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Comprehensive prevention for a safer world...

Natalie Fisher-Spalton

The XVIII International AIDS Conference (AIDS2010) takes place in Vienna from July 18 to 23, 2010. As a member of the Conference Coordinating Committee, the World YWCA has worked to ensure that issues facing women and girls are central to the Conference agenda. And with the 2010 global target for universal access to HIV prevention, treatment, care and support looming, it has become clear that current solutions are failing women and girls.

In a world where the spread of HIV and violence intersect, and where women and girls are disproportionately affected, a comprehensive approach to prevention is urgently needed. Central to this is the creation of safe spaces where women and girls can make choices about their sexual and reproductive health and live free from violence, stigma and discrimination.

PREVENTION

Broadly speaking, prevention is about ensuring something does not happen. That '*something*' can be an action, such as violence or transmission of a virus like HIV. It is far more effective and desirable to eliminate the problems we wish to avoid, rather than having to address the consequences after the fact.

Whether it is violence against women, HIV and AIDS, or other sexual and reproductive health and rights (SRHR) issues, taking a broad approach to prevention, which recognises that these issues frequently intersect makes sense. Promoting, protecting and respecting human rights, including women's rights, gender equality and freedom from stigma and discrimination, are essential in a comprehensive approach to prevention.

Mujeres Adelante

A NEWSLETTER ON WOMEN'S RIGHTS AND HIV

Editorial...

On the eve of the International AIDS Conference in Vienna in July 2010, this third issue in the series of special *ALQ/Mujeres Adelante* editions on women's rights and HIV continues to highlight ongoing debates on the adequacy of the AIDS response to especially women's rights, realities and needs.

This edition explores the realities of women and '*minorities*' in a range of contexts, raising the question as to how far we have come in protecting and upholding human rights in the context of HIV and AIDS. Some of the issues discussed include the need for comprehensive HIV prevention approaches for women and girls to create a safer world; the implications of excluding sex workers' rights in the '*feminist*' discourse, as well as the specific realities, challenges and needs of sex workers in Southern Africa accessing healthcare services; the extent to which sexual and reproductive health and rights are adequately addressed in national AIDS policies across 12 countries of the Global South, including South Africa; coercion in healthcare settings by means of '*forced*' termination of pregnancies in South Africa and '*coerced*' sterilisation of Roma women in Slovenia; and sexual and gender minorities in the AIDS response in India, as well as civil rights and social life of '*queer*' people in Zimbabwe.

This issue also explores the right to adequate housing for positive women; discusses the role of the African Commission to address the links between gender violence and HIV; shares '*musings*' on the '*deafening silence*' on AIDS in 2010 and the need to '*make some noise*'; and includes a '*conversation*' with Prudence Mabela.

Acknowledging that current solutions to HIV prevention are failing women and girls, **Natalie Fisher-Spalton** explores the notion of '*safe spaces*' as a pre-requisite for successful prevention strategies. She discusses the various links between violence and HIV, calling for greater investment in women and their capacity, for adequate political and policy commitment, as well as financial resources, and for AIDS responses that address the multiple challenges facing women. Emphasising the urgency, she argues that the key to effective HIV prevention is the creation of '*safe spaces*' in which women and girls are able to take control of their bodies and their lives, and are in the position to exercise their rights without fear of violence, stigma and discrimination.

The contestation of sex workers' rights in the women's movement and its impact on HIV prevention is the focus of the article by **He-Jin Kim**. Examining various arguments portraying sex work as '*violence*', and sex workers as '*victims*', she looks at the extent to which

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World YWCA global advocacy efforts continue to push for comprehensive prevention and the creation of safe, secure and inclusive spaces for women, young women and girls to exercise their rights. This includes a call for greater investment in comprehensive HIV prevention strategies that are grounded in sexual and reproductive health and rights and address violence against women.

...current solutions are failing women and girls...

At AIDS 2010, the World YWCA will host the satellite session '*WANTED: Comprehensive Solutions for All Women*'. This session will emphasise linkages between SRHR, HIV and violence against women, and promote the combined elements of empowerment, safety and information in achieving comprehensive prevention for women and girls. It will also explore how to progress AIDS responses that address the multiple challenges facing women.

VIOLENCE AGAINST WOMEN

Globally, it is estimated that six out of ten women experience physical and/or sexual violence in their lifetime. A World Health Organisation study of 24,000 women in 10 countries found that the prevalence of physical and/or sexual violence by a partner varied from 15 percent in urban Japan to 71 percent in rural Ethiopia, with most areas being in the 30 to 60 percent range.

...a comprehensive approach to prevention is urgently needed...

Another study in South Africa found that women who have been forced to have sex are almost six times more likely to use condoms inconsistently, than those who have not been coerced. This clearly demonstrates the link between violence and the increased risk of HIV infection. While marital rape is a prosecutable offence in at least 104 countries, and 90 have laws on sexual harassment, in too many countries significant gaps in legal protection remain. There are no specific legal provisions against domestic violence in 102 countries, and marital rape is not unlawful in at least 53 nations.

Violence against women is a global health crisis of epidemic proportions, and too frequently, it is a cause and consequence of HIV. Violence, and the threat of violence, dramatically increase the vulnerability of women and girls to HIV infection, by making it difficult for women to abstain from sex, or to demand that their partners be faithful or use condoms. Violence is also a barrier for women in accessing HIV prevention, care and treatment services. Women and girls have the right to access these services, just as survivors of violence have the right to access counselling, legal assistance, healthcare, shelter and other vital support.

Organisations like the YWCA are working actively in communities around the world to support women survivors of violence and abuse through policy and legislative advocacy, emergency shelters, hotlines, counselling, skills training and awareness raising. Central to this is empowerment and providing enabling spaces where women are able to take control of their lives.

these discourses not only perpetuate rights violations of sex workers, but also further fuel discrimination, violence and stigmatisation of sex workers in the specific context of HIV. The author argues that without a commitment to sex workers' rights and leadership at the core of HIV programming, the notion of sex workers as '*incapable of agency and choice*' will continue to undermine HIV prevention efforts '*targeting*' sex workers.

Continuing the discussion on sex workers' rights, **Jayne Arnott** introduces findings from a report assessing sexual health and rights of female, transgender and male sex workers in Botswana, Namibia and South Africa. Based on the voices of sex workers, the article highlights the barriers sex workers face in accessing healthcare, the widespread human rights abuses sex workers are subjected to, and clearly articulates the priorities and needs of sex workers in these countries. Calling for the protection of sex workers' health and rights, she stresses the need to advocate for, and invest in evidence-based programmes and health initiatives that both reduce HIV transmission and defend sex workers' rights.

The links between the recognition of especially women's sexual and reproductive rights, adequate access to sexual and reproductive healthcare, and effective national AIDS policies and programmes have long been established. The 2001 UNGASS Declaration of Commitment on HIV and AIDS is one of the tools to measure the progress made in this regard. **Alessandra Nilo** and **Wilza Villela** explore some of the findings of a multi-country South-South Project monitoring and evaluating the adequacy of policy responses to women's sexual and reproductive health and rights and HIV and AIDS, and **Marieta de Vos** introduces highlights from the UNGASS Forum on sexual and reproductive health and rights in South Africa. The findings of the 2010 analysis showed not only country-specific challenges, but also similarities across the 12 participating countries, in that there is a general lack of integration between HIV-related policies, sexual and reproductive health and rights policies, and policies for women – highlighting the failure to translate promises and commitment into *'real benefits for women'*.

In the context of coercive practices in sexual and reproductive health services, **Lydia Mavengere** examines '*forced*' termination of pregnancy in South Africa, and **Sabrah Møller** looks at '*coercive*' sterilisation of Roma women in Slovenia. Despite South Africa's legislative framework affording women the '*choice of termination of pregnancy*', women are, as argued by Lydia Mavengere, coerced into terminating their pregnancies '*for no other reason*' than their positive HIV diagnosis; a practice based on, and perpetuated by, widespread stigma and discrimination within the health sector, as well as the notion that positive women should not have children, or at least limit the number of children to '*not more than two*'.

Healthcare as a means of discrimination and other rights abuses is further explored by Sabrah Møller, providing an overview of sterilisation practices of Roman women and the law in Slovenia, as well as international interventions seeking redress. A practice '*justified*' to be in the '*interest of the health of the population*', the article highlights the '*systematic sterilisation*' of Roma women not only as a gross violation of women's right to informed consent, but also as part of a prevailing systemic discrimination against the Roma population.

The gender dimensions of sexual minorities and the response to HIV and AIDS in India are discussed by **Tahmid Chowdhury, Lily Walkover, L. Ramakrishnan, Pawan Dhall, Manish Soosai, Tyler Crone,** and **Sai Subhasree Raghavan**. The article provides an overview of historic conception and representation of sexual minorities in India, reviews the specific vulnerabilities of sexual minorities in the context of HIV and AIDS, and suggests targeted interventions required to adequately address HIV risks and vulnerabilities of sexual minorities. Emphasising '*deeply entrenched inequity*' and '*social marginalisation*' as the main barriers to accessing rights, the authors argue that '*simply*' enhancing the status of sexual minorities, without addressing the structural violence perpetrated against them, is not '*enough*' to reduce their vulnerabilities to HIV.

In light of increasing anti-gay politics and anti-homosexuality laws on the African continent, **Kate Griffiths** explores the rights of sexual and gender

It is also about investing in young women and their capacity to be champions in their communities and countries in responding to violence against women, sexual and reproductive health and rights, and HIV. This is an important priority for the World YWCA, and one that will be taken up in Vienna through the young women's forum, '*Our Rights, Our Bodies*'. This forum will provide a unique opportunity for young women to discuss issues on the agenda at AIDS 2010, and to build knowledge and identify advocacy opportunities to make an impact on the conference agenda.

SAFE SPACES

The notion of '*being safe*' speaks to the enjoyment of universal human rights and being free from stigma and discrimination. It is about enabling women, especially young women, to make decisions about their lives, including sexual and reproductive choices, such as marriage and the number and spacing of children.

Women, young women and girls define their '*world*' in many ways. It is the private spaces of family in homes, bedrooms and kitchens. These intimate spaces should offer love, caring, healing and support, as well as nurture the full potential in every person. Yet too often, these private spaces are where women and girls experience domestic violence, are violated, abused or neglected. It is also the place where women and girls, often unknowingly, contract HIV and other STIs.

...push for comprehensive prevention and the creation of safe, secure and inclusive spaces for women, young women and girls to exercise their rights...

Public space, on the other hand, comprises places of social, community and economic activity, such as schools, playgrounds, parks, streets, markets and places of worship. These spaces, which are supposed to be empowering, enjoyable and foster collective identity, relationships and livelihoods, have sometimes been spaces where violations of women's sexual and reproductive health and rights have occurred. They are spaces where women and girls, too frequently, live in fear and have their freedoms and rights curtailed.

...to progress AIDS responses that address the multiple challenges facing women...

The YWCA is a strong advocate for the creation of safe spaces at every level. In more than 22,000 communities around the world, YWCAs provide safe and empowering spaces for women, young women and girls without fear of discrimination, stigma or prejudice. They also actively initiate and support programmes to promote safety and security for women and girls, including freedom from violence and discrimination in homes, schools, workplaces, communities and countries. Guiding this work, is a belief that safe spaces are those in which women and girls, in all their diversity, can achieve their full potential. All women are entitled to live in safety and security, regardless of their HIV status, age, creed, race, gender, sexual orientation, ability or ethnicity.

minorities in Zimbabwe. Examining the extent to which the country's political, economic and constitutional crisis impact on the daily lives of '*queer*' people, she describes how political and legal harassment, as well as economic hardship, combined with homophobia, stigma, discrimination and incidences of '*coercive rape*' lead to a situation which suggests the closure of political spaces for advocates of '*gay rights*'. Although political and social spaces for lesbian, gay, bisexual, transgender and '*queer*' people in Zimbabwe are diminishing, the article argues that there are still '*spaces of hope*'.

Looking at the African Commission on Human and Peoples' Rights, **Wendy Isaack** examines the role of regional human rights mechanisms in addressing the links between gender violence and HIV. She analyses the regional human rights institutional architecture, including the ways in which the African Commission executes its protective mandate, focusing primarily on human rights treaties and declarations addressing both HIV and AIDS and violence against women. To adequately address the links between gender violence and HIV, she argues that the creation of a Special Rapporteur on the Right to Health would be the '*most appropriate*' method to respond to the '*devastating impact*' of HIV and gender violence in Africa.

The introduction of medical male circumcision for HIV prevention has raised a number of concerns as to the implication of this news intervention on women and women's risks. **Cindra Feuer** introduces key findings and recommendations of a five-country study in Southern and Eastern Africa on women's perception of, and engagement with, medical male circumcision for HIV prevention; and **Jayne Arnott**, looking at the South African study, raises the question of '*where are the women?*'. Although the data across all countries indicate support for medical male circumcision to be introduced, the data also highlight a great need for intensified education and awareness raising on the advantages and disadvantages of medical male circumcision for HIV prevention. In the South African context, women felt very strongly that for this new intervention to be successful, the roll-out of medical male circumcision has to be accompanied by initiatives addressing gendered power inequalities and gender violence, as well as an increased access to women-controlled HIV prevention. Despite county specific nuances in knowledge levels about, and support for, the roll-out of medical male circumcision for HIV prevention, both articles argue that without women's involvement the impact of this new prevention technology might be questionable.

Positive women's right to adequate housing is the focus of discussion by **Brook Kelly**. Exploring the links between homelessness and women's risks and vulnerabilities in the context of HIV and AIDS in the United States, the article introduces the realities and challenges of positive homeless women in Washington, DC, and argues that affordable housing is an unrealised human right for many positive women in the US. Looking ahead '*on the road to human rights at home*', the author concludes that the US has much farther to go in alleviating '*stigma at home*' and to fully recognise housing as a human right for women living with HIV.

The various realities portrayed in the articles, although very diverse in their contexts, seem to all point to and highlight the persistence of human rights abuses and violations based on, and in the context of, HIV and AIDS – mainly '*targeting*' women, and especially '*vulnerable and marginalised*' women. At the same time, there seems to be a common argument across all articles that without addressing the '*drivers*' of these pandemics, such as gendered power imbalances and inequalities, stigma and discrimination, and deep-seated prejudices and homophobic attitudes against the '*non-conforming*' person; and protecting and upholding the rights of all people, AIDS responses will continue to have limited effect; women's rights, realities and needs will persist to be lacking in policy and programme design, and rights abuses will remain the reality for many people, despite commitments and promises to recognise human rights, and especially women's rights, in the response to HIV and AIDS. And so, for Vienna and beyond the answer lies in *Rights Here. Right Now!*

JOHANNA KEHLER

The World YWCA will bring safe spaces to the Vienna International AIDS Conference. Through its exhibition booth in the Global Village, the YWCA will provide a safe place for all women and girls attending the conference to meet. The booth will creatively explore issues of safety and safe spaces for women and girls, and encourage participants and visitors to contribute their ideas.

...providing enabling spaces where women are able to take control of their lives...

MOVING FORWARD

A vision for a '*safe*' world must include freedom from violence in both the public and private spheres, as well as universal access to HIV prevention, treatment, care and support. Women urgently need access to full and comprehensive sexual and reproductive health services. The provision of safe spaces for women and girls, alongside comprehensive prevention, is vital in achieving this vision.

As Sharon Bong, a scholar of feminism and theology, highlighted at the World YWCA Asia Pacific Regional Training Institute, these ideas are founded upon a conviction about the value of every human person, endowed with rights and entitled to a life with dignity. She argued that to realise our full human potential and to live life abundantly, women must be free from fear, want, oppression or catastrophe.[4]

...the notion of *'being safe'* speaks to the enjoyment of universal human rights and being free from stigma and discrimination...

Safe space is about the personal security of women and girls, and the right to live in safety and free from violence in every dimension of life. Safe space is also about ensuring that HIV and STI prevention is in the hands of women. It is about the economic security of women, including freedom from poverty, and the ability to make choices about where to live and work, and to move freely from place to place. And it is about the political security of women, and the right to live in peace and participate in all facets of democracy. Consistent with UN Security Council Resolution 1325 on Women, Peace and Security, women must be actively involved in conflict prevention, conflict resolution and peace processes.

Laws and policies have been put in place in many countries to address these issues, though they remain inadequate in themselves without the resources, strategies and education required for success. At the global level, there has been an increasing focus on peace and security resolution over the past decade, and the vital importance of women's participation in all facets of democracy. Aspects of the Beijing Agenda and the Declaration of Commitment to HIV have been infused into the Millenium Development Goals (MDGs). As the policy framework for development, with a re-energised focus on the agenda established at the International Conference for Population and Development (ICPD), this is critical. Yet, fragmentation persists with insufficient attention and analysis of how these agendas intersect, and how these efforts could work together to

deliver better results for women and girls.

…live in fear and have their freedoms and rights curtailed…

Financial resources for the promotion of gender equality and women's rights remain unacceptably low. Insufficient political and policy commitments have resulted in community-based service organisations, like the YWCA, carrying a disproportionate burden of responsibility without the matching resources.

Minimum standards that all countries should have in place include, ready access to emergency hotlines, shelters, post-rape care that includes post-exposure prophylaxis, and free legal aid. This '*frontline*' response can be strengthened by working with police, healthcare professionals, legal aid workers, and the judiciary, and by supporting the development of effective multi-sector referral systems for survivors of violence.

The key to comprehensive prevention, however, is expanded and sustained investment and human capacity to deliver. Political neglect and underfunding has resulted in most efforts responding to the emergency needs and rights of already-abused women and women living with HIV; largely delivered by women's groups and other civil society organisations operating on shoe-string budgets. As such, insufficient attention has been paid to prevention.

…how these efforts could work together to deliver better results for women and girls…

The donor community should rise to the challenge of supporting comprehensive approaches, rather than funding narrow sectors. While it may be difficult to track and measure, the long-term benefits for women and girls far outweigh the challenges. Comprehensive prevention offers real possibilities for women and girls to '*live life abundantly, free from fear, want, oppression or catastrophe*'.

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Shut out of the debate...

The impact of excluding sex worker's rights

Sex workers are a highly stigmatised demographic, which positions them as very vulnerable to HIV infection and rights abuses. It is also clear that their stigmatised position in patriarchal society fuels the violence and discrimination that sex workers face. However, it is important to note the effect abolitionist arguments have on the effectiveness of HIV prevention within sex worker communities. Arguments that portray all forms of sex work inherently as *'violence'* and all sex workers categorically as *'victims'* of this violence, do nothing to address the stigma and discrimination that sex workers face, and that underlie their increased vulnerability in the context of HIV. On the contrary these arguments, arguably, often further aggravate sex workers' vulnerability.

He-Jin Kim

SEX WORK AND THE WOMEN'S RIGHTS MOVEMENT

Sex worker's rights are a much contested issue, especially in relation to the women's movement. Arguably, the absence of sex worker's rights in many women's rights arguments is based on a history of framing prostitution as a women's rights violation within '*feminism*'. Bell (1994) observes that the '*prostitute body*' has been a site of struggle for feminists, because it is

> *…a terrain on which feminists contest sexuality, desire, and the writing of the female body.*[1]

She argues that in the 1970s – up until the 80s with the introduction of post-modern feminism – feminist ideologies theorised the '*prostitute's body*' into feminist spaces, but that there was no space for the prostitute to speak for herself,

> *…particularly if her speech might contradict the feminist construction of her body.*[2]

Many feminists have claimed that sex work is harmful to women; while some argue that this is an inherent feature of sex work itself, others consider that this is the result of the societal context in which it happens.[3] Weitzer (2005) argues that radical feminists such as Andrea Dworkin, Kathleen Barry, Sheila Jeffrey and Catherine McKinnon, have presented prostitution, pornography and the sex industry as the ultimate form of male domination over women.[4] Prostitution in this perspective is not argued to only involve acts of violence, but is considered a form of violence by definition. As he points out,

> *…violence is depicted as 'intrinsic' and 'endemic' to prostitution – categorically, universally, and trans-historically.*[5]

Language in such thoughts is very specific in how it names sex workers; with wordings, such as '*prostituted women*', '*sex slaves*' or '*survivors*', used, instead of '*prostitute*' or '*sex worker*'.[6] Farley (2003) objects to the word prostitute by equating prostitution with battering of women:

> *We do not refer to battered women as 'battering workers'. And just as we would not turn a woman into the harm done to her (we don't refer to a woman who has been battered as a 'batteree'), we should not call a woman who has been prostituted, a 'prostitute'.*[7]

Such arguments inherently imply that prostitution is something that is *done to women*, something women undergo, implying automatically the absence of agency and choice. The idea of anyone choosing sex work, any agency or decision-

making by a sex worker is disregarded as impossible in such instances. Farley takes the absence of agency of sex workers even further by saying that:

> *…if observers don't observe the stereotype of 'harmful' prostitution, for example, if they do not see a teenaged girl being trafficked at gunpoint from one country to another, if what they see is a streetwise teenager who says 'I like this job, and I'm making a lot of money,' then they don't see the harm.*[8]

Her argument implies that even if a sex worker states clearly that they have agency, they should just not be believed. Farley proposes that one should not ask if a sex worker consented, but whether or not a sex worker has had any '*real alternatives to prostitution for survival*'[9], implying that the agency and voice of any sex worker, who does not quote their own experience as one of clear coercion and violence, should be considered suspect. By equating prostitution with violence that by definition is done *to* sex workers, the voices and opinions of sex workers are categorically shut out of the debate.

These views are very strong and they did, arguably, have an effect on a wider women's rights movement. Doezema relates of her participation at the 1995 United Nations Fourth World Conference on Women in Beijing, that she and other delegates from the Network of Sex Work Projects (NSWP) and the Global Alliance Against Trafficking in Women (GAATW) lobbied for every mention of prostitution as a form of violence against women in the final conference document to be prefaced by the word '*forced*'.[10] She further states that

> *…because sex workers' human rights were not mentioned in the draft document, it was impossible to introduce this concept at the Conference.*[11]

…any agency or decision-making by a sex worker is disregarded as impossible…

Recently, the trafficking debate has also been linked to the discussion concerning sex work. As opposed to the GAATW, the Coalition Against Trafficking in Women (CATW) has stated that all prostitution is in itself trafficking.[12]

…any sex worker, who does not quote their own experience as one of clear coercion and violence, should be considered suspect…

There are many anti-trafficking NGOs, which have perpetuated the images of the '*prostitution as violence*' and '*victim of prostitution*', through their rhetoric and the arguments they use. Rhetoric, which in some ways can be considered objectifying the victims they seek to save.[13]

EFFECTS ON HIV PREVENTION

HIV prevention efforts that are not considered clearly anti-sex work have been argued to be problematic, because they do not help '*victims of prostitution*', and therefore, perpetuate '*violence*'. Similarly, HIV prevention strategies that focus on teaching women strategies to convince clients to use condoms are claimed to be '*promoting prostitution and violence*'[14]. In this

context, Donna Hughes has been quoted as saying that

> *…HIV/AIDS education is wasted on women who have no voice or power against their rapists and therefore rescue is the only humane, ethical intervention.*[15]

…whose meaningful involvement is essential to effective HIV prevention efforts…

In 2007, a draft of the *UNAIDS Guidance Note on HIV and Sex Work* cited the importance of exit services. The Scarlet Alliance, an Australian sex worker's rights NGO, rightfully commented on this, arguing that

> *…linking service delivery to 'exiting' programmes can have a devastating effect on sex workers who need to access such services. If a provision of service is provisional on a person no longer doing sex work, then those people are faced with a choice between feeding their families with their sex work income, or accessing programmes that may or may not have positive effects on their income in the future.*[16]

…sex workers are categorically shut out of the debate…

During the Bush Administration in the United States, proponents of the abstinence, rescue-oriented, and abolitionist views of sex work tended to favour the Anti-Prostitution Pledge that was attached to PEPFAR funding. Oddly enough, the Christian conservative right has banded together with radical feminists to argue that trafficking in persons is inextricably linked with sex work. Proponents of the Anti-Prostitution Pledge argued that abolition of prostitution, rather than risk reduction, must be at the forefront of HIV prevention efforts.[17] As a result, all NGOs who received funding had to pledge their expressed opposition to prostitution, resulting in many NGOs working with sex worker communities in the developing world to either change their programmes, or refuse funding. Meena Seshu says of the decision by SANGRAM to refuse signing the Anti-Prostitution Pledge and reject PEPFAR funding that

> *…the truth is, we're working with these sex workers, we're telling them that if they use condoms men will be saved from HIV. That is the agenda of the state. You're asking them to help you fight HIV. And in the same breath you are telling them that they are terrible people and that you're against them. It just doesn't make sense.*[18]

Such a clear stance against prostitution, basically implying that it is wrong, will alienate sex workers, whose meaningful involvement is essential to effective HIV prevention efforts.

In 2004, the *Act on the Punishment of Acts of Arranging Sexual Traffic* was enacted in South Korea, consisting of two laws that legally re-defined all forms of sex work as '*sex trafficking*', and all sex workers as '*victims of sex trafficking*'.[19] These laws came into effect after a long campaign by the Network for the Eradication of Prostitution, a coalition of women's NGOs in

South Korea,[20] and were drafted and supported by the Ministry of Gender Equality and Family. Implemented in 2004, this legislation has led to a collapse of HIV testing facilities, and other services for sex workers provided for by the public health departments in South Korea, as this legislation took precedence over public health regulations regarding HIV and sex work.[21] In this case, the focus on '*prostitution as violence to women*'[22] clearly resulted in criminalisation, which in turn, has damaged health services for sex workers.

As opposed to a focus on '*rescue*' and '*exit strategies*' as HIV prevention methods for sex workers, rights-based approaches and harm reduction have proven to be effective in responding to sex workers' HIV risks; mainly through empowering sex workers with knowledge and prevention tools. As an example, launched in 1992, the Sonagachi Project began as a small project to provide sex workers in Calcutta, India, with information about HIV, condoms and STI testing. It was started in the Sonagachi red light district, and has become a multi-faceted community effort that empowers sex workers in many ways that go beyond HIV prevention.[23] Empowerment through knowledge and tools for health has always been at the centre of this project. Peer educators disseminate information about sexual health and HIV, and provide condoms to sex workers, madams and clients. The project has expanded and now includes various other components not specifically related to health and HIV, such as literacy classes, and day care programmes for their children. The Sonagachi Project has been identified as a World Health Organization (WHO) model project.[24]

…focus on *'combating'* the stigmatisation of sex work, rather than *'combating'* sex work itself…

STIGMATISATION AND DISCRIMINATION

Debra Satz (1995) has argued that

> *…if prostitution is wrong it is because of its effects on how men perceive women and on how women perceive themselves. In our society, prostitution represents women as the sexual servants of men.*[25]

Satz further proposes that the negative image of women, which includes the stigma of '*loose women*', is perpetuated by how prostitution '*shapes and influences the way women as a whole are seen*'.[26] Thus, the arguments from abolitionist women's activists are, arguably, not only concerning the '*suffering of prostitutes*', but also how prostitution affects all women, not just sex workers. Actions and dress codes lead people to certain expectations about what that person is saying about themselves, and prostitution is in such a context considered to be degrading, because if a woman behaves in a manner that fits the stereotype of what men commonly perceive as '*a whore*', she is degraded by that association.[27]

The '*whore stigma*' is certainly a large factor when it comes to discrimination and violence against sex workers. It is also true that this affects not just sex workers, but everyone who is perceived as a '*whore*'. It is for this reason important to address this stigma that sex workers face, by countering the '*whore stigma*' and the notions that women who transgress certain sexual boundaries, or who engage in certain sexual practices, should

be punished, as this will further the rights of all women in society, not just sex workers. Justifiably, Nussbaum (1999) argues that feminists should focus on '*combating*' the stigmatisation of sex work, rather than '*combating*' sex work itself, because of its supposed contribution to the stigmatisation of women. She further argues that the problems associated with prostitution are components of many other kinds of work and social practices, such as marriage, and that these problems are not inherent to the work, but are often a function of the sex workers' working conditions and treatment by others.[28]

…such victimisation itself constitutes a form of discrimination…

When put in the context of HIV prevention, this becomes very clear. Traditionally, sex workers have been stigmatised as '*vectors*' of HIV transmission. Sex workers have long been viewed as either a demographic that has to be '*controlled*' in the interest of general public health, or as a passive target group for health services and prevention.[29] Arguably, this view of sex workers as '*vectors*' through which HIV is transmitted to the general public, is built upon the stigma of sex workers as '*loose women*' and '*whores*' – women who do not prescribe to '*moral*' and '*appropriate*' female behaviour – fuelling discrimination, violence and further stigmatisation in the specific context of HIV.

…a demographic that has to be *'controlled'* in the interest of general public health…

The alternative position of the sex worker as a '*victim of prostitution*', where prostitution is redefined as violence in itself, as proposed by many anti-trafficking and abolitionist activists, does, however, nothing to address the stigmatisation that fuels the discrimination and violence against sex workers. Furthermore, it can be argued that the clear positioning of prostitution as violence, something so '*wrong*', and '*dirty*' that nobody possibly could voluntarily be involved in this, further aggravates stigma, because people who are perceived to still have chosen sex work are even more at risk of discrimination. Also, such victimisation itself constitutes a form of discrimination. Sex workers' voices and opinions are often suppressed, or are deemed suspect, when they do not fit the '*victim profile*'. Sex workers are in many ways infantilised as incapable of agency, choice, or power to change their own lives, or influence their own communities. Therefore, the positioning of sex workers as '*victims of prostitution*' does not further the empowerment of sex workers, but instead hinders sex workers' meaningful involvement in HIV prevention. Sex workers are not only essential in order to reach communities and demographics, but also to understand the sex industry. Victimisation of sex workers only encourages the notion that sex workers lack any agency to create change, and therefore, one has to refer to '*experts*', often coming from outside sex worker communities, who too often fail to put sex workers' rights and well-being at the centre of HIV programmes.[30]

CONCLUSION

Feminist discourses that have framed prostitution to be by

…a commitment to sex worker leadership at its core…

definition violence, have contributed to perceptions of '*prostitutes as victims*', which are still perpetuated and show strong influence in many HIV prevention policies. This prevailing notion conflicts with the actual reality that sex work is a form of labour, as it constitutes remuneration for services. It also prevents any sex worker from voicing agency, as they are effectively infantilised. In the context of HIV, this is extremely problematic as effective HIV prevention can only exist if communities are involved in a meaningful way.

Furthermore, because it is in fact the stigma that fuels discrimination and violence, and thus, sex workers' increased vulnerability to HIV infection, effective HIV prevention means addressing this stigma. However, as argued in this article, abolitionist arguments do exactly the opposite; as they perpetuate and even increase the stigma that sex workers are subjected to. HIV programmes cannot just '*target*' sex workers; on the contrary, they should have a commitment to sex worker leadership at its core, as well as the elimination of stigma and discrimination.[31] Inherently this means that such programmes must have a strong basis in sex worker's rights.

FOOTNOTES:

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20. 'Seongnodong [Sex work]' Seoul, Centre for Women's Culture and Theory, 2007.
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23. 'Sonagachi Project – India' The communication Initiative Network [www.comminit.com/en/node/116130/347]
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Rights not rescue...

Female, transgender, and male sex workers' human rights in Botswana, Namibia, and South Africa

Jayne Arnott

...It is no exaggeration to say that sex workers are facing a health and human rights crisis in Southern Africa. Despite this fact, very little is being done to protect sex workers' rights, and even less, to promote these rights. Instead, a significant proportion of funding is going towards initiatives such as 'rehabilitation' that have not been proven to work: there is no evidence that they lower the numbers of people in sex work or reduce HIV. As a result, sex workers are seeing their access to evidence-based HIV-programming severely compromised. This is a major infringement of sex workers' human rights to life, health, information, and non-discrimination...[1]

INTRODUCTION

The *Rights not Rescue* report[2], published in June 2009 under the auspices of the Sexual Health and Rights Project (SHARP) and Open Society Institute (OSI), is based on the findings of a situational assessment carried out between May and June 2008 on the sexual health and rights of sex workers in Botswana, Namibia, and South Africa. Interviews and focus group discussions were carried out with 87 female, transgender, and male sex workers working on the streets, on highways, at truck stops, in brothels, in agencies, near mines, and in informal settlements across the region. Interviews were also conducted with non-governmental organisations in the region that work with sex workers.

Sex work is, at present, illegal in these countries, and sex work is largely viewed as '*immoral*' and '*exploitative of women*'. The findings documented the voices of sex workers – female, male, transgender and migrant – regarding their experiences of widespread human rights abuses, including high levels of violence and the barriers they face in accessing health and legal services. The report further explores how laws and policies impact on sex workers' ability to improve their working conditions, and to address issues of health and safety as individuals, as well as collectively.

FOCUS

This article will not review the entire report, but rather attempt to highlight what sex workers were saying about how they experience access to health services; what their main priorities are in relation to staying healthy and safe; as well as what support they are seeking to take forward interventions that would be of benefit to them in their work and in their lives. The participants in this situational analysis were clear about

the priority needs and barriers that they faced – and it is hoped that organisations, policy makers, funders and governments who engage with this report will act on this evidence to support sex workers in achieving change in their working conditions and access to sexual health and rights-based services.

The recommendations contained within this report are included at the end of the article to highlight the range of issues explored and documented by this study.

...unable to access adequate HIV prevention, testing, counselling, and treatment services...

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The research found that sex workers were unable to access adequate HIV prevention, testing, counselling, and treatment services, and reports how acutely sex workers are affected by HIV-related stigma. The report also noted that a prevailing belief still exists in the region that sex workers are a threat to the health of society, being perceived as '*AIDS carriers*' or '*reservoirs*' of HIV.

...sex work is largely viewed as *'immoral'* and *'exploitative of women'*...

Testing for HIV is a cornerstone of HIV prevention and treatment services; yet, many sex workers interviewed in this study did not know their HIV status. It was noted that, for some, costs were a barrier as, for example, participants in Namibia reported being turned away when attempting to test for HIV at no cost, even though the policy states that HIV testing is free for those who cannot afford the fee.

Sex workers in the study reported avoiding HIV testing, because of the emotional repercussions of a positive test result, as well as concerns that they might be prevented from doing sex work. Fears regarding legal sanctions being brought to bear on positive sex workers are not unfounded in the light of new legislation criminalising the transmission of HIV already adopted in many African countries, and draft bills proposed in others.

The report explores how access to safer sex materials is a key element towards preventing HIV, and empowering people, whether HIV-negative or living with HIV, to protect their health. This research found that many sex workers were unable to access sufficient quality condoms; with female condoms even more difficult to access.

There were also reports about the difficulties in accessing sufficient condoms at clinics, with staff either restricting the quantity of condoms, or embarrassing sex workers by commenting on how frequently they requested condoms.

Lubricant, for use with latex condoms, is an essential HIV prevention commodity for sex workers, but its importance

has yet to be recognised and supported by governments or other funders. None of the sex workers interviewed was able to access free lubricant. As a result, many sex workers reported discomfort or injury after prolonged work hours, particularly when work involved anal sex, and some reported resorting to Vaseline and other oils, which can result in condom breakages.

Sex workers interviewed strongly expressed the need for more HIV prevention information that would help them use safer sex materials correctly and effectively. The report documents widespread condom breakages that could indicate that condoms may be of low quality, or stored or used incorrectly. Many sex workers interviewed had not received any education on how to put a condom on, and even fewer had witnessed a condom demonstration.

Sex workers reported that despite their efforts to encourage condom use, many clients pressurise them to engage in unsafe sex or, in some instances, threaten them with violence, if they refuse to comply. Very limited access to information that could assist sex workers in developing negotiation skills to promote condom use with clients was reported; with younger sex workers even less able to negotiate condom use, because they have less experience and more fear of abuse and violence.

...turned away when attempting to test for HIV...

...concerns that they might be prevented from doing sex work...

Sex workers also said that they lacked explicit, relevant, and sex-positive information that would help them eroticise safer sex for their clients.

Sex workers interviewed repeatedly emphasised that education programmes for clients are needed to change their attitudes toward safer sex, and that programmes which assume sex workers would take sole responsibility for enforcing condom use are insufficient. Participants spoke about how education efforts that reached male clients did make a difference and that clients did not disagree as much as they used to regarding condom use. The report noted concern in that, despite these successes, all of the client education projects that the researchers encountered had either ended, or were expected to end, in the near future.

All three countries offer free ARV treatment to citizens living with HIV who cannot afford medication, but the researchers received reports in all three countries that many sex workers who are living with HIV cannot, or do not, access treatment. Financial concerns were frequently cited as barriers to accessing care, including unaffordibility of transport and other costs associated with medical services or treatment. Policies, such as needing to show a fixed address, as in Namibia, also created barriers to treatment access.

In addition to financial barriers that are experienced by all low-income people in the region, sex workers who are living with HIV have to confront the double stigma of their profession and of being HIV-positive. Fear of discrimination is so strong that many sex workers who are living with HIV fail to get treatment and die prematurely. Positive sex workers also lacked basic and vital information that would help them comply with treatment regimens, and maintain their health. It was reported that there was almost no information available on subjects, such as HIV re-infection or harm reduction strategies for taking ARVs.

...unable to access sufficient quality condoms...

The report documents that sexual and reproductive health services in the region lack coherence and integration necessitating multiple visits to different locations, which places stress on finances and health. Sex workers experience this fragmentation of sexual and reproductive health services more acutely, because they need to access these services frequently in order to obtain safer sex commodities, STI testing, advice, and information.

The majority of sex workers interviewed said that they do not disclose that they sell sex to health service providers. Non-disclosure has implications for treatment, advice, and education that is potentially available at health services. The main reason given by the participants for non-disclosure were fear of discrimination, condemnation, and bad treatment from health providers. Participants reported seeking alternatives to treat their health problems that were often inadequate or dangerous to their health, rather than face discriminatory treatment by clinic staff.

Sex workers, who are pregnant and living with HIV, experience health needs that span both HIV-related services and reproductive health services. Participants noted that sex workers often cannot access services to prevent vertical transmission of HIV, and as a result, their babies are more likely to be born with HIV.

Some family planning services may not be available at all in the public health system. Termination of pregnancy, for example, is illegal in Botswana and Namibia. Participants narrated incidences in which sex workers faced additional stigma in trying to get medical assistance following unsafe abortion attempts.

The participants who were migrants related great difficulty accessing healthcare. There were also reports from South Africa of reluctance to leave the brothels where they worked,

...programmes which assume sex workers would take sole responsibility for enforcing condom use are insufficient...

due to fear of police or violent xenophobic attacks. This greatly limits migrant sex workers' access to any kind of comprehensive treatment or care or assistance in cases of emergency.

It was reported that migrants usually have to pay higher fees for the services that citizens receive for free, or at low cost, at public clinics. South Africa is the only country in the region that offers ARVs to migrants for free. Fees were an insurmountable barrier to care for many of the participants, as were the xenophobic attitudes of health staff. Consequently, many migrant sex workers said they avoided public health facilities all together. This compromises their access to safer sex materials and other essential health services.

...seeking alternatives to treat their health ... rather than facing discriminatory treatment by clinic staff...

The report explores how the governments in the region concerned, when conceptualising interventions for sex workers, such as in the context of national HIV plans, mostly assume that all sex workers are women. Male and transgender sex workers are thus '*invisible*' to health providers and policy makers, and this means that the health of many sex workers is jeopardised, because they do not access services.

Transgender sex workers interviewed in Namibia were unable to avail themselves of hormone therapy or sexual reassignment surgery, unless they travelled to South Africa. The costs of doing so were prohibitive to all those interviewed. In South Africa, some transgender sex workers reported that '*black market*' hormones and contraceptive pills are used in order to avoid stigma and hostility from doctors. This meant that they had no medical supervision and were unaware of the possible side effects.

'WISH LIST' FROM SEX WORKERS IN RELATION TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

South Africa

- Prioritised the provision of basic safer sex materials, such as free high quality male and female condoms, and free lubricants; recommending that condoms and lubricants be available to sex workers when and where they need them, including on the streets, at indoor venues, and for their personal use.
- Called for halting police activities that undermine the provision of safer sex materials, such as the confiscation of condoms, as they are negating existing health promotion efforts supported by government, including the Department of Health.

Botswana

- Prioritised low cost or free user-friendly health services, as a key intervention for their communities.

- Suggested dedicated health services run by sex workers themselves, as this would help address barriers that sex workers face in terms of accessing sexual and reproductive healthcare.
- Emphasised the need for programmes that respect sex workers' privacy, and provide non-judgmental care.
- Called for the integration of practical and meaningful safer sex education, including tips such as how to check clients for STIs, as well as how to get payment from clients in advance.

Namibia

- Highlighted the need for more user-friendly, high quality health services that cater for a full range of sex workers' sexual and reproductive health needs.
- Sex workers in Walvis Bay reported no service needs, expressing frustration with existing and persisting HIV and AIDS education interventions that seemed irrelevant to their lives. They expressed an overload of the same information and same interventions that point to programmes that are not informed by sex worker's context, realities and needs.

...compromises their access to safer sex materials and other essential health services...

...male and transgender sex workers are thus *'invisible'* to health providers and policy makers...

RECOMMENDATIONS TOWARDS PROTECTING SEX WORKERS' HEALTH AND RIGHTS

To Civil Society Organisations[3]

Advocate for the human rights of male, female, and transgender sex workers. Rights-based NGOs promoting the rights of women, LGBT communities, migrants, and people living with HIV can create awareness about the ways in which sex workers' rights are violated in a broad range of constituencies. These organisations can advocate for, and disseminate information about, the ways in which sex workers' rights may be protected, respected, and fulfilled. These organisations can also train healthcare staff to interact sensitively and appropriately with communities of sex workers, and to provide services to support these communities.

Advocate for evidence-based programmes that reduce HIV transmission and defend rights. Human rights violations and poor working conditions fuel sex workers' vulnerability to HIV. It is imperative to address these fundamental underlying causes in order to address sex workers' HIV risks.

Support mechanisms for redress of human and labour rights violations. NGOs can disseminate information about,

…train healthcare staff to interact sensitively and appropriately with communities of sex workers…

and facilitate access to, official mechanisms and processes whereby sex workers can challenge human rights violations. These mechanisms include patient and victim charters, official complaint procedures for mistreatment by health and/or police personnel, access to legal aid, and mediation and arbitration around labour issues.

Support sex worker-led programmes and initiatives. Sex workers are part of the solution, and are best placed to understand what their constituencies need. Civil society organisations should invest time and resources into supporting the development of sex worker leaders who can represent their communities and inspire change.

To Governments[4]

Decriminalise sex work. Governments are urged to recognise and address the relationships between laws criminalising sex work and the human rights violations that result from these laws and policies.

Invest in evidence-based and rights-based health initiatives for sex workers. This recommendation is consistent with commitments identified in national AIDS plans across the region.

Support sex worker-led anti-discrimination and human rights trainings for police and health clinic staff.

Ensure that sex workers have access to police protection. Sex workers should have access to the same protections as others in each country in order to address crimes committed against them.

Hold police accountable. Appropriate disciplinary measures must be taken against police officers who misuse their position and power to extort money and sex from sex workers; subject them to degrading treatment; illegally detain them, or otherwise abuse sex workers' human rights.

…best placed to understand what their constituencies need…

Oppose policies implemented through police raids against sex workers. Governments, UNAIDS, and other UN bodies should explicitly oppose HIV or sex work policies that are

implemented through police raids, or that give police more power to exploit sex workers, or to use physical or sexual violence against them.

...a climate of almost total impunity...

To Funders[5]

Fund and support sex workers' own collective organising and other groups that promote sex workers' rights and health. In many parts of the world, sex worker-led or rights-based projects have shown that they are best suited, and best equipped, to address HIV risks and promote human rights. Their successes are documented in both the public health and human rights literature. They offer a powerful example of how funding and institutional partnerships in support of sex worker organising can achieve tremendous results.

Support mainstream human rights groups and other NGOs to collaborate with sex worker groups to document and confront violence. In the three countries studied, violence against sex workers, including by government officials, has been allowed to continue in a climate of almost total impunity. Documenting and publicising human rights violations is an important advocacy strategy for change.

Support health and rights initiatives dealing with the specific challenges faced by migrant and LGBT sex workers. Migrant sex workers face major obstacles when they attempt to access healthcare and other social services. This systemic exclusion is linked to xenophobia and stigma against migrants and must be addressed. Male sex workers often face homophobia and stigma when they attempt to access appropriate health services. Transgender sex workers, particularly those undergoing physical transitioning, lack access to respectful and adequate medical care.

FOOTNOTES:

1. Crago, A-L. & Arnott, J. 2008. *Rights not Rescue: A Report on Female, Male and Trans Sex Worker's Human Rights in Botswana, Namibia and South Africa. Executive Summary.* Open Society Institute Sexual Health and Rights Project/Open Society Initiative for Southern Africa.
2. Arnott, J. & Crago, A-L. 2009. *Rights not Rescue: A Report on Female, Male and Trans Sex Worker's Human Rights in Botswana, Namibia and South Africa.* Open Society Initiative for Southern Africa/Open Society Institute Sexual Health and Rights Project.
3. *Ibid*, p81.
4. *Ibid*, pp80-81.
5. *Ibid*, p82.

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Real benefits for women...?

Sexual and reproductive health and national AIDS policies

Alessandra Nilo and Wilza Villela

Considering that it is impossible to address women's vulnerability to HIV without an active process of empowering women, the Brazilian NGO GESTOS, in 2007, began a South-South Project in partnership with organisations from different social sectors in Latin America, the Caribbean, Asia, Africa and Eastern Europe, to identify gaps and progress in implementing actions of sexual rights and reproductive rights of women and girls to face the HIV and AIDS epidemics. The activities included capacity building and the creation of strategies to mobilise the community for actions of promotion, research surveys and monitoring.

The Project '*Monitoring the Sexual and Reproductive Health within the National AIDS Policies*'[1] was funded mainly by the Ford Foundation, with support of UNDP and UNAIDS, and was launched in 2007 to supervise the objectives of the UNGASS/AIDS[2] goals, aiming to improve the countries' responses towards strengthening public policies and sexual and reproductive health services for women. The first phase (2007 – 2008) had the participation of 16 countries[3].

At that time, a special guideline was designed to collect data by civil society, an UNGASS AIDS Forum on sexual and reproductive health and rights (SRH&R) was established in each country, and the results were validated through participatory processes with representatives from different social movements. The meetings and workshops were denominated *UNGASS AIDS Forum on SRH&R*.

...it is impossible to address women's vulnerability to HIV without an active process of empowering women...

The main issue highlighted in this first phase showed that although many countries had developed policies and guidelines to protect women's sexual and reproductive health, their implementation was not satisfactory. The government's promises and commitments were not translated into real benefits for women, and there were frequent references in the country reports to lack of access to the services, as well as the low quality of services provided. Poor professional capacity to deal with sexual and reproductive rights and AIDS-related issues was also common; the prejudice against women living with HIV was a frequent problem among different countries, and so was the lack of data

…although many countries had developed policies and guidelines to protect women's sexual and reproductive health, their implementation was not satisfactory…

related to gender-based violence. In all countries AIDS policies and policies for women followed separate paths, with no interconnection or dialogue between them.

Based on these results, the second phase (2009 – 2011), in which 12 countries participated – Argentina, Belize, Brazil, Chile, Indonesia, Kenya, Peru, South Africa, Uganda, Ukraine, Uruguay and Thailand – the research focused on four main issues: a) sexual education, b) sexual and reproductive rights promotion and HIV prevention for young women, c) sexual and reproductive healthcare for women living with HIV, and d) strategies to face gender-based violence against women. Again, the project has made it possible to identify gaps, especially in the field of reproductive health of adolescents and young people; secondary prevention (positive prevention, vertical transmission); and gaps in collaboration among healthcare institutions and organisations that provide social services.

The analysis we made for 2010 (still to be published) showed that although there are many differences among the countries, there are also a lot of similarities among them. Most of the countries refer to at least some initiatives to guarantee sexual education for girls and young women, mainly in the schools, but it occurs on an irregular basis, with more emphasis on the description of the reproductive process, than on the discussion of sexual autonomy. It was confirmed that the existence of a strong lack of any integration of HIV-related policies and policies for women is an obstacle to reducing their vulnerability. Furthermore, women living with HIV are strongly discriminated against when exercising their reproductive rights. And in all countries there is no provision of designated quota for positive women's direct participation in the decision-making processes for the design and monitoring and evaluation (M&E) of their respective national AIDS policies.

Parallel with the researching process ifor 2010, the returns obtained from the surveys in 2008 also formed the basis for an agenda of advocacy actions to be implemented in 2009 – 2011, with

…in all countries AIDS policies and policies for women followed separate paths, with no interconnection or dialogue between them…

priorities being defined by the groups participating in the UNGASS-AIDS Forum on SRH&R in each country. To face all the challenges described, the establishment and development of M&E tools has become a critical issue in most countries where there is great disparity among the speeds of implementation of the planned actions by governments.

...the use of international instruments is a useful and effective way of organising the dialogue between civil society and governments...

In general, between 2007 and March 2010, we have directly mobilised more than 500 civil society organisations, which have had the opportunity to meet the commitments made at the UNGASS-AIDS, and deepen the discussions on their own national policies on AIDS and sexual and reproductive health. As a result, we observed that in all countries the relationship between civil society, government and UN agencies have markedly improved – especially towards the production of the UNGASS/AIDS Country Report in 2010. Also, this project shows that the use of international instruments is a useful and effective way of organising the dialogue between civil society and governments, and that it is possible to articulate several different segments in order to undertake actions that have an impact on the epidemic at country level, taking AIDS discussions beyond the AIDS movement or health sectors. It helps to bring together different movements around cross-cutting issues associated with the AIDS response and the promotion of human rights.

Finally it is important to stress that the results obtained were only made possible by the efforts and dedication of the coordinating organisations of each country[4], as they developed partnerships with Gestos based on the ideal of cooperative construction, and with local autonomy for determining priorities in the implementation of research and advocacy strategies.

FOOTNOTES:

1. See [www.ungassforum.org]
2. Gestos – HIV+, Communication and Gender Issue (www.gestos.org) has been following up on the UNGASS-AIDS since 2001, sharing its experience with many organisations in Brazil and other countries.
3. Argentina, Belize, Brazil, Chile, India, Indonesia, Kenya, México, Nicaragua, Peru, South Africa, Uganda, Ukraine, Uruguay, Thailand, and Venezuela.
4. The coordinating organisations for each country were: FEIM (Argentina), Alliance Against AIDS (Belize), Gestos (Brazil), GAPA-SP (Brazil), Corporación Chilena de Prevención del SIDA – Acción Gay Paolo (Chile), Indonesian Network of PLHIV – JOHTI (Indonesia), Vía Libre (Peru), MOSAIC (South Africa), Raks Thais Foundation (Thailand), UGANET – Uganda Network of Law and Human Rights (Uganda), UNYPA – Uganda Network of Young Positive Paddy Masembe (Uganda), All Ukrainian Network of PLWA (Ukraine), and MYSU & ASEPO (Uruguay).

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Monitoring public policies...

Highlights from South Africa's UNGASS Forum

In 2007, Mosaic and Health Systems Trust initiated an UNGASS Forum with the aim of contributing to South Africa's bi-annual UNGASS reports. The Forum, consisting of over 40 women's and human rights organisations, focuses on the linkages between, and integration of, sexual and reproductive health and rights (SRHR) and HIV and AIDS at various levels.

Marieta de Vos

Meeting a number of times over the past three years, the Forum made recommendations to address the gaps and challenges of integration efforts in South Africa. This initiative is part of a collaborative effort of sixteen NGOs from twelve countries, intended to nurture a south-to-south community-based research and advocacy network for monitoring and evaluating public policies on women's SRHR and HIV and AIDS.

In 2009/10 the Forum gathered information on the above issues, resulting in a report which tracked the progress made by the South African Government towards achieving the UNGASS goals that specifically relate to women and girls' sexual and reproductive health and rights. The report gives qualitative accounts of the experiences of women, girls and children in relation to the UNGASS indicators, and goes beyond official statistics provided in the government report. The report focuses on three main elements, namely:

- Sexuality education, including IEC programmes;
- Sexual and reproductive health and rights services; and
- Violence against women

...this initiative is... intended to nurture a south-to-south community-based research and advocacy network for monitoring and evaluating public policies...

The executive summary of the report, which was submitted to the South African National AIDS Council (SANAC) under the banner of the Women's Sector, was annexed to South Africa's 2010 UNGASS Report, giving credence to the importance of the integration between SRHR and HIV and AIDS.

While this contribution does not allow for a detailed description of the findings of the report, the following highlights some key recommendations included in the report:[1]

- To develop an overarching sexual and reproductive health

and rights policy that integrates HIV and AIDS into SRHR programmes, and conversely, SRHR into HIV and AIDS programmes.

- To adequately address issues of HIV and AIDS and SRHR of abused women in the domestic violence legislation; and to develop an overarching policy framework with implementation guidelines.
- To review and update contraception and termination of pregnancy policies, with a view to providing comprehensive SRHR services and choices to women living with HIV.
- To finalise the integration of cervical cancer as an SRHR issue into HIV policies, and make the HPV vaccine available to women and girls in the public sector.
- To finalise the delayed National Policy Framework of the Sexual Offences Act to ensure adequate protection for victims of sexual violence.
- To decriminalise sex work to protect the health of sex workers, and of the public that utilises their services.
- To review and update ARV treatment guidelines to cover relevant SRHR issues beyond ARVs.

At a structural level the UNGASS Forum recommended the development of a unified M&E framework that is informed by human rights; takes SRHR and quality of care issues into consideration more effectively; and that allows for collection of disaggregated data on SRHR and HIV and AIDS at national, provincial and local levels. The up-scaling of technical skills in government departments and NGOs to implement the Maputo Plan of Action, which aims to provide universal access to SRHR for all citizens, is paramount. Linked to this is the training of nursing, medical and community health workers to integrate SRHR, HIV and AIDS care, as well as screening, counselling and referral of women experiencing domestic and sexual violence.

…to resolutely interrogate cultural norms and traditional practices, in as far as they increase women's and girls' vulnerability to HIV and other SRHR abuses…

Other recommendations regarding access to services include:

- To improve access to services for under-serviced vulnerable populations, such as lesbian, gay, transgender and intersex people, sex workers, and women with disabilities
- To fund research on the epidemics among women who have sex with women (WSW), LGBTI people, and other minority *'most-at-risk-populations'*
- To develop a large scale programme that works with

traditional leaders and communities to resolutely interrogate cultural norms and traditional practices, in as far as they increase women's and girls' vulnerability to HIV and other SRHR abuses

- To promote and provide the Female Condom (FC) on a large scale throughout South Africa

…the SANAC Women's Sector intends to utilise the report to guide its advocacy and service-related programmes for the next two years…

The process of gathering information for the report was a difficult but rewarding one. The SANAC Women's Sector intends to utilise the report to guide its advocacy and service-related programmes for the next two years. Based on the information gathered, already five advocacy alerts have been developed: *Fertility aspirations of HIV positive women*; *Cervical health for HIV positive women*; *Violence against women and HIV/AIDS*; *Lesbian Health and HIV/AIDS;* and *Medical Abortion and HIV*.

There is also the urgent requirement to include linkages and integration between SRHR/HIV/AIDS into the service delivery areas of South Africa's Global Fund proposal(s).

FOOTNOTE:

1. For a copy of the full report go to [www.mosaic.org.za].

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Forced to consent...

Termination of pregnancy *'choices'* for positive women

The 1996 passing of the *Choice on Termination of Pregnancy Act* (No 92 of 1996, as amended in 2004), by South Africa, resulted in changes to the sexual and reproductive health of women, as well as *'a 52% reduction in incidence of infection resulting from abortion'* [1]. Today, South Africa is in relation to its African counterparts, considered to be more progressive with regards to legal recognition and protection of women's sexual and reproductive rights and health.

Lydia Mavengere

This article will argue that since the passing of the Act, it has emerged that the supply of termination of pregnancy services is not able to satisfy the demand; that women are failing to access services, due to a combination of long waiting periods, and discriminatory attitudes and behaviours, resulting in healthcare personnel carrying out unnecessary procedures on women living with HIV. This article further argues that women are being coerced into terminating their pregnancies, for no other reason than the fact that they are living with HIV, yet the same health sector is unable to meet the demand from women genuinely requiring TOP services.

The bulk of the evidence produced to date refers to forced sterilisation, yet the incidences of forced termination of pregnancy are in existence. The article will discuss the cycle of stigma and discrimination faced by women; noting that women living with HIV face stigma and discrimination at the hands of family and community; and ultimately at the hands of healthcare workers, where they would expect to get assistance.

The cycle does not end there; after coerced termination of pregnancy women must go back into the community to face yet more stigma and discrimination. In a community where '*motherhood is revered*'[2] and termination of pregnancy is stigmatised, women are placed in a position of risking ostracism by the community.

THE CHOICE ON TERMINATION OF PREGNANCY ACT

According to its Preamble, the Choice on Termination of Pregnancy Act (CTOP) recognises women's constitutional right to make decisions concerning reproduction and to be in control of their bodies; legalises termination of pregnancy; repeals restrictive provisions of the Abortion and Sterilisation Act of 1975. The Preamble is also very clear about the purpose of the Act, reaffirming that

> *…termination of pregnancy is not a form of contraception or population control...*[3]

The CTOP Act outlines circumstances under which pregnancy may be terminated, and emphasises the need for counselling as part of TOP service provision.

> *The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.*[4]

The Act is also very clear on the need for the consent of a woman, noting that

> *…the termination of a pregnancy may only take place with the informed consent of the pregnant woman.*[5]

…termination of pregnancy, if not outright sterilisation, is often presented as the only option…

The 2004 Amendment of the CTOP Act further exempted '*24 hour maternity services from having to obtain approval for termination of pregnancy*'[6]. With this amendment, more facilities are made available, where terminations of pregnancy could take place. The Amendment further altered the penalty for illegal terminations to

> *…a fine or imprisonment for a period not exceeding 10 years...*[7]

thus extending it from the six month period stipulated in the principal Act of 1996.

INTERNATIONAL OBLIGATIONS AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The South African Choice on Termination of Pregnancy Act adequately responds to a number of international human rights obligations pertaining to women's sexual and reproductive health and rights, including the AU Protocol on the Rights of Women. Murrithi (2007) notes that

> *…the women's protocol is also the first international human rights instrument to expressly frame women's reproductive rights as a human rights issue and guarantee a woman's right to control her fertility.*[8]

…it also appears that a number of unnecessary terminations of pregnancies are taking place…

Murrithi continues in stating that:

> *The Protocol drew inspiration from the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), which state members are to 'eliminate discrimination against women in the field of healthcare' and guarantees women 'the right to access to health care services', and to 'decide freely and responsibly the number and spacing of the children and have access to information, education and means to enable her to exercise this right'.*[9]

More recently, the International Women's Health Coalition (IWHC), highlighted the specific targets set by the United Nations Millennium Development Goal 5 (MDG5[10]) for improving maternal health. The IWHC (2009) cautions, however, that

> *…maternity care is just one element of the comprehensive sexual and reproductive health package needed to achieve MDG 5. The five essential elements of a comprehensive SRH package are: (1) comprehensive sexuality education, (2) access to contraception, (3) safe abortion, (4) maternity care, and (5) diagnosis and treatment of sexually transmitted infections (STIs), including HIV. This package of services enables girls and women to decide whether and when to get pregnant, to decide whether to carry a pregnancy to term, and to experience pregnancy and childbirth safely.*[11]

BOTTLENECKS IN ACCESSING SAFE TOP

Worldwide it is believed, that

> *…half of all unplanned pregnancies end in induced abortion, and half of all abortions are performed under unsafe conditions, 97 percent of them in developing countries*.[12]

Most '*abortions*' occur in developing countries – 35 million annually, compared with seven million in developed countries – a disparity that largely reflects the relative population distribution.[13]

In South Africa, the law provides for TOP services to be available on broad grounds, but adequate access to services provided by qualified personnel remains scarce.[14] Thus, despite amendments to the CTOP Act, to include additional facilities that could carry out terminations of pregnancy, women's access to services in the public health system in South Africa is limited, resulting in long waiting periods in order to access termination of pregnancy services. The IWHC notes that even where '*abortion*' is legal, women's access to safe and adequate services is limited in most countries, due to:

- Excessive regulatory and administrative barriers in public and private healthcare institutions;
- Shortage of skilled TOP service providers;
- The refusal by some healthcare providers to be trained in, or to provide, TOP services and;
- Girls and women's lack of information, money or transportation.[15]

…positive women often find themselves being coerced into medical procedures, such as termination of pregnancy and sterilisation…

COERCION IN THE HEALTH SECTOR

Exploring the impact of HIV-related stigma and discrimination on access to healthcare services, the Pan American Health Organisation (2003) notes that

> *…stigma is a means of social control, defining social norms and punishment for those who deviate from the norm. At the heart of stigma lies the fear that those who are stigmatized threaten society*.[16]

Despite a progressive constitutional and legislative framework in South Africa guaranteeing the right to choice, access to information, as well as bodily and psychological integrity, women, and especially positive women often find themselves being coerced into medical procedures, such as termination of pregnancy and sterilisation, based on HIV-related stigma and related rights abuses when accessing sexual and reproductive healthcare. PAHO further argues that:

> *…at domestic level, there often remains a considerable gap between this legal theory and the reality of individuals. In particular, the weakest members of society are both more vulnerable to HIV and HIV-related discrimination and have least recourse to the law to protect them from discrimination*.[17]

Further discussing the causes and impact of HIV-related stigma, discrimination and other rights violations on levels of access to healthcare services, Genberg et al (2009) note that

these rights abuses have '*a substantial impact on people living with HIV and AIDS*', and argue that although

> *…not as closely linked to the layered stigma observed in concentrated epidemics, HIV-related stigma may still be heightened in populations vulnerable to the historical and socioeconomic processes shaping the social inequalities fuelling HIV/AIDS epidemics and influencing access to and use of prevention, treatment and care services.*[18]

As far back as 2001, the Treatment Action Campaign (TAC) published a pamphlet warning members that

> *…some women undergo abortions or are sterilised without knowing enough about their rights and options to make the most suitable choice.*[19]

While not well documented, the 2001 TAC brochure is arguably an indication that cases of coercion in sexual and reproductive healthcare services have been in existence in South Africa for quite some time.

In South Africa, termination of pregnancy without the supervision of trained healthcare practitioners is illegal, yet many women are unable to access TOP facilities, due to a combination of factors, such as lack of information, resources and capacity, and bottlenecks provided by a healthcare system that requires a lot more resources to respond to the demands of the population. Within these constraints, it also appears that a number of unnecessary terminations of pregnancies are taking place, with reports of women being coerced into terminating their pregnancies, because of their positive HIV status.

Murrithi (2007) argues that

> *…women living with HIV and AIDS are often discouraged by medical practitioners to have children and, in some cases have been sterilized to prevent them from bearing children, due to the possibility of transmitting HIV to their child. The right to bodily integrity, right to family, the right to control fertility, and the right to decide whether or not to have children are violated, and women who choose to have children, are often viewed by society as irresponsible.*[20]

…incidences in which women are forced to 'consent'…

In exploring some of the challenges positive women are facing when accessing sexual and reproductive healthcare, the International Community of Women Living with HIV/AIDS (ICW) notes that

> *…it became evident that there were reports that women in South Africa and other Southern African countries were receiving injectable contraceptives, together with a HAART regimen, to ensure that they would not become pregnant.*[21]

…what right does anyone have to limit the choices of another human being?…

These acts are often carried out on unsuspecting women, who view their medical practitioner with much respect, and therefore, will accept everything they say. Women often believe that their '*doctor knows what is best for them*'. In other situations however, it is often a case of language barriers, and women

not understanding the procedures they are being asked to undergo. What it all points to, is that women's bodies are being violated without their knowledge.

There are also incidences in which women are forced to '*consent*' to termination of pregnancy and/or sterilisation procedures, in order to access other sexual and reproductive healthcare services. Smith (2009) notes that in South Africa

> *…a 14-year-old girl was told she could have an abortion only on condition that she agreed to sacrifice her reproductive rights*.[22]

References to such incidences are also made by ICW members in South Africa:

> *…the doctors also found out I was pregnant. I did not want to have a child at this stage and requested the pregnancy be terminated. The doctors only agreed to the termination on condition that I consented to sterilisation. I had no option*.[23]

…coercive use of contraceptives could be linked to paternalistic population-control measures…

These examples clearly indicate that healthcare practitioners are abusing the trust placed by clients, and giving directed advice, through, for example, advising positive women to limit the number of children to *'not more than two'*. The question, however, remains; what right does anyone have to limit the choices of another human being? In the same light, it appears that women who choose to have their pregnancies terminated are often '*choosing*' the proceedings on the basis of sometimes misleading advice.

…healthcare practitioners are abusing the trust placed on them by clients…

According to ICW (2008):

> *...HIV positive women may 'choose' to have an abortion, because they are misinformed about the possible impact of a pregnancy on their health and that of their child; they may be told that the risks of prenatal transmission are high.* (…) *Misperceptions are heightened by health workers who promote a view that HIV positive women should not have children. Indeed, a number of our members have felt that sometimes healthcare workers present abortion as the only option once a positive woman becomes pregnant*.[24]

Holland-Muter (2007) further notes that:

> *Women living with HIV and AIDS suffer discrimination, often at the hands of healthcare workers, when women are pressured to abort or undergo forced sterilisation, for example, by being threatened to only have access to ARV treatment, if she agrees to undergo sterilisation procedures*.[25]

Women living with HIV have had children successfully on the PMTCT programme, yet, little information is given about this to women, as termination of pregnancy, if not outright sterilisation, is often presented as the only option. As stated by ICW,

> *…women were counselled to not become pregnant, and*

also that they had varying understandings on the side effects of treatment. Some reported that they had realised only later that the injection they were receiving was a contraceptive, and so this had not been their informed choice.[26]

de Bruyn (2006)[27] reported similar findings, noting some anti-retroviral treatment programmes require women to use provider-defined contraceptive methods to be eligible for treatment. It could also be argued that such coercive use of contraceptives could be linked to paternalistic population-control measures that take charge of women's fertility by withholding information from clients.[28]

These coercive practices in sexual and reproductive healthcare, which positive women are subjected to, not only constitute gross human rights violations, but are also in violation of Article 14 of the AU Protocol, which states

…that women's sexual and reproductive health is to be both respected and promoted, which is predicated on women's right to control their fertility and by an obligation of states to provide adequate, affordable health services.[29]

THE WAY FORWARD

Healthcare workers that coerce women into undergoing termination of pregnancy procedures are exercising population control, violating women's sexual and reproductive rights, and acting against provisions of the CTOP Act, which clearly states that termination of pregnancy has to be based '*non-directive counselling*' and '*informed consent*' of the pregnant woman. Furthermore, as stated by ICW, coercive practices are a violation of the rights of women living with HIV to

…unbiased healthcare, self-determination, to decide the number and spacing of our children, to freedom from gender-based discrimination, and to freedom from inhuman treatment.[30]

What is required going forward, is capacity building amongst both healthcare providers and women living with HIV, so as to ensure adequate knowledge of, and adherence to, women's sexual and reproductive health and rights. The ICW suggests the provision of information about access to safe and legal TOP services, adding that it should form part of a holistic package of information and advice that also includes prevention of vertical transmission of HIV services.

…women's bodies are being violated without their knowledge…

Improved information about, and access to, preferably free, unbiased, legal, safe and confidential pregnancy, childbirth, and/or abortion services for HIV-positive women, and better training and awareness-raising for health workers to reduce the frequency of forced abortion and forced sterilization of HIV-positive women.[31]

Finally, as argued by ICW, public health systems need to look more seriously at comprehensive prevention of vertical transmission of HIV services that focus on the health of both the mother and of the child. Closer attention needs to be paid to the MDG5; and the five essential elements of a comprehensive sexual and reproductive health

package, which are (1) comprehensive sexuality education, (2) access to contraception, (3) safe abortion, (4) maternity care, and (5) diagnosis and treatment of sexually transmitted infections (STIs), including HIV.

…even where *'abortion'* is legal, women's access to safe and adequate services is limited…

FOOTNOTES:

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3. Choice of Termination of Pregnancy Act, No 92 of 1996, Preamble.
4. *Ibid*, Section 4.
5. *Ibid*, Section 5(1).
6. *Ibid*, Preamble.
7. *Ibid*, Section 6(1)(d).
8. Murrithi, C. 2007. 'A tool for claiming sexual and reproductive rights: The AU protocol on the rights of women'. In: *ALQ*, March 2007, pp9-13. p9.
9. *Ibid*, p12.
10. The goal of MDG5 is to improve maternal health and achieve universal access to reproductive healthcare by 2015 by reducing the maternal mortality ratio and increasing the proportion of birth attended by skilled health personnel. Achieving universal access to reproductive health is measured by (1) contraceptive prevalence rate, (2) adolescent birth rate; (3) antenatal care coverage and at least four visits; and (4) unmet need for maternity planning. [www.mdgmonitor.org/goal5.cfm]
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13. Guttmacher Institute. 2009. Facts on Induced Abortion Worldwide: In Brief. [www.guttmacher.org/pubs/fb_IAW.pdf]
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29. As quoted by Murrithi, 2007, p11. See Murrithi, C. 2007. 'A tool for claiming sexual and reproductive rights: The AU protocol on the rights of women'. In: *ALQ*, March 2007, pp9-13.
30. International Community of Women Living with HIV/AIDS. 2008. 'Addressing the needs of HIV-positive women for safe abortion care'. June 2008. p1. [www.icw.org/node/338]
31. *Ibid*, p2.

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Dis-information and mis-information...
Forced sterilisation of Roma women in Slovakia

Sabrah Møller

The discrimination against the Roma population dates back to Nazi Germany, in which the Roma population was sterilised without their consent as a means to prevent the Roma population from reproducing. The end of the Third Reich did, however, not end the discrimination against the Roma. In fact, the discrimination and other rights abuses of the Roma population still prevails in several countries today.

INTRODUCTION

The perspective of this paper is on Slovakia and its treatment of the Roma people. Slovakia joined the European Union (EU) in 2004, and thus fulfilled the Copenhagen Criteria[1]. The overall focus of this article is on the reproductive health of Roma women, and how they have been subjected to discrimination and other rights abuses by hospitals, medical authorities, and the government. The article will provide a historical overview on discrimination against the Roma population; explore how healthcare can be used as a means of discrimination; and introduces some of the findings of a study conducted by the Centre for Reproductive Rights on coercive sterilisation of Roma women in Slovakia.

DISCRIMINATION AGAINST ROMA POPULATIONS

Roma women experience discrimination not only as Roma, but also as women. The intersections between these various kinds of marginalisation cause Roma women to be particularly vulnerable to discrimination and other rights abuses. But before investigating how such discrimination particularly takes place in Slovakia, a definition and a historical overview of the kind of discrimination particularly against Roma people will be illuminated.

In Nazi Germany, Roma people were subjected to persecution throughout Europe. As of 14 July 1933, the Nazi government legalised forced sterilisation of Roma women, and other population groups, which were declared '*unwanted*'. This law was passed as a means to control the Roma population from reproducing, since, as argued by the Nazi government, Roman people were '*diseased*', and allowing the Roma to reproduce, would thus allow the '*disease*' to spread.

The practice of coercively sterilising Roma women did not come to an end after the Second World War. In Czechoslovakia, financial incentives were given for Roma women to be sterilised. Although, the sterilisation programme was available to the whole population, and everyone was equally entitled to receive compensation for being sterilised, Roma women were particularly targeted to undergo sterilisation procedures.[2]

Since the end of the communist rule in Eastern Europe, Roma people have been subjected to further discrimination, occurring at all levels, but more specifically when it comes to housing, education, employment, public services, as well as criminal justice.[3] In Slovakia, Roma people are usually placed in settlements, which have limited access to basic services, such as water, electricity, and infrastructure. The unemployment rate is normally high in these areas, as most of Roma people have

not attended school, or, at most, graduated from secondary school.[4] Further violations of their human rights are due to a lack of recognition from the local communities and authorities alike, which complicates registering for public services, such as school, voting, and/or residential permits.

In 1988, the Czechoslovakian government passed a law, which aimed at sterilising Roma women, without implicitly mentioning the sterilisation of Roma women as its purpose. The law undermined the right of the Roma women to give consent to the sterilisation procedure, stating that the sterilisation of Roma women would be in '*the interest of the health of the population*'.[5] The Act further stipulated that women would receive up to 25,000 Slovak Crowns for being sterilised; an amount equalling a year's salary.

…various kinds of marginalisation cause Roma women to be particularly vulnerable to discrimination and other rights abuses…

MEDICAL '*JUSTIFICATIONS*'

Medical personnel in Slovakia justified the use of sterilisation against Roma women based on various factors, most of which were outdated and inaccurate. As most Roma women cannot read[6], they were not in the position to read their medical records and/or understand consent forms, without adequate explanations and assistance. Some of the reasons given for sterilisation included that when women undergo a caesarean procedure, all the following deliveries have to be caesareans as well. In addition, women who did deliver through caesareans, had the procedure done with vertical incision in the upper abdominal area, and not, as it should have been performed, with a horizontal incision in the lower uterine segment, increasing the risks of complications in future pregnancies. Based on this misguided information, doctors will convince women that undergoing more caesareans would severely jeopardise their general health and well-being, and may also result in death of either the unborn child or the woman herself. The international medical perspective on caesareans does not justify that a woman can only have a limited number of caesarean births.

…a means to prevent the Roma population from reproducing…

The practice of sterilisation of Roma women without consent also raises questions as to the role of the Slovakian government at the time, the challenges it poses to the government itself and its membership of the European Union; as well as how the international community react to the atrocities committed against the Roma population.

STERILISATION REALITIES AND EXPERIENCES

In terms of sterilisation, it is important to bear in mind the different notions of '*coerced sterilisation*' and '*forced sterilisation*'. '*Coerced sterilisation*' refers to a situation in which women are '*forced*' to agree to undergo the sterilisation procedure; and '*forced sterilisation*' means that women are unaware of the procedure taking place.[7]

In 2002, the Centre for Reproductive Rights (CRR) began to investigate the violations of human rights of Roma women, particularly focusing on cases of sterilisation without consent.

Based on interviews with women who were pregnant and gave birth at a clinic, data on their experiences with the Slovakian healthcare system have been generated. While the research identified a wide range of human rights abuses, the following will only highlight some of the findings pertaining to '*coerced*' and/or '*forced*' sterilisation realities and experiences of Roma women in Slovakia.

Coerced sterilisation

Roma women who had previously given birth were told by doctors that there would be increased health risks during the next pregnancy, and women may even die, if not sterilised – highlighting some of the exaggerated statements made by medical personnel to get women to '*consent*' to being sterilised. Even though women may have agreed to being sterilised, unveiling the methods with which women's consent was obtained, raises serious concern.

A 20 year old mother of two, from Rudnany, stated that she was asked during child birth to sign a paper that allowed the doctor to sterilise her right after the delivery of her child, without any further explanations about risks and implications of such procedure. Interviews with healthcare providers, particularly doctors, further revealed that doctors recommended that a woman should be sterilised after her second or third caesarean birth, as additional caesareans can '*lead to a ruptured uterus, causing grave harm or even death to the woman or her foetus*'.[8] In addition, one doctor stated that he would sterilise a woman after her third caesarean, without her consent, if he thought that the health risks for future pregnancies are severe enough.

…Roma women were particularly targeted to undergo sterilisation procedures…

Despite the inaccuracy of the medical information presented to women, there is also a concern about the '*timing*' when women are given this information; as most women were presented with the '*choice*' of sterilisation during child birth rather than in a more conducive environment, in which women can get the information and make an informed choice.

Forced sterilisation

The data also revealed that 40 % of the 60 women interviewed were only told about the performed sterilisation after the procedure had taken place; and some recalled being asked to sign the consent form after the procedure had been done. In most cases, women only realised that they were sterilised, because they were not able to conceive after their last delivery. A 32 year old woman from Richnava with five children testified:

> *...before I was released, they gave me something to sign, but I did not know what it was and they did not explain it to me. Later I was given a medical release report where it was written that I was sterilised.*[9]

In another case, an 18 year old woman from Drahnov discovered she was sterilised, became upset with the doctor performing the procedure without her consent, and was then told she could reverse the operation by paying 5,000 SKK, which equalled the monthly social benefit her and her husband received.[10]

Being sterilised at a young age is another concern. A young woman from Bystrany, who have had two caesareans, was told, at

the age of 17½ that she needs to be sterilised as she was '*too narrow*'; even though her medical records show no indications to that effect.[11] Her parents were not involved in the signing of the consent; she signed, as a minor, to consent to the procedure, even though the law states that underage minors, who are not married, need the consent of their parents to procedures, such as sterilisation.

…exaggerated statements made by medical personnel to get women to *'consent'* to being sterilised…

STERILISATION AND THE LAW IN SLOVAKIA

In 1972, the Regulation of Sterilisation (The Regulation) was passed in Slovakia. The 1966 Law on Health, which was to be a part of the Regulation, clearly stated that

> *Sterilisation can be performed only with the consent or based on specific request of the person who shall undergo sterilisation under the conditions established by the Ministry of Health*.[12]

Doctors and other medical personnel, as well as the Ministry of Health, considered the Regulation on Sterilisation as valid and used in practice. More specifically, the Regulation on Sterilisation states that a woman below the age of 35 can only undergo sterilisation if she has four or more children who are alive. A woman above the age of 35 can undergo sterilisation if she has three or more children who are alive. The Regulation also determined that if there are incentives to perform sterilisation, the decision made by the woman should be evaluated by the hospital's sterilisation commission, which consists of the director of the hospital in question, the chief gynaecologist of the hospital, and a sterilisation expert.[13] The request to perform a sterilisation is to be completed by the doctor with the patient's consent, and submitted to the commission. An examination of the person will then take place within three weeks after submitting the request to the commission. The commission can only accept the sterilisation, if there is medical justification for doing so. Furthermore, a document regarding the discussion and decision of the sterilisation is required. For the sterilisation to take place, all the requirements have to be fulfilled to perform a sterilisation which is in line with the law.

…sterilisation of Roma women would be in *'the interest of the health of the population'*…

The above clearly indicates that the law is obviously '*ignored*' by medical staff who makes up its own justifications as to why the Roma women should be sterilised, and who pays little attention to the outlined legal requirements for performing sterilisation procedures on women in Slovakia – not only violating national and regional laws, but also international laws protecting women's right to informed consent in sexual and reproductive healthcare.

INTERNATIONAL INTERVENTIONS

Slovakia has since become a member of the European Union in 2004. On 28 April 2009, Slovakia was sentenced by the European Court of Human Rights (ECHR) for violating the rights of eight Roma women, who had been denied access to their medical records regarding their reproductive health. The

…most women were presented with the *'choice'* of sterilisation during child birth…

women suspected to have been sterilised without their consent, after they realised that they were no longer able to conceive. The women contacted the Centre for Civil and Human Rights (CCHR) to get legal assistance to view their medical records. When the women approached the clinics, the medical personnel turned them away, or argued that the women themselves had to copy the files in question, as there was no particular reason for the clinic to photocopy the records.

CCHR stated that refusing to take photocopies of their records was a violation of the women's right of her personal life. Furthermore, being denied access to information on her reproductive health was also considered a severe violation of the applicants' rights. Each woman was awarded 3,500 Euros for damages.[14] Slovakian officials appealed the case, but it was overruled, and the Slovakian government had to pay compensation to the women.

Even though Slovakia today is a member of the European Union, human rights violations still take place. Ostalinda Maya, a women's rights advocate from The European Roma Rights Centre confirms that. In 2009, the Czech government officially issued a statement of regret about performing sterilisations of Roma women without their consent. Maya explains that the Slovakian government has remained silent about it until now, but she hopes that the Czech government's response will urge the Slovakian government to perform similar actions and compensate women who have been subjected to coerced and/or forced sterilisation.

Earlier in 2009, before the court settlement, the Slovakian government denied that there was sufficient proof of sterilisation procedures occurring in Slovakia. However, Maya, argues that cases of sterilisation without consent are still occurring:

> *The systematic sterilisation programme ended with the fall of communism. But we know that after that there were still forced sterilisations, some very, very recently. There is still a strong degree of racism towards the Roma that exists in* [Czech and Slovak] *society*.[15]

FOOTNOTES:

1. The Copenhagen Criteria, established at the June 1993 European Council in Copenhagen, Denmark, stipulates criteria for a new member state of the European Union as follows: 1) stable institutions guaranteeing democracy, the rule of law, respect and protection of minorities through human rights; 2) a functioning market economy which should have the capacity to master competition, as well as the market forces within the Union; and 3) accepting the obligations of the membership by adhering to the aims of a political, economic and monetary union. [http://europa.eu/scadplus/glossary/accession_criteria_copenhague_en.htm]
2. Center for Reproductive Rights. 2003. *Body and Soul: Forced Sterilization and Other Assualts on Roma Reproductive Freedom in Slovakia* . [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/bo_slov_part2_0.pdf]
3. *Ibid*.
4. *Ibid*.
5. *Ibid*.
6. *Ibid*.
7. *Ibid*.
8. *Ibid*.
9. *Ibid*.
10. *Ibid*.
11. *Ibid*.
12. *Ibid*.
13. *Ibid*.
14. European Court of Human Rights, 2009. [http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=849867&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649]
15. Stracansky, P. 2009. *BALKANS: Apologising to Sterilised Roma Women – Slovakia´s Turn*. [www.galdu.org/web/index.php?odas=4174&giella1=eng]

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Viewed as 'feminised'...

Gender dimensions of sexual minorities and the response to HIV and AIDS in India[1]

Tahmid Chowdhury, Lily Walkover, L. Ramakrishnan, Pawan Dhall, Manish Soosai, Tyler Crone, and Sai Subhasree Raghavan

INTRODUCTION

Concerning the HIV epidemic in India, as in many other nations, men who have sex with men (MSM), transgendered people, and other sexual minority groups are considered to be *'high-risk groups'*, with high prevalence of HIV among them. Unlike with other high-risk groups, such as female sex workers, HIV transmission is often misjudged to be contained within sexual minority populations, and they are often conceptualised as a monolithic group separate from the rest of society. However, one cannot presume that there are fixed distinctions between populations with no overlap, as individuals do not necessarily fall into single categories – for example, many MSM are also married to women, and therefore, can potentially transmit HIV to both men and women. In India, the transmission route of HIV is predominantly sexual, responsible for 87.4% of the 2.47 million cases.[2]

…HIV transmission is often misjudged to be contained within sexual minority populations…

To address the specific HIV vulnerabilities of sexual minority groups, the complex gender dimensions of these groups must be taken into account. Though there has recently been an increased focus on gender, the discussions around engendering the HIV response in India until now have focused largely on a binary conception of gender; of female and male. Gender is not a biological designation, but rather a socially constructed conception of the attributes associated with being male and female. Gender is a spectrum, and a binary comprehension of it ignores key populations that have traditionally been marginalised, but must not be ignored, most notably men who have sex with men and transgender people. Therefore, though significant focus should be placed on the vulnerabilities of women, the empowerment of other marginalised gender groups that are similarly disempowered, because they are viewed as '*feminised*', must be concentrated on as well, as the vulnerabilities of all of these populations are interconnected.

In order to effectively reduce the vulnerabilities of women and sexual minorities, pervasive societal attitudes must change. The traditional roles of man/woman, husband/wife, provider/homemaker, must be re-imagined. Although gender dynamics cannot be equalised in a single generation, interventions encouraging specific behavioural changes and focusing on empowerment can have a large impact on reducing the vulnerability of sexual minorities to HIV. Analysing the HIV response from a gendered lens is not just about focusing on women as female, or on sexual minorities as frequently feminised populations, but about emphasising the social forces that place individuals in marginalised situations.

To create effective targeted interventions to change the behaviour of dominant social groups and empower marginalised groups, the historical underpinnings of gender dynamics in the Indian context must be understood. An understanding of the theoretical background of gender in India will help to inform interventions that aim to equalise the power differential between sexual majority and minority groups.

…the vulnerabilities of all of these populations are interconnected…

This article provides a brief background of the historic conception of gender and sexual minorities in India, followed by a review of the vulnerabilities of various gender groups to HIV. In addition, this article explores some of the issues regarding sexual minorities that must be tackled to specifically respond to the vulnerabilities of sexual minorities to HIV.

GENDER THEORY AND SEXUAL MINORITIES IN THE INDIAN CONTEXT

Like with women, the increased vulnerability of sexual minorities to HIV is partly due to physiological factors, but also due to the stigma and discrimination that come from stepping outside normative gender roles. The perception of most sexual minorities as '*feminised*' individuals adds to their low societal status, increasing the structural violence perpetrated against them.

…the social forces that place individuals in marginalised situations…

To comprehend the gender-based vulnerabilities of sexual minorities, the difference between gender, sex, and sexuality must first be understood. '*Gender*' can be defined as the behavioural, cultural, or psychological traits typically associated with one sex.[3] The concept of '*gender*' is distinct from '*sex*,' which can be defined as biological forms differentiated by reproductive organs and denoted in most species as '*female*' and '*male*'; and '*sexuality*', which refers to the sexual interests of an individual.[4] Traditional gender roles have frequently been used to exert social control by one gender over the other, over resources, and in extreme cases, over individual bodies. Because HIV is primarily a sexually transmitted disease in India, it is important to understand these distinctions and the impact that these categories have on an individual's vulnerability to HIV.

The following section will describe representations of gender and same-sex relations in Indian texts, reviewing salient aspects of this history in order to better understand the creation of current cultural dynamics and traditional gender roles that influence sexual minorities' vulnerability to HIV.

Ancient and medieval texts

As Ruth Vanita explains in her discussion of ancient Hindu texts such as the *Vedas* and *Upanishads*, contemporary definitions of '*men*' and '*women*' have hardened in comparison to ancient texts, in which gender is seen as much more fluid, especially in its relationship with sexuality.[5] This discussion follows from her analysis of the dominant social view

of homosexuality at the time, which she describes as '*unsanctioned*', but treated as a '*minor offence*', citing much more severe punishments meted out for sexual crimes, such as rape of a minor.[6]

In Indo-Muslim texts that emerged during India's medieval period, homosexual sex is clearly banned, yet four eyewitnesses are required for persecution, implying that punishment would have been rarely meted out.[7] Increased acceptability of homosexual activity, however, arises from within Sufism, the mystical dimension of Islam. Further, specific poetic movements that arose towards the end of this era show continuing changes in the perception of gender and sexuality, and social acceptance of variance among both.[8] An example is the emergence of Rekhti poetry in the late eighteenth and nineteenth centuries, which was written by men in the female voice and banned for obscene language and explicit descriptions of lesbian sex.[9]

…to equalise the power differential between sexual majority and minority groups…

…due to the stigma and discrimination that come from stepping outside normative gender roles…

Colonial artefacts

The impact of British Victorian culture, and the way in which it interacted with social restrictions introduced during Muslim rule and in the rise of Hindu fundamentalism, is debated.[10] During the nineteenth and twentieth centuries, homophobia increased, as epitomised by the introduction of an anti-sodomy law, Section 377 of the Indian Penal Code, by the British.[11] This had been a very direct and important link with the current spread of HIV in India, as it literally made certain sexual acts illegal, driving those who partake in these acts underground and making programming aimed at increasing safer sex between men difficult. The advocacy efforts of the Naz Foundation (India) Trust, and other organisations, has resulted in this Section being read down on July 2, 2009; decriminalising same-sex relations among consenting adults[12]. However, the influence that Section 377 has had on Indian society will have long-lasting effects that must continue to be confronted.

Historical representations of gender and vulnerability to HIV

It is important to understand the history of the construction of gender in the Indian context, in order to understand the current gender roles that are assigned to women and sexual minorities, the ways in which this impacts their vulnerability to HIV, and what can be done to reduce those vulnerabilities. History shows that gender roles and the concept of '*men*' and '*women*' have changed over time. Sub-cultures within India have shown considerable acceptance of the importance of women's participation in society, as well as that of sexual minorities, and it has been argued that increasingly conservative restriction of the roles of women and feminised populations has arisen in the last century, influenced by Hindu fundamentalist, Muslim Moghul, and British Christian Victorian systems of thought. These restrictions have led to the disempowerment of women

and other feminised populations, which has in turn reduced their ability to negotiate for their own right to health. In order to empower sexual minorities to reduce their vulnerability to HIV, it is necessary not only to give them basic tools, such as education, condoms, and medicine, but also to grant them an equal place in society, in terms of such basic rights as property ownership and literacy, as well as the social freedom to act on these rights.

SEXUAL MINORITIES AND HIV AND AIDS

In 2007, 7.4% of MSM in India were living with HIV and AIDS.[13] However, accurate statistics regarding sexual minorities in India are difficult to obtain, because many men do not report their same-sex behaviours, lack consciousness of their sexual identity, or do not identify their activity as MSM, because their partners are not perceived as men.[14] Many MSM do not exclusively engage in sexual activity with other men; through marriage and sexual encounters, *kothis* (men who are penetrated), *panthis* (men who penetrate), and *hijras* (male to female transgender people who are often penetrated) and their sexual partners often also act as a bridge population, passing on HIV to the general female population.

This paper does not address issues affecting women who have sex with women; partly because of the much lower risk that sex between women carries for transmission of HIV, than sex between men and between men and women. It is also in part because the double marginalisation they face, of being female and expressing sexual interest in other women, renders them socially invisible to a large degree.[15]

The physiological vulnerability of MSM and transgender populations to HIV in India

Penetrative anal sex carries an especially high risk of HIV transmission for the receptive participant.[16] The risk is several times higher, than the next riskiest sexual activity: women engaging in unprotected vaginal sex with an HIV-positive man. The rectal lining is thin and can easily tear, and even small lesions are enough to allow access for the virus. Even without lesions, it is theorised that the cells of the rectal lining may have a lower natural immunity to HIV, than those in the vaginal lining.[17] Further, the presence of other sexually transmitted infections, such as syphilis, gonorrhoea, and Chlamydia, increase the risk of HIV transmission.

…stigma and discrimination of sexual minorities can result in physical and emotional distress, furthering vulnerability and disempowerment…

The impact of stigmatisation on the vulnerability of MSM and transgender populations to HIV

In India, men who are anally penetrated by other men are highly stigmatised, as the receptive act is perceived as feminine.[18] Such stigmatisation based on misogynistic stereotypes resulting in the '*feminisation*' of males, and the way in which groups, such as *kothis* and *hijras* challenge traditional gender norms, leads to various human rights abuses, blackmail, violence, rape, and denial of resources.

Discrimination also often results in a hierarchy among

people living with HIV, in that positive sexual minorities are often stigmatised by other people living with HIV, whose routes of transmission are thought of as '*normal*' – a hierarchy that also arises between positive female sex workers and women living with HIV who are not involved with sex work. Feminised males are vulnerable not only because of poverty, but also because of the sexual and gender roles they play within male sexual practices.[19] Further, stigma and discrimination of sexual minorities can result in physical and emotional distress, furthering vulnerability and disempowerment.

…it cannot be assumed that even their self-described gender roles are exclusively maintained…

Among *kothis*, *panthis*, and *hijras*, it cannot be assumed that even their self-described gender roles are exclusively maintained.[20] For example, crossing of '*gendered*' boundaries exists among *kothis*, who sometimes penetrate other males, although this type of behaviour is kept secret. Males who engage in sexual activity with *hijras* often do not consider themselves to be engaging in homosexual activity, since the *hijras* are considered to be like women. Men who have sex with *kothis* and *hijras* easily merge into normative society, their sense of masculinity maintained, because they are the penetrators, not of other men, but of '*not-men*'.[21]

TAKING ACTION

There must be targeted interventions to address the specific vulnerabilities of sexual minorities to HIV more holistically, putting a larger emphasis on the empowerment of these populations. Intervention approaches targeted at women detailed in a previously published companion piece[22] are largely relevant for sexual minority populations as well.

The vulnerabilities to HIV of sexual minorities arise from deeply entrenched inequity. In order for a person to act upon their human right to health, they must be recognised by society; as social marginalisation is the underlying barrier that prevents sexual minorities from being able to support their own health. In order for sexual minorities to claim their full right to health, their status as full members of society must be acknowledged.

The past decade has been an important historical moment for asserting the rights of sexual minority in India and increasing their visibility. Indian media and Bollywood, the Indian film industry, in particular, have done much to mainstream depictions of sexual minorities. Though the behaviour of sexual minorities is still largely depicted as '*unnatural*', the number of neutral or positive representations is increasing. And with the recent reading down of Section 377 of the Indian Penal Code to decriminalise same-sex relations, high-profile events such as *Kashish*, the first official queer film festival to be hosted in India introduced

…social marginalisation is the underlying barrier that prevents sexual minorities from being able to support their own health…

in April of 2010, have been possible, further increasing the visibility of sexual minority issues. Furthermore, sexual minority advocacy groups and coalitions have strengthened, and events such as gay pride parades are becoming increasingly common in cities across India.

…simply enhancing the status of sexual minorities is not enough to ensure that structural violence does not continue…

Though it is imperative that the rights of sexual minorities be upheld and equal status in society be achieved in order for their vulnerabilities to HIV to be reduced, simply enhancing the status of sexual minorities is not enough to ensure that structural violence does not continue to be perpetrated against them. Because societal perceptions of sexual minorities are as a '*feminised*' population, and so linked to perceptions of women, a main goal for the empowerment of sexual minorities, a parallel goal must be to improve the status of women as well. Without focusing on the rights of women as well, equality for sexual minorities will be difficult to achieve.

FOOTNOTES:

1. This article is a continuum of a previously published article on engendering the response to HIV and AIDS in India. See Chowdhury, T. et al. 2010. 'Pervasive societal attitudes must change: Engendering the response to HIV and AIDS in India'. In: *ALQ/Mujeres Adelante,* January 2010 Edition, pp36-46.
2. Indian Ministry of Health and Family Welfare, National AIDS Control Organisation. 2008. *UNGASS country progress report 2008: India.* New Delhi: NACO.
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4. *Ibid*.
5. R. Vanita, R. & Kidwai, S. Eds. 2001. *Same-sex love in India: Readings from literature and history*. Delhi: Macmillon India. pp22-23.
6. *Ibid*, p25.
7. *Ibid*, p111.
8. *Ibid*, pp120-123.
9. *Ibid*, p191.
10. *Ibid*, p196.
11. Ibid, p194.
12. 'Gay sex decriminalised in India'. *BBC News*, June 2, 2009. [http://news.bbc.co.uk/2/hi/south_asia/8129836.stm]
13. Indian Ministry of Health and Family Welfare, National AIDS Control Organisation. 2008. *HIV sentinel surveillance and HIV estimation in India 2007: A technical brief*. New Delhi: NACO.
14. Khan, S. 2004. *MSM and HIV/AIDS in India*. Naz Foundation International.
15. Fernandez, B. & Gomathy, N.B. 2003. *The nature of violence faced by lesbian women in India.* Mumbai: Tata Institute of Social Science.
16. UNAIDS. 2000. *AIDS and men who have sex with men*. Geneva: UNAIDS.
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19. *Ibid*.
20. *Ibid*.
21. *Ibid*.
22. Chowdhury, T. et al. 2010. 'Pervasive societal attitudes must change: Engendering the response to HIV and AIDS in India'. In: *ALQ/Mujeres Adelante,* January 2010 Edition, pp36-46.

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Visibility and backlash...

Civil rights and social life of LGBTQ people in Zimbabwe

Kate Griffiths

The rights of sexual and gender minorities have become an increasingly tense subject across Africa, as both the visibility of gay, lesbian, bisexual, queer and transgender identities have become heightened in daily life and the media, while punitive legislation and alarmist anti-gay politics have spread across a number of African nations. Thirty-seven (37) countries on the continent have criminalised homosexuality, while only South Africa has established specific constitutional protections and legal partnership rights for same-sex couples.

In Zimbabwe, this backlash is best observed at the pubs and clubs that once hosted a burgeoning gay nightlife in central Harare – now shuttered or transformed into bland, general audience sports bars and watering holes; reminders of the more hopeful 1990s and the nation's ongoing economic crisis.

THE PERSONAL AND THE POLITICAL IN ZIMBABWE

Here, a dynamic of increased visibility, criminalisation and political attacks on the rights of '*queer*' people has been a significant element of social and political life since the 1990s, but has reached a new apex as the main political parties in the fragile unity government and civil society take on the process of rewriting the nation's constitution and preparing for new elections. In this context, homosexuality rests at the centre of a number of social and political fault lines – '*western*' influence versus African '*tradition*', global human rights standards versus national '*sovereignty*', Christianity versus secularism, majority rule and the rights of minorities, fast-changing gender roles and the spread of the HIV and AIDS epidemics.

Amidst a political situation, marked by starkly drawn party divisions and periodic political violence, homosexuality seems to be one of the very few areas in which leaders in both ZANU-PF and the MDC come close to agreement. In 1995, in the midst of a controversy around the appearance of the human rights organisation, Gays and Lesbians of Zimbabwe (GALZ), at the International Book Fair in Harare, Zimbabwean President Robert Mugabe and leader of ZANU-PF famously compared gays to '*dogs and pigs*', saying that he found gays '*repugnant to* [his] *human conscience*', a stance he has reiterated in the current incarnation of the debate. Meanwhile, Morgan Tsvangirai, the country's Prime Minister and leader of the opposition party, the Movement for Democratic Change (MDC), sparked confusion as to the stance of his party saying that while he found homosexuality personally offensive, there is '*no place*' for hate speech against social and political minorities in Zimbabwe, including LGBTQ people. His own remarks, however, crossed the line into confused intolerance, with his statement that

> *…the president has spoken about gay rights, about some men who want to breathe into other men's ears. I don't agree with that. Why would you look for men when our women make up 52% of our population? Men are much fewer than women.*[1]

Most importantly, both leaders agree that legal protections for gay, lesbian, bisexual and transgender

individuals and same sex-relationships have no place in the next constitution.

Nevertheless, the headlines blare political leaders' personal indignation and ignorance on the subject of homosexuality, and the increasingly narrow political space for defending gay rights in the law, do not tell the whole story of the development of gay, lesbian, bisexual and transgender identities, organisational and social life in Zimbabwe, and obscures both the danger and the hope that sexual and gender minorities face as part of daily life. While publicly LGBTQ identities, communities and organisations have become increasingly visible in Zimbabwe since the 1990s, increasingly repressive laws, social and political violence and extreme economic conditions have taken their toll on '*queer*' people individually and collectively. Caught in the middle of Zimbabwe's own culture wars and high-stakes politics, '*queer*' people can and do successfully search out spaces of sanity, safety and hope.

ZIMBABWE'S LEGAL BACKLASH

The constitutional debate on gay rights in Zimbabwe is not the first time the question of gays and the law has been broached. Though homosexuality itself is often condemned by anti-gay campaigners as a foreign, western or colonial imposition on African societies, historical and anthropological evidence suggests that homosexual sex had legitimate social roles in many African societies. Modern Zimbabwean laws criminalising homosexuality instead have their roots in British colonial law, exported to its many colonies forbidding sodomy, defined as '*carnal intercourse against the order of nature*'. This formulation in some instances is interpreted to forbid not only sex acts between two women, but also anal sex between men and women.

In current Zimbabwean law, sodomy is defined as anal sex between two men, and is illegal. Following the emergence of a visible and organised gay community in the 1990s in Zimbabwe, this language was significantly expanded in 2004, extended from banning private, difficult-to-prove behaviours to outlawing vaguely defined public displays. This legislation made illegal any physical contact between two men that any '*reasonable person*' would regard as '*indecent*'. Harkening back to the colonial era, common law also prohibits undefined '*unnatural acts*', which could be used to prosecute lesbians, bisexual women, and gender-non-conforming people of all stripes. It is this combination of laws, which is generally referred to when journalists and commentators note that homosexuality is illegal in Zimbabwe.

…punitive legislation and alarmist anti-gay politics have spread across a number of African nations…

These laws are rarely enforced in terms of policing the private behaviours of consenting adults, but they have served to drive a once-visible gay night life in major cities, like Harare, underground. Human Rights Watch[2] reports that the laws have generally been used to prosecute acts of rape and child molestation, though the law and prosecutors are largely indifferent to consent, instead focusing on forensic evidence intended to prove that *'unnatural acts'* have taken place. These prosecutions conflate rape, child abuse and homosexuality, by using anti-gay legislation to prosecute acts that are already illegal. The historical and political imagination of homosexuality in Zimbabwe tends to reinforce this conflation, in part due to

a same-sex rape scandal involving Rev. Canaan Banana, Zimbabwe's first president, which resulted in Banana being imprisoned and defrocked. In some key instances the laws – along with blackmail attempts – have been used to harass and silence LGBTQ activists, including Keith Goddard, a leader of GALZ.

…both leaders agree that legal protections … have no place in the next constitution…

DAILY DISCRIMINATION

Even more fundamental to the daily lives of '*queer*' people, than this threat of political and legal harassment, is the day-to-day discrimination that many face, particularly those who are obviously gender non-conforming. For many Zimbabweans, homosexuality contravenes not mainly, or only, their conceptions of '*African-ness*' and '*tradition*', but also a conservative brand of Christian morality that has its roots not only in the early days of colonial anti-vice legislation and missionary enthusiasm, but also in the increasing popularity of non-denominational form of American Christian evangelicalism, which imports its own highly-politicised approach to homosexuality and gender identity. Books, lectures and gospel music containing messages of personal empowerment and American-style '*family values*' from evangelical media powerhouses, such as Joyce Meyer, Rick Warren, T.D. Jakes and Joel Olsteen, resonate not only in the US's stadium-scale mega-churches, but find purchase amongst Zimbabwe's heavily Christian and socially conservative middle-class.

These preachers are well-known celebrities in Zimbabwe. It is no wonder that debates both in the highest levels of government and those at the kitchen table have begun to resemble the *'culture wars'* that have fuelled US political divisions for more than three decades. For these missionaries, Uganda is a model on the African continent for combating HIV with Christian morality; Uganda is also the African nation with the most restrictive legislation with regard to homosexuality, with penalties including death. Each round of increasingly repressive legislation has been cheered on by Ugandan preachers, often along with their counterparts and allies from the United States.

Stigma pervades not only at the levels of media and legal discourse, but also at the levels of micro-politics of the street, the pub, the workplace and the home. One unnamed informant for this article described daily street harassment and public humiliation, based on his perceived sexual orientation, often followed up with private sexual advances ranging from harassment to hesitant, shame-laced curiosity. Others described rejection from family and friends, and the need to maintain a pose of heterosexuality in many contexts of their lives, ranging from work to neighbourhood and family life. According to Fadzai Muparutsa, a spokesperson for GALZ, this daily discrimination has impacts on LGBQT persons' access to shelter, employment, health services, education and other basic needs, which has already been very restricted by the ongoing economic crisis in Zimbabwe.

RAPE AND RUMOURS OF RAPE

One form of extra-legal enforcement of heterosexuality and gender norms has received attention, due to a recent report by the US Embassy[3] which details widespread incidents of so-called '*corrective*' rape targeted at '*queer*' people. According to the report, many of these crimes were not reported to the

police, due to generalised stigma, as well as an authoritarian atmosphere in which violence and rape at the hands of government and party agents have also been documented.

At the same time, the public imagination is pre-occupied with frequent (but rarely verified) reports of rape of men at the hands of women, according to lurid tales that appear regularly in tabloid news sources, and are sometimes picked up by the mainstream Zimbabwean and diasporic press. The US Embassy report notes that gay men, as well as lesbians, have reported being victims of rapes organised by family and community members in order to '*cure*' their sexual orientation, while GALZ confirms that they have also received reports of such incidents. Due to lack of enforcement of rape laws, shame and stigma, statistics on the frequency of corrective rape are not available. Nevertheless, anecdotal evidence, gathered by GALZ, suggests that sexual violence targeted at LGBTQ people in Zimbabwe is most often perpetrated by men, whether their victims are male or female, and that women are the most likely victims.

Legal reforms alone may not be sufficient to resolve this violation of human rights. Corrective rape is a problem that has received much attention from human rights activists and LGBTQ organisations in South Africa, where a string of brutal gang rapes and murder of lesbians has received international attention over the last two years. Despite a more hospitable legal climate for sexual minorities, the problems of violence, stigma and discriminatory enforcement make day-to-day security and personal safety for LGBTQ persons a still distant goal.

One informant argued that the ever-present threat of violence, black-mail and lack of protection from legal authorities shapes his daily life, in part by making it difficult to refuse seemingly non-coercive sexual advances from men. For lesbian women, the threat of sexual violence likewise limits public and private expression of gender, sexual orientation and same-sex relationships.

…obscures both the danger and the hope that sexual and gender minorities face as part of daily life…

ECONOMIC CRISIS, CHALLENGES AND CHANGE

GALZ reports that the challenges facing LGBTQ people in their daily lives, as well as as an organised social force, are compounded by Zimbabwe's ongoing economic crisis. According to the organisation, the hyper-inflationary period of 2006 to 2008 meant that for LGBTQ persons, as for most Zimbabweans, security of housing, food and other basic necessities became paramount. The challenges faced by sexual and gender minorities in securing family support, education, healthcare and employment were compounded by the overall decreasing availability of these life-sustaining resources.

During this period, large numbers of Zimbabweans emigrated to Botswana, South Africa, Australia, New Zealand and the United Kingdom. A few LGBTQ Zimbabweans sought amnesty as a result of persecution on the basis of their sexual orientation. In terms of both the organised and un-organised LGBTQ community, emigration reduced their numerical strength and ability to maintain a public, organised presence as advocates and even as consumers. GALZ saw its official membership reduced to 60% of its mid-nineties high-water mark, while the specifically gay night clubs, once visible in Harare's central district, closed or were replaced by low-key, general-audience pubs, a few of which continued to '*tolerate*' gay clientele. Instead, social space for sexual minorities has become more private, transitory and

segregated by gender, dominated by private entertaining and outdoor dance parties, publicised via word-of-mouth.

At the same time, economic crisis and the outflow of Zimbabweans to foreign countries have resulted in opportunities for transformed family dynamics, as well as increased contact between LGBTQ Zimbabweans and LGBTQ communities in Southern Africa and elsewhere. An informant explained that while stigma and violence are features of gay life in foreign communities, just as in Zimbabwe, the experience of emigration offered more freedom socially and economically, if only as a result of being somewhat further removed from family and community of origin.

For some women, both lesbian and otherwise, the economic crisis has reconfigured family relationships, as families become increasingly dependent on single incomes and remittances from family members abroad, as well as profits from cross-border trading, a heavily female occupation. Though, for the largest group of women and LBGTQ people these extreme circumstances compound their oppression within and outside of the household, for some women, these changes have put them in the position of breadwinner for the first time, increasing their decision-making power. For others, the need to emigrate for work or educational opportunities has led to increased distance from family and community, which can mean both increased hardship and greater personal freedom.

SPACES OF HOPE[4]

Over the last month, the concurrence of both leading parties and their leaders that the rights of sexual minorities '*have no place*' in the ongoing constitutional debate suggests a closure of political space for advocates of LGBTQ rights. This consensus reinforces the misconceptions that homosexuality is '*un-African*', and the result of imperialist and foreign influence and synonymous with rape and child abuse. Instead, foreign and local influences abound on both sides of the heated culture wars now reappearing in Zimbabwe.

…social space for sexual minorities has become more private, transitory and segregated by gender…

At the same time, this closure of political space for the advancement of legal protections for gays and lesbians does not tell the whole story of the social space for LGBTQ people in Zimbabwe, in either a negative or positive sense. Daily life is instead largely shaped by economic hardship, discrimination, secrecy and a present threat of violence. At the same time, GALZ organisers persist in building their presence in the public sphere, while gay communities continue to function underground in an increasingly trans-national manner, as a result of economic crisis and emigration.

FOOTNOTES:

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3. US Embassy. *2009 Human Rights Report: Zimbabwe*. March 11, 2010. [http://harare.usembassy.gov/human_rights_report.html]
4. For more information on the concept of 'safe spaces' see Susser, Ida.2009. *AIDS, Sex and Culture: Global politics and survival in Southern Africa*. Wiley-Blackwell.

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Regional human rights mechanisms...

Addressing the intersections of violence against women and HIV and AIDS in Africa

For many African lawyers and activists, there were two major human rights concerns on the occasion of the 47th ordinary session of the African Commission on Human and Peoples' Rights (African Commission) which was held in the Gambia from 14 – 27 May 2010.[1] These interrelated issues, occurring with relative impunity in sub-Saharan, include the routine violations of women's human rights in the context of HIV and AIDS, and the persistent criminalisation, arbitrary detention and persecution of LGBT people.

Wendy Isaack

INTRODUCTION

The African Commission is a critical body which forms part of the institutional architecture for the protection of human rights in Africa. So it is interesting that while the African Commission was still holding its private session, and after most human rights defenders had left the Gambia, President Binguwa Mutharika of Malawi pardoned Steven Monjeza and Tiwonge Chimbalanga who had been convicted on a charge of carnal knowledge against the order of nature and sentenced to 14 years in prison with hard labour by a Malawi Magistrates court - consensual homosexual conduct is criminalised under sections 153 (a) and (c) of the Malawi Penal Code. In granting the pardon on humanitarian grounds, President Mutharika maintained that the two men had committed a crime against religion, culture and the laws of Malawi. The President of Malawi did not condemn or call for the repeal of the Penal Code.

In Namibia, three positive women are presently suing the Ministry of Health for allegedly being sterilised without their consent by a state hospital. It has been reported that since February 2008, fifteen cases of coerced sterilisation of positive women in Namibian public health facilities have been documented.[2] The case was postponed to September 2010.

During the NGO Forum preceding the African Commission session, I had the opportunity to moderate a panel discussion hosted by People Opposing Women Abuse (POWA).[3] The purpose of this discussion was to reflect on the significance of the ratification, domestication and implementation of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[4] (Maputo Protocol) in addressing the intersections of violence against women and HIV and AIDS, and to consider the role of the African Commission in this regard.[5] In preparing for POWA's participation during the session, it had become apparent that while there were positive developments within the regional human rights system in its recognition and protection of women's rights and the elaboration of various declarations dealing with HIV and AIDS, there were still major gaps in the full gamut of rights protections. Our assessment revealed that the regional human rights system had yet to develop the norms and standards to adequately address the devastating impact of the intersection of HIV and AIDS and violence against women in Africa. Ultimately, the primary purpose of this panel discussion was to commence a conversation with, and build consensus on the urgent need for the African Commission to establish a mechanism, which would address these concerns. In

…contributed to setting appropriate human rights standards in the context of the HIV and AIDS pandemic…

this regard, the panel discussion proposed, and the women's rights special interest group of the NGO Forum adopted, a draft resolution calling for the creation of a new mechanism – a ***Special Rapporteur on the Right to Health***. This new mechanism would serve as the focal point for the protection and promotion of the rights to the best attainable state of physical and mental health, with a specific focus on addressing the impact of the intersections of HIV and AIDS and violence against women in Africa.

In analysing the regional human rights architecture and considering, in particular, the various ways in which the African Commission executes its protective mandate, this paper argues that the most appropriate method for addressing these concerns is the creation of a new mechanism, namely a Special Rapporteur on the Right to Health; or the establishment of a Working Group on the right to the best attainable standard of physical and mental health, or rather the integration of economic, social and cultural rights into the mandates of existing Special Rapporteurs and Working Groups. The paper is structured in two parts: part 1 discusses the socio-legal context, including the prevalence of HIV and AIDS and violence against women in sub-Saharan Africa and briefly considers the problematic legislative trends of criminalising HIV transmission; and part 2 is a discussion and critical reflection on the mandate of the African Commission and consideration of relevant African Union treaties and declarations dealing with HIV and AIDS.

PREVALENCE OF HIV AND AIDS AND VIOLENCE AGAINST WOMEN IN SUB-SAHARAN AFRICA

It is now well established that violence against women is both a cause and a consequence of HIV and AIDS and that the feminisation of both pandemics have resulted in violations of women's human rights. The devastating impact of the intersection of violence against women and HIV and AIDS has been widely documented

> *…discrimination against women, due to gender inequality, is multiple and compounded at the intersection of patriarchy and other sites of oppression, which subjugate women to a continuum of violence, making them susceptible to HIV and AIDS.*[6]

In sub-Saharan Africa, the dual pandemics of violence against women and HIV and AIDS represent two major human rights and public health concerns requiring urgent government attention, with research indicating that this region has become the global epicentre of the epidemics, accounting for more than one third of HIV infections in the world[7]. Of these, women constitute 61% of adults living with HIV.[8] Furthermore, according to a UNDP study, the HIV epidemic has had a dramatic effect on Eastern and Southern Africa, where the majority of people with HIV in the world

…examine, monitor, advise and publicly report on human rights violations…

live.[9] Other studies indicate that women account for over 60% of the total 22.4 million people living with HIV in sub-Saharan Africa.[10] On average, for every two HIV positive men there are three HIV positive women.[11]

While the true extent of violence against women in Africa is not known, current research indicates that there are high levels of intimate partner violence and that – whether during peace time, during conflict or post-conflict periods – many women routinely experience sexual or other forms of violence at some point in their lifetimes. The most recent data published in the United Nations Secretary General's Campaign indicates the incidence of intra-family violence against women and girls in Sub-Saharan Africa as follows:[12]

- In sub-Saharan Africa between 13% and 45% of women are assaulted by intimate partners during their lifetimes
- In Namibia – over one third (36%) of 1500 ever-partnered women reported having at some time experienced physical or sexual violence at the hands of an intimate partner
- In South Africa, 7% of 15-19 year olds had been assaulted in the past 12 months by a current or ex-partner; and 10% of 15-19 year olds were forced or persuaded to have sex against their will
- In Kenya, 43% of 15 to 49 year old women reported having experienced some form of gender-based violence in their lifetime
- In Ethiopia, 49% of ever-partnered women have experienced physical violence by an intimate partner, with 59% experiencing sexual violence
- In Tanzania, 47% of ever-partnered women have experienced physical violence by an intimate partner, with 31% experiencing sexual violence
- In Uganda, 59% of Ugandan women aged 15 to 49 have experienced physical and/or sexual intimate partner violence in their lifetime

It can, therefore, be stated with relative certainty that millions of women in the region struggle on a daily basis as survivors of violence, as women who are HIV positive, and as caregivers in families or communities immediately affected by both HIV and violence.

Whether in the private or public sphere, in times of peace or violent political conflict, in situations of generalised or concentrated epidemics, violence against women, and generally gender inequality, has played a critical role in increasing women's vulnerability to HIV infection. While all African Union states have signed and ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and twenty-seven (27) have ratified the Maputo Protocol[13], it seems that there are either no laws that protect women from violence, or where laws exist the mechanisms are inadequate to enforce their implementation. In her 2005 report, the UN Special Rapporteur on violence against women, in noting the multiplicity and compounded impact of discrimination against women, wrote:

…it is doubtful if the mandates would be extended to address the crisis of the HIV and AIDS pandemics in Africa…

> *In spite of the number of women contracting HIV/AIDS through the violent means, States have yet to fully acknowledge and act upon the interconnection between these two mutually reinforcing pandemics. By and large, Governments fail to take into consideration gender discrimination in formulating HIV/AIDS policies.*

> *… National policies and action plans would be vastly more effective if they acknowledged and acted on the interconnectedness between the twin pandemics.*[14]

A further concern in this context is the recent trend in some African states of enacting legislation that specifically criminalises HIV transmission and exposure. Generally, there are two ways in which HIV transmission can be criminalised, namely laws specifically criminalising HIV transmission, and secondly through the application of existing criminal law to cases involving exposure to, or the transmission of, HIV. In his April 2010 report to the Human Rights Council, UN Special Rapporteur, Anand Grover, examines the relationship between the right to the highest attainable standard of health and the criminalisation of three forms of private, adult, consensual behaviour, including HIV transmission.[15] In this report, the Special Rapporteur notes that while criminalisation of HIV transmission has formed part of the global response to HIV and AIDS, legal sanctions have resulted in human rights violations and undermined public health goals that it sought to achieve at inception.[16] In the context of women's rights,

…the disproportionate impact of states failure to protect the human rights of women and marginal groups…

> *…the criminalisation of HIV transmission also increases the risk of violence directed towards affected individuals, particularly women, HIV-positive women are 10 times more likely to experience violence and abuse than women who are HIV-negative.*[17]

…seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services…

In sub-Saharan Africa, we are witnessing a proliferation of laws criminalising HIV transmission, where states are attempting to develop responses to HIV and AIDS. As set out in the report of the Special Rapporteur:

- Sierra Leone, Section 21 of the Prevention and Control of HIV and AIDS Act (2007) criminalises mother-to-child exposure to HIV[18]; – a person infected with HIV (and aware of the fact) must '*take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of pregnant women, the foetus*' with criminal sanctions imposed for the failure to do so[19];
- In Zimbabwe, Section 79 of the Criminal Law (Codification and Reform) Act, No 23 of 2004, stipulates that if anyone who realises '*that there is a real risk or possibility*' that she or he might have HIV, and intentionally does anything which he or she realises involves a real risk or possibility of infecting another person with HIV, he or she shall be guilty of deliberate transmission of HIV[20];
- In 15 countries in West and Central Africa, laws have been implemented which criminalise the transmission of the HIV virus '*through any means by a person with full knowledge of his/her status to another person*'[21]; and
- Benin, Guinea, Guinea-Bissau, Mali, Niger and Togo

have also enacted laws that criminalise mother-to-child transmission.[22]

A coalition of human rights and women's rights groups have noted with grave concern, that applying criminal law to HIV exposure or transmission is not only unjust and ineffective public policy, but that it will further exacerbate gender-based violence and increase women's vulnerability to HIV infection.[23] It is now generally accepted by human rights groups and UN specialised agencies that while penal measures were initially introduced because HIV prevention strategies were not working, laws criminalising HIV transmission infringe human rights and increase the risk of violence. Gender inequality, discrimination and various forms of violence against women render women susceptible to HIV; conversely, HIV and AIDS exacerbate women's vulnerability to rights violations. In the African context, and in alliance with the former Special Rapporteur on violence against women, it is argued that

> *…as patriarchy intersects with other sites of oppression, such as class, race, ethnicity, displacement etc., discrimination becomes compounded, 'forcing the majority of the world's women into situations of double or triple marginalisation'.*

…emphasises and acknowledges the universality, inalienability, interdependence and indivisibility of human rights…

REGIONAL HUMAN RIGHTS INSTITUTIONAL ARCHITECTURE

The African Commission is a quasi-judicial treaty body established by Article 30 of the African Charter on Human and Peoples' Rights[24] (Banjul Charter). The Banjul Charter was adopted by member states of the Organisation of African Unity (OAU), and recognises individual civil and political rights, socio-economic rights, as well as peoples' rights. With its secretariat based in Banjul, the Gambia, the African Commission is composed of 11 members, holds bi-annual meetings, and has a dual mandate to protect and promote human and people's rights in Africa, as set out in Article 45 of the Banjul Charter. Article 45 (1) stipulates the promotional mandate of the African Commission generally as follows:

i) undertaking studies of legal problems in the field of human and peoples' rights;
ii) dissemination of information on human and peoples' rights;
iii) formulate and lay down principles and rules aimed at solving legal problems relating to human and peoples' rights, and upon which African governments may base their legislation; and
iv) Conduct regular missions to African states to evaluate the human rights situation in those states.[25]

The protective mandate, set out in Article 45(2), obliges the African Commission to ensure the protection of human and peoples' rights through the application of procedures and mechanisms which include:

i) undertaking investigations in respect of human and peoples' rights issues/problems which have been brought to its attention by either organs of the African Union (previously the OAU) or any other person capable of enlightening it;[26]

ii) application of the communication procedure, whereby violations of human and peoples' rights are referred to the African Commission, by state parties or individuals and/or by NGOs, against state parties which are in violation of their obligations under the Banjul Charter.[27]

…an important advocacy tool for civil society actors for holding state parties accountable…

In addition to the communications procedure, Article 62 of the Banjul Charter obliges states parties to submit periodic reports, describing the legislative and administrative measures taken, with a view to giving effect to the rights and freedoms recognised and guaranteed by the Charter. The procedure for examination of periodic state reports is designed to enable the African Commission to engage in a dialogue regarding the challenges and difficulties in realising the rights and freedoms enshrined in the Charter. States parties to the Banjul Charter are required to submit reports every two years. However, not a single state has submitted more than three periodic reports to the African Commission. Other countries, even though they have ratified the Banjul Charter, such as Botswana, Cote d'Ivore, Djibouti, Equatorial Guinea, Gabon, Guinea Bissau, Liberia, Malawi and Sierra Leone have never submitted a single report to the African Commission on measures taken to protect and promote human rights.[28]

…the impact of its protective function has been severely limited…

While the African Commission is an important institution for the promotion of human rights in Africa, and has since its establishment achieved some measure of success in relation to its promotional function, the impact of its protective function has been severely limited by numerous factors. Some of these can be attributed to the quasi-judicial nature of the African Commission, which means that as opposed to making binding decisions following communications, it only has the powers to make recommendations, which are often not implemented and enforced at country level. A further challenge is the lack of a formal follow-up mechanism to ensure the enforcement of its recommendations following activity and state reports.

Noting these challenges, the African Commission has progressively developed within its protection mandate, other mechanisms for addressing various human rights problems and according protection needs in a number of thematic areas. For instance, the mandate of the Special Rapporteur on Rights of Women in Africa[29] and the mandate of the Special Rapporteur on Freedom of Expression in Africa[30] address two distinct, yet, equally significant human rights concerns in Africa. Generally, the African Commission has the powers to create mechanisms referred to as a Special Rapporteur to focus on either a specific vulnerable or marginalised group, such as women or indigenous people, or to address a thematic area of concern, such as freedom of expression. These mechanisms play a significant

role in developing human rights standards, and where necessary guidelines, on their specific area of focus. For our purposes, they are furthermore mandated to collaborate with relevant actors, including non-governmental organisations, other special procedures from the United Nations and other regional human rights systems. Of notable success is the launch of the Guidelines for State Reporting under the Maputo Protocol by the Special Rapporteur on the Rights of Women in Africa during the 47th Ordinary Session. A major concern for women's rights activists is that despite more than 20 years of the African Commission's existence, there has not been a single communication decided on rights of women in Africa, and that despite more than 27 ratifications of the Maputo Protocol, no State Party has included in their reports measures taken to advance women's rights. These guidelines will serve as an important advocacy tool for civil society actors for holding state parties accountable to protecting, respecting and fulfilling women's rights in Africa. To further support its work, with its protective mandate, the African Commission has created working groups on various on topics and for specific groups. For instance, the Working Group on Indigenous Populations[31] and the Working Group on Economic, Social and Cultural Rights[32] have been established to assist the Commission in their work of formulating human rights standards and guidelines on specific topics.

Basic human rights principles and standards are core elements for the development of effective strategies to address the intersections of HIV and AIDS and violence against women. Rights-based programming emphasises and acknowledges the universality, inalienability, interdependence and indivisibility of human rights. Noting that violations of civil, political, economic, social and cultural rights increase vulnerability to HIV; that stigma and discrimination lead to human rights violations; and that these violations impede an effective response to HIV, this paper argues for the urgent creation of a regional mechanism, which will ensure that African Union States comply with their international obligations to respect, protect and fulfil the rights in the Banjul Charter. The significance of the human rights-based approach to the intersections of violence against women and HIV and AIDS is that not only will it establish the normative framework and impose legal obligations on states for rights violations, but it will also provide useful guidance for the design, implementation and evaluation of national policies aimed at responding to these twin pandemics. Based on the aforesaid and the various ways in which the African Commission performs its protective functions, a critical question is whether or not the time is ripe for the creation of a mechanism on the ***Right to Health***, or whether or not it is more appropriate to commence with the establishment of a Working Group to investigate the issues further.

…the powers to make recommendations, which are often not implemented and enforced at country level…

NORMATIVE STANDARDS IN THIS CONTEXT: AFRICAN UNION TREATIES AND DECLARATIONS

The African Union has adopted legally binding human rights treaties and various declarations dealing with HIV and AIDS. The African Commission has also adopted a number of resolutions articulating the gender dimensions as major issues of human rights concern. Provisions of the Banjul Charter, the Maputo

Protocol and the various commitments made by the African Union over the last decade or more, establish the foundations for the full protection and promotion of all human rights. First, Article 16 of the Banjul Charter provides:

(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health; and

(2) States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The Working Group on Economic, Social and Cultural Rights of the African Commission has elaborated on the normative content of Article 16 in the *Declaration of the Pretoria Seminar on Economic, Social and Cultural Rights in Africa* to include, amongst other things:

i) Availability of accessible and affordable health facilities, goods and services of reasonable quality for all;

ii) Access to reproductive, maternal and child health care based on the life cycle approach to health;

iii) Immunisation against major infectious diseases;

iv) Education, prevention and treatment of HIV and AIDS, malaria, tuberculosis and other major killer diseases; and

v) Education and access to information concerning the main health problems in the community including methods of preventing and controlling them.[33]

In adopting the above-stated Declaration, participants at the seminar noted the disproportionate impact of states' failure to protect the human rights of women and marginal groups, including refugees and internally displaced persons, and specifically called on African Union member states to

…adopt special measures for women and address the economic, social and cultural rights of vulnerable and marginalised groups including children, indigenous peoples, displaced persons, refugees, persons living with HIV/AIDS and the disabled.[34]

The Maputo Protocol, also commonly referred to as the African Union Women's Rights Protocol, is a regional treaty, drafted in accordance with Article 66 of the Banjul Charter, establishes the normative framework for the protection and promotion of women's human rights in Africa, and is a ground-breaking treaty in its expressed prohibition of all forms of violence against women in both private and public spheres.[35] The significance and potential of the Women's Rights Protocol lies in the fact that it contextualises the situation of African women and makes explicit the protection of women's rights in areas previously not protected in other mainstream human rights documents. For instance, it is the first treaty to protect the right to abortion under certain circumstances; it provides extensive protection to women in situations of armed conflict, and reiterates the need to accord women refugees protection under international law.[36] Furthermore, for the first time in international law, the Maputo Protocol makes explicit reference to HIV and AIDS in the context of sexual and reproductive health and rights. Article 14 reads:

…laws criminalising HIV transmission infringe human rights and increase the risk of violence…

1. States Parties shall ensure that the rights to health of

women, including sexual and reproductive health is respected and promoted. This includes: (…)

d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; and

e) the right to be informed of one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices.

The Maputo Protocol, in terms of Article 14 and numerous other provisions relating to the elimination of harmful cultural and traditional practices, duties of states parties to eliminate discrimination and provide specific legal protection from violence against women in the private and public spheres, and specific articulation of women's rights to equality, is designed to deal with the root causes of HIV in Africa.

In addition to the Banjul Charter and Maputo Protocol, the African Union has adopted several declarations aimed at setting standards for state responses to HIV and AIDS. First, in respect of the Solemn Declaration on Gender Equality in Africa adopted in 2004, African Union Heads of State in expressing concern about the status of women and the negative impact of the high incidence of HIV and AIDS on women's lives, agreed to:

Accelerate the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both the Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Disease. More specifically to ensure that treatment and social services are available to women at the local level making it more responsive to the needs of families that are providing care; enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care for people living with HIV/AIDS, particularly women; increase budgetary allocations in these sectors so as to alleviate women's burden of care.[37]

The Solemn Declaration on Gender Equality is one of the most significant commitments made by African Union leaders in their response to prevailing gender inequalities and the HIV pandemic. However, less than half of African Union member states have submitted their baseline reports on the progress made in terms of gender mainstreaming and complying with commitments made in terms of the Declaration. In terms of the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)[38], African Union Heads of State not only declared that the HIV epidemic had reached epidemic proportions and created a state of emergency on the African Continent, they also pledged 15% of their national annual budgets and committed to ensuring equal rights for people living with HIV and AIDS. Other relevant frameworks include first, the Maputo Plan of Action or the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework, which seeks to take the continent forward towards the

…legal sanctions have resulted in human rights violations and undermined public health goals…

goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015.[39] Secondly, Gaborone Declaration on the Road Towards Universal Access to prevention, treatment and care, underlines the need for the development of an integrated healthcare delivery system based on an essential health package and the preparation of a costed health development plan. While these Declarations are non-binding instruments, they do carry persuasive value in terms of which African Union Member States have committed themselves to, amongst other things, enacting legislation to protect and respect the lives of people living with HIV, and allocating adequate budgets, which will ensure effective responses to the systemic inequalities that exacerbate HIV and AIDS.

…either no laws that protect women from violence, or where laws exist the mechanisms are inadequate to enforce their implementation…

CONCLUDING REMARKS

The African Commission currently has six Special Mechanisms or Special Procedures to address specific human rights concerns, but it is doubtful if the mandates would be extended to address the crisis of the HIV and AIDS pandemics in Africa. Over the last couple of years, the African Commission has also established at least 6 working groups to investigate various human rights issues; of particular relevance to the discussion is the Working Group on Economic, Social and Cultural Rights alluded to above. A critical question is whether or not HIV and AIDS is the only urgent health concern in Africa. While this brief paper has focused on the intersections of HIV and AIDS and violence against women as comprising grave pandemics, these are by no means the only components of the right to health protected by the Banjul Charter.

Furthermore, various African Union declarations have identified malaria, preventable maternal mortality and morbidity, tuberculosis and other infections diseases as a cause for major concern and serious impediment to the enjoyment of fundamental human rights in Africa.[40] In addition to African Union treaties and declarations, the African Commission has also contributed to setting appropriate human rights standards in the context of the HIV and AIDS pandemic. For instance, in terms of *Res.53(XXIX)01 on HIV/AIDS Pandemic – Threat Against Human Rights and Humanity*, in noting the escalation of the pandemic in sub-Saharan Africa, the African Commission declared the HIV and AIDS pandemics a human rights issue, which is also a threat against humanity, and called on all states parties to the Banjul Charter to allocate adequate resources that reflect a determination to adequately respond to HIV and AIDS.[41]

The establishment of a Working Group is not a preferred option, since it would probably be tasked with the mandate to investigate and research issues, which have already been extensively reported. This paper argues for the creation of, within the protection mandate of the African Commission, a ***Special Rapporteur on the Right to Health*** to amongst other functions, examine, monitor, advise and publicly report on human rights violations in the context of the right to health in Article 16 of the Banjul Charter, and paying special attention to the devastating impact of HIV and AIDS and violence against women in Africa.

FOOTNOTES:

1. The African Commission on Human and Peoples' Rights is a treaty body established by the African Charter on Human and Peoples' Rights charged with the mandate to protect and promote human and peoples' rights in Africa and holds bi-annual sessions. [www.achpr.org/english/_info/mandate_en.html]
2. Petition on the Athena Network listserv at www.athenanetwork.org. See also [http://news.bbc.co.uk/go/em/fr/-2/hi/world/africa/10202]
3. People Opposing Women Abuse (POWA) is a feminist women's rights organisation based in Johannesburg, South Africa. Since 2007, POWA has enjoyed Observer Status with the African Commission on Human & Peoples' Rights in accordance with ACHPR/Res. 33(XXV) 99: Resolution on the Criteria for Granting and Enjoying Observer Status to Non-Governmental Organisations Working in the field of Human and Peoples' Rights (1999). [www.achpr.org/english/_doc_target/documentation.html?../resolutions/resolution38_en.html]
4. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd Ordinary Session of the Assembly of the Union, July 2003. Available at [www.achpr.org/english/_info/women_en.html]
5. Panellists included Madame Commissioner Soyata Maiga, Special Rapporteur on the Rights of Women in Africa of the African Commission; Ms Sibongile Ndashe, a lawyer from INTERIGHTS, Ms Nonhlanhla Sibanda, senior researcher at POWA and Dr. Hannah Forster, Director of the African Centre for Human Rights and Democracy Studies. The statement of the work of the NGO Forum presented to the African Commission on Human and Peoples' Rights is available at [www.achpr.org/english/Speeches/47%20session/Ngos.pdf]. POWA also co-convened the two-day *LGBTi Rights are Human Rights* parallel meeting with regional and international partners and human rights groups, including INTERIGHTS, Global Rights, Coalition for African Lesbians, AMSHER and International Gay and Lesbian Human Rights Commission (IGLHRC).
6. Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Erturk, *Intersections of Violence Against Women and HIV/AIDS*. E/CN.4/2005/72, p2.
7. RTI International. 2008. *Drugs, Sex, and Gender-Based Violence*. Research & Policy Brief.
8. UNAIDS. 2007. AIDS Epidemic Update. Geneva, UNAIDS.
9. UNDP Guide to an effective human rights response to the HIV epidemic, 2007. In nine Southern African countries at least 14% of adults aged 15 to 49 years are currently living with HIV.
10. Averting HIV and AIDS. [http://www.avert.org]
11. UNFPA. 2005. State of World Population Report. [www.unfpa.org/swp/swpmain.htm]
12. United Nations Secretary-General's Campaign. *UNITE to End Violence Against Women*.
13. Of the 27, 9 Southern African states have ratified namely: Angola, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe – some with reservations.
14. Report of the Special Rapporteur on Violence Against Women.
15. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Anand Grover, 27 April 2010. A/HRC/14/20 – the other two included same-sex conduct and sexual orientation and sex work.
16. *bid*, note 14, para 51.
17. *Ibid*, note 14, para 71.
18. *Ibid*, note 14, para 52.
19. *Ibid*, note 14, para 67.
20. *Ibid*, note 14, para 59.
21. *Ibid*, note 14, para 60.
22. *Ibid*, note 14, para 66.
23. See also, *10 Reasons why Criminalisation of HIV Exposure or Transmission Harms Women* [www.athenanetwork.org] An example: a woman was prosecuted under Section 79 of the Zimbabwe Criminal Law (Codification and Reform), Act 23 of 2004, for having unprotected sex while HIV-positive, despite HIV not even being transmitted to the 'victim' in question. In Special Rapporteur Report, note 14, para 64.
24. African Charter on Human and Peoples' Rights, commonly known as the Banjul Charter, was adopted by Eighteenth Assembly of Heads of State and Government, June 1981, and entered into force on 21 October 1986. Available at [www.achpr.org/english/_info/charter_en.html81]
25. Banjul Charter, Article 45(1)(a-c).
26. Banjul Charter, Article 46.
27. Chapter III of the Banjul Charter deals with Communications.
28. Status on Submission of State Initial and Periodic reports to the African Commission, updated April 2010. [www.achpr.org/English/_intro/statereport_considered_en.html]
29. Madame Commissioner Soyata Maiga (Mali) is the incumbent Special Rapporteur on the Rights of Women in Africa, mechanism created by ACHPR/res 38 (XXV) 99, with an 8 part mandate, including primarily serving as a focal point for the promotion and protection of the rights of women in Africa amongst the 11 Commissioners. [www/achpr.org/english/_info/women_mand.htm]
30. Advocate Pantsy Tlakula (South Africa) is the incumbent Special Rapporteur on Freedom of Expression in Africa, mechanism created by ACHPR/res.71 (XXXVI) 04, with a 6 part mandate, including analysing national media legislation, policies and practices within member states and advising them accordingly. [www.achpr.org/english/resoultions/resoultion76_en.html]
31. ACHPR Working Group on Indigenous Populations is composed of six members tasked with supporting the work of the African Commission in the promotion and protection of the rights of indigenous populations and communities. [www.achpr.org/english/_info/index_WGIP_ent.htm#1]
32. Working Group on Economic, Social and Cultural Rights established by resolution ACHPR/Res (XXXVI) and tasked with a mandate to develop and propose to the African Commission Draft Principles and Guidelines on Economic, Social and Cultural Rights and to generally conduct research on this area see for example the Report of the Progress Report of Working Group. [www.achpr.org/english/Commissioner's%20Activity/44th%200S/Special%]
33. Declaration of the Pretoria Seminar on Economic, Social and Cultural Rights in Africa proposed by participants at a workshop held in Pretoria from 13 – 17 September 2004, and proposed for adoption by the African Commission at its 36th Ordinary Session.
34. *Ibid*, note 30, p10.
35. Banjul Charter, Article 66 reads '*Special protocols or agreements may, if necessary supplement the provisions of the present Charter*'.
36. Articles 4, 11 and 14(2) of the Maputo Protocol.
37. Solemn Declaration on Gender Equality in Africa, adopted by the Heads of State and Government of Member States of the African Union, meeting in the Third Ordinary Session, Addis Ababa, Ethiopia, July 2004, para1. [www.chr.up.ac.za/centre_projects/gender/docs/AfricaSolemnDec04.pdf]
38. Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, African Summit, Abuja, Nigeria April 2001.
39. Special Session of the African Union Conference of Ministers of Health, Maputo Mozambique, Sp/MIN/CAMH/5(I), Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2007 – 2010.
40. See for example the ACHPR/Res.135(XXXXIIII).08: Resolution on Maternal Mortality in Africa in terms of which the African Commission noted that Africa has the worst records of maternal deaths in the world, accounting for more than 250 000 deaths annually.
41. ACHPR/Res.53(XXIX)01:Resolution on HIV/AIDS Pandemic – Threat Against Human Rights and Humanity. [www.achpr.org/english/resoultions/resoultions58_en.html]

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A cautious nod to the cut...

Women weigh in on medical male circumcision [1]

In 2007, the World Health Organization (WHO) and UNAIDS recommended that male circumcision be recognised as an additional intervention to reduce the risk of heterosexually acquired HIV infection in men. Since then, 13 countries in Eastern and Southern Africa have taken up the call to scale-up medical male circumcision for HIV prevention. Individual countries are at varying levels of the implementation process.

Cindra Feuer

WHO's recommendation was based on three randomised clinical trials in Kenya, South Africa and Uganda, finding that circumcised men have about a 60 percent reduced risk of acquiring HIV from women than their uncircumcised counterparts.

However, data assessing the effect of circumcision on *male-to-female* HIV transmission are conflicting. One observational and one prospective study among HIV sero-discordant couples showed reduced transmission from circumcised men, but the only randomised controlled trial (RCT) to date suggested no short-term benefit of circumcision. The RCT was stopped early, after an interim analysis showed no evidence of efficacy. In addition, the trial suggested that if a couple does not abstain from sex until the surgical wound from the man's circumcision has completely healed, the woman may be at increased risk of acquiring HIV, if her partner is HIV positive.

…data assessing the effect of circumcision on male-to-female HIV transmission are conflicting…

In addition to potential increased rates of HIV infection for women with newly circumcised partners, there are other fears driving women's resistance and concern around medical male circumcision's implementation for HIV prevention. WHiPT (Women's HIV Prevention Tracking) was created out of response to these uncertainties, as a network to monitor prevention research and rollout and to ensure that women's overarching concerns are met. Specifically, WHiPT has documented these perceived and real fears, and is embarking on advocacy campaigns based on its findings to ensure that the scale-up of medical male circumcision for HIV prevention also benefits women.

WOMEN'S CONCERNS, WHIPT'S INCEPTION

In 2008, AVAC and the World Health Organization recognised the need, especially among positive women, for dialogue around medical male circumcision. In June of the same year, over 35 civil society representatives – the majority of whom were women living with HIV in sub-Saharan Africa – gathered in Mombassa, Kenya, to discuss the implications of male circumcision for women. The two-day meeting, named Civil Society Dialogue on Male Circumcision for HIV Prevention: Implications for Women, was organised by AVAC and directly preceded a WHO expert consultation on the same topic, held at the same location.

WHO sponsored the civil society participants from its meeting to attend the civil society dialogue, and AVAC invited and sponsored an additional group of women activists and advocates from sub-Saharan Africa to attend the civil society dialogue.

Over the course of the two-day session, positive women, researchers, WHO representatives, gender and reproductive health advocates, and a range of other stakeholders shared information and concerns around male circumcision for HIV prevention and its implications for women.

Participants recognised the need for an expanded array of HIV prevention options, alongside comprehensive care and treatment programmes. In this context, they supported male circumcision as an additional strategy, provided it was added to, and complemented and strengthened by, existing offerings, and did not weaken or remove resources from prevention services for women and/or broader health systems.

The context for this support was a set of strongly articulated concerns about the strategy, particularly as it would impact men's risk behaviours, shared sexual decision-making, spending allocations for women-focused HIV prevention, and stigma and blame directed at positive women. (See box for details.) Addressing these concerns is an essential part of any attempt to introduce male circumcision for HIV prevention.[2]

After the Mombassa civil society dialogue, delegates from Kenya (Women Fighting AIDS in Kenya), Namibia (Namibia Women's Health Network), South Africa (AIDS Legal Network), Swaziland (Swaziland for Positive Living), and Uganda (Mama's Club and Health Rights Action Group) expressed interest in putting into action safeguards that would mitigate women's vulnerabilities around male circumcision. Hence, with the support of AVAC and ATHENA, the WHiPT (Women's HIV Prevention Tracking) project was launched in November 2008.

Women's Concerns

- Resources for male circumcision should not be diverted from other HIV preventions, specifically female condoms and microbicides, as well as structural and behavioural interventions, and treatment efforts.
- Resources for sexual and reproductive health and rights programming, as well as around empowerment (or gender equality) should not be diverted to male circumcision. Rather, male circumcision should act as an entryway for men's participation in their own sexual health and education around gender equality.
- From here on, there needs to be meaningful participation of (positive) women in research, policy development, and programme planning and implementation of male circumcision.
- No conclusive evidence exists to demonstrate any direct benefit of male circumcision for women. Modelling studies suggest indirect protection will eventually accrue to women, but that in the short-term increased feminisation of the epidemic is likely.
- Male circumcision may engender an increased perception of women as vectors or transmitters of disease, and thus may lead to increased gender-based violence.
- Male circumcision may bring a false sense of protection and this will in turn compromise even further a woman's ability to negotiate conditions of sex (if and when sex happens, condom use, etc.) and increase gender-based violence.

HEARING FROM THE WOMEN: WHIPT METHODOLOGY

To inform policies and programmes related to medical male circumcision, WHiPT country teams were formed in Kenya, Namibia, South Africa, Swaziland and Uganda out of networks of women living with HIV, who work predominantly at a community level. Each team developed a work-plan tailored to their context and trained women in qualitative data collection to capture local women's impressions of medical male circumcision. WHiPT teams developed a standard interview questionnaire and focus-group template to be adapted to local contexts. Teams met to evaluate data across countries for common and context-specific themes.

…not weaken or remove resources from prevention services for women and/or broader health systems…

Sample survey questions include:

- What have you heard about medical male circumcision?
- Do you think male circumcision for HIV prevention can be introduced into your community?
- What are men saying and doing (attitudes to sex, sexuality, HIV risk) about male circumcision as a protective strategy against HIV infection?
- Do you think male circumcision for HIV prevention would impact on gender-based violence in your community?
- What additional services should be provided along with male circumcision for HIV prevention?
- What HIV prevention methods do you currently have access to?

Across the five WHiPT country teams, a total of 494 interviews were conducted and 25 focus group discussions were organised and carried out in various regions of each country over the past year. These included Kisumu, Kuria and Mombasa in Kenya; Katutura and Khomas in Namibia; Port Elizabeth, Eastern Cape and KwaMakhuta, Kwazulu Natal in South Africa; Manzini and Hhohho in Swaziland; and Kampala and Kapchorwa in Uganda. The different locations represent rural, peri-urban and urban settings, as well as communities practicing traditional male circumcision and those that do not. Some Ugandan and Kenyan regions surveyed practice female genital mutilation, which carries its own implications within the roll-out of medical male circumcision for HIV prevention. Most of the women surveyed across the regions had not yet experienced the advent of male circumcision roll-out – except for in parts of Kenya – so the data collected is mostly based on what women anticipate will happen once scale-up happens in their communities.

…what women anticipate will happen once scale-up happens in their communities…

WHIPT FINDINGS ACROSS COUNTRIES

From the outset it is important to note the distinct differences between women in circumcising communities and women in non-circumcising communities that exist across the country regions in this survey. Within the socio-cultural context of traditional male circumcision practices, women's levels of involvement in, and engagement with, the introduction and roll-out of medical male circumcision for HIV prevention is distinctly different to

women in communities in which male circumcision as rite to manhood is not an integral part of culture and tradition.

As such, women in the traditionally circumcising samples, such as South Africa's Eastern Cape, largely responded to MMC for HIV prevention in their role as mothers, with little engagement on the impact of MMC on women's sexual health and rights as partners to men who will be, or have been, medically circumcised. To the contrary, in non-traditionally circumcising communities, women engaged with the concept of MMC for HIV prevention primarily as partners and hence, were more focussed on the impact of medical male circumcision for HIV prevention on their sexual health and rights.

The socio-cultural tensions around male circumcision and the exclusion of women from gaining access to information came through clearly in the data. As traditional male circumcision is a '*sacred*' and '*secret*' male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women's information seeking behaviour. Thus, for women to access and act upon information related to MMC and HIV, the information must be specifically tailored for women, taking into account the socio-cultural context and the realities of women in both traditional and non-traditional male circumcising communities.[3]

Knowledge levels regarding MMC as an HIV prevention strategy

Data across all five countries indicate that a significant number of women at a community level have heard about traditional male circumcision, but not medical male circumcision. For those who have heard about MMC, it does not necessarily translate into having *'factual knowledge'* about MMC. Reporting varied among countries on women's understanding that MMC is only partially protective against HIV risk, the need for condom use after MMC, and the need to abstain from sex during the period of wound healing.

Interestingly, Swaziland and Kenya, the two case studies furthest along in MMC roll-out, demonstrated the least knowledge in these areas. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the roll-out of MMC programmes, as well as highlight the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

…information must be specifically tailored for women…

Support for MMC

While the data clearly indicate the support for MMC to be introduced to communities, data also highlight the need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention.

The data further suggest relatively high levels of perceived support amongst men. They do, however, also indicate that while supporting the introduction of MMC for HIV prevention in principle, this support is qualified by the need for women's greater involvement in MMC for HIV prevention discussions and decisions; as well as the noticeable tensions between traditional and medical male circumcision practices.[4]

Perceived impact of MMC on women

Although, the data clearly highlight a general lack of

perceived benefits of MMC for women and women's protection, they also suggest that if MMC would be linked to other prevention methods, such as condoms, and to additional services, such as education and training, the introduction and roll-out of medical male circumcision for HIV prevention could have a protective factor for women.

Respondents from Namibia felt strongly that MMC should not be introduced as an HIV prevention method, but instead for hygienic purposes. This would help curb behaviour disinhibition that may accompany a new HIV prevention intervention.

The data confirm that most women are not in the position to negotiate condom use and are least in control over HIV prevention options. Taking into account that medical male circumcision for HIV prevention is not a stand alone HIV prevention method, and that MMC can only be an effective addition to available HIV prevention options when combined with other preventative methods, such as condoms, it is crucial to ensure that male and female condom promotion and distribution becomes an integral part of MMC for HIV prevention processes.

…need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention…

The data highlight relatively high perceived levels of gender-based violence, which arguably reflects communities' realities of high levels of violence and abuse. However, the data also strongly suggest that the introduction of MMC for HIV prevention may lead to increasing levels of gender-based violence, as men may refuse condom use after MMC and women are likely to be blamed for HIV and STIs, arguably indicating the need to address these risks as an integral part of MMC for HIV prevention initiatives and programmes.

…support is qualified by the need for women's greater involvement in MMC for HIV prevention discussions and decisions…

Another potential danger to women is the observed misperception that male circumcision is equated with female circumcision or female genital mutilation (FGM) as an HIV prevention method. Some women surveyed from Uganda and Namibia believed that FGM would be protective against HIV. Women also thought that the advent of MMC would increase the practice of FGM.

Lastly, the data point to a specific need for women to organise and mobilise around their concerns related to MMC. There was a call for increased access to, and availability and development of, women-controlled HIV prevention strategies.

WAY FORWARD

Based on the research findings, the study recommends that in light of a lack of a policy framework there is a need to engage policy makers to ensure the timely finalisation of a rights-based policy regulating MMC for HIV prevention in Southern and Eastern Africa.

It is recommended to monitor that resources are not diverted from HIV prevention programmes for women. Advocates are calling for increased HIV prevention programming and interventions for women running parallel to MMC for HIV

prevention. Existing challenges of, and barriers to, HIV prevention, such as gendered power imbalances and inequalities, must be addressed as an integral part of MMC implementation.

…crucial to ensure that male and female condom promotion and distribution becomes an integral part of MMC…

Furthermore, acknowledging the need for adequate education and awareness raising campaigns on MMC for HIV prevention, it is essential to ensure the dissemination of accurate and factual information around MMC, particularly addressing women's realities, risks and potential benefits, and emphasising the partial protection from HIV infection for men.

Finally, taking into account the challenges and inherent tensions between traditional and medical male circumcision, there is a further need for broad consultations and investigation of potential mechanisms of combining the two male circumcision practices, as well as a need to engage in ongoing research, especially around women's actual and desired role and involvement in discussions and decisions about male circumcision within circumcising communities.

WHIPT ADVOCACY

The following includes some of the advocacy strategies, which are informed by the study findings:

- MMC literacy with women to build their capacity to share MMC-related information in their communities
- Development of messaging around MMC specific to women in relation to the roll-out of MMC at the country level
- Development of gender indicators for the monitoring and evaluation of MMC in national roll-out programmes
- Sharing findings of the WHiPT project with relevant policy makers
- Opportunity to build linkages to female condom advocacy
- Resource monitoring and budget-tracking of MMC for HIV prevention

FOOTNOTES:

1. This article is based on preliminary findings of a 5 country study exploring medical male circumcision and its implications for women.
2. A full report on the proceedings of the Mombassa meeting can be obtained from [www.malecircumcision.org]
3. For more information, see Arnott, J. & Kehler, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?*. Cape: South Africa. AIDS Legal Network.
4. *Ibid*.

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Where are the women…?

The roll-out of medical male circumcision for HIV prevention[1]

'There was no blood, or a need for bandages', he said. 'In fact all of them were comfortable with the procedure and after getting the snip, they got back into their cars and went back home.'[2,3]

Jayne Arnott

Surely, it is not about '*getting the snip*' and going home. Where are women as partners, lovers, wives and mothers, if they are not gaining access to medical male circumcision as an opportunity for information sharing and joint counselling around sexual health and rights, and the protection of women from HIV infection?

WOMEN SPEAK OUT ABOUT MALE CIRCUMCISION

> *…no, women have nothing to do with male circumcision, as they are not part of it from the beginning…*[4]

A dominant theme running through the responses in a study on women's readiness for medical male circumcision as HIV prevention method[5] was that of feeling excluded and powerless to speak out, and become engaged in, the roll-out of medical male circumcision (MMC) as an HIV prevention strategy in South Africa. Given that medical male circumcision partially protects men only from female to male STI and HIV transmission, women are rightfully voicing the need for active engagement in the development of policies and programmes regarding medical male circumcision for HIV prevention.

> *…it is good for men, not for women, because it is only men who are protected from HIV and STIs. As for me, no I am not protected…*[6]

WOMEN WANT TO BE INVOLVED…

> *…women need to be a part of taking this important decision, education and after care…*[7]

Women in the study voiced the urgent need for more community awareness and open dialogue; and also for government to lead on messages that could facilitate women's engagement in dialogue with men around MMC. They called for more information to enable women to engage in discussions with their partners and their sons, and expressed the inherent cultural tensions around women being historically excluded from traditional circumcision processes.

> *…more workshops are needed for us as women to make everybody aware of this scenario…*[8]

> *…women want to be involved, but are isolated because this is a man's secret…*[9]

SUPPORT FOR MMC, BUT…

> *…yes, I would support it, because it would help us women to decide on whether we want our children to be circumcised…*[10]

Overall, the participants supported MMC as an HIV prevention strategy, as they saw benefits primarily with regards to the reduction of STI's and HIV for both their sexual partners and their sons. However, women did not perceive MMC as offering them any protection, and pointed out that for women

to be protected, MMC needed to be combined with other interventions, including condom use and safer sex education, as well as counselling prior to circumcision.

The dominant perception was that MMC would lead to an increase in risk behaviour in men, with an associated increase in gender-based violence and stigma for women.

> *…this will encourage more males to be ignorant about the effects of HIV, and even their partners are on big risk…*[11]

> *…men are prioritised, and women will be blamed for HIV, as it happened before…*[12]

WHERE ARE THE PREVENTION PROGRAMMES FOR WOMEN?

> *…for me there is nothing available for now, there is nothing available for women, nothing…*[13]

Whilst supporting MMC as a prevention strategy, there was also a strong call for increased programming and implementation of female-controlled HIV prevention programmes both parallel to, and as an integral part of, MMC for HIV prevention programmes.

> *…female condoms need to be more and well designed, not big like it is now, there are not enough…*[14]

There was a call for female condoms to be more accessible and available, as well as the development of HIV prevention methods focussing on women, support systems for women, and the need to address the unequal power relations between women and men.

As one participant summarised what women are striving towards:

> *...having equal power with men on sex issues…*[15]

FOOTNOTES:

1. This contribution is based on findings of a pilot study on women's perception of, and engagement with, the introduction and roll-out of medical male circumcision for HIV prevention in South Africa. The pilot study was conducted by the AIDS Legal Network in late 2009/ early 2010 in two provinces. For more information see, Arnott, J. & Kehler, J. 2010. *Medical Male Circumcision for HIV Prevention: Are Women Ready?*. Cape Town. AIDS Legal Network. [www.aln.org.za]
2. [www.iol.co.za/index.php?set_id=1&click_id=2937&art_][wq id=vn20100307091536685C170950]
3. From an article originally in the *Tribune,* dated March 7th 2010, announcing that a trial male circumcision programme initiated in KwaZulu Natal had got off to a good start.
4. Quotations from the pilot study.
5. Arnott, J. & Kehler, J. 2010. *Medical Male Circumcision for HIV Prevention: Are Women Ready?*. Cape Town. AIDS Legal Network. [www.aln.org.za]
6. Quotations from the pilot study.
7. *Ibid*.
8. *Ibid*.
9. *Ibid.*
10. *Ibid.*
11. *Ibid.*
12. *Ibid.*
13. *Ibid.*
14. *Ibid.*
15. *Ibid.*

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On the road to human rights at home...

Positive women's search for adequate housing in the U.S.

Brook Kelly

Late last year in the District of Columbia, the capitol of the United States, a woman named Renee Paige, mother of two, lost the battle for survival, because she had no place to live. After her HIV infection left her weak with two bouts of pneumonia, she became unable to care for herself and eventually became homeless. The Washington Post reported that she had been sleeping on park benches and came to a community meeting where she told the group 'I have AIDS, and I am soaking wet'. *Ms. Paige died on a bench not far from the homeless shelter – which like other over-crowded shelters in D.C. – lacked the capacity to take her, and the many others in need.*

Sadly, the circumstances of Ms. Paige's death are not unique. Although the government provides people living below the poverty line a social security check, this amount is so meagre as to only provide enough money to live in a shelter and buy food, not to afford a decent place to live.

WOMEN CONSTITUTE ONE OF THE FASTEST GROWING GROUPS OF POSITIVE AND HOMELESS PERSONS IN THE UNITED STATES

HIV and AIDS rates in the United States reflect disproportionate economic, racial and gender disparities resulting in an HIV-positive population that has the multiple burdens of HIV disease, joblessness, homelessness, and generally poor health. Nationally, '*blacks*' account for about half of all AIDS cases, while making up only 13% of the US population as a whole. In some southern states, '*blacks*' account for up to 70 to 80% of HIV and AIDS cases. When both race and gender are taken into account, the HIV rates are staggering. In the nation's capitol, Washington D.C., 90% of the HIV and AIDS cases among women, are among black women, and this rate is expected to rise.

The epidemic among women, especially women of colour, is growing – from 8% of new HIV diagnoses in 1985 to 27% of new infections in 2007. The crisis of affordable housing contributes to the spread of HIV and limits the effectiveness of HIV treatment efforts, particularly for women. At minimum wage, a woman would need to work 21 hours per day, seven days a week to afford a two bedroom rental apartment at D.C.'s fair market rate. Perhaps not surprisingly, families with children are one of the fastest-growing segments of the homeless population.

In the nation's capitol, as many as 80% of homeless families are headed by women. With the global economic crisis and recession, unemployment and housing foreclosure rates in the US have sky-rocketed, leading to an increased rate of homelessness among families. Unstable housing diminishes the ability of positive women to adhere to HIV treatment and places them in situations where they must take risks to provide shelter for their families. Homeless women are at greater risk for HIV infection and, once positive, they are less able to protect their health and survive, much less thrive with the disease. For these

reasons, federal, state and local government must ensure gender sensitive housing policies that account for the unique challenges women face, because such policies play a crucial and dual role in any successful HIV policy - they work to both prevent HIV and facilitate better care and treatment adherence.

…the multiple burdens of HIV disease, joblessness, homelessness, and generally poor health…

Positive women interviewed in D.C. – which has the highest rate of HIV in the US – overwhelmingly cited the lack of affordable, or subsidised housing that meets the needs of women and their families, and an over-taxed shelter system that cannot provide safe and confidential environments for women living with HIV, as the most problematic issue for them. Shelters are overcrowded, unsafe, and the staff is often unprepared to serve people with chronic and possibly fatal illnesses like HIV.[1]

HOMELESSNESS PLACES WOMEN IN VULNERABLE SITUATIONS AND COMPROMISES WOMEN'S RIGHTS TO HEALTH, DIGNITY, AND SAFETY

Compared to the general population in the US, homeless individuals have an HIV prevalence rate three to nine times higher, and are seven to nine times more likely to die from HIV and AIDS.[2] Homeless people living with HIV die at a rate five times higher than housed people living with HIV.[3] As caretakers for their children, women who head most homeless families[4] are more likely than men in similar situations to find themselves having to exchange sex for shelter, food, or money[5], or remain in abusive relationships that could make them more vulnerable to HIV, or less able to care for themselves and their children if already HIV-positive.[6] Homeless women with children are less likely to prioritise their own health needs, as they focus on finding shelter for their families. Without responding to housing – a first concern of those most at risk for HIV and those with HIV – the United States cannot effectively fight the epidemic.

One positive woman in the District described the cycles of vulnerability so many women living with HIV face when they do not have a place to call home:

> *If you don't have housing and you aren't settled*, [you're] *not gonna take* [your] *meds, or go to the doctor*. [You] *can't get to it*. [You] *can't feel better about* [your]*self. If you don't feel good about yourself… you'll take recreational drugs*.[7]

…unstable housing diminishes the ability of positive women to adhere to HIV treatment…

For many people living with HIV, the structure that housing provides is one of many psychological, or emotional pre-requisites for treatment adherence with physical implications for health. A woman residing at Miriam's House, a D.C. housing facility for positive women, described what would happen if she could not stay there:

I would go back to my aunt's house. I'd be bad about

> *taking meds. I would just lay there and not take them when I didn't feel good. I would be lax about doctor's appointments. Miriam's House puts stability in my life... I need some* [stability].[8]

…government must ensure gender sensitive housing policies that account for the unique challenges women face…

Although many municipalities do have temporary housing programmes, or a shelter system, there are many barriers for women trying to access a bed for the night. Many programmes do not allow people to participate, if they are struggling with drug addiction, or have a criminal or drug charge on their record. Shelters often have strict closing times that do not coincide with most people's work schedules, making daily entry into the shelter a choice between work and a place to sleep.

When women are unable to obtain a home of their own, or gain access to a shelter in order to gain a temporary place to stay, they may be forced into dependencies where they trade favours for housing. They may be more likely to perform sexual favours, in which they have little control over condom use, in return for shelter.

Another positive woman interviewed related the extremely vulnerable position many women find themselves in when they have no home, and are unable to enter the shelter system:

> *If you* [are] *a woman, and you* [are] *homeless, and you meet a guy who has his own place, you* [are] *gonna go with him because then you have someplace to lay your head for the night. That's common. You've got a lot of people and especially women. If you miss that 4 o'clock bed* [deadline to be admitted to shelters in D.C.] *then you can't get into a shelter. So you meet John Doe at the gas station and you go to his house and sleep with him so you've got someplace to stay. You ain't using no condom, and you know, when you* [are] *out there, you* [are] *streetwalking, you sell your body*. [If] *I give you an extra $10 not to use a condom then you* [are] *gonna go bareback without the condom*.[9]

When a woman is forced to provide sexual favours, to be exploited sexually, just to obtain shelter, this places her at a great risk for contracting HIV. And, if the woman is HIV-positive and in poor health, the virus is more likely to be transmitted during unprotected sexual contact.

For positive homeless women, if they are lucky enough to gain entry into a municipal homeless shelter, the shelter itself can sometimes be a location that causes great risk to their health, and infringes on their right to confidentiality. Despite state and municipal obligations to comply with the Americans with Disabilities Act that recognises HIV as a disability, necessary accommodations are often not made for people living with HIV. The over-crowding and substandard sanitary conditions, so pervasive in the shelter system, can prove fatal for people with immune deficiencies.

In addition, time and time again, shelter occupants' right to medical confidentiality are infringed when shelter workers, not properly trained to deal with issues related to HIV and AIDS, expose occupants' HIV status without their consent; refuse to allow occupants to bring in the necessary food they need to take their medications in order to avoid crippling side effects; and properly store, or provide access to HIV medications.

AFFORDABLE HOUSING IN THE UNITED STATES IS AN UNREALISED HUMAN RIGHT FOR MANY POSITIVE WOMEN

The U.S. Department of Housing and Urban Development (HUD) defines affordable housing as a household that spends no more than 30 per cent of its income on housing. In 2007, about 22 per cent of rental households were spending more than half of their income on rental costs, and 8.8 million renter households with low incomes were spending more than half of their income on housing.[10] The number of households facing serious affordability constraints increased by 33 per cent between 2000 and 2007, and the poorest and most vulnerable people face the heaviest burdens in terms of housing costs.

…positive women's human right to housing in the U.S. remains unrealised…

Although existing policies recognise the importance of the role housing plays for people living with HIV, positive women's human right to housing in the U.S. remains unrealised. There are immense waiting lists for available programmes, such as subsidised Section 8 housing – the largest federal programme that provides rental subsidies for people below a certain income level – or the federal programme Housing Opportunities for People With AIDS (HOPWA) – an HIV-specific programme that provides housing assistance and related supportive services for people living with HIV through a grant making process, and other supportive housing programmes. In addition to literally years' long waiting lists, people with criminal, or drug records can be denied or evicted from federal housing programmes, based on these records. Every minute that a woman is unable to attain housing puts her in positions that heighten her risk to HIV infection, or make care and treatment adherence that much more challenging.

HOUSING AS A HUMAN RIGHT FOR WOMEN LIVING WITH HIV

Although the United States was an historic leader in the foundation of the international human rights systems, the US government is often more at ease enforcing human rights abroad, than at home. With the new administration, however, there has been a greater recognition of the importance of fulfilling human rights obligations at home, including the right to housing.

The United Nations Special Rapporteur on Adequate Housing, Raquel Rolnick, was invited for the first time to visit the U.S. in the fall of 2009. The Special Rapporteur visited cities across the country, meeting with a wide array of people from government officials to grassroots organisers. She commented that a country as wealthy and powerful as the United States has the responsibility to affirmatively alleviate barriers to adequate housing, and dispel disparities in housing that result from economic, racial, and gender inequality. The US Positive Women's Network (PWN) testified before the Special Rapporteur on positive women's housing rights in the United States, and submitted written recommendations. Recommendations for the US government were:

…forced into dependencies, where they trade favours for housing…

- **The emerging National HIV and AIDS strategy must include a gender sensitive access to housing component**. The US is in the process of developing its

first national HIV and AIDS strategy, which will provide unprecedented cross agency coordination to respond to HIV domestically. It is crucial that a gender analysis be employed in the development of this strategy to ensure gender sensitive policies are created that take into account the multiple challenges HIV-positive and affected women face that are exacerbated by the failure to provide the most basic human right of adequate housing.

The national strategy should also require that state and local governments develop comprehensive plans to deal with HIV that include the provision of adequate housing for all, in order to both prevent HIV and care for people living with HIV.

- **'*Housing First*' programmes should be available nationwide, become standard, and be adequately funded**. '*Housing First*', or other housing programmes that use risk reduction models, to prioritise getting people into housing by meeting people where they are, as opposed to establishing pre-conditions for participation, are key to addressing the needs of the most vulnerable populations. Resources should be devoted to developing programmes that help women with histories of drug addiction and mental illness gain housing. Women who have criminal records as a result of crimes of poverty, such as solicitation, or drug possession, should not necessarily be excluded from benefits programmes, and should in fact receive substantial housing support, when re-entering into the community after incarceration.

- **Target HIV '*Hot Spots*' for increased affordable housing**: Focus affordable, subsidised, and temporary housing programmes in HIV '*hot spots*', like underserved rural areas, or the US south, where the local government has failed to fulfil its obligations, and women's vulnerability to HIV infection, particularly for women of colour and low-income women, is highest, due to the confluence of homelessness, mental health issues, and substance use.

…the over-crowding and substandard sanitary conditions … can prove fatal for people with immune deficiencies…

- **Better integrate HOPWA, and other housing programmes, with supportive services for positive people**: The successful integration of services and voluntary programmes to help address violence against women, trauma, drug dependency and mental health into HOPWA and other housing programmes is key to addressing the complex and intersecting needs of women living with, and affected by, HIV. Faster and more accurate referrals to supportive services; voluntary on-sight support programmes, including mental health therapy, drug treatment, and peer support programmes, are also key.

Many of the Positive Women's Network's recommendations and oral testimony were reflected in the Special Rapporteurs'

final report to the U.S. government, wherein Rolnick called for non-discrimination in housing, especially for people with disabilities, including HIV and AIDS, increased housing services for families and people living with HIV, and for expansion of the definition of homelessness to include those living with family or friends, due to economic hardship – all recommendations that would increase housing opportunities for infected and affected women.

Another sign of the United States' re-entry into the international human rights community was the Obama administration's decision to join the United Nations Human Rights Council. As part of the USs membership, the government will be reviewed on its domestic human rights record by the Council for the first time as part of the Universal Periodic Review process aimed at improving human rights on the ground in each member state. The US will submit a report to the UN Council. Community coalitions have organised cluster reports around important issue areas to offer an alternative viewpoint to the official government report. The PWN, in partnership with a number of national and grassroots organisations, submitted a report on the human right to housing. The U.N. will review the U.S. governmental and cluster reports later this year in Geneva.

The location of the 2012 International AIDS Conference in Washington, D.C., will be a monumental opportunity for both the global and domestic AIDS community to hold the US accountable for their international and domestic commitment to HIV prevention, care, and treatment. The United States lifted the HIV and AIDS travel ban in 2009, making a global AIDS gathering in the nation's capitol possible, but more importantly the lifting of the ban was a public recognition that the policy was not based on evidence, but rather on fear and stigma.

The US has much farther to go, however, in alleviating stigma at home: we continue to have laws that criminalise HIV transmission and exposure, and sex work; HIV in the U.S. has become a disease that disproportionately burdens groups already stigmatised by racism, sexism, homophobia, and poverty. Holding the 2012 International AIDS Conference in Washington, D.C., the city with the highest AIDS rates in the country, can serve as a much needed spotlight on many of the United States' most forgotten people who live in the shadow of the White House: people living with HIV; people without a home; people without a voice.

FOOTNOTES:

1. National AIDS Housing Coalition. 2007. Housing is HIV Prevention and Health Care: Findings from the National Housing and HIV/AIDS Research Summit Series. Presenter's Guide 11. [www.nationalaidshousing.org/toolkit/research_findings_PPguide.pdf]
2. *Ibid*.
3. *Ibid.*
4. Wider Opportunities for Women. 2008. D.C. Women's Agenda Mayor's FY 2010 Budget for Women in D.C. (on file with author).
5. See A Capitol Offense: The gender dimensions of Washington D.C.'s HIV/AIDS crisis: A human rights report by the women's Collective and the International Women's Human Rights Clinic at Georgetown University Law Centre. September 2009. [http://womenscollective.org/index.php?option=com_content&task=view&id=190&Itemid=1]; Interview with Attorney, Women Empowered Against Violence (WEAVE), Washington, D.C., 13 February 2009.
6. *Ibid*.
7. Focus Group with HIV-Positive Women. The Women's Collective, Washington, D.C., 12 February 2009.
8. Focus Group of HIV-Positive Women. Miriam's House, Washington, D.C., 17 February 2009.
9. Focus Group of HIV-Positive Women. The Women's Collective.
10. Department of Housing and Urban Development (HUD), *FY 2010 Budget. Road Map for Transformation*, p9.

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Time to make some noise..

Musings

It is 2010, and the silence is deafening. AIDS is sliding off the political agenda, even as its toll on communities around the world continues. The United Nations General Assembly Special Session on HIV/AIDS feels like a momentous, yet distant past.

Tyler Crone

I recall a professor telling me in the early 1990s that if I focused on gender and HIV, I would be out of a job before long. It is nearly twenty years later and gender inequality remains a central cause and consequence of the HIV epidemic.

Another professor, a leading voice in HIV prevention research, I recall telling me in 2001 that if people in Africa accessed ARVs, then '*they*' would just have more sex. Less than a decade ago, the global community thought access to ARVs was an unlikely '*pipe-dream*', and the HIV world was pitting prevention against treatment. In 2001, the then head of USAID, Andrew Nastios, stated in essence that 'Africans' can't tell time, because they don't wear watches, so treatment was not viable in deeply affected, resource poor settings. Treatment was only the privilege of the few, not the right of the many.

...it is 2010 and the silence is deafening...

I hear the '*tick tuck*' argument again – '*there are too many new infections, the cost of treatment is too high*'. It seems to be the return of the '*us*' and the '*them*' phenomena. Instead of an embrace of the large-scale success of treatment access celebrating the lives saved, the new infections averted, and the dignity, hope, and health restored; there is a backlash against HIV, against treatment, and against the model of global health achievement, which it represents.

I saw Magic Johnson on the television the other day. He was not presented as someone who is HIV positive; he was just Magic Johnson – sports announcer, basketball star. With treatment, we have finally begun to achieve what has been a seeming mirage...'*normalising*' HIV, so that it is just like any other chronic condition. In a world of treatment access, a person living with HIV would be no different, than a person with high blood pressure or diabetes – and so, the days when women would be thrown out of their homes, or children out of their schools, would feel so distant that we could begin to forget the terror, stigma, shame, and blame, which HIV wrought.

At the very moment where I believe we, as a global community, began to meet a critical tipping point of expanding access to ARVs and realising health as a right, not a privilege; I also see us letting go – rather than building from – our collective achievement and loosing sight of our collective humanity.

So as I look to AIDS 2010, I want to see meaning to a conference that calls for '*rights here, right now*'. There is no real AIDS response, without the meaningful involvement and potent leadership of people living with HIV driving it. There will be no real progress in addressing maternal child health, without embracing and advancing the sexual and reproductive health and rights of positive women. There will be no real success in HIV prevention, when we lack women-controlled tools, and fail to address gender inequalities. And, there will be no real halting stigma and discrimination, when law and policy responses to HIV include criminalisation or coercive sterilisation.

It is 2010; the silence is deafening and it is time to make some noise!

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In conversation with Prudence Mabele[1]

Prudence Mabele is a South African human rights activist and a leading advocate for people living with HIV. Prudence is the Founder and Executive Director of the Positive Women's Network South Africa.

JK: When and how did you become a human rights activist?

PM: It all started around 1993. I found out about my HIV status in 1990, and the more I was talking to my friends and colleagues, I realised that I was violated because of my HIV status. A lot of things were taken away from me, even the right to stay at that institution and study.

At the time, AIDS was still said to be a *'gay disease',* and so I really wanted to find and organise women like me to start a conversation and to share our experiences. But it was difficult. I managed to find one sex worker here and one woman there, and yet I knew that there were many. And that's how I started organising and getting involved – around my own experiences and difficulties of living with HIV. After some time we managed to get different people together who were positive and we started the National Association of People Living with HIV. But even there I found out that we, as positive women, are meant to be the beneficiaries, but women were not in leadership positions, or even close to them. Nobody was even preparing women for these kinds of positions and this was bothering me a lot. Most women were poor, uneducated and it was frustrating for me to see how this was used to explain that women cannot assume the position of leaders. And so we started talking about rights and what their rights are, what women's rights are.

Looking back now, I see someone who was just a volunteer at the time, doing a lot of things – it was an amazing experience. I managed to not only speak to women in South Africa, but also to many other women outside South Africa, and in fact globally.

JK: What do you think is the most pressing issue for women now, and what has changed since then?

PM: Now, there is a lot of information. Even female condoms are somewhat available now; and women have achieved this. And then there are the drugs women can take to reduce the risk of HIV transmission to their babies. So yes, things have changed a bit since that time. But then, the agenda is still run by men on behalf of women, and I am not sure if women have

lost their ground or if they are just too tired to challenge that – even within women's groups.

I used to say that women are the ones getting to know their HIV status, since they go to the ante-natal clinic where women are mandatory tested for HIV, which will lead to violence; and people didn't believe me. I think now, we have gone as far as making the links between HIV and violence, which we didn't want to do before. But still, we often don't see the bigger picture of women's rights violations.

There are still many challenges for women, it is really tough. Agenda's are being developed for women living with HIV, sometimes even without positive women being there. At times, I think, we have lost the ground, even internationally. We are giving all the resources to strategies like medical male circumcision, which are taking the spotlight – while we have never seen research for women done with such urgency. And even with male circumcision they do not look at the bigger picture of what does this new intervention mean for women. After all these years of teaching women, of talking about women's rights, of discussing the problems around condom negotiations, and the need to look at the economic status of women – the issue have not changed much, they really have not changed much!

JK: What issues do you feel most passionate about?

PM: At the moment there is lots of talk about the meaning of UN protocols and structures, like UNGASS and CSW. I am battling to translate this into my day-to-day life, and I want to find a way so that these protocols and processes can really translate and be meaningful to any woman, to ordinary women's lives.

I am passionate about just making a change to any woman at a grassroots level and seeing women being their own leaders in their own communities, and be more like agents of change. And I believe this has to happen and can happen.

JK: What is your biggest achievement?

PM: Convincing government that treatment for everyone in Africa is a human rights issue. Governments must provide treatment. These are the biggest achievements. We were instructing governments to stop talking and start providing treatment to all Africans – *'you talk and we die'.* Taking these actions was a big achievement.

The other achievement, I think, is to say and start to understand that HIV and AIDS are feminised. We need to stop saying that women are vulnerable, we need to start identifying the things

that make them vulnerable and deal with them. Although the disappointment is always that they would introduce a new programme that would again take a woman two steps back.

JK: What is your biggest disappointment?

PM: The biggest disappointment is that even though every country around the world started to work with women; yet violence against women is still a big threat to their lives and safety. It seems no matter what we are doing, we are still not going far enough for women.

JK: What would you say needs to change?

PM: Patriarchy! Men should start respecting women, respecting women for being women, for being their mothers, their grandmothers, their daughters – for just being and to start looking at women as human beings. Women are human beings and they need to be respected, they need to be loved and then we would start going somewhere. But all the inequalities, the injustices and all of this tribalism and sexism and all the other *'isms'*, they make us not to have a better place to live. And so, I guess, it is patriarchy that needs to change!

JK: If you had one wish…?

PM: I wish that no woman would have to say that she has no treatment, no matter what regimen she needs, just to be given that chance to live by taking this antiretrovirals. Treatments also should translate into women's lives in a much better way. The treatment that is available is old, and really impacts on women's bodies; it makes women deformed, and causes a lot of problems. Governments would say no, we don't have the money to invest in better treatment – and I wish they would invest in women, because if you empower women, you empower entire communities.

FOOTNOTES:

1. The interview was conducted by Johanna Kehler (JK) of the AIDS Legal Network (ALN) on 12 April 2010.

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