

Re-sexualising the epidemic

DESIRE, RISK AND HIV PREVENTION

Even in the 'era of treatment' successful HIV prevention remains an enormous challenge. In this article **Jonathan Berger** argues that there is a need to pay more attention to sex and desire in the design of HIV prevention programmes and to move away from stereotyped explanations of vulnerability that ignore agency and desire in the decisions that people make about sex. The article also warns against the continued marginalisation of people who engage in 'dirty sex' from access to HIV prevention programmes and services.

Background

HIV prevention programmes in sub-Saharan Africa are premised on the understanding that, unlike in the developed world, the predominant mode of transmission is heterosexual sexual intercourse. In our part of the world, unprotected sex between men and women is said to account for the vast majority of HIV infections, with most of the remaining infections – transmitted from mother-to-child during pregnancy, labour or breast-feeding – being the indirect result of such unprotected sex (Pisani, 2000:67).

The African epidemic is further understood as one in which women – especially poor women – are significantly more vulnerable to HIV infection than men. Such vulnerability is based both on biology and the lower social status of women. Not only are women subjected to sexual abuse, they often find themselves in coercive sexual relationships where they are unable to insist on condom use, frequently remaining faithful to abusive partners who are not (Frasca, 2003:14-15). In short, 'women are more vulnerable to HIV than men ... and more at risk of HIV biologically because they are women' (Berer, 2003:9 (emphasis added)).

Such an analysis is useful in that it helps us to begin understanding what is distinctive to patterns of HIV transmission in sub-Saharan Africa in general and our region in particular, and why policy-makers cannot blindly follow prevention models that have evolved to deal with vastly dissimilar epidemics elsewhere. While we have much to learn from the rest of the world, which includes other parts of our own continent, the discourse of gender and vulnerability provides a necessary starting point for the development and implementation of prevention programmes that are responsive to the particular needs and circumstances of our context.

But our reality is far more complex and nuanced than the analysis tends to suggest. By telling part of the story as if it were the entire story, the vulnerability picture often painted is both inaccurate and misleading. As an example, consider the significantly higher levels of HIV infection in young women aged 15 to 24 that are automatically cited 'as evidence of young women's greater vulnerability (Berer, 2004:9). The claim is made despite the evidence showing that young men in the 25-and-older age category are quick to 'catch up', that young women are having much more sex than their male counterparts and that only a minority of all sexual encounters are unwanted (Pettifor *et al*, 2004:37-50).

Further, the analysis is incomplete and under-inclusive in a number of respects, quite notably in its hetero-normative approach to sexuality. Lumping all men together into a single 'less vulnerable' category, the discourse effectively 'dispatch[es] the homosexual HIV/AIDS epidemic into invisibility' (Frasca, 2003:15). Gay-identified men and other men who have sex with men simply do not feature in an epidemic of heterosexuals. The analysis does little – if anything – to explain the extent to which men's vulnerability depends on whether or not they are exclusively heterosexual (Frasca, 2003:15).

Most disturbingly (and perhaps unwittingly), the attempt to find a single theory to explain a complex phenomenon tends to overplay vulnerability in a way that risks entrenching the realities of many women's lives. Conceived of as desexualised beings trapped in men's power and promiscuity, African women are simply waiting to be infected. In suggesting a solution that lies primarily in changing power relations so that women can protect themselves from those men that cannot be made responsible, the discourse of vulnerability risks rendering the essence of gendered relationships as immutable and unchangeable.¹

This discourse is at odds with the increasing recognition that 'there is no single explanation for the HIV/AIDS epidemic', and that in countries such as South Africa, a 'unique combination of factors influences the pattern and profile of the epidemic' (Walker *et al*, 2004:20). Acknowledging the need to recognise 'the important contribution of gender as one conceptual framework in HIV/AIDS', we must also consider 'the theoretical strengths and critical capacities of other analyses ... to amplify our understanding of how HIV is pursuing its trajectory through the population of this planet' (Dowsett, 2003:27-28).

Given that '[s]ex, power and risk lie at the heart of understanding HIV/AIDS in contemporary South Africa' (Walker *et al*, 2004:20), the gender and vulnerability analysis can and must be complemented by a focus on sexuality,² even if it means challenging the very beliefs that many people hold dear. It may, for example, mean

¹ While not excused for their unacceptable behaviour, men are to some extent also characterised as victims of the system. Thus prisons, the migrant labour system and dangerous forms of work that are forced onto men by economic circumstances are all relied upon to explain why men often have no choice but to engage in risky sexual behaviour (Campbell, 2004:28-31).

² See also Campbell, p. 2, where the author recognises that each of a range of 'perspectives forms an essential frame in the kaleidoscope of factors that are implicated in the development and persistence of the HIV epidemic in developing countries, making a crucial contribution to understandings in this area.'

accepting that women enjoy sex for the sake of sex; that some married men enjoy having sex with other men as well as their wives; and that cultural practices such as virginity testing may be placing young men and women at risk of infection. More disturbing for policy-makers and implementers, it may mean recognising that many of our HIV prevention programmes are fuelling, rather than putting the brakes on, the further spread of the epidemic.³

So how should the focus on sexuality be conducted? First, we need to accept the 'remarkable variability in sexual expression and desire', recognising that sexuality is 'fluid, mutable and incomprehensible within that simplistic binary of heterosexual or homosexual' (Dowsett, 2003:27). Only by rejecting a simplistic understanding of sexuality that is inextricably tied to the exercise of power and gendered relationships are we able to see HIV/AIDS for what it is in addition to a disease of poverty and gender inequality – 'an epidemic of desire' (Dowsett, 2003:25).

Second, despite our laws and customs telling us 'who is permitted to be sexual with whom, and at what age' (Berer, 2004:7) we need to recognise that there is great variation in our sexual practices. But recognition of the diversity of sexual expression is not enough. We need to understand what type of sex we have, why we have the type of sex that we have, and why we have sex when we do and with whom we do. This means understanding in what way desire drives people to engage in various forms of 'dirty sex' and what this means for HIV prevention programmes.

In essence, there are two categories of 'dirty sex' that we ordinarily choose to ignore: those that involve 'unacceptable' sexual partners, such as people of the same sex and commercial sex workers, and those that involve 'unacceptable' practices, such as anal sex and sado-masochism. At the outset, it is important to note that we do not know the extent to which such sexual practices form an integral part of the 'reality of our sexual lives', or whether more people are in fact engaging in these and other forms of 'dirty sex' than society cares to admit.

³ In this regard, see Campbell, p. 3, where the author argues as follows: 'Change and innovation are of particular importance in relation to an epidemic such as HIV because epidemics are, by definition, extraordinary events. They arise because existing understandings of health and illness, and existing public health systems and institutions, are inappropriate for addressing the particular form the epidemic takes, and for stemming the particular mechanisms by which it spreads'.

All of the complexities regarding sexual practices get overlooked when we reduce AIDS simply to an issue of gendered power relations. We quickly forget that about half the adults in the world with AIDS are men, that men do not only have sex with women (and sometimes have sex with both women and men), that the vagina is not the only route of sexual infection, that women are not always faithful to their sexual partners and that men often are, and that men and women infect each other (Berer, 2004:9).

Third, we need to understand how and in what way the typical gender analysis has the potential to feed into and reinforce a conservative moralistic approach to sex, sexuality and HIV prevention. By painting the world as one of women's vulnerability and men's lack of responsibility, where both know their respective places, we perhaps lend some credence to the dismissal of 'most sexual relations as illicit and therefore not deserving of protection' and the view of 'condoms as symbols of illicit sex rather than as a safe and highly effective means of dual protection'. By ignoring – or marginalising – the 'role of sexuality and diversity and meanings of sexual relations', the 'distorted and distorting gender analysis ... perversely ... helps to maintain gender stereotypes' (Berer, 2004:9).

Finally, we need to see that the gender and vulnerability analysis does not take us very far in explaining why 'people knowingly engage in sexual behaviour that could lead to a slow and painful premature death' (Campbell, 2004:1), and that it often overshadows 'other equally structural ways in which HIV is transmitted' (Dowsett, 2003:22). Knowing how and why women are unable to protect themselves from HIV infection in abusive or coercive relationships does not help us to understand why many 'empowered' women fail to protect themselves and engage in unsafe sex. Gender-based violence, abuse and coercion do not fully explain 'what is happening in sexual relationships that makes both men and women vulnerable to HIV and STIs in epidemic proportions' (Berer, 2004:9).

The spotlight on sexuality should therefore focus on achieving two clear goals. First, it should attempt to paint an inclusive, non-judgmental and accurate picture of the diverse and varied ways in which we have sex and why we do so, recognising that '[i]n any country, confronting the reality of the complex sexual lives of its citizens is bound to be difficult' (Dowsett, 2003:28). Second, it should seek to appreciate how the sexual relations that people have could be protected and made safer. This can only take place if it is understood that 'support for safe, consensual sexual relations, inside as well as outside marriage ... [is] a legitimate subject of public education and expenditure' (Berer, 2004:10).

This paper does not do complete justice to either. Instead, it seeks to contribute to the debate in two small but distinct ways. First, it attempts to highlight some of the 'dirty' issues that are all too often overlooked but nevertheless form an essential part of the broader picture. In doing so, it tries to identify a few of the essential questions that need to be – but are usually not – asked. Second, it explores why some people fail to place themselves in safety when having sex in circumstances where they are in a position to do otherwise – in other words, why they make 'bad' choices or 'fail to choose rationally' (Chan *et al*, 2003:40).

The 'dirty' issues

As a necessary (albeit insufficient) condition for ensuring that people protect themselves and/or their sexual partners from HIV infection,⁴ prevention messages need to speak to the reality of our sexual lives if they are to have any impact on our behaviour whatsoever. How and in what way such messages should be conceived and delivered lies beyond the scope of this paper, which rather seeks to tackle some of the types of sexual practices that need to be addressed when HIV prevention programmes are developed and implemented.

Because we generally do not ask the relevant questions, we simply do not know the answers. But what we do know suggests that 'dirty sex' may indeed be playing a pivotal role in driving the epidemic in our part of the world, having profound implications for the reassessment of existing, and the development and implementation of new, HIV prevention programmes. This hypothesis is based on three interrelated factors.

First, there is evidence showing that some of those who engage in 'dirty sex' also have 'clean sex' partners. Such a category of persons includes married men who have sex with other men as well as their wives, men who have intercourse with commercial sex workers as well as their regular partners, male prisoners who have sex with other men whilst incarcerated but with women upon their release, and women who have sex with men other than their migrant labourer husbands (Lurie, 2003:2245-2252). What we do not know is the extent to which this occurs.

⁴ While recognising that '[g]iving people information about health risks is unlikely [in and of itself] to change the behaviour of more than one in four people', it is nevertheless important to get the information right. See Campbell, 2003, p.10.

Second, 'clean sex' such as intercourse between two HIV-negative persons in a *de facto* monogamous relationship is indeed safe sex, as safe as abstinence insofar as HIV infection is concerned. But the risk of infection arises and increases as the sex becomes 'dirty' and 'dirtier', as we move beyond the idealised sexual relationship. Consider anal sex as an example. All things being equal, it is more likely to result in HIV transmission than vaginal intercourse per sexual encounter.

Third, Southern African countries have high levels of HIV prevalence and incidence amongst all sexually active persons and not only amongst those persons who are seen to engage in 'dirty sex' with each other. While gay men, commercial sex workers, prisoners and survivors of sexual assault may be disproportionately affected, even those often perceived to be safe – such as whites – are at a relatively high risk of infection.⁵

It thus seems reasonable to infer that the high levels of HIV infection seen in Southern Africa can only be explained by a much higher prevalence and incidence of 'dirty sex' than is generally admitted, particularly by those who also engage in 'clean sex'. If this is true, it has two key implications for public health policy. First, it requires that the state and other important role-players invest resources into appropriate research that aims to give as accurate and comprehensive a picture as possible of how society actually has sex. Second, it means designing and implementing HIV prevention programmes that move beyond the sanitised paradigm of sex without desire, viewing sex as more than that which gives expression to and nurtures warm and fuzzy monogamous relationships.⁶

Rather than detailing all forms of 'dirty sex' that may be practiced in this part of the world, this section of the paper focuses instead on two examples – sex between men and anal intercourse between men and women. In focusing on 'almost clean sex',⁷ however, it perhaps risks perpetuating the marginalisation of even 'dirtier' forms of sex, such as sex work and sado-masochism. Nevertheless, it is important to begin with what the evidence suggests is of significant relevance to our part of the world.

⁵ Shisana *et al* (2002:59) explain that the estimated HIV prevalence among whites in South Africa is much higher than that observed in predominantly white societies, for example in the USA, Australia, France and UK, which have HIV prevalence less than 1%. 'The HIV prevalence among whites and coloureds clearly indicates that a dynamic epidemic is occurring in these groups'.

⁶ See *S. v. Jordan and others (Sex Workers Education and Advocacy Task Force and others as Amici Curiae)* 2002 (6) SA 642 (CC) at paragraph 83, where the minority decision links the 'private and intimate character' of the 'sex act' with the 'nurturing [of] relationships ... [and the] taking [of] life-affirming decisions about birth, marriage or family'.

⁷ This probably applies only to a country like South Africa, where sex between men is increasingly seen less and less as a prime example of 'dirty sex'.

Sex between men

In most parts of our region, consenting sexual activity between two people of the same sex is both highly stigmatised and criminalised. In Zimbabwe, for example, a constitutional challenge to the common law offence of sodomy, defined as 'unlawful intentional sexual relations per anum between two human males',⁸ failed primarily on the basis that 'Zimbabwe is a conservative society on questions of sexual morality and the Court should not strain to interpret provisions in the Constitution which were not designed to put Zimbabwe among the front-runners of liberal democracy in sexual matters'.⁹

While this is perhaps not unexpected in a country where the head of state has for many years been at the forefront of a sustained campaign to vilify lesbian and gay people, a seemingly more tolerant country such as Botswana not only continues to criminalise various forms of sexual conduct between men, but has also 'equalised' the criminal prohibition by extending it in 1998 to include sex between women.¹⁰ A recent Court of Appeal decision on the constitutionality of certain provisions of the Penal Code that criminalise same-sex sexual activity held that 'the time has not yet arrived to decriminalise homosexual practices even between consenting adult males in private' and that '[g]ay men and women do not represent a group or class which at this stage has been shown to require protection under the constitution'.¹¹

In such a hostile environment, it is perhaps unsurprising that HIV prevention efforts largely ignore the needs of gay men and other men who have sex with men. Just as the criminalisation of commercial sex work for the most part places vulnerable women at risk, so too does the continued criminalisation of sex between men make it difficult for

⁸ *S. v. Banana* 2000 (3) SA 885 (ZS) at 903H.

⁹ *Ibid* at 935H - J. See, however, the dissent of Gubbay C.J. at 903B - 910J.

¹⁰ Prior to its amendment, section 164(c) of the Botswana Penal Code provided that any person who 'permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for seven years.' The subsection now extends the crime to any person who 'permits any other person to have carnal knowledge of him or her against the order of nature'. Section 167, which previously prohibited 'indecent practices' between men, now criminalises the conduct of any person who 'whether in public or private, commits any act of gross indecency with another person, or procures another person to commit any act of gross indecency with him or her, or attempts to procure the commission of any such act by any person with himself or herself or with another person, whether in public or private'.

¹¹ The Court of Appeal held that the appellant could not be charged under section 167 because at the time of the 'offence' in 1995, the section discriminated on the basis of gender. The court also found that section 164(c) did not, and does not, discriminate on the basis of gender.

health authorities and civil society organisations to conduct successful HIV prevention campaigns among gay men and other men who have sex with men.¹² In such contexts, high levels of stigma and the law work hand-in-hand to reinforce each other and render 'unAfrican' forms of desire potentially life-threatening. By driving same-sex desire 'underground', law and social stigma contribute towards increasing the numbers of people who engage in both 'dirty' and 'clean' sex.

Yet even in South Africa, where lesbian and homosexual people have the full protection of a Constitution that prohibits unfair discrimination on the basis of sexual orientation,¹³ where consensual sex between men has been decriminalised,¹⁴ and where Parliament and the courts are increasingly granting and recognising full legal protection for same-sex relationships,¹⁵ sex between men largely remains off the HIV prevention agenda. All too often we hear the excuse that the majority of HIV infections in our part of the world occur via heterosexual intercourse, as if attending to the needs of sexual minorities is necessarily at odds with prevention efforts amongst the majority of the population.

In Africa, infection rates among gay men and other men who have sex with men are unknown, with national statistics even in a country such as South Africa being largely

¹² In India, for example, the police allegedly used the provisions of the Indian Penal Code in 2001 to close the offices of two non-governmental organisations that work in the field of male sexual and reproductive health. Numerous materials were confiscated from the offices, including brochures and videos on HIV prevention, as well as condoms and lubricant. A number of people, including the executive director of the two organisations as well as numerous staff members of both, were allegedly arrested on charges of conspiring to commit sodomy under section 377, read with sections 109 and 120b, of the Penal Code. Section 377 punishes 'carnal intercourse against the order of nature with any man, woman, or animal', with the other two sections dealing with abetment (the act of instigating another person to commit a crime) and criminal conspiracy respectively. See International Gay and Lesbian Human Rights Commission, 'Police raids and sodomy arrests in India' (17 July 2001), available online at <http://www.q.co.za/2001/2001/07/18-indiaarrests.html>.

¹³ See section 9(3) of the Constitution of the Republic of South Africa, 1996.

¹⁴ See *S v Kampher* 1997 (4) SA 460 (C) and *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC).

¹⁵ See, for example, *Langemaat v Minister of Safety and Security and Others* 1998 (3) SA 312 (T); *V v V* 1998 (4) SA 169 (C); *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC); *Farr v Mutual and Federal Insurance Co Ltd* 2000 (3) SA 684 (C); *Satchwell v President of the Republic of South Africa and Another* 2002 (6) SA 1 (CC); *Du Toit v Minister of Welfare and Population Development and Others (Lesbian and Gay Equality Project as amicus curiae)* 2003 (2) SA 198 (CC); *J and Another v Director-General, Department of Home Affairs and Others* 2003 (5) SA 621 (CC); and *Du Plessis v Road Accident Fund* 2004 (1) SA 359 (SCA). For a list of recent legislative developments, which range through statutes dealing with employment, the media, lotteries, pensions, medical schemes, housing, civil aviation, road traffic, domestic violence and estate duty, see Satchwell at footnote 27, Du Toit at footnote 33 and *Minister of Home Affairs* at footnote 41.

based on antenatal surveys that by definition exclude gay men (Walker *et al*, 2004:36). Yet even when the possibilities for accessing relevant information have arisen, more representative surveys have failed to ask the type of questions or record relevant responses that may shed some light on the topic. By simultaneously allowing anal sex to slip into the broad definition of sex and failing to differentiate between heterosexual and homosexual anal sex, for example, such surveys perpetuate the culture of silence (Reddy *et al*, 2003; Pettifor *et al*, 2004).

Not only does an almost complete lack of state-funded HIV prevention work among gay men and other men who have sex with men unjustifiably limit the constitutional rights of many men to life, dignity and access to health care services, but it also ignores the impact on the so-called heterosexual epidemic of 'straight-identified' men who, while in sexual relationships with women, are having sex with other men (Lane *et al*, 2004b). But 'otherising' sex between men, we as a society ensure that same-sex desire remains stigmatised and a potential source of infection for both men and women.

Anal sex between heterosexuals

In a world where 'sex with oneself remains a highly stigmatised behaviour, [even] though it harms absolutely no one and is the safest form of sex' (Berer, 2004:7; Walker *et al*, 2003:34), it should come as no surprise that we are extremely uncomfortable about discussing 'dirty' forms of sex that are generally associated with highly stigmatised groups such as gay men and prisoners. But our reluctance to talk about anal sex, for example, does not appear to stop many heterosexuals from engaging in the practice.¹⁶ On the contrary, the available evidence suggests that our silence on the matter may indeed be responsible – in part – for the 'promotion' of anal sex as a 'safe' alternative to vaginal sex.

A study presented at the recent XV International AIDS Conference in Bangkok, for example, notes that current HIV prevention strategies may 'unwittingly encourage misperceptions' that anal sex is relatively safe. The data analysed in the study suggest that condom use is higher during vaginal intercourse than during anal intercourse

¹⁶ Some, such as former Justice McNally of the Zimbabwe Supreme Court, disagree. In finding that the common-law crime of sodomy in Zimbabwe does not constitute unfair discrimination on the basis of gender, despite it only criminalising anal sex between two men and not between a man and a woman, the learned justice provides the follow 'insights' into the sexual habits of heterosexuals: 'But realistically, and without going into sordid detail, how often does it happen that men penetrate women per anum? How often, if it does happen, is it the result of a drunken mistake? Or an excess of sexual experimentation in an otherwise acceptable relationship?' (*S v Banana*, above note 8 at 935A - B).

among heterosexuals who engage in both (Lane *et al*, 2004a). Similarly, an earlier study conducted among truck drivers in KwaZulu-Natal indicated that of those who had sex with sex workers,¹⁷ 71 per cent reported sometimes or always using condoms. Yet of the 42 per cent of men who practiced anal sex with the same sex workers, only 23 per cent reported ever using a condom during anal sex. In other words, condom use dropped radically when shifting from vaginal to anal sex (Ramjee & Gouws, 2000).

In addition to the assumption that heterosexuals may be engaging in anal sex because it simply feels good and satisfies their sexual needs and desires, there are two further hypotheses advanced to explain the 'phenomenon'. The first possible reason why heterosexuals may be choosing to have anal sex may have nothing to do with HIV prevention and everything to do with contraception. The study on anal sex and condom use presented in Bangkok thus identifies the need for further research to investigate anecdotal reports that anal sex is being used as a form of birth control (Lane *et al*, 2004a).

The second hypothesis notes the concern that in areas where 'virginity testing' has become commonplace, young women may be engaging in unprotected anal sex. The rise of such cultural practices has been accompanied by a corresponding rise in infection rates in girls of the relevant age group (Leclerc-Madlala, 2003:21). Leclerc-Madlala argues that 'girls might be agreeing to or perhaps suggesting anal sex to their partners as an alternative to vaginal penetration' because they are '[a]fraid to 'fail' their virginity tests' (Leclerc-Madlala, 2003:21).

The type of sex that people have is not only relevant for the development and implementation of HIV prevention programmes based on behavioural change, but also has significant implications for biomedical approaches to HIV prevention. As an example, consider basic science and clinical research into microbicides, antimicrobial gels or creams that could be applied topically to block the transmission of HIV and other sexually transmitted infections but have yet to be developed. Early research shows that the chemical structure of any successful microbicide may in large part depend on whether it is to be used either vaginally or rectally (D'Adesky, 2004; Ndinda, 2004).

¹⁷ Of the 320 men interviewed, 34 per cent always stopped for sex during their journeys.

Asking the right questions

Two recent surveys conducted in South Africa seem to suggest that the country may finally have woken up to the need to engage the 'dirty' issues. In many respects, both the South African National Youth Risk Behaviour Survey of 2002 (the NYRBS), 'one of the first studies undertaken in South Africa, and possibly in Africa, to establish the prevalence of key risk behaviours' (Reddy, 2003), and the report of the Reproductive Health Research Unit (RHRU) entitled *HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds* (Pettifor, 2004) represent a considerable breakthrough. Yet both are seemingly still unwilling to venture into really 'dirty' territory.

Take chapter 6 of the NYRBS report, which focuses on a number of specific aspects of 'sexual behaviour', such as age of first sexual encounter, the number of sexual partners, recent sexual activity, consistency of condom use and knowledge about protection against HIV infection. All questions asked in respect of such issues represent a significant advance, given our reluctance thus far to acknowledge that it is quite natural for young people to have sexual needs and desires and to act upon them.

However, the survey either failed to ask or the report fails to record whether the reported sex was either anal or vaginal (or both), whether it took place with a person of the same or opposite sex (or both), or whether it took place with a regular or casual partner (or both). So while the report gives us some idea of whether youth are using condoms when having sex, it sheds no light on whether condoms are used more or less in certain types of sex, whether they are being used more or less depending on the nature of the sexual relationship, or whether they are being used more or less depending on the sex of the sexual partner (Reddy *et al*, 2003).

The RHRU report goes a lot further. Using the same broad definition of sex, which includes both anal and vaginal intercourse, the report begins to explore issues such as the impact of relationships on condom use and the reasons why youth are having or not having sex. Interestingly, the report notes that sexually active young women are having more sex than men (both over the last 12 months and since their sexual debuts), are less likely to report always using a condom or using a condom during their last sexual experience, and are more likely to report having symptoms of sexually transmitted infections (Pettifor, 2004:37-50; Bradshaw *et al*, 2004:143-144).

But the report contains some fundamental errors. It does not explore what constitutes a regular sexual partner, failing to understand that the notion of relationship differs from person to person. Further, it does not explore whether people who are having

casual sex are also involved in relationships, whether the sexual intercourse reported is anal or vaginal (or both),¹⁸ or whether such intercourse is with someone of the same or opposite sex (or both). In addition, it does not seek to explore the sexual behaviour of those who are already living with HIV. Without asking many of the right questions, we are unable to make complete sense of the data presented.

Why are people 'choosing' not to place themselves in safety?

Health education has for some time largely been based on the assumption that 'increased knowledge about the causal links [between disease agents, behaviour and lifestyle] would enable individuals to make rational decisions and avoid risks' (Ahlberg *et al*, 2001:26-36). Public health initiatives have therefore treated people as rational actors in need of education about any particular disease and how to prevent themselves and others from infection (Chan, 2003:40). Armed with such knowledge, people will choose to avoid risk by incurring a relatively small – but certain – loss (such as the pleasure of condomless sex) to avoid a possible but greater loss in the future (such as AIDS-related illness and/or death) (Ahlberg *et al*, 2001:32).

Yet research suggests that sexual behaviour is largely not 'shaped by the conscious decisions of rational individuals' (Campbell, 2003:7), with information about the 'future consequences of risk' possibly playing 'only a minor role in sexual behaviour change' (Ahlberg, 2001:33; Walker *et al*, 2004:20; Campbell, 2003:7). Instead, many external factors influence the extent to which we are able to exercise our 'choices', such as 'who we have sex with, how and where we have sex, our views about sexual morality and even the objects of our sexual desire' (Walker *et al*, 2004:22). This is not to suggest that we have no control whatsoever in making decisions about sex, but rather that our desires and actions cannot be explained in isolation of the broader context that informs the choices we make.

Thus Campbell argues that the 'forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services' (Campbell, 2003:7). Similarly, Ahlberg notes that '[s]ocial norms, which define meanings and regulate social interaction, expectations and behaviour, are perhaps more important [than knowledge about the possible effects of unsafe sex]' (Ahlberg, 2001:33). Simply put, HIV prevention work is severely undermined when done without a proper understanding about the 'determinants

¹⁸ From a presentation made at the XV International AIDS Conference in Bangkok in July 2004, it appears that the matter was indeed considered by the researchers in the RHRU study (Lane *et al*, 2004a).

of sex and sexuality' (Campbell, 2003:7). The remainder of this paper therefore focuses on some of the reasons why people 'choose' not to place themselves in safety and engage 'knowingly' in high-risk sex.

Perceptions of risk

To translate knowledge about the potential danger of exposure to HIV into action, one needs to feel that one is at risk of infection. This is difficult to do when the disease is 'otherised' – categorised as a disease of others (Campbell, 2003:7). Even in South Africa, where significant attempts have been (and continue to be) made to counter initial perceptions that only certain groups are at risk of infection,¹⁹ studies show that some young men see HIV 'as a disease associated with atypical behaviours such as rape and commercial sex, or with excessive alcohol consumption' (Campbell, 2003:124).²⁰ If they were to become infected, such young men argue, it would be the fault of others (Campbell, 2003:124).

Recent legal developments in South Africa seem to give effect to such dangerous perceptions. In terms of section 2 of the Criminal Laws (Sexual Offences) Amendment Bill, B50-2004, for example, exposure to possible HIV infection is expressly criminalised as a form of rape.²¹ More recent (but as yet unpublished) versions of the Bill, while continuing to criminalise exposure to possible HIV infection, seek to create a separate statutory offence of harmful HIV-related behaviour instead of bringing the alleged offence within the ambit of an expanded definition of rape (Berger & Hassan, 2004).

In this way, HIV infection is seen as something that comes from outside and is not the result of our own conduct. The way to protect 'innocent victims' is to stop those with HIV from infecting others, thus blaming those who 'knowingly' place others at risk as 'irresponsible' and perpetuating the view that our own conduct is unproblematic (Chan, 2003:43). Once the state takes care of the 'criminals' in our midst, we are no longer at risk of infection.

¹⁹ See, for example, many of the HIV prevention materials distributed by South Africa's Department of Health, also available online at <http://www.aidsinfo.co.za>. In particular, see 'Wrong ideas about HIV and AIDS' in *Talking about HIV and AIDS*, where in response to the 'wrong idea' that 'AIDS is only a disease of white people' or 'only a disease of black people', the Khomanani/Soul City publication clearly states that 'AIDS is a disease that affects all races, colours, faiths and nations'.

²⁰ Not only is HIV not simply associated with such behaviours, but rape, commercial sex and alcohol abuse are sadly not particularly atypical behaviours in countries such as South Africa.

²¹ The latest published version of the Bill is available online at <http://www.info.gov.za/gazette/bills/2003/b50-03.pdf>.

While this type of 'otherisation' might explain why some youth do not believe they are at risk of HIV infection, it appears as an unlikely 'excuse' for the majority of youth in South Africa who do not believe that they are at risk of HIV infection (Pettifor *et al*, 2004:51-62; Campbell, 2003:124). Given high levels of AIDS-related morbidity and mortality, this specific form of HIV-denialism seems particularly disturbing. While one's youth is not ordinarily seen as a time to be worried about death and dying, but is rather associated with fun, games, experimentation and risk (Walker *et al*, 2004:33), the reality of young people's lives in this part of the world is somewhat different. It is therefore particularly puzzling that South African youth see serious, responsible behaviour as something only to be associated with commitment and marriage (Walker *et al*, 2004:33).²²

These low perceptions of risk among youth are reasonably well-documented in South Africa. Take the NYRBS as an example, which records that only 12.2 per cent of learners surveyed believed that they could get HIV at some future point in their lifetimes.²³ Such low perceptions of risk seem to translate directly into action. Thus while 65.9 per cent of learners interviewed believe they are able to protect themselves against HIV infection, only 44.8 per cent of those who are sexually active usually use condoms. An even lower number of sexually active learners – some 28.8 per cent – reported always using condoms (Reddy *et al*, 2003:55-56).

The RHRU report paints a strikingly similar picture. An extremely high percentage of respondents, 93 per cent, reported that they were aware of what could be done to prevent HIV infection, with a majority identifying condom use alone. Yet an awareness that condoms must be used 'consistently and correctly' has not translated into consistent and correct condom use, with 67 per cent of sexually active youth reporting that they did not use condoms consistently and as many as 31 per cent of sexually active youth reported that they never used condoms. Most disturbing, 63 per cent of those already infected believed that they were at little or no risk of HIV infection.²⁴

²² It is interesting – but disturbing – to note that 'serious, responsible behaviour' does not necessarily mean safe sex.

²³ Interestingly, there was no significant difference in responses from male and female learners.

²⁴ Participants in the study were not informed about the results of their HIV tests. The RHRU report explains: 'HIV testing was anonymous. HIV test results were linked to the behavioural questionnaire through a unique identification number, but could not be linked to an individual by name or other personal identifiers. Those individuals who wished to know their HIV status were referred by the

Neither the NYRBS nor the RHRU report ask about or record the reasons why youth believe they are at such low risk of HIV infection. It is unclear whether the respondents were asked the question, or if it was simply not recorded in the final reports. Furthermore, no explanation for a failure to transform knowledge into action was either sought or advanced. In other words, the reports do not offer any explanations as to why youth did not use condoms consistently and correctly, even though they knew that such behaviour could protect them from HIV infection. We are thus left with a wholly unsatisfactory account of youth risk behaviour because many crucial questions remain unasked or the answers unrecorded.

As 'easy' as ABC

The mainstay of most prevention programmes in our part of the world is the message of ABC – abstain, be faithful and 'condomise'. While abstinence from sex is undoubtedly the most effective way to avoid HIV infection, the abstinence message is clearly failing, given that most men and women are already sexually active by the end of their teens (Pisani, 2000:70). At best, well-designed and implemented abstinence programmes may result in sexual debut being delayed for a few years.²⁵ But such programmes also run the risk of stigmatising those who engage in sexual behaviour, making it potentially more difficult for them to protect themselves and others from HIV infection.

Those who are not able to abstain from sex are simply told to be faithful. Yet being faithful can only really protect one from HIV infection if one is in a position to have a monogamous sexual relationship with 'one, faithful, uninfected partner for the duration of ... [one's] sexual life' (Pisani, 2000:70). In practice, however, the 'be faithful' message is interpreted selectively. Some of the 'faithful' stick to one partner at a time or one partner in perpetuity, usually without any knowledge of their partner's HIV status and often without any assurance of faithfulness on his or her part (Pisani, 2000:70).

When all else fails, we are told to 'condomise'. In other words, condom use is not the gold – or even silver – standard, but rather a last resort. In a context where condom use

interviewers to the nearest HIV testing centre. This is in accordance with [World Health Organization] WHO guidelines for HIV testing for surveillance purposes ... and satisfied the requirements of the Committee for the Protection of Human Subjects, University of the Witwatersrand, Johannesburg, South Africa' (Pettifor *et al*, 2004:18).

²⁵ See Pettifor *et al*, p. 40, where the authors explain the importance of delaying sexual debut: 'A delay in the age at first sex is one of the many factors attributed to the decline in HIV, therefore the proportion of youth having sex at an early age is another important indicator'.

is already highly stigmatised,²⁶ such messaging undermines consistent and correct condom use. This is because the ABC message characterises condom use as necessary only when one (or one's partner) is unfaithful. In other words, the ABC package strengthens the perception that many people may have had for some time – that condom use indicates a lack of trust and infidelity (Varga, 1997:48).

Trust in relationships is reported by some commentators as being considered as all-important and expected to operate unconditionally, without any discussion of past sexual history or even HIV status (Campbell, 2003:126; Walker *et al*, 2004:41). Thus a majority of sexually active young men and women are said to believe that condoms are generally unnecessary in 'steady' relationships. 'Steady', however, does not necessarily mean long-term or even monogamous. Instead, it may simply mean a regular 'official' partner as opposed to a secret or casual lover (Campbell, 2003:125). In other words, being in a 'steady' relationship does not necessarily exclude the possibility of one or one's partner having other sexual partners.

To complicate matters further, being 'faithful' becomes significantly more dangerous as HIV prevalence increases. Thus Pisani argues that where HIV prevalence is very high and knowledge of HIV status very low, such as in Southern Africa, 'it is nothing short of irresponsible to suggest that monogamy (much less serial monogamy) can protect an individual from exposure to this fatal disease' (Pisani, 2000:70). In other words, being in a *de facto* monogamous sexual relationship in a high prevalence country places one at a very high risk of HIV infection where one's or one's partner's HIV status is unknown.

In this context, the availability of significant financial resources for HIV prevention programmes through the United States President's Emergency Plan for AIDS Relief (PEPFAR) is indeed cause for concern.²⁷ With its undue focus on abstinence-only programmes and operating against the backdrop of the 'Global Gag Rule',²⁸ which

²⁶ There is a strong perception that only unhealthy people use condoms (Walker *et al*, 2004:33) with condom use stigmatised because condoms have become associated with disease.

²⁷ For a brief official description of PEPFAR, see Office of the Press Secretary, 'Fact Sheet: Extending and Improving the Lives of Those Living with HIV/AIDS', available online at <http://www.whitehouse.gov/news/releases/2004/06/print/20040623-1.html>.

²⁸ Officially called the Mexico City Policy, the 'Global Gag Rule' became US policy under President Reagan and was in force until rescinded by President Clinton on January 22, 1993. It was reinstated by President Bush on 22 January 2001. See George W. Bush, 'Memorandum for the Administrator

precludes U.S. federal funding for government programmes and organisations that provide abortion services or even information on the availability of such services, PEPFAR can only make matters worse. Simply put, the conditionalities associated with the available funds have the potential to further entrench the dangerous message of ABC and to undermine many progressive aspects of sexual and reproductive health policy that may temper the message.

Satisfying 'needs'

'Human beings are sexual by nature' (Berer, 2003:7), with sex often being about nothing more than satisfying need and desire. 'If nothing else,' Berer notes, 'one thing seems certain – people will never stop having sex or wanting to have sex' (Berer, 2003:7). In other words, pleasure-seeking explains much sexual behaviour. But condoms reduce the pleasure of sex (Walker *et al*, 2004:34). How then do we ensure condom use when it seems to undermine the very reason why many people engage in sexual conduct in the first place? How do we deal with the reality that 'flesh-to-flesh' is simply more pleasurable, something that many people believe they 'must have'? How can our safe sex messages work if we do not speak to the realities of people's lives?

Campbell considers two key hypotheses in respect of a particular category of persons – migrant mineworkers. The first hypothesis sees 'flesh-to-flesh' sex possibly resulting from general loneliness and 'reduced opportunities for intimate social relationships' (Campbell, 2003:34). Thus people are recognised to be more likely to engage in unprotected sex when they do not have a 'supportive social environment' and where they feel 'lonely and isolated'. In such circumstances, unprotected sex may act as a surrogate for 'emotional intimacy that is lacking in other areas of their lives' (Campbell, 2003:33).

The second hypothesis speaks of a 'macho sexuality' that comprises an 'insatiable sexuality, the need for multiple sexual partners and a manly desire for the pleasure of ... flesh-to-flesh'. The sense of masculinity that is central to mineworkers' day-to-day coping with the very real dangers of working underground is understood as partly responsible for increasing their risks of exposure to HIV infection (Campbell, 2003:32).

of the United States Agency for International Development - Subject: Restoration of the Mexico City Policy', available online at <http://www.usaid.gov/whmemo.html>. For a description and critique of the 'Global Gag Rule', see The Global Gag Rule Impact Project, 'Access Denied: U.S. Restrictions on International Family Planning', available online at <http://www.globalgagrule.org>.

In other words, the mineworkers' coping mechanisms for dealing with their working lives results in them engaging in sexual conduct that simply gives expression to their masculine identities.²⁹

While the 'need' for flesh-to-flesh sex is most probably not limited to the human desire for greater pleasure, Campbell's findings and hypotheses do not assist us in determining the extent to which such unsafe sex results from simple desire or other more structural causes. Further, it is unclear whether her conclusions, even if largely valid, are more widely applicable. While her work is crucial in getting us to think outside of the box, it does not take us very far in ascertaining the relevance thereof for the development and implementation of prevention programmes. More importantly, it does not assist us in designing safe sex messages that promote condom use while at the same time recognising that 'flesh-to-flesh' is more enjoyable.

Deeply held beliefs and peer norms

Much of the literature explores the disconnect between being in possession of basic information about HIV and safe sex and the ability and willingness to change sexual behaviour in accordance with such knowledge. In her work with mineworkers, Campbell notes that safe sex facts and messages 'are not simply passively accepted by their audiences, but must compete with alternative beliefs, experiences and logics that may be more compelling than the information that the health educator seeks to impart' (Campbell, 2003:26). Simply put, a competing set of 'facts' and 'truths' may often serve to undermine the clear messages that form the basis of most HIV prevention campaigns.

Certain gendered norms and deeply held beliefs on sexuality, for example, may mean that some (or many) young people are having sex within a context that regards men as being sexually driven and women as 'largely passive victims of male desire' (Campbell, 2003:124). If true, this would have significant implications for condom use. So, too, would the pressure reportedly put on women 'strenuously to resist any suggestion that they might themselves want to enjoy sex', possibly playing an important role in ensuring that they portray any sexual encounters as 'unintended'. Thus the bad reputation that is seen to be associated with the use of condoms may inhibit the carrying of condoms so as to counter perceptions that young women are looking for sex (Campbell, 2003:127).

²⁹ In the alternative, Campbell (p. 34) posits a third hypothesis – the 'frequent assertion of what are regarded as healthy and manly sexual urges could arguably serve to compensate for reduced opportunities for assertion of masculine identities in other contexts.'

Young men, on the other hand, may be under pressure to have multiple sexual partners and to give full sexual expression to their desires within a context informed by peer norms on male sexuality and desire that reportedly see young men as unable to think rationally and control themselves (Walker *et al*, 2004:29). Thus while HIV prevention programmes that promote condom use are cloaked in the language of rationality, young men may in fact be under enormous social pressure to give uninhibited effect to passion, desire and the irrationality of sexual urges (Walker *et al*, 2004:34). In such circumstances, inconsistent and incorrect (or no) condom use may indeed be a rational and probable outcome.

Further, norms of masculinity may be encouraging risk-taking behaviour by leading young men to believe that they should be knowledgeable and experienced in all matters sexual, possibly resulting in those who are not being less likely to seek information relating to sex (Walker *et al*, 2004:24). Related factors may have a similar impact on young women's health-seeking behaviour. Thus the fear of admitting that one is sexually active may mean that many young women do not want to access condoms at places such as clinics.³⁰

While there is a need to critically reassess the validity of many of these 'established truths' regarding gendered norms, norms of masculinity and deeply held beliefs on sexuality, the available evidence seems to suggest that when all of these factors are thrown into the mix, we are left with a plausible explanation for why many young men and women are 'choosing' not to place themselves in safety and are engaging in very risky sexual behaviour. In other words, young men and women may simply be doing what is indeed 'expected' of them.

Conclusion

This paper has argued that at best, approaches to HIV prevention work that simply try to persuade people to amend their 'wicked' ways can only have a limited impact on behaviour change. Instead, effective programmes are those that work towards creating the circumstances 'that *enable* behaviour change' (Campbell, 2003:35). This means dealing openly and honestly with the lives that people actually lead and the sex that they actually have, developing and implementing HIV prevention programmes that reflect the real world in which we live and not the idealised vision of the 'mainstream' that is now being reinforced by the fundamentalist right.

³⁰ Walker *et al* explain that this is especially true when some health care workers make it plain that young people should not, in their view, be having sex at all.

In essence, we need to expand the discourse of prevention by promoting the concept of risk reduction, moving away from simplistic messages that misleadingly allow us to believe that the difficult work we have to do is as easy as ABC, CNN or any other catchy acronym.³¹ Instead of programmes that tell people to do what many are unwilling or unable to do, we need prevention interventions that focus on reducing the risk of infection.³² At minimum, this means engaging beyond the abstinence, faithfulness and 'condoms as a last resort' paradigm. It also means challenging 'accepted wisdoms' and, if necessary, abandoning or changing the ways in which we have operated for some time.

This paper has sought to do two things: first, to place a spotlight on some of the 'dirty' issues that are all too often overlooked by public sector HIV prevention programmes; and second, to explore some of the reasons why many people may be 'choosing' not to place themselves in safety by engaging in sexual conduct with a high risk of HIV infection. In so doing, it has attempted to contribute towards the debate on what can be done to 'support the likelihood of healthier sexual behaviours' (Campbell, 2003:9). In essence, the paper has attempted to draw attention to the inadequacies of mainstream HIV prevention programmes that continue to place sexually active people at risk.

If the paper's hypothesis on the relationship between the inadequacies of our prevention interventions and the scale of the HIV epidemic is correct, it means that hundreds of millions of Rands are being spent annually on largely ineffective and potentially dangerous programmes. This scandal cannot be allowed to continue. We need to hold our governments to account and demand that they develop reasonable prevention plans based on high quality, appropriate research. We must ensure that researchers do not avoid asking the questions that they ordinarily prefer to ignore. In addition, international agencies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization need to take the lead in calling for the urgent re-evaluation of mainstream HIV prevention programmes.

³¹ See, for example, 'CNN vs ABC (CNN = condoms, needles and negotiating skills/ABC = abstinence, be faithful, condomise)', Oral Session Db02 (Monday, 12 July 2004, XV International AIDS Conference (at 34 of the 'Final Program'). The relevant section of the final programme is available online at <http://www.ias.se/bangkok/admin/images/upload/424.pdf>.

³² To some extent, such an approach already forms part of the work of an international agency such as the Joint United Nations Programme on HIV/AIDS (UNAIDS). But the good harm reduction work done in relation to injecting drug users and men who have sex with men, for example, is still conducted within the ABC paradigm. In this regard, see 'UNAIDS Questions & Answers, August 2004 - Q&AIII: Selected Issues: prevention and care', available online at http://www.unaids.org/html/pub/una-docs/q-a_iii_en_pdf.pdf.

The Declaration of Commitment on HIV/AIDS: 'Global Crisis – Global Action', adopted by a special session of the UN General Assembly in 2001, provides a shaky basis for action by speaking of 'a wide range of prevention programmes ... aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour' at the same time as describing – and effectively marginalising – many of those who engage in 'dirty sex' as 'members of vulnerable groups'.³³ If they are to be able to play a meaningful role in the development and implementation of HIV prevention programmes that work, the UN and its agencies must be able to break free from the immoral hold of conservatism advanced by countries such as the United States, the Holy See, Sudan, Syria, Pakistan, Malaysia, Egypt, Libya, Iran and Saudi Arabia.

For too long, we have worked in ways that have led many people to assume that the only significant gap in our response to the epidemic has been the failure of our governments to provide access to appropriate treatment and care. Having reached consensus within our region and internationally that all people with HIV/AIDS have a right to access antiretroviral therapy where medically indicated, we must now work towards ensuring that all people are able to exercise their fundamental rights of access to appropriate HIV prevention services.

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³³ Resolution A/RES/S-26/2 at paragraphs 52 and 58 respectively, available online at <http://www.un.org/ga/aids/docs/aress262.pdf>.

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