Homosexuality, Sex Work, and HIV/AIDS in Displacement and Post-Conflict Settings: The Case of Refugees in Uganda

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This article aims to disrupt the silence, invisibility and erasures of non-heteronormative sexual orientations or gender identities, and of sex work, in HIV/AIDS responses within displacement and post-conflict settings in Africa. Informed by Gayle Rubin's sexual hierarchy theoretical framework,[1] it explores the role of discrimination and violation of the rights of sex workers and of gender and sexual minorities in driving the HIV/AIDS epidemic during displacement. Specific case materials focus on ethnographic research conducted in urban and rural Uganda. Recommendations for policy, practice and programmes are outlined.

Introduction: A Productive Ethnographic Paradox for Rethinking HIV/AIDS Responses

Is it possible to address the HIV/AIDS prevention, care and treatment needs of sex workers, same-sex-loving individuals and gender non-conformers in displacement and post-conflict settings in Africa? Contrary to dominant discourses of victimhood and marginalization, I found a productive paradox among a group of same-sex-loving refugees who were also sex workers striving to prevent and treat HIV/AIDS in their midst. I begin with a synopsis of Les Saints,[2] a local organization in Uganda,[3] to facilitate rethinking of appropriate responses to HIV/AIDS. The organization promotes policies and programmes relevant to sex workers who are sexual and gender minorities in displacement and post-conflict settings.

Les Saints is a support organization run for and by refugees who are also '*wacheche*' – a colloquial label for sex workers and same-sex-loving or gender non-conforming people in Uganda. Les Saints provides its members an organic avenue to access diverse health rights. The organization started in response to community outreach by the Refugee Law Project – a university programme serving forced migrants in Uganda. Although sex work and same-sex practices are outlawed as 'crimes against morality' in the penal code of Uganda,[4] Les Saints organized and provided services to individuals within these sexual sub-cultures who were displaced by conflict. Formally founded in 2009 in the city of Kampala, Uganda, Les Saints had 85 members by September 2012. Members resided in the city and in three rural settlements for refugees. Built around the charisma, resourcefulness, experience and leadership qualities of its founder and director – a royal chief in his homeland – Les Saints mainly reached French-speaking individuals from the Democratic Republic of the Congo

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(DRC), Rwanda and Burundi. A few members communicated only in Kiswahili. The director of Les Saints had fled his home country when his homosexuality was publicly disclosed to the entire nation. Drawing from his experience as a traditional chief, he rebuilt and led a constituency of fellow gay and lesbian refugees, many of whom exchanged sex for money. Strategically housed in three office rooms rented from a local police station, Les Saints was publicly presumed to offer HIV/AIDS services to all refugees.

My research in rural settlements revealed that support organizations for people living with HIV/AIDS in Uganda excluded non-heteronormative modes of being. Les Saints therefore addressed a critical gap in HIV/AIDS responses. The organization provided information, education and communication materials; community awareness-raising seminars and workshops; support networks and space for organizing and assembly; legal aid and medical care; and HIV-prevention commodities to its members. Service delivery was accompanied by on-the-spot translation into French, Lingala and Kiswahili languages. A lawyer and medical doctor employed by the Refugee Law Project offered diverse services. All the members interviewed in this study appreciated the multiple benefits they received from Les Saints, particularly medical support for sexually transmitted infections (STIs) associated with sex work or same-sex practices. A refugee himself, the medical doctor was praised by his patients for understanding the many challenges they faced. However, even when HIV/AIDS services were freely provided in a safe and supportive space such as Les Saints, not all the members utilized them, as revealed in the data.

> I took the HIV test last year but I failed up to now to get the results. When you are a cheche, you may fail to continue selling yourself because you fear to pass on the disease to your customers. So, how will I meet my needs if I stop sexing because of AIDS. I don't need to add those worries onto myself. (24-year-old gay man and sex worker from Congo)

> The HIV tests here are free but I have never taken them because I do not want to confirm what I think I know. I was fucked around a lot by different men when I was still struggling to feed myself. If he had a condom or not, okay, as long as they had money to pay me. Many times we were all drunk and so we were carefree. Sometimes it was group sex because the money was more for me. I think I got the HIV virus. Also, remember I told you that those soldiers at the border used me for days without condoms. If the test tells me today that I have HIV, you will come back next week to see us and find me dead because I am not strong enough to live with that news. (22-year-old gay sex worker from Congo)

The nuanced experiences and narratives of individuals within sexual cultures and forced migrant groupings congregating in Les Saints offer a clear, yet poignant, lens to examine the interactions between sex work, non-heteronormative sexualities, non-conforming gender identities and HIV/AIDS responses within displacement and post-conflict settings. Their experiences of organizing – despite discrimination and multiple violations – also speak to the roles of and relations

between the state, civil society and international bodies such as the United Nations High Commissioner for Refugees (UNHCR)[5] in actualizing appropriate responses to HIV/AIDS during and after conflict.

The Problem: Debates, Biases, and Silences about the Linkages between HIV/AIDS and Conflict

HIV/AIDS prevention, care and treatment in displacement and post-conflict contexts is mainly constituted as a health issue. Programmes are consequently based on biomedicine, public health and health education. They increasingly target sexual violence as an issue,[6] because of growing recognition that this is a notable means of HIV transmission during and after conflict.[7] However, there is a debate as to whether or not sexual violence in war increases HIV/AIDS incidence and prevalence. One camp argues that the conditions that often arise during conflict – such as widespread sexual violence, forceful vaginal or anal intercourse that ruptures genital tissue, genital ulcerations related to untreated STIs, HIV infection of one or both sexual partners, unprotected sex, cross-generational partnerships, multiple sex partners, and failing health systems – yield higher rates of HIV transmission.[8] Another camp maintains that the evidence does not indicate any associations between conflict and increased HIV prevalence.[9] Regardless of this ambivalence,[10] programmers recommend integrating HIV/AIDS services alongside sexual and reproductive healthcare into the standard minimum package of healthcare delivered in displacement and post-conflict settings.[11] Consequently, voluntary counselling and testing (VCT) for HIV, symptomatic treatment of STIs and promotion of condom use should be routinely offered in displacement and post-conflict settings. Prevention of vertical transmission through delivery and breast milk (PMTCT), antiretroviral therapy (ART) and antibiotic prophylaxis against early progression to AIDS should also be made available in these settings. However, refugees and internally displaced people are often excluded from HIV-related programmes and policies.[12] When parallel systems for healthcare delivery do not exist in displacement and post-conflict contexts, individuals and communities seek their sexual and reproductive health services (including maternal and child health, and the management of STIs or HIV/AIDS) from integrated local healthcare systems.[13]

A shortcoming of current available prevention, care and treatment services for HIV/AIDS in displacement and post-conflict contexts is the overt concentration on normative heterosexualities. In this framing, sex is narrowly constructed as penile–vaginal penetration with a regular partner or partners with whom one can negotiate condom use, invite to couples VCT sessions and oversee adherence to a strict anti-retroviral regimen. There is an ideological emphasis on heteronormative practices and relations only, which are socially accepted as ‘good sex’. Feminist anthropologist Gayle Rubin[14] proposes a theoretical model of an ‘erotic pyramid’, through which all available sex acts are mapped and socially appraised, based on a hierarchical system of sexual value. Socially approved sexual acts are located within ‘the charmed circle’ and labelled ‘good’, ‘normal’, ‘natural’ or ‘blessed’ sexualities. Denigrated sexual acts are perceived

as social vices located within 'the outer limits' and labelled 'bad', 'abnormal', 'unnatural' or 'damned' sexualities. 'Good sex' is reaffirmed, publicized and socially rewarded. 'Bad sex' is condoned, repressed and socially penalized. In Rubin's model, good sex is characterized as heterosexual, married, monogamous, procreative, non-commercial, in pairs, in a relationship, same-generation, in private, without pornography, involving only bodies (no manufactured objects), and 'vanilla'. 'Bad sex', on the other hand, is characterized as homosexual, unmarried, promiscuous, non-procreative, commercial, alone or in groups, casual, cross-generational, in public, involving pornography, involving manufactured objects, and sadomasochistic. Drawing from Rubin's theory of sexual hierarchy, it is evident that based on social appraisal, subversive sexual practices and non-conforming sexual orientations and gender identities tend to be entirely excluded from programmes that seek to address HIV/AIDS in Africa, let alone in displacement and post-conflict settings.[15]

This response to HIV/AIDS in displacement and post-conflict settings in Africa overwhelmingly serves patriarchy, hegemonic masculinities and heterosexist and heteronormative social orders. Sexual cultures and practices that fall outside the charmed circle of dominant heterosexual hierarchies are silenced and invisibilized within structures of programming, policies and service delivery. A systematic literature review reveals that alternative sexual orientations and gender identities are barely articulated in the diverse efforts to combat HIV/AIDS in Africa generally, and particularly in displacement and post-conflict settings. South African judge Edwin Cameron[16] cogently articulates multiple facets of this silence:

> Across Africa, for too many aching years, there has been an immense silence about African men and women who yearn for, desire, love and embrace same-sex partners. The silence denied truth, for throughout history same-sex practice has been as prevalent here as anywhere else in the world. The silence wrought injustice, for it was born from repression and fear, and from disrespect for those who yearned, desired, loved and embraced. Worst, the silence has exacted a terrible toll in lives. As our continent has faced a deathly epidemic of sex-borne disease, the silence has cost lives, for the muteness about same-sex practice has extended devastatingly, to a muteness about prevention, care and treatment.

This silence and erasure even extends to scholarship, research and evidence-based interventions, because HIV in Africa is framed as dominantly heterosexual in transmission.[17]

This article attempts to disrupt the silence, invisibility and erasure of alternative sexualities and gender within displacement and post-conflict HIV/AIDS responses. It does so through examining the experiences of sex workers and of gender and sexual minorities displaced into Uganda by armed conflict. The article focuses on two guiding questions:

(1) What is the role of discrimination and the violation of rights of gender/sexual minorities and sex workers in driving the HIV/AIDS epidemic in displacement and post-conflict settings?

(2) What are the implications of discrimination and the violation of rights of gender/sexual minorities and sex workers for the response to HIV/AIDS in Africa?

Ethnographic Materials and Methods

Case materials are drawn from two multi-method ethnographic datasets collected between August 2010 and August 2012 among sexual minorities and refugees in urban and rural Uganda.[18] In each case, study participants were sampled using a combination of purposive, snowball and theoretical sampling techniques. Key informants in leadership or administrative positions proposed potential participants who were invited to participate in research activities depending upon their willingness and availability. A Ugandan medical anthropologist (the author of this essay) collected the data with a group of social science research assistants who were conversant in the relevant local languages. Furthermore, because the studies were participatory, co-researchers respectively chosen from local sexual minorities organizations and the forced migrant population were part of the ethnographic research team. Training of the researchers comprised an intensive methodology and ethics workshop, involvement in the development, piloting and revision of the research tools, as well as regular seminars.

Data collection triangulated ethnographic participant observation, repeat individual in-depth interviews, focus-group discussions, policy review and content analysis of public media (see Table 1).[19] All interviews and discussions were recorded using digital audio-recorders. The recorded voices were transcribed verbatim, translated from the local languages into English where necessary and computerized via word-processing software. Observations were recorded in fieldwork journals, which were also entered into the database. Textual data were subjected to discourse analysis using Atlas.ti software designed for the manipulation of large volumes of qualitative data. Preliminary findings and interpretations were variously shared with representatives for verification and feedback, which informed subsequent revisions of reports. Although the research findings cannot be generalized to all African

TABLE 1
SUMMARY OF DATA-COLLECTION METHODS

	LGBTI ethnographic study	Refugees study
Focus-group discussions	20 groups	25 groups
Individual interviews	54 *wacheche*, 412 nationals,	223 settlement-based refugees
Participant observations	Kampala, Jinja, Masaka, Mukono	Kiryandongo, Oruchinga, Kyaka II, Nakivale
Stakeholder analysis	48 health providers, 72 police officers, 12 lawyers	18 implementing partners, 22 settlement officers, plus Office of the Prime Minister (OPM) staff
Period	August 2010–February 2013	January 2010–December 2012
Ethical review	Uganda National Council of Science and Technology	Uganda National Council of Science and Technology

contexts of displacement and post-conflict, they offer a lens into very context-specific issues, raising broader policy and programmatic questions.

Ethical approval of the study was provided by the Uganda National Council of Science and Technology. Individuals gave verbal and written consent to participate in the study, after access to communities was granted by key gatekeepers who comprised leaders of diverse study sub-populations. Interview excerpts are included in this article to illustrate the direct voices of sexual and gender minorities who tend to be excluded from policy and academic papers. Names are excluded to protect the identities of individuals.

Criminalization of Same-Sex Practices and Sex Work as Barriers to Access HIV/AIDS Services

Laws that criminalize same-sex behaviour and sex work contribute to systemic exclusion of these sexual cultures in national and humanitarian HIV/AIDS responses in Africa. On the continent, only South Africa legally protects individuals against discrimination on the grounds of sexual orientation. Legal penalties in other countries range from fines or imprisonment for misdemeanours, to capital punishment, with death administered through either hanging or stoning, for felonies.[20] Stricter anti-gay laws were recently tabled before the parliaments of African states such as Uganda, Nigeria, Ghana, Burundi and Rwanda. Various statutory books in these countries articulate criminal penalties for sex work – which they define as prostitution – and non-heteronormative sexual orientations and gender identities, using legal frames such as 'anti-sodomy laws', 'outlawing of same-sex marriage' or 'prohibitions of carnal knowledge against the order of nature'. Programming interventions for healthcare for these sexual cultures is consequently criminalized.[21] In surveillance states where subversive sexualities are policed, individuals may fail to access available services for fear of disclosing their so-called 'non-conforming sexual practices'.

Displaced persons in Uganda have varying levels of awareness of the legal frameworks governing sexual conduct and relationships within their contexts of displacement. All interviewees were aware that homosexuality was generally condemned in mainstream Ugandan society. It has been interpreted as: (1) sin in dominant Christian and Muslim discourses; (2) foreign decadence and mimicry of Western deviance; (3) un-African (i.e., contrary to African tradition/culture); (4) a form of psychosis; and (5) immorality.[22] Most of the interviewed refugees in same-sex relationships did not know that the Anti-Homosexuality Bill of 2009 proposes the re-criminalization of homosexuality in Uganda,[23] and introduced stricter penalties – including monetary fines, mandatory HIV testing, short-term or life imprisonment and even the death penalty.[24] Many refugees learned about the bill after arriving in Uganda, during meetings organized by Les Saints or other human rights organizations.

> I did not know about the laws of Uganda which allow the arrest of gays and lesbians. I did not know that they kill people like me until I attended a seminar organized about security. (31-year-old lesbian from Rwanda)

> When I was coming to Uganda in 2010, I did not know about the laws. I was running for my life because the rebels were butchering us in the village. But then it is like I ran from the pot into the fire. (28-year-old gay sex worker from Congo)

> For me, it was when the police arrested me and my friends because we were dressed in skimpy clothes for women, high heels, painted faces and nails, that I knew that the law does not allow men to wear clothes for women in this country. When asked [to name] our crime, the police said we were causing public nuisance. Those policemen never returned my wig and high heels when they released me. They are thieves. (32-year-old transgender sex worker from Congo)

> The police always arrest me because I live and dress like a woman. And yes, I am a queen. (28-year-old trans-woman from Congo)

Interviewees were far more aware of the illegality of sex work than of the illegality of homosexuality in Uganda. Personal experiences of arrest by the police exposed refugee sex workers to the illegal status of their income-generating activities.

> When I entered the circle of refugees who sell sex, the first thing I learnt was to avoid places the police patrol. When a Ugandan prostitute is arrested, the police have sex with her if she wants to be released without trying. What will happen to me, a refugee? (31-year-old sex worker from Congo)

> My duty as the director of this organization means that I do not sleep enough because I am often woken up in the middle of the night to go and rescue members from the police station because they were arrested while selling sex on the streets of the clubs. (43-year-old gay man from Congo)

Criminalization of sex work and same-sex practices impacts negatively on individuals with non-heteronormative sexual orientations and gender identities. When subjected to human rights violations and violence as a result of their sex work or same-sex practices, many interviewees revealed that they did not report the incidents to the police because of fear of potential re-victimization from public disclosure of their sexual orientation or sex work. In this way, the law inadvertently protects perpetrators of homophobic and transphobic violence from punishment, and simultaneously exposes the victims to injustice by curtailing access to mechanisms of legal redress. Data analysis revealed numerous instances in which perpetrators of 'hate-crimes' against sex workers, same-sex-loving individuals and gender minorities went unpunished because the victim refused to report the case. Criminalization therefore drives members of these subversive sexual cultures further underground.

> That time when I was arrested, as I was waiting for the court case, the policemen would allow other men to come into the remand cell where I was and these people would force themselves on me. I think they were

> paying the policeman on night-duty. I was raped three nights when in this cell. But when our lawyer came for my case, I never told him because how can you report the policemen for not protecting you when you are in their custody? (28-year-old trans-woman from Congo)

Furthermore, sex workers, same-sex-loving and transgender individuals were unable to access appropriate healthcare services essential for the prevention, care and treatment of HIV/AIDS and other STIs. The Anti-Homosexuality Bill of 2009 proposed to penalize health workers, educators and other service providers, as well as parents, landlords and teachers who supported same-sex-practising people but did not report the homosexuality to police within 24 hours.[25] Although it was still only a bill by June 2013, many service providers behaved as if it had already passed into law. Interviewees reported that health workers were reluctant to offer care and treatment, particularly if the presenting conditions were related to same-sex practices. Other health workers ostracized, stigmatized and discriminated against same-sex-loving and gender non-conforming individuals, often disclosing their sexual orientation to other healthcare providers or patients. Consultations with health workers revealed that many were not equipped with the skills, knowledge or expertise to deal with conditions specific to non-heteronormative sub-cultures.

> Some of our members get mouth or throat gonorrhoea from giving the blow jobs. But then the doctors do not know that someone can have gonorrhea in the throat. (43-year-old gay man)

> Those days when I was still selling sex every night because I needed small-small money for food, cosmetics, shoes, nice clothes, cigarettes and styling my hair, I would get hemorrhoids. But, how to treat these hemorrhoids?
> Interviewer: Hemorrhoids? What was this like?
> You mean you don't know hemorrhoids? This is blood and pain coming in the anus. And when you go to have toilet, you feel as if a hard thing wants to force its way out of you. You have blood on the underpants. But then I would go back and have sex after drinking beer because I need the money. When the pain was very serious, I went to hospital because it is cheaper. But my friend, when I reached there, after waiting in the line for more than two hours, I feared to tell the doctor because I feared that he will refuse to treat me. So I told him that I have a severe back pain. He gave me strong painkillers. It was my friends who told me to go to the pharmacy to buy some medicine which helped them before. (22-year-old gay man from Congo)

HIV Risk within Non-Heteronormative Sexual Cultures in Displacement and Post-Conflict Settings

Sex work, same-sex practices and gender non-conformity abound in displacement and post-conflict settings in Africa, regardless of prohibitive laws, social sanctions

and taboo. Converging and diverging in significant ways, the displaced migrants added diversities and nuance to local transgressive and subversive sexual cultures existing in their host communities. While some interviewees had been involved in sex work, same-sex practices and gender non-conformity in their home communities prior to migration, others were initiated into these non-heteronormative behaviours during flight, displacement and in the post-conflict context. Furthermore, while some of these initiations were autonomously self-determined through self-discovery and experimentation, others were violently imposed by external factors such as same-sex rape by militia, or experimenting with sex work in order to survive after extended spells of hunger.[26] Sexual violence was reportedly encountered during flight, displacement and repatriation phases of forced migration, with impacts on psychological and physical well-being continuing long into the post-conflict phase. Violence was integral to sexual and gender-minority sub-cultures in displacement and post-conflict settings. Negotiation of safe-sex practices was often impractical, particularly given the asymmetrical power relations involved in sexual violence:

> Those boys who raped me were drunk. They said I a-shame the Kenyan refugee community because I love a fellow woman as if I am a husband. That if I have a pregnancy then people will know that I have been with a man. None of them used a condom. As a lezie, I was not on family planning. So I got pregnant. I took the thing out when I missed my period. (24-year-old lesbian from Kenya)

> Some men have got very big things. Some of those Dinka men can be like a full-grown cassava root. And yet they also like it live [unprotected sex]. But then they pay much money. The problem is that he goes for long because he chews *amailungi*. In the process he can even tear your anus. They call it *okupasula* in Luganda. When it happened to me, I prayed to die because all the time I used to laugh at people who suffered it. I was shamed. But the man paid for my treatment until I got better. But then if he had HIV, then I got it. Or if I had HIV, he got it from the wounds he left in me. (32-year-old gay sex worker from Rwanda)

> Sofia loved me very much. And I also loved her. She would support me, give me money, buy me things for the home and also for my child. We loved each other very much. But as I said before, it is not safe for us to be free here as lesbians in our love. One night, we were in a bar in Kabalagala. Sofia wanted me so much. So we started romancing each other right there.

> Interviewer: You mean you were doing this in the public bar?

> It was night time. We were both drunk. We were in love. We started romancing in the bar. Then we went outside in a corner. We were busy on each other. And then two men caught us at it. They threatened us. They shouted, 'We are going to report you to the police. Every time the police

> say that you people are there but hiding. Now you are here, loving each other in public. We are reporting you now.' It was bad. As a refugee, the last thing you want is police to arrest you. I started pleading. The men told us that if we want to stop them from reporting us, that we give them sex. We begged. They refused. So each of them used us. One was on me as the other is on my Sofia. After coming out of me, the one who was in me went on Sofia. And the one from her came in me. There were no condoms. I got pregnant (31-year-old lesbian and former sex worker from Congo)

Alcohol consumption is associated with risk factors for HIV transmission, such as multiple partners and inconsistent use of condoms.[27] The importance of studying the ways in which social contexts of drinking alcohol influence sexual risk-taking has been noted by various scholars.[28] In both urban and rural areas of displacement and post-conflict settlement, bars are among the easiest spaces to solicit commercial sex patrons and to negotiate for new same-sex liaisons. Buying and accepting alcohol and food are often cues for initiating a transactional sexual relationship, particularly when male partners initiate the connections. Accepting alcohol from strangers usually signifies an agreement to reciprocate with sexual favours later, and often generates violence such as insults, beatings or even rape when the female partner declines to provide sex. While many participants viewed alcohol as an aphrodisiac, others reported that it inhibited their judgement and encouraged them to engage in socially denigrated sex work or same-sex practices. However, some individuals involved in sex work reported that in hindsight they learned too late to refrain from socially consuming alcohol in public venues such as bars: some had undergone experiences of gang-rape by strangers after their drinks had been laced with drugs that induce loss of consciousness. This experience was reported particularly within gay-friendly clubs and pubs in the suburbs of the city of Kampala. Perpetrators were reported to be mostly Ugandans, who were usually wealthier and more powerful than refugees. While rural-based refugees and displaced people regularly consumed alcohol, the research mainly reported contexts of sex work as involving purchase of alcohol by a member of the host community, who then assumed access to the sexual services of the displaced person/refugee.

> I stopped drinking alcohol after learning a nasty lesson. One night when my appointment did not show up to the bar like we had agreed on the phone, a Ugandan guy bought me a drink. I was happy. I went to the toilet and he put a drug in my beer. When I lost my senses, he took me to his house. Four men used me for over three days. They had no lube and no condoms. It was just sex, sex, sex. They even recorded some parts to stop me from reporting them. On the fourth day, that man gave me four thousand shillings, which was enough for my transport fares back to my house. These days I do not drink beer anymore. (23-year-old gay man and sex worker)

Factors that influence people to engage in sex work include poverty, lack of subsistence, diminished employment opportunities and challenges to sustainable

livelihoods in contexts of displacement. The goal is usually to earn some disposable income in order to meet basic needs such as food, fuel, healthcare, functional shelter, clothes and school fees. However, many interviewees reported that landlords, neighbours and community leaders had evicted them from their respective shelters when knowledge of their sex work, same-sex practices or non-conforming gender had been discovered. Some were expelled from school, work, church fellowships or other clubs of belonging. This restriction of access to shelter and support networks further alienated sexual and gender minorities, thereby making them more difficult to target and reach.

HIV/AIDS Services for Sex Workers and Sexual/Gender Minorities in Displacement and Post-Conflict Settings

The right to enjoy the highest-attainable standard of health is interconnected to other human rights such as the right to life, equality before the law, access to information and education, freedom of association and organization and freedom of expression. However, there is limited access to appropriate healthcare services for people of non-heteronormative sexual orientation and gender identities in the general population, let alone within displacement and post-conflict settings. No parallel systems exist in Uganda: the delivery of healthcare for displaced people is integrated into the current healthcare systems, which are heteronormative, and therefore sometimes homophobic and transphobic. People whose gender identity is not heteronormative, such as those who cross-dress or people who are transgender, transsexual or intersex, reported overt and immediate discrimination in healthcare settings when seeking services. Transsexual women were often targeted with forcible reparative counselling sessions, because some mainstream healthcare providers felt unable to accept their transgressions against normative gender binaries that dictate masculinity from male bodies and femininity from female bodies. Effeminate self-performances by people in male bodies were widely interpreted as signs of weakness and thus abnormal. Transsexual men were often interrogated about their gender identities when they sought access to health services and products, especially if these were related to sexual and reproductive health.

> You go to the clinic because you need attention and then the nurses and doctors keep probing you, 'Are you a man or a woman?' The stares can even chase you out of the queue. It can be like you are the centre of a circus. (31-year-old trans-man and lesbian from Rwanda)

> When I went to ask for abortion after that rape, the nurse asked me how I can be pregnant yet I am a man. I had passed very well as a man. But then I needed an abortion. It was difficult to explain this thing. I just told her that I am a man with a vagina connected to a womb. She sent me away from the clinic and told me she is going to pray for me to get saved. (27-year-old transsexual man and lesbian from Congo)

Same-sex-practising people generally lack public access to HIV-preventive services and products during displacement. There are very few relevant, age-appropriate or accurate information, education and communication (IEC) materials on this issue. There are also few avenues for delivering information related to HIV/AIDS as it pertains to diverse sexual sub-cultures. This gap is further accentuated by language barriers, especially when individuals are displaced in locations where their native language is different from, or unknown by, the host communities. These barriers therefore often prevent displaced people from accessing information produced by and for same-sex-practising communities in the host communities. Furthermore, it is difficult for same-sex-practising displaced people to unpack and comprehend specially packaged and targeted IEC messages. These communities tend not to be part of local same-sex-practising sub-cultures, and lack local cultural sensibilities as well as the nomenclature, signs and symbols necessary to decipher and apply such knowledge. In any case, the public media, health educators, institutions of learning and most civil society organisations are usually afraid to design or deliver the IEC messages and materials that are necessary for preventing HIV/AIDS transmission among same-sex-loving people. This is due to criminalization, heterosexist censorship, taboo and social proscriptions against homosexuality. Radio stations and popular artists have been heavily censored and even penalized for designing and publicly disseminating IEC materials for same-sex-practising people in Uganda. Local lesbian, gay, bisexual, transsexual and intersex (LGBTI) organizations and international organizations such as the United Nations Children's Fund (UNICEF) have also experienced public condemnation and penalization for such activities.[29]

Preventive products and commodities that protect against the transmission of HIV/AIDS among same-sex-practising people include male and female condoms, dental dams, water-based or latex-compatible lubricants, rectal and vaginal microbicides and pre- and post-exposure prophylaxis (PREP and PEP). These products are not readily available in public health systems in Uganda, and information about them is generally limited. Testing and treatment for STIs, including voluntary counselling and testing for HIV/AIDS, is heavily heteronormative. Counsellors in Uganda are reportedly mostly ill-equipped to counsel same-sex-loving partners. In order to minimize stigma and discrimination within testing environments, individuals reportedly disguised or concealed their non-heteronormative sexual orientations. The information and advice they received was consequently inappropriate and irrelevant to their actual needs. Furthermore, although rape was a common experience for lesbians, they were excluded from groups targeted for HIV/AIDS responses. These services therefore lacked relevant information for this sub-culture. Access to abortion services for lesbians who conceived during so-called curative or corrective rape were highly criminalized, unless abortion was medically indicated for the protection of the mother or fetus.[30] Dr Kihumuro Apuuli, director of the National AIDS Commission, stated that homosexuals did not deserve anti-retroviral therapy, because they were responsible for contracting HIV through immoral and deviant sexual behaviours. Neither Uganda's national HIV/AIDS policy nor its health systems strategy comprehensively addresses the specific needs of same-sex-practising

individuals and communities in the general population, let alone in contexts of displacement. In extreme cases, the possession of same-sex paraphernalia has been penalized and criminalized, even that which promotes safe-sex practices. It has been noted that 'discouraging people in sex work from protecting themselves by penalizing the possession of safer sex materials is perhaps the most shortsighted human rights violation of all'.[31]

Given the neglect and failure of the Ugandan government to provide healthcare services specifically for the prevention, care and treatment of HIV/AIDS among sex workers, non-heteronormative sexual orientations and non-conforming gender identities, where do members of these sexual and gender minority groups turn for access to these interventions? This study found that many avoided the formal sector of public healthcare delivery.

Others formed relationships of reciprocity, advice and support networks with locals whose sexual orientations and gender identities were also non-heteronormative.

> There is a boy from Kampala here who is my best friend. He brings me lubricant from their LGBTI organization called Ice Breakers. He is a bottom like me. Sometimes we masturbate each other until we come. But for him, I do it for free—no money. If he was not poor like me, maybe he would be my lover. But now, I can't love a poor one like me. (28-year-old gay sex worker from Congo)

A few of the interviewees claimed they had obtained acceptance as members of local lesbian, gay, bisexual, transsexual, queer and intersex (LGBTQI) support organizations based in Kampala. Information, education and communication materials, appropriate counsel and safe-sex commodities were routinely distributed free of charge within these local organizations. The most commonly mentioned hindrances to joining local organizations were language barriers, fear of being associated with politically organized advocacy groups and lack of knowledge of queer support spaces. The importance of rare grassroots organizations such as Les Saints therefore cannot be over-emphasized. However, as highlighted at the beginning of this article, in addition to providing and promoting prevention products and services, it is important to address negative assumptions that may prevent same-sex-practising communities from using these services. If governments do not intervene in the healthcare needs of the members of subversive sexual cultures, it is important at least to grant permission for the formation and registration of non-governmental organizations (NGOs) that do target these populations. It is equally important to support the work of these NGOs through funding, capacity building, provision of technical skills and associated resources.

Discussion and Recommendations for Policy, Programmes and Practice

The proliferation of global voices that advocate for sexual minority rights as human rights has not translated into the protection of same-sex-loving people or sex workers in displacement and post-conflict settings in Africa. Instead, the

widespread violation of human rights against people who do not conform to heteronormative standards persists. Cary Alan Johnson provides a lucid explanation of this situation:

> The vulnerability of same-sex practicing men and women is not due to any biological predisposition, but is the result of an interlocking set of human rights violations and social inequalities that heighten HIV risk. Anti-gay discrimination is fuelling the African HIV/AIDS epidemic.[32]

Displacement and post-conflict contexts raise important questions about citizenship and the claims to citizenship of a dispossessed constituency, whether they are displaced within or across national borders. Does an asylum-seeker or a refugee have rights in Africa? Does an internally displaced person possess human rights equal to those of other citizens in Africa? If they have rights, whose responsibility is it to give effect to these rights, especially within displacement and post-conflict settings in Africa? Does the displacement and post-conflict context demand an exceptional approach to human rights claims? When the same asylum-seeker, refugee or internally displaced person is gay, lesbian, transgender, intersex or a sex worker, do the human rights claims change? Do human rights claims change for sexual and gender minorities, or are all humans equal? The rights to life, health and protection from cruel and degrading treatment, as well as the right to security of person and property, are critical examples of irrevocable and inalienable rights that confirm the non-negotiable nature of human rights claims, even within displacement and post-conflict settings in Africa. The rights of sex workers and sexual/gender minorities are human rights, even in displacement and post-conflict settings.

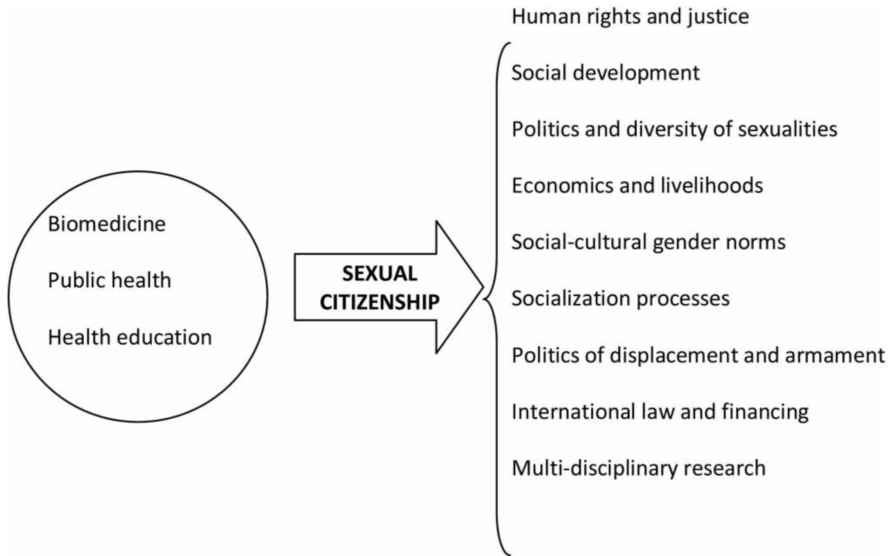
There is an urgent need to shift paradigms from a miniscule biomedical approach to HIV/AIDS, to a health and human rights approach, in displacement and post-conflict settings in Africa (see Figure 1).

According to Alice Miller:

> A health and human rights approach to sexuality can be part of politically astute and self-conscious coalition strategies ... can contribute both to reviving calls for social justice in health for the most diverse range of people and to transforming the nature and practice of state accountability in ensuring the conditions in which all persons can be healthy.[33]

Under this paradigm, there is a tripartite ordering of governmental responsibilities to (1) respect, (2) protect and (3) fulfil human rights obligations. The basic principles of the health and human rights approach oblige HIV/AIDS responses to be more inclusive of sex work and alternative sexual orientations and gender identities. These principles include the primacy of non-discrimination and equality; a focus on the dignity of the person; the interconnectedness and interdependency of the realization of rights; and participation in determining issues affecting individuals or groups.[34] Thus, health, specifically sexual health, and HIV/AIDS responses must be re-situated within social justice work, and within the broader transformation of society.

FIGURE 1
TRANSCENDING MINISCULE BIOMEDICAL RESPONSES TO CLAIMING SEXUAL CITIZENSHIP



Reconstruction and peacebuilding efforts must urgently expand their conceptual frameworks of sexual politics (including sexual violence, modes of HIV transmission, risky sexual behaviour and bridging population groups). The current framing of sexualities is inherently too narrow to effectively address non-heteronormative sexual orientations and gender identities and sex work and the provision of HIV/AIDS services to people within these groups. And yet the disruptions caused by displacement largely affect these minority groups. Although rape in war is generally represented as a heterosexual violation (usually of women by men), homosexual rape of civilian men by gun-wielding groups of powerful men or vigilante rebels is a common punishment meted out during war. The so-called corrective rape of lesbians or other same-sex-loving or transgender women occurs during conflict, flight and displacement. Hate-crimes against same-sex-loving individuals, effeminate men and masculine women sometimes are the very cause of displacement. Homophobia and transphobia pervade public services in Uganda to the extent that they even affect institutional processes of seeking asylum and negotiating refugee-status determination and settlement. Addressing poverty, creating avenues for income generation and enhancing the livelihood base of individuals – particularly women but also transwomen – is important to reduce the numbers of people who enter into sex work solely for the sake of meeting their subsistence needs. Sex work is work, and the rights of sex workers must be respected, protected and fulfilled in displacement and post-conflict settings. The exploitation, violation and discrimination of sex workers by service providers and state institutions must be addressed. The

criminalization of non-heteronormative sexual orientations, sex work, and abortion in Uganda and other African countries is a massive violation of interlocking rights of same-sex-loving people and commercial sex workers in displacement and post-conflict settings. It is important to develop multiple strategies and actions aimed at legal reform and decriminalization of these important components of sexual and reproductive health. Africa does contain some national examples of decriminalization: for example, South Africa constitutionally recognized sexual orientation as grounds for non-discrimination, and also legalized same-sex unions in 2006, while Senegal legalized sex work and established the registration, routine health checks and protection of sex workers. It is important to highlight that while South Africa and Senegal have progressive laws protecting same-sex relationships and sex work respectively, these are rarely applied fully in practice. Thus, decriminalization must be part of a broader shift that includes other forms of structural reforms.

Heteronormative ideologies obstruct planning and programming for social justice for sexual and gender minorities. They therefore hinder equitable access to public services, such as housing and community participation; appropriate health and sex education; protection by the state's institutions of justice and security; and relevant healthcare and justice mechanisms for legal redress. Specific to HIV/AIDS, appropriate services for communities of non-heteronormative sexual orientations and gender identities are largely missing from programming and service delivery in displacement and post-conflict settings. Essential commodities for safe and pleasurable sex include water-based lubricants, dental dams, male and female condoms, dildos, rectal and vaginal microbicides, post-exposure prophylaxis, pre-exposure prophylaxis, contraception including post-exposure-contraceptives (PEC) such as the 'morning after pill', and free abortion services. These must be made available to sexual and gender minorities and sex workers. HIV counselling for both pre- and post-test phases must be reconfigured to include same-sex realities in order to be relevant and effective. The content, presentation and strategies for disseminating information, education and communication materials must be tailored to be inclusive of non-heteronormative audiences. If this is not the case, appropriate materials and messages must be designed for sexual/gender minorities and sex workers. The ABCD model of prevention ('Abstinence, Be faithful to your sex partner, Condom use, and Disclose your HIV status') is not necessarily relevant to alternative sexual cultures, which may involve multiple concurrent partnerships, frequent partner changes, pleasure, profits, pressure, violence and substance use. Healthcare workers in displacement and post-conflict settings must be re-oriented in their medical education, so as to equip them with the skills, knowledge and expertise necessary to address, without judgement, the needs of same-sex-loving individuals, gender non-conformers and sex workers. In contexts of widespread societal homophobia and transphobia, and in national contexts where non-heteronormativity and non-conforming gender identities are criminalized, safe spaces must be created for same-sex-practising communities. Such spaces must be equipped with appropriate resources for delivering HIV/AIDS services in displacement and post-conflict settings. International funding must open up spaces of intervention that are

currently closed within particular national contexts, specifically when these closures are contrary to international laws and conventions that address rights violations of particular minority groups. The development and humanitarian industries must get over their obsession with bad sex and start to think about pleasure and safety.[35] Rather than freezing budgetary allocations to non-heteronormative and non-conforming sexual cultures because they are conceptualized as immoral, unhealthy and criminal, international funding should be re-allocated to addressing ways in which the existence of these sexual cultures may lead to increased HIV risk in displacement and post-conflict settings.

New research on HIV/AIDS in displacement and post-conflict contexts is urgently needed. For, as Charlotte Watts and colleagues have stated: 'For too long, we have had a narrow perspective of the epidemic and its drivers. We need a more nuanced understanding of the epidemiology of the virus and the contexts that create HIV vulnerability.'[36] It is important to increase the quality, quantity and robustness of Africa-based research studies, scholarship and knowledge-generation about sex work, non-heteronormative sexual orientations and gender identities. It is crucial to achieve this specifically within displacement and post-conflict settings. Although inter-related, problems and issues pertaining to sex work are distinct from those of non-heteronormative sexualities and non-conforming gender identities. Tailor-made studies must focus on unpacking the nuanced complexities of each of these sexual cultures, as well as their intersections within displacement and post-conflict settings. Multi-disciplinary research on the interactions between homosexualities, sex work and HIV/AIDS rates within displacement and post-conflict settings is particularly timely and critical, given the debate about the conclusions from the evidence that is under way within the humanitarian, security, epidemiology and academic research domains. Comparative analyses between diverse contexts, using multiple methodologies such as qualitative approaches from the social sciences, sero-prevalence surveillance studies and longitudinal studies developed over time, must test currently existing bodies of theory. They must also generate new theories about the links between HIV/AIDS, displacement and post-conflict settings, and non-heteronormative sexualities and gender identities. Johnson asserts that 'if questions related to same-sex identity and behaviour are never asked, there will never be any relevant data collected, and claims that homosexuality doesn't exist in Africa will continue unchallenged'.[37] Likewise, extended interdisciplinary research using multiple methodologies to investigate specific forms of rights violations and discrimination against sex workers, and the ways in which these may contribute to raising risks of HIV transmission in different displacement and post-conflict settings, is crucial.

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NOTES

1. Gayle Rubin, 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality', in Carole S. Vance (ed.), *Pleasure and Danger: Exploring Female Sexuality*, Boston, MA: Routledge and Keagan Paul, 1984, pp.3–44.
2. 'Les Saints' is a pseudonym used to protect the confidentiality and anonymity of this group.
3. Uganda hosts refugees from neighbouring countries including Burundi, the Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Rwanda, Somalia and Sudan. Northern Uganda is also a post-conflict setting recovering from protracted civil war.
4. Sylvia Tamale, 'Law, Sexuality, and Politics in Uganda: Challenges for Women's Human Rights NGOs', in Makau Mutua (ed.), *Human Rights NGOs in East Africa: Political and Normative Tensions*, Philadelphia, PA: University of Pennsylvania Press, 2009, pp.51–74.
5. Collaborating with national institutions and implementing partners comprising international, regional and local stakeholders, the UNHCR oversees and coordinates mobilization and delivery of humanitarian aid and services during and after conflicts. In 2011, 33.9 million people patronized UNHCR, including 14.7 million internally displaced persons in 27 countries, and 10.5 million refugees. See United Nations High Commission for Refugees, *The State of the World's Refugees: In Search of Solidarity*, Geneva, 2012.
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12. Spiegel et al. (see n.9 above).
13. Elizabeth A. Rowley, Gilbert M. Burnham and Rabbin M. Drabe, ‘Protracted Refugee Situations: Parallel Health Systems and Planning for the Integration of Services’, *Journal of Refugee Studies*, Vol.19, No.2, 2006, pp.158–86.
14. Rubin (see n.1 above).
15. Cary Alan Johnson, *Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa*, New York: International Gay and Lesbian Human Rights Commission (IGLHRC), 2007.
16. Edwin Cameron, preface to Johnson (see n.15 above), p.vii.
17. Marc Epprecht, *Heterosexual Africa? The History of an Idea from the Age of Exploration to the Age of AIDS*, Athens, OH: Ohio University Press, 2008; Johnson (see n.15 above), pp.31–4.
18. These disparate studies were conducted by the same team of core researchers, overlapped in time period, and intersected in their consideration of the experiences of LGBTI forced migrants or LGBTI refugees. This article concentrates on an aspect of this intersection because it considers the implications for HIV/AIDS for sexual minorities and sex workers who are forced migrants.
19. The methodology is discussed in detail in Stella Nyanzi, ‘Refashioning Sexual Safety Away from Home: Contextual and Structural Factors Contributing to Young Refugee Women’s Vulnerability and Resilience to HIV/AIDS in Uganda’, Working Paper No.38, Kampala: Human Rights and Peace Centre (HURIPEC), 2012.
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25. Ibid.
26. Nyanzi (see n.19 above) discusses the heterogeneity of sex workers in rural refugee settlements in Uganda.
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29. Nyanzi (see n.22 above).
30. Tamale (see n.4 above).
31. Johnson (see n.15 above), p.47.
32. Ibid, p.2.
33. Alice M. Miller, ‘Uneasy Promises: Sexuality, Health, and Human Rights’, *American Journal of Public Health*, Vol.91, No.6, 2001, pp.861.
34. Miller (see n.33 above), p.862.
35. Susan Jolly, ‘Why the Development Industry Should Get over its Obsession with Bad Sex and Start to Think about Pleasure’, Working Paper No.283, Brighton: Institute of Development Studies, 2009.
36. Watts (see n.8 above), p.iii99.
37. Johnson (see n.15 above), p.33.