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Mujeres Adelante

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

In Focus...

Eastern Europe: Women's Rights Before its Too Late!

Kate Griffiths

Eastern Europe is currently the region on the planet where rates of new HIV infections are rising dramatically, with a 66% regional increase since 2001. Ukraine and Russia are the most severely impacted, while treatment access among Eastern European countries is far below necessary, with less than a third of those who need it receiving antiretroviral therapy.

While intravenous drug use remains the primary mode of transmission in the region, some experts fear that the epidemic is on the verge of making the switch to a generalised heterosexual epidemic, which could place many more lives at risk. Sexual transmission is already the source of 42% of infections, with the sexual partners of drug users and sex workers the most at risk. As a result of this trend, increasing numbers of women are contracting HIV, in addition to being affected by their partners' status. In some countries in Eastern Europe, including Ukraine, women now make up nearly half of the population of people living with HIV.

While the pandemic in Europe may include its own unique features, as Katarzyra Palerjanik argued, women, and women with HIV *'have the same problem in every country'*, disempowerment, violence, stigma and discrimination. Women also face increased biological and social risk of contracting HIV, with young women especially vulnerable worldwide.

According to Dr. Iatamaze Veruamvivi, director of the Women's Centre, the epidemic in Georgia is linked to these regional factors, as well as to regional migration, both in terms of immigration from higher prevalence countries to lower prevalence nations, but also because as these nations make their *transition* from communist systems to capitalism, increasing levels of migrant labour have helped to spread HIV. In Georgia, this has resulted in 2,300 cases of which 25% are women.

In addition to difficulty accessing treatment, basic prevention measures are also seriously lacking. Service providers report very low demand for condoms, while sexual education is limited or unavailable in most countries. According to Zhara Malyilyan of Armenia, one high school principal, when asked why sexual education is not provided, answers '*the less they know the better*'.

Mayilyan also explains that gender norms and stereotypes make it particularly difficult for women to protect themselves from HIV. Women are generally expected to marry their first sexual partners, while unmarried men are likely to visit sex workers. Married women and sex workers are both unlikely to negotiate condom use. In one survey, women who were asked if they had ever experienced spousal or *partner rape*, most responded that they felt that providing sex on demand was their '*duty*'. Most women living with HIV are infected through sex with male partners. These realities indicate that women are socially disempowered; in Armenia, there are no elected women leaders.

These conservative gender norms are not '*traditional*' in the sense of being timeless and ancient, instead more conservative social realities have emerged in Eastern Europe as a result of the transition, as well as the rise of fundamentalist religious trends, including Christian and Muslim organisations that oppose the de-stigmatisation of sex, condoms, sex work, drug use and people living with HIV. These movements have also helped to isolate and disempower women, as they push for subordinate roles for women and limitations on women's sexual health and reproductive rights.

A further complicating problem

Whats inside:

for people living with HIV in Eastern Europe is the deterioration of public infrastructure as part of the *transition*, including declining healthcare systems. This means that access to healthcare is limited to all citizens, while people living with HIV face stigma, including rejection from clinics where doctors and clinic staff fear that if they admit patients living with HIV, their existing clients will abandon the clinic. In some instances women with sever uterine bleeding were turned away from ambulances and hospitals, due to their HIV status.

Women living with HIV in Eastern Europe face dual discrimination, as people living with HIV and as women. This can include workplace discrimination, where women with HIV are socially isolated and often forced out of jobs. For women living with HIV whose partners die of AIDS, the situation is often particularly grim. Facing rejection by their in-laws, they are likely to loose their inheritance, their homes and often their children. The attitude is summarised in a saying which is translated as '*why would I now want a stranger in my house*'?

Women who are also intravenous drug users or sex workers can be triply discriminated against. Women in these positions are seen by man, from police to healthcare workers to family and friends as *not having rights*. Roma women with HIV are likewise in the situation of being triply discriminated against and are also socially isolated. They may also face increased risk of HIV and violence in that they live largely as migrants.

…religeous… movements have also helped to isolate and disempower women, as they push for subordinate roles for women…

…promoting women's rights as a critical intervention…

Finally, young women are particularly at risk, largely due to higher levels of drug use, unemployment, migration and ignorance about HIV transmission and healthy relationships. Fewer than 10% of young women demonstrate correct basic knowledge of HIV prevention information.

The Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (***ASTRA***) is promoting women's rights as a critical intervention at a key stage in the regions epidemic. This includes the right to be free of coercion and violence both inside and outside the healthcare system, and guarantees of women's sexual and reproductive rights. The organisation emphasises the importance of pre-empting forced contraception, sterilisation and abortion, practices which plague women living with HIV around the world. They also call for strong youth education in sexual and reproductive health.

As a network of local organisations that both advocates and provides services ASTRA is already part of the solution in a region where countries are too often divided. By bringing experts and advocates together to argue unapologetically for the effectiveness and justice of women's rights, they have already helped set the stage for effective interventions to turn the epidemic in their region around.

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

Jayne Arnott

Ensuring Safety, Security and Autonomy…

Gender- based violence was the focus of the oral poster session '*Ensuring Safety, Security and Autonomy: Why must we overcome gender-based violence?*' on Wednesday, 21 July 2010.

Michaela Leslie-Rule introduced findings of a participatory research study that engaged a group of Tanzanian women around defining the language of love, intimacy, sexuality and violence. Leslie-Rule explored how women's responses revealed that inter-personal violence was very much a private issue and women participating in the study presented with some tolerance for inter personal violence. When exploring what types of physical and sexual encounters were considered to be violent, the severity of the physical injury seemed to be the determining factor. Women also spoke in a manner that seemed to indicate an expectation that it was normal to experience some amount of force or coercion from partners in sexual encounters. This was not always experienced as violence.

Women spoke about sexual agency and desire using proverbs and allegories that are passed down from grandmothers and women elders in the community. It is taboo for mothers and daughters to discuss issues related to sex. This type of information sharing presents opportunities for interventions that could address inter-personal violence and reduce the risk of HIV, for example, through reaching grandmothers and elders who are passing on sexual information to '*shift*' stories in ways that can better equip women to articulate female sexuality and sexual desire. Leslie-Rule noted that it is often women's lack of sexual knowledge and sexual agency that can lead to violence in sex.

Gender equality is viewed predominantly as a goal that the government must work towards, and placed in the public sphere with women articulating the need, for example, for education and economic equality and this is prioritised over gender equality in the private sphere. Women can perpetuate gender norms that support gender inequality and this limits opportunities for men and women to be co-creators of tolerant environments.

If gender equality is perceived as being something that the public sphere has to address, then the question is how can governments and public services strengthen their policies and programmes to integrate and promote gender equality both within the public and the private sphere.

The session ended on the note that is more than enough evidence regarding the links between GBV and HIV, the intersections, and the bi-directionality. It is time to prioritise action!

Jayne is with the AIDS Legal Network, South Africa.

Homophobia and HIV in Africa

Jayne Arnott

This session '*Men who have sex with men: Homophobia and HIV in Africa*' explored some of the political, social and cultural barriers to ensuring quality service provision of HIV prevention, treatment and care to MSM in Africa. This was a significant session with a singular focus on homophobia in Africa and the impact on HIV and AIDS prevention, treatment and care for MSM. The speakers spoke in a united way regarding the severity of homophobia in Africa and with an equally strong voice regarding strategies and interventions to access justice and equal rights and access to prevention, treatment and care services.

Common threads running through the session, with presentations on homophobia in countries such as Malawi, Cameroon, Uganda and Zambia were increasing trends to introduce new clauses criminalising homosexuality; invoking harsher sentences; re-activating dormant sodomy laws; and utilising an array of other laws to threaten, harass and detain men who have sex with men, or in some cases, appear to be men who may have sex with men.

What are LBGT activists and rights-based organisations doing to access justice, rights and services in this climate of oppression and state brutality? A core call was for human rights activists from outside Africa to avoid intervening in a way that exacerbates the situation, given the discourse on homosexuality as a western import and un-African. There is an urgent need to address the lack of legal defence services, as lawyers are too scared or unwilling to defend individuals. The realisation of human rights is not just about access to condoms and lubricant, but access to justice, and access to full HIV prevention and health services, without direct or indirect legal impeachment.

When asked from the floor what support could be given, an eloquent response was, no more workshops, learn to listen to us and to activists on the ground, give resources we know are needed and help with skills training to take the struggle forward.

Jayne is with the AIDS Legal Network, South Africa.

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

Relegated to the Global Village...

The Trans women's network from Latin America and the Caribbean hosted a session that highlighted the lack of attention paid to the specific issues affecting trans women in the fields of HIV advocacy and research. While the speakers, Marcela Romero and J. Villazan, opened by discussing the issues affecting trans women in Latin America and the Caribbean, the session quickly evolved into a workshop on the needs of trans women from every country.

Villazan highlighted the lack of research on trans woman and HIV in her region, where only two studies specifically track prevalence among this population, suggesting that rates in Peru and Argentina have rates as high as 35% among trans women. According to JoAnne Keatly, speaking form the floor, rates are similar among San Francisco's trans population with rates among African American trans women at as high as 56%.

Nevertheless, researchers continue to neglect trans women, a population who are vulnerable to HIV co-factors, including violence and drug use, but who are also likely to survive as sex workers, and who in some countries may play a central epidemiological role. Instead, government agencies, including the Centers for Disease Control in the United States include trans women in the research category '*men who have sex with men or MSM*'.

This elision goes beyond a failure of the research agenda, to the funding structures of advocacy and service delivery, as well as to the representation of trans women at the main session of the IAS conference this week. Said Keatly:

> *...I am angry. I am angry at the organisers of this conference, because I feel we must be heard. Instead we've been relegated to the Global Village and offered a stage to do drag shows.*

By failing to distinguish between populations of people living with HIV who are gay men and those who are trans women, the statistics ignore what may be an even greater crisis among trans women, and conceal the possibility of diverse transmission modes and mechanisms. Trans women activists argue that funding MSM led organisations for trans programming also leads to a lack of trans representation at the organisational level and to continuing increased marginalisation.

These concerns of invisibility and marginalization echo those of lesbian and bisexual women also battling stigma and marginalisation in the movement for health and human rights.

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

Women's Realities...
Testing rights for pregnant women?

Luisa Orza and Fiona Hale

In 2007, the WHO published guidelines on provider initiated ('*opt-out*') testing in an effort to increase the number of people being tested for HIV. Gender and human rights advocates have raised concerns about '*opt-out*' testing opening up potential for human rights to be compromised or violated. Policy-makers have dismissed these concerns as based on anecdote, and have asked for evidence to support these arguments.

Today in the Women's Networking Zone of the Global Village at AIDS2010, the results of a research project supported by the Open Society Institute's Public Health Watch were announced by three South African-based human rights organisations: AIDS Legal Network, Just Associates and Justice and Women (JAW). The results evidence how provider initiated HIV testing in the context of pregnancy has become another form of violence against women.

'*Opt-out*' testing assumes an equal relationship of power between client and service provider. Yet, women in the study were relatively young. Many of them had grown up in families disrupted at an early age by HIV. They had been absorbed into extended family systems, had often given up on education and were frequently unemployed. Sexual relationships with men were often a route to survival, making negotiation of condom use difficult. For many, pregnancy was their first point of entry to health services, and their life circumstances often combined to render them especially vulnerable to compromises, abuses or human rights violations in the healthcare setting.

Pregnancy was often an additional, unwanted burden to already complicated lives. Many women had conflicting feelings about the pregnancy, but there was no room in clinics to discuss this. They were immediately pushed into having an HIV test, thereby facing yet another potential burden that they didn't feel ready to face – that of an HIV positive test result.

Women's rights in the areas of counselling, consent and confidentiality were regularly compromised or violated. In over-stretched services, rural clinics are often staffed primarily by nurses (with infrequent visits from doctors), who themselves are overburdened both at home and in their communities, as well as in the workplace, and may indeed be facing many of the problems their clients encounter, including being HIV positive themselves. Confidentiality is often compromised. Nurses and counsellors have queues of women to see, and often announce test results in front of others, or through open doors with teeming waiting rooms behind them.

Pregnant women receiving an HIV positive diagnosis commonly experience judgemental attitudes at the hands of health providers, including in the delivery room, where women living with HIV may be attended to only after HIV-negative women have been assisted, due to lack of medical implements and fear of infection if these are used first to assist positive women. For women choosing not to test, punitive measures were reported, including refusal of care. Such is the dehumanisation of the health systems that women frequently choose not to go back to health service providers until they are really sick. Conversely, the smallest measure of kindness was received with incredible gratitude.

Provider initiated testing also needs to be seen in the context of power relationships the women experience in their households and families. After giving birth, women may not feel able to disclose their status to their partner and his extended family. To do so would compromise their personal security and livelihood. Lack of power to negotiate condom use continues after the birth of the first child. With a second pregnancy, women report being treated with increasing judgement and brutality by exasperated service providers sometimes resulting in unwanted sterilisations, while in the delivery room. Consent given under this kind of duress is a clear violation of rights and amounts to forced sterilisation, an issue which is gaining traction in international human rights advocacy in Southern Africa, and a form of institutional violence against women.

The President of South Africa has committed to huge scale-up of HIV testing, setting a target of having 15 million people tested for HIV in the coming year. Most of these will be women, many of them pregnant. Health services cannot hope to cope with such numbers while protecting the rights of counselling, consent and confidentiality of those most in need of it. Counselling is often replaced with information provision and pressure to test. There is little understanding of readiness to test, and research is needed on this.

There is a clear need to increase testing, but human rights must be protected. To ensure this, there is a need for further analysis of gender and power relations in health systems in the context of pregnancy and in the context of HIV testing, as well as a review of current testing models of practice to encourage both women and men to test outside of the context of pregnancy.

Luisa and Fiona are gender and HIV consultants.

...provider initiated HIV testing in the context of pregnancy has become another form of violence against women...

...'*opt-out*' testing assumes an equal relationship of power between client and service provider...

Women's Voices...

Sophie Strachan

Familiar with feeling criminalised

Being sent to prison and being on trial is a traumatic experience on its own. Receiving a diagnosis, whilst in prison, is very frightening and traumatic.

It has been seven years that I learnt of my immediate response, when being given my diagnosis in prison. I had blocked it from my memory, my experiences of trauma had various elements, from a partner nearly dying, to feeling completely helpless and powerless over my loss of liberty, as a result of which I was not allowed to see him.

Being exposed to women frequently trying to commit suicide in the dorms I shared with other inmates, together with my enforced isolation and feelings of shame, impacted on my psychological and emotional well-being massively that I subsequently lost three quarters of my hair through sheer stress.

Being strip searched naked, officers finding bags of my hair and reading on HIV in my cell was a great violation of my rights to dignity and privacy, and triggered previous events where violation had been experienced.

Many women, including myself, leave prison with a diagnosis of post-traumatic stress. Since being in recovery, I have spent long periods of time in trauma therapy; it has taken years to unravel just my experience of prison.

My post traumatic stress means loss of health of those around me triggers me into extreme anxiety which is exacerbated by significant years of physical violation in active addiction. Moreover, the traumatic feelings were amplified by my own experience of blatant discrimination from health professionals in healthcare settings where discriminatory practice caused great harm, psychologically and emotionally. It is outraging that the prison service is incapable of differentiating between the state of depression and feelings of suicide. It is incomprehensible that people with mental health issues can ask for help, there is none.

The moment a woman enters a prison, a world of daily uncertainty presents itself, along with a loss of freedom and liberty, and a person's identity. Some will gain a perceived identity, due to an addiction to substances, prostitution, mental health, sexual orientation, immigration and an HIV status.

As a women in recovery from active drug addiction, living with HIV and an 'out lesbian', I am all too familiar with feeling criminalised, due to a preferred sexual orientation, a past IDU, and a health condition that still 30 years on from the first isolated case is still hugely stigmatised.

Being in prison should not be a barrier to accessing the right HIV treatment and support, and yet prisoners are forced into isolation due to astonishing levels of discrimination. Fear of persecution is a significant barrier to women accessing support around their HIV status. Where as with other illnesses one can seek support on the wings, with HIV this just could not be considered. I felt incredible shame and isolation when I received my diagnosis, although my saving grace was Positively UK. I believe my experience would have been completely different had I not been fortunate enough to engage with this organisation. I feel it also important to say my confidentiality was maintained by healthcare staff.

…fear of persecution is a significant barrier to women accessing support…

Loss of liberty and freedom does not equate to a complete loss of human rights.

Sophie is with Positively UK.

UPCOMING EVENTS

Thursday, 22 July

09:00-10:30 *Plenary Session* Session Room 1

9:45-10:45 *Young Womenís Perspectives: Abortion and Sexual Orientation in the African Context* Women's Networking Zone

11:00-12:30 *Advocating for Women-Centered HIV Prevention Technologies and Environments* Mini Room 8

LBT: Gender and Sexualities GV Session Room 1

12:15-13:30 *Launch of the Womenís HIV Prevention Tracking Project: A Five-Country Study on the Implications for Women of Medical Male Circumcision for HIV Prevention* Women's Networking Zone

14:30-16:00 *Leaders against Criminalization of Sex Work, Sodomy, Drug Use/Possession, and HIV Transmission* Session Room 4

18:00-19:30 *Vagina Monologues: Women Speaking Out to Address the Intersection of Violence and HIV* Women's Networking Zone

18:30-20:30 *Transforming the National AIDS Response to Address Womenís Rights* Mini Room 6

Special report: Why the silence?

Jayne Arnott

Sexual rights as stand alone rights in the context of HIV prevention seem to have slipped out of the human rights discourse in relation to HIV and AIDS. For effective HIV prevention approaches we need to engage with, and talk about sexuality, support and promote sexual rights, and advocate for the right to sexual information and the right to sexual choices.

The various panellists in the Tuesday's satellite session on '*Sexual Rights and HIV Prevention*' focused on sexual rights of women and youth, the criminalisation of same-sex sexuality in Africa, critical HIV prevention for MSM from a sexual rights perspective, and sexual rights – a challenging topic in Eastern Europe and Central Asia.

Claudia Ahumada, from the World AIDS Campaign, started her presentation by noting that this was the only stand-alone session at the conference on sexual rights! We really need to challenge the '*lip service*' to integrating sexual rights into HIV and AIDS responses.

Why is it that we are not supporting women living with HIV to exercise their sexual rights? We should be outraged that positive women are being subjected to gross rights violations in relation to having sex and making (or not being able to make) reproductive choices, with violations ranging from dissuading women from having children through to forced abortion and sterilisation practices. Why the silence? If we cannot talk about sexuality, support sexual choices, and integrate these rights into HIV and AIDS responses, how can we begin to address HIV and AIDS prevention interventions, programmes and services that work and respect human rights?

Posing the question of '*What do we mean by meaningful youth participation and what hinders us from reaching this?*', Ahumada talked about what youth need in relation to sexual education and services, and argued that adults continue to make assumptions about what youth need, which often leads to barriers to access to relevant information and services, including HIV prevention services.

Ahumada further elaborated on a series of impractical laws regarding access to sexual information and services based on the age of consent that are in place across the globe and that impact greatly on youth '*ability*' to access HIV prevention and to make informed sexual choices. In Chile, for example, if you are under 14 years old, you cannot consent to sex and if you do, it is then considered statutory rape, including sex between peers. The law further states that anyone under the age of consent, seeking information or services around sexual and reproductive health within the public health service, must be reported to the police.

So how do we reach and engage youth in information sharing, promoting sexual rights, safer sexual activity and sexual autonomy within a climate of criminalisation, as well as measured and controlled access to sexual knowledge and services.

…we really need to challenge the *'lip service'* to integrating sexual rights into HIV and AIDS responses…

Ronny Tikkannen from Sweden focussed on developing a knowledge-based norm in relation to HIV prevention for MSM. In essence, he promoted a more constructive approach to HIV prevention interventions that focus on unmet needs, rather than an approach that pathologises individuals, such as focusing on '*risk taking*' behaviour. A pathological discourse promotes a '*them and us*' situation, and is counter-productive in HIV interventions. As Ronny aptly noted '*We are all capable of taking sexual risks and having unsafe sex*'.

Three unmet needs were presented in relation to sexual rights and needs of MSM in the context of HIV prevention. Firstly, the right to information that is relevant to the prevention of HIV transmission, which means developing prevention information that does not only focus on condom use. Secondly, MSM have the right to qualitative counselling and information in relation to HIV testing that expands into improved healthcare in general.

And lastly, there is a need for a non-normative knowledge base of sexual information regarding same sex practices, as sexual information and the promotion of safer sex practices are often framed within a normative heterosexual context. '*Good*' sexuality and sexual practices equals two people in love at home and using condoms, be they same sex partners or not. This places, for example, casual sex as less valuable and thus, more '*risky*' as it challenges the norm. Tikkannen referred to a survey conducted with MSM, in which some men spoke about casual sex in a bathhouse as being '*bad*', as it is seen as outside the norm and as more '*risky*', even when it is protected sex.

Whilst Tikkannen focussed on MSM, he also pointed out that this framework can apply equally to other populations. Given the applicability of this framework to other population groups, the question remains, where are the programmes that address women's realities and explore alternatives in relation to sex, to sexual pleasure and to protection from HIV? Where are the policies, interventions and services that respect women's sexual rights first and foremost for their own sexual fulfilment and sexual health needs as well as for relevant HIV prevention?

...we are all capable of taking sexual risks and having unsafe sex....

Jayne is with the AIDS Legal Network, South Africa.

Regional Voices... I am alive!

Sabrah Møller

Joy Lovelet Crawford, in the session *Gender Inequality and Sexuality: New solutions for old problems* on July 21, introduced the programme entitled '*I am alive! Protecting the sexual and reproductive health and rights of positive women in Jamaica',* and highlighted different challenges of positive women in Jamaica.

HIV in Jamaica is to a large extent a burden carried by the young women aged 15 to 19 years, and this group is three times more likely to be infected than the similar age group of men; as the women contract HIV from older men. Crawford further established that similar data applies to women ages 20-24. In the programme '*I am alive!'* the women are typically between 17 and 22 years of age, and are all mothers. As the title of the programme reveals, first thing the women are taught is to embrace the fact that they are alive in spite of their HIV diagnosis.

In order to join the programme, Crawford emphasised that the women must be able to commit for at least one year, so the selection process based on interviews is a thorough one. Within the first year, workshops on self-discovery, positive proactive parenthood, sexual and reproductive rights, as well as prevention for positives are conducted. The outcomes of the programme has been a higher degree of motivation of the women, developing leadership skills, child care skills, nutritional and physical care of children, improved the reading skills of the women, and finally, improved relationships between the young women and their family members.

Although the programmes is overall very successful, Crawford concluded that there are still some challenges ahead, including that even though the reading skills of the women had improved, they still experience difficulties reading and understanding scientific information presented in their medical files.

Sabrah is with the AIDS Legal Network, South Africa.

Fiona Hale

In my opinion...

A day at the Women's Networking Zone

I spent much of today at the Women's Networking Zone.

This is a vibrant space within the Global Village of the International AIDS Conference. Open and welcoming, it looks bright and beautiful, with its colourful red, orange and pink cushions, benches and chairs. Under a decorative washing line fluttering with women's underwear of all shapes and sizes, (a '*panting line*'), a welcome table is heaving with information on women's advocacy, experiences, research and initiatives. Women sit on comfortable sofas to talk. And a full programme of sessions runs throughout the day, drawing in people who have come specially, and those who just happened to be walking by.

The set-up may be relaxed and informal, but the discussions here are serious. Women's experiences of stigma; how the 'evidence base' works for women; the rhetoric of funding for women's priorities; the rights of young women; tensions and challenges within the women's movement – all of these and other often tricky issues were highlighted, unpacked, argued. From the first session of the morning, when women shared their poetry, stories and performance narratives, the tone was set – this is a space where women's experiences and perspectives are welcomed, where the personal really is political. During the course of the day, speakers included women who are in professional positions of some power, and powerful women working as activists, advocates and mobilisers. What was striking was the passion and the humanity each of the speakers brought to the space.

Women – and men – from all regions of the world came by. Fiery women activists working at grassroots, national and global levels came together with women in professional roles, including epidemiologists, researchers, government representatives and indeed the Austrian Local Conference Co-Chair, Dr. Brigitte Schmied.

I asked a couple of women why they had come to the Women's Networking Zone. Promise Mthembu from South Africa told me,

> *It's a safe space, and it's accessible. We are discussing issues here that won't necessarily be on the mainstream programme – feminist issues that are important to us. And it's a meeting space where we can talk to other women.*

And Martina Lebinger, from Saba in the Netherlands Antilles, had come by chance.

> *I didn't come here on purpose, but it is very interesting to see women who are visible, who are working and fighting for women's rights, and also women who are working at higher levels. That is really important.*

I'm looking forward to spending more time at the Women's Networking Zone this week – being part of the discussions about the work that women are doing around the world, gathering ideas and developing momentum for beyond Vienna 2010. The WNZ programme looks full and fascinating – and if today was anything to go by, the rest of the week will be both inspiring and thought-provoking.

Fiona Hale is a gender, HIV and sexual and reproductive health advocate.

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