The Moral and Legal Debates of Sexual Surrogacy Therapy in South Africa : Intimacy and Care

How does Sexual Surrogacy Therapy fit into notions of healthcare, legalized notions of sex work and social prohibitionism against sex work in South Africa?

A dissertation submitted to the Department of Political Studies of the University of the Witwatersrand in fulfilment of the requirements for the Degree of Masters of Arts

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March, 2023

DECLARATION

By submitting this thesis titled, *The Moral and Legal Debates of Sex Surrogacy: Sex, Intimacy and Care*, I declare that this is my original research and that has not been submitted before for any degree nor for any examination in any university. This paper contains no material written by another person except where due reference is indicated.

Keabetswe Brooke Khutsoane (Signature)

14/03/2023

Date (DD/MM/YYYY)

Dedication

“Modimo re boka wena, tsohle di entswe ke wena”
All the days of my life, I will praise you.

Keabetswe, dinako tse neng o itlhoba boroko, o tlogela ba lelapa la gago gore o bone botshelo jo bo botoka…Ke tshepa fa o lebelela kwa morago, o bona moputso wa phatlha ya gago.

Bambola mia… Francecso, I would have not done this without your support. Thank you for holding my hand for the past 10 years. Two wonderful children later, you remain the glue that keeps everything together and continue to be my source of love, strength and most importantly peace. I truly know what love is, a sonnet 116 kind’a love, my love.
Sei tutto per me, ti amo.

Jordan, my pride. Papa, I mean it when I say that you can achieve anything. You are the smartest and kindest boy ever. I am so proud of you and can't wait to see you do great things. I love you boy.
Jasmine, my joy. In many ways, I see myself in you, my little best friend. Gelsonina, no matter where you go in life, or who you grow up to be, I will always be right behind you, encouraging you to live your dreams mama. I love you.
Remember, family always comes first, take care of each other.

MaMalemane, ke feditse. I can now sleep peacefully mama. Until further notice, a ke sa di kena tsa sekolo. Thank you for your constant support. I have no words to express what you mean to me mama. I love you deeply.

To my mother, Queen Khutsoane, My little Sister, Lesedi and the rest of family and friends, Kealeboga, Le kaosane

Prof. Shireen Hassim, Prof. Antjie Schuhmann and Dr. Julian Brown, thank you for being patient with me and your supervision throughout my MA journey.

This thesis would not have been completed without the financial support of the Wits University Postgraduate Merit Award and the Andrew W. Mellon, governing intimacies scholarship.

KEALEBOGA

ABSTRACT

The decriminalisation of sex work in South Africa is a highly controversial issue that has caused a great deal of debate in recent years. This study presents a survey of the possibilities of legalising sexual surrogacy therapy as a therapeutic option for gender and sexual minorities, particularly for people living with disabilities and those who have undergone gender affirming surgery. It investigates the potential benefits and drawbacks of a legalised system and whether certain regulations should be implemented in order to protect those involved. A survey of how sexual surrogacy therapy as a therapeutic option is shaped in terms of South Africa's legal and political frameworks while considering socio-political implications.

The study reviews existing literature to demonstrate the need for a legal and ethical consideration of sexual surrogacy therapy in South Africa's healthcare system to address sexual exclusion and health inequalities. To do this, I outline the value of sex and argue that sex is an essential and fundamental aspect of a flourishing human life. I then bring attention to the necessity for the socialisation and institutionalisation of sexual surrogacy therapy through a discussion on sexual justice; sexual autonomy; and the rights and sexual citizenship of gender and ***sexual minorities. While this is not a study on the legal status of sex work in South Africa, I perform a constitutional test of Section 9 and 10 of the South African Constitution, 1996 and the Sexual Offences and Related Matters: Act No. 32 of 2007 with reference to the*** Sexual Offences Act 23 of 1957, ***to determine*** *the legal grounds and limitations of the current laws around sex work towards a discussion on the feasibility of sexual surrogacy therapy in contemporary South Africa's healthcare system. Finally, I conclude that the transformation of social attitudes towards sex and sex work is necessary and important for ensuring due process for sexual justice in South Africa.*

ABBREVIATIONS AND ACRONYMS

CA	Capabilities Approach
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
GAS	Gender Affirmation Surgery
GSM	Gender and Sexuality Minorities
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
NHI	National Health Insurance
OP	Original Position
PMB	Prescribed Minimum Benefits
SST	Sexual Surrogacy Therapy
UDHR	Universal Declaration of Human Rights

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CHAPTER 1

1.1 Introduction

The act of sex is an intriguing subject due to the emotions it evokes, its capacity for pleasure, and the social and cultural beliefs that surround it. People typically hold varying opinions about how sexual activity should be conducted, by whom, and for what reasons. The purpose of human sexual activity is multi-faceted, constituting an essential aspect of humanity and, therefore, should be regarded as a fundamental human right (Gianotten, 2023). The aim of this study is to conduct a comprehensive review of existing literature and debates surrounding the concept of sexual surrogacy therapy. Additionally, it aims to investigate the therapy's potential to address the sexual exclusion experienced by certain members of the transgender and disability communities, especially within an African context. Sexual Surrogacy Therapy (SST), also known as Sexual Partner Therapy, is a specialized form of therapeutic intervention designed to tackle the complex sexual and emotional challenges individuals may face. This involves the engagement of a trained surrogate partner who works closely with a client, creating a secure and supportive environment for them to explore and develop intimacy skills. This approach differs from traditional talk therapy as it incorporates experiential exercises and guided interactions to assist clients in overcoming barriers related to intimacy, communication, and sexual function (Liu-Pham, 2011). This therapeutic modality offers a unique and tailored approach to support individuals on their journey towards a more fulfilling and satisfying intimate life.

This survey is important because it helps identify the gaps in literature and ongoing discourse on the role of sexual activity in therapeutic care and present an opportunity to identify institutions and ways within which sexual surrogacy therapy could potentially be meaningfully integrated. I begin this thesis by discussing three views on the value of sex, namely, the procreation view; the recreational view and lastly, the flourishing "*plant like"* view (Nussbaum, 2011). I then argue that the procreation and recreational views of sex focus on the physicality of sex and neglect other aspects of sex while the latter, highlights the social; political and emotional aspects of sex. These distinctions are important as they provide a comprehensive outline of sexual surrogacy therapy beyond its physical nature and encapsulates it as a holistic treatment approach that not only prioritises a clients/patients' needs but addresses various physical, psychological and social facets of their lives.

Once I have reviewed and discussed these views, I then discuss issues of sexual exclusion as experienced by Gender and Sexual Minorities (GSM), particularly the transgender and disability community. I discuss how these exclusions are perpetuated by misconceptions, discrimination, inequality, and maintained by insouciance, indifference, and the lack of any aspiration to address sexual injustices and other intersecting injustices that exist in contemporary South Africa. By exploring *Theory of Justice* by John Rawls (1999), I argue that the sexual exclusion of minority groups is an injustice. By the same token, I discuss the principles of distributive justice. Essentially, distributive justice concerns itself with the fair allocation of resources among diverse members of a community (Maier, 2009) and requires that health services be accessible according to need. When there are barriers that prevent access to certain services, distributive justice is compromised. While the application of this theory is important to discuss as a theory of justice, it unfortunately has limitations as it does not specifically address matters of sexual exclusion experienced by the minority groups abovementioned. I employ Martha Nussbaum's (2000) Capabilities Approach (CA) as it is a better suited approach to use for the discussion on matters related to sexual exclusion. The CA is a normative approach to human welfare. It addresses the actual capability of a person to achieve well-being rather than on their right or freedom to do so. I show how CA is a framework that attempts to enable individuals, families, institutions and countries to have authentic and measurable discussions about matters of value, things of importance, and meaning. I position sexual exclusion as an issue of access and discuss it in relation to other matters of access that jeopardise or have the potential to jeopardise requirements of sex such as sexual citizenship, information, resources, choice, privacy, bodily autonomy, equality and dignity.

The current legal status of total criminalisation of commercial sex work in South Africa is not the central topic for this paper; however, it is important to discuss because, although sexual surrogacy therapy is in practice widely associated with commercial sex work, it is often dubbed 'glorified prostitution'. Therefore, it is impossible to have a discussion on the possibility or consider sexual surrogacy therapy without reviewing the current legal status, ethical questions, and other related matters that pertain to commercial sex work in South Africa. Therefore, I employ instruments that are commonly used in relation to commercial sex work and present a discussion that highlights the potential of enacting laws as per the international norms which South Africa is signatory to at a domestic level, the duty of upholding the principles of the Bill of Rights. This discussion is presented as part of a constitutional test of the Sexual Offences Act 23 of 1957 and the Sexual Offences and Related Matters: Act No. 32 of 2007 which are the laws that currently criminalises commercial sex work in South Africa. This test is performed to determine the legality of sexual surrogacy therapy as a feasibility in post-apartheid South Africa.

The distinction between sexual surrogacy therapy and commercial sex work can be obscure, but it is important to distinguish for the legal argument for this thesis. Activist Carol Leigh first introduced the term 'sex work' as an alternative to 'prostitution' in the 1970s, feeling the need for a term that wasn't pejorative or laden with connotations like 'prostitute' and 'prostitution'. While the term 'sex work' has served the purpose of destigmatising commercial sex work from prostitution, it is important to recognise that 'sex work' is a complex, nuanced concept with various aspects. It should be regarded as an umbrella term encompassing clinical sexology, psychosexual therapy, intimacy and sex-focused therapy, sexual surrogacy therapy, and other commercial sex work. I use the term commercial sex work or commercial sex worker as an alternative rather than prostitution. By adopting the term "commercial sex work" or referring to individuals as "commercial sex workers" rather than using the more general term "sex work," we not only aim to destigmatize this profession, but also seek to prompt a paradigm shift in societal perceptions. It is crucial to recognize that commercial sex work encompasses a spectrum of dimensions, integrating itself into a broader professional sphere that intersects with aspects of sexuality, sexual health, and overall well-being. It should not be narrowly construed as a mere alternative to the conventional notion of prostitution, which often revolves around fulfilling the sexual desires of a 'consumer' or client. Scholars and authors like Kamala Kempadoo (2003) and Prabha Kotiswaran (2011) have been instrumental in advancing discussions on this subject, shedding light on the multifaceted nature of commercial sex work and its integral role within the broader framework of professions related to sexuality, sexual health, and healthcare. This perspective not only challenges prevailing stereotypes but also encourages a more nuanced understanding of the complexities inherent in the field of sex work. In turn, this re-evaluation has the potential to engender more empathetic and informed policies and attitudes towards those engaged in this profession.

It's crucial to recognize that a key distinction between other forms of sex work and, in this instance, sexual surrogacy therapy, lies in the engagement of sexual activity or physical contact with a 'client,' and the legal status surrounding it. When evaluating the ethics and legality of sexual surrogacy therapy in South Africa, it may be simplistically categorized as prostitution due to the financial transaction involved. However, in reality, sexual surrogacy therapy doesn't always entail sexual acts, and certainly does not revolve primarily around sexual intercourse. Instead, it incorporates various forms of psychotherapy, placing a significant emphasis on the interaction between the body, its capabilities, and the mind. The primary objective of sexual surrogacy therapy is healing, much like any other form of therapy. It should be viewed as a healthcare imperative in South Africa, especially in facilitating gender and sexual minorities to articulate their sexual needs and gain access to sexual healthcare. However, the practice of sexual surrogacy therapy poses a

distinctive challenge to the South African constitution. One can easily discern the potential legal ramifications for healthcare professionals when involved in sexual surrogacy therapy. This extends to both collaborating with and referring a patient to a sex surrogate, as such actions might be deemed unlawful. Moreover, any financial gains derived from this three-way therapeutic collaboration could be legally contentious. As soon as the surrogate transitions from providing informational support to engaging in physical contact with intimate parts of the body, it becomes an act prohibited by law, effectively categorizing the surrogate as a sex worker rather than a therapeutic practitioner.

In the context of contemporary discourse surrounding commercial sex work, sex, and sexuality in South Africa, this thesis emphasizes the vital need for a human rights-based framework to address such matters. It further posits that sexual surrogacy therapy should be considered an integral component of sexual healthcare. Organisation such as Sonke Gender Justice and the Sexual and Reproductive Justice Coalition, on the accessibility of sexual and reproductive healthcare for marginalized groups have consistently revealed the significant costs associated with sexual exclusion. They have also highlighted the inadequacies or absence of appropriate treatments and care in various contexts. Within this framework, the thesis delves into an examination of the repercussions of sexual exclusion on gender and sexual minorities within South Africa's healthcare system. Additionally, it provides an overview of the currently available sexual treatment options and assesses their effectiveness. These treatments encompass a spectrum, ranging from counselling and psychological intervention to sex therapy and Gender Affirming Surgery (GAS).

While these measures are essential, there exists a pressing need for a broader societal shift in attitudes towards sex therapy, the sex industry, sexuality diversity, and the sexual rights of gender and sexual minorities. Recognizing that social transformation is an ongoing process, I delve into the significance of professional associations as potential advocates for the sexual rights of gender and sexual minorities, advocating for the legalization of sexual surrogacy therapy as a facet of sexual justice. Through an examination of nations where sexual surrogacy therapy has been legalized and integrated into their healthcare systems, I draw parallels to advocate for its integration within South Africa's healthcare framework. This discussion culminates in the assertion that Sexual Surrogacy Therapy (SST) not only facilitates the sexual inclusivity and well-being of gender and sexual minorities but also holds potential benefits for all sexually active individuals in South Africa, particularly those within the gender and sexual minority spectrum. It argues that embracing sexuality and sexual diversity is a stride towards advancing sexual justice for all, consequently fortifying the safeguarding and promotion of other fundamental human

rights.

1.2 Primary Research Question

This paper highlights the potential of sexual surrogacy therapy and demonstrates the need for the therapy's ethical, legal and healthcare considerations. While the research is not intended to advocate for the decriminalization of sex work in South Africa, it highlights the shortcomings of the continued criminalisation of sex work in South Africa and the constitutional grey area around the right to sexual activity. The main objective of this paper is to consider the legalisation of sexual surrogacy therapy and demonstrate a need for the ethical, legal and healthcare considerations of sexual surrogate therapy by performing a constitutional test of the Sexual Offences Act 23 of 1957 and the Sexual Offences and Related Matters: Act No. 32 of 2007 to answer the question:

How does Sexual Surrogacy Therapy fit into notions of healthcare, legalized notions of sex work and social prohibitionism against sex work in South Africa?

In addition, the following sub-questions were probed:

1. Is it legally possible to implement sexual surrogacy therapy in South Africa?

2. In what ways can sexual surrogacy therapy enhance sexual intimacy, facilitate emotional healing, and provide care for individuals with disabilities or those undergoing gender affirming surgery?

3. Is the current healthcare system capable of integrating sexual surrogacy therapy?

4. What are the social implications of sexual surrogacy therapy in South Africa?

1.3 Methodology

1.3.1 Introduction

This paper reviews the history and evidence-based literature regarding sexual surrogacy therapy with the focus on two groups identify as gender and sexual minorities being, (i) individuals who are living with physical disabilities and, (ii) those who have undergone gender affirming surgery (GAS) or that might undergo this surgery. These gender and sexual minorities illustrate the need for ethical, legal and healthcare considerations of sexual surrogacy therapy. This paper test the theoretical and practical framework of sexual

surrogacy therapy and broaden the discussion on the politics of sex and sexuality, bodily autonomy, social capital, and institutional inclusion of the abovementioned group of people of which the thesis understands as a minority. By exploring the current support available to transgender and individuals living with disabilities, the paper discusses the ethics and benefits of the consideration of including sexual surrogacy therapy in the healthcare system and performs a constitutional test of the Sexual Offences Act 23 of 1957 and the Sexual Offences and Related Matters: Act No. 32 of 2007 to investigate and determine the legal grounds for sexual surrogacy therapy as a feasibility in contemporary South Africa. Considering the nature of the questions asked in this study, it will be suitable for me to adopt a qualitative research methodology, particularly a comparative study design and secondary data analysis. This research methodology is consistent with previous research on sexual surrogacy therapy and further allow me to identify and interpret data into reasoned explanations of sexual surrogacy therapy in contemporary South Africa. A few contemporary examples includes a study that explores the outcome and impacts therapy of sexual surrogacy therapy on individuals satisfaction, happiness and overall wellbeing (Liu-Pham, 2021) and research that delves into ethical dilemmas and considerations surrounding the practice of sexual surrogacy therapy in sexual medicine (Rosenbaum, 2014). These examples demonstrate the diverse range of research conducted on sexual surrogacy therapy, emphasizing its relevance and importance in the field of sexual health and therapy. My research methodology aligns with these previous studies which enables me to contribute to the body of knowledge on sexual surrogacy therapy, particularly in the context of contemporary South Africa.

1.3.2 Comparative study design

My reason for choosing a comparative study design is to understand and establish the reasons for varying outcomes in countries that share similar characteristics which further informs the exercise of this study of establishing the feasibility of sexual surrogacy therapy in South Africa's legal and healthcare system. The use of a comparative study to study legal behaviour, which are variations in the methods and degrees of governmental social control of behaviour; and political phenomena, is methodologically useful to understand why different outcomes may exist in various societies and how these differences could inform another. Comparative research methodology differs from methods that aim to critically assess theory, methods and results from existing qualitative research in an attempt to generate and synthesize meaning, but assists in the process of facilitating new research question by analysing existing data (Hinds et al., 1997). For instance, while there is an existing theoretical body of work on sexual surrogacy therapy in the United States and other countries, the data does not give an African or South African perspective however,

the data is relevant in a South African context and is comparable.

Therefore, this thesis briefly reviews sexual surrogacy therapy in countries such as Germany and the Netherlands; and others where civil society is advocating for the legalisation or recognition of sexual surrogacy therapy, to determine how sexual surrogacy therapy has been framed and legalized as a health/human rights issue. To achieve this, I survey international legal instruments that promote and uphold the rights of the gender and sexual minorities identified and further analyze how various actors could inform the institutionalisation of sexual surrogacy therapy in South Africa. By examining the experience of GSM in the healthcare system enables us to identify the value that sexual surrogacy therapy may have in South Africa. This thesis is grounded in social justice research, specifically equality, diversity, and inclusion theory. Research is considered social justice research when it is grounded in the set of theoretical traditions that ensures the fair treatment and opportunity for all; and eradicates prejudice and discrimination based on an individual or group of individuals characteristics.

1.3.3 Secondary Data Analysis

Because there is no academic research conducted in South Africa on sexual surrogacy therapy, this research conducts a secondary analysis of qualitative data as a means of analysing pre-existing data collected outside South Africa towards a process of re-contextualizing and reconstructing the data into a South African context. The qualitative data is gathered from books, articles, academic journals and research reports that mostly use Masters and Johnsons (1970) work on sexual surrogacy therapy. The review of secondary literature is important for two reasons. Firstly, it allows me to contextualise the history of sexual surrogacy therapy in various contexts. Secondly, it allows me to familiarise myself with the theoretical and empirical literature on the subject and to identify gaps in knowledge that I need to address in my study, particularly for a South African context. Utilizing secondary data analysis for this study on sexual surrogacy therapy is substantiated by a wealth of recent literature emphasizing its efficacy in certain research contexts. Tripathy (2013) underscores that secondary data analysis, when approached ethically, can offer valuable insights and address research questions effectively. Johnston (2014) further supports this method, asserting that it has come to the forefront as a robust research approach. Additionally, Swart et al. (2015) provide guidelines and recommendations for good practice in secondary data analysis, enhancing its credibility as a valid research methodology. Moreover, Elliott (2015) highlights the potential of secondary data analysis, particularly in the college context, signifying its versatility in various research domains. These contemporary sources collectively affirm the appropriateness and relevance of secondary data analysis as a methodological choice

for investigating sexual surrogacy therapy, underscoring its potential to yield valuable and meaningful insights. Erasmus and Gilson (2008) suggest that, "documents can provide an entry point into the language or discourses that are used in relation to particular policy" (366). Due to the limitation of research available, this method is suitable for this study as it not only provide nuanced and reliable data but will further help create and inform an academic archive of work that seeks to potentially expose South Africans to a non-reductionist approach to the complexities of sex and sexuality.

Secondary data analysis grants me the opportunity to formulate questions that are specific to a particular context, in the case of this study, in South Africa. The data this thesis considers are policies and conventions such as the Convention on the Rights of Persons with Disabilities which addresses sexual and reproductive health of people living with disabilities, towards the integration of sexual surrogacy therapy in the Netherlands and Germany for persons living with disability, which allows this research to extend the feasibility of the therapy in South Africa. These policies and conventions where accessed online through sex care organisations such as the Flekszorg, the Handicap and Sexuality Foundation and the Foundation for Alternative Relationship Mediation.

It is worth noting that this study is not focused on the actual therapy sessions of sexual surrogacy therapy and how they are conducted but the integration of sexual surrogacy therapy as a recognized form of therapy in South Africa's healthcare system. This is because each therapeutic session is customised to individual patient needs.

1.4 Ethical consideration

During the process of collecting data, it was of at most importance that the ethical standards of the University of the Witwatersrand where maintained. This research did not involve any interaction with human subjects or participants. I have used data previously collected by other researchers for similar research that have used human subjects, and have undergone ethics reviews.

1.5 Limitations

As one of the first academic papers to address the concept of sexual surrogacy therapy in South Africa, discussions will be influenced by previous foreign studies in academic writing. This research aims to lay the groundwork for further research, academic writing and discourse of the possibilities of this kind of therapy in South Africa and possibly Africa in its entirety. In the attempt to provide an overview of the

issues at hand, this research has adopted a general outlook and in so doing, it does not specifically give an account or determine whether sexual surrogacy therapy has moralistic implications in South Africa, but rather to explore its contribution towards a liberation of sexuality and to inform society of the possible opportunities it presents as part of the legal and healthcare system.

1.6 Literature Review

> *"One cannot learn about sexuality in a practical way without actually experiencing intimate behaviour with a partner"* - Masters and Johnson, 1970:146 (Freckelton, 2013)

Sexual Surrogacy Therapy: Precedents and Debates

In the1970s Masters, a physician and Johnson, a sex therapist, established the Masters and Johnson institute. They conducted ground breaking and controversial research on the physiology of human sexuality. The Masters and Johnson institute was initially established to assist married couples recover from and/or manage sexual dysfunctions within their marriage. Although understanding people's experiences of sex provided important information for their research, Thomas Maier (2009) author of *Masters of Sex,* states that Masters and Johnson went beyond personal experiences and sought to understand exactly how the body worked so that they could devise different types of therapeutic programs that would address various problems that married couples were experiencing sexually - Their work is key to the concept of sexual surrogacy therapy because it shows the multidimensional and complicated nature of addressing human sex and sexuality.

Masters and Johnsons (1970) most influential work was documented in a book titled *Human Inadequacy.* The duo reported physiological findings and insights achieved by means of simple and primitive techniques of psychotherapy and of physical rehabilitation. The study included five-hundred and ten couples who suffered from severe forms of sexual inadequacies. Among them were wives in their fifties who had been married for decades and claimed to have never reached an orgasm; husbands who were described as impotent; husbands who were attracted to other men and married women who were still virgins (Masters & Johnson, 1970:149). The Masters and Johnson Institute accepted these couples for a course of daily therapy for two weeks. The therapy sessions were intensive, short-term and involved some psychotherapy; cognitive therapy and sex education. Their extensive therapeutic initiatives and subsequent discoveries were were later detailed in their book. Within its pages, the authors not only catalogued these programs but also

underscored the pressing need for comprehensive sex education. Moreover, they emphasized that sexual dysfunctions often stemmed from various preventable factors.

Masters and Johnson further stress the fact that sex involves the participation of both partners and if one partner suffers from a sexual inadequacy, both partners are therefore affected. The duo therefore strongly recommended that in such a case, both partners are actively involved in the therapy sessions - this method was known as the *duos technique* (Masters & Johnson, 1970). They believed this approach further encouraged communication between partners, communication that was either subdued or non-existent in a sexual context. During the therapy sessions, Masters and Johnson used physiological methods to treat erectile and ejaculation dysfunction for men and anorgasmia and painful intercourse for women (Roberts, 2007: 200). The *duos technique* was proven to have an eighty percent success rate of all cases treated (Masters & Johnson, 1970; Roberts, 2007:200). The pair believed that attitudes and ignorance rather than mental and physical illnesses and limitations were responsible for most sexual problems. Masters and Johnsons highlights that “the therapeutic program for relief of sexual dysfunction is fundamentally a process of marital unit education with concomitant dissipation of misconception, misinformation and taboo. The educational program is designed primarily to encourage the sexually dysfunctional individual not to attempt to improve upon, but hopefully to return to, the basic physiological patterns of natural sexual responsivity" (Guttmacher, 1970).

Although Masters and Johnson (1970) initially created the therapy for married couples, they later realized that there was a large number of single people, particularly men, who were in need of their services (Rosenbaum et al., 2014). To address this, the duo made the shocking and unorthodox methodological decision to pair single patients with women who volunteered to act as sex surrogates, under the strict direction of a trained phycologist. This was the inception of the concept of SST (Rosenbaum et al., 2014). As respected individuals, their decision redefined and shifted notions of sex work while making a shocking contribution to a movement that challenged traditional codes of behaviour related to sex, sexuality and sex education. However, as abovementioned, all the surrogates in their research were women which then disqualified individuals who were biologically identified as women from receiving this therapy. Progression was halted by the discovery that married women were amongst the volunteers. This unfortunately informed public perception on sexual surrogacy as a by-product of sex work and that it was in actual fact “glorified prostitution” (Shapiro, 2002). This grey area was contextualized around the idea of volunteerism without compensation (Masters & Johnson, 1970). The Masters and Johnsons Institute was located in Saint Louis,

Missouri. The then Missouri laws prohibited married people from engaging in sexual intercourse beyond their marriage (Maier, 2009:168). While many had suspicions that volunteers were compensated, an interesting lawsuit against Masters and Johnson emerged from one of the volunteering surrogate's husband who sued the duo for him having "lost the conjugal rights" of his wife and suffered "great humiliation and disgrace in his social and domestic relationships" due to the nature of his wife's volunteerism as a surrogate. The case was intended to further prove that volunteers were remunerated. However, due to the lack of evidence and the volunteer maintaining to have granted her consent without compensation, the case was dismissed (Maier, 2009:169).

Sexual Surrogacy Therapy and Sex Work

"When you go to a prostitute it's like going to a restaurant. You choose from the menu, you eat, and when you leave, the proprietor hopes you will return and tell your friends. Seeing a surrogate is like going to a culinary school. You learn the recipes, develop your skills in the kitchen, broaden your palate, and then go out into the world with your newfound knowledge. If all goes well, you create delicious meals for select dining partners again and again"

– Cheryl Cohen-Greene, 2012 (157)

While there have been great efforts to demonstrate that all sex work is work, the difference between a sex surrogate and a commercial sex worker is important for the sake of this research and towards a nuanced understanding of the work SST for its legal and ethical considerations. It is worth noting that the term "sex worker" will be used as a non-stigmatised term, in an effort to move away from pejorative words like prostitutes, whores, bitches etc. this is in line with the idea that prostitution, as all other types of work rather than an activity that demeans the service provider.

One can only imagine the discomfort that this kind of therapy would bring to any society because of an undercurrent association with prostitution, particularly because both sex surrogates and sex workers are paid for their services. However, sex surrogates have a different approach to providing services for their clients, unlike the commercial role of sex workers which is assumed to be less likely therapeutic (Roberts, 2007:218), sex surrogacy offers, "An expectation in shared physical intimacy, while working with the client's sexuality, self-concept and body responses. It allows for the modelling of both sexual closeness and social skills" (Rosenbaum et al., 2014: 158). Generally, many seek the services of sex workers on the basis

of sexual indulgence, while sex surrogates aim to treat sexual dysfunctions beyond sexual gratification and involve building confidence, social and physical-awareness; consciousness and skills in areas of physical and emotional intimacy (Appleyard, 2011). Masters and Johnson's (1970) work was indeed the foundation towards a different narrative of sexual therapy. However, by today's standards, the study has irrefutable limitations towards sexual emancipation. One of the noticeable flaws of the study is its limited concentration of the complexities of sexuality and people living with physical disabilities. In South Africa, the traditional Masters and Johnson (1970) approach which involved a client, therapist and a surrogate partner would be unlawful because of the legal status of sex work (Sexual Offences and Related Matters: Act No. 32 of 2007). Most professionals, such as sexologists, in South Africa, who offer services as sexual therapist surrogates, are forced to cut out the middle person - the therapist, and to act as both therapists and surrogate partners to avoid facing criminal charges (McIntosh, 2018). While this may raise questions about the legitimacy; regulation and monitoring of the therapy, the realities of the sex work in South Africa does not always offer a safe space for a three-person therapeutic team as recommended by the International Professional Surrogates Association (IPSA) due to legal implications. The IPSA is a non-profit organization that was established in 1973 with the sole purpose of advancing the work of SST, it training and certification to sex surrogates (Apfelbaum, 1977; Dannacher, 1985; Noonan, 2002).

In the eighties, Noonan's (2002) research on sex surrogates was regarded as the definitive research on the subject and is referenced in several articles. The research consisted of sending out questionnaires to ninety-seven surrogate partners who are members of the IPSA. Through a process of snowballing, he obtained a sixty percent response and the data collected was used to determine and evaluate the activities the surrogates engaged in with their clients. Contrary to popular beliefs, Noonan (2002) argues that in this therapy goes beyond sexual intercourse and that it is important to note that actual penetration is a small part of the therapy (Roberts, 2007). In a television series titled *Taboo,* popular sex surrogate Susan Cohen-Greene, stated that in the event of actual penetration, the act is approximate ten seconds long. Additionally, The Kinsey Report (2008) reported that, "13% of a client's time with a surrogate partner involved physical interaction, such as directly teaching sexual techniques. Some surrogate-partner relationships do not involve sexual contact at all, depending on a client's preference or the nature of the concern" (Zur Institute. Surrogate Partner Therapy/Sexual Surrogacy-To Refer or Not to Refer, n.d.). The report further highlighted that registered sex surrogates work in conjunction with, or under the supervision of, a licensed mental health professional. Sessions between a sex surrogate and a client can last between four to six months or four to six sessions, this is obviously not a typical arrangement with sex workers.

Given the differences above, it is quite clear that there is a distinct line between sex surrogates and sex workers. The questions about the ethics and legality of this practice remains problematic. Considering the current state of sex work in South Africa, sexual surrogacy therapy would simply be regarded as prostitution due to the exchange of money.

Sexuality and Sex work in Post-Apartheid South Africa.

The representation of African sexuality by colonialists contributed to the engineering of African non-culture and aided the project towards a reconfiguration of Africans to the transformation and development of a "civilized" sexuality aligned with that of the colonizer (Tamale, 2011:14-15). This 'development' entailed the policing and configuration of African behaviour, including sexual behaviour. In a book titled *Sexuality and Social Justice in Africa*, Marc Epprecht (2013) highlights that this reconfiguration of African sexuality was met with imperialist assumptions of African people, which included racialized stereotypes; the sexualization and objectification of the African body, which included the abuse of African women by colonial settlers and the denunciation of traditional practices such as circumcision, labia elongation and same-sex marriage (40). Academic and human rights activist, Sylvia Tamale (2011) argues that this reconfiguring was reflective of the colonial obsession with manufacturing African sexuality as the "other" in relation to Victorian sexuality, which was understood as a "civilized" and conservative sexuality that is informed by moralistic edicts and Christianity (16). Such discourse is important as they reveal much about power and its relation to a bigger discussion around the policing of sexuality. The 'othering' of African sexuality allowed the bourgeois to produce and maintain power.

In today's world, it is evident that the colonial project mentioned above has manifested itself through the propagation of various beliefs. Religious systems inform discourses on sexuality, which involves an intersection between religion and moral correctness (Mutua, 2000:452). Regardless of variation in ideologies, scale or influence, all religious systems have set codes of conduct, rules and regulations that guide everyday interactions which include sexual behaviour. In contemporary Africa, we see a manifestation of the obsession with the regulation of sexual bodies. In South Africa, there is a controversy over the decriminalization of sex work that dates back to the early 1970s and while it is important to understand the post-apartheid discourse on sex work, it is equally important to understand the attitudes towards sexuality and sex work in apartheid South Africa to provide a historical precedent.

The policing of sex work has a long history in South Africa and its multiplexity is found in discourses that

existed then and still today, particularly around female sexuality, sex work, healthcare and human rights. In the first half of the twentieth century, discussions on sex and sexuality were taboo. Burns (2007) writes, "even after the 1950s and 1960s, when the taboo-status became more relative, it has to date remained a discussion with disreputable overtones" in society. The Immorality Act 23 of 1927 regulated South African sex lives during the apartheid era. It was later renamed as the Sexual Offense Act of 1957 and introduced amendments stipulating that activities associated with sex work such as pimping, soliciting and brothel-keeping were illegal. The Act further prohibited all forms of miscegenation between all races however despite this, there were reports of white men and black sex workers engaging in sexual intercourse. In 1988, the Sexual Offences Act was further amended with the introduction of section 20(1) (aA). This amendment brought about a new approach and the current legal position as it provides that any person who has sexual encounters for a fee and/or a reward, is guilty of an offense. Essentially, all known aspects of sex work were deemed a crime. This amendment famously became as a result after the Supreme Court of Appeal, then known as the Appellate Division, held that in the case of State v Horn,1988, the sex worker did not constitute an offence by rendering sexual services (S v Horn (62/87) [1988] ZASCA 46 (17 May 1988)). It was understood that the sex worker could not be prosecuted of any crime from living off the earnings of the service she rendered. This was taking into account that the law criminalized the conduct of third parties such as pimps and/or madams. The ruling is well known as the most recent memory in South Africa's history when sex work was unambiguously decriminalized.

In contemporary South Africa, we see legal frameworks addressing sexuality, and new medical and moral debates that have made discussions around sex and sexuality important and an urgent human rights matter. SWEAT (The Sex Workers Education and Advocacy Taskforce), a South African non-profit organisation, advocates for decent working conditions for sex workers and the decriminalisation of sex work. The organisation argues that "workers would also benefit from labour law and would get pensions when they retire.

> "The Department of Labour would also monitor working conditions and the sex workers would be treated with the dignity afforded to other workers under the Bill of Rights "
>
> (SWEAT, 2006)

In an article titled *The Movement to Decriminalize Sex Work in South Africa*, scholar, Janet M. Wojcicki (2003) gives the roots of the post-apartheid movement to decriminalize sex work. In part, she argues that

some of the discourse produced during this time period was fairly liberal. She further asserts that in the 1970s, there was some sense on the part of government and medical officials that suggested that a call to decriminalize was a rational and reasonable option when discussed from a to public health benefits perspective (93-94). This position is one that is still prevalent in post-apartheid South Africa, however, there is still controversy over the decriminalization of sex work in general. The relationship between the law and morality is debated parallel to that of unlawful sexual practices and human rights. These debates have revealed a fractured public sentiment. On the one side of the debate are members of the public and other stakeholders that holding diverse views for the decriminalization and/or legalization of sex work. Amongst these views are suggestions that the decriminalization would result in regulation, access to better healthcare by sex workers, more informed heath decisions and the effective combating sex work related crimes (will not escape this revolution, 2001:19). Others are of the view that sex work should continue being criminalised and argue that decriminalisation would lead to increased crime such as human trafficking and result in an increased number of sexually transmitted diseases, particularly HIV/AIDS. However, since the 1990s, the public health crisis created by HIV/AIDS as well as efforts made by various stakeholders within the public health conversation, to advocate for sex and sexuality education as part of national 'safe sex' campaigns, contributed to the maturing and normalization of a public discourse on sex, began having serious conversations concerning the possibility of decriminalizing or legalizing sex work. This has accompanied a new constitutional framework around sexual rights and sexual identities. To a considerable extent the popular perception of the subject's clandestine, private and taboo character has been re-evaluated over the last ten years. Regardless, there are ongoing attempts that suggest that remunerative sex work could be decriminalized or legalized under the constitution order (Burns, 2007).

Disability and Sexuality

"Sexual health and the need to have a safe and fulfilling level of intimacy, is a human right," says Désir, "and we were disappointed to discover that nearly no information exists to inform disabled individuals of this in South Africa. With so many queries on a day-to-day basis from physically challenged individuals, we knew that we had to do something to promote change in South Africa with regards to lifting the lid on intimacy, sexuality and the right for this – whether you are abled or disabled."

Désir, 2018 (Straton, 2018)

Democracy in South Africa meant opportunities for people living with disabilities, such as the potential to

realize and to access both public and private life domains that have increased their presence in an integrated and meaningful way (Kahn, 2017). Through education and support, a significant amount of people living with disabilities have been able to initiate and maintain social and sexual relationships. One cannot deny that there are healthy romantic relationships among people with disabilities (Milligan & Neufeldt, 2001) however, there is still a large number of people living with disabilities who do not have access to such relationships in contemporary South Africa. For many people living with physical disabilities, "uncomplicated" things such as the ability to access spaces where others are able to meet potential partners can be challenging (Milligan & Neufeldt, 2001). As a result, many individuals and organizations have seen the need to advocate for more inclusive conditions and the acceptance of the act of sex as a human right and the ability to express and exercise this right for all human beings (Evans, 1993). While we do not often think of sexual intercourse as a human right, it is becoming a key element in the advocacy of the sexual rights and a key element in the battle against the subhuman treatment of people living with physical disabilities; and has become part of some important disability policies in South Africa and across the globe (Ward, 2014; Ministry of Social Affairs, 2001; United Nations: General Assembly, 1993).

Some governments and organizations have gone as far as developing and suggesting new strategies aimed at improving the rights of people living with physical disabilities to express their sexuality through the use of sex surrogates. In Germany and neighbouring Netherlands, people with disabilities have had opportunities to sexual assistance for years. The Dutch government pays for the use of sex surrogates for disabled people through subsidies and by prescription (Ward, 2014). With sex work and SST legalized in the country, the government has further boosted the intimate endeavours of people living with disabilities (Ward, 2014). As much as the Dutch government has taken a step towards the sexual liberation for people living with disabilities, a large number of people who do not have obvious physical disabilities but mental and sexual dysfunctions are still left out of the equation which can raise the question of inclusion, exclusion and exclusiveness of sexual citizenship. It is obvious that many in contemporary society have a hard time understanding sexuality and the right to sexuality, SST becomes more complicated, and many citizens, particularly in the Netherlands, object to using tax money to support such therapy. Regardless, advocates; academics; social workers; and doctors support this government and stress that the initiative is "not about supporting the sex business, but is rather promoting a right and addressing health issues" (Ward, 2014). Although there is no direct grant for sex in the Netherlands, recent reports have indicated that the Dutch government grants citizens living with disabilities twelve sessions annually. Many hope that this initiative by the Dutch government be institutionalized as this would be a progressive and revolutionary breakthrough

for people living with disabilities in the Netherlands and could potentially influence other countries to implement the same or similar policies for its disabled citizens (Ward, 2014).

Gender Affirming Surgery and Healthcare

"*You don't go through 20 or 30 years of being uncomfortable with your body and then, through hormones and surgery, be able to experience your body in all its richness. It just doesn't work quite that way."*

Dr. Laurie Bennette Cook (Weisman, 2017)

"I also work with transgender people, mostly trans women, but one time I worked with a trans man on how to give and receive pleasure using his surgically constructed phallus. Each client serves as a new learning experience!"

Kendra Holliday, 2018 (Wong, 2018)

These quotations highlight the complex and nuanced experiences of transgender individuals in relation to their bodies and the importance of gender-affirming surgery and healthcare. The first quotation by Dr. Laurie Bennette Cook (2017) emphasizes that transitioning through hormones and surgery is not a simple or instant process. It acknowledges that for many transgender individuals, there is a long history of discomfort with their assigned sex at birth. Achieving a sense of comfort and alignment with one's gender identity is a gradual process that requires time, effort, and sometimes medical interventions. The second quotation by Kendra Holliday (2018) touches on the importance of sexual well-being for transgender individuals who have undergone gender-affirming surgery. It highlights the need for individuals to explore and understand their bodies in a way that aligns with their gender identity. The example of working with a trans man on how to experience pleasure with "his surgically constructed phallus" underscores the significance of sexual health and satisfaction as part of overall well-being. Both quotations stress that gender-affirming surgery and healthcare play a crucial role in allowing transgender individuals to feel more comfortable and aligned with their true selves.

The South African framework of health and human rights provides for a theoretical and practical application of general human rights principles in the healthcare system which include the wellbeing of patients. This is important for GSM who experience historical and contemporary systematic marginalization, exclusion and discrimination in healthcare (Müller, 2017). Research has shown that sexual and gender minority patients

experience discrimination, stigmatization and at times are denied access to healthcare as a result of their sexual orientation and gender identity. South Africa is no exception (Tarsha et al., 2016), particularly transgender bodies who consider GAS as in integral component of their transition. GAS typically involves a range of multidisciplinary therapeutic processes for patients which concludes with one or a few surgeries to convert natal/fetal genitalia (Hage & Karim, 2000). Post-surgery care for patients is important as it not only involves self-care but presents interpersonal challenges such as adjusting to and learning about their new bodies. Thus, the process of recovery is usually long and commonly involves the suspension of sexual activities for various physical and emotional reasons (Hill-Meyer, 2014).

In countries where sexual surrogacy therapy is legally available, a central contention in favour of it for transgender individuals hinges on the medical advantages it offers. This argument is supported by the involvement of a qualified, licensed sex surrogate, as well as a therapist who guarantees the delivery of both ethical and expert support, alongside creating a secure and comforting sexual setting for patients. For individuals who do not have a partner(s) to explore their bodily function with, or are unsure of how to explore their body, it seems beneficial from a theoretical standpoint for them to have the option to receive assistance from someone who is educated and professionally trained about the patient's surgical transition. This may eventually encourage bodily and sexual self-awareness resulting in self-confidence and pleasant sexual encounters. Transgender individuals who have undergone surgery experience significant health problems which are directly related to their reassignment journey, as they constantly have to navigate and negotiate care within a heteronormative healthcare system. For example, to ensure that people in need of chronic medication are taken care of, Medical Aids in South Africa are legally required to fully cover the cost of lifelong conditions such as asthma, diabetes and hypertension. Conditions such as these form part of a category known as *prescribed minimum benefits* (PMBs) (Msomi, 2018). PMBs further include emergency care, mental illness and heart disease. The South African constitution clearly indicated that every citizen has the right to all healthcare services as healthcare is a fundamental human right for all citizens. This is further emphasized in the National Health Act (2004), which highlights, protects and promotes the right to dignity and healthcare of minority and vulnerable groups which include senior citizens, women, children and those living with disabilities. It is worth noting that the constitution and the National Health Act (2004) are specific regarding those identified as a vulnerable group, this does not include individuals who identify as transgender. Efforts to reform the South African healthcare system came through the

implementation of the National Healthcare Insurance (NHI). The NHI is expected to improve services and advance equality and competency and efficiency in the healthcare system, however, the recent released Medical Schemes Amendment Bill proposes cancelling PMBs in favour of a more comprehensive package of conditions and services. It is unclear which conditions would be included. As it stands, gender-affirming treatment which includes vitals and sometimes lifelong medications such as Hormone Replacement Therapy (HRT), such as estrogen and testosterone, do not fall under the category of PMBs (Msomi, 2018). Most transgender patients have to pay for the medication themselves regardless of being on a medical aid (Msomi, 2018).

The Bhekisisa health journalism centre surveyed six of the country's largest medical aid schemes, namely, the Government Employees Medical Scheme (Gems), Fedhealth, Discovery Health, Momentum Health, Bonitas and Profmed. These schemes are responsible for a total of more than three-millions people or almost a third of all privately insured South Africans, according to the Council for Medical Schemes latest annual report (Msomi, 2018). In their survey, Bhekisisa found that all schemes, with the exception of Discovery health, require members on HRT to pay for the chronic medication themselves (Msomi, 2018). Discovery Health has a programme that pays for both surgery and treatments, however, to qualify for this benefit, one must be a member of the schemes Executive plans which are among the medical aids most expensive options, for a minimum of three years. Discovery's executive plan cost almost R6000 a month in premiums (Msomi, 2018), this is unaffordable for most people. Furthermore, it is worth noting that the report suggest that Discovery had only approved care for two patients who applied to be part of the program (Msomi, 2018).

In South Africa, gender reassignment therapy is perceived as part of the management of a dysphoria (Wilson et al., 2014), this is not only violent and uninformed, it further dismisses the procedure as experimental, elective or cosmetic, but a reconstructive and medical necessity. This speaks to the extent of discrimination and disregard for this minority within the healthcare system in South Africa. Interestingly, should a medical aid refuse to pay for surgery after a patient is cleared by a doctor, the patient is advice to seek legal advice because as there may be a violation of the patient's constitutional right (Msomi, 2018). Section 9 of the constitution clearly prohibits discrimination on the grounds of gender; therefore, one could argue that the exclusion of all gender affirming care in the PMBs is contrary to the constitution, specifically the rights to equality, dignity and access to healthcare.

Sexual Surrogacy Therapy and Social Attitudes

"Those who are facing a life without marriage and sex, for whatever the reason, are just like the rest of us. And that's why there's no catch-all, pat answer. But I do know this: love isn't a therapy you pay for. We weren't created to be surrogates; stand-ins for love. Christ paid dearly so that love could be free."

Ashley Moore (Mehta, 2013)

The quotation above conveys a perspective on the nature of love, intimacy, and the idea of paying for intimacy (sexual surrogacy therapy). It suggests that people who may not have the opportunity for marriage or sexual intimacy, for various reasons, share a common human experience with everyone else and emphasises that there is no one-size-fits-all solution or easy answer for those facing such circumstances. The reference to Christ paying dearly for love could be a metaphorical or religious perspective, suggesting that love, in its purest form, is a profound and meaningful aspect of human existence that transcends commercial transactions or transactions of any kind. Overall, the quotation is expressing a philosophical viewpoint that questions the idea of paying for love or intimacy and emphasizes the inherent value and significance of love in human life from a religious point of view.

Religion in Africa is multifaceted and includes unique belief systems that are a result of the syncretism of western religious systems and tradition/ancestral beliefs (Epprecht, 2013: 66). This is common in South Africa as many believe in both Ancestors and God, however Christianity as a religious system is dominant. While there is no research on SST and religious attitudes in South Africa, it is without doubt that this kind of therapy will be read through a religious lens. In Christianity, the Bible is the most sacred collection of texts and scriptures and it is very clear about its position on the act of sex and sexuality.

The Bible states that sex is a gift from God to married people. God created human beings, a male and female, and when He brought the first man and women together in marriage, He said, "They must become one flesh." (NIV, Genesis 2:24). This bond included the pleasure of sexual intimacy along as it was with a close emotional connection. The Bible further describes the pleasure that husbands find in marriage: "Rejoice with the wife of your youth.'' Let her own breasts intoxicate you at all times. "With her love may you be in an ecstasy constantly" (NIV Proverbs 5:18, 19). The Bible also shows that God also intends for wives to enjoy sex. The Bible says: "Husbands and wives should satisfy each other's sexual needs" (NIV, 1 Corinthians 7:3). While the Bible addresses disability and mental illnesses (NIV John 9: 2-7; NIV Mark 10:

14-15; NIV Leviticus 19:14; NIV Luke 13: 10-15; NIV Galatians 4: 13-14), it does so in other contexts and does not explicitly discuss sexual intercourse and disability or sexual dysfunctions. The biblical standpoint on intimacy and sexuality applies to everyone and doesn't differentiate between people with or without disabilities. Unlike Masters and Johnson's decision to alter their therapy to cater for unmarried people (1970), the Bible and essentially Christianity, doesn't consider people with sexual inadequacies, disabilities, homosexuals or divorced people. Essentially, perceptions of sex work are informed by religious opinion that views sex work as "sin" and sex workers as "fallen or sinful" women, splitting the world into a dichotomy of good and bad girls/women, and treating it as a moral issue (Position Paper on sex work, 2016). Furthermore, one can argue that these views very rarely stigmatize the buyers of commercial sex work who are mostly men. SWEAT emphasizes that rather than focusing on the 'immorality' of sex work, society should focus on gender equity issues, appropriate exit programmes and decriminalisation (Sutherland, 2009). The movie *The Sessions* (2012) take an interesting turn on religion. While Mark O'Brien as a patient keeps his catholic faith throughout the sessions and once stating that "I need to believe in God", Cheryl Cohen-Greene gives up her catholic upbringing because of the negative sexual messages within her Catholic religion and chooses to help Mark free of any religious restrictions. However, as much as people are free to change their religion, the dangers of religious fanaticism and the disregard for sexuality and the right to sexuality will still prevails as religious views in contemporary society. This creates a continuum of violence and disregard for sexuality instead of emphasizing the importance of sexual rights and creating a society that concerns itself with humanizing sex standards and practices.

In *Hiding from Humanity* (2004), Martha Nussbaum considers the interesting intersection between Disgust, Shame and the Law. Nussbaum discusses the role that disgust and shame play in our personal and social lives parallel to the formulation and administration of the law. The author suggests that some emotions such as anger and compassion, serve important functions in a liberal state as they are intelligent responses that are attuned both to events in the world and to an individual's values and sometimes goals. She further argues that some emotions such as shame and disgust are different as they are likely to be normatively distorted and thus unreliable as guides to public practice. These emotions are particularly interesting in the for this paper as they are closely related to the attitude towards any sexual related work. Nussbaum (2004) contends that Disgust is typically unreasonable as it embodies "magical ideas of contamination, and aspirations to purity, immortality and nonanimality"(14) . The author further argues that disgust has often been employed to target vulnerable groups. Shame on the other hand can be a valuable moral sentiment in an individual's personal life as it in some instances encourage ethical actions and can reinforce social values, Nussbaum

argues that Shame cannot be reconciled with equal regard for the dignity of all citizens, in the case of the paper, for sex workers. Shaming penalties are dangerous, unreliable and can cause many social harms such invoking mob justice and cause individuals to become more alienated. Nussbaum suggest that Disgust and Shame should remain a part of individuals personal and social life but should never play a role in the legal sphere.

1.7 Overview of the Chapter

Chapter One serves as an introduction to the study. It presents the background of the topic and outlines my theoretical framework and locates the study in the broader conceptual and theoretical debates and contestation that inform my area of enquiry as well as to the broader context of South Africa. This chapter highlights how my research has been strongly influenced by and within a body of well-established literature that has informed research that addresses emerging discourses regarding the institutionalisation and legalisation of sexual surrogacy therapy, sex work as work, GSM's, sex and disability and the relationship between the law and moral duty. The chapter also outlined the research methods that were used in the process of gathering data and the analysis of the research design.

Chapter Two to Chapter Four serve as my analytical chapters. *Chapter Two* serves as a foundation for the discussion of the consideration of sexual surrogacy therapy in South Africa. Particularly in the South African healthcare system.

In *Chapter Two*, I presents a discussion on the value of sex and then discuss the problems that are as a result of the sexual exclusion of GSM. I aim to make the point that sexual activity is important for human flourishing and should not be regarded as a privilege but a necessity for all sexual beings. I highlight the importance of sexual activity beyond the idea of it being simply for procreation or pleasure. Additionally, I make the point that the ways in which sex and sexuality are conceptualised, influence sexual agency, understandings of sex and opportunities to sex. Furthermore, I examine two theories, Rawls (1971) theory of Justice and Martha Nussbaum's (2000;2002) Capabilities Approach, to demonstrate how sexual exclusion can be understood as an injustice, a sexual injustice.

In Chapter Three, I provide a brief discussion on the governance and evolving nature of intimacy and then discuss reasons and possible ways sexual surrogacy therapy should be considered in South Africa. I contend that South Africa has good reason to consider alternative ways to promote sexual opportunities within the

healthcare system and make legal provisions for such. This chapter further provide a human rights perspective on how the integration of human rights approaches into the South African healthcare system and social policies, could offer the opportunity to address existing challenges, particularly around rethinking the sexual citizenship of gender and sexual minorities.

Chapter four concludes by providing a constitutional test of the Sexual Offences and Related Matters: Act No. 32 of 2007, to investigate and determine the legal grounds for the argument of sexual surrogacy therapy as a feasibility in contemporary South Africa. The Chapter consults international instruments to determine if South Africa is in line with International obligations and standards. Finally, the chapter consider Section 22 and 23 of the Bill of Rights to determine whether sex work can legally be deemed as work and finally show how a rights-based approached adopted by the thesis in fit into international human rights law that the chapter sets out.

CHAPTER 2

2.1 Introduction

I have established that sexual activity makes provision for a variety of important goods such as procreation, pleasure and intimacy. These can be an important aspect of one's personal and sexual identity and thus can contribute to a holistic life. However, there are people that are denied access to the goods of sexuality, in particular, people living with disabilities and those who seek care after undergoing Gender Affirming Surgery (GAS). In this chapter, I will outline three perspectives of the value of sex which are: the procreation value, the pleasure value and lastly a flourishing 'plant like' value. While important, it is clear that the procreation and pleasure values of sex disregard essential elements of sex which the flourishing value addresses. I then discuss ways in which Gender and Sexuality Minorities (GSM) are denied their sexual citizenship and opportunities to express their sexuality. Part of the exclusion continues because of narrow views of sex which will be discussed. Furthermore, I maintain that given the right theory, we may be able to conceptualise and understand the sexual exclusion and its implications on GSM. To illustrate, I discuss and comparing Rawls theory of Justice and Martha Nussbaum *Capabilities Approach*. The fundamental aim of this chapter is to highlight that the ways in which sex and sexuality are conceptualised, influence sexual agency and understandings of sex and opportunities to sex. Moreover, the flourishing view of sex suggests a foundation for establishing the political importance of sexual rights. While there is a shared experience of discrimination and stigmatization, the experience of GSM vary and do not constitute a homologous experience, particularly in regards to health care needs. However, their minority status is rooted in heteronormativity and the term GSM is used to emphasise the shared experience of these minorities, while acknowledging this, trans and/or people living with a disability are who this paper regards to as GSM.

Section One

2.2 Key Concepts

It is important that I provide an outline of some important terms and concepts before I begin this discussion. By GSM, this paper refers to people who have significant physical impairments and not cognitive impairments. Some scholars have suggest that disabilities and impairments differ and argue that while impairments refer to a physical condition, one may find themselves in a disabling environment (Sheldon 1999 : 644). For instance, a person living with cerebral palsy may need an assistive device to access public spaces that are accessible that are disabilities friendly. To this end, provided such spaces exist, the persons

impairment may not be disabling. While the services of Sexual Surrogacy Therapy (SST) has been extended to people with cognitive impairments such as intellectual disabilities, for the purposes of this paper, I will focus on people with physical impairments as cognitive impairment is beyond the scope of this paper. I should add that while the concepts of sex and sexuality are similar, they are not the same nor are they interchangeable. Therefore, for the purpose of this paper, it is important that I make a clear distinction between the two. Sex refers to sexual activity, the *act* of sex while sexuality is conceptualised on an personal basis as ones sexual feelings, thoughts, attractions and behaviours towards others. For example, one can find another/ others physically, sexually or emotionally attractive- these are a part of ones sexuality. Sexuality is diverse and personal, and is an important aspect of one's identity.

2.3 The Three Values of Sex

In South Africa, sex is understood as something that is primarily physical and this is evident in curriculums on sexual education disseminated in our education and public healthcare systems. The main focus is predominately on safe sex education, HIV/AIDS, contraceptives and abstinence (Campbell & MacPhail, 2002). While such education is important, particularly in South Africa, the content of this kind of sex education fosters a society has limited knowledge on sex education and perpetuates the idea that sex is for enjoyment, as suggested by pleasurable views on sex, and for reproduction purposes, as suggested by procreation views on sex. I maintain that these views are limited and underestimates the capability of sex. On the other hand, the flourishing view on sex includes both elements of pleasure and reproduction and appreciates their importance while recognising other values of the value of sex such as physical self-regulation, identity and intimacy.

2.3.1 The Procreation View

This view of sex is one that suggests that the purpose of sex is exclusively for reproduction. A proponent of this view would typically maintain that sex is not to be misunderstood to be an end in itself but as a part of a process towards reproduction. Therefore, any sexual acts other than that with the ultimate goal of reproduction is morally impermissible. Not only does this view carry heteronormative views, it is inherently homophobic. Should sex be solely for the purpose of procreation, it would be limited to heterosexuals. This view makes the assumption of two sexes, and disregards gender and sexual diversity. This view is narrow, presumptuous and exclusionary of the real diversity of sexual relation. Additionally, the procreation view is confining to the extent that one could argue or understand sex to be a privileged practice to be enjoyed by

certain individuals for the sole purpose of reproduction. Not only does this view promote cisnormative ideologies, it has connotations that could evoke emotional and psychological harm. Such believes are rooted in religion and moral education.

2.3.2 The Pleasure View

The pleasurable view maintains that the value of sex primarily is the physical pleasure that is experienced as a result of sexual activity. Aspects of sex such as intimacy and desire can be seen as goods provided they contribute to sexual pleasure. A proponent would argue that sex is simply to be pleasurable and enjoyed without the pressures of having to procreate. In as much as I agree that pleasure is an important aspect of sexual activity, this is a rudimentary view on sex that disregards many elements of the social and complex goods of sex. In an article titled "Plain Sex", Alan Goldman (1977) suggests that "sexual desire is desire for contact with another body and for the pleasure which contact produces; sexual activity is activity which tends to fulfil such desire of the agents" (268). Essentially, Goldman (1977) argues, that the purpose of any sexual activity is the pleasure which physical contact presents. Such views excludes elements such as the desire for love, affection and communication which could be the reason or result between individuals who may be engaging in sexual activity. Goldman (1977) adds that sexual desire is "simply the desire for physical contact with another person" (269) and maintains that thinking of sex in terms feelings of love and affection; or reproduction, we place unnecessary moral limitations and restrictions on sex. Furthermore, he argues that, "there is no moral implication whatsoever. Any analysis of sex which imputes a moral character to sex acts in themselves is wrong for that reason. There is no morality intrinsic to sex" (280). To some extent, this value is appropriate for SST as it concerns itself with offering therapeutic care that results in healing and ultimately sexual pleasure of a patient while avoiding expression of feelings of love and affection. While many may express such feelings through sex, they are not inherent features of sexual activity or intimacy.

In another book titled *Gender and Social Theory,* Mary Evans (2003) gives a simple distinction between love and intimacy by suggesting that the former involves emotion and is an attribute of a person rather than a connection. Evans (1993) defends this by arguing that feelings of love can occur despite the lack of reciprocity or acknowledgment between people while the latter is the quality of an interpersonal connection which is coupled with interactions and an acknowledgement of a relationship and intention from parties involved. By the same token, the Goldman views on sexual relations emphasise relations of a sexual nature are only immoral when they lack mutuality or when they are not "freely or rationally endorsed by all parties" (282) however, he maintains that even when an act of sex feels objectifying, one needs to understand their

partners desire and by "allowing oneself to be a sexual object as well and by giving pleasure or ensuring that the pleasures of the act are mutual" (283). One of my critiques is of Goldman's (1977) conceptualisation of sexual objectification (and potential abuse) as a value of sex. For instance, majority of the criticisms of SST for GSM, particularly for people living with disabilities, is centred around the possibilities of sexual and physical abuses. Goldman's (1977) submission that sexual objectification could be justifiable as long as the parties involved are rendered sexual objects, is problematic. He provides, "even in an act which by its nature 'objectifies' the other, one recognises a partner as a subject with demands and desire by yielding to those desires, by allowing oneself to be a sexual object as well" (283). Sex should not be objectifying and most importantly, no one should be treated as an object, especially in the case of SST where the relationship is professional, but they should be treated with dignity and respect. It is possible to argue that Goldman perhaps means that one is able to acknowledge their partners desires and simultaneously be aroused by their physical appearance, scent, etc. which to some extent is understandable in Kantian terms, as morally acceptable to regard another individual as a means for something but not as *merely* a means. Goldman (1977) further argues that sexual pleasure is simply "brief and repetitive" (283) and not cumulative. Therefore, sexual pleasure is only valuable " to the specific act which generates them but not the lasting kind of value which enhances ones whole life" (283). Goldman's simplification of sex is suggested by the title his article, *Plain Sex*, and as such, not much value can be held to his arguments. His overly simplified view and value of sex is quite frankly, how many understand the value of sex work, particularly commercial sex work. This view fails to acknowledge other goods of sex that in actual fact, do play a part in long term values that can enhance one's life, and maintains that sex is inherently, for pleasure (Goldman 1977, 283-284). If this was the case, it would mean that other physical pleasures could be comparable to sexual pleasure thus, rendering the act of sex unnecessary. I maintain that sexual pleasure is not merely physical pleasure and should be interpreted within a larger scope as a type of pleasure that consolidates both physical and social aspects, which can ultimately enhance one's life. There is a deeper interest in sex which goes beyond the physical and there are various examples in society such as the governing of intimacies and social attitudes that highlight this.

2.3.3 The Flourishing "Plant-like" View

A good starting point to understanding Martha Nussbaum's work is by understanding her concern with the relationship between philosophy and everyday politics, particularly the practical business of human life- be it one's personal life or questions around how we organise ourselves in and as a society. I have established

two fundamental concerns in her work which are that of the ability to flourish as an individual and our vulnerability. In an interview, Nussbaum noted that we are "more like a plant than like a jewel, something rather fragile, but whose very particular beauty is inseparable from fragility" This metaphor suggests the connection between our vulnerability and the ability to flourish. Plants flourish but jewels simply exist in a constant form without movement or ability of flourishing. As such, the term 'the flourishing '*plant-like*' view, borrows from Martha Nussbaum's concept of flourishing life which she presents as the goal of any human being (Nussbaum 2011, 125). The procreation and the pleasure views conceptualise sex as primarily physical, however, this section discusses the flourishing "plant like" view which provides a different perspective by emphasising the other goods sex offers such as social and political goods towards a flourishing life. While I agree that sex is inherently physical, I maintain that sex can be both pleasurable and procreative and such is not as a matter of course in both, either or at all times when individuals engage in sexual intercourse. Additionally, I argue that sexual pleasure in fact, is crucial and essential in ways that other physical pleasures simply are not. Scholars such as Michell Tepper (2000) have demonstrated the importance of sexual pleasure and argued that it can be life affirming for some GSM. Considering existing academic literature on sex in South Africa, I have established a tendency of writing about sex in a filtered or excessively intellectualised manner, or conservatively as to suggest that it serves a greater purpose, a purpose beyond pleasure. Such places some level of shame to ideas of sex as a matter of pleasure or for reasons beyond what society understands as normal or morally acceptable.

Beyond being physical, much like other social collaborative relations and activities, sex is inherently social in its manifestation. Sex as a social aspect is positioned in the collaboration and to some extent, the reciprocity involved between individuals engaging in sexual activity. While this does not entail a connection between the individuals, i.e., people who do not know each other well or at all, can engage in sexual activity, the social aspect of sex still stands. In an article titled *Masturbation and Women's Sexuality*, Jacqueline Fortunata (1980) highlights that sex is socially unique in that it has the ability to familiarise people faster than other social activities and makes it possible for one to know another person in a unique way. In relation to political goods, sex and sexuality does contribute to the conceptualisation of a person's identity in a significant way. Moreover, sexuality often overshadows other identities one may have. For example, a teenage Xhosa boy may want to demonstrate his maturity or 'coming of age' for certain traditional customs, it would not be through the assessment of his physical or intellectual capabilities, social status or financial means, but through his sexual identity and freedoms, in this context, as a result of a traditional process of "uklwaluko" which is traditional circumcision initiation or rite of passage into manhood. This highlights a

more comprehensive sense of political identity as sexual agency and identity in this sense as it affirms ones inclusion in their community (Siebers, 2012: 41). This highlights sexuality as something that is uniquely human and the participation in sex to have value for reasons beyond sexual acts.

In respect to identity, sex makes provision for one to not only learn about their own sexual identity but the sexual identities of others. Fortunata (1980) argues that sex is a process of inquiry and 'coming to know', this highlights the significance of the relationship between sexual identity and inclusion in the human community. When someone is seen as anything other than cisgender, their sexuality may be used to describe their difference rather other dissimilarly amongst a group of people. In his autobiography titled, *How I Became a Human Being: A Disabled Man's Quest for Independence*, Mark O'Brian, reflects on his time with his sex surrogate partner. He writes, *"... seeing the surrogate had changed me in ways that I couldn't see then. I found that I was more confident about my sexuality"* (O'Brien & Kendall, 2003). From this quotation and other accounts in his autobiography, one can see how sex allowed Mark the opportunity to be part and included in a 'world' that he had been excluded before his SST sessions and experience. To this end, disability therapist Tobin Siebers ask, "what is it about sex that bestows a human status" (Siebers, 2012, 41). This question compels one to think about the relationship between sexuality and it's impact of sex in one's life.

I now will discuss the final aspect of the "flourishing view" which is the importance of sexual responsibility. This is largely conceptualised as 'sexual health' or 'sexual and reproductive health' and address the physical aspect of sex. Considering that I have argued that sex is more than just physical, I want to extend that sexual responsibility should embrace and include the physical social, emotional and political aspects of sex. This is not to take away from the importance of protecting themselves and their partners from physical issues that can result from sex such as sexually transmitted diseases or unwanted pregnancies. However, there is a need to address other aspects of sexual responsibility beyond the physical. This can be as simple as having conversations about sex with a sexual partner(s). With regards to the physical aspect of sex, sexual responsibility should include the idea of one taking responsibility for their own pleasure. For example, if a sexual partner does something that one may find uncomfortable, one should be able to communicate their discomfort. In terms of responsibility in the social aspect of sex, it becomes important for one to take into account their partners sexual abilities, preferences, willingness and feelings. Unlike values held by the pleasure view on sex, here, one needs not to objectify their partner or oneself in sex. This would be a disregard of the social aspect of sex. Taking into account the political aspect of sex, such as identity and

community with others, it is important that people are respectful of sexual and gender diversity. If one is sexually active, they should understand that to some extent, their sexual choices can in turn, affect others.

2.4 Sexual Exclusion

While I acknowledge that the concept of justice is somewhat complex and abstract, I believe that many would agree that justice is necessary. One aspect of the idea of justice is to make provision for the accessibility of opportunities and goods for equal and quality lives. The denial of sexual expression and experiences for GSM is an injustice. In an article titled *The Politics of Sexual Citizenship*, Sanders (2007) writes that, "Persons with disabilities struggle to access the familiar social environment that enables sexual expression, sexual opportunities and relationship building" (443). In my view, theories of justice should fundamentally provide that every individual has the equal opportunities and rights to basic liberties. To this end, the multifaceted nature of sexual goods such as pleasure and identity need to be recognised and accommodated in the same was as other multifaceted human goods such as religion, marriage, family and friendship are recognised. I will discuss in greater detail the theory of justice in relation to sex in greater detail in the next section of this chapter as sexual justice. In the following subsection, I will detail some ways in which the sexual exclusion of GSM is continuously perpetuated. It is important to be cognisant of the fact that the perpetuation of this exclusion is a complicated matter as it has various contributing factors which will be discussed throughout this paper.

2.4.1 Narrow Views of Sex and Sexuality

There is the misconception and people undergoing GAS is the last 'destination' for patients. The inaccessibility of GAS has created a false narrative that suggest that people who have been 'fortunate' enough to undergo the surgery should be thankful and not complain about things that they may experience after the surgery. In South Africa, there is a long waiting list that stretches as long as 15 years of people who want to undergo the surgery. It is easy to imagine how one would be seen as problematic for voicing out challenges that they may experience after receiving the surgery because it is seen to be a 'privilege' and quite frankly, cosmetic. Another misconception is that people living with disabilities are asexual, have no interest in sex or are not capable of having sex. This is largely assigned to people according to how they may present physically, genitals are not the only site one can experience sex nor are they a locus of sexuality. As expressed by Siebers (2012), normative views on sexuality enforce restrictions or "distinctive mapping of the body into limited erogenous zones" (47) of people living with disabilities - many other parts of the

human body can be receptive to sexual touch. The human body is sexually adaptable, as Siebers (2012) suggests that "while certain aspects of the body are not open to transformation, sexual desire and erotic sensation are remarkably flexible" (47). I have established that there is a prevalent association of sex with spontaneity or timing. People are more open to sex "just happening" without planning or thought and that planned sex is unauthentic. While this may be the case in a situation where two people are in a sexual relationship or arrangement, such ideas do not always accommodate people who (i) may have little privacy because of disabilities, (ii) whose sexual opportunities are largely dependent on making arrangement or (iii), like people who may have undergone GAS and may need assistance adjusting to their new bodies, particularly in the domains of sex and sexuality. These GSM often require either planning their sexual or multidisciplinary post-operative care.

2.4.2 Sex Normativity : The Public and Private Debate

Another way in which sexual exclusion is perpetuated is through the debate in and between the public and private dichotomy of sex and views that suggest that sex and its goods should be private. For example, in South Africa, sex is largely understood as largely a private issue however, there are resources and services like sexual and reproductive healthcare and sex education that are publicly available. However, an individual's access to sex and the quality of one's sex life becomes a private matter which while many may appreciate this, such can be problematic to those that need assistance to access sexual opportunities. On that note, Siebers (2012) criticises the concept of "sex life" and maintains that it is ableist and assumes ones inherent control and power over their sexual life and opportunities. He notes, "the concept of *sex life* encapsulates many of the ways in which the ideology of ability distorts current attitudes about sexuality. Hence the imperative in today's culture is to "work on" ones sex life, to "improve" or "better" it, to "spice it up" – all for the purpose of discovering the "ultimate pleasure" (Siebers 2012: 42). By the same token, when sex is associated with these GSM, it becomes a medical matter, particularly for people living with disabilities. While this may be the case for people who have undergone GAS, there just is not enough literature that gives solutions for non-medical problems that commonly occur post-operation. Research has suggested that while some transgender bodies experience significant post-surgery changes in their sensations during sexual intercourse, which include pleasant arousal and orgasms, others struggle and never fully adjust to their new bodies (De Cuypere et al., 2005; Lawrence, 2005; Wierckx et al., 2011). It is important to understand the implications that come with assuming a new role during sexual intercourse particularly for one's first sexual encounter post-surgery, which may present discomfort that may

subsequently lead to sexual avoidance and/or isolation. Two studies conducted in the United States separately reported that twenty-two percent of Female-to-Male transgender individuals had not engaged in sexual activities until after an average of eight years post-surgery (Wierckx et al., 2011) and a previous study reported that forty-six percent of Male-to-Female individuals had not engaged in sexual activities after an average of six years (Kirk, 1997). These understood to be private matters and addressing them is left to the discretion of the people who have undergone the GAS. On that note, Siebers (2012) extents that long-term care facilities for people living with disabilities, "purposefully destroy opportunities for disabled people to find sexual partners or to express their sexuality" (45) as there is limited privacy and some degree of control of their sexuality. While I agree with Siebers, I maintain the medicalisation of GSM sex life is not all bad and for the purpose of the bigger argument of this paper, it may be necessary for the institutionalisation and the normalisation of sex work, particularly, SST, in healthcare systems hence, in this context, I partly disagree with this statement "personal choice and autonomy are constructive features of the private sphere but once subjected to medicalisation, individual preference and self-determination evaporates" (Siebers, 2012: 46). In many ways, social institutions support certain choices one makes such as marriage or advancing ones education. For example, in choosing to advance my education, I was offered financial support by a fellowship and I am also frequently given discounts for simply being a student. By contract, social institutions may not support, promote or extent sexual opportunities for people who may face obstacle or need their support.

2.5 Intimacy

Intimacy means different things for different people but it has widely been accepted according to cultural and historical frames of reference and is generally defined as the quality of closeness in interpersonal relations between people from a physical and cognitive position. However, there is no universal definition of intimacy or what constitutes an intimate relationship as it is subjectively experienced. It is worth noting that the focus of this chapter is on SST as a therapy that combines both sexual intercourse and the practices of intimacy and care that, much like the work of sexologists, include a study of sexual behaviour, feelings and interactions, assists patients reconcile concerns associated with their sexual experiences, with the aim of improving it. SST offers a new concept of intimacy beyond the idea of intimacy as an emotional connection that is at times associated with love or love-making. While the difference between having sex and love-making is subjective, I believe that the difference is the intention behind each act. This is important to note since the two may look, feel and be similarly experienced. Sexual intercourse is physical and in the

case of SST, involves addressing mental wellness, while love-making is described as the act of using sex to express feelings of emotions such as love. Mary Evans (1993) gives a simple distinction between love and intimacy by suggesting the former involves emotion and is an attribute of a person rather than a connection. Evans (1993) defends this by arguing that feelings of love can occur despite the lack of reciprocity or acknowledgment between people while the latter is the quality of an interpersonal connection which is coupled with interactions and an acknowledgement of a relationship and intentions from parties involved. Intimacy can be a difficult notion to understand and while it is often reduced to sexual relationships, the grey area exist because some sexual relationships involve *practices of intimacy* (Jamieson, 2011) However, while expressing feelings of love is a practice of intimacy, in most cases, people in romantic relationships needs to merge the declaration of their love for each other, which can be understood as a practice of intimacy, with other practices of intimacy to ensure the success of their relationship. Hence it is common to hear people use the phrase "love is not enough" insinuating that more 'work' has to be done for a relationship to be a success. The significance of love to intimacy is illustrated by instances of their separation - this is important for a discussion on relationships between patients and service providers such as sex surrogate therapists, who render and include practices of intimacy outside the parameters of emotional connections such as love.

Intimacy can be grouped in four categories: emotional, physical, intellectual and experimental intimacy (Muniruzzaman, 2017). Emotional intimacy goes hand in hand with trust. The idea of people falling in love is closely associated with emotional intimacy. Emotional intimacy, particularly in sexual relationships, manifest itself through a sexual attraction and regular conversations (Lowndes, 1996). Physical intimacy simply involves touch, be it sexual or non-sexual touch (Lowndes, 1996). Intellectual intimacy occurs when people exchange ideas, opinions and enjoy exploring each other's intellectual capacity and capability. Experimental intimacy involves people involving themselves with each other. Unlike emotional or intellectual intimacy, experimental intimacy involves little to no conversations, sharing of thoughts, emotions or feelings but a mutual activity with each other (Muniruzzaman, 2017). These distinctions of intimacy or intimate relationships can change from relationship to relationship and over time. Lynn Jamieson (2011) refers to practices of intimacy as "practices which cumulatively and in combination enable, create and sustain a sense of a close and special quality of a relationship between people" which is gradual and is fostered through a process which is put to work - essentially, arguing that intimacy should be 'operationalised' for an intention. Unfortunately, previous research conducted on the operationalisation of intimacy have done so by measuring relationships that are interdependence or have mutual influence

(Bercheid et al, 2008), particularly by documenting how people conduct themselves within families, parent(s) -child relationships, romantic relationships, friendships or any other relationship that are socially recognised as having a special quality of close connection (Jamieson, 2011) and not in patients-professional relationships, when intentions are to give patients practical care, particularly in industries of healthcare.

In a book titled '*The Transformation of Intimacy: Sexuality, Love, and Eroticism in Modern Societies'*, Anthony Giddens (1992) explains the concept of the transformation of intimacy and how the culture of intimate relationships has gradually evolved from the modern to the post-modern society. He argues that transformation varies for every country, society, era and is multi-dimensional. Jamieson (2011) reiterated Giddens (1992) sentiments stating that "the cultural celebration of 'intimacy' is not universal, but practices of intimacy are present in all cultures." Giving or receiving practical acts of care as a practice of intimacy is often overlooked and one way this exclusion is perpetuated is through narrow views of sex, sex work and human sexuality. SST is one such practice which has maintained a sense of cultural fascination and controversy since the late twentieth century. While it has recently found a reputation of being a unconventional it has been regarded to as a ground-breaking method of therapy and a commendable act of care. There has been extensive research and projects that introduce the possibility of aiding the sexual needs of people living with disabilities and most recently, those who have undergone GAS, which have had significant impact in planting a seed of interest in various societies and institutions to bring about change and the sexual inclusion of GSM. (Owens, 2002; Earle, 2001; The Sexual Freedom Coalition, 2004). For instance, one way of advancing sexual inclusion in societies and institutions could be through the use of civil society advocates who are prepared to champion issues of sex for GSM. This may include educating the public and providing them with information and resources, facilitating workshops and discussions between stakeholders and GSM. Furthermore, as I will elaborate in the upcoming chapter, professional associations can serve as an initial platform for undertaking this endeavour. The concept of public advocacy is important for social change and could influence others to understanding and supporting causes, be it governments, organisations, associations, individuals and/or communities.

I have discussed and explained that sex is a fundamental social and human good that is necessary for a flourishing life and for social institutions to recognise this fact, it is important that there is a change in our attitude and thinking around sex and sex work, particularly for the consideration of SST, and, as I discuss in the next section, towards sexual justice.

Section Two

2.5 Introduction

Discourse around matters of justice and human rights for minority groups, particularly the disability community, are generally centred around issues of access to housing, education, employment, social grants, healthcare and other related matters and hardly address their sexual citizenship, as highlighted by these authors: "The drive for the inclusion of people with physical disabilities in contemporary efforts to improve sexual and reproductive health access is underlain by the prevailing wisdom in disability scholarship that the sexuality of people with physical disabilities has hitherto been nullified, with people with physical disabilities systematically excluded from conceptions of sexuality, from sexual health services, and generally considered to be – and treated as – lacking sexuality" (Hunt et al. 2017: 66). This makes their sexuality seem unimportant and trivial. While I may argue that this needs to be addressed as it is a legitimate and urgent issue of justice (sexual justice), others may argue that "ending poverty and social exclusion comes higher up on the list of needs, than campaigning for a good fuck" (Shakespeare, 2000, 160). However, I maintain that, a good fuck, as suggested by Shakespeare, is an important part of the human good and its denial is an injustice. Unfortunately, we all hold different believes regarding justice, what it entails and its role in society hence why some people may not see the sexual inclusion of GSM worth addressing as a matter of justice. While there has been significant growth in research published on GSM as well as ground-breaking legal and policy changes, there is a need for the unique services SST provides in South Africa. Longstanding, important topics have evolved, and scholars have expanded into new areas of relevance for therapists and healthcare professionals working with GSM. In this section, I discuss Martha Nussbaum and Amartya Sen's capabilities approach to justice and Rawls theory of justice. I maintain that given the right theory, we may be able to conceptualise and understand the sexual exclusion of GSM and its implications on their lives. Where legalised, the use of SST by GSM illustrates broader issues on the sexual exclusion and the need for sexual inclusivity.

2.5.1 Theories of Justice

I begin this section by discussing Rawls theory of justice because it is mostly used and highly regarded when addressing issues of justice. Rawls view of justice as fairness provides us with a comprehensive argument of liberal egalitarian views as a tool to understand justice in society. He writes, *"Laws and institutions, no matter how efficient and well-arrange, must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on justice that even the welfare of a society as a whole cannot override.*

For this reason, justice denies that the loss of freedom for some is made right by a greater good shared by others. It does not allow the sacrifices imposed on a few or outweighed by the larger sum of advantages enjoyed by many" (Rawls, 1999: 3). While I agree with Rawls theory, it becomes unsuitable for addressing issues of sexual exclusion. The CA proves to be more appropriate to adequately address and frame these issues.

2.5.1 *(a)* Rawls Theory of Justice.

As a theory of justice, utilitarianism aims to distribute opportunities, resources and information in a way that maximises the wellbeing of a society. Therefore, the interest of the population in its entirety supersedes that of individuals. Rawls theory of justice is an alternative to utilitarianism. This theory aims to provide answers to the question of how social institutions are meant to be structures so that there is fair terms of cooperation in a society (Rawls, 1999:10). He uses the idea of a hypothetical contract where parties agree to some terms of what would constitute a just society. Rawls employs an idea he calls the Original Position (OP). In the OP, parties are in a hypothetical veil of total ignorance and have no knowledge of any of their physical abilities or disabilities, talents, socio-economic status or any social goods. Essentially, this is to suggest a level playing field where parties are expected to be influenced by fairness so as to determine what the principles of justice ought to be, without prioritising themselves or their needs. It is at this point that parties will develop and exercise their moral powers, that is, (i) their rational ability to form, revise and pursue a conception of goods, be reason and (ii) their capability to be sensible and to have a reason of justice. **-** these are the 'higher-order interests' that people in the OP aim to promote. Essentially, individuals in this OP are anticipated to agree on primary goods that will accommodate everyone. Rawls lists these primary goods as, (i) basic rights and liberties such as freedom of thought and liberty of conscience, (ii) the freedom of movement and free choice of occupation, (iii) powers and prerogative of offices and position of authority, (iv) income and wealth and (v) the social bases of self-respect (70-80).

Rawls makes no mention of sex as a primary good, that is, my first limitation with his theory. While I believe that his argument would be that people need to use the primary goods as tools to decide what kind of sexual lives to pursue, I realise that that would assume some level of autonomy or control over ones sexuality or sexual opportunities that some people may not have. While the intention is to promote these primary goods, I maintain that there is a reality 'behind the veil of ignorance' of society but at a more individual/personal level, that continue to marginalise certain individuals as sexual partners. For example, parties might agree that all people, regardless of their physical limitations, should have equal opportunities to experience their

sexuality and enjoy sex, however, this may not be that simple. Rawls makes the assumption that people with equal opportunity and fair share of primary goods would be able to pursue their personal lives and conceptions of the good. While this is plausible for some people, there are others who do not have independence or control over certain aspects of their lives as noted in the section above.

One is still able to pursue individual interests regardless of "the veil of ignorance". Rawls illustrates this with an example of Smith who is in the OP yet motivated by personal interests (Rawls, 1999: 11). While Smith may agree on the primary goods, regardless of his status or position outside the OP (i.e. A wealthy and famous Christian queer writer), the social primary goods are things he would be forced to value regardless of sexual orientation, net worth or religion. However, the primary goods used as a means of accessing and pursuing individual conceptions of the goods are not accommodative to requirements of people who may find themselves in different situations.

Economist Amartya Sen articulates this by stating that, "The primary goods approach seems to take little note of the diversity of human beings. If people were basically very similar, then an index of primary goods might be quite a good way of judging advantage. However, people to have very different needs for example, with health, longevity, climatic conditions, location, work conditions, temperamental and even body size. So what is being involved is not merely ignoring a few hard cases, but overlooking very widespread and real differences (Sen, 1980: 215-216). Essentially, we all are different, have different needs and capabilities and capacities to convert means- primary goods, into valuable ends – a flourishing life. To illustrate this, a person living with a physical disability and a person living without a physical disability may earn the same income. Rawls theory would consider this an equal access of primary goods. However, this view overlooks the limitations and challenges one would encounter, for example, accessing certain public spaces or being able to drive around in any car. Nussbaum (2006) maintains that, "No matter how much money we give the person in the wheelchair, he will still not have adequate access to public spaces unless public space itself is redesigned. Maybe a very rich person could afford a full-time chauffeur and a set of bearers who could carry him up the stairs of rampless buildings. However, this is not a sensible goal/solution- we would still have not gotten to the root of the matter, which is that this person should not have to rely on a chauffeur or a bearer. The redesign of public space is essential to the dignity and self-respect of people with impairments" (167). While a similar argument can be applied to other GSM, my concern with Rawls theory is not solely due to the aspect of distribution and its limitations but the ability of the primary goods approach to incorporate sex and sexuality and capture sexual exclusion as a problem.

2.5.1 *(b)* The Capabilities Approach

As a theoretical framework of justice, equality and wellbeing, the CA is influenced by the work of scholars such as Aristotle. The CA is a multidisciplinary and multipurpose framework that maintains that one's freedom to achieve wellbeing and a purposeful life, is a matter of what one is able to do and what they are able to be (Robeyns, 2006). In this section, I will employ a general elements of Sen and Nussbaum's views and applications of the capabilities approach. As a proponent of the approach, Ingrid Robeyns (2006) work will be referenced throughout. I have mentioned that the CA is a better theory to address issues of disabilities and sexual exclusion as a matter of justice. Before I unpack how that is the case, it is important to give an overview of the CA. Robeyns (2006) provides that, " The core claim of the capability approach is that assessments of the well-being or quality of life of a person, and judgements about equality or justice, should not primarily focus on resources, or on peoples mental states, but on the effective opportunities that people have to lead the lives they have reason to value" (351). The CA suggest things/indicators we should pay attention to or look for when assessing how well one is doing in their life. These indicators are,- human capabilities. The theory provides that human capabilities, are the metric in which capabilities are to be interpreted, understood and measured as opportunities to achieve or pursue human functionings. Functionings can be understood as ones reality (*actuality*) and doings. For example, one can be well mannered, kind and educated *(actuality)* and a self-employed, active member of society *(doings)*. However, it is important to note that some functioning can be, " univocally good (e.g., being in good health) or univocally bad (e.g. rape), the goodness or badness of various other functionings may not be so straightforward, but rather depend on the context and/or the normative theory which we endorse" (Robeyns, 2006).

The CA provides that decisions about justice ought to be reached after considering ones opportunity to achieve functionings/ having the capability. Essentially, capabilities are inherently valuable *(talent)* and not instrumentally valuable *(money)*. One of the main reasons the CA makes distinctions between functionings and capabilities, is that we do not end up with a kind of hierarchy that would privilege an account of good lives but to establish a scope of ways of life one that one can choose (Robeyns, 2006). Sen (1980) provides the important idea that there may be, what she defines as "refined functionings" (Fleurbaey, 2006). These would designate a functioning that makes provision for the possibility of the range of functionings mentioned above. Sen (1980) gives this examples, "'fasting', as a function is not just starving, it so choosing to starve when one does not have other options" (52) – one may have the capability to keep nourished, but

may choose to fast as a part of their way of life. This is why it is important to focus on capabilities and not functioning when making judgements about justice. The CA also highlight functionings as constitutive of one's life. Nussbaum (2006) supports this with the emphasis that a life worthy of human dignity, "has available in it, "truly human functioning" (2006: 74). This is to say that "one cannot be a human being without at least a range of functionings, they make the lives of human beings both lives and human" (Robeyns, 2006)

Nussbaum (2011) outlines ten capabilities and provides that they are necessary for a flourishing life. The list is a as follows:

(1) Life: Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be worth living.

(2) Bodily Health: Being able to have good health, including reproductive health…

(3) Bodily Integrity: Being able to move freely from places to places; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.

(4) Senses, Imagination and Thought: Being able to use the senses, to imagine, think, and reason – and to do these things in a "truly human" way. Being able to use one mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religion exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain.

(5) Emotions: Being able to have attachments to things and people outside ourselves; to love those who love and care for us; to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety.

(6) Practical Reason: Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance)

(7) Affiliation: (A) Being able to live with and towards others, to recognise and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (B) Having the social base of self-respect and nonhumiliation; being able to be treated as dignified beings whose worth is equal to that of others

(8) Other Species: Being able to live with concern for and in relation to animals, plants, and the world of nature.

(9) Play: Being able to laugh, play, to enjoy recreational activities

(10) *Control over one's environment: (A)* Political. Being able to participate effectively in political choices that govern one's life. *(B)* Material. Being able to hold property and having property rights on an equal basis with others; having the right to seek employment. (Nussbaum 2011:33-34)

It is worth noting that in the third capability listed, Nussbaum (2011) mentions sex and sexuality. The flourishing 'plant-like' view of sex that I have discussed in the previous chapter, could be extended to other capabilities that are listed above. For example, the Procreation view of sex could be related to *Bodily Health* and *Bodily Integrity.* The Pleasure view of sex can be related to *Senses, Imagination and Thought* and to some extent, *Play.* The social aspect of sex can be related to *Emotions* and *Affiliation*; and the political, to *Practical Reason* and *Control over ones environment.* One thing that makes the CA stand out, is its ability to recognise ference in people's abilities to convert means into *functionings*. For example, there may be a group of people with the same access to resources, however what they are able to achieve with these resources is what would be in question. Essentially, it is not enough to ask if people have the means of converting a resource into opportunities or outcomes, there is a need for us to focus on the ends when thinking about ones wellbeing and quality of life. As explained by Robeyns (2006), "means can only work as reliable proxies of peoples opportunities to achieve those ends if they all have the same capacities or power to convert those means into equal capability sets". However, I have mentioned that people will differ in their ability to convert means into valuable ends, while ideal, it is almost impossible for everyone to achieve equal outcomes. This is relevant for the discussion on sex and GSM, because they differ in their opportunities for sexual experiences.

2.6 Conclusion

It is worth noting the problem with using the CA to address issues of GSM and sexual exclusion as a matter of justice is that the CA is not necessarily a theory of justice but a theoretical framework that can be used to measure a standard of justice, almost like a metric of justice. Robeyns (2006) suggests that for the CA to be a full theory of justice, it should be able to "explain on what basis it justifies its principles or claims of justice." For instance, Rawls, justifies this with the use of the OP theory. While Nussbaum speaks to human dignity and a life that has some capacity of human functioning, this idea can be misleading as human dignity, thus human functionings, cannot be the determinant for the basis of our claims of justice because we do not use functionings as the measurement of justice, but rather, opportunities to realise human functionings. Considering sexual activity, this is an appropriate approach as I maintain that the capability to access such opportunity is what is valuable.

In this chapter, I have described ways in which I believe sex has social, political and physical goods and emphasised the importance of sexual responsibility to a more adequate view of sex and sexuality. I maintain that the flourishing view is most appropriate to capture the value of sex and makes it easier for a comprehensive argument for the consideration of SST in South Africa. This would allow society to interrogate narrow views on sex and to see sex as an important human good, particularly for GSM, who have been systematically denied opportunities for sexual experiences in South Africa.

CHAPTER 3

3.1 Introduction

In the previous chapter, I provided a discussion and overview of the problems of sexual exclusions. In this chapter, I introduce the concept of sexual citizenship as a matter of addressing sexual access, and uphold Tobin Siebers' (2012) sentiments that sexual citizenship should include "access to information about sexuality; freedom of association in institutions and care facilities; the demedicalisation of sexuality; addressing sexual needs and desires as part of healthcare; and the "re-professionalisation of caregivers to recognise, not deny, sexuality and privacy on demand" (47). The chapter further discuss reasons and possible ways SST should be considered and legalised in South Africa. I contend that we have good reason to consider alternative ways to promote sexual opportunities within the South African healthcare system and make legal provisions as such. For those reasons, this chapter provides a human rights perspective on how the integration of a human rights approach could offer opportunities to address existing challenges, particularly around rethinking the sexual citizenship of GSM. SST is in no way a comprehensive solution to sexual exclusion, however, it is a credible solution that can address some aspects of the injustice of sexual exclusion. While sexual inclusion and/or justice requires that we address all issues of access to sex, this chapter further addresses one central issue: access to sexual partner(s) (sex surrogate). In South Africa, no law provides an answer to the question *"is the act of sexual intercourse a human right?"* but grants the rights to sexual orientation, gender identity and expression to citizens (Bill of Rights, 1996) which I believe is, to an extent, problematic. This chapter addresses the challenges resulting from the inability to answer this question. This is important because while I argue for the inclusion of SST in healthcare, I believe that sexual inclusion and sexual justice involves and requires the transformation of social attitudes and certain laws. Societies and social institutions play a fundamental role in the governing of peoples sexualities and other intimate parts of their lives, therefore, this chapter will begin with a brief overview of intimacy.

3.2 Issues of Access

In the previous chapter, I discussed issues and obstacle that contribute and perpetuate the sexual exclusion of GSM, with a focus on people living with disabilities and those who have undergone GAS, through narrow views of sex and the public and private debate. The following section will discuss sexual exclusion as an issue of access. While this may be understood in different ways, I will refer to access, or the lack of access, as the ability to access opportunities of sex and abilities or capabilities of experiencing sex. This is necessary for the purpose of the following section to aid conversations about narrow views of sex. I have listed three

things that are necessary for sexual opportunities to occur:

***Autonomy/Choice**:* One needs to be able to have the autonomy over their bodies and have the ability to make choices regarding their sexuality.

Privacy: There is a level of privacy that needs to be granted when sex occurs. This shows respect and extends some degree of dignity to those involved and others.

Resources: One should have access to resources, be it information or services such as sexual and reproductive healthcare.

While this is not always necessary, for the broader purpose of this paper, there is an additional element that is necessary for sex to occur, being a sexual partner, in this case, a sex surrogate. I will illustrate that the GSM identified, often lack access to some or all of these, thus becoming an issue of access.

3.2.1 Autonomy and Choice

GSM often experience a lack of autonomy regarding their sexual matters, particularly people living with disabilities. In a book titled *Physical Disabilities and Sexuality: Stories from South Africa* (2021), people living with disabilities narrated their personal experience with their sexuality and difficulties. For instance, the story of Tas shows his experience living with a disability. He spoke of the importance of being well-groomed and well-dressed for him to feel good about himself and to feel attractive to women. However, because of his disability, there are obstacles that occur that make his opportunities to sex challenging. When we talk of autonomy and choice, most time, we think of one's ability to exercise their personal power over things that they have control of, essentially, the right or condition of self-governance the ability to make a choice.

Many people that live in care homes/facilities may require permission from their relatives to receive visitors, engage in a romantic relationship or engage in sex. For example, one study illustrated a case of a man who met someone in a care facility and decided to form a romantic relationship and live together. Because they had the power to do so, one of the mans relative decided against this living arrangement, which led to a separation (Frankowski & Clark, 2009:31) .In another case, a couple that met at a living in a care facility were separated when one of their children decided to move their father to a different facility and managed to cut contact between him and his partner (Frankowski & Clark, 2009:31).

Tas story gives a different perspective. The story is not one of abuse or a lack of choice, but he speaks about his dependence on others for intimate care. Tas comments: *"It's mostly male nurses who work with us and it feels uncomfortable to actually ask a male nurse to shave your public hair or whatever. Its sometimes a tight situation because you don't know what position you put that male nurse in and what mindset he has or whatever….Sometimes it is very difficult because you're letting people into a very personal space of yourself also. You know, sometimes what makes it really difficulties that you don't have any control over your body parts anymore. So, at times you will get an erection, which is quite unpleasant. I don't know why, but sometimes we still get an involuntary erection. That is also one of the things that we need to… you always need to have an open relationship with that person so you need to talk about a lot of things that put you in tricky situations"* (Hunt et al., 2017). The two cases mentioned illustrate how decisions of relatives override the sexual autonomy of their loved ones and the potential emotional harm that this may cause. Moreover, while there may be a need for full time care and attention for some people living with disabilities and others such as elderly people, there is a need for some level of autonomy that needs to be granted for them to make choices and have a say in the ways they wish to conduct their lives.

Sex can be challenging for individuals who have undergone GAS. While one may argue GAS provides some sense of autonomy and exercise of their right to choice, there is an issue of access that comes into play once one experiences physical challenges and changes after the surgery and/or when one simply needs information regarding their sex change. This may create a barriers and limitations to ones sexuality. Generally speaking, some aspects of the law make it difficult for people to have autonomy and make certain choices regarding their sexual lives. This is related to the next issue of access.

3.2.2 Resources

In the point above, I mentioned that important of accessing information and support as resources for some GSM to gain sexual opportunities. This section expands that idea as I argue that the way in which spaces are operated and designed have significant impact on sexual opportunities for GSM. In terms of operations,- in healthcare facilities, it is the way in which patients are treated, the lack or limited information or services and their attitudes towards a GSM that will affect whether or not a patient will return for treatment. In one instance, Vic, a disabled man noted, "as far as sexual health and reproductive clinics are concerned, I usually go once a year for bladder check-ups. But I don't really attend such clinics. There aren't really sex clinics to look at stuff. It's almost like sex is non-existent for people with disabilities" (Hunt et al., 2017). Additionally, the way in which an area or space is organised and designed give an impression of its

principles. Anderson and Kitchin (2000) argue that *"the ways in which a space is organised, reproduces dominant cultural ideologies and excludes certain social grouping"* (1166). This speaks to inaccessible spaces, in this instance, sexual health clinics. For example, if a healthcare clinic is not wheelchair friendly, the message this sends out is that it does not prioritise the sexual health of people living with disabilities thus discouraging patients. It is difficult to discuss issues of access to resources for people who have undergone GAS, particularly in a South African context because there is simply not enough information, particularly post-operative information. I argue that this is largely due to the limited surgeries that can be performed in the country. The inability to perform a sufficient number of surgeries, is in itself, another issue of access.

3.2.3 Privacy

I believe privacy is one of the most important element of sex. While this is not necessarily the case for everyone or every sexual act, I argue that privacy during sex is a universal rule which is largely influenced by principles of morals, dignity and respect. Essentially, In choosing to have sex, one is exercising their fundamental right to privacy. As an issue of access, I will make reference to barriers to sexual opportunities to GSM, again, with a focus on people living with disabilities in care facilities. However, it is important to note that people living in care facilities/homes are not only people who live with disabilities as many other people need palliative care, however, I choose to focus on this group because of the direction of this paper, which is the inclusion of SST within South Africa's healthcare system. For people living in such spaces, barriers include the lack of privacy in multiple ways. For example, as a result of sharing rooms and in some cases, their dependence on a fulltime caregiver, patients have limited sexual freedoms. This is a reality in such facilities, particularly in South Africa where such facilities are inundated. With this in mind, one may argue that a patients wellbeing and health should be prioritised and take precedence over matters of privacy or sex, however, as I have highlighted in the previous section, sexuality is a very important aspect of a holistic approach to healthcare.

3.2.4 Sexual Partner(s)

For people who may need SST for medical purposes , in this case, people living with disabilities and those who have undergone GAS, we need to be cognisant of the power dynamics at play which is in fact, a huge area of criticism regarding SST. For people living with disabilities in particular, there may be an imbalance of power that could create conditions for or result in both emotional and physical abuse. The lack of a sexual

partner or the lack of the opportunity to access a sexual partner is one of the fundamental problems in regards to the inaccessibility to sex. Again, this does not mean that sex is not possible in other ways, however, for these GSM, the help or involvement of a second person is necessary. One could have access to resources, information about sex and privacy to engage in sex, but for some, without a sexual partner, sex may still prove to remain a difficult activity. In section one, I indicated other ways in which sexual exclusion is perpetuated, one being, narrow views of sex. As Siebers (2012) indicated, in terms of sexual relationships, "disability signifies sexual limitation, regardless of whether the physical and mental features of a given impairment affects the ability to have sex" (42). It is important to challenge stereotypes and negative attitudes in society about sexuality, not because GSM need the validation of the public but to bring about change with matters that affect their lives

3.3 Sexual Citizenship

Citizenship and the Right to Citizenship as described by the South African constitution, refers to "ones' membership of a political geographical community- the State. As a status, "citizenship is associated with rights of one's physical presence within a particular state which then extend to the rights of political association, participation and the freedom of movement and residence" (Fraser, 1997:69). Sexual citizenship, also known as, intimate citizenship refers to the extent to which territorial presence, public participation and citizen's exercise of rights and freedom as sexual creatures, are animated by sexual desires and activities (Pieterse, 2015: 2). Essentially, sexual citizenship is implicated in how citizenship is conceived in particular forms of the governance of citizens and intimacy (Johnson, 2017).

Diane Richardson (2000), a celebrated scholar who has contributed extensively on literature on sexual citizenship, has observed that there is no one definition of sexual citizenship and holds that sexual citizenship can (i) be used to denote a collection of legal and political rights, (ii) to emphasise the consumption or goods and services to sexual practices and identities or to (iii) stress cultural and societal aspects of sexuality and citizenship. Other scholars have emphasised that sexuality has played an important role in how citizenship right are constructed (Bell and Binnie, 2001: 10). While I agree with these, there is a fundamental problem identified with the development of citizenship rights which makes it difficult to conceptualise sexual rights. In an article titled *Reason and Feeling in Thinking about justice*, feminist scholar, Susan Okin (1989) argues that the development of citizenship rights, particularly in the western world, were developed around the conception of the citizen as a male and a head of the household where women were subordinate. What this means is that citizen rights are inherently heterosexual and can therefore be considered as *heteronormative*

sexual citizenships (Johnson, 2002: 316–336; Richardson, 2000). The concept of sexual citizenship is useful to draw attention to the heteronormative nature of ways in which various citizenship rights were initially constructed. Richardson (2000) argues that as a result, the LGBTQ+ community has limited abilities to exercise their sexual citizenship. When considering the concept of *heteronormative sexual citizenship*, one can argue that minorities, for example, people who want to undergo GAS, can be disadvantaged or have their constitutional rights violated. Richardson (2000: 83–100) identified three major aspects of sexual rights which are implicated in sexual citizenship. These three aspects include sexual practice; the rights of self-definition and identification; and rights gained through political institutions and legal systems. It is important to note that matters relating to sexual citizenship are not just political but are also economic and social; as such, it becomes crucial that the rights of minority sexual groups be recognized and represented (Bell and Binnie, 2000: 20).

In South Africa, contemporary discussions on commercial sex work are becoming more of a human rights and decriminalisation debate however, the importance of the act or practice of sex is often disregarded. For example, the right to touch, sexual satisfaction and pleasure and more especially to protect the rights to equality and non-discrimination, autonomy and bodily integrity, and the freedom of expression as enshrined in South Africa's Constitution. As mentioned above, the South African Constitution guarantees the right to sexual orientation, gender identity and the freedom of expression, however, a question that is important for the implementation of SST remains - is the act of sex a human right? The inability to answer this question highlights a grey area in South Africa's legal system that is arguably used to infringe on the sexual rights of citizens, particularly GSM. One can argue some of the limitations that make it difficult to make sex or sexual pleasure a human right is the moral issues around the responsibilities that come with such a right, the lack of resources and institutions that deal with sexual health, lack of sexual awareness and adequate education, that is seen through the discrimination that minorities face at when they try to achieve their sexual rights. The closest attempt towards addressing this question was through the development of South Africa's sexual rights charter which stipulates the right to enjoy sex. The charter further maintains that in sexual relationships, one has the right to enjoy sex just for the pleasure of it, be treated as an equal sexual partner, be treated with dignity and respect, express your desires, needs and concerns - and be listened to, be the one to initiate sex and choose your sexual partner, whether they are the same or the opposite sex. Unfortunately, the charter is a non-legal document developed by various stakeholders to hold its signatories morally accountable to conduct their everyday business to reflect the principles contained in the charter. As it stands, one can argue that sex can be recognised as a basic need but not a human right in South Africa.

South Africa is has a long and ugly history of sexual violence which gained a reputation of being one of the most violent countries in the world and in recent years, has been dubbed as the rape capital of the world (Bonthuys & Monteiro, 2004). Some have argued that making 'the act of sex' a human right would contribute to more problem and the justification of abuse such as rape (Rosewarne, 2011). For example, if such was a human right, it could be contended that an abuser (rapist) was simply trying to satisfy their victim through sexual activity which would made rape more difficult to prove. Such raises concerns and consent may become an even more blurred issue in such cases. Additionally, it could be argued that granting such a right could mean that a person can demand to be provided with sexual acts as it would be understood as their right. Furthermore, this notion could be dangerous and exclude people who are asexual. While these are valid concerns, they are concerns that are to be mitigated by the dictum of choice. As much as sex might be a right, just as other rights, it cannot be exercised at the expense of other rights or without responsibilities.

For the realisation of sexual justice, which I believe translates into sexual empowerment, it is required that there is a level of a reformulation and rethinking of discourses around sex- a multidimensional and process-orientated approach. Beyond the recognition of the sexual rights of GSM, there is a need to recognise sexual activity as an essential aspect of the human good for all sexual being. One of the ways in which this can be done, is by addressing social attitudes about the concept of sex and existing views of sex. The sex industry, particularly the commercial sex industry, is part of the South African social landscape and regardless of its current legal status, it can and has the potential to have a significant positive contribution to many lives. The criminalisation of the commercial sex work industry is commonly justified through associated harms that exist in the sex and sex work industry. While it is fair to pay attention to such, particularly for the purposes of making the sex industry safer, we need not buy into the argument that this industry is the reason these harms continue to exist. Rape, human trafficking and other abuses are not exclusive to the wider sex or commercial sex industry, but do exist in non-commercial sex industries and other socially acceptable sexual relations. In regards to SST, the cooperative use of SST and traditional sex therapy is a controversial and an unpopular form of therapy. While it may raise moral and ethical issues in society, it reveals an element of sex work and/or the sex industry that is worth exploring in South Africa.

3.4 Sexual Surrogacy Therapy in South Africa

In South Africa, sex therapy is generally understood as a type of psychotherapy that aims to address emotional, physical, mental or any other problems that might be affecting ones sexual function, desire or drive for intimacy (https://avrispilka.co.za) . These are typically explored with the help of a therapist or

counselling psychologist. While there is no formal studies in South Africa for one to become a sex therapist or sexologist, sex therapists in South Africa, they typically have a background in sexual and reproductive healthcare, psychology, social work or are physician who offer counselling services for people experiencing sexual problems. These professionals are typically registered with the Health Professions Council of South Africa (HPCSA) and should have undertaken sexual attitude reassessment seminars (SARs) as a fundamental part of their training. However, the services that these therapists offer is exclusively through talk and does not include experiences of physical touch or sexual intercourse as opposed to the therapy that involves sex surrogates which include experiences of physical touch or if necessary, sexual intercourse.

Between 2015 and 2017, The Disability and Sexuality Project- a programme that explore the prevailing myths and attitudes towards the sexuality of people with physical disabilities in South Africa, conducted a study on the sexual and reproductive health of people with disabilities in South Africa (*Disability and Sexuality: Stories From South Africa*, n.d.) This study showed that the rights to sexual and reproductive health for people with disabilities are regularly impinged upon and provided that this exclusion stems from assumptions about the sexuality of people living with disabilities. To date, this minority group is still fighting for their rights to express their sexuality and be prioritised in South Africa's healthcare system. By the same token, commercial sex workers have been fighting for their right to be seen as legitimate workers and SST offers them the opportunity to do so. Sex workers could potentially be trained to be professional sex surrogates. It would make sense for the South African government to legalise sexual surrogacy for such reasons that would be to the benefit a government that seems to be struggling with tackling commercial sex work and catering to the sexual needs of people living with disabilities. Generally, therapeutic, counselling and rehabilitation efforts for GSM are very limited and inefficient in public healthcare. For example, during the first wave of the Covid-19 pandemic minorities, particularly people living with disabilities, were unable to access healthcare facilities, receive therapy, rehabilitation or medication (McKinney et al., 2021). This was a shared experience for people living with disabilities however, there is a double burden that takes place when in such spaces for people living with disabilities who fall under the category of GSM. There exists more complexities and experiences of exclusion when people living with disabilities are gender non-conforming or transgender.

"....there's already stigma attached to disability and then if someone identifies as gay too, it's an added stigma and people also ignore that you have sexual needs.." – Dr. Victor de Andrade

("SA Will Not Escape This Revolution, 2001)

SST is a form of therapy that aims to increase patients confidence and comfort in sexual activity through support that can involve sexual intimacy with a trained sex surrogate. It is important to note that this might not always involve sexual intercourse but other therapeutic tools. The therapy can be used for various treatments including the treatment of sexual dysfunctions and sexual anxieties. Most commonly, SST used for people living with physical disabilities (Shapiro, 2017) and most recently for people with specific/mild cognitive impairments and I propose, for patients who have undergone GAS. Many scholars and organisations have presented the South African governments with various reasons for the decriminalisation of all aspects of sex work however, this paper presents a possibility for the legalisation of one specific aspect of sex work – the legalisation of SST for GSM in South Africa.

It is important to note that there is a difference between decriminalising and legalising sex work. The decriminalisation of sex work entails that there would remove all laws that criminalise sex work. This would potentially render the work that commercial sex workers do as legitimate work and they would be given the same rights and protection of labour laws. Legalisation on the other hand, means that sex workers would have to work under specific and controlled conditions. For example, If SST is legalised, sex surrogates may have to belong to an association, be registered as a sex surrogate to authorities or a governing body, expected to carry and producing an identification card to identify themselves as commercial sex worker, they may be allocated specific areas such as specialty hospitals where sex surrogate would be required to work and or be forced to go for regular health check-ups. While this may be invasive or bureaucratic, it may be a step in the right direction as legalisation would not only result in the regulation of the sex work and acknowledgement as any other respected profession in South Africa but it would possibly force the government to consider establishing better working conditions for those who work in the sex industry or any person who may choose to train and become a sex surrogate. Due to the actions that are associated with and understood to constitute commercial sex work in South Africa, it is easy to interpret SST as an extension to commercial sex work. However, in a country where there is a clear need for the services SST offers, the government has the opportunity to make provisions and legalise this aspect of sex work, regulate and finance it as an extension of sexual care through a healthcare approach. The legalisation of SST requires one to undergo training. I believe this would reduce the stereotype, discrimination and abuse experienced in the sex work industry. Additionally, legalisation would initiate the use of sexual surrogacy therapy as a part of healthcare, particularly as a core professional rehabilitation and therapeutic service provided for GSM. As most people

seeking medical or wellness services, individuals that seek this therapy would then be regarded to as patients and not 'clients' as commercial sex workers typically regard to those seeking their services. Not only is this important for the public to make sense of and understand the difference between commercial sex work and SST, it would further give legitimacy and integrity to the therapy and those who seek it as part of their healthcare.

3.4.1 Sexual Surrogacy as a Therapeutic Modality

An important thing to consider is the limited interventions available to people needing sexual and/or reproductive healthcare in South Africa. One could question whether the available interventions are appropriate. For example, if a patient suffers from vaginismus or erectile dysfunction, there are numerous medical options available to them (Freckelton, 2013). If the difficulties are as a result of psychological reasons such as Post-traumatic stress disorder, lack of confidence, depression or anxiety caused by sexual traumas such as rape or other sexual abuses, having a therapist who would talk and listen rather than a physically 'hands on' therapist, I believe, would adequately help a patient. However, what happens when such interventions are not adequate? Giving a patient tools to work on their sexual needs would work assuming they have a sexual partner but what if this is not the case? While it is likely that therapist cannot help every one of their patients sexual problems or limitation regardless of offering some kind of intervention, there will be cases that they simply are not able to assist. SST offers the opportunity to broaden the scope of treatments available. In his autobiography, Mark O'Brian reflected on his time with his sex surrogate partner and shared : *"After a year passed, I felt depressed. I realised that seeing the surrogate hadn't changed my life, that no-one was attracted to me. For years afterward, I felt angry at myself for wasting my time and money on the surrogate. But seeing the surrogate had changed me in ways that I couldn't see then. I found that I was more confident about my sexuality"* (221). From this, one could see the kinds of issues and concerns that SST can raise, particularly ethical and emotional concerns however, this also presents and highlights the importance of a professional therapist and trained sex surrogate. It is a therapists responsibility to not only refer patients to but monitor and evaluate the process and outcomes of the sessions between a patient and a sex surrogate.

3.4.2 Professional Association

There are numerous professional bodies in South Africa. These can either be voluntary or statutory bodies. Voluntary bodies are those that create an enabling environment for professional development in a discipline,

and growing the maturity of that discipline by contributing to its body of knowledge, its relevance, governing principles and accessibility to new and existing practitioners. Statutory bodies on the other hand, are bodies such as the Health Professions Council of South Africa (HPCSA) and the South Africa Nursing Counsel (SANC), which are established as a result of an Act of Parliament and govern the practice of specific occupations. These are societies and associations that are typically non-profit companies or Non-governmental Organisations (NGOs) that generally take to serve the purpose of their profession by upholding certain codes of ethics in their profession or field. There are associations such as the South African School Psychologists Association (SASPA), The South African Psychoanalytical Initiative (SAPI), the South African Association for Counselling Psychology (PsySSA), Counselling Psychology SA (CPSA), Occupational Therapy Association of South Africa, Association for Supportive Councillors and Holistic Practitioners (ASCHP) and the Physiotherapy Association of South Africa (PASA) that primarily promote practice that they believe best benefits their patients. These practices include codes of ethics when referring a patient to another professional who are able to assist with services that they are able to provide or that are outside their scope of work and other issues such as prescription/script-writers rights.

As it stands, there is no official sanction, discussion or support on the use of SST by any leading sex workers organisations or alliances such as the Wits Reproductive Health and HIV Institute (Rhi, n.d.), the Sex Workers Education and Taskforce (SWEAT), Sisonke or sexologist associations such as the Southern African Sexual Health Association (SASHA) and Sexology SA, which gives one an idea of the lack of information about SST in South Africa. The International Professional Surrogates Association (IPSA) supports a worldwide community of professions such as sex surrogates, therapists and individuals that are in need of surrogacy therapy, particularly in the healthcare system. Most of these organisations or professionals associated with them are invested in advocating for the decriminalisation of commercial sex work or addressing commercial sex workers healthcare rights and needs. While the decriminalisation of all aspects of sex work would be ideal, the South African government has not shown any interest or intention to decriminalise commercial sex work or any aspect of sex work. As much it is true that the problems associated with the legalisation and regulation vs the decriminalisation of commercial sex work has been extensively written about, with the former discouraged in South Africa, professional associations are one of the ways that can help accelerate the implementation of SST in healthcare. Professional Associations such as HPCSA, which holds twelve professional boards under its ambit, were established to provide control over the education, training and registration of health professionals registered under the Health Professions Act. Unlike organisations that solely advocate for the decriminalisation of sex work, like the IPSA, the HPSCSA

has the ability to make a strong case for the legalisation of SST. There are rules, ethical guidelines and standards that are established for the professional practice of sexual surrogacy therapy and for sexual therapists to follow. Like the Hippocratic Oath that most physicians take to promise to "*Do no Harm*", the IPSA works on such principles, particularly for patients who may be in distress and turn to SST for help. Such a patient would be referred to the other person in the three-persons model, being the phycologist. Considering the current status of sex work in South Africa and the lack of trained sex professionals such as sex surrogates. In the event that a person living with a disability opts to see a commercial sex worker for a sexual experience, they would not be able to receive the necessary phyco-social support before, during or after their experience because the commercial sex worker would not a have the right tools or training to recognise that the patient is distressed. South Africa has the opportunity to learn from the IPSA and establish an association as such to provide training to individuals who may wish to become sex surrogates and give professional support to patients in need of such services.

One of the leading associations for physiotherapist in The United States of America is the American Association of Sexuality Educators, Counsellors and Therapist (AASECT) published an article which addressed the stigma and controversy surrounding SST. AASECT maintained that the stigma is largely exacerbated by counselling professionals and their disregard for its use and most importantly, the lack of professional organisations that support the practice. One can argue that this is the case in South Africa. In an article published by News24, Elna Mcintosh (2018), a well know clinical sexologist in South Africa, maintains that it is important and necessary for couples to confront any sexual breakdowns without the presence of a third partner. For singles, she holds that the goal is "to put your energy into real, potential mates instead of a "surrogate"" (McIntosh, 2018. She further expressed that "There is also something to be said for spending time alone, getting to know your mind and body outside of sex with *another person"* (McIntosh, 2018). While professionals such as Macintosh might have their personal and professional reasons to hold such opinions, it can be argued that these opinions are based on assumptions rooted in heteronormativity and ableism. There needs to be a shift in the way healthcare professionals to address their personal beliefs and biases about sex work and the profession of sex work in general. If such professional therapists are not aware of the way sexual surrogacy therapy works or its potential, there needs to be research conducted to grant them the knowledge of the therapy. While this might not change personal beliefs, the clinical importance of having such services in South Africa should take precedence. Be it for religious or cultural reasons, South Africa has laws that conflict with numerous citizens beliefs. For example, abortion was legalized during the transition from apartheid to independence and democracy, under the Choice

on Termination of Pregnancy Act (CTOPA) in 1996 (Favier et al., 2018). The law was successful because it drew heavily from a public health and rights-based framework and not from individual beliefs. Additionally, for one to have an abortion, there is a process that needs to be followed: a request should be made at a healthcare clinic; the pregnancy is then confirmed; counselling is provided; an appointment for the termination is made and then a referral letter is given to a facility where the procedure will be performed (Favier et al., 2018). A similar framework could be applied to legally incorporating SST into the public healthcare system however, it is impossible to consider SST as therapy without the cooperation or consultation and referral from a sex therapist.

"If it doesn't involve a therapist, it is not surrogate therapy" - Vena Blanchard

An important element of SST is the three-way relationship between the patient, sex surrogate and professional. However, It important to acknowledge that in South Africa, for a professional that would be involved, be it a sex therapist, clinical psychologist, social worker or are physician in the three-persons therapeutic team, to refer their patients to a commercial sex worker, as there are currently no trained sex surrogates in South Africa, it would be deemed an illegal act and would be putting their license at risk. By the same token, one could argue that the concept of SST is in actual nebulous in South Africa as law does not explicitly prohibit it as a health and wellness therapy modality but prohibits some actions involved within the therapy when they function outside the parameters of the healthcare system. Essentially, there are some things that are not necessarily illegal but can be deemed illegal if the correct procedure of practicing or accessing them is not followed. For example, In South Africa, Ritalin and Concerta are schedule-six medication to treat attention deficit hyperactivity disorder (ADHD). Schedule-six are the highest legally scheduled drugs in South Africa therefore, their distribution is rigorously controlled because they are extremely effective and could be easily abused. One can only access such medication after a series of consultations with a psychiatrist. It would be illegal for a pharmacist to have or dispense such medication without a prescription and is punishable by law. The same logic could be applied to the legalisation of sexual surrogacy therapy, particularly a healthcare professionals referral to a sex surrogate. Just as a psychiatrist would prescribe medication they deem suitable for their patients, the patient needing to see a sex surrogate would need to have a referral from a healthcare professional such as a therapist. And just as a pharmacist has the right to advise patients on a generic alternatives for their prescribed medications, a sex surrogate can advise the healthcare professional and/or patient on ways they see fit to help the patient. It is not uncommon in the therapy and rehabilitation industry for an three-way multidisciplinary team of healthcare providers to

work together. For example, pelvic floor physiotherapists typically treat pelvic floor muscle pains, urinary or faecal incontinence and sexual dysfunctions. If the therapist observes that sexual difficulties may be as a result of a comorbidity, they may seek the assistance of someone with an educational and professional background to work with the patient or any other appropriate specialist. It is typically advised that a therapist refer their patient to someone who they have a working relationship with and whose expertise are well documented. As a team, they are able to provide patients with the best treatment plan to get the best results. However, consistent with any discussion and treatment of people who work in the sex industry in South Africa, particularly commercial sex work, the stigmatisation tends to fall on those providing sex services making those that need their services invisible group, irrespective of them being a significant part in the sex trade, as they- the clients, create a demand for such services. One can argue that while the two examples provided highlight the realities of the South African healthcare system as inherently sex-phobic that could be aggravated by the institutionalisation of SST, they also provide the opportunity to look deeper into all aspects of the sex work industry as it exists in contemporary South Africa.

Most associations and organisations promote sex-positive and affirmative approaches to sexuality and yet, without education there will be a lack of willingness to support sex work as something they could support or consider the possibility of SST and its effectiveness in their profession. This could attribute to the current legal status of sex work and ethical concerns which makes it hard for associations to even consider SST as gender and sexualities affirmative therapy. It is easy to argue that existing understandings or conceptions in South Africa about commercial sex work and the stigma associated with it would lend itself to increase assumptions that sex work is to be associated with 'normal' professions. Australia is one such country where commercial sex work is legalised and regulated, however, one study in highlighted that sex workers in the province of Queensland, ninety percent of sex workers operate illegally due to impossible regulatory measures. By the same token, there is no governing or educational criteria for sex surrogates or SST for individuals who would like to train to become sex surrogates nor has it been a therapy that is considered in Australia's healthcare system. However, the legalisation of commercial sex work probed national discourse on the possibilities of SST which lead to submissions made by civil society, academics, advocacy groups, healthcare professionals and professional associations to the parliamentary inquiry into draft legislation for the National Disability Insurance Scheme (NDIS) to include a sexual assistance to their services offered to Australians living with disabilities (Yau, 2013). This highlights the impact the dissemination of information and knowledge of SST can have in a society.

There have been some level of curiosity about in SST in South Africa as therapist have reported that clients have brought it up in their sessions. On the Weekends Breakfast Radio Show on Cape Town FM a UK based sex surrogate, Bea Meadow explained what SST is and what it entails to South African listers (King, 2021). This conversation sparked a public conversation about the possibility of the therapy in South Africa. This was met with varying opinions however, majority of listeners believed that the therapy would be a good addition to existing treatments. This conversation highlighted that many people do not know about SST and while some South African professionals have some knowledge about it, they mostly dismiss it as unethical and illegal without any interest of exploring its potential. This stops any possibility of introducing it to patients or the general society that would probe some level of advocacy or conversations around this therapy. As a result, GSM are continuously denied sexual activity because of antiquated laws that are evidently based on dated conceptions and limited information. Because most research focuses on the legal and ethical concerns of SST, there is little information on the long-term effectiveness of SST however, South Africa can evaluate the efficacy of the therapy in countries where it is legal. Countries such as Israel, the Netherlands, Germany, France, New Zealand and in countries where it is considered exclusively for medical reasons such as the United Kingdom. Handisex is an international organisation run by sexologist and massage therapist Asgerbo Persson and sexuality advisor Kim Steimle in Denmark and like the IPSA, they provide sexual services which include sexual education; sensual massages; sexual guidance; assisted masturbation and SST for people living with disabilities (*Handisex*, n.d.). For elderly and victims of diseases or illnesses, the organisation offers other customised sexual services. The Danish government provides an eighteen months course for their social workers, or similar professions such as psychologist, in the field of sexuality and disability for those who want to achieve a special certificate as a sexual advisor. Interestingly, as a sex adviser, one is able to bridge the traditional sexual surrogacy therapy three-persons model and can provide both theoretical (therapist) and practice (sex surrogate) services in group homes or other living institutions for people living with disabilities. While this is another example of a model SST can be institutionalised and regulated in South Africa, it important to note that there is a fundamental difference between the countries mentioned above and South Africa.

3.5 Legalisation of Sexual Surrogacy Therapy

I now turn to a discussion on the legalisation of sexual surrogacy therapy (SST) in South Africa and contemporary debates considering the lack of evidence supporting treatment efficacy and substantive ethical legal principles were respect for persons choices, privacy and confidentiality, integrity and matters of justice

are considered (Varkey, 2020). Interestingly, these are same legal principles that are used in the debate on the decriminalisation of sex work in South Africa. SST can be an effective intervention that may enhance sexual medical treatment. However, SST must be offered according to legal, professional and ethical standards which will be discussed and consolidated in the following section.

In South Africa, the work of sex surrogates has long been conducted by commercial sex workers, particularly for people living with disabilities. However, as one could imagine, SST is bound to be met with some controversy regardless of its purpose and/or intended use. Commercial sex workers and activists believe that sex work is a valuable and necessary form of work that should be decriminalised as it has great potential to provide services to a greater number of people (Ley, 2022). These commercial sex workers regard themselves as assistants, therapists and educators and not just as people who merely provide sexual relief to strangers or clients (Ley, 2022). This has recently sparked discussions focused on legal and human rights issues and the role of commercial sex workers for GSM and the therapeutic service they could potentially have in the sexual and reproductive health services (Exilarchic-key & Stickney, 2019). One of the legal criticism of SST is the payment sex surrogates receive for their service. In South Africa, this would be equated to the 'rewards' commercial sex workers get as compensation of their services which is prohibited by law (Sexual Offences and Related Matters: Act No. 32 of 2007). This could present a challenge for the institutionalisation of sexual surrogacy therapy and for sex surrogates as they will have to constantly have to prove their work and services as *other than* or *more than* merely for financial benefit. While it is easy to argue that only in the most technical sense is the argument for a consideration of SST about who may have sexual intercourse with whom, when and why. At a practical and symbolic level, it is about a sense of integration and self-determination and at a general and conceptual level, it concerns the nature of the open, democratic and pluralistic society that is envisaged by the constitution of South Africa. However, the fact remains that SST involves a tactile element with the possibility and/or the possibility of sexual intercourse that results in the provider being paid for their work. This leave little to no legal grounds for denying SST as a sexual service such as commercial sex work. As much as commercial sex workers provide the service sex surrogates provide, if such services are provided in spaces and establishments where commercial sex services are provided such as brothels, it becomes hard to legally render SST beyond the concept of prostitution.

The involvement of a healthcare professional might complicate the matter further as they might be seen as someone encouraging a patient to commit a crime or accused of running a kind of escort agency that provides

or prescribes the use of sex surrogates to their patients. These potential violations highlight the problems that present themself in relation SST in South Africa. Essentially, sex surrogates will not be exempted from the existing laws on commercial sex work thus, making this therapy legally complex. While the decriminalisation of commercial sex work would present an opportunity for the possibility of commercial sex workers to offer their services to more people, it will not necessarily induce a change or the recognising of SST in healthcare system or legal discourse. This highlights the difference between commercial sex work and the work of sex surrogates and SST provides. As much as SST would initially be regarded to as sex work in South Africa, the legalisation of the therapy would prevent the legal status of commercial sex work, be it criminalised or decriminalised, to have any implications on sex surrogates and SST. For example, simply decriminalisation of all aspects of commercial sex work may result in brothels and escorts being regulated. This might make the role of sex surrogates obscure and may result in therapists being reluctant to make referrals to them.

'We are a dying breed. I think some of that has to do with the fear of liability that psychotherapists have; there are people who think this work is excellent, but fewer therapists want to risk their licenses' –

Linda Poelzl. (Freckelton, 2013)

The legalisation of sexual surrogacy therapy should be for the sole purpose of serving the medical needs of GSM as part of the South Africa's healthcare mandate to protecting and advancing their sexual rights and respecting their sexual citizenship, principles of freedom and equality through proper monitoring and evaluation. This could grant healthcare professionals the confidence to refer patients to a sex surrogate without risking their profession or being accused of solicitation. It is worth noting that the ethics of such referrals have been written about with a focus on people living with disabilities however, there has been a growing interest for the possibility of sexual surrogacy for patients who have undergone GAS.

The following sections will take into consideration these GSM issues to demonstrate the potential of SST as well as illustrate ethical concerns

3.5.1 Transgender/Gender Affirming Surgery and Sexual Surrogacy Therapy

Laws that affect areas of sexual and reproductive health and rights; the lack of adequate training of healthcare professionals and resources, not only creates barriers to access and quality of care, but reinforces notions of the South African public healthcare's institutional stigma. It further allows for conditions and the

continuity of environments that are conducive to homophobia and discrimination in the healthcare system. To date, there are only six public clinic that provide gender affirming care namely, the Chris Hani Baragwaneth Hospital, Helen Joseph Hospital, Greys Hospital, Red Cross War Memorial Children's Hospital and most noteworthy, Steve Biko Academic hospital and Groote Schuur Hospital which offers comprehensive services which include GAS for transgender individuals (Wilson et al., 2014). The Transgender Unit at the Groote Schuur Hospital is particularly interesting because it is a multidisciplinary unit that provide care through teams of various healthcare specialists such as psychologists, psychiatrists, social workers, endocrinologists, gynaecologist and surgeons. The unit has a strong relationship with the local transgender community and organisations which help inform the provision of services and patients access to the Unit. The healthcare professionals associated with the Unit pride themselves for this grass roots and community based model. However, there have been a few institutional challenges that hinder its provision of services. The Unit has limited theatre time which means the provision of GAS is rarely conducted and as a result only two or three operations can be done annually and a surgical waiting list of up to fifteen to twenty years (Wilson et al., 2014).

Other medical procedures are prioritised in hospitals because GAS is considered to as cosmetic and not a medical necessity. For those who are fortunate to receive the surgery, the care that is provided after the surgery is limited and it is safe to say that as much as there may be physical therapy available after GAS, there is simply limited information or education provides on the genital changes to expect in relation to one's sexual intimacy or training and intervention that is provided to assist transgender individuals get acquainted to their new bodies. It is assumed that these individuals will simply health, recover and adjust to sexual activity after the surgery. However, people have reported to experience physical and emotional difficulties after undergoing GAS (Cuperee et al, 2005) which are then left to patients distressed with little to no assistance. SST is able to offer such patients the opportunity to address physical and emotional distress or dysfunctions and/or limitation after GAS. While the use of SST for this patient population has not been sufficiently researched just as much as for people living with disabilities, it can be encouraged as a treatment modality for the transgender community. Dr Sonjia Kenya, a U.S. based medical professor, sexologist and sex education at the University of Miami has written about the potential of SST for transgender individuals and holds that "People who have transitioned from one sex to another, they've undergone a new gender assignment, they may use a surrogate to be comfortable now having sex in their new body" (Tarsha et al., 2016). These are my sentiments and I believe that such this therapy should strongly be considered in South Africa.

In 2018, The Wits Reproductive Health Institute (Wits RHI) received a five year USAID Award for advancing the South African sexual and reproductive health response for marginalised groups. The RHI sought to open four clinics around South Africa that would serve minorities, particularly the transgender community in the Eastern Cape, the Western Cape, and Gauteng. This was widely celebrated as there was no identified network providing healthcare or other services to marginalised groups in most of these areas. These are one of many efforts by civil society or professionals to address the lack of resources or adequate treatments in South Africa's healthcare system. However, the clinics simply provides services that public hospitals and clinics fail to adequately provide such as family planning, screening for tuberculosis, HIV testing and counselling, the distribution of male and female condoms, the provision of antiretroviral (ART) treatments, oral pre-exposure prophylaxis treatment (PrEP) and hormone treatment, which begs the question of the possibility of SST as a post-surgical care. While studies in other countries have shown that psychological care and physiotherapy is insufficient for some patients and that post-operative sexual distresses may be successfully treated using SST, one cannot make this argument for South Africa as it does not exist in South Africa and therefore no evaluations can be made for patience struggling to accustom to their new bodies and reclaim their sexuality without proper research or clinic studies.

3.5.2 Physical Disabilities and Sexual Surrogacy Therapy

People living with disabilities are citizens who are entitled to rights like any other person in South Africa however, they are continuously disregarded and arguably treated like second class or subordinate citizens, particularly those who solely subsist on public resources. The lives of people living with disabilities can be challenging. Some physical disabilities hamper mobility, the ability to generate income or any other financial prospects and relevant to this study, sexual intimacy and the ability to sexually express oneself. I would argue that sex, sexuality and disability is to date, a taboo topic in South Africa and provokes some sense of moral panic that delegitimises and stigmatises the sexual agency of people living with disabilities. There is a need for a nationwide conversation about their sexual citizenship and their human rights in South Africa and more policies that are inclusive. To this end, we find that in South Africa, the law and government has done very little to increase the likelihood of people living with disabilities to being afforded the same opportunities to access the sexual expression and relationships that citizens have. This is not to say that people who are not living with disabilities are being assisted in realizing their sexuality, however, those living with disabilities should be accorded help as they are a minority group that is faced with prejudice and asexual assumptions regarding their sexuality. According to The Disability and Sexuality Project, prevailing

myths and attitudes towards the sexuality of people with physical disabilities in South Africa is substantive (*Disability and Sexuality: Stories From South Africa*, n.d.). Most research conducted on disability and sexuality speaks primarily to issues and themes which include debunking myths about sexuality and disability, discrimination, child bearing, marriage and sexual education (Potgieter & Khan, 2005:28). Such findings are important to encourage discourses that hinder social and structural barriers on matters relating to disability and sexuality, however, more needs to be done to address the limited sexual interventions available for them.

3.6 Healthcare and Sexual Surrogacy Therapy

I will now employ a human rights approach for a health and human rights framework to highlights debates and difficulties that arise when GSM seek healthcare in the South African health system. The section provides an overview and examine the legal framework in connection to gender identity, sexual orientation, and healthcare on an international and domestic level. This draws attention to the discrimination and marginalization that GSM suffer in health care in South Africa and the possibility of change through a collaboration of sex work (SST) and health care.

The use of a health and human rights framework provide analytical tools for "comprehensive theoretical and practical application of general human rights principles in a healthcare context" (Müller, 2017). This is instrumental in helping understand, define and identify violations, prejudice, discrimination, exclusion and abuse (Freedman, 1994). This interdisciplinary approach of health and human rights has the ability to amplifying healthcare inequalities for GSM who experience historical and contemporary marginalisation; and has great potential to influence change. History shows that frameworks of human rights has been used as a tool for maintaining and reinforcing power and discrimination based on race, class and gender, by systems, such as the apartheid system in South Africa, to justify exclusion and marginalisation. It therefore becomes important to understand what health as a human rights entails to ensure that such is not granted unqualified value in both healthcare and legal systems. The South African law can be used as a tool for social change and in this regard, to drive a sense of justice within the healthcare system towards advancing health equity. By the same token, the law can aid discrimination against the vulnerable by institutionalising inequality, imposing barriers to access and create obfuscation rather than render solutions and protection. We see this most often in the way commercial sex workers are treated. Criminal laws are commonly enacted to promote a moral norm rather than to punish a harmful act by so doing, commercial sex workers are often held accountable for their violations furthermore, the legal status of sex work in South Africa means

commercial sex workers do not have input in the formation of health policy decisions that affect them. (Chi Mgbako, 2013). Therefore, the health and human rights framework not only offers a new way of thinking about health practices but offer an opportunity to take into consideration the responsibility we have to repairing past and existing structural injustices in the healthcare system, particularly for the vulnerable and those whose health and human rights are compromised which in the context of this paper, are GSM.

In recent years, South African scholars have amplified the idea of sexuality, sexual citizenship and related matters within a health and human rights framework (Müller, 2017) however, there is limited analysis on the specific experience of GSM that seek sexual and reproductive health. There is however, bodies of literature that documents the abuse, denial to healthcare and bias GSM in healthcare (Müller, 2017) which has leads to their reluctancy and disinclination to seek sexual health services, which delays access to care. It is worth noting that in South Africa, the marginalisation, discrimination and abuses experienced by GSM are not only perpetuated by healthcare workers and professionals, but is deeply rooted in the healthcare system that can be traced back to apartheid in which the state was inherently discriminatory towards non-whites and GSM (Barker 2010: 79). For instance, medical research, particularly in the field of psychiatry have historically produced "scientific evidence" to support and justify discriminatory believes pertaining to sex, gender, sexuality and identity (Rosario et al., 2006). A common argument against homosexuality was that it was unnatural and morally wrong while science was natural and immutable. This argument was widely used by those in power to promote a certain group of peoples social and political goals and in healthcare with the justification that it is scientifically proven, and therefore justifiable. For Example, in the apartheid years, a high ranking general ordered that *"all possible steps had to be taken to combat the phenomenon of homosexuality or lesbianism in the army"* (Canaday, 2002) and it was reported that approximately 900 people were forced to undergo aversion therapy which involved shock and behavioural therapy, narcoanalysis, chemical castrations and medical torture (Canaday, 2002). Currently, South Africa's constitution includes one of the strongest provisions on the right to healthcare. Article 27(a) of the constitution provides that all citizens have the "right to access healthcare, including reproductive healthcare". Additionally, the South African Patient's Rights Charter and the Batho Pele Principles, are two documents that especially detail patient's rights which the former specific to healthcare and the latter being applicable for all services provided by the South African government in all sectors (Minister of Health and Others v Treatment Action Campaign and Others, 2002). While this is commendable, South Africa's public healthcare facilities have fallen into disrepute for years post-apartheid (Coovadia et al., 2009) and overwhelming evidence, particularly exposed by the recent Covid-19 pandemic, show that the quality of

healthcare has been compromised by carious challenges that have had a negative impact on the quality of healthcare. In an article titled *Health and Health Care in South Africa- 20 Years after Mandela*, academics Mayosi and Benatar (2014) argue that "a response to South African health care challenges would need to address the social determinants of health (which lie outside the health system) as a national priority, strengthen the health care system, and facilitate universal coverage for health care" (Mayosi & Benatar, 2014). Social determinants are "circumstances in which a person(s) is born, grows up in, live, work and age" and in regard to their health, "the systems put in place to deal with illness" (WHO, 2017) "income and poverty, knowledge and education, housing and infrastructure, race and relevant to this study, social protection and sexual and gender norms" (Ataguba et al., 2015). For GSM, sexual and reproductive health services have been little to non-existent and when a phenomenon like access to sexual health is determined by various social determinants, it can be challenging to propose solutions in a society where structural inequality remains a problem. Therefore, a health and human rights approach becomes crucial towards for the case for sexual rights as part of the larger discourse of availability, access and quality of healthcare for GSM in South Africa. Sexual rights are fundamentally about human beings and their ability to make choices about how they express their sexuality and conduct their sex lives (Ataguba et al., 2015). This looks different from person to person and the context within which they are realising their sexual rights. For example, In some countries, predominately in developed countries, discussions on sexual rights are mostly centred around self-determination, sexual expression and orientation while in others, like South Africa, conversations tend to focus on dynamics about consent and "how to say "no" to unwanted sexual advances or coercion" (Hlatshwayo & Klugman, 2011) and not much on the sexual expression.

3.6.1 International influence and Sexual Rights

Before 1993, sexuality and sexual rights did not exist in the international rights discourse (Parker, 1997). The 1993 World conference on Human Rights in Vienna was the preliminary conference where the Declaration and Programme of Action called for the eradication of sexual harassment and gender-based violence. This was a huge step forward for the transformation of the international community towards the protection of women and their rights. This was strongly lobbied by women's rights groups and activists and their concerns were later extended in the Declaration of the Elimination of violence Against Women and included detailed and precise condemnation against the abuse of women. These advances were important because they created the opportunity and influence for the 1994 International Conference on Population and Development (ICPD) in Cairo, where sexual rights, sex, sexuality, and sexual health became part of the

Human Rights discourse and declared as a right that should be promoted and protected (Parker, 1997). These sexual rights were founded on principles of bodily integrity, personhood, equality and diversity (Corrêa, 1997) and defined sexual health as a reference to "a satisfying and safe sex life" (United Nations, 1994:43). This sparked international debates as the principles were argued to be based on heteronormativity. This was due to the fact that the Cairo document did not include the emancipatory notion of sexual rights such as the freedom of sexual expression, orientation or pleasure. This was the case for many years that followed and was heavily criticised for its failure to construct what many rights activists and groups that understood as affirmative and emancipatory notions of sexual rights, particularly in relation to sexual healthcare and general health that went beyond medical definitions but also a social factors towards promoting wellbeing, dignity and human health for all. However the ICPD was a step in the right direction and is credited for having forged the link between sexuality and health as a human right and a year later, the "first declaration to embody the concept pf sexual rights, and expanded the ICPD definition to cover both sexual and reproduction by upholding the right to exercise control and make decisions concerning ones sexuality" (Pizzarossa, 2018). Interestingly, the year 1994 also marked the end of legislated apartheid but not the end of entrenched structural inequalities, including the health and wellbeing of most South Africans. (Mayosi et al., 2012; Whiteside, 2014).

For transgender people who want to undergo GAS, the Alternation of Sex Description and Sex Status Act 49 of 2003 is a fundamental legislation which allows and defines the parameters of sex reassignment. Section 2(1) of Act 49 states that *"*Any person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment, or any person who is intersexed may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register." While it is possible to access hormone treatment in, the State is yet to institutionalise systems to do so in a public healthcare setting. As abovementioned, the surgery is current performed two hospitals in South Africa, The Steve Biko Academic Hospital in Pretoria and Groote Schuur Hospital in Cape Town. Perhaps the most disappointing fact is that these two hospitals not only have a long waiting list for the surgery, but that both hospitals are able to perform a total of four operations year. Patients who are able to afford private healthcare will get the surgery done overseas as there are limited, they are commonly excluded from sexual and reproductive health care (Hunt et al., 2017) and are also faced with challenges and stereotypical assumptions that they are less sexual beings which at times hinder their self-esteem and sexual development. Recent studies have shown that sexual health problems and practice difficulties in sexual activities are more prevalent with people living

with disabilities (Hunt et al., 2021). However, there is evidence that show that *"when optimally supported by medical interventions, rehabilitation professionals, intimate partners, and others—people with physical disabilities can engage in meaningful and satisfying sexual lives"* (Hunt et al., 2017) and this suggests that South Africa needs to strongly consider advancing their medical interventions for GSM.

3.7 Specialty Healthcare Facilities

One possibility for the legal recognition of SST therapy is through the implementation of speciality facilities that will offer healthcare services such as sexual surrogacy therapy for GSM. Speciality healthcare facilities are not a new phenomenon in South Africa and have exist in many healthcare practices as children's hospitals such as the Nelson Mandela children's hospital (NMCH), eye hospitals such as St. John's hospital, psychiatric hospitals such as Weskoppies psychiatric hospital and others. Marie Stopes is an example of a community based clinics that specialises in providing sexual and reproductive healthcare services. Such facilities have the important role of treating patients who need specific care while complementing other sites of patient care which include academic medical centres and caters for patients who require the services of rehabilitation personnel with specialist skills. South Africa can adopt and follow the ethical guidelines provided by the IPSA and establish similar facilities to offer SST as an extension of therapeutic service for people living with disabilities and those who have undergone GAS in specialty facilities. A speciality hospitals for the transgender community that offers SST could ensure that patients receive the appropriate care to regain as many functional abilities and skills as possible to potentially integrate back into the community or that they equipped with the necessary skills that will afford them the ability to be independent of care. Additionally, such facilities would legitimise sexual surrogacy as a healthcare service and help address other issues such as accelerating the number of GAS that can be performed annually; extend the scope of post-operation care and therapeutic options and possibly bridging the inequality gap that exists in the healthcare system as intended with the implementation of the National Health Insurance (NHI) Scheme. In 2019, The South Africa's government released the National Health Insurance (NHI) Bill whose aim is to extend universal healthcare to all citizens irrespective of their socio-economic status and redress the inequalities of public healthcare and implementing transformational policies for an inclusive healthcare coverage. The Bill highlights the prioritisation of addressing the health needs of people living with disabilities however, there have been concerns that may not improve the quality of healthcare for the LGBTQI+ community, particularly the transgender community. As it stands, the NHI fails to acknowledge the specific needs of the community.

The Centre for Intimacy, Consciousness and Self-Awareness (ICASA) was established in the United Kingdom in 1994 as a treatment facility for psychogenic sexual concerns. The centre offered services that clinical psychologists offer today. The founder of ICASA, Dr Brown, has created an archive of work that speak to sexual and reproductive health and SST. He is famously known for his creation of a ten-step technique and training programme that include: (1) building safety; (2) touch; (3) nudity; (4) desire; (5) healing the genitals; (6) the kiss; (7) sexual energy and the orgasm; (8) mutuality (9) sexual intercourse, lovemaking, and, (10) taking action. The clinic offered a study program, mentorship and treatment with the use of sex surrogates for their patients. More relevant, the Dr Ronit Aloni Clinic is the only facility in the Israel that offers sexual surrogacy therapy. The therapy was initially made available to soldiers who are in need sexual rehabilitation and funded by the Ministry of Defence for soldiers who have been badly wounded or disabled by as a result of their work. The Ministry believed that there would be soldiers that would not be able to afford the therapy and opted to set aside state funds to finance the therapy. Today, the clinic provides services to anyone who is referred to the clinic for treatment. The Dr Ronit Aloni Clinic has conducted a reasonable amount of research and published journals about the therapy in Israel. The research is one of the most relevant and easily available information on the development and support of SST alongside the IPSA and ICASA. Through the establishment of speciality facilities for GSM and the implementation of the NHI, South Africa could closely regulate and finance SST. The cost of SSTcan range between £200-£240 per hour which is approximately R4200-R5000 including the healthcare professionals fees. Not only would most South Africans be unable to afford these fees, 81.2% of South Africans cannot afford health care and as it stands. Depending on a what medial aid plan one is on, medical aids schemes either do not pay the full amount or may not pay at all for therapy with a psychologist or psychiatrist which typically range between R600-R4000. This gives one an idea of the socioeconomic implications should SST was offered privately and not in the public healthcare system. The South African government could undergo a process of insourcing the services of sex professionals and employ them so that they can offer this service at no cost to patients. I make this suggestion because unlike those in the nursing profession, surrogates are specifically trained to help facilitate fulfilling and healthy sex for patients. Therefore, funding SST as a medical necessity will legitimise it as any other medical intervention, break the stigma of it being seen as "glorified prostitution', or the idea of the illegal purchasing of intimacy (sex) and offer existing sex workers (and anyone else who would like to work as a sex surrogate) the opportunity to legalise their work.

3.8 Conclusion

Research on SST shows that it has significant value to addressing sexual issues for GSM especially were legalised. However, it is important to note that in a South African context, SST would be deemed illegal thus, this paper places special value on the legalisation of SST for people living with disabilities and those that have undergone GAS. The GSM discussed in this paper make up a small number in South Africa and while some may not agree with using tax funds to pay for SST, they too are entitled to adequate public healthcare and should not be at the mercy of the public to decide whether or not SST is acceptable but rather have professionals to consider its medical implications. Healthcare professionals have the ability to champion this conversation as they are not only qualified to do so but have existing structures such as professional associations to influence inclusive and transformative policies. Considering the legal status of the sex work and the condition of the healthcare system in South Africa, one is able to argue that the implementation of SST will not be without challenges however, there are a few examples that can be considered, compared and used as a template for its possibility in the South African healthcare system. The promotion of equality of people living with disabilities and those who need sexual assistance can help normalise the fact that every citizen in South Africa has the right and need for expressing their sexuality individually, with a partner or assistance which should not depend on public opinion or ones socioeconomic background. SST is a plausible option with respect to some issues around sexual exclusion, particularly because the role of the surrogate is essential to provide individuals with the appropriate skills, knowledge and confidence to ultimately pursue and maintain intimate relationships. Not only does the implementation of SST offer the opportunity to advance the sexual citizenship of minorities, it offers solutions that could help accelerate and uphold democratic and constitutional principles. South Africa would be the only country on the African continent to provide such services and have the opportunity to create a new archive of data on SST and test the effectiveness of such therapy. This would be ground breaking and could offer some level of regulatory measures to the commercial sex work industry. However, existing societal attitudes around sex and sex work should be challenged in order to realise the potential of the sex work industry.

CHAPTER 4

4.1 Introduction

In the introductory chapter, I explained that this paper would survey the literature on sex surrogacy within the context of legal debates around sex work in post-Apartheid South Africa. In this chapter, I turn to examine the ways in which the constitutional framework creates a context within which SST might be understood as a legal concept. I examine the subsidiary legislation that defines sex work more broadly, and discuss how surrogacy fits into these definitions. This chapter explores international human rights instruments that are relevant to the labour rights of commercial sex workers and international norms to which South Africa is party to. There are numerous international human rights instruments that can be considered however, the instruments that will be used in this paper will consist of UN Conventions. These are important tools as they are legally binding to States, such as South Africa, that are signatories. Furthermore, a constitutional test on commercial sex work as provided by the Sexual Offences and Related Matters Act 32 of 2007 and the Sexual Offences Act 23 of 1957 will follow a discussion of the right to freedom of trade, occupation and profession and the fair labour that is enshrined in the South African Constitution and the protection of human rights in accordance with the Bill of Rights. This will be done to determine the legal grounds for the argument of sexual surrogacy therapy and its feasibility in contemporary South Africa. This chapter will begin by contextualising sex work within a human rights framework by using the Universal Declaration of Human Rights to understand the legal status of sex work in South Africa and establish potential violations of the rights of commercial sex workers. These instruments include the International Covenant on Civil and Political Rights of 1966 (the ICCPR), the International Convention on Economic, Social and Cultural Rights of 1966 (ICRSCR), The Convention on the Elimination of All Forms of Discrimination Against Women of 1979 (CEDAW) and the Convention for the Suppression of Traffic in Persons and of the Exploitation of the Prostitution of Others of 1949.

4.2 Defining Human Rights

Human rights are essentially, a response to the atrocities that occurred throughout history. Human rights are granted to humans by virtue that they are human beings regardless of religion, sex, race or any difference that exist and differentiate them. This belief is held in the preamble of the Universal Declaration of Human Rights. The South African Constitution embrace such principles as it interprets human rights as rights that are afforded to one simply because they are human. Although not legally binding, the Universal Declaration of Human Rights (UDHR) sets out the essential rights and freedoms shared by all human beings. Human

Rights are enforced by human rights law as treaties (Whelan, 2011). Treaties are formal and legally binding agreements and bodies of principles that aim to maintain stability and diplomatic relations between States (Whelan, 2011). They are an important aspect to guaranteeing international cooperation, peace and security between and in different states. Human rights have a long history of being informed by moral debates and justifiable claims that hold the core value that all human being should be equal. Essentially, this makes human rights universal and inalienable, thus, making them applicable to all human beings without discrimination however, with some restriction in exceptional cases. For example, the right to exercise some individual rights may be restricted or criminalised should they infringe on the rights of others. Additionally, Human rights are *indivisible, interrelated, and interdependent* (Whelan, 2011). This means that one human right can affect another; that no one right can exist without another nor can they be treated in isolation or importance of one another (Whelan, 2011). It is important to note that for one to fully realise their human rights, certain obligations should be respected, for example, Section 16 (1) of South Africa's constitution states that "Everyone has the right to freedom of expression, which includes freedom of the press and other media; freedom to receive or impart information or ideas; freedom of artistic creativity; and academic freedom and freedom of scientific research. However, such can be enjoyed if they do not violate the rights of others. Human rights are not only maintained and upheld through and by institutions, bodies and organisations who advocate for human rights but by the common understanding that human rights set the fundamental norms by which all persons ought to be treated. The United Nations maintains that human rights are important as they protect the ability of all human beings to develop intelligence, choice, satisfy their needs and other needs. By the same token, human rights are established to afford all human being dignity, liberty and the opportunity to determine their own path for their lives, which includes commercial sex workers who have historically been 'othered' and not afforded protection by States due to the work they do. Interestingly, trafficked and exploited sex workers seem to have access to protection from the state while voluntary and adult commercial sex work (consensual) is criminalised. For example, Article 6 of the CEDAW recommends that "States parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women."

Some argue that sex work can never be a trade of free choice -Pro-Nordic Feminism (Mathieson et al., 2016), particularly in South Africa where poverty and inequality is rife and maintain that commercial sex work is inherently sexual exploitation and should not be acknowledged as legitimate work. However, various studies have shown that in South Africa, commercial sex workers come from different social and cultural backgrounds and that not all commercial sex workers are coerced into doing such work and that

they choose to do the work for various reasons. Some have argue that they enjoy the flexibility the industry provides, some enjoy income that commercial sex work provides and others have been empowered by this work. The Beijing Declaration and Platform for Action of 1995 supports this view and holds the view that voluntary sex work not only a empowers sex workers but a legitimate way of making a living. While bad financial situations might explain why some people get into the sex industry, it does not constitute a sufficient reason for all commercial sex work. The distinction and discourse between voluntary and coerced sex work is important as it has not only replaced the argument that commercial sex work is inherently forced but it allows society the opportunity to think about sex work in a different perspective. The reality is, commercial sex work is inherently driven by profit but its legalisation will ensure that commercial sex workers make a decent living in safe and regulated environments. Some studies have shown that majority of commercial sex workers who choose to work in the sex work industry, do so simply to generate income (Manamela, 2018). One could argue that their objective is no different from that of street vendors, street sweepers, garbage collectors or people doing other jobs that others may find unpleasant.

4.3 International Human Rights Framework

The International Human rights framework is fundamental in determining what can be considered a right. As abovementioned, all humans, including commercial sex workers have rights, simply by virtue of being human. It is imperative that international legal frameworks be considered when establishing whether South Africa has an obligation to protect the rights of sex worker's human rights through the ratification or abrogation of the current laws. International law has direct and indirect impact on the policy making in South Africa (Slye, 2001). To understand this impact and determine the role of International law domestically, the South African Constitution is a good point of reference. Section 39 (1) of the Constitution states that "*When interpreting the Bill of Rights, a court, tribunal or forum must promote the values that underlie an open and democratic society based on human dignity, equality and freedom; must consider international law; and may consider foreign law."* What this means is that South Africa should consider international law when interpreting the Bill of Rights. This highlights the significance of International law and its effect on the way the law should be interpreted and the values it should uphold. South Africa is a signatory to numerous conventions that address commercial sex work and instruments that aim to protect human rights. These includes the Universal Declaration of Human Rights, which is a predecessor to the Bill of Rights.

4.3.1 Convention for the Suppression of the Traffic in Persons and of the Exploitation of

the Prostitution of Others of 1949

The Convention for the Suppression of Traffic in Persons and of the Exploitation of the Prostitution of Others is important particularly when speaking to the difference between voluntarily adult sex work and coerced or exploitative sex work. For decades, this convention was the only one that dealt with the trafficking of sex workers until the Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children was adopted by the General Assembly in 2000 and took effect in 2003. This Protocol supplemented the UN convention against Transnational Organized Crime of 2000 which was the general protocol on human trafficking (Doezema, 2002).

The preamble of the Convention states that an "individual, the family, and the community are of great importance, thus they should be protected." Therefore, those who are found guilty of exploitation of sex work, are as required by the Convention, to be punished. This includes a person(s) who is guilty of procuring or encouraging another into sex work. The management of brothel for sex work is prohibited by the Convention. Article 6 of the Convention states that, "Each Party to the present Convention agrees to take all the necessary measures to repeal or abolish any existing law, regulation or administrative provision by virtue of which persons who engage in or are suspected of engaging in prostitution are subject either to special registration or to the possession of a special document or any exceptional requirements for supervision or notification." This Convention is regarded as a ground breaking international instrument relating to sex work however, as suggested by Article 6, the Conventions position on sex work is for the non-regulation of sex work but holds strong views on sex work as a result of human trafficking or coercion. Therefore, those in the commercial sex work industry need protection or to be saved. The Convention holds a criminalisation view on commercial sex work as it has been criticised for violating the rights of sex workers. While the intention may be to protect sex workers from being trafficked, the Convention uses the repression of sex work against commercial sex workers themselves without the protection of their rights. The 2000 Protocol on the other hand, provides protection to sex workers. It defines trafficking as "recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion." This definition can be used for the advocacy and recognition of voluntary and adult sex work. States are therefore able to recognise sex work as labour and regulate it according to their labour standards and are prevented from criminalising sex work or denying their protection of the law disguised as a fight against human trafficking (Doezema, 2002). While the 1949 Convention has a criminalising approach on sex work, the 2000 Protocol offers an updated stance and offer recognition to sex

work and the need to protect sex workers.

4.3.2 International Covenant on Civil and Political Rights of 1966

The United Nations General Assembly adopted the International Convention on Civil and Political Rights in1996 (ICCPR) to give effect to the Universal Declaration of Human Rights (UDHR). The ICCPR emphasises that for a full realisation of the human rights as stipulated in the UDHR, it is crucial that conditions are established that make it possible for all human beings to enjoy their civil, political, economic and cultural rights. It is worth noting that like the ICCPR, the International Covenant on Economic, Social and Cultural Rights (ICESCR) is another treaty that gives effect to the UDHR. All States that have signed and ratified the ICCPR are expected to uphold, respect and promote the rights and freedoms stipulated in the convention. In 1998, South Africa ratified the ICCPR which then bound it to institutionalise certain measures that would give effect to the ICCPR. The Covenant states that all people, including commercial sex workers, have the right to enjoy all rights granted by the covenant. These values are upheld by the South African constitution.

The Constitution guarantees that all citizens of South Africa, sex workers included, the right to freedom and security. This includes the rights to be free from arbitrary arrest and detention, the right to be free from "violence from public or private sources; the right to be free from torture and other cruel, inhumane or degrading treatment and the right to bodily and psychological integrity" (Weatherall & Priestley, 2001). Violence in the general population is increasing annually however, commercial sex workers, particularly that are women are more exposed to extremely high levels of violence as murder rate among them has only but increased in the past decade. The government is obliged to uphold and defend sex workers rights to freedom and security however, there is a long documented history in research that show that these fundamental rights are constantly violated after being arrests with little to no consequences for those violations by police. Article 17 of the covenant, which South Africa is a signatory to, stipulates that everyone has the right to not be subjected to arbitrary or unlawful interference with their privacy, nor to unlawful attacks on their honour or reputation, as well as the right to be protected by law against such interference or attacks. The rights stipulated in the ICCPR are non-derogable rights. Non-derogable rights are rights that cannot, under no circumstances, be breached. Essentially, one cannot lose their right to these rights irrespective of them being a sex worker. The ICCPR protects the rights of sex workers and gives States the opportunity to ensure the realisation of their rights. The legal status of sex work in South Africa prevents

commercial sex workers from unionising, which means they cannot engage in processes with the government to improve their working conditions. This is a further violation on sex workers constitutional rights and a bridge by the governments of their international human rights obligations to protect and promote sex workers freedom of association and fair labour practices.

The Maputo Protocol

South Africa is bound by African regional human rights treaties that uphold these rights, such as the African Charter and the African Women's Protocol. The rights to security are enshrined in Articles 4 and 6 of the African Charter and Article 4 of the African Women's Protocol. The South African Constitution states that " everyone has inherent dignity and the right to have their dignity respected and protected." The right to dignity is a fundamental human right which is well documented in the ICCPR, the African Charter and the African Women's Protocol which obligates South Africa to protect all citizens, including sex workers who have historically endured the indignity of institutionalised discrimination and other violations by the State. The African women's protocol requires signatories to take "appropriate and effective measures to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public," and that perpetrators of violence be punished. It further highlights the relation between the criminalisation of sex work and violence against women, stating that "prostitutes are especially vulnerable to violence because their status, which may be unlawful, tends to marginalise them. They need the equal protection of laws against rape and other forms of violence."

The legalisation of sex work in South Africa has the potential to empower sex workers and fulfil South Africa's constitutional obligation. It further has the potential to allow commercial sex workers, the opportunity to form a professional organisation and associations that will afford them access and the protection by South Africa's employment laws and influence the government and policy on issues that enable the exploitative working conditions and unfair labour practices. Granting sex workers the ability to come together, organise and unionise will help address past violations and the discrimination have endured from their clients, police officers, healthcare workers and they will be able to report crimes and hold their attackers accountable. Furthermore, the criminalisation model causes arbitrary arrests, discrimination, loss of life and hindrance in accessing health care. Ultimately, the objective of the ICCPR supports a decriminalisation response to sex work.

The World Charter for Prostitutes' Rights, 1985

The World Charter for Prostitutes' Rights fundamentally calls for the decriminalisation of all aspects of 'adult' sex work, which it defines as voluntary. The charter holds that the decision to work in this industry should be respected at all times. This upholds and acknowledges individuals freedom of choice. The Charter further states that sex workers should be guaranteed : "all human rights and civil liberties," (Shibboleth Authentication request, n.d) which include the "freedom of speech, travel, immigration, work, marriage, motherhood, and the right to unemployment insurance, health insurance and housing" (Shibboleth Authentication request, n.d). The Charter calls for the protection of "work standards," which include the eradication of laws that continue to discriminate sex worker (s) and should insist that sex workers should have the freedom to choose their place of work, residence and "*provide their services under the conditions that are absolutely determined by themselves and no one else. Thus, a call for the eradication of all laws that can be interpreted to deny freedom of association or freedom to travel to prostitutes was made."* (Shibboleth Authentication request, n.d). By the same token, the South African government has a Constitutional obligation and international human rights commitments to fulfil and protect the rights of all citizens to adequate healthcare. The current legal status on sex work is a violation of the rights of sex workers to healthcare because not only does it not provide condition to adequate healthcare but exacerbates and institutionalises stigma and discrimination against sex workers in healthcare ("Sex Work Decriminalisation: Commission on Gender Equality, SWEAT, South African Law Reform Commission, Department of Justice, Parliamentary Legal Services | PMG," 2016). Should sex work be legalised, South Africa would not only fulfil its legal obligations, but help lower sex workers vulnerability to diseases and infections and reduce their risk of being victims of violence ("Sex Work Decriminalisation: Commission on Gender Equality, SWEAT, South African Law Reform Commission, Department of Justice, Parliamentary Legal Services | PMG," 2016). The South African Constitution guarantees that all citizens, sex workers included, the right to access healthcare services, which include sexual and reproductive healthcare services. South Africa is bound by international human rights treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and regional treaties which recognise the rights to health. The United Nations Special Rapporteur on the Right to Health, Dr Tlaleng Mofokeng, a South African medical doctor, holds that the criminalisation of sex work violates sex workers rights to health in numerous ways, she stated that the "decriminalisation would remove stigmas associated with sex work, including the stigmas faced by sex workers seeking healthcare" (Payne, 2018). If South Africa were to legalise sex work will be in a better position to insist on safer sex from their clients and report those that violate them in any way. Sex workers would be able to assist in the formulation of healthcare policies that concern them as well as

informing training of healthcare professions on the needs of sex workers as they are well placed to offer insight into healthcare strategies that concern them.

4.3.3 International Convention on Economic, Social and Cultural Rights of 1966

The United Nations General Assembly adopted the International Convention on Economic, Social and Cultural Rights (the ICESCR) in 1996 but only came into effect in 1976. As mentioned above, the IESCR is the second treaty that gives effect to the Universal Declaration of Human Rights (UDHR) along with the ICCPR. Together, the two Conventions and the Declaration make up the International Bill of Human Rights. The preamble of the ICESCR expresses the principle of the rights stipulated by the UDHR as a common standard of achievement for all peoples rights to enjoy their economic, social and cultural rights, and civil and political rights. The ICESCR provide that *'all peoples' must enjoy the economic, social and cultural rights contained in the covenant."* All member states that have ratified the Convention have an obligation to promote, uphold and create conditions for the realisation of these rights to and by their citizens. In 1994, South Africa became a signatory of the ICESCR and ratified in 2015. As a member state, South Africa is expected to allocate resources that will enable the realisation of these rights. As such, sex workers within the category of 'all peoples' by virtue of being human beings and should be granted all these rights. Article 6(1) of the ICESCR provides that *everyone* has the right to work, which includes the right to make a living by work which anyone freely chooses or accepts. Thus, member States are obliged to safeguard this right. Furthermore, Article 7 holds that everyone has the right to enjoy favourable working conditions, fair wages and remuneration, decent living and equal opportunities, safe and healthy working condition and other benefits. While the ICESCR does not explicitly mention sex workers rights, it does guarantee their rights by sex workers, it indicated that all people which includes sex workers, are meant to enjoy the rights stipulated. The ICESCR recognises and guarantees the right to work therefore conventional sex workers who freely choose' to enter the sex work industry should be viewed as exercising their right to work. The convention supports a framework that recognises sex work as work and grants sex workers the right to work in safe and regulated conditions. As a result, one can argue that the ICESCR supports the decriminalisation of sex work.

4.3.4 The Convention on the Elimination of All Forms of Discrimination Against Women

The United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979. The adaptation of the convention was largely based on a need for an instrument that would be effective in establishing and maintaining adequate protection of women against gender based violence. South Africa became a State party of the convention after signing

the Convention in January of the year 1993 and later rectifying the convention in December of the year 1995 without reservations. The Conventions main aim include ensuring that all forms of discrimination against women, including systematic discrimination is eliminated. The discrimination of women is described as "Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." Commercial sex work is not mentioned as a justification for non-discrimination and unfortunately, this can hinder commercial sex workers rights to profession. It is important to note that there are more female sex workers in the sex work industry than male sex workers and that it is a common composition of the industry that women are the majority of sex workers and men are traditionally the clients (Erbe,1984). However, commercial sex work is not listed as a ground for non-discrimination and it can be argued that the discrimination of sex workers is based on the act of sex and it hinders sex workers rights to participate in the economy of sex work. Commercial sex work does not infringe on any rights but rather exercise their bodily autonomy and freedom to express their sexual rights. It is worth adding that commercial sex work is not listed in what the convention would regard as exploitative practices. This highlights that the convention holds that sex work should not be criminalised. South Africa's constitution guarantees that all citizens have the right to the freedom of trade, occupation and profession and the government has made commitments that legally, require that the rights of commercial sex works are fulfilled, particularly their right to free choice of work is realised. The current legal status of sex work does not only deny sex workers their right to make decision to work in the sex industry, but it violates it by making it illegal to make that decision, which essentially means that sex workers basic right to self-determination is disregarded. Should South Africa decide to legalise sex work, not only would it fulfil its commitments under international law and to its citizens, it would recognise sex work as a legitimate form of labour, thus bettering conditions of sex work and further validate sex workers bodily autonomy and recognise that sex workers deserve to work in conditions that are safe, free and fair as other professions. As a signatory of CEDWA, South Africa should fulfil all obligations established by the Convention to achieve objectives of CEDAW which aims for equality and the protection of all women against violence, exploitation and discrimination.

Article 23 of the UDHR states that "everyone has the right to free choice of employment and the right to work in favourable conditions" provided that their work does not harm or affect other people negatively. The Declaration holds that the states should bare the duty of making sure that the working conditions of

'everyone", which includes sex workers, in an industry that is regulated by law and as protected as a citizen of that state, regardless of the work they do. Article 20 of the UDHR affirms that the rights to freedom of assembly, which can be interpreted to sex workers rights to association and to form unions as other professionals do. Therefore, any laws that prohibit such, can be challenged on the basis of the Declaration. South Africa has an obligation to protect the rights of all its citizens, which includes sex workers as provided in the UDHR. The UDHR is a binding instrument of customary laws regardless of treaty ratifications and thus, binding South Africa to protect sex workers rights to the freedom of assembly and association. Other international and regional Human Rights treaties that South Africa is bound, protect labour related association rights are the African Charter and the ICCPCR; and two conventions of the International Labour Organisation (ILO) , namely, convention No. 87 (1948) which concerns the Right to Organise and No.98 (1949) which concerns the Application of the Principles of the Right to organise and Bargain Collectively. The Congress of South African Trade Unions (COSATU) supports the decriminalisation of sex work and has called for the support and inclusion of sex work and sex workers in South Africa's job creation strategy (Frankowski & Clark, 2009). The trade union has also encouraged its affiliates to raise awareness in sex work and help reduce the stigma and discrimination that is associated with the sex work industry (Frankowski & Clark, 2009).

4.4 Significance of sex work criminalisation on human rights

The international human rights framework stipulates that all people are equal and that they have rights that they should be able to enjoy. As indicated in the conventions, the criminalisation of commercial sex work is an infringement of these human rights. Inevitably, sex workers other rights, such as the right to bodily integrity and dignity are thus violated. Therefore, a decision on these rights is important as they are commonly violated when sex work is criminalised. South Africa has an obligation to take into account international law when interpreting the Bill of Rights. To this end, it is crucial to discuss the right to work, bodily integrity, non- discrimination and dignity as international interpretation of such rights have a substantial effect on the Constitutional rights in South Africa.

4.4.1 The right against deprivation of liberty

The Universal Declaration of Human Rights (UDHR) stipulates that no person may be arbitrarily deprived of their liberty and Article 9 of the International Covenant on Civil and Political Rights (ICCPR) guarantees the right to liberty. However, member states are able to justify the deprivation of certain liberties in

accordance with their domestic laws. Essentially, this right is not absolute and can be justified by the enforcement of criminal law. General Comment No.35 titled Liberty and Security of Person (Article 9) provides that States are obliged to take measures to protecting the right to liberty of person against the deprivation by third parties. For example, one cannot be arrested for standing at a street corner at night, as much as such behaviour is associated with sex workers. Arrests and detention becomes arbitrary once it is not in accordance with established law, this is also confirmed in General Comment No. 3 titled Liberty and Security of person. Arbitrariness refers to aspects of inappropriateness or lack of process in an arrest or detention. It is unjust and against the law. In comment No 18 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) titled, The right to work, the committee express that States should not discriminate or prevent anyone from accessing employment. Generally, commercial sex workers are susceptible to violence from authorities that abuse their power (Deering et al., 2014). In South Africa, it is common for police not to follow correct procedures when affecting arrests or detentions (Fick, 2016). Sex workers have reported assault, harassment and rape by police officers. Others have reported being kept in police vans for long hours while the police drive around neighbourhoods, often mistreating them (Fick, 2016). The arrest of sex workers are often not to achieve justice but often for their abuse by authorities (Fick, 2016). The legal status of sex work in South Africa makes it easy for police officers to break the law and avoid responsibility or accountability for their abuse towards sex workers. This is a violation of sex workers right to liberty and dignity.

4.4.2 The right to non-discrimination

The right to equality and non-discrimination is stipulated in of the UDHR (Article 2). This right is also prescribed in numerous UN human rights instruments. In General comments No. 18 titled Non-discrimination, the human rights committee held that the term 'discrimination' as used in the ICCPR should be understood to imply distinction, preference and exclusion based on " race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Furthermore, in General Comment No. 22 titled the Right to sexual and reproductive health, the human rights committee held that the right to sexual and reproductive health is interdependent with other rights. Therefore, if the freedom of everyone to make choices with their body is taken away, this leads to discrimination. As mentioned above, sex workers experience discrimination from various institutions and this discrimination manifests itself in the inaccessibility of commercial sex workers to certain services. For example, South African police officers have been accused of crimes because of their unlawful status which not only discourages sex workers from

reporting crimes but leads to them further being violated (Fick, 2016).

4.4.3 The Right to Dignity and Bodily Integrity

Human dignity simply implies the value that is placed on a person and speaks to the respect that everyone is entitled to. In General comments No. 14 titled The Right to the Highest Attainable Standard of Health (Article 23), the Committee on Economic, Social and Cultural Rights, provides that the enjoyment of human rights means that everyone has to live a life of dignity as it is a fundamental right. Sexual violence is the highest among commercial sex workers, particularly amongst female sex workers (Alemayehu et al., 2015). This can be attributed to the lack of services that is specific to sex workers medial needs. While there are services such as the provision of free condoms in South African government clinics (NDOH, 2022), such is available to all citizens and not necessarily a service for commercial sex workers. One can argue that the treatment of commercial sex workers by the State is poor as it does not create conditions to accommodate them but aid for the stripping of their right to dignity. All citizens, regardless of their profession or socioeconomic status should be treated with respect. The criminalisation of sex work perpetuates conditions that exploit and violate sex workers right to dignity. In an article titled, *Bodily Integrity and Conceptions of Subjectivity* (2009) , author Patosalmi Mervi, defines bodily integrity as the "ability to have freedom of movement, security against violence, sexual satisfaction, and reproductive choice"(8). Martha Nussbaum (2000), defines bodily integrity as "*being able to move freely from place to place; having one's bodily boundaries treated as sovereign, i.e. being able to be se cure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.*"(78) These definitions suggest that everyone should have total control of their body thus, when an person decides to work as a sex worker, they should have the freedom to do so freely. Regardless of the law, this choice should not be the basis in which their rights are violated. For example, In General comments No. 22 titled : the Right to sexual and reproductive health, the Committee on Economic, Social and Cultural Rights provides that every women has the freewill to make choices regarding her body, sexuality and has the right to be protected from violence and free from discrimination. This maintains that women should be granted the right to have access to healthcare, resources, information and services that ensures the full realisation of the rights to sexual and reproductive health as provided by Article 12 of the ICESCR. To this end, the legal status of commercial sex work in south Africa does not recognise the autonomy of women and their freedom to use their bodies to generate income which hinders their right financial freedom.

4.4.4 The right to choose one's trade, occupation or profession freely

The International Labour Organisation (ILO) Convention of 1964, is an employment policy that highlights that all every human being is entitled to '"full, productive and freely chosen employment". This is in line with article 23 of the UDHR that stipulates that "Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment." General comment No 18 of the ICESCR is titled The right to work and stipulates that "a person's dignity is expressed when they exercise their freedom to choose the work they want to do, and this work must be performed free from violence and harassment, including sexual harassment". The right to work requires States to implement employment policies that create conditions that enable productive employment opportunities that will respect, protect and fulfil the right to work for all citizens. To this end, States are expected to adopt legislation that does promotes equal access to work. General Comment No 23 titled The Right to just and favourable conditions of work and it emphasises that everyone is entitled to work under safe and healthy conditions. General comment No.19 speaks to violence against women and stipulates that while socioeconomic hardship can lead many into sex work, their right to employment protects their decision to work in the sex industry as they should have the right to a profession of their choice, fair labour practices and the freedom to use their body to generate income.

4.5 Case Studies

Chapter Two of the South African Constitution is the Bill of Rights. Section 22 and 23 is particularly significant for commercial sex workers as it provides that all workers' rights should be protected by law. In this section, the effectiveness of the Sexual Offences Act and Related Matters Act 32 of 2007, is tested through an analysis of the case of *S v Jordan and Others (Sex Workers Education and Advocacy Task Force and Others as Amici Curiae) 2002.* Furthermore, the case of *Kylie v Commission for Conciliation Mediation and Arbitration (CCMA) and Others* 2010 is considered to determine whether the Labour Relations Act No 66 of 1995 (LRA) applies to sex work in South Africa.

The Immorality Act was amended in 1988 with the introduction of section 20(1)(aA) after a case that found that commercial sex worker could not be convicted for living off their earnings of their own work as sex worker. The initial Immorality Act 23 of 1957 did not criminalise sex work but criminalised activities related to sex work such as brothel keeping. In the case mentioned above, the court could only criminalise the involvement and conduct of third parties such as pimps and madams, who are typically a person who solicits

customers for sex workers and acts as a manager or 'boss' to sex workers (2002 (6) SA 642 (CC). Section 20(1)(aA) of the Immorality Act criminalises sexual intercourse for a reward. The Act provides that "Any person 18 years or older who- (a) has unlawful carnal intercourse, or commits an act of indecency, with any other person for reward, shall be guilty of an offence." The Constitutional Court faced a challenge regarding whether criminalizing commercial adult sex work infringes, among other rights, the right to equality and privacy. In deciding this case, judges were not unanimous in their decision, thus a dissenting judgement was affirmed (2002 (6) SA 642 (CC). One can argue that this is a representation of the general public's thoughts when it comes to matters relating to commercial sex work in South Africa. In this case, a brothel owner, a brothel employee and sex worker were convicted for contravening the Sexual Offences Act 23 of 1957. They appealed to the court arguing that the relevant provisions were unconstitutional. Interestingly, the High Court agreed that the section of the Act that criminalised sex work for reward was indeed unconstitutional, however, the court dismissed the appeal in respect of Sexual Offences Act 23 of 1957 which criminalised the keeping or management of brothel. This resulted in the enactment of the section that sets out the law as it is today.

In the following section, I discuss the right to equality and the right to privacy in relation to sex work. The right to privacy is of great significance, because the criminalisation of sex work may be a result of the violation of sex workers privacy.

4.5.1 Equality

To determine whether the contents of section 20 (1) (Aa) of the Sexual Offences Act of 1957 amounted to unfair discrimination, the Court interpreted the section of the Act on the basis of gender and held that the section penalises anyone who engages in sex for reward and does not discriminate on the basis of gender. In addition, the court determined that the purpose of the prohibition was to end commercial sex work and that 'one of the ways of curbing commercial sex is to strike at the merchant using criminal sanctions' (2002 (6) SA 642 (CC)). Essentially, the court was in support of the criminalisation of sex work. However, this presented a problem as the issue regarding 'who' the merchant is, had not been adequately dealt with. There are more female sex workers in the sex work industry (Konstant et al., 2015) and it is common in the sex industry that women are the majority of sex workers and men are traditionally the clients (Konstant et al., 2015). The fact that when a man is a sex worker, there is usually some specificity and emphasis on his position as a *male* sex worker rather than just a sex worker. This illustrates the normality and expectation of sex workers being female (Kalwahali, 2009). Even when male sex workers are involved, their clients tend

to be other males as it uncommon for male sex workers to have female clients (Kalwahali, 2009). Regardless of this, the fact remains that the law will commonly harass sex workers and not their clients. Ultimately, it can be argued that the 'merchant' is commonly a female sex worker. The legal status of sex work in South Africa aids in female commercial sex workers mostly being arrested or detained while their clients are not. The Court established a difference between a sex worker and a customer in section 20(1) (aA) of the Sexual Offences Act of 1957 is a common differentiation that is made in some statues and that "The differentiation made by the section must be viewed against the fact that a man or woman who pays for sex is guilty of criminal conduct and liable to the same punishment as the prostitute" (2002 (6) SA 642 (CC)). What this meant is that a buyer of sex/client would be viewed as an accomplice and seen to also committing an offence under section 18 of the Riotous Assemblies Act and thus, liable to the same punishment as the sex worker.

This was an interesting application by the court as the Riotous Assemblies Act of 1956 is an act that intended to consolidate the laws relating to unruly assemblies and the prohibition of the cause of feelings of hostility between the European and non-European inhabitants in Apartheid South Africa (Riotous Assemblies Act,1956). It has been described as a security legislation to suppress political opposition towards the apartheid government and does not provide or make reference to the buying or selling of sex nor does it make reference to the criminalisation of sex work in South Africa (Riotous Assemblies Act 17 of 1956). Critiques argued that the Court's reference to section 18 of the Riotous Assemblies Act in the implication of a buyer of sex is based on the assumption that the section intended to implicate a buyer of sex and that this was an indication that the court "is uncertain if the legislature had the intention to criminalise the buying of sex under the Riotous Assemblies Act" (*South African Law Reform Commission, Project 107, Sexual Offences, Adult Prostitution*, 2015). While it is important to note that section 11 of the Sexual Offences Amendment Act criminalises the buying of sexual services or acts (Criminal law, amendment Act 32 of 2007), neither the South African Police Service (SAPS) nor the National Prosecuting Authority (NPA), has been able to obtain and produce statistics of arrests made of buyers of commercial sex (SALRC Report (Project 107). To this extent, one can argue that the criminalisation of the buyers of sex is ineffective as there seems to be no measures put in place to control and measure its effectiveness. Furthermore, the stance that the court holds that Section 20(1) (aA) is gender-neutral is unjustifiable as there are more female sex workers than there are male sex workers in South Africa. In 2017, sex workers advocacy group SWEAT, estimated that there were between 31000 and 94000 sex workers in South Africa with the majority of them being black South African women (Konstant et al., 2015). In 2013, the South African National AIDS Council reported that there were between one hundred and thirty thousand and one hundred and eighty

thousand sex workers in South Africa. Out of these, ninety percent were female and ten percent are male or transgender. As a result, one could argue that enacting legislation that criminalises the commercial work industry is discriminatory against female sex workers.

4.5.2 Dignity and Privacy

Section 1(a) of the Constitution provides that South Africa is founded on values of Human dignity, the achievement of equality and the advancement of human rights and freedoms. Thus, making the concept of dignity and respect central to the South African Constitution. These values and rights are protected in the Bill of Rights which holds that 'Everyone has inherent dignity and the right to have their dignity respected' (Section 10). The right to privacy is closely associated and is as important as the right to dignity.

The right to privacy means that everyone should be able to hold whatever information or anything personal private. However, the court held that sex workers' rights to privacy is limited by Section 20(1) (Aa) and maintained that 'the exploitation of sex in private does not justify a claim of the privacy clause" (2002 (6) SA 642 (CC)). Consequently, the judge provided that : 'Commercial sex involves the most intimate of activity taking place in the most impersonal and public of realms, the market place; it is simultaneously all about sex and all about money' (2002 (6) SA 642 (CC)). The court held that by making her sexual services available for hire to strangers in the (public) 'marketplace' , the sex worker disregards much of its private and intimate characteristics. This stance is problematic because the services provided by commercial sex workers do not typically occur in a public space which is similar to other professions. For example, the day to day running of a psychiatric practice, is a private matter but the marketing of the practice, much like the advertising of commercial sex work or services, may be conducted publicly. Section 83 of the full *S v Jordan* (2002) judgement did not find it problematic that the sex worker was not nurturing relationships or taking life-affirming decisions about birth, marriage or family but simply making money thus unacceptable. This was an indication that the law does not prohibit adult/consentual sexual intercourse, except when money is involved. The court admitted that people are entitled to engage in sexual activities and choose to do what they please with their bodies provided that there is no exchange of money for those sexual activities. As Elsje Bonthuys and Carla Monteiro put it, "sexual services should be given freely' to remain out of the sphere of criminal law" (2004), This can be problematic as it discredits sex work as legitimate work, hinders their right to generating income and disregards sex workers right to self-autonomy. It may be true that some sex workers work in the sex industry due to socio and economic constrains, however, just as any worker in any industry - an important objective is financial gains. Therefore the *reward,* is a commercial interest and

should be considered as an income.

4.5.3 The Right to Work

From the controversial yet ground-breaking judgement of *Kylie v Commission for Conciliation Mediation and Arbitration and Others 2010*, an analysis of sex work as legitimate work and a profession can be made in terms of the Labour Relations (LRA) Act No 66 of 1995. In 2006, the Commission of Conciliation Mediation and Arbitration (CCMA) heard a case wherein Kylie, a Cape Town based sex worker was dismissed from her place of employment- a massage parlour, wherein she performed various sexual acts. She argued that she was unfairly dismissed. The CCMA stated that they did not have jurisdiction on the case due to the work Kylie was doing as a sex worker as it was illegal. It was held that she therefore, cannot be protected from the unfair dismissal as provided by section 185 (a) of chapter 8 of the Labour Relations Act. Additionally, a Commissioner at the CCMA argued that although sex workers are not explicitly excluded from the LRA, it also does not mean that they are included. The commissioner added that including commercial sex workers would mean that all citizens that are paid to do unlawful activities, would need to be granted the protection of the Act. What is both interesting and obscure is that the legal status of sex work was good constitutional reason for the Commissioner to make such claims, however, these are the same reasons applied to argue that the commissioner was unjust. Considering section 23 of the Constitution, the Court provided that "Sex workers cannot be stripped of the right to be treated with dignity by their clients, it must follow that, in their other relationship namely with their employers, the same protection should hold. Once it is recognised that they must be treated with dignity not only by their customers but by their employers, section 23 of the Constitution, which, at its core, protects the dignity of those in an employment relationship, should also be of application." ((Kylie v Commission for Conciliation Mediation and Arbitration and Others, 2010) . It is important to note that while, Section 23 guarantees everyone a right to fair labour practice, section 39 (2) of the Constitution require a tribunal when it interprets legislation. To consolidate this, interpretation of what constitutes an employee needs to be determined in terms of the LRC which is constitutionally required with reference to Section 23 and its guarantee to *everyone.* This highlights the supremacy of the constitution. This perspective was confirmed in the case of *Khosa and Others v Minister of Social Development and Others*, 2004. A paragraph in the judgement states that "The word "everyone" is a term of general import and unrestricted meaning. It means what it conveys. Essentially holding the believe that once the state puts in place a social welfare system, everyone has a right to have access to that system. The Court was faced with the task of determining whether the appellant was protected

by section 23 of the Constitution and the right to fair labour practices contained in the LRA. If protected, the appellant would be entitled to a remedy for their unfair dismissal. The court subsequently ruled that although section 23 of the constriction provided that "everyone has the right to fair labour practices", it did and could not protect a person (s) engaged in illegal practices/employment. The LRAs main purpose is to advance "economic development, social justice, labour, peace and the democratisation of the workplace (Kylie v Commission for Conciliation Mediation and Arbitration and Others, 2010). Therefore, courts need to take this into account to protect those employees who are vulnerable to exploitation in the workplace" (Kylie v Commission for Conciliation Mediation and Arbitration and Others, 2010). It was on this bases that the appellant appealed the ruling. The appeals court maintained that constitutional rights, which included the rights to fair labour practices, should be afforded to *everyone*, even if the work is illegal. However, the court determined that the CCMA has jurisdiction to determine the appellants dispute ('Kylie' v CCMA and others 2010 (4) SA 383 (LAC) While the case was not much of a success, it highlighted the grey areas in South Africa's legal system and ways in which it can be used to ones advantage. This was amplified by the final ruling by the Labour appeals court which considered the appellant as an employee as provided by the LRA and the Constitution. ('Kylie' v CCMA and others 2010 (4) SA 383 (LAC)). Relating to the previous chapter, the court noted that sex workers could consider forming and/or joining trade unions which would help protect and promote their interest. ('Kylie' v CCMA and others 2010 (4) SA 383 (LAC).

4.6 The Link : Sex is a human rights matter

In chapter two, this paper highlighted ways in which gender and sexual minorities (GSM) are denied their sexual citizenship and opportunities to express their sexuality due to existing (narrow) views of sex and sexuality. Additionally, a rights-based framework was established for a discussion on opportunities to sex. The following section links the broader discussion of the possibility of Sexual Surrogacy Therapy (SST) in South Africa with the international human rights laws set out in this chapter.

Just as any legal system , South Africa's legal system uses criminal law to deter and prosecute harmful behaviour as well as to protect its citizens and others from harm. By the same token, these criminal laws are applied to prohibit access to and the provision of certain sexual recourses. South Africa is an interesting case because while commercial sex work is illegal, there are no explicit laws regulating or prohibiting SST. However, it is likely to be interpreted as commercial sex work, not because of the practical aspect of the therapy but the payment of the service, which would render it illegal. It is important to understand and

present SST for what is it, a specialised form of therapy and its use for medical and therapeutic purposes.

SST cannot be interpreted as commercial sex work as it offers something different. From the human rights instruments discussed above, it is clear that there are potential grounds for the argument for SST as it falls into a legal grey area. There is an opportunity to present SST as sex work which is different from commercial sex work and therefore, not bound by existing and contemporary legal restrictions of sex work in South Africa. When considering domestic laws and treaties which South Africa is a signatory to. This presents an opportunity to localise international obligations and standards which would possibly encourage regulatory structures and enforcement measures that guarantee the protection of those involved in SST, as well as the opportunity to learn from countries such as Germany, France and the Netherlands, which have legalised this practice. As much as South Africa is an independent state that has the capacity to decide laws and regulations, its constitution reveal the extent to which it has the authority, framework and processes to promote and protect human rights. As one of the best known constitutions (Young, 2022), there is an opportunity for South Africa to advance laws and regulations that affect sexual health to alignment with international human rights laws and standards, by removing barriers to access advancing and the sexual citizenship of SST for GSM.

4.7 Conclusion

The Universal Declaration of Human Rights (UDHR) provides that human rights are inherent to all human beings. These rights are universal and inalienable and should therefore be granted to all humans without discrimination. Unless some rights infringe on other people's rights, particularly, the rights of minorities, the exceptional case of restricting certain rights might apply. Sex workers are human beings and on this basis, should enjoy their rights without discrimination. While some have suggested that sex work cannot and should not be recognised as legitimate work as it is inherently forced and can never be voluntary, it can be argued that such abolitionist ideologies fail to recognise women sex workers rights to choose sex work as a profession. Poverty can be recognised as a leading issue for one to work in the sex industry, however, this too can be recognised as a solution to poverty. People who decide to enter the sex work industry do so to generate money and there should not be any shame in that. Sex work is extensively addressed by international human rights instruments, however, the interpretation of these instruments does offer the ability to protect sex workers from violence, discrimination, exploited or from being trafficked. International human rights laws aim to eradicate conditions that exist to exploit sex work and not sex work itself. This is significant as it conveys a message to the international community that sex work is not inherently bad or

destructive to society, and the importance of treating commercial sex workers as human beings that should enjoy their rights and be protected. As mentioned above, the abuse sex workers endure in South Africa can be attributed to the legal status of sex work and the deprivation of their rights such as their right to work, dignity, non-discrimination, liberty and bodily integrity. South Africa is a signatory to the conventions and covenants discussed in this chapter and is expected to uphold the objectives and aims of these international instruments. It can also be argued that to date, commercial sex work in South Africa remains an unregulated. The two cases discussed above highlight this by exposing historical grey areas, flaws and limitations of the current legal status of sex work in South Africa.

To date, the criminalisation of sex work has proven to have little to no impact or success in eradicating commercial sex work or the sex work industry but has rather made provision for conditions of violence, exploitation, and discrimination of sex workers. While this paper does not make a case for the decriminalisation of commercial sex work, it makes a case for the legalisation of one aspect of sex work, being SST, for therapeutic purposes. Considering the possible legal interpretation of SST, as commercial sex work or "glorified prostitution", the current legal status of commercial sex work remains a challenge. To this end, a legislative decision of revoking section 20(1) (aA) and legalising some aspects of sex work and including sexual surrogacy therapy and/or decriminalising sex work, would provide some sense of restorative justice aid towards ending practices of discrimination and stigmatization, that serve to retain commercial sex workers on the margins of society. This would be a possible step towards a truly inclusive constitution which could play an important role in facilitating social change that is necessary for the sexual inclusion of GSM. If the south African government acknowledged the complexities and as shown in this thesis, the multifaceted nature of sex and sex work, and it's importance to social relations, we realise how sexual inclusion relates to the inclusion and participation of GSM in society as referenced in the Treaties. Sexual exclusion in South Africa, as in many parts of the world, disproportionately affects marginalized communities, notably individuals with disabilities and those who have undergone gender-affirming surgery. These groups face unique challenges in cultivating intimate relationships, ranging from a lack of privacy to limited access to specialized support. The legalization of SST emerges as a promising solution to these multifaceted concerns. By providing a structured framework for navigating intimate relationships, it offers a safe space for candid conversations about intimacy, addressing issues of privacy head-on. Moreover, a human rights-based sexual justice approach to SST in South Africa could be transformative. Grounded in principles of dignity and inclusivity, it ensures that every individual, regardless of background or circumstance, has the agency to pursue fulfilling and consensual intimate relationships. This approach not

only upholds fundamental rights but also strives to dismantle barriers that hinder marginalized individuals from accessing the support they need. By fostering a more inclusive and just environment for intimate relationships, South Africa has the potential to lead the way in reshaping the landscape of sexual inclusivity and justice on a broader scale.

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