

the right to access safe and legal abortion

Monday 23 July 2012

Mujeres Adelante

Daily newsletter on women's rights and HIV – Washington 2012

In Focus...

Kate Griffiths-Dingani

Best and worst of times in the AIDS response...?

The opening plenary session of AIDS2012, the XIX International AIDS Conference held this year in Washington D.C., USA centred on the ambitious goal to 'End' HIV and AIDS, with many speakers referencing the exciting scientific evidence that 'treatment as prevention' is more effective than previously hoped at preventing new infections, making real the possibility that 'the beginning of the end of the epidemic' is in sight. After three decades of conferences, programmes, research and clinical practice, we have truly begun to turn the global tide.

The conference venue in D.C. in part represents the medical, social and political progress against the disease; it's the first IAS conference held in the United States since 1990, in San Francisco. The choice to hold the gathering of more than 25,000 researchers, policy makers, activists and clinicians in D.C. was made possible by a domestic and international campaign

against a U.S. immigration policy that prevented '*HIV positive travellers*' from entering the country, a campaign which culminated in the '*travel ban*' being lifted in 2009, through a bipartisan effort. The return of the conference represents the progress that Kathleen Sebelius, Secretary of Health and Human Services, United States, imagined would warrant congratulations from early AIDS activists who died of the disease, if only they were able to now witness it. Several other speakers, including the left-wing Congresswoman from Oakland, CA, Barbara Lee and Ambassador Mark Dybul, United States, who worked under the Republican Bush administration, emphasised the degree to which AIDS treatment and prevention -- once the purview of a small group of dedicated activists -- have become '*bipartisan*', uncontroversial and a reflection of mainstream '*American values*'.

But on another level, the choice to hold the conference in the capital of the United States also indicates the continuing crisis facing the International AIDS community. Since the onset of the global financial crisis in 2008, funding for HIV treatment has been severely under threat, with

cuts and stagnation in new donors and donations coinciding with the ascent of the Obama administration. Welcoming remarks from speakers as disparate as Elly Katabira and the new World Bank President, Dr. Jim Kim, emphasised the generosity and '*love*' of the American people for those living with from around the world, repeating the importance of the United States in efforts to '*scale-up*' treatment and prevention, and the historical role of the USA and President Bush's PEPFAR programme as the largest single source of AIDS treatment and prevention funds. Michel Sidibé of UNAIDS repeated his remarks from Vienna in 2010, calling for a Robin Hood tax on global financial transactions that could make-up the shortfall in funding required to meet international targets for halving new infections, ending mother-to-child transmission, and keeping mothers alive by 2015. He argued that Dickens famous first line from *A Tale of Two Cities* might be particularly apt for the International AIDS community in 2012.

The contradictory situation, where in the real opportunities to reverse the epidemic may be hampered by insufficient funds has created a similar '*best of times, worst of times*'

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sensibility for activists and women living with HIV. With nostalgia for what Barbara Lee called the ‘*historic achievement*’ of Bush’s PEPFAR legislation being leveraged from the dais to bring pressure on the current administration, activists and civil society organisations are being increasingly praised from unlikely quarters for historic achievements in the ‘*fight against AIDS*’, and provided with important platforms to address the conference. Dr. Kim cited the forward-thinking insights of activists from ACT-UP in the early days of the epidemic to Durban 2000 as central to the successes we have already seen from harm-reduction efforts to drug pricing research timelines and treatment access, and pledged that work with activists and ‘*civil society*’ will be a hallmark of his tenure at the World Bank and bank efforts not only to end AIDS, but also in its efforts to eradicate poverty.

Nevertheless, Zimbabwean activist Annah Sango, speaking for the

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International Community of Women Living With HIV (ICW), expressed the frustration of infected and affected activists and women facing the same unanswered questions conference after conference and year after year, and a lack of accountability by those with the power to move the agenda forward. ‘*Why*’, she asked the crowd ‘*do the same old problems continue to prevent women from accessing treatment? Why are women still marginalised in terms of resources? Why are governments still failing to protect women from violence? Why do women living with HIV face forced sterilisation in Namibia, South Africa [and elsewhere]? Why are we still debating basic sex education?*’ Most pointedly, she noted that the International AIDS community has in fact moved backwards in terms of measurable leadership from people living with HIV, and women living with HIV in particular.

As Dr. Kim noted, activists have led the International AIDS Community, even when reviled or marginalised for it; now is the time for women impacted by the epidemic to move ahead with their boldest demands, despite temptations to strategically scale-back in a moment of financial uncertainty. As Sango puts it, ‘*Now is the time to make waves...Nothing for us, without us!*’

Kate is an anthropologist and writer, who lives in Brooklyn, NY and frequently works in Durban, South Africa.

Claudia Stoicescu, Sophie Pinkham

Women-centred harm reduction interventions...

Women who inject drugs have received relatively little attention in the global response to HIV. Nevertheless, there is a growing body of evidence to suggest that women who inject drugs experience increased risks for injection-related harms, including higher rates of HIV. Further, in many parts of the world, drug use conflicts with the socially accepted roles of women as mothers, partners and caretakers, resulting in harsher stigma, discrimination, and human rights violations both at the community level and within services. In particular, women who inject drugs often face barriers to accessing sexual and reproductive health services and exercising their right to make informed, free choices about their sexual and reproductive health.¹

Recent years have seen an increased focus on effective, evidence- and rights-based interventions for women who inject drugs. Harm Reduction International has reviewed existing evidence of the risks faced by women who inject drugs to develop a proposed package of interventions based on international good practice. Research has shown that sexual behaviour plays a greater role in HIV risk for women who inject drugs than it does for men. Coverage of vertical prevention programmes is often lower for women who inject drugs, and gender discrimination and neglect reduce their access to healthcare vis-à-vis other populations. Incarcerated women who inject drugs remain a neglected minority in prison-based harm reduction and HIV prevention programmes.

Gender-specific harm reduction interventions can address the particular vulnerabilities faced by women who inject drugs, and multidisciplinary

programmes are needed to address the multiple factors increasing HIV risk for this population. A proposed ‘*menu*’ of HIV prevention and treatment services for women who inject drugs has been developed to be included in the 2012 Global State of Harm Reduction report, also being launched at AIDS2012. The proposed package includes additions to the existing comprehensive harm reduction package proposed by the World Health Organization and UN agencies² to attract and retain more female clients. This includes women-specific materials and activities (e.g. short-term childcare); multi-component interventions that address specific risk factors for women who inject drugs (e.g. case management, parenting support, responses to intimate partner/sexual violence); and women-specific stand-alone services, such as multi-disciplinary maternity services for women who inject drugs or women-only rehabilitation centres.

Please join us in the Women’s Networking Zone, on **Monday, 23 July 2012, 12:45 – 1:45**, where the proposed package will be presented as part of a discussion on Achieving Sexual and Reproductive Health and Rights for Women and Girls Living with HIV, through Innovative Community Approaches.

Footnotes:

1. Roberts, et al. 2010; Sherman, 2008; Olszewski et al, 2009.
2. WHO, UNODC, UNAIDS, 2009.

Claudia is a Public Health Analyst with Harm Reduction International and Sophie is an Independent Consultant.

News from the Global Village...



News from the 'margins'...

Lynette Mabote

Opportunities for impact...

Yesterday's satellite *'Reaching Key Populations Through SHR/HIV integration: Opportunities for Impact'* focused on investigating the key opportunities to reach key populations, through sexual and reproductive health and rights and HIV integration.

Lacking in our interventions over the past ten years has been the inclusion of the *'voice of the client'* in this agenda.

According to Sunita Grote of AIDS Alliance, India, the vulnerabilities of sex workers and female IDU's had to be understood as a guide to build on what already existed. *'This meant moving beyond the 'easy bits' in creative and effective service delivery as an entry point to integration'* Grote said.

'Responses must be targeted and tailored in diverse epidemics', said Clansy Broxton, the Senior MARPS Senior Advisor of USAID. She added that contextual appreciation was critical in developing SMART integration strategies and targeting the unmet needs of key populations.

Sub-Saharan Africa, having a more generalised epidemic remains bound by draconian legislative measures, which criminalise same-sex consensual relations. In some settings, promotion of approaches, going beyond HIV and addressing sexual and reproductive health needs of key populations, have stimulated this agenda. Natalie Nkoume from CAMNAFAW, Cameroon, shared results from a project which focused on healthcare service providers and LGBTBI populations in Douala.

'Continuous engagement with communities and government is pivotal in addressing the

value judgments, and promoting environmental changes for key populations whose needs were previously overstepped', states Nkoume. Results highlighted from a quantitative and qualitative research study undertaken by NEPHAQ, Kenya, in 2010 revealed that adolescents (girls and boys) born HIV positive and now sexually active, were faced with barriers of access to sexual and reproductive health services, especially access to family planning services at local facilities in Nairobi.

Reaching key populations through the integration of sexual health and reproductive rights and HIV remains a key building block to realise right-based approaches. However, with inadequate funding and piecemeal solutions, we will continue to come to spaces like this, and repeat ourselves. Perhaps it is now time to act more and speak less...

Lynette is with ARASA.

Tyler Crone, Rachel Yassky, Johanna Kehler

Women's Realities... Gender and HIV – A litmus test

Realising MIWA, the meaningful involvement of women living with HIV, means building programmes and policies with the most affected at the centre. Do we have women living with HIV and women across all of our diversity represented at this conference? The answer is mixed.

After a mass sign-on letter and outcry, the conference organisers created space for an additional plenary to be given by a woman living with HIV. Our *'MAKE WOMEN COUNT!'* plenary speaker was not invited on the first list – and her inclusion was a result of pressure from stakeholders across the United States and globally. The fundamental principle of having the most affected speak from their lived expertise remains contested. Women who use drugs or who do sex work are shut out, due to immigration restrictions. Sex worker rights advocates are instead organising a parallel forum in Calcutta, because of the entry bans they face in the United States.

We'll keep on this point of realising MIWA – and suggest other examples of where this principle is being left behind. New campaigns are coming-up to halt vertical transmission – which continue to be the only specific *'female-controlled'* prevention strategy the mainstream HIV response seems able to promote. These campaigns, designed to *'eliminate'* mother to child transmission of HIV, portray women as objects and the vessels to

be managed or controlled. Pregnant women are featured as grim-faced, with writing in black marker across their swollen bellies, or as Barbie-like pink dreamy caricatures of pregnant women reminiscent of a *'Hallmark'* card. Our feminist selves recoil from these images, ones that drift far afield from women's lived reality. MIWA? We think not.

At a gala to champion the ambitious and important goal of ending vertical transmission of HIV, nary a cry of *'woman'* could be heard. Where are women as essential partners? The most motivated and passionate people we know, who are carrying the charge of healthy babies and healthy families and healthy communities, are my fearless friends and heroes who are WOMEN AND MOTHERS living with HIV. We are reminded of a pivotal Lancet piece two professors of mine from Columbia – the late Allan Rosenfield and Deborah Maine authored in **1985** – *'Where is the M in MCH?'* This was a wake-up call to the maternal and child health field to put women at the centre, where all the research in the field overwhelmingly evidences they belong. This was also a transformative moment, in which we moved from the narrow confines of maternal and child health toward the more encompassing, robust and more woman-centred frame of sexual and reproductive health and rights as captured in the 1994 ICPD Programme of Action.

We will use two more issues as my *'litmus'* test for where we are in addressing gender in the context of HIV.

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In 1990, Zena Stein published *'HIV Prevention: The Need for Methods Women Can Use'* – a paper that is identified as a catalytic platform for the microbicide movement. In 1990, the same year the International AIDS Conference was last held in the United States, the call for a microbicide was made. As of today, the call remains unmet. The promise of the Caprisa findings has yet to be realised – and we still don't have this tool in women's hands. Similarly, the FDA approved the female condom in 1993. And

while a new generation has come of age who can use this vitally important tool, it is still not in the hands of the women who demanded it and whose health and welfare could be enhanced by its use.

At the same time, voluntary medical male circumcision for HIV prevention was taken-up with rapid speed and an almost unchecked flow of funds. Kenya has a goal of circumcising more than one million men by 2013 – and 150 parliamentarians in Zimbabwe have just pledged to undergo circumcision to demonstrate their political will.

Our last *'litmus'* test – yesterday, amazing panellists had discussions at a satellite event co-sponsored by ATHENA, UN Women and others. Again and again, women's absence in the seats of power was underscored. Where are the gender experts at the Global Fund secretariat? Where is the investment in women's advocacy? And where is the funding for women's human rights? How is it again – or how is it always – the case that women are pushing uphill? That we are turning the tide, despite the obstacles we face? We know we have friends and strong champions who invest in us across the UN – across the donor community – across civil society – and yet – we still see that far too many of us don't know how our advocacy, our work, and our community will garner the resources need to stay afloat, to hold on, to push forward and to realise the promise of a different tomorrow.

Tyler and Rachel are with the Athena Network and Johanna is with the AIDS Legal Network, South Africa.

Sierra Mead

Taking stock of evidence...

In today's sphere of HIV research, there is no longer a question of whether gender-based violence is associated with HIV. The link between gender-based violence and HIV was reaffirmed in Sunday's pre-conference satellite session: *Gender-Based Violence and HIV/AIDS: Taking Stock of Evidence and Setting an Implementation Research Agenda*. The panellists – Dr. Charlotte Watts, Dr. Kristin Dunkle, Professor Kate Shannon, Professor Michele R. Decker, and Meryem Aslan (Chief of UN Trust Fund to End Violence Against Women) – commonly recognised that gender-based violence is both a cause and a consequence of HIV infection, and brought unique evidence and perspectives to this session, which took a systematic look at studies on the impact of gender-based violence against sex workers, as well as physical and sexual violence against women and its significant association with HIV. Throughout the session, the conclusion arose that despite the obvious correlation between HIV and gender-based violence, there is lacking realisation that reducing both gender-based violence and new HIV infections will take a multi-sector approach. The question remains, how can we work together to confront the significant relationship between gender-based violence and HIV?

There is less focus on sex workers and violence against sex workers in the discussion of the elevated burden of violence and HIV. Both Shannon and Decker provided relevant data to the disproportioned burden of physical and

sexual violence against female sex workers. In a systematic review of current studies and available evidence that focuses on sex workers, violence, and HIV related outcomes, only 11 studies met eligibility criteria of covering both physical and sexual violence.

The significant lack of data is a problem, as sex workers face the brunt of gender-based violence and, it is vital to note that where *gender*-based violence is concerned, there is even less data on male and transgender sex workers. Moreover, while gender-based violence is commonly associated with women, homophobic violence against lesbian, gay, transgender people has also expanded the impact of HIV infections. Effectiveness of the HIV response will be limited without more research on the relative stakeholders and perpetrators of violence (i.e., police and customers), the significance on the work environment (brothels, street, bars, self-advertisement, entertainment) and its potential association with HIV infection. Reducing violence against female sex workers will reduce the burden of HIV, and it is time to evaluate and scale-up HIV prevention programming to include violence against women, *all women*, including sex workers.

Gender-based violence is associated with HIV and despite the evidence, knowledge, and understanding, violence against women programmes rarely work side-by-side with HIV services and

vice-versa. Violence against women is, unfortunately, more often addressed separately from HIV. It is the responsibility of every sector that focuses on a particular form of violence to open its doors to HIV research and understand that the two are intrinsically linked and related. Practitioners who work in the health sector and HIV should be able to recognise different forms of violence and understand its relation to the disease. Aslan in particular pointed out that by fusing specialties on both individual and institutional levels, education and community outreach programmes can only grow stronger.

There is substantial infrastructure in terms of HIV programmes and support and it is time to combine this with programmes available for violence against women. While it is imperative to 'combine' different aspects of programmes and approaches to effectively address the links between gender-based violence and HIV, it also takes one more kind of change, and the inclusion of one more sector in this conversation: men. Until masculine norms are reconstructed and expectations of male behaviour are modified, gender-based violence, and more specifically violence against women, will remain a strong element of the HIV epidemic.

Sierra is with the AIDS Legal Network, South Africa.

UPCOMING EVENTS

07:00-08:00 *An Intergenerational Dialogue on the SRHR of Young Women Living with HIV*
Mini Room 7

08:30-10:30 *Plenary: Ending the Epidemic: Turning the Tide Together*
Session Room 1

10:30-11:30 *Violence Against Women Living with HIV: An international overview*
WNZ

11:00-12:30 *A Labour Rights Approach to HIV and Sex Work: Working with Sex Workers to Protect Human Rights,*

Prevent and Eliminate Violence and Sexual Harassment and Promote Equal Access to Social Protection Schemes

GV Session Room 2

12:45-13:45 *The Global Plan: What Does it Mean for Women's Rights?*
WNZ

14:30-16:00 *Turning the Tide Against Violence*
Session Room 4

Ending Criminalisation: Legal and Advocacy Strategies to Address and Repeal Discriminatory Laws

GV Session Room 1

14:30-18:00 *My Body, My Rights: Ethics and Human Rights for Women Living with HIV in Research,*

Care and Treatment Settings

Mini Room 8

16:30-17:30 *The Intersection of Homelessness and HIV Incidence*

WNZ

18:30-19:30 *HIV and the Law: Insights on How to Advocate for Enabling Legal Environments for African and Black Populations Across the Diaspora*

GV Session Room 2

18:30-20:30 *Rhetoric to Reality: Delivering Integrated HIV and Family Planning Services*

Session Room 5

18:45-19:45 *Female Condom Fashion Show*

GV Main Stage

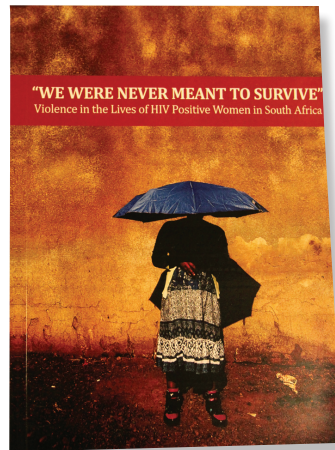
Special report:

'We were never meant to survive...'

In April 2012, the One in Nine Campaign released a report titled *'We Were Never Meant to Survive': Violence in the Lives of HIV Positive Women in South Africa*. The report presents HIV positive women's experiences and analyses of violence, and aims to expand social conceptions of the links between violence and HIV transmission in two ways: first, by expanding understandings of inter-personal violence beyond sexual violence and, second, by incorporating structural, systemic and socio-cultural forms of violence into definitions of violence.

The report explores five themes that emerged in the focus group discussions and interviews with HIV positive women in two provinces of South Africa.

The first theme concerns the silencing effect of the discourse surrounding HIV on women's experiences of violence. It examines the contrast between HIV positive women's attitudes to disclosing their HIV status and undertaking HIV activism, and their reticence in speaking about their experiences of violence. Telling in this regard is the claim made by a few participants that there existed no forms or instances of gender-based violence in their communities. Confining understandings of violence mainly to sexual violence threatens to invisibilise other forms of violence



that undermine women's agency and lead to the instrumentalisation of responses to violence in government and NGO policies, which speak of 'gender-based violence', only insofar as it may be shown to be a cause and/or effect of HIV transmission, not because it is a violation of people's fundamental rights to bodily and psychological integrity.

A second theme concerns the effects of abuse or neglect by family members, particularly mothers, on the lives of HIV positive women. Here, the report seeks to demonstrate the transmission of violence from mother to daughter, such that women often find themselves caught in the same cycles of poverty, unemployment and economic dependence as their mothers, even as they may hold their absent or negligent mothers responsible for the abuse they faced as children, as well as their current plight. Thus, participants speak of women who demand that their daughters contribute to the family income at young ages and while they

may still be in school, knowing, often from experience, that the only way for girls to bring home food or money is through transactional sex with boyfriends or other sexual partners. The social and economic pressure to be sexually active at a young age results in early pregnancies, unfinished education and lack of employment; it also reduces women's capacity to negotiate sex and relationships. Women's lack of access to livelihood and to housing emerges as the key reason for this continuing generational transmission of violence and disempowerment among women.

The third theme provides another dimension to the idea of the feminisation of HIV. The section on *'women's disease'* tracks the ways in which almost all the ideological, social and practical burden of HIV testing, prevention and treatment rests on women, even as women have little control over methods of protection and little power to challenge social and sexual norms. Often lacking decision-making authority in the family and community, women are nevertheless setup as the guardians of family and public health, and thus as ultimately culpable for the presence of HIV in the community. Further, pregnant women who access health services often find themselves left with no choice but to get tested for HIV; they speak, for instance, of being told by healthcare staff that they will not receive midwife services if they do not get tested for HIV. In the continuing climate of stigma and gendered stereotypes attached to being HIV positive, women find themselves stuck between male partners who use them as tests (ascertaining or confirming their own HIV status when the women get tested,) and a healthcare system and broader community that treat them as the originating vectors of transmission.

The fourth thematic exploration revolves around the idea of HIV as destiny, showing the ways in which becoming HIV positive seems to be an inevitability in poor women's lives.

...a healthcare system and broader community that treat them as the originating vectors of transmission...

... the crisis of self-care in HIV positive women activists' lives...

It examines the circumstances that lead women to enter into sexual relationships with men, and the social and economic constraints on women's ability to negotiate the terms of these relationships. This exploration gives the lie to the belief that women can protect themselves from infection, as long as they are monogamous and in relationships that are free of direct force and violence, as implied by the national strategic plan. It also suggests that the social and economic violence that expose women to HIV infection require as much attention as violence that may follow disclosure. Women's male sexual partners almost always accept the news that their girlfriends or wives are HIV positive without surprise or

anger, often confessing or implying afterwards that they already knew they were HIV positive.

A final theme explored in the report exposes the 'positive' woman – the HIV positive woman activist who faces immense pressure from family, community and from organisations to always display strength and a positive outlook when speaking of her HIV status and to be a relentless advocate for testing and treatment, regardless of any personal challenges she may face. This exploration examines the crisis of self-care in HIV positive women activists' lives and suggests that the rhetoric of 'positive living' may in fact silence women from speaking about other, 'negative' aspects of their lives. It also briefly looks at

some of the challenges faced by HIV positive women on treatment, such as body-distorting side-effects of medicines and their inability to find employment. Thus, women speak of continuing to be economically disempowered and unable to negotiate safer sex, while being expected to be social symbols of empowerment and HIV prevention.

The One in Nine Campaign is a feminist collective of organisations and individuals in South Africa.
www.oneinnine.org.za

The full report can be accessed at
www.oneinnine.org.za/58.page.

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Luisa Orza

Home is where the heart (of an effective HIV response) is...

Homelessness and unstable housing are significant factors in HIV incidence for women and girls, and have been identified as a structural driver of the HIV epidemic in all settings. Insecure housing intersects with other factors, which increase vulnerability to HIV acquisition and its impacts, including poverty, gender inequality, and HIV-related stigma, discrimination, and violence. Nevertheless, the issue of secure housing, including through ensuring property and inheritance rights, is often overlooked in advocacy to address women's and girls' vulnerability to HIV and to achieve sexual and reproductive health and rights for women and girls in all our diversity.

Women's and girls' right to own and inherit land and property continues to be undermined in both policy and practice, and in particular through the primacy of customary law in many countries, even where an apparently equitable or gender neutral legal framework exists¹. Insecure land tenure and property rights push women and girls into poverty and weaken their ability to protect themselves from or cope with the impact of HIV infection, thereby contributing to its further spread. Weak tenure status intersects with women's generally lower economic status, gendered norms around childbearing and -rearing, care giving, and sexual passivity, and cultural practices, such as *lobola*, bride-price, polygamy, and widow inheritance and -cleansing.

The issue of homelessness and unstable housing will be explored during AIDS2012 in the Women's Networking Zone, looking at experiences of dialogue, advocacy and innovative solutions in the US, Kenya and other parts of Africa, and sharing strategies to incorporate into HIV prevention, care and support programmes and advocacy for women. Specifically, sessions led by the US National AIDS Housing Coalition, the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), and the Huairou Commission, will share

experiences and findings from research into the intersection of homelessness and HIV vulnerability in the US; the reconstruction of community-based 'courts' in Kenya, adopting a rights-based approach to peacefully and equitably resolve disputes over property; and grassroots social protection mechanisms driven by home-based caregivers, respectively.

Recognising and addressing the gender dimensions of homelessness, housing insecurity, and lack of ownership of land or other assets, is key to understanding and achieving broader issues of women's and girls' access to economic security, income generation, and social protections and safety nets, and to strengthening the HIV response for women and girls.

Join us in the Women's Networking Zone to explore the intersections of property and inheritance rights and HIV, to deliberate approaches for an effective response, and to showcase existing good practice.

Monday, 23rd July, 16:30 – 17:30, **WNZ Annex**
The intersection of Homelessness and HIV Incidence – National AIDS Housing Coalition

Wednesday, 25th July, 13:00 – 14:00, **WNZ Main Stage**
Using Customary Structures to Address Disinheritance and Denial of Land and Housing to Widows and Children Living with HIV – Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) & Open Society Institutes, East Africa (OSIEA)

Thursday, 26th July, 13:00 – 14:00, **WNZ Main Stage**
Building an Economy from the Bottom up: Grassroots Women's Strategies for Establishing Economic Security in the Context of HIV and AIDS – Huairou Commission and the Global Coalition on Women and AIDS (GCWA)

FOOTNOTE: 1. See for example USAID, Land Tenure, Property Rights and HIV/AIDS

Luisa is an independent consultant and women's rights advocate.

In Our Opinion...

The right to know...women and Depo-Provera

Women and men need to be informed about the positive and negative aspects of Depo-Provera. This is but the latest illustration of the importance of comprehensive education and the need to insist on women's informed autonomy in public health interventions.

There are no simple solutions for the protection of women from HIV. Each new dilemma forces us to return once more to the need for ongoing support and education for women about the fundamental issues of birth control and HIV transmission. New challenges, such as the link between Depo-Provera and increased risk of HIV, underscore the need to raise awareness about gender issues so central to protecting women from infection. Is it not time to accept that poor women – indeed all women – can be educated to adequately assess the options available and the risks involved?

We require informed consent for all research interventions. All such, ethical requirements are based on the principle that research subjects are thinking human beings who can make informed choices. In the same vein, we cannot proceed in the area of reproductive health and the risks of HIV and other infections without treating all women as autonomous human beings who have the basic rights to training and education about their own bodies and sexuality. We not only have to treat women as autonomous human beings, but we need to educate women to make sure they can understand and choose the forms

of contraception and HIV risk prevention best for them.

In order for women to make appropriate decisions, we are impelled to invest in much more extensive and ongoing education and training for both providers and women. Women need to learn about possible reproductive options, and providers need to learn how best to transmit such knowledge in a respectful and constructive engagement with their clients. A more comprehensive education and training will serve as a long overdue crucial investment for the future. It will be an essential platform for implementation, as new options are developed or new threats emerge.

We propose the following active steps:

1. We need to develop an approach to HIV treatment and prevention that is based on the fullest possible education of women and men about their own anatomy, the risks of infection and other problems, and the possible solutions and choices available.
2. We need to share our ongoing findings in reproductive and AIDS prevention and treatment with the public, and especially with clients using HIV clinics and family planning services. In order for women to be positioned personally to evaluate their use of family planning methods and AIDS prevention and treatment, we need to develop methods of communication and community mobilisation to an extent we have not yet begun to see.

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3. Open discussion about women's bodies and sexual relations will lay the groundwork for community understanding and implementation, as the newer anti-HIV technologies become increasingly available: pre-exposure preparations, male contraception, microbicides and rings. All such new technologies need distribution and further evaluation.

Only when women and men have access to full explanations and understanding of these new options can they plan their families and also protect themselves from HIV.

4. We need further research into the social situations in communities, among youth and between intimate partners that reinforce the use of existing barrier methods, such as the male and female condom, and the possible use of other options. Adequate prevention will require the communication of effective information and understanding for all.
5. Beginning with an explanation of the only devices we have that will confer protection against both unwanted pregnancies and HIV, the male and female condoms, we need to provide ongoing support for women and men to continue to use these methods. We can then discuss the new options, their promise and their drawbacks.

Ida is a professor of anthropology and Zena is an epidemiologist of Columbia University.

Supported by the Oxfam HIV and AIDS Programme (South Africa) and the South Africa Development Fund

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