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Mujeres Adelante

Daily newsletter on women's rights and HIV – Vienna 2010

In Focus...

Sexual Rights are Human Rights!

Kate Griffiths

Sexual rights – to dignity, privacy, education, autonomy, health, reproductive choice and the search for fulfilment and pleasure – are central to the human experience. But for young people, and too often, for people living with HIV, sexual rights are infringed by the paternalistic, stigmatising or criminalising approach of healthcare institutions, governments and individuals.

On Thursday, young members of the International Planned Parenthood Federation (IPPF) of Latin America and the Caribbean addressed this topic in a workshop led by young people, for young people, arguing that sexual rights are human rights for everyone, including youth. This session also helped to explain and promote a new *'declaration,'* which develops a framework for defining and protecting sexual rights.

According to this manifesto, sexuality is an integral part of personhood, and sexual rights apply to all. Pleasure is a central part of sexuality, and requires freedom from harm. The text states that sexual rights should be limited only insofar as they infringe on others' human rights. IPPF notes that the sexual rights of those *under 18* differ from those older than 18, in that evolving capacities to exercise rights. Finally, the right to education and the right to make decisions to reproduce or not, are fundamental human rights.

IPPF members made clear that young people face specific obstacles to securing sexual rights. These

include barriers to health services and education, particularly because youth are often depended on educational systems, which may or may not provide services and information around sexuality. They often face legal and practical barriers to accessing routine sexual healthcare, contraception and abortion. Privacy is also complicated because of the non-majority legal status of youth, and some youth may face coercion from partners and family around their sexual and reproductive health.

LGBTQ youth are denied sexual rights in particularly dramatic ways, often facing homelessness, poverty, violence, family and community rejection for pursuing sexual choice and gender expression, and are more vulnerable than adults at a critical period in their lives.

Persons living with HIV also face specific threats to their sexual and reproductive autonomy, including stigma from potential partners, their own and their partners' families. Healthcare providers are also negative about the sexual and romantic relationships of people living with HIV. People living with HIV often feel – and are often told – that love and family life are out of reach, despite evidence that this is not true.

Given these threats to universal sexual rights, youth living with HIV are severely impacted. In the Caribbean people under 25 make up half the population, while HIV is the leading cause of death among people aged 15-44. IPPF aims to defend sexual rights in the region as a whole, by providing targeted health services that address the needs of young people, LGBTQ youth and youth rendered homeless by poverty and stigma. IPPF also support comprehensive sexual education in countries in Latin America and the Caribbean as a crucial first step toward establishing sexual rights as human rights, while promoting peer education of the variety presented at this years' IAS Youth Pavilion.

This framework, sexual rights as human rights, is both provocative and useful not only for youth and people living with HIV, but for all human beings. Too often sexual health and reproduction are treated only as sites of disease, not sources of pleasure, fulfilment and personhood.

Kate is a writer and ethnographer based in Durban, South Africa.

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LBT: Gender and Sexualities

Jayne Arnott

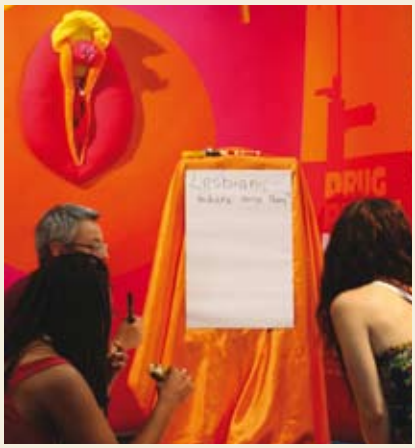
Why are lesbians so invisible in the HIV world? Sophie Strachan from UK Positively suggested a number of possible reasons – the belief that HIV does not exist in the lesbian community, that culturally in some countries it is not the norm to be open and talk about these topics, and the ever present fear of ostracism from ones own, as well as from the lesbian community.

Sophie has been facilitating a group with LBT positive women for four years and shared some of the difficulties that group members faced in exploring their sexuality, a delicate and personal subject, within the group setting. Some women found it easier to express themselves through writing and developing a newsletter that is distributed to health professionals and others, is an effective awareness-raising tool and in working towards more responsive health services.

The discrimination around sexual orientation and the stigma attached to HIV creates multiple barriers in exploring ones sexuality and sexual desires, and, according to Sophie, individuals are often still exploring and/or affirming their sexuality and sexual desires before becoming infected, and for some, this doubling of stigma and discrimination can lead to retreating and denying their true sexuality. Women can also internalise stigma and feel shame around believing that they can go on to have intimate sexual relationships with themselves and with others.

Kelli Dorsey from Different Avenues based in Washington DC spoke about her involvement with girls and women of colour who work in the sex trade, 85% of whom identify as queer. Dorsey outlined an approach that worked with LGBT youth and women with a focus on leadership development and organising around rights and access to services. That many LGBT youth are displaced from their homes, due to their sexuality, and were given support where they were at in respect of gender and sexuality.

In the discussion that followed, Strachan spoke about the silence around women who come into prison and engage in what is termed '*switching*'; having sex with women. Authorities deny that this is happening and do not cater for this with any information and/or safer sex services. There is a need to gather information around sexual practices with more than one gender and support the LBT



community to mobilise around addressing the invisibility of women's sexual diversity. This invisibility is denying LBT women collective and effective responses and services in relation to HIV/STI and AIDS.

Jayne is with the AIDS Legal Network, South Africa.

Will and resources…

Zena Stein and Ida Susser

'*Eliminate Mother to Child Transmission of HIV Right Now and Everywhere*' – That was the message in Dr. Elaine Abrams clear up-to-date and detailed analysis of what is needed to eliminate vertical transmission. We know how it happens; we know how to prevent it; we know how to treat the mother and child.

Yet a tragic gap remains between our knowledge of how to proceed and the actual eradication of vertical transmission of HIV. What is needed is the will and the resources.

Later sessions during the day filled out the policies recommended currently by WHO to prevent mother to child transmission. Dr. Nigel Rollins of WHO stressed that now that we know how to prevent it, effective implementation will require detailed follow-up of births, infections and deaths, data not yet widely available. But it is clear that the gap between knowing what to do and the global implementation of an eradication of vertical transmission programme should be closed. As this gap is closed so, in parallel, will the health of the women involved improve.

Two themes affecting women, but not developed in these sessions, were highlighted elsewhere. One was the need for induced abortions to be accessible as a reproductive right for pregnant women with HIV. Dr. Regina Barbosa and her team in Brazil studied this question and found that induced abortion was definitely needed by positive women, just as for uninfected women, and all should have this choice available.

Another issue raised by Dr. Gabriele Fischer of Vienna was the need for reproductive services by positive IDUs. In many countries these women are denied the services they need … counselling, testing, medications for mother and child and substitution therapy, certainly for the duration of the pregnancy.

Appropriately treated, mother and baby do well, but failing the services, the outcomes are often tragic.

Zena is an epidemiologist of Columbia University.

Novel approaches to HIV testing...

The session *Novel Approaches to HIV Testing* on July 22 presented an interesting debate on HIV testing and human rights. Morolake Odetoyinbo from Nigeria stressed that testing alone not is enough. From a public health perspective it may be an advantage to know your status in order to get treatment, but she also emphasised that social issues, such as isolation and being denied to work, could discourage testing, and called for a broader approach beyond testing. Mark Heywood from South Africa agreed with the general idea that HIV testing is important, but not sufficient in and of itself. He considered HIV testing being the first step to further care, but it should never should be single method of HIV prevention. Rather, the focus should be on what comes after, a comment which sparked a discussion amongst the audience.

One question asked from a New York based paediatrian underlined the importance of testing alone as an effective HIV prevention method, as it is necessary to know one's status in order to get further treatment. She also pointed out that a human rights approach to HIV testing was too sensitive and would delay early diagnosis of HIV. Heywood responded by saying that testing might lead to treatment in the West, but in a South African context, HIV testing in fact leads to discrimination.

Another question was raised by a Kenyan based lawyer, who asked if lawyers in fact were blocking medical personnel to do their job. Odetoyinbo appreciated the existence of lawyers for being able to ensure that human rights are not violated in HIV testing. She mentioned an example from her home country in private universities where students not can graduate if their HIV status is positive. Heywood similarly praised lawyers as having an important role in order to ensure people have proper access to care.

Sabrah is with the AIDS Legal Network.

News from the '*margins*'... Kate Griffiths

The costs for women's rights?

How much would it cost to end gender discrimination on the planet earth? Is that even a reasonable question to ask? Should we strive to be 'reasonable' anyway? These and other visionary questions were on the agenda at a session today entitled *'Price Check: How Much is Needed for Gender and AIDS?'*. According to one speaker, women who make up the majority of new HIV infections worldwide, receive only 30% of the funding aimed at HIV prevention and treatment. Given that these disparities, as well as women's vulnerability to HIV, are shaped by gender discrimination and patriarchy, what would it mean for HIV to end gender discrimination totally, everywhere in the world?

Chaired by Paula Donovan, the session was inspired by an idea: what if gender advocates and HIV activists stopped asking for '*a slice of the pie'* and started questioning the pie itself? What if, asks Cynthia Enloe, *'we started being unreasonable?*'.

Rather than asking '*what can we do with the little money we are given*?', can we instead imagine asking first '*what do we need?*' and then '*how much will it take to get it?'*. In a moment of budget cuts and increasing austerity, such an approach may seem audacious, but as Pregs Govender pointed out, moments of crisis may also be moments to reassess fundamental ways of approaching problems. Now is the time, she argued, *'to build on the women's movement of the past'*, and stated with confidence '*this is not a dream, this will happen*'.

Women from the floor took up these questions with creativity, interest and also friendly critique. One speaker reminded the assembled crowd that ending gender discrimination would mean not only attention to HIV and exacerbating factors like women's poverty, gender violence and access to education, but also to the diversity of people impacted by gender bias, including gay men, lesbians and transgender people. Another speaker argued for attention on feminist forms of organisation as central to an effective movement. A third took issue with the concept of putting a '*price*' on women's rights and a reinvigorated, radicalised movement, saying that feminists in *'my country* [the UK]'*didn't win the vote by making a budget, but by throwing themselves under horses*'.

But this formulation may be too literal. When we ask ourselves '*what do we need*' to achieve gender equality, or to end AIDS, we will not only be thinking in strictly dollar terms, but also in terms of courage, commitment, organisation, political education, community resources and ultimately social power.

> *We are only 15 minutes ahead of you…I think, ultimately, we will have to answer these questions as we move forward.* – said Donavan.

Kate is a writer and ethnographer based in Durban, South Africa.

Women's Realities...

Luisa Orza

Mitigating the impact of violence

Domestic violence is a form of interpersonal communication in which one of the family members, a partner or an ex-partner wishes to control or suppress another. It is representative of unequal and inequitable gender relations in society. It is a global phenomenon, which takes multiple forms of control and suppression, including, but by no means limited to the following.

- A drunk husband hits his wife;
- A woman's partner often tells her that she is unattractive;
- A woman's partner refuses to use condoms;
- A father demands from his adult daughter to dress according to his wishes;
- A man says to a woman that he will kill himself if she leaves him;
- A mother forbids her adult daughter to have intimate relationships, due to her HIV positive status;
- A woman's partner does not allow her to communicate with her friend who he believes may negatively influence her.

During a session in the Women's Networking Zone, a small group of 8 participants from the UK, Russia, and Dominican Republic were asked about their lived experiences of violence. Only 2 members of the audience said they had not experienced violence or witnessed violence at close hand.

My father used to shout all the time. It was terrifying.

In my culture violence is part of daily life. A striking experience for me was when a father of one of my best friends tried to rape me when I visited her.

My father used to beat my mum up when I was little.

My father had [sexual] *relationships with two women living in the same house – my mother and another woman. He created a patriarchal hierarchy of control.*

I was in a previous relationship where I experienced different kinds of emotional violence.

Our clients are HIV positive women most of them face violence and violations of human rights in clinics when health care workers refuse to provide services to them.

Linking participants' lived experiences of violence with study findings on violence against women living with HIV, this session emphasised the need to mitigate the impact of all forms of violence.

Violence against women living with HIV is widespread and takes on additional forms in both the domestic/intimate realm and in healthcare settings, workplaces and the broader society, including stigma, judgemental attitudes and denial of rights and services.

A pilot study into violence against HIV positive women carried out in St Petersburg, Russia, among 200 HIV positive and 200 HIV negative women revealed that HIV positive women were significantly more likely to experience domestic violence than their HIV negative peers, due to stigma, discrimination, psychological and social problems. These can lead women into a cycle of depression and feelings of low self-esteem, which in turn leaves women more vulnerable to domestic and institutional forms of violence. In addition, women living with HIV were found to be less aware of support services and more likely to try to cope with problems on their own. HIV positive women who decide to have children are particularly vulnerable to violence, which can lead to the abandonment of children. An estimated 20% of infants born to HIV positive mothers in St Petersburg each year are abandoned often as a result of actual or fear of intimate partner violence, or stigma, discrimination, judgemental attitudes and violence from partners, family members, community members and service providers.

...domestic violence is representative of unequal and inequitable gender relations...

...women living with HIV were found to be less aware of support services and more likely to try to cope with problems on their own...

In 2008 to 2010, *Doctors to Children* and *Healthright International* developed and tested inter-agency model for prevention of violence against HIV positive women in St Petersburg, Russia, providing training to professionals on issues related to HIV and violence against women; developing an inter-agency protocol for effective services to HIV positive women who had experienced violence and their children; and, providing psycho-social support and services to HIV positive women who had experienced violence and their children, including through safe '*halfway*' houses.

A second survey carried out to measure the results of the project revealed increases in awareness among women living with HIV about services to support women who had experienced violence and a reduction in the number trying to cope with violence on their own. Skills and knowledge among professionals on issues related to HIV and violence against women was found to have increased.

Halfway houses provided a safe space for women living with HIV and their children, and enabled children to remain with their mother. One woman, whose partner became violent after she tested positive for HIV during pregnancy describes the experience of moving to the halfway house as a life changing experience.

I moved to the half way house and a social worker talked with me and improved my emotional condition. My daughter began to sleep calmly again. They helped me to get money from the state and find work. I now work in a hostel for people living with HIV. I have met a great guy who loves me and now we are married. He also loves my daughter so much.

Luisa is a women's rights and HIV consultant and the WNZ coordinator.

* For more information on this and other Doctors to Children activities, please contact pr@vd-spb.ru or see the newly launched Russian web portal for HIV positive women www.womenhiv.ru

Advocate's Voices...

Jayne Arnott

Where HIV is a crime, not just a virus

Sixty three (63) countries have HIV specific laws, 27 of them in Africa, with 3 countries criminalising vertical transmission – and more on the way. A panel of speakers presented on data tracking this epidemic; of the impact of HIV criminalisation on women in Latin America; strategic litigation on individual cases; and the Tanzanian HIV Law that criminalises stigma against people living with HIV, while at the same time criminalising HIV transmission.

At question and answer time, a participant commented that the tactics and strategies presented seemed more applicable for the global north, not the south. I had been contemplating this as we shifted from countries that have laws in place supporting mandatory HIV testing of pregnant women and criminalising vertical transmission, to a presentation on using established case law regarding non-definitive forensic evidence.

I heard that phylogenetic analysis could not prove who infected who, and that undetectable viral loads are considered un-infectious in Switzerland. And about Honduras, where all positive people who wish to conceive must abide by the rules and regulations set out by the health department.

The criminalisation of HIV is playing itself out in differing ways. It seems that we have increasing incidences of individual prosecutions in the North, which rightfully call for, amongst others, litigation tactics. But what for the South, with feminised and generalised epidemics and HIV laws that increasingly present the potential to prosecute people for HIV exposure and transmission. They may not be prosecuting in numbers, but they are policing people living with HIV, supporting rights violations and creating barriers to accessing services. They are also responsible for gross sexual and reproductive rights violations of women.

The criminal clauses in HIV laws across Africa may be inactive, unworkable, and too broad, but the ideology that brought them there is entrenched within governments and within communities. They justify and provide the impetus to increase surveillance and arrests, and facilitate the utilisation of a plethora of other laws and policies to effectively criminalise people who are to have the potential to expose others to, or transmit HIV.

In a preceding session titled 'Leaders against Criminalisation of Sex Work, Sodomy, Drug Use/Possession, and HIV transmission', Michel Sidibë, Executive Director UNAIDS, spoke to the criminalisation of HIV as not only oppressing vulnerable groups, but singled out women in particular who have no access to justice, and concluded that these laws just did not make sense. Jill Geer, Director General, International Planned Parenthood Federation UK, supported this, saying that they were very bad laws based on ideology and created in a vacuum; that effective responses to halting HIV need to centre on addressing sexual violence and human rights abuses.

There was a recognition that strategic shifts were needed and that we could not continue, in an ad-hoc way, to prevent people going to Jail. Some of the strategies proposed included not just addressing governments, but engaging parliamentarians in public dialogue, creating spaces for social dialogue, ensuring access to justice and investing in capacity building in order for people to claim there rights and increase their advocacy from the ground.

The session ended with a declaration of commitment to the decriminalisation of sex work, sodomy, drug use/possession and HIV transmission. Significantly the commitment recognised that ëthese laws should not be replaced by a regulatory system that is equally prejudicialí, and ended with a recognition that ëNot only do these laws lead to serious human rights abuses, but they grievously hamper HIV prevention.

Jayne is with the AIDS Legal Network, South Africa.

UPCOMING EVENTS

Friday, 23 July

11:00-12:00
Reproductive Rights of Women with HIV in the Global South
GV Session Room 2

11:00-12:15
Women to Washington
Women's Networking Zone

11:00 - 12:30
Unwanted Pregnancy and Abortion: Challenges for Women and Decision Makers
Session Room 3

13:00 - 15:15
Rapporteur Sessions
Session Room 1

15:30 - 17h00
Closing Session
Session Room 1

Special report: Legislating Sex Work

Kate Griffiths

Sex work advocates gathered today in a mini-session to assess the impact of sex work legislation both in countries around the world and across time. In a historical overview by the Lawyers Collective's Tripti Tandon, it became clear that throughout its history, sex work legislation has been determined less by results than by political pressure, and has a long history of being tied to gendered moralities, public health, feminist concerns, and drug use.

Today's sex work legislation is no different, with evidence about effectiveness often taking a backseat to fears of trafficking, conservative religious morality or misguided efforts to protect victims of trafficking and violence. Drawing on evidence from British history, as wells as the experiences of sex workers and sex work organisations in India, China, the UK, New Zealand and Sweden, the panellists argued that decriminalisation and sex workers self-organisation is the most effective model for curbing the spread of HIV, as wall as for protecting the human rights of women and other sex workers.

Tandon traced the history of sex work legislation back to cannon law of the Catholic Church, which considered prostitution a sin, like all sex outside of marriage. Criminal penalties did not apply, however.

With industrialisation in England, public order became a concern and a '*crackdown*' on street workers and so-called '*bawdy houses'* represented the first criminalisation of sex work. In the 1860's this model was replaced with a public health focus as the military became concerned with protecting the health of soldiers, and therefore passed several iterations of the Contagious Diseases Act, which implemented mandatory testing and imprisonment in hospitals for sex workers. Not long after, these regulations came under attack by feminists of the age, not for violating the rights of sex workers to consent to medical treatment and testing, but because by regulating sex work, advocates felt that the government was sanctioning abuse and violence against women. Ultimately, the law was repealed and replaced with codes based on strict Victorian morality, which resulted in greater stigmatisation, clandestine work, and pimping and police abuse of sex workers.

Today, sex workers rights face similar foes and sex work legislation produces similar results. In the last few years, not only some feminists, but also some religious communities have rallied opposition to *'trafficking'* or non-consensual sex work, involving the kidnapping of foreign women. While sex worker organisations argue that trafficking is rare, such campaigns can result in the adoptions of harsh legislation that makes sex workers more vulnerable to HIV, but also to homelessness, rape, and poverty.

Global Fund researcher Swarup Sarkar has identified three kinds of strategies that can combat HIV transmission via sex work (which he argues is the most cost-effective point of intervention.) These include state-led punitive measures, such as seen recently in Thailand and the Philippines; NGO-led service delivery; and finally sex worker self-organisation as seen in India. Of the three, long-term improvement in infection rates have been achieved only through the latter, supporting activists' contention that criminalisation and punitive

...criminalisation and punitive approaches do not achieve public health goals...

approaches do not achieve public health goals. In one example from Norway, self-organised sex workers were able to reduce the spread of a virulent strain for herpes by temporarily halting sexual practices, such as protected oral sex, until the outbreak subsided.

In China, where sex work legislation is draconian, calling for punishment of forced labour, sex workers from Phoenix in Yunnan point out that criminalisation of drug use is also a major factor in isolating sex workers in ways that increase their vulnerability. Drug users there face mandatory HIV testing at random and are particularly vulnerable to police abuse, if they are migrant workers, who are thus unregistered in the province.

In the modern day UK, a new wave of punitive legislation targets clients rather than sex workers, reminiscent of the *'Swedish model'*. These laws nevertheless have similar impacts on sex workers to the older versions of the 1860's forcing women into street work by criminalising landlords and to greater clandestine work making them more vulnerable to violence, including rape. This vulnerability has been demonstrated in a string of murders of sex workers known as the Bradford murders. According to Pye Jakobbsson, the '*Swedish model'* in Sweden has a similar effect. One friend and street worker she mentioned claimed that *'before the law I was never raped. After the law, I can't count the number of rapes*'. Despite arguments that the law protects women, women find little support from the police and experience increased stigma.

An alternative to models which criminalise clients is decriminalisation, as practiced in New Zealand since 2003. Presented by Tim Bennet, former NZ parliamentarian, the impact of the law, which legalises sexual contact between consenting adults, is increased safety, condom use and lowered risk of spreading HIV.

Achieving decriminalisation required cooperation between sex workers, feminists, LGBTQ organisations and health officials, as wells as members of parliament. As the history of such measures and the epidemiology of health and sex work demonstrate, it is the power of organised communities, not merely great evidence, that can achieve good law, better health and secure the rights of women and sex workers.

Kate is a writer and ethnographer based in Durban, South Africa.

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Prepare, protect and promote

Anca Nitulescu

The media is an important tool for raising awareness and greatly influences public opinion on a variety of issues, including women living with HIV. All too often, media portrays 'negative' images of people living with HIV, which further fuels the social stigma and discrimination experienced by many women living with HIV.

'*HIV positive women getting involved with the Media: Why Bother?*' – was the title of a media training that took place on Tuesday. The interactive session, jointly facilitated by GSSG and Positively UK, highlighted the importance of working with the media and encouraged positive women to engage with the media as a tool to raise awareness, and to change public opinion about positive women's lives and challenges. Although encouraging participants to engage the media, the session also cautioned about potential risks in dealing with the media and mentioned some of the issues that should be taken into consideration before, during and after dealing with media enquiries.

'Being a journalist myself, I would encourage people to always be very careful before deciding whether or not they want to be interviewed. Journalists are not always trained in HIV, but they are good in doing their job' – said Harriet Langanke. She pointed out that confidentiality is crucial; and that people have the right to ask more information regarding the purpose of the interview before they make a decision – and if you feel uncomfortable about the interview, just simply decline.

'*Prepare, protect and promote*' was Silvia Petretti's message. She also advised participants:

> *Always prepare yourselves before the interview, but also protect your identity in case you don't want it to be revealed. Also, it is very important to promote and raise HIV awareness, by educating media people so that the general public can also be educated around the issues that HIV-positive people come across.*

At the end of the session, women attending the session were offered the opportunity to share their personal story for publication in the next issue of DHIVA and Positively Women magazines, which will have a special focus on the International AIDS Conference in Vienna.

Anca is Romanian now residing in the UK and the WNZ media coordinator

Sabine Lex

In my opinion...

All too familiar...

At this year's International AIDS Conference I have been one of the coordinators of the Women's Networking Zone in the Global Village. In my day-to-day life I am a project coordinator at AIDS Hilfe Wien, an organisation in Vienna that provides services, such as voluntary counselling and testing, prevention, day care, and counselling. AIDS Hilfe also acts as a liaison between people living with HIV and specialised medical services and programmes.

Unfortunately, the situation of women living with HIV in Austria is all too familiar. Due to widespread stigma in Austria, most women living with HIV are not open about their positive status. In fact, there is only one woman in Austria who is openly positive. Thus, it is hard to tell exactly how women living with HIV in Austria are affected. On the other hand, people living with HIV are in a double bind, because it is only through many people openly disclosing their status that we can address the strong stigma associated with HIV and AIDS in Austria. Many of the men who are openly positive are already stigmatised for other reasons, including as people who use drugs. This is especially true for people who visit AIDS Hilfe for services. Since the organisation is well known in the community, anyone seen entering or leaving AIDS Hilfe is assumed to be living with HIV. As a result, many people who need services fear being questioned about their HIV status if they are seen near AIDS Hilfe, and so they prefer not to access services there in order to avoid the associated stigma.

Perhaps due to widespread stigma many people in Austria, particularly women, are reluctant to test for HIV. Most Austrian women living with HIV contract HIV between the ages of 30 and 40, but they tend not to be diagnosed until they have developed AIDS. In response, the Austrian government implemented mandatory counselling and testing for pregnant women starting in January 2010. AIDS Hilfe's position on this somewhat controversial policy is that, although voluntary counselling and testing is certainly preferable to mandatory testing, it is good for people to know their status early.

One of the positive aspects of holding the International AIDS Conference in Vienna this year is that it draws the attention of politicians to issues, such as voluntary counselling and testing and criminalisation. Hopefully it will both influence politicians and put pressure on them to respond more effectively to the spread of HIV and the needs of people living with HIV in Austria.

I hope that holding the conference here in Vienna will also help to educate the public about HIV and AIDS. Many people in Austria are unaware of the impact of HIV, and so I hope that the extensive media coverage the conference has drawn will influence the attitude of the general public as well. As a woman who also coordinates programmes for women, I am of course interested in how women's issues are addressed at the conference. While there have been some important advances for women recently (e.g. Tuesday's announcement about the success of the CAPRISA study on microbicides), I think we still need to pay more attention to women's leadership and empowerment, particularly the leadership and empowerment of women living with HIV. On a larger scale, I think we also need to look beyond the conference and aim for greater involvement of women in other leadership positions, such as through political office.

We need more visible women's leadership in order to create a shift in both politics and society.

Sabine Lex, Project Coordinator, AIDS Hilfe Wien.

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