

Treatment

Gender inequality and corrective rape of women who have sex with women

By Alexa Mises

The bloody, lifeless body of a woman was discovered in a creek outside of Johannesburg, South Africa. Twenty-five gaping wounds were found on her face, chest, legs and feet. There was evidence that she had been raped by multiple men. Even after her body had been removed from the scene, officials never took the time to clean up the blood and collect the woman's torn clothing strewn about the dirt. It was April 2008, and the woman was Eudy Simelane. In this act of violence, the South Africa's Women's National Football team lost a star player, South Africa lost an activist for equal rights, and the Kwa Thema region lost one of its first openly lesbian women.¹

Gender inequality poses a major threat to public health in South Africa. Lack of sexual power for women means they cannot consistently exercise their right to protect themselves against unwanted pregnancies and sexually transmitted infections (STIs), including HIV. A study presented by researchers at the Centers for Disease Control and Prevention (CDC) at the 2004 International Conference on Women and Infectious Diseases found that South African women who used condoms inconsistently were more likely to report having less control in their relationships, and more likely to have been forced to have sex by their most recent partner.²

Women in South Africa have less sexual and economic power than men. Strict gender roles condone and encourage multiple partnerships for men, while placing expectations of monogamy and blind faith on women. Gendered power inequalities place women who challenge their male partners' sexual wishes, including not using a condom, at risk for violence

or suspicions of infidelity. These roles impact South Africans from a young age. A study of youth in a Xhosa township finds that males obtain control over females' sexual experiences through coercion and sometimes violent action.³ Simultaneously, norms within southern African cultures designate sex as primarily procreative, discouraging comprehensive and honest talks about sexuality and safer-sex practices.⁴

Migratory and labor trends in the larger region contribute to gender inequity. South Africa shares mining and agricultural economies with neighboring countries, including Zimbabwe and Zambia.⁵ Men commonly work as laborers, moving between these three

At least 31 lesbians have been murdered in South Africa since 1998.

countries in search of work. While away from home, these men are more likely to have multiple sex partners, putting themselves and their partners at greater risk for HIV and STIs upon their return.⁶ In 2002, 12% of South African women between ages 15–24 were infected with HIV, versus 6% of men. This discrepancy is explained by greater biological susceptibility combined with sociocultural and economic factors. Economic vulnerability plays a large role in women's lack of power in negotiating sexual encounters, and especially for younger women contextualizes barriers to safer sex.⁷

The tolls of gender inequality go beyond such health disparities, and are adding up in death tolls. South

African women face a new epidemic, one that threatens their lives and creates additional barriers to HIV prevention. South African lesbians and other women who have sex with women (WSW) challenge dominant South African ideas about gender identity. Some WSW are sexually and brutally punished by local men for being gay and violating traditional gender presentation. This punishment is referred to as “corrective rape.”

Reported incidents of corrective rape have been growing, and many unreported cases remain uncounted. South African officials rarely declare these crimes as hate crimes, despite the fact that the victims are targeted for being WSW. In July 2007, two women were found in a Johannesburg township after being gang-raped, tortured, tied with their underwear and shot execution-style in the head.⁸ In a report about corrective rape issued by ActionAid, a friend of the women said:

They were outside a bar, a crowd of people were abusing them and calling them tomboys, but Sizakele said ‘no we are not tomboys, we are lesbians,’ then they left and we never saw them again.⁹

These two women, Sizakele Sigasa and Salome Massooa, were some of the first women to live openly as lesbians in the Meadowlands Township in Johannesburg.¹⁰ Sigasa was a well-known gay and women’s rights activist, as well as an HIV activist.

ActionAid has actively documented responses to incidents of corrective rape in South Africa. In a video featured on *The Guardian’s* website, both female victims and local men were interviewed. One middle-aged man said the reason a woman becomes a lesbian is, “because of the failure of the relationship they had, so they turn now to this new thing of being a lesbian.” Another young man said:

If there is someone who is trying to rape a lesbian, I can appreciate their thing. It’s just to let them know that they must be straight. For me, I have no time to rape them but if another guy wants to teach them the way, they must rape them, they must rock them. Once she gets raped, I think she’ll know which way is nice.

The South African Constitution states that no person or member of the state may discriminate on the basis of a range of social statuses and identities, including gender, sex, marital status, and sexual orientation.¹¹ However, there have been 31 recorded murders of lesbian women in South Africa since 1998, and of these murders only one has resulted in a conviction.¹² In one of many examples of unresolved justice, a 19-year-old lesbian woman from Khayelitsha, Cape Town, was beaten, stoned and stabbed to death.¹³ Six men were arrested for the crime but no official has publicly considered the

crime as a hate crime, which would be punishable by a different consequence than rape alone.¹⁴ Survivors of corrective rape in South Africa report experiencing verbal abuse before the rape focused on “teaching a lesson” to the woman, showing them how to be a “real woman” and what “a real man tastes like.”¹⁵ The targeting of WSW, coupled with the verbal abuse aimed at their gender presentation and sexual orientation, indicates that these crimes are fueled by misogyny and homophobia. While the Constitution states that national legislation must be enacted to prevent or prohibit unfair discrimination, rapists are clearly almost never held accountable.

Rape increases the likelihood of HIV transmission in many capacities. Violence against women by intimate partners in the home or by strangers increases the risk of HIV infection for women and of further violence.¹⁶ Rape and sexual assault weaken a woman’s control over when, with whom, and how they have sex, significantly increasing the risk of HIV.¹⁷ Whether or not the offender is an intravenous drug user may increase the likelihood that he has HIV. Once it is established that the offender is HIV-positive, the violent force with which some rape occurs may contribute to HIV-transmission.

Some WSW are sexually punished by local men for being gay.

Unprotected sex, genital trauma including vaginal and/or anal tears, and bite injuries increases the likelihood of HIV-transmission, and are all characteristic consequences of rape.¹⁸

This atrocity is not taking place in South Africa alone. In Zimbabwe, a young lesbian woman was locked up by her family and raped by an older man until she became pregnant.¹⁹ In Thailand, a Burmese lesbian and factory worker went shopping with a male friend. He and several other men told her she was wasting her beauty as a lesbian. All six men raped her. No one came to her defense following the incident, despite the fact that everyone at the factory knew what had happened.²⁰ In the United States, a woman in Georgia filed a civil lawsuit alleging that a former deputy police officer raped her because she is a lesbian.²¹ The woman said the officer vowed to “teach her a lesson.”²²

The rape and murder of South African national soccer star Eudy Simelane brought attention to corrective rape in the international arena. While factors such as migration affect safe-sex practices and the spread of HIV in South Africa, corrective rape exacerbates the problem. Simelane’s mother said, “Why did they do

this horrible thing? Because of who she was? She was stabbed, 25 holes in her. The whole body, even under the feet.”²³ Three men were brought up on charges for the murder. As of August 26th, 2009, the trial was ongoing.²⁴

Sixty-six member countries of the United Nations delivered the first ever statement on sexual orientation and gender identity at the UN General Assembly on December 12, 2008.²⁵ Neither South Africa or the United States signed on in support. The statement reaffirmed “the principle of non-discrimination which requires that human rights apply equally to every human being regardless of sexual orientation or gender identity.”²⁶ Later, the United States supported the UN General Assembly Joint Statement on Sexual Orientation, Gender Identity, and Human Rights. The U.S. is also a member of the UN Human Rights Council.²⁷

It is the responsibility of the international community to take the necessary measures to enable women to have power over their health, safety and security by addressing violence against women in all of its forms. In moving forward, attention must be paid to the interlocking and deadly outcomes of institutionalized homophobia, misogyny and stigmas surrounding HIV prevention.

Alexa Mieses was a JK Watson Fellow at GMHC in 2009. To view references, go to www.gmhc.org

Men who have sex with men and the global HIV/AIDS epidemic

By Krista Lauer

Recent data make clear that men who have sex with men (MSM)¹ are seriously affected by HIV around the world. In low and middle-income countries, MSM are on average 19 times more likely to be infected with HIV than the general population.²

HIV prevalence rates among MSM have been reported as high as 30% in Jamaica and 25% in Thailand. In Sub-Saharan Africa, the primary target of the Presidents Emergency Plan for AIDS Relief (PEPFAR), the U.S. global strategy to combat AIDS, HIV prevalence rates among MSM have been recorded at 43% in coastal Kenya, 25% in Ghana, 21% in Malawi, 20% in Botswana, and 12% in Namibia.³

Homophobia, stigma and discrimination fuel HIV transmission, driving MSM underground, where shame

and secrecy exacerbate HIV risk. Fear of rejection,⁴ public humiliation,⁵ ridicule by health-care workers,⁶ pressure to have children,⁷ and blackmail⁸ are but a few reasons why MSM may conceal their behavior. As but one example, in April 2009, Uganda’s tabloid newspaper Red Pepper published a full page article listing the names and descriptions of 50 suspected homosexuals, including photos of four individuals. Gender-based violence against men perceived to be gay has been reported at extreme levels in the Caribbean,⁹ Iraq¹⁰ and elsewhere, ranging from verbal harassment to physical violence, including torture and murder. Homosexuality is illegal in 80 countries around the world, and is actually punishable by death in five of those nations, as well as in parts of two other countries.¹¹

Globally, MSM are on average 19 times more likely to be infected with HIV than the general population.

Those men who are willing and able to come forward and access HIV services are, on average, out of luck. A 2007 meeting of the Global HIV Prevention Working Group estimated that only 9% of MSM are reached with HIV prevention services.¹² More recent global data is telling in its own way—analysis of the 2008 UNGASS country reports from Latin America, the Caribbean, Eastern Europe, the Middle East, Asia, and Africa found that 71% of countries did not even report on the number of MSM receiving HIV prevention services.¹³

Disturbingly, many men may not even realize they are at risk. Misconceptions that sex between men carries no risk of HIV transmission have been widely reported in Africa and in the Caribbean in both anecdotal reports and published research literature.^{14,15} Prevention messaging and imagery that focuses exclusively on heterosexual transmission may suggest that HIV risk is only a factor between partners of the opposite sex—especially given that the word “sex” in certain contexts can indicate reproduction.¹⁶ Where men do know the risk of HIV transmission between men, access to the necessary prevention products can be a big issue. Oil-based products like Vaseline and body creams are more commonly used in some contexts because they are less expensive and more widely available than water-based lubricants,¹⁷ though they have the distinct disadvantage of breaking down latex condoms and rendering them ineffective.

While delivering the Jonathan Mann memorial lecture in health and human rights at the 2008 International AIDS Conference, Jorge Savedra pointed-

GMHC treatment
ISSUES
Treatment
ISSUES

EDITOR: NATHAN SCHAEFER

ASSISTANT EDITORS: SEAN CAHILL, ALANA KRIVO-KAUFMAN

ART DIRECTOR: ADAM FREDERICKS

GMHC Treatment Issues

is published by GMHC, Inc.

All rights reserved.

Noncommercial reproduction is encouraged.

GMHC Treatment Issues

The Tisch Building

119 W. 24th Street, New York, NY 10011

www.gmhc.org

© 2009 Gay Men's Health Crisis, Inc.

Support for *GMHC Treatment Issues*
was made possible through educational grants
or charitable contributions from the following:

GlaxoSmithKline, Pfizer, Roche

edly noted that “we have failed to bring down the incidence among MSM because, with some exceptions, we have not tried.”¹⁸ Public denouncements against MSM in recent years by political and religious leaders continue to be a significant hurdle to addressing HIV among MSM as a priority issue.¹⁹ Ugandan President Yoweri Museveni asserted in 1999 that “we don’t have homosexuals in Uganda.”²⁰ In 2008, Gambian President Yahya Jammeh vowed “stricter laws than Iran” on homosexuality, pronouncing that he would “cut off the head” of any gay person found in Gambia.²¹

The lack of research and data on HIV among MSM makes their plight less obvious or even unknown to regional and national AIDS control organizing bodies. Without reliable information on the number and percentages of MSM living with HIV, it is harder to justify allocating resources towards reaching them with HIV services. MSM must be integrated into routine HIV surveillance practices to ensure that planners have the most up to date information on the state of their local epidemic. Scaling up efforts is also hindered by a lack of funding, which globally is not proportional to the scale of the epidemic among MSM: merely 1.2% of prevention funding goes towards combating HIV among MSM.

More voices are needed to bring these issues to light, but significant social, structural and policy barriers exist. Aside from laws criminalizing homosexu-

ality and general hostility toward MSM, restrictive regulations and laws can get in the way of effective advocacy. In some countries, organizations that seek equal rights and empowerment for MSM are ineligible to gain official non-governmental or non-profit organizational status, which often precludes them from receiving donor funding. Harassment of HIV outreach workers who seek to educate and serve MSM is likewise detrimental.

Success in treating MSM infected and affected by HIV around the world will require extremely broad social and political changes as much as localized clinical services. There are encouraging signs for the road ahead. The 2008 reauthorization of PEPFAR includes a new directive for HIV prevention education specifically targeting MSM.²² The 2009 HIV Implementers’ Meeting—a gathering largely comprised of PEPFAR grantees and other frontline HIV service organizations—included, for the first time, a workshop solely dedicated to reaching MSM, and several other presentations on MSM. Among the innovative projects discussed was making use of cell phones—ubiquitous in many African contexts—to deliver HIV prevention information, coupled with MSM-trained counselors just a phone call away. The program was a resounding success in Ghana.

Both the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNAIDS have recently released new strategic documents on reaching MSM and other sexual minorities. A worldwide coalition of MSM activists, the Global Forum on MSM and HIV, is linking allies from all world regions together to educate and advocate for the health and human rights of MSM. U.S. Global AIDS Ambassador Dr. Eric Goosby and UNAIDS Executive Director Michel Sidibé spoke at a September 2009 Congressional Briefing on MSM and the global HIV epidemic—unprecedented public support for reaching MSM through PEPFAR.

So what, exactly, is needed to address HIV among MSM? The 2009 World AIDS Day theme, “Universal Access and Human Rights,” could not be a more fitting directive.

Krista Lauer, MSc., is Manager of International Policy at AIDS Project Los Angeles, and Policy Associate at the Global Forum on MSM and HIV. She currently serves as Chair of the HIV Policy Working Group on MSM and Other Sexual Minorities. To view references, go to www.gmhc.org