new classes of people and/or new instances of discrimination.

11 *Toonen* (n 10 above) para 3.1.

12 As above.

13 UN General Assembly Universal Declaration of Human Rights, 10 December 1948 217 A (III).

14 *Toonen* (n 10 above).

15 Art 60 African Charter.

16 Art 61.

17 Universal Declaration of Human Rights (n 13 above).

18 Art 2(1) ICCPR.

19 Art 26 ICCPR.

20 Art 2(2) ICESCR.

In presenting their central thesis, Murray and Viljoen²¹ argue that the drafters of the African Charter borrowed from ICESCR. They hence argue that, in the wording of the non-discrimination provisions of the African Charter, the utilisation of the phrases 'such as' and 'or other status' indicates that the grounds for non-discrimination within the Charter are not exhaustive, meaning that it is possible that the right to non-discrimination on the basis of sexual orientation is implied within the provisions of the African Charter.

2.3 Right to health

The right to health, as it was first articulated in ICESCR, does not imply the right to be healthy, which is impossible to guarantee. Instead, it is understood as the right of all persons, irrespective of their sexual orientation,²² to the 'highest attainable standard of physical and mental health'.²³ The definition of the right to health is not confined to clinical health care, and has been interpreted to include the underlying determinants of health, such as 'healthy occupational and environmental conditions and access to health-related education and information, *including on sexual and reproductive health*'.²⁴ Affirming this, the African Charter recognises a general right of individuals to 'enjoy the best attainable standard of physical and mental health',²⁵ and further obligates states to take 'the necessary measures to protect the health of their people'.²⁶

The right to health is a classical socio-economic right in that it is programmatic in its nature, meaning that states are required to enact laws and devise policies that create the conditions necessary for its realisation. This characteristic of socio-economic rights has called to question their justiciability. However, the fact that international law has evolved to recognise that all human rights are 'interdependent, indivisible and mutually supporting'²⁷ has led to the recognition and enforcement of the existence of a right to health. The African Commission has confirmed the justiciability of socio-economic rights under the African Charter in both *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria*²⁸ and *Purohit & Another v The*

21 R Murray & F Viljoen 'Towards non-discrimination on the basis of sexual orientation: The normative basis and procedural possibilities before the African Commission on Human and Peoples' Rights and the African Union' (2007) 29 *Human Rights Quarterly* 89.

22 UN ESCR Committee General Comment 14: The right to the highest attainable standard of health (art 12), 11 August 2000, E/C12/2000/4 para 12.b.

23 Art 1(1) ICESCR.

24 General Comment 14 (n 22 above) para 11 (our emphasis).

25 Art 16(1) African Charter.

26 Art 16(2).

27 DM Chirwa 'The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine' (2003) 19 *South African Journal on Human Rights* 556.

28 (2001) AHRLR 60 (ACHPR 2001).

Gambia.²⁹ The latter case established that the right to health was not limited to access to health care, but also included 'every other supporting treatment, management or service'³⁰ that promotes the best standard for 'everyone regardless of age, sex or gender'.³¹

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) articulates the meaning of the right to health with respect to women. It provides that state parties should take 'all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to healthcare services'.³² It also recognises the importance of the provision of educational information for wellbeing and health.³³ Discrimination for the purposes of CEDAW is defined as 'any distinction, exclusion or restriction made on the basis of sex that has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, *irrespective of their marital status ...* of human rights and fundamental freedoms'.³⁴ While CEDAW is a landmark document because of its codification of women's rights in explicit terms, it falls short because of its vagueness and tendency to frame the needs of women solely in relation to men, without recognising the inherent heterogeneity of the category 'woman'.

Socio-political, economic and structural factors determine the extent to which women can realise their rights and freedoms.³⁵ It is critical to recognise that in heterosexist societies, where female personhood tends to be framed exclusively in terms of motherhood and the associated stereotypical heteronormative, gender roles, silences about the differences between women and the power hierarchy thus created often mean that 'othered' women, such as those who engage in same-sex amorous relationships, are further marginalised in ways that limit their equal access to and participation in the public sphere. This silencing of non-normative women is further aggravated by the construction of non-discrimination for same-sex practising individuals as a matter that hinges on non-interference with the right to privacy. Programmatically speaking, this facilitates heterosexism in public discourses about women's health because at its most minimalist construction, the right to non-discrimination on the basis of sexual orientation merely requires the state to respect the private space, without any consideration of how the very same principle can be used to ensure the full and equitable realisation of the

29 (2003) AHRLR 96 (ACHPR 2003) para 96.

30 V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the protection of sexual and reproductive rights' (2011) 11 *African Human Rights Law Journal* 380.

31 As above.

32 UN CEDAW Committee General Recommendations 19 & 20, adopted at the 11th session, 1992, art 12(1).

33 CEDAW Committee (n 32 above) art 10(h).

34 CEDAW Committee art 1 (our emphasis).

35 M Judge 'Invisibility in plain sight ... lesbian women and HIV' (2008) March *ALQ: AIDS Legal Network* 10.

sexual health rights of counter-heteronormative women. Feminist legal scholars Oloka-Onyango and Tamale argue that women's rights are not simply a private affair, but also extend directly into the essential operations of the state and public sphere,³⁶ therefore, what may be required from the state is positive action as opposed to permissiveness.

The ways in which African states define and enforce women's health rights become crucial because identity construction is dependent on the negotiation and renegotiation of meanings over time.³⁷ Similarly, human rights function as 'powerful symbols'³⁸ in addition to being tools for the realisation of full citizenship by disenfranchised groups. The exclusion of 'othered' bodies in nation states' human rights discourses determines the extent to which citizenship can be accessed.³⁹ Klugman identified three requirements related to the concept of citizenship: the distribution of resources; the recognition of all human beings regardless of their non-conformity; and the availability of mechanisms for people to gain representation.⁴⁰ The erasure of non-normative identities has led scholars⁴¹ to criticise the inherent heteronormativity of traditional definitions of citizenship and has led to 'sexual citizenship' advocacy to establish a counter-hegemonic discourse. Conceptually, sexual citizenship identifies how sexualities shape people's ability to access full citizenship,⁴² and acknowledges that the 'private and intimate'⁴³ practices of sex form part of the realms in which healthy citizenship is constructed. The recognition of the former is particularly important in societies where hierarchies of gender and power work in unison to oppress women and exasperate their vulnerability to violence and disease.⁴⁴

It is trite knowledge that citizenship and rights are mutually-dependent concepts; therefore sexual citizenship should be understood as referring to a status entailing a number of different sexual rights claims. Sexual rights were first put on the agenda at the

36 J Oloka-Onyango & S Tamale 'The personal is political or why indeed women's rights are human rights: An African perspective on international feminism' (1995) 17 *Human Rights Quarterly* 711.

37 K Plummer 'The social reality of sexual rights' in P Aggleton & R Parker (eds) *Routledge handbook of sexuality, health and human rights* (2010) 45-55.

38 Plummer (n 37 above) 49.

39 D Richardson 'The social construction of immunity: HIV risk perception and prevention among lesbians and bisexual women' (2010) 2 *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care* 33-49.

40 B Klugman 'Race, class, gender and sexuality: Challenges for an inclusive citizenship' (2008) 39 *South African Review of Sociology*.

41 Corrêa *et al* (n 5 above) 155.

42 Plummer (n 37 above).

43 Oloka-Onyango & Tamale (n 36 above) 106.

44 J Oriol 'Sexual pleasure as a human right: Harmful or helpful to women in the context of HIV/AIDS?' (2005) 28 *Women's Studies International Forum* 392-404.

International Conference on Population and Development (ICPD),⁴⁵ and it is here that they were erroneously constructed as a sub-category of reproductive rights. The ICPD Programme of Action defined reproductive health as a state where people 'are able to have a satisfying and safe sex life'.⁴⁶ The ICPD went further in identifying reproductive health as being inclusive of sexual health, defined a necessary condition for 'the enhancement of life and personal relations'⁴⁷ and not merely requiring medical interventions related to reproduction and sexually-transmitted diseases. At the Fourth World Conference on Women, sexual rights took prominence and the common position of African states was in favour of the language to sexual rights. African representatives accepted the language of sexual rights because of its usefulness in addressing the impact of gender inequality on women's vulnerability to violence and their powerlessness in the face of HIV.⁴⁸

Fundamentally, sexual rights do not create new rights; instead, they are understood as ensuring the implementation of existing rights to the terrain of sexuality.⁴⁹ This idea of sexual rights as being 'akin to fundamental human rights'⁵⁰ means that, conceptually, sexual rights can be related to other rights, such as the rights to information, education and health, while still requiring distinctive measures for their realisation. This understanding is reflected in how sexual rights are constructed in the Beijing Declaration, which states:⁵¹

The human rights of women include their right to have *control over and decide freely and responsibility on matters related to their sexuality*, including sexual and reproductive health, *free of coercion, discrimination and violence*. Equal relationships between women and men in all matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

This paragraph is commonly referred to as the 'sexual rights paragraph',⁵² because it establishes the most widely-accepted and understood framework for sexual rights. The aforementioned criticisms of CEDAW with respect to women's rights to health can be stated here too: Both the ICPD Platform for Action and the Beijing Declaration frame sexual health rights in reproductive terms and therefore tie them to heteronormative sexual practice. This implies

45 B Klugman 'Sexual rights in Southern Africa: A Beijing discourse or a strategic necessity?' (2000) 4 *Health and Human Rights* 149.

46 UN Population Fund (UNFPA) *Report of the International Conference on Population and Development*, Cairo, Egypt, 5-13 September 1994, 1995, A/CONF.171/13/Rev1, para 7.2.

47 As above.

48 Plummer (n 37 above) 151.

49 Plummer 152.

50 Corrêa *et al* (n 5 above) 393.

51 United Nations Beijing Declaration and Platform of Action, adopted at the 4th World Conference on Women, 27 October (our emphasis).

52 Z Hlatshwayo & B Klugman 'A sexual rights approach' (2001) 16 *Agenda* 14.

that the right to sexual health only applies to heterosexual women. To phrase this in other terms, this drafting error implies that non-normative women do not require the right to sexual health. When it is considered that the importance of the right to sexual health is discussed in the context of HIV/AIDS, it can be argued that this omission perpetuates the idea of 'lesbian immunity'⁵³ to sexually-transmitted diseases at the level of global norm construction. The need for the elaboration of sexual health and sexual health rights was noted by the Special Rapporteur on the Right to Health when (s)he stated that it was misguided to subsume sexual health rights under reproductive rights because of the fact that 'many expressions of sexuality are non-reproductive'.⁵⁴

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)⁵⁵ was adopted to bolster the rights of women under the African Charter, and its most commendable features are its explicit reference to the sexual health rights of women as they relate to HIV and STIs, and its clearer articulation of the correlated obligations of state parties. Prior to this, the African regional system was a mess of declarations and commitments, which did little to empower women to hold their nation states accountable for the realisation of their sexual health rights.

The relevant provisions of the African Women's Protocol are articles 14(1)(d) and (e), which read:⁵⁶

States parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

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- (d) the right to *self-protection* and to *be protected* against sexually-transmitted infections, including HIV/AIDS;
 - (e) the right to *be informed* on one's *health status* and on the health status of one's partner, particularly if affected with *sexually-transmitted infections*, including HIV/AIDS ...

The General Comments of the Special Rapporteur on the Rights of African Women⁵⁷ elucidate the meaning of the right to sexual health in the context of HIV/AIDS, in accordance with the Commission's mandate to 'formulate and lay down ... [persuasive] ... principles and rules'.⁵⁸

53 SJ Fishman & EH Anderson 'Perception of HIV and safer sexual behaviours among lesbians' (2003) 14 *Journal of the Association of Nurses in AIDS Care* 52.

54 ESCR Committee, Special Rapporteur on the Rights to Health: Right to sexual and reproductive health, E/CN.4/2004/49 para 55.

55 African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 11 July 2003.

56 As above.

57 African Commission General Comments on arts 14(1)(d) & (e) of the African Women's Protocol, 6 November 2012.

58 Art 45(1)(b) African Charter.

One of the most striking features of the General Comments' understanding of the right to sexual health is how it is understood to speak to interactions between environmental (such as poor institutions), biological and behavioural factors and how they interact in the creation of women's vulnerability to HIV. This is most clearly shown through the recognition of the right of an individual to be informed about both their own sero-status and that of their partner,⁵⁹ and the way that the Commission has interpreted this right.

It has been argued that couples who embark on long-term sexual or romantic relationships or marry unaware of their partner's HIV status are a source of new HIV infections, and that the sero-negative partners in such discordant relationships are one of the largest and most vulnerable groups in Africa.⁶⁰ This flies in the face of popular presentations of promiscuity as being more correlated to risk of exposure than monogamy, and also highlights the importance of women's access to 'adequate, reliable, non-discriminatory and comprehensive information about their health'.⁶¹ Studies conducted in Southern Africa have shown that the self-reported sero-positive status of lesbian and bisexual identified women is between 6,6 and 9,6 per cent,⁶² which is an alarming sero-prevalence level for a 'no risk' group. It should be noted that, while self-reporting surveys are less statistically credible than studies, they do point to the fact that women who have sex with women are indeed affected by the HIV-virus, and therefore require equitable access to sexual health rights.

The right to be informed about one's health status is applicable to all women irrespective of their marital status. Critics of the Women's Protocol argue that the rights therein continue to be framed in heteronormative terms, using the 'mothercentrism' of the provisions and their silence on same-sex rights as examples.⁶³ However, when one considers that the African Charter, in true patriarchal fashion, locates women's rights in the context of family rights, then it can be argued that the phrase 'irrespective of marital status' is a clever way of deconstructing a hegemonic womanhood through the utilisation of the words (read symbols) used to create it - women no longer have to conform to traditional values in order for their sexual health rights to be recognised. For non-normative African women, their unmarried

59 Hlatshwayo & Klugman (n 52 above).

60 De Cock *et al* (n 3 above) 709.

61 General Comments (n 57 above) para 14.

62 T Poteat *et al* 'Sexual practices, identities and health among women who have sex with women in Lesotho – A mixed-methods study' (2014) 16 *Culture, Health and Sexuality: An International Journal for Research Intervention and Care* 120; TG Sandfort *et al* 'Forced sexual experiences as a risk factor for self-reported HIV infection among Southern African lesbian and bisexual women' (2013) 8 *PLoS one* e53552; H Wells & L Polders 'Gay and lesbian people's experience of the healthcare sector in Gauteng' <http://www.out.org.za/index.php/library/reports?download=20:hiv-and-std-among-gays-and-lesbians> (accessed 29 November 2013).

63 CEDAW Committee General Recommendations (n 32 above).

status is usually seen as a marker of their deviance. However, the recognition afforded to women regardless of their marital status leaves room for the emergence of 'disruptive' but viable performances of womanhood and female sexuality.⁶⁴

The programmatic nature of the right to sexual health is reiterated by the fact that its realisation is tied to the ability of the state to create enabling conditions for the empowerment of women with respect to 'protection rights', and that these 'protection rights' include well-recognised and established rights – such as the rights to education, equality and dignity.⁶⁵ The principles articulated within the General Comments reflect deference to the well-established 'four-pronged' approach to state parties' obligations; namely, that state parties have to: respect,⁶⁶ protect,⁶⁷ promote⁶⁸ and fulfil⁶⁹ the sexual health rights within the Charter in accordance with the principles laid down in the General Comments.

The language of sexual health rights is more readily accepted than that of sexual rights, especially because of the challenges presented by HIV. However, the term has come to be recognised as an umbrella term in the field of sexuality,⁷⁰ primarily because sexual rights were constructed tools to challenge hegemonic ideas about sexuality and how they affected the self-ownership of the marginalised subject. To construct these tools, feminist activists simply attached the word 'sexual' to the pre-existing concepts of health and rights.⁷¹ The promotion of sexual rights by focusing on sexual health is strategic in that it 'side-steps' engaging with 'progressive and conservative challenges around sexuality'.⁷² However, it has been argued that this has also led to the limitation of sexual rights because popular human rights practice deploys rights on the basis of a violations model, as opposed to also focusing on 'positive rights to pleasure and enjoyment'.⁷³ Public silences about sexual health as pleasure and a focus on violations may be because of the highly-subjective nature of sexuality and the difficulties that would be encountered in articulating a right to pleasure in the form of law or policy.

The silence by the African Women's Protocol on the matter of sexual orientation presents a problem insofar as it fails to challenge 'hetero-hegemony' directly. However, a literal reading of the

64 V Reddy 'The queer politics of (homo)sexuality and matters of identity: Tentative notes in the context of HIV/AIDS' in Aggleton & Parker (n 37 above) 438.

65 General Comments (n 57 above).

66 General Comments para 21.

67 Para 22.

68 Para 23.

69 Para 24.

70 Corrêa *et al* (n 5 above) 113.

71 As above.

72 AM Miller 'Sexual but not reproductive: Exploring the junction and disjunction of sexual and reproductive rights' (2000) 4 *Health and Human Rights* 89.

73 J Horn 'Re-righting the sexual body' (2006) 6 *Feminist Africa* 8.

provisions of the Women's Protocol makes it difficult to deny the fact that the right to sexual health in the context of HIV/AIDS applies to *all* women, regardless of whether or not they comply to the essentialised construct of African womanhood. What the existence of the right to sexual health has meant for African WSW almost a decade after the enactment of the Protocol will be discussed in the forthcoming sections of this article

3 Methodology

The methodological framework used was a feminist virtual ethnography. This type of research is also referred to as internetnography⁷⁴ and ethnographies of cyber society.⁷⁵ Ethnography is a qualitative form of research that generally asks questions about social and cultural practices of groups, with the aim to gain an in-depth understanding of how individuals in different cultures and subcultures make sense of their lived reality.⁷⁶

Lysloff⁷⁷ indicated how the internet could provide a new kind of materiality that has the potential to be the basis of a complex social network that can be interpreted as community. Ross⁷⁸ further argued that the internet provides the opportunity to grapple with one's sexuality in a way that was not previously available to marginalised sexualities, as it creates an additional stage to coming out with more assurance, namely, the possibility of online lurking which allows the chance to observe others' interactions and to reflect on one's own sexuality and desire. One can immerse oneself in aspects of the virtual culture, the language and practices, attitudes and beliefs, and try them out, so to speak, in a relatively safe environment before coming out in the 'real' world. Online networks can thus strengthen and reinvent community as it can serve to build bonds with the wider social world, whilst facilitating cultural empowerment.⁷⁹

We spent on average two to four hours a day online as participant observers over a period of one year, and were guided by Abu-Lughod's⁸⁰ advice that ethnographies should ideally include an exploration of the tension between people's everyday experiences and the larger structures through which they are meant to make meaning

74 R Tapper 'Anthropology and (the) crisis' (2001) 17 *Anthropology Today* 13-16.

75 SG Jones (ed) *Cybersociety 2.0: Revisiting computer-mediated community and communication* (1998).

76 S Reinharz *Feminist methods in social research* (1992).

77 RTA Lysloff 'Musical community on the internet: An online ethnography' (2003) 18 *Cultural Anthropology* 233-63.

78 MW Ross 'Typing, doing, and being: Sexuality and the internet' (2005) 42 *The Journal of Sex Research* 349.

79 T Bosch 'Online coloured identities: A virtual ethnography' in A Hadland *et al* (eds) *Power, politics and identity in South African media. Selected seminar papers* (2008).

80 L Abu-Lughod 'Writing against culture' in RG Fox (ed) *Recapturing anthropology: Working in the present* (1991) 157-158.

of their lives as our focus in taking field notes, and over time revealed the prevalent norms and understandings in these spaces. Mbilinyi⁸¹ argues that 'knowing is a complex process, heavily dependent on what questions are asked, what kind of knowledge is sought and the context in which cognition is undertaken'. This approach opened up an additional space to explore the meanings of non-heteronormative social media users' experiences, and helped to unpack and personify complicated and multifaceted realities being discussed.

Research questions were developed based on input from community members and adjusted according to comments received to assure that they adequately reflected the interest and concerns of participants. We also consulted with a medical doctor to ensure that the HIV/AIDS-related information we disseminated was correct. The urgency of medical consultation became clear when we realised that misinformation about risks related to WSW sex was widespread. To further gauge the discursive practices and ideas WSW held around the subject, we attempted to conduct focus group sessions, but these were largely unsuccessful. We realised that participants were far more likely to share experiences in anonymous online forums. To facilitate continued discussion, a version of this article will be published in the spaces we engaged with through this study to ensure a reflexive and on-going process.

3.1 Tools for analysis

Another area of focus has been to gain a greater understanding of the relationships between participants. Spending a lot of time on the site observing was extremely useful to gain knowledge on the particular group norms and understandings, and informed interpretations of identity performance.⁸²

In addition to this, we also tried to be keenly aware of the different tools people adopt in their symbolic interactions with one another, including social languages, discourses, intertextuality and conversations.⁸³

3.2 Data collection

Apart from closely following the discourses in the Facebook groups, Twitter conversations, African LGBTI-focused blogs, and microblogs (such as Tumblr), to arrive at a thick description; HOLAA! also ran parallel modes of data collection using the HOLAA! website,⁸⁴ to distribute a questionnaire comprised of a list of open-ended questions

81 M Mbilinyi 'Research methodologies in gender issues' in R Meena (ed) *Gender in South Africa* (1992).

82 L Kendall 'Recontextualising "cyberspace": Methodological considerations for online research' in S Jones (ed) *Doing internet research: Critical issues and methods for examining the net* (1999).

83 JP Gee *An introduction to discourse analysis: Theory and method* (2005).

84 <http://www.holaafrica.org> (accessed 31 October 2014).

that requested WSW on various social media platforms to anonymously share their experiences of HIV and STIs to be published as part of the 'HOLAA! Talks HIV & STIs' month of July. Over the study period, we were able to collect 54 completed questionnaires. Participants were also invited to send in material to be published on the site over the same period. The form was advertised on Facebook Groups for African LGBTI women as well as on the organisation's Twitter account. Through channels such as shares and retweets, the form managed to gain traction in diverse online spaces. Participants were from several countries, such as Namibia, Kenya, Zimbabwe, Nigeria and Ghana. However, the majority of respondents were South African, given the numerous active South African LGBTI groups in social media spaces. Nevertheless, the perceptions of WSW on the issue did not differ markedly among countries, which in itself is alarming when one considers that South Africa's democratic liberalism appears to have achieved little for the health rights of WSW. The majority of those who engaged in the online discussion stated that they were exclusively attracted to women or more attracted to women than men, whilst most reported to be sexually active. Relationship statuses varied from single to polyamorous. Information gathered from HOLAA! was difficult to disaggregate in terms of demographics because several stories were submitted anonymously. However, it was possible to get a broad perspective on the dominant discourse on HIV and STIs among LGBTI women in these online spaces.

4 Study limitations

It is essential to consider who defines research questions, because they influence the integrity and usefulness of findings, as well as individuals' willingness to participate freely and openly. However, in the process of doing the research for this article, we soon realised that research initiated from within a community is exceedingly hard to get into mainstream discussions, because acquiring the relevant ethical clearance to question people about their sexualities is prohibitively expensive for organisations such as HOLAA! that operate without funding. This is deeply worrying because research topics in the HIV/AIDS industry are indeed largely determined by donor organisations that appear to be mostly conservative and unsympathetic to the needs of WSW. It is therefore critical that avenues are created for people from affected communities to be the researchers and constructors of knowledge on their bodies and lived realities, rather than requiring an intermediary with money.

This study followed a snowball sampling approach, which raises questions about the representativeness of the sample, and additional studies following a more structured approach are therefore suggested. In addition, studies on internet users in the African context are scant, but 2013 statistics from Nielsen, a reputable South African research

company, indicate that internet users in the country are more likely to have tertiary education and a relatively high income compared to the general population, and the situation is likely to be the same in other African contexts.

Because of the relatively small size of this community, the effect may not be significant on the overall infection figures, but because the pandemic continues to disproportionately affect sub-Saharan Africa (approximately 70 per cent of all new HIV infections in 2012),⁸⁵ continuing to ignore it is probably ill-advised. This study's findings confirmed the findings of the 2013 UNAIDS report indicating that risky sexual behaviour is on the rise in several countries, such as Burkina Faso, Congo, Côte d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, Tanzania and Zimbabwe.

5 Data findings

Dominant discourses surrounding HIV and sexual health have managed to cloak issues pertaining to WSW in a silence that has facilitated a lack of information or the proliferation of misinformation. Since the 1990s, researchers⁸⁶ have highlighted the dearth of research on WSW transmission of HIV, and it is particularly worrying that our research, conducted 20 years later, still reflects similar findings to those encountered as early as 1992 that found that WSW demonstrate a lack of knowledge on safe(r) sex and HIV-preventative strategies.

This absence of a focus on WSW within HIV and STI programmes has allowed for the perception that WSW are less or not at risk of contracting STIs and HIV to proliferate within society, especially LGBTI communities. Few respondents indicated seeking and finding relevant information or care, indicating an extremely low level of adequate access to sexual health rights among participants.

During July 2013, HOLAA! published a blog post compilation of some of the anonymous submissions by African WSW on their experiences of HIV and STIs, which served as the most significant source for this study's data collection. Interactions of WSW were clearly outlined. One contributor to the post stated: 'We, myself and my queer lady friends, speak about it as something that doesn't happen to us.'⁸⁷ This quote was one that spoke to the experiences of other respondents, as this was reflected in various forms within other sources, including Facebook posts as well as within the compilation of anonymous submissions that were procured for the purposes of the aforementioned post. The data showed that 35 per cent of

85 UNAIDS Report on the global AIDS epidemic, November 2013 <http://www.unaids.org> (accessed 31 October 2014).

86 V Tallis 'Lesbians and AIDS' (1992) 15 *Agenda* 69.

87 Hub of Loving Action Africa (HOLAA!) 'HIV and me: African LGBTI women speak on HIV/AIDS Part 1' 11 July 2013 <http://www.holafrica.org> (accessed 31 October 2014).

respondents felt that they were at risk of STIs and HIV which, coupled with the low risk at which they see themselves in terms of contracting HIV, shows how many felt they were at low levels of risk.

The idea of not having these conversations within the social space is reflected when one contributor stated that queer women viewed the issue 'at a distance'.⁸⁸ Another contributor mentioned: 'I guess you never feel anything for the disease or virus until you're hit with a very disturbing result that you too are infected.'⁸⁹ The reality that the matter was infrequently discussed widely within the female LGBTI community was repeatedly highlighted and several appeals were made for increased awareness.⁹⁰ Various respondents did state that they often did not speak on the issue (as seen in the above quotes), bypassing the idea as something that 'happened to other people'. Often women stated that they had not discussed the matter at length with their friends, and most indicated that information on safe sex practices and WSW was largely gathered from the internet and LGBTI organisations.⁹¹

5.1 HIV and same-sex couples

Knowledge on and participation in serotesting and safe(r) sex amongst couples were the exceptions among submitted narratives, although some did stress a strong focus on the need for safer practices and increased availability of relevant information and resources.

One narrative specifically described how a same-sex couple had tackled the issue of serodiscordance when a woman found out that her partner was HIV positive. The partner had disclosed her HIV status and the two proceeded to get tested together. The author tackled the issue of safe sex by stating: 'To be honest, I felt uncomfortable with having oral sex as we did not use protection (as usual).'⁹² On Facebook, some level of engagement with safe sex was, however, evident, as some users mentioned getting tested often with their partners. One user stated: 'Safe sex is of utmost importance to me. I regularly get tested and make sure that whoever I'm having sex with is tested as well.'⁹³ When collating the responses, we found that 95 per cent of respondents stated that safe sex practices, which included testing, were important.

Nevertheless, several Facebook users indicated that they had engaged in sexual relations without considering safe sex or being tested. One claimed that she regarded asking a woman to be tested

88 HOLAA! 'HIV and me: African LGBTI women speak on HIV/AIDS Part 2' 12 July 2013 <http://www.holaafrica.org> (accessed 31 October 2014).

89 As above.

90 HOLAA! (n 87 above).

91 Anonymous 1 *Protected Facebook group 1*, March 2013 <http://www.facebook.com>.

92 Anonymous 'My girlfriend is HIV+ but we fight through' 18 July 2013 <http://www.holaafrica.org> (accessed 31 October 2014).

93 HOLAA! (n 88 above).

or to use protection as a form of 'disrespect'.⁹⁴ Disturbingly, the most prevalent narrative was that WSW who engaged in risky sexual behaviour did so because they had 'not thought' about the consequences of such behaviour, or that safety was of no concern in 'the heat of the moment'.⁹⁵

5.2 Prejudice, sexual identity and infection

Several participants indicated their reluctance to be tested and/or to discuss safer sex or their health status because of the perception that 'real' lesbians should be unable to contract sexually-transmitted diseases. These responses, once again, highlighted the oppressive power of the dominant perceptions that WSW sex is not 'real' sex, the erasure and vilification of bisexual individuals in LGBTI circles as somehow more promiscuous and thus dangerous, as well as the lack of safe spaces and support to discuss experiences of sexual violence and rape. A contributor stated that 'it is very sad how lesbians contract these kinds of diseases and yes, there is a lot of discrimination for people living with HIV or STIs'.⁹⁶

Another woman acknowledged:⁹⁷

Speaking out can be an issue as there is a big stigma in this community. Questions will be asked if you are really a lesbian or bisexual ... The fear of being outcast [means] you die in silence.

In the story entitled 'Choosing life', the author recounted how lesbians could be excommunicated from the community if they came out as HIV positive.⁹⁸ She pleaded⁹⁹

to all the lesbians out there who are living with the virus and feel there is no one to talk because you are scared [of] how your fellow lesbians will take your HIV status, you are not alone but the key is to live a positive lifestyle. To all the lesbians, please stop judging us, we are living with the virus.

This notion was one that was also held by a number of other respondents, with some stating that one's sexual orientation would be questioned if they stated that they had the virus. These responses encapsulated the heightened prejudice within the WSW community and reflected that a substantial part of sexual identities are tied to sexual practices.

94 South African lesbian group 2013 <http://www.facebook.com>.

95 Anonymous 2 *Protected Facebook group 1*, March 2013 <http://www.facebook.com>.

96 HOLAA! (n 88 above).

97 As above.

98 Lihle 'Choosing life: Getting tested and dealing with the results' 1 July 2013 <http://www.holaafrica.org> (accessed 31 October 2014).

99 As above.

5.3 Health workers

The collected data on experiences within the health sector mirrored literature on the subject, indicating that sexual orientation and gender non-conformity greatly affected an individual's ability to access health care and the quality of information received. This often resulted in two unfortunate effects: discomfort with revealing one's sexual orientation, and the consequent absence of information or the provision of inadequate information within the healthcare realm. Good practice when dealing with LGBTI clients includes neither avoiding sexual orientation issues, nor focusing solely on them when the client does not see it as pertinent to their problem. Inappropriate practice includes assuming that a client is heterosexual, indicating that a gay or lesbian identity is bad or inferior, and a lack of knowledge on issues of concern to LGBTI clients.¹⁰⁰ The shortcomings of the healthcare system were summarised by a participant who acknowledged: 'There is a lot of prejudice, I feel. And in the absence of this, there is a lot of misinformation.'¹⁰¹ Of the respondents, 40 per cent stated that they had received their information from a clinic, with the majority seeking information either from the internet, an organisation or through friends. This showed that the healthcare system was not a place in which people could source information.

The limited protection of LGBTI people's confidentiality and rights to medical privacy is a critical and under-addressed concern. Participants in this study indicated pervasive heterosexism throughout their experiences with seeking health care. Discomfort was a common thread in the online narratives. One Facebook user claimed feeling 'nervous and scared' about being open about their sexuality.¹⁰² Another stated that when they had engaged with a healthcare worker in Ghana, it had been 'really awkward'.¹⁰³ She further asserted that her confidence helped her to obtain decent treatment, but had she been 'shy' she felt they would have 'preached' to her. She explains:¹⁰⁴

I went after a non-consensual sex encounter with an ex-boyfriend but I didn't feel comfortable enough to tell the doctor, so I just told her he had infected me and she advised me to continue to stay in the relationship with him as that would be best.

100 American Psychological Association (APA) 'Guidelines for psychotherapy with lesbian, gay and bisexual clients' (2000) <http://www.apa.org> (accessed 31 October 2014); BJ Liddle 'Therapist sexual orientation, gender, and counselling practices as they relate to ratings of helpfulness by gay and lesbian clients' (1996) 43 *Journal of Counselling Psychology* 394-401.

101 Respondent 1, African lesbian group, Facebook April 2013 <http://www.facebook.com>.

102 Respondent 1, Closed lesbian Facebook group, April 2013 <http://www.facebook.com>.

103 Respondent 1, African against homophobia Facebook group, March 2013 <http://www.facebook.com>.

104 As above.

She stated that there was continuous heteronormative rhetoric during the visit, as the sisters who helped her with her birth control needs asked her when she was to marry and advised her to stop taking birth control. This was a sentiment echoed by others across numerous groups, with some stating that experiences centred on ideas of heterosexual rituals and practices.

The common thread was that they had felt some degree of discomfort during their visits to healthcare facilities, with many choosing not to disclose their sexual orientation, fearing the reaction or merely finding it difficult to. Several also stated that their sexual orientation was not taken into account during their visit. One respondent spoke on how a health worker testing her for HIV had refused to recognise her relationship with her girlfriend and therefore refused to test them as a couple.¹⁰⁵ Of those respondents who spoke on their interaction with healthcare professionals, the majority spoke about the inability to engage with these issues within their communities due to the homophobic nature. Some had, however, reported having a positive experience with a healthcare worker, but this was in the private health sector.¹⁰⁶

Another issue was the lack of information within the healthcare sector. Of those who had approached healthcare workers, few stated that they felt they had been well informed about their safe(r) sex needs.¹⁰⁷ Many felt that the questions they had been asked had not catered to their specific needs and the information that had been provided had been inadequate. One Facebook group member spoke to the ease at which she had managed to approach a local LGBTI organisation, having got very little help from her local general practitioner.¹⁰⁸ Another user stated that her interaction with the healthcare worker had been fine; however, she felt that knowledge on the sexual health needs of same-sex practising women was lacking.¹⁰⁹ Members of various groups felt that safe sex strategies spoke more towards heterosexual relationships, as most of them said that they were aware of 'straight safe sex strategies'. From the research we found that 79 per cent of those who responded on their experiences found that this information was not available to them through the healthcare system.

The dual nature of discomfort, misinformation and/or a lack of information have led some to refrain from visiting healthcare practitioners, and a certain 'anti-health practitioner' rhetoric has developed within communities.

105 Respondent 1, Friends of open closet April 2013 <http://www.facebook.com>.

106 Respondent 1, South African lesbians (SALES) April 2013 <http://www.facebook.com>.

107 Respondent 2, Closed Facebook group April 2013 <http://www.facebook.com>.

108 Respondent 1, Lesbians of the Western Cape April 2013 <http://www.facebook.com>.

109 African against homophobia Facebook group (n 103 above).

5.4 Misinformation meets no information: Effects on healthcare practices

One Namibian participant indicated that the taboo surrounding same-sex relationships amplified the stigma for those who sought WSW sexual protection measures.¹¹⁰ Another noted that there were no targeted campaigns dealing with 'lesbian issues',¹¹¹ and this has led to high levels of misinformation about how HIV truly affects WSW. The idea of having no access to information was echoed when 46 per cent of respondents stated that they did not know where to get this information, having no knowledge of organisations that gave information or barrier methods. Of the ones who did have *some* access to information, they found that it was mainly over the internet, with 61 per cent saying that they got the information from the internet.

5.5 High-risk persons

This troubling phenomenon is encapsulated in the words of one woman from the HIV & Me HOLAA! post in which she says: 'I always thought we were the low-risk, especially me. I'm butch, never been with a guy.'¹¹² This speaks to a sentiment that came up repeatedly, that WSW hid themselves 'behind a false wall of protection'.¹¹³ The idea of lesbian immunity is also prevalent within heterosexual communities. One woman confirmed that an HIV status would put one's sexual identity under suspicion when she said: 'Families will wonder: Why is she infected? Isn't she a lesbian?'¹¹⁴ The lesbian immunity myth is reflected in the fact that 61 per cent of respondents identified bisexual women as forming part of the groups identified as being most at risk of contracting HIV as they interacted with men more. Furthermore, only 22 per cent of respondents stated that that lesbians fell under the label of 'high-risk group'. Most stated that heterosexual men and women, homosexual men and bisexual women were those who needed to be wary of HIV and STIs.

6 Data analysis

As the intensity of the HIV crisis has grown, public health campaigns have framed issues surrounding sexuality within discourses of rights and empowerment, which have heightened the profile of violent sex, and opened up spaces for public debates on performances of masculinity that are defined by violence. Recently, the focus has been overtly on what has problematically been termed 'corrective rape of

110 South African lesbians (n 106 above).

111 African against homophobia Facebook group (n 103 above).

112 As above.

113 As above.

114 As above.

lesbians'. However, at the same time, health discourses have also framed women who have sex with women as a low-risk group and, therefore, given the scale of the problem, very little attention has been paid to the risks faced by these women in public health campaigns.¹¹⁵ In the contexts that form part of our study, homosexual bodies and practices are stigmatised, and it appears that, because women view themselves as not at risk of HIV and other STIs and highly at risk everywhere else, they are willing to regularly engage in risky practices. Despite being generally well-informed about the general risks, they do not feel that it is particularly relevant to their lives, or that sex itself is the one area where they need to worry about consequences. It could also be that they are well aware of the fact that they may be at risk or even infected, but are very reluctant to disclose this fact because it might expose them as not being 'real lesbians'. Furthermore, the high rates of sexual violence against lesbians and gender non-conforming women could further exacerbate HIV infection within this group.¹¹⁶

To understand how an individual's understanding of sexuality can be affected by hegemonic discourse, one has to problematise the idea of sexuality as something that is strictly innate and subjective and beyond the reach of social power dynamics. The HIV pandemic in Africa has been used to support the notion of a monolithic African sexuality,¹¹⁷ resulting in the exoticisation of same-sex sexual practices. Particularly striking was the reference made to the differential risk between the 'sexual activities' of WSW and 'actual sex'. This construction of lesbian sex as 'play' reflects a trivialisation of female same-sex eroticism and implies an acceptance of the inherent social instability of this sub-group. It has been argued¹¹⁸ that this construction of same-sex sexual activity as 'sex games', in relation to the perceived more authentic and serious act of heterosexual reproductive sexual practice, is something which is embedded within African cultural understandings of sexuality. In this context, this trivialisation works in the same way as silencing, in that it implies a taboo and undesirability, and perpetuates prejudice.

If one understands sexualities as 'emergent'¹¹⁹ because the related meanings are continuously created and contested in the public space and within sub-communities, the most powerful influences on human sexuality are social norms.¹²⁰ Governmental discourses promote

115 M Mbali 'Gay AIDS activism in South Africa prior to 1994' in Reddy *et al* (n 4 above); I Meyer & ME Northridge (eds) *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (2007).

116 Reddy *et al* (n 4 above); Wells & Polders (n 62 above).

117 M Epprecht *Heterosexual Africa? The history of an idea from the age of exploration to the age of AIDS* (2008).

118 As above.

119 Reddy (n 64 above).

120 S Kippax 'Safe sex: It's not as simple as ABC' in Aggleton & Parker (n 37 above) 184-192.

compulsory heterosexuality and further reinforce it through sub-regional and national strategic plans and policies, for example, the 2010-2015 SADC strategic plan.¹²¹ It is therefore not surprising that those whose realities did not conform to this norm viewed HIV 'at a distance'.

References to 'heterosexual transmission' reflect a biomedical understanding of the sexual experience, which assumes that sexual desire, behaviour and identity all move in the same direction.¹²² This has resulted in people with alternative sexualities viewing their identities as a safeguard against any and all STIs, including HIV.

6.1 Locating WSW in the HIV pandemic

The manner in which WSW locate themselves regarding HIV is multipronged. First, the false perception of 'lesbian immunity' to HIV¹²³ means that women affected by the virus are forced into a second closet because, as stated by one participant, 'speaking out can be an issue as there is a big stigma'. Therefore, biphobia tend to be widespread in this community because they are perceived to threaten lesbians' immunity from the disease.¹²⁴ However, several women who identify as lesbian indicated that the group was far from homogenous, and 'many ... sleep with men ... and engage in other risky sexual behaviour'.

Second, the assumption that sexual identity predicts sexual behaviour influences safer sex negotiations.

Third, a fear of marginalisation affects women's perceptions of safe(r) sex and the spaces where it is discussed. In this study, some safer sexual practices involved some or other level of behavioural modification. In some cases, this meant 'regularly get[ting] tested' and also ensuring that one knows the serostatus of one's partner, while in others it meant serosorting on the basis of perceived risk. There was, however, no correlation established between a knowledge of one's own serostatus and that of one's partner and the practice of safer sex. This is reflected most clearly in the anecdote relayed by a woman in a serodiscordant relationship, where the state of affairs made her feel 'uncomfortable with having oral sex'. However, she and her partner did not cease to engage in this activity, nor did they 'use protection'.¹²⁵ In another anecdote from a serodiscordant couple; the

121 Southern African Development Community (SADC) 2010-2015 *HIV and AIDS Strategic Framework* 2.1.

122 Corrêa *et al* (n 5 above) 135.

123 J Power *et al* 'Absent sexual scripts: Lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information' (2009) 11 *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care* 67-81.

124 D Richardson 'Constructing sexual citizenship: Theorising sexual rights' (2000) 20 *Critical Social Policy* 105-135.

125 Protected Facebook group 1 (n 91 above).

seropositive woman wrote of her struggles with a seronegative partner who 'does not see the point of using protection'.

Another statement on the site was:¹²⁶

[i]f only everybody can make it a habit of visiting a doctor on a yearly basis and the VCT clinic occasionally. Knowing one's status is very important. Me and my partner always go to VCT every three months and this has helped a lot as I have become her best friend and alarm at the same time.

Matters of sexual health were deemed to be important, even by those within monogamous relationships, with some going for regular testing, thus realising that they too could be infected with HIV. However, and far more prominently, a pattern of 'not testing' was evident in the data, as reflected in the following statement: 'I have had sex with people before getting tested and don't think twice about it.'¹²⁷ Another lamented the lack of information amongst her peers, saying: 'In my experience, queer women are the most complacent and their general knowledge of STIs is dismal.'¹²⁸

The data also revealed a hierarchy of testing, with far fewer people indicating taking STI tests than for HIV.

The reckless abandon, which appears to underpin lesbian and bisexual women's sexual practices, may reflect a form of resistance to the sexual hierarchies that exist within society. These hierarchies normatively assess sexual identities, behaviour and practices in an attempt to regulate whose sexuality can be portrayed as publicly acceptable.¹²⁹ Therefore, resisting the public, even if it is through mechanisms that are aimed at the reduction of the risk of transmission of HIV and STIs, WSW can be seen as engaging in attempts to 'normalise'.

Nevertheless, WSW do recognise their own risk, but in disorganised ways. Denial and ignorance work together in lethal ways to undermine the sexual health rights of WSW. The African Women's Protocol recognises the rights to equality, information and education and dignity as some fundamental determinants of the realisation of 'self-protection' rights to sexual health. However, the fundamental conditions for the realisation of the right to sexual health are interpreted as being dependent on the enabling socio-cultural environment that the state creates. The easiest way to determine the extent to which sexual health rights truly exist is an evaluation of the relationship WSW have with the public health system and how that affects their ability to access information related to safer sexual practices and health care when it is required.

126 HOLAA! (n 87 above).

127 HOLAA! (n 88 above).

128 As above.

129 Corrêa *et al* (n 5 above).

6.2 Locating WSW in health care

More than 50 per cent of participants have not visited a health clinic or consulted with a healthcare worker on sexual health. This sense of alienation from the public health system is directly correlated with the heterosexism women experience when they seek medical advice, which is compounded by the fact that health workers lack the necessary training to deal with the sexual health concerns of WSW.¹³⁰

Considering these data in relation to the African Charter or those to sexual health under the African Women's Protocol, it is clear that a lack of information prevents WSW from accessing sexual health rights. However, advocating sexual rights for WSW on the basis of these violations and deprivations may not be an optimal response, particularly because of the protracted processes of state mechanisms. Therefore, the importance of emphasising positive sexual rights cannot be underestimated, because the preservation of hegemonic gender norms and order is regularly used to control and eliminate content that is seen to go against traditional values, particularly those that relate to the family, and women's roles. A focus on positive rights also has the effect of de-stigmatising alternative sexualities, and helps to call into question and challenge inimical discourses in the mainstream media, for instance, the deeply-troubling and persistent use of problematic language, such as the term 'corrective rape'.

Current public health practice limits the ability of this group to construct innovative and self-generated responses to HIV in the context of social positioning because of systematic deprivation of information. For WSW to exercise their agency and develop a set of negotiated practices that will act as 'community'-generated guidelines as to how risk will be mitigated, they must have access to information about sexual health risks and needs. Kippax¹³¹ argues that prevention information is actively appropriated through talk and collective action, and it is this process that enables the construction of lasting and appropriate strategies to address the pandemic. However, WSW cannot 'self-protect' if states are not acting in ways to ensure that they are 'protected from' heterosexist discrimination and absent scripts about their lives, wants and needs.

7 Summary

The HIV pandemic clearly affects the lives of WSW. Within the African regional system, the right to sexual health has been provided for bar any consideration of a woman's marital status. While sexual orientation is not explicitly recognised as a ground for non-discrimination within the African system, the African Women's Protocol is understood to apply to *all* women. However, in spite of

130 Tallis (n 4 above).

131 Kippax (n 120 above).

these guarantees, our study showed that WSW had limited access to information packages that catered to their sexual health needs. This was particularly apparent in the anecdotes women shared about their experiences with healthcare practitioners and their perceptions of the healthcare system, and the fact that predominant discourses around HIV exclude WSW.

Participants who had discovered information about HIV/AIDS admitted to having done so through the internet and/or LGBTI-oriented organisations. The utility of the 'web space' in facilitating discussion between marginalised social actors and the dissemination of information has been illustrated by the findings of this study. However, this does not detract from the fact that queer female sexualities have been driven underground by silence. This *lacuna* in public health discourse has led to the perpetuation of the idea of 'lesbian immunity' in Sapphic spaces. This has resulted in both individual and community-level denial. This 'denialist' phenomenon is expressed most acutely by the disjuncture between professed knowledge of HIV/AIDS and the need for safer sex, and the ways in which women enact their sexual practices (which are often unsafe and based on unverifiable information).

The article has highlighted the importance of access to accurate, widely-available and relevant sexual health information, for the realisation of the right to sexual health. Although the article examines this in the context of WSW, it can be said to apply to all vulnerable women (for instance, sex workers). The creation of effective strategies for the mitigation of the pandemic can only come from collaboration between the public health system and affected communities, through the ways in which communities will interpret the available information and create their own set of prevention ethics. In order for this to occur, there has to be information, otherwise people at the margins of what is considered sexually 'good' will continue to be silenced into insignificance and therefore vulnerability to HIV.

8 Recommendations

Africa is in a unique position because the African Women's Protocol represents the first instance of the codification of the rights of women with respect to HIV and AIDS. This allows for the space to set global precedent in terms of tackling the notion of entrenching the rights of marginalised women within the realm, especially WSW.

Although the Women's Protocol has been ratified by most African states, the degree to which it is domesticated within these states will affect how effective it is, particularly for WSW who have little or no legal rights protection, let alone equitable access to health care. The manner in which the Women's Protocol will be applied largely depends upon the extent to which domestic courts are willing to integrate and utilise regional treaties to impact their laws and shape their policies. The impact of African regional mechanisms has been

extremely limited within domestic systems, which reveals that the African system 'has hardly made a dent',¹³² and also pointing out the Europhilia of certain jurisdictions – which sees them readily applying international law over regional law.¹³³

Another challenge is the Women's Protocol's explicit reference to sexual rights. It has been noted that, while African states were among the most ardent supporters of the language of sexual rights, during the Fourth World Conference on the Rights of Women, they also resisted the implications of these rights for sexual minorities.¹³⁴ Therefore, the manner in which the courts interpret the meaning of the provisions will determine how effective the Protocol would be. However, due to the universal and plain meaning of the word 'woman', it is clear that even the most formalist and literal approach cannot justify the deprivation of the rights of WSW. Therefore, questions will most likely turn on the definition of 'sex' and 'sexual'. It has already been outlined that predominant thinking does not view female same-sex sexual activity as sex *per se*, and this may influence how the courts interpret the provisions. This will especially be the case in states where same-sex consensual conduct is criminalised on the basis that it is 'unnatural carnal knowledge'.

Due to the highly-political nature of judicial decision making,¹³⁵ it remains doubtful that judiciaries in Africa will utilise the African Women's Protocol in order to guarantee the rights of WSW – particularly because of its inherent heteronormativity. Therefore, the Protocol is, arguably, most effective as a tool for activist mobilising, particularly when it comes to receiving research grants that will allow for increased research into the field and allow for the collection of significant information about WSW sexual practices, perceptions and seroprevalance.

The idea of utilising the African Women's Protocol as a means of activating awareness surrounding the rights of WSW should be coupled with the idea that the document itself be used as a framework on which these rights can be built. The activism and awareness building should seek to focus on the gaping holes present within various realms of knowledge, namely, within the healthcare sector as well as within communities. Once these are identified, they should seek to be enshrined within the Women's Protocol. Those seeking to ensure that WSW find a suitable space within the human rights health-based framework must ensure that these barriers are dealt with, as the proliferation of information is extremely important

132 J Oloka-Onyango 'Human rights and sustainable development in contemporary Africa: A new dawn, or retreating horizons?' (2000) 6 *Buffalo Human Rights Law Review* 39.

133 OC Okafor *The African human rights system: Activism, forces, and international institutions* (2007).

134 Plummer (n 37 above).

135 P Lenta 'Constitutional interpretation and the rule of law' (2005) 16 *Stellenbosch Law Review* 272.

in making sure rights are realised. It is pertinent that advocacy efforts and, eventually, any influencing and changing of the African Women's Protocol will need to address this gap in knowledge, research and access to information.

Web 2.0 technologies are well suited to advocacy and political organisation, and are often used by activists to make connections, as they enable discussions on easily-accessible platforms that allow these discussions to become more visible and available to a greater audience of people. In countries with regressive gender systems, where certain topics – certainly alternative sexualities – are regarded as taboo, a democratic deficit is created, and those who are discriminated against can either take a passive accepting stance, or create parallel spaces for participation to build up the kind of social capital needed to address the hostility of their immediate environment.¹³⁶

The internet space should, whilst being used as a tool for activism to further these rights, also be used as a means of ensuring that persons within communities potentially enjoy these rights by providing a platform of information. The sharing of information can bolster the work done by organisations in seeking to protect the rights of WSW when it comes to HIV and STIs. As misinformation or no information is a huge barrier to enjoying these rights, the online space can go a long way towards correcting this problem.

Furthermore, we found that young African women who do not subscribe to the hetero-norm use Web 2.0 tools to create a large number of extremely active groups where gender/sexuality topics are (often heatedly) discussed. In addition, these tools are used to organise offline social events, such as poetry events, parties and panel discussions. Organisations like HOLAA!, Inkanyiso, Buwa, CAL Secretariat, LEGABIBO, and the One in Nine campaign have been quite successful at using these tools to garner support and mobilise their members to take action against discrimination.

These tools are, however, not only used for advocacy and promotions against discrimination and violence, as several of the blogs, Facebook groups or pages and conversations on Twitter placed a lot of emphasis on positive sexuality rights. This goes against the usual trend of debates on sexuality rights that tend to focus mostly on negative sexuality rights, such as curbing exploitative pornography, the protection of children from harmful content, and female genital mutilation. The 'publicness' of these spaces is critical because it allows for these stories and contestations to count in a public way, and for community members to determine the course of discussions.

Because non-heteronormative people appear to be particularly active in social media spaces, with relevant groups rapidly

136 E Iskander 'Connecting the national and the virtual: Can Facebook activism remain relevant after Egypt's January 25 uprising?' (2011) 5 *International Journal of Communication*.

proliferating,¹³⁷ the potential to base behavioural interventions to reduce sexual risk behaviour and avert STIs and HIV seems substantial. A major benefit is that it allows users to create and publish content, share their experiences, build knowledge commons, and communities of practice around particular subjects.¹³⁸ This will seek to counter the problems of misinformation and the lack of information that hinders the enjoyment of rights.

The findings of this study suggest that, because the use of social media in Africa is increasing at an astonishing rate, this could provide an extremely effective and also cost-effective avenue to host much-needed social behaviour campaigns that can nurture subcultures of safety for marginalised groups who tend to gravitate to online space, because they feel unsafe offline. It further suggests that harmful information can also be reproduced at an alarming rate, as many seek to enter these spaces to seek advice that is not readily available elsewhere.

The article therefore bases its recommendations on the need to fill the information gap in order to bolster the realisation of rights. It recommends that activists use the online space as a means of pushing for the inclusion of WSW within the African healthcare rights realm, most specifically the African Women's Protocol. Online (and other) spaces should seek to further the idea that WSW should form a part of the conversation surrounding HIV and STIs in order to ensure that they enjoy the same protection enjoyed by other groups.

One focus of this advocacy should be on the lack of information that hinders the physical enjoyment of these rights, whilst also focusing on the lack of rights within the framework in general. The problem of the misinformation or lack of information should be identified as a barrier within society and the healthcare system. Advocacy for the formulation and further development of a rights-based document should seek to address this problem of misinformation and lack of information. It should be ensured that knowledge production and proliferation form an integral part of any initiatives surrounding WSW and HIV and STIs, as these form a part of the foundation on which people can base their enjoyment of rights.

Furthermore, it recommends the creation of numerous online spaces in which WSW can specifically discuss these matters within the African context. In addition to this, activists and feminist lawyers should be informed about the ways in which the Women's Protocol can aid in the furtherance of the health rights of WSW, as this would encourage them to integrate its provisions in their respective mobilisation and litigation strategies. Furthermore, this space can and should be supplemented by open-access research into matters

137 C Antonites & K Mugo '#FillThisSpaceIfYouAreAnAfricanWoman' (2014) 28 *Agenda*.

138 C Lampe *et al* 'Familiar Face(book): Profile elements as signals in an online social network' in *Proc CHI* (2007).

pertaining to WSW, produced within the medical and academic spheres. These spaces should be accessible and safe, ensuring anonymity, and should be linked to social media platforms, especially Facebook, which prove the most popular.

The creation of various spaces can eventually be brought together in a 'hub' that could act as a portal to information. We also recommend further research into matters producing knowledge that is easily accessible to these communities through these various online spaces. The creation of Facebook pages, Twitter accounts and a website on HIV/AIDS and STIs that speaks specifically to the needs of WSW within the African context can prove a powerful tool towards empowerment in terms of sexual reproductive rights, allowing them better access on the continent.