the right to access safe and legal abortion
without fear
Monday • 20 July 2009
Mujeres Adelante
without the fear of criminalization
without coercion
Newsletter on women's rights and HIV – IAS 2009
the right to safe, healthy motherhood

In Focus...

Suzannah Phillips

Without knowledge or consent...

The *'battle'* over reproductive rights for positive women in Chile

With an HIV prevalence rate of 0.3 percent and universal access to antiretroviral treatment, Chile might seem like an unlikely battleground for the struggle over the rights of HIV positive women. Yet, in stark contrast to the strides that Chile has made in providing universal access to ARVs, the state has failed to respond to the pervasive stigma, discrimination and misinformation around HIV and AIDS in healthcare settings, resulting in a widespread denial of reproductive rights of HIV positive women in Chile. In response to this situation, VIVO POSITIVO, a Chilean organisation advocating on behalf of people living with HIV, and the Center for Reproductive Rights, an international legal organisation, recently filed a petition before the Inter-American Commission on Human Rights on behalf of a woman, who was forcibly sterilised, because she was HIV positive.

Coercion in Healthcare Settings

While coercive sterilisation of HIV positive women is not a state policy in Chile – indeed, Chilean law requires written informed consent for all surgical sterilisations and prohibits discrimination against people living HIV in healthcare facilities – coercive sterilisations of HIV positive women and other discriminatory practices continue to occur with impunity as a result of the deep-seeded stigma associated with HIV.

In 2003, VIVO POSITIVO conducted a study on the sexual and reproductive rights of women living with HIV, in Chile, that revealed high incidence of pressure and coercion in healthcare settings. Of the women interviewed, 56 percent indicated that they were pressured to use contraceptives to prevent pregnancy, and of the women, who had undergone surgical sterilisations after learning they were HIV positive, 50 percent reported either that they were pressured by healthcare providers to do so, or that the intervention was performed without their knowledge.[1]

Recent interviews with healthcare users and providers in Chile confirm that such coercion is still rampant. In these interviews, HIV positive women have reported many types of coercion that healthcare providers employ to promote sterilisation. Some physicians have used guilt, preying on the isolation and fear that their pregnant HIV positive patients felt, and chiding women for risking the birth of an HIV positive child. Others have presented sterilisation as the woman's only option, either by withholding information about alternative choices or withholding medical treatment until the woman consents to the procedure. Still others have taken matters into their own hands, performing or attempting to perform tubal ligations in conjunction with caesarean operations, taking advantage of the vulnerability of an anesthetised patient. One healthcare provider openly admitted that she strongly encourages HIV positive women, who have at least one child, to be sterilised, suggesting that it was in their best interests.

The impact of these coercive practices often goes beyond the specific physical and psychological harm to the individual victim. Interviewed women, who reported past experiences of institutional discrimination, confessed that fear of future ill-treatment either prevented them from seeking necessary healthcare services or, in some cases, led them to conceal their HIV status from treating physicians. Fear of coerced sterilisation might also discourage women living with HIV from relying on skilled birth attendants during delivery, having the perverse effect of increasing what is an otherwise low risk of mother-to-child HIV transmission.

F.S. v. Chile

The case of F.S., a young woman from rural Chile, is emblematic of the widespread discrimination that HIV positive women face in institutional settings in Chile. F.S. learned she was HIV positive during routine pre-natal screenings, while pregnant with her first child. Despite her initial fears, F.S. was relieved to learn that the chances were good that her child would be born healthy and HIV negative –the risk of mother-to-child transmission of HIV in Chile is less than two percent. Over the next months of her pregnancy, F.S. took all the necessary steps to carry to term a healthy child, seeking regular pre-natal care and antiretroviral medication, despite having to face the harsh critiques of attending nurses who consistently chastised her for '*carrying a child in her situation*'. F.S. delivered her child through a caesarean section, and awoke later that morning to good news: she had given birth to a healthy, HIV negative son. The nurse then delivered a blow: this would be her only child. During the operation, the surgeon had sterilised her, without F.S.'s knowledge or consent.

Following her sterilisation, F.S. attempted to vindicate her rights, and, with the help of VIVO POSITIVO

Whats inside:

and a local lawyer, filed a criminal complaint against the operating doctor. Notwithstanding the blatant illegality of the surgeon's actions – Chilean law criminalises physical harm resulting in impotence – the substandard investigation into F.S.'s allegations and the subsequent trial were marked by irregularities and bias, and the doctor was acquitted of any wrongdoing.

By allowing widespread, institutional discrimination against HIV positive women to persist with impunity, the Chilean state is violating its international human rights obligations. The coercive sterilisation of F.S., and the subsequent denial of justice, is symptomatic of this widespread denial of reproductive rights.

In reaction to the State's reluctance to implement policies to curb such coercive practices and its failure to hold doctors accountable when forced sterilisations have taken place, VIVO POSITIVO and the Center for Reproductive Rights presented F.S.'s case to the Inter-American Commission on Human Rights in February 2009, alleging that Chile violated its obligations enshrined in the American Convention on Human Rights and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women.

The petition maintains that the coerced sterilisation of F.S. violated her rights to physical and psychological integrity, humane treatment and dignity, personal liberty, privacy, family life, health, and her right to be free from gender-based violence. In addition, the petition argues that the denial of justice violated her right to effective judicial remedies. F.S. is entitled to these rights and freedoms, without discrimination on the basis of her gender or her HIV status.

By presenting an international complaint, the Center for Reproductive Rights and VIVO POSITIVO are seeking redress for F.S. and the implementation of policy and normative changes necessary to safeguard the rights of women living with HIV to make reproductive health decisions free from coercion.

Why International Litigation?

International litigation can be an effective tool for advancing reproductive rights at the domestic, regional and international levels. On the one hand, international litigation can promote compliance with international human rights obligations. On the other hand, such cases help establish legal precedent that can be persuasive both in future litigation in domestic and international fora and in advocacy campaigns.

International litigation can help bridge the gap between human rights that are protected by law, but that are repeatedly violated in practice, as is the case in Chile. Decisions handed down by international or regional adjudicatory bodies may extend beyond reparations for an individual victim, recommending, in addition, legislative and policy changes to supplement or enhance existing frameworks to prevent similar rights violations in the future.

..the denial of justice violated her right to effective judicial remedies...

...allowing widespread, institutional discrimination against HIV positive women to persist with impunity...

Beyond the potential to effect change within Chile, international litigation around the issue of coercive sterilisation has the potential for wider influence. A favourable decision in the F.S. case can help strengthen regional and international efforts to challenge the practice of coercive sterilisation by affirming that the reproductive rights of people living with HIV are human rights, and by establishing precedent that can influence favourable decisions in other regional and international tribunals. Recent reports out of the Dominican Republic, Kenya and Namibia demonstrate that coercive sterilisation of HIV positive women is a global phenomenon.

The battle that VIVO POSITIVO and the Center for Reproductive Rights are waging in Chile will hopefully bring us one step closer to ending such practices globally.

Suzannah is the Columbia Law School Henkin-Stoffel Fellow, and is dividing her fellowship between VIVO POSITIVO and the Center for Reproductive Rights. For more information: suzannah.phillips@gmail.com.

Footnotes:

1. Francisco Vidal, Marina Carrasco, and Rodrigo Pascal, *MUJERES CHILENAS VIVIENDO CON VIH/ SIDA: ¿DERECHOS SEXUALES Y REPRODUCTIVOS?*, 68, 106 (2004).

Breast is best... Breastfeeding and survival

Zena Stein and Ida Susser

The plenary presentation by Louise Kuhn on *HIV in women and children* is of great importance. Not only is it an absolutely up-to-date and precise account of where we are in terms of prevention, antenatally and post-natally, of maternal infant transmission of HIV, but it also points unambiguously to where we need to go – appropriate medication for the mother before and after giving birth; lactation counselling; and medication of the infant, as required.

We can be overjoyed that breastfeeding is once again reinstated as essential for child survival, especially in poor countries, and especially in Africa. Threatened by the advent of formula some three decades ago, artificial feeds were successfully beaten back. Then it seemed that the spectre of HIV would once again fill the clinics with its expensive and unnecessary products, hazardous in many places. Listening carefully to Dr Kuhn, and attending to the missteps in Rakai, Uganda (increasing mortality six-fold), and also in Botswana (doubling the mortality), we are able to assert, once again, that '*breast is best*' for babies.

It is interesting to reflect that just in the last few years, major epidemiological and clinical studies have shown this truth once again. Babies who are breastfed, and especially those who are exclusively breastfed for the first few months have fewer episodes of serious illnesses; they are slightly brighter; and when adults, they have less obesity and diabetes. Mothers who breastfeed, are less obese, and have less breast and ovarian cancer. There are fewer new births following immediately after the index one. Moreover, the advantages to child survival are even more marked for HIV infected infants who are breastfed, as compared to those who are not.

Now, as Louise tells us, with advances in treatments, placing the mother's health high on the agenda, we can reduce the prenatal infection of the infant and add protection to her breastfed baby, whether the infant is infected or at risk of infection. And as we have always known, a happy healthy mother is, like breast milk, best for the baby.

Of course, complete and integrated programmes need motivation, planning, and funds. But, at last, with important results of these many careful studies, both of people infected and not with HIV, in countries of poor resources and wealth, the roadmap is in place across the world.

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Women's realities...

Maria de Bruyn

Women as holistic persons...

Sexual and Reproductive Health and Rights for Young Women

Over the past decade, there has been much rhetoric and some action concerning the need to develop gender-based and human rights-based approaches to HIV and AIDS-related policies and programming. This has led to some advances, such as increased attention to the intersections between HIV and AIDS and gender-based violence and measures that can greatly reduce the birth of HIV positive babies. However, simultaneously, the focus on women in relation to the pandemic has come to centre around only two of their '*roles*': that as vectors of (perinatal and sexual) HIV transmission and that of victims (of violence against women).

> ...we must define what that integration of HIV and reproductive health will entail...

One of the examples of how this has played out is obvious. The emphasis on women as vectors has led to the implementation of 'prevention of mother-to-child transmission' (PMTCT) programmes in all countries. (An important note: it would be preferable to revert to the originally used, and more gender-neutral, terminology of prevention of perinatal or vertical transmission programmes). The importance accorded to these programmes results in periodic announcements by UN agencies, and civil society organisations, about the coverage of such programmes and needs for additional funding to expand them. UNAIDS' guidance on constructing core indicators for reporting to the 2010 UN General Assembly review of the Declaration of Commitment to HIV/AIDS includes an entire chapter on prevention of perinatal transmission.

In some cases, some well-funded programmes have been able to become PMTCT+ interventions, which also provide antiretroviral drugs to women and their children after the postnatal period. But even then, the concern has mainly been to ensure the survival of women, so that they can continue to care for their children, i.e., in their role as mothers. Such ongoing antiretroviral therapy is not (to my knowledge) being offered to HIV positive women, who miscarry, have stillbirths, or who choose to terminate unwanted pregnancies.

A truly gender-based approach to women and HIV and AIDS would look at women and girls (as well as men and boys, but here my focus is mainly on women) both as persons independent of their societal roles and in relation to their multiple roles and needs. When considering HIV and reproductive health, this means we need to shift the focus away from an emphasis on prevention of perinatal transmission to a more comprehensive consideration of HIV and AIDS in relation to reproductive health.

On 2 March 2009, at the 53rd Session of the UN Commission on the Status of Women, UNAIDS director, Michel Sidibé, stated:

> *The social revolution will require strong efforts on many fronts – some of which I have spoken about before…First, give women and girls the power to protect themselves from HIV. We are already facing a recession of care. We cannot allow HIV to contribute further to this burden. This requires investment in universal access to comprehensive sexual and reproductive health services. Now is the time to join forces to fully integrate delivery of antenatal, sexual and reproductive health and HIV services. Let us seize this moment. Second – we must respect and protect human rights. The social construction of gender will not be solved by services alone. The AIDS movement has used the power of human rights to transform society's approach to the epidemic.*

If we are to heed Sidibé's recommendations, we must define what that integration of HIV and reproductive health will entail. Broadly speaking, it should – at the very least – include integration and/or linkages between HIV-related interventions and services that address the following elements of reproductive health:

- Non-discriminatory and widely available access to reproductive health services – not limited to family planning and prevention of perinatal transmission – but also encompassing prevention (vaccines), screening and treatment of reproductive tract infections and cancers; multiple forms of prevention barrier methods, including female condoms; contraception in relation to antiretroviral therapy, emergency contraception and safe abortion care.
- Comprehensive sexuality education and voluntary HIV testing for everyone, especially women outside the antenatal care setting.
- Attention to the specific sexual and reproductive needs and desires of HIV-positive youth just entering puberty and women entering the post-menopausal period.
- Neglected areas of programming, including risks and needs for lesbian and bisexual women related to HIV, substance abuse and depression issues for women affected by HIV and AIDS, ways to deal with unwanted pregnancies, options for parenting other than biological parenthood.

It is past time that we engage in dialogues to define and plan for linking and integrating HIV and AIDS services with areas of reproductive health in addition to family planning, prevention of perinatal transmission, and ending/managing violence against women. The 2010 UNGASS review will offer us an excellent opportunity to push for an HIV/AIDS Reproductive Health Initiative that we can all endorse and support.

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Women's Voices...

Sophie Dilmitis

Where is the commitment...?

Sexual and Reproductive Health and Rights for Young Women

In the next 10 years, 100 million young women will marry, before they turn 18[1]. And we know that young married girls are more likely to experience violence and exposure to HIV.

Today, nearly 60% of the 104 million children, who do not attend school, are girls. HIV infection rates are higher for girls, who do not finish primary school.[2] Most girls, either in or out of school, do not have access to sexuality education.

We live in a world where at least one in three women has been beaten, coerced into sex, or abused in her lifetime. Fear, lack of legal protection and the societal acceptability of violence, prevent women from seeking help and justice. Women subjected to violence are at higher risk of acquiring HIV and young women are even more vulnerable.

Sexual rights protect people's right to decide when, where, how, and with whom they choose to have sexual experiences. Sexual rights include mutual respect, consent from both parties and equality. Therefore, young women must have all information about how to protect themselves and their sexuality. When young women are empowered and supported, they can choose whom to marry and when.

In order to protect themselves, young women should have access to life-saving devises, like female and male condoms. In 2007, only 9% of high-risk sexual acts worldwide, happened whilst using a condom. The supply of both female and male condoms is significantly below levels that would impact on the HIV epidemic in a substantial way. Condoms, today, should be used to prevent contracting and transmitting HIV, STIs and pregnancy, yet, condoms seem to only be marketed as an STI prevention technology and not as a contraceptive tool. Every year, 340 million women contract sexually transmitted infections, which must be treated,[3] and still today, most women are unable to negotiate the use of condoms. With everything we know today, this is still something that is not taught.

Reproductive rights enable people to make informed and educated choices about starting a family. A young woman should be able to decide how many children she would like to have, when and how she decides to have those children and to have them safely. Reproductive rights ensure freedom to make informed decisions about contraception or birthing methods.

80 million women have unintended pregnancies every year[4], either because they lack information, lack contraception, or contraceptive methods fail. 200 million women say they would prefer to avoid pregnancy, but lack effective contraception. Family planning is one of the most cost-effective ways to improve maternal and child health, and yet receives, on average, less than 2 percent of all official development assistance.[5]

Over 60,000 women die from unsafe and illegal abortion, which is part of the five hundred thousand maternal deaths that occur annually. Maternal deaths reflect the unequal and unjust society we live in: in the USA, the lifetime risk of maternal death is 1 in 2,500; in Ethiopia, it is 1 in 14; and pregnancy is the leading cause of death for young women aged 15 to 19 worldwide[5]. Obstetric fistula, a living death, resulting from unattended complications of childbirth, affects over two million women and girls[7].

Today over 15 million women around the world are living with HIV. Women often receive HIV tests during pregnancy, without their knowledge or consent, which is a gross violation of human rights.

Many women are at risk of contracting HIV within their marriages, and we are seeing an increase of HIV infections in couples, who are considered to be low risk. Information for sero-discordant couples about associated risk of HIV infection is hard to come by, and information on successfully treated sero-discordant couples, is even harder to come by.

...family planning... receives, on average, less than 2 percent of all official development assistance...

UNFPA estimates almost two million women living with HIV become pregnant[8], and all too often, a pregnancy of a woman living with HIV is stigmatised. Positive women often deliver alone, or are sterilised, without consent or the knowledge of what sterilisation means.

Many times positive women struggle to access correct information and, to make matters worse, many times, positive women are not free to say that they are sexually active. Sexual pleasure is a fundamental part of all our lives, and sexual intimacy is known to play a valuable part in maintaining psychological well-being. We are all sexual beings, whether or not we choose to engage in sex. To pretend otherwise, is to deny a fundamental part of our existence as human beings.

Positive women, do not always know when it is safest to get pregnant and what medications could avoid peri natal transmission. Only 31% of pregnant HIV positive women have access to once-off doses of Nevirapine, but what is just as important, is access to antiretrovirals that protects the mother, ensuring her survival to raise her children.

The International Conference of Population and Development (ICPD), held in Cairo in 1994, concluded with

…lack of legal protection and the societal acceptability of violence prevent women from seeking help and justice…

pledges to achieve universal access to reproductive health services for everyone in all countries by 2015. The Millennium Development Goals echo the ICPD goals and call for a specific commitment to reduce maternal mortality by 2015. Next year, the world will also review the commitment government leaders made in the Declaration of Commitment on HIV and AIDS. As advocates for women and young women's health, we must not only hold our leaders accountable for these promises, but also find ways to ensure they are achieved.

The World YWCA's Global Strategy on Sexual and Reproductive Health and Rights (SRHR) and HIV and AIDS, identifies four areas around which urgent action is required to make an impact on SRHR for all women – especially young women.

These are:

1. Providing comprehensive prevention
2. Creating safe, secure and inclusive spaces for women, young women and girls
3. Developing leadership and capacity, especially with young women as champions and leaders around SRHR, HIV and VAW
4. Ensuring quality documentation and good monitoring and evaluation of YWCA programmes

While the World YWCA makes its own contributions, the movement continues to ask for accountability and commitment towards actions that invest in the SRHR of women and girls, uphold their human rights, and end stigma and discrimination.

We dream to live in a world, where a woman can:

- Decide for herself when, and if, she has a sexual relationship – this alone would eliminate child marriage.
- Have access to all the information on sexual and reproductive health and rights, as well as HIV and AIDS, to make informed decisions.
- Access land and employment so that she is empowered to decide when, and if, to have a sexual relationship and/or be married.
- Live in a world free of violence. Violence will never be acceptable. In cases where violence has occurred, women would have access to safe shelter, counselling, support, legal options and post-exposure prophylaxis, so that she has a better chance of not contracting HIV, if there was a possibility of HIV exposure. Women should not have to carry to term an unintended pregnancy resulting from rape.
- Access information, screening and treatment for other sexually transmitted infections besides HIV.
- Be protected by knowing that male circumcision is implemented in a way that protects women.
- Receive the necessary support to care for people living with HIV – since women are the majority of those providing care.

We want to live in a world where, as a girl grows into a young woman:

- She has sexuality education, teaching her life-skills in taking responsibility for her own sexuality.
- She learns how to use female and male condoms, has access to '*no-cost*' condoms, and knows how to negotiate condom use.
- She knows how to prevent unintended pregnancies with effective contraception, and she can access contraception suited to her needs.
- She knows that, if she has a haemorrhage, every health facility is required to help her survive.
- She knows that when she is pregnant, she can have a safe delivery and is cared for through the days after the birth to make sure that she does not die and leave an orphan.
- She knows how HIV is transmitted and how HIV is not transmitted, and knows how and where to get confidential voluntary counselling and testing to learn of her HIV status.
- If she tests HIV positive, she knows about, and has access to, triple therapy treatment (the most effective treatment). Her reproductive rights are respected. She chooses when, and if, to have children. She chooses whom to tell about her HIV status.
- And as a young girls get older, she would have regular screening and treatment for cervical and breast cancer.

…reproductive rights enable people to make informed and educated choices…

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Footnotes:

1. Inter-Agency Task Team on Education. Girls Education and HIV prevention. UNAIDS 2008.
2. Inter-Agency Task Team on Education. Girls Education and HIV prevention. UNAIDS 2008.
3. WHO. 2009. *HIV prevention, treatment, care and support through sexual and reproductive health services.*
4. J. Joseph Speidel, Cynthia C. Harper, and Wayne C. Shields (September 2008).
5. How Family Planning Protects the Health of Women and Children, May 1, 2006
6. Ibid.
7. UNFPA. Obstetric Fistula.
8. Maria de Bryn. 2008. Reproductive Choice and women living with HIV/AIDS. Chapel Hill, NC: ipas. [www.ipas.org]

Special Report

Jacqueline Patterson

Race, Ethnicity, and Indigeneity…

Uniting factors in activism on VAWG and HIV

> *Racism, in its intersection with gender, leads to women of colour being the most vulnerable population in the world.* [Dr. Peter Aggleston, UNAIDS]

As reported by Sarah Ford, of the Unitarian Universalist Service Committee, Aggleston decried the invisibility of these groups, the fact that their existence is denied by powerful discriminatory attitudes and practices, including the denial of information and healthcare. He called the western world to task, stating that racism has kept the west from learning from other nations.

> *Cultural differences should not be used as a reason to ignore the successes and lessons from around the world.*

On March 2nd 2009, preceding the 52nd United Nations (UN) Commission on the Status of Women, 25 women gathered in New York at a meeting convened by Women of Color United and the Women of Color Resource Center to discuss how women of colour in the United States, may become more engaged in international spaces. We determined that, especially as the financial crisis increasingly diminishes space for sharing of best practices, coalition building, and amassing power to affect progressive change, women and girls of colour in the United States must find their place in limited international linkage spaces and connect with our sisters worldwide for joint organising and activism for progressive bilateral and multilateral policies on violence against women, and increasing rates of HIV in women and girls. At the meeting, Elmira Nazombe of the Racial Justice Office of the United Methodist Office at the UN, and Naina Khanna of the US Positive Women's Network noted a tension in wanting to form relationships with our sisters across the globe, but that, while recognising our marginalisation within our own shores, we also do not want to be viewed as trying to take more space, than is our due in an international context, given our nation's position of relative access and privilege. One of the first steps, the group agreed, is to start to *increase the use of the human rights frame in the United States (US)*, so that when we link with our global sisters, we are all speaking a common language, and using similar reference points for setting standards.

The US Center for Disease Control 2007 Surveillance report demonstrates that African American women in the United States are 23 times more likely to be HIV positive, than white women, and AIDS is the leading cause of death for African American women aged 25-34 years. Though African American and Latin American women only comprise 24 percent of the population, they comprise approximately 81 percent of persons living with HIV. American Indian/ Alaska Native women have 3 times the HIV prevalence rate of white women in the US. Some of the cities with high populations of people of colour in the United States have HIV infection rates that are comparable to countries in Sub-Saharan Africa. For example, in Washington DC, where the population is 65% African American, the rate of HIV among adults, at 5%, is on par with rates in post-conflict Rwanda and the Democratic Republic of Congo. Though Asian and Pacific Islander women do not have significantly higher rates over other racial groups, the gender differences are important to note, as young Asian and Pacific Islander women aged 15-24 are more than 3 times as likely to be HIV positive, as young men.

…the case for urgent action is clear…

Although data is not the most reliable, available rates of violence against women and girls (VAWG) of colour in the United States also reflect racial, ethnic, and indigenous disparities:

- According to the National Resource Center on Domestic Violence, (NRCDV) African American females experience intimate partner violence at a rate 35% higher, than that of white females, and about 2.5 times the rate of women of other races. However, they are less likely than white women to use social services, battered women's programmes, or go to the hospital because of domestic violence.
- In an Asian and Pacific Islander Institute on Domestic Violence survey, 41-60% of Asian Pacific Islander respondents reported experiencing domestic violence (physical and/or sexual) during their life times, the upper end of the range being twice the global average.
- According to the National Violence Against Women Survey (NVAWS), Hispanic women were 25% more likely than non-Hispanic women to report that they were raped by a current or former intimate partner at some time in their lifetime. 48% of Latinas, in one study, reported that their partner's violence against them had increased, since they immigrated to the U.S.
- According to the NVAWS, 37.5% of Native American/ American Indian women are victimised by intimate

partner violence in a lifetime, defined by rape, physical assault, or stalking.

Among the social determinants of violence are many of the same issues that also contribute to heightened vulnerability to HIV. Key determinants include low socio-economic status and resulting dependence on remaining in abusive relationships; gender inequity, which places women in an unequal role in relationships; low levels of education; substance abuse issues; sexual identity discrimination; lack of culturally appropriate support mechanisms, such as prevention and mitigation programming in communities; racial, ethnic, and indigenous discrimination, as well as xenophobia; immigration and fear of deportation; stigma and fear of isolation; disproportionate incarceration of women of colour; distrust of '*the system*' and particularly law enforcement; and related forced choice of '*racial/ethnic/tribal/nationhood loyalty*' over justice for individual or women's rights.

Violence against women and girls is both a cause and consequence of HIV and AIDS. These pandemics are linked via physical/biological, emotional, and social mechanisms. Women who are HIV positive are more likely to experience violence, due to stigma and discrimination, dependence and inability to leave relationships, and otherwise. And women in violent situations are at higher risk for HIV, due to inability to negotiate safer sex for fear of violence, through vaginal tears from forced sex, and other means. Some examples demonstrating the linkage, among women of colour in the US, are as follows:

- A Journal of Counseling and Clinical Psychiatry study found that Native American Women, who were physically-emotionally abused as children, had 5.14 times greater odds of having a sexually transmitted disease in their lifetimes, than did women who experienced only marginal or no physical-emotional abuse.
- A study from Women and Health of primarily African American and Latina women in the Bronx, found that both violent (experienced by 81% of respondents) and non-violent traumas (experienced by 97% of respondents) appeared to play a role in the behaviours that place women at risk of HIV infection.

…social determinants of violence are many of the same issues that also contribute to heightened vulnerability to HIV…

The rates of HIV and VAWG, the mechanisms linking VAWG and HIV and AIDS, and many of the social determinants for women and girls of colour in the US, mirror the circumstances for women and girls in the global south. Furthermore, many of the macro-level forces governing prevention and response, such as the policies, programmes and practices of multi-lateral entities, including the UN agencies, and the International Monetary Fund(IMF), the World Bank, as well as bilateral entities, such as the private sector and the US government, provide common ground for joint advocacy and action. Women in the US are particularly uniquely positioned to work with women of the global south to take action on the US government, which often takes the same failed policies and practices towards women from the domestic agenda and exports them globally with even more rigor and resulting damage worldwide.

…a tension in wanting to form relationships with our sisters across the globe…

Considering the demonstrated dire nature of the situation for women and girls of colour in the US, the case for urgent action is clear. Women of colour from the US have much to learn from women globally, who have more experience in using human rights framing, and have much to share regarding addressing the intersection of VAWG and HIV and AIDS. The common factors that are shared and mechanisms for change that can be jointly engaged by women of colour in the US and women globally are easily identifiable.

The US government, UN entities, IMF, World Bank, and even the private sector seem small when confronted by legions of determined women and girls across the globe, linking arms in united purpose towards mutual aims. An African Proverb says *'When Spiders Unite, They Can Tie A Lion*'. It is past time for us to work more closely together to hold national governments and multilateral entities accountable, so that bilateral and multilateral policies, programmes, and practices are in compliance with existing international treaty bodies and conventions. We also need to work to fill the gaps in established agendas around addressing VAWG, HIV and AIDS, and the myriad issues impacting the well-being of women and girls of colour world wide.

In response to a suggested collaboration between women of colour in the US and women of the global south, Delphine Serumaga of Uganda stated

> *This is good because women of colour in the US are saying, 'We're feeling what you're feeling. Is there something we can do together?' as opposed to bringing a model from somewhere else and trying to impose it here.*

This sentiment is reminiscent of the famed quote by Lili Watson, an aboriginal woman from Australia:

> *If you have come to help me you are wasting your time. If you are coming because your liberation is linked with mine, let us work together.*

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In our opinion…

Tyler Crone and Johanna Kehler

Is the AIDS response working for women?

Moving forward to AIDS2010 in Vienna

We approach this conference eager to see what new scientific findings have emerged since Mexico City to answer the question of whether or not the AIDS response is indeed working for women. Do we have new tools in our toolkit? Do we have new science from which to build novel strategies and to address the structural drivers of the pandemic? Are there findings that we can mobilise around? Will there be a presentation this week that will radically alter our approaches and transform our knowledge base? When will there be a HIV prevention breakthrough for women, akin to the momentum and significance of medical male circumcision for men? When will there be new technologies, or the embrace of existing ones, such as the female condom, that all women, regardless of their HIV status, can use to enjoy pleasurable and safer sexual lives?

But even before we reach these '*big*' questions, what about the simple ones? Do studies now all include sex-disaggregated data? Are the findings analysed for their impact on women and men? Is the first author of the study a woman? Have we reached a saturation point of research about women and by women, in proportion to the impact the pandemic has on women, particularly the young and the poor?

The answer is '*not likely*'. For example, in a study of accepted abstracts for the 2007 IAS Conference in Sydney by Evan Collins, only 18.1% (non late-breaker abstracts) of accepted abstracts were directly relevant to women and/or girls. Both the submission of abstracts and the relative acceptance of abstracts on women and girls were lower than other areas of research. Further, the majority of the research, identified as directly relevant to women and girls, focused on maternal/infant health and PMTCT.

And now, building from this finding in 2007 that the majority of the research directly relevant to women and girls was focused on maternal/infant health, will we see science that is addressing the totality of women's lives? Have we moved beyond the '*silo-fication*' that is all too common? What does the research community offer to women who are living with HIV, and are struggling to maintain their health and the welfare of their families? Or to women who are seeking to become pregnant and deliver healthy babies, regardless of their HIV status? Or to HIV positive women, who need treatment, but do not have children and therefore, have less of an entry into healthcare where service delivery is primarily focused on the perinatal setting? Of course, the health and welfare of mothers, children, and families is a primary concern; however, the late Allan Rosenfield's provocative question of '*where is the M in MCH?*' continues to apply.

Lastly, how are we conceptualising research? Do the questions we ask assist the broader community of stakeholders in the AIDS response, such as researchers, advocates, policy makers, and programme implementers, including, centrally, persons living with and affected by HIV? Are we narrowing the gap between research and women's realities? Are we finding ways of applying research to respond to women's needs and women's risks? Are we asking the '*right*' questions? Are we mapping and analysing and responding to the structural drivers of the pandemic – including gender inequality and poverty?

…to reconcile the demands and dictates of rigorous research with the realities and totality of women's lives…

The late Jonathan Mann would often speak of the public health utility of a condom when the young woman, trying to negotiate its use, has no power to do so. Even though it has been over a decade since his death, his point remains at the heart of where we may, or may not, be failing to develop an adequate and honest AIDS response for women.

Our commentary is filled with questions that we seek to pursue as a conversation with the scientific community, in search for answers of how to reconcile the demands and dictates of rigorous research with the realities and totality of women's lives.

We invite you to join in this discussion – to contribute and share your perspective – and to be a part of our conversations toward AIDS2010 in Vienna.

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