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DESIRES DENIED: SEXUAL PLEASURE IN THE CONTEXT OF HIV

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INTRODUCTION

British human rights lawyer, Helena Kennedy, in her ground-breaking book, “Eve was Framed”ⁱ wrote:

“Rape involves an invasion of the parts of a woman’s body preserved for chosen intimacy, for communication of her deepest feelings, for pleasure of a deep and exquisite kind, for the creation of life. It is a violation which rages against women.” (Kennedy 2005 p 138.)

This chapter isn’t about rape but about what it means for a woman to learn that she has HIV and to believe – and be told - that she can no longer have sex or children. The quote above is the nearest analogy I have found to what having HIV as a woman can feel like. I am not trying to pretend that rape and having HIV are one and the same. I am extremely fortunate never to have been raped. But living with HIV as I have knowingly done for the past 19 years, these words struck a particularly strong chord for me. Forced sex and forced asexuality are opposite sides of the same coin: they are both rooted in control over women and over our rights to choose what to do or not do with our bodies. Both forced sex and forced asexuality deny women our rights to our own autonomy with regard to our sexual – and reproductive – pleasure.

This chapter seeks to explore HIV in the context of a widely held and wholly false assumption that women’s rights to sexual pleasure – and to having (more) children - should be withdrawn if she has HIV. This is not just about invasion, violation and rage. It is also about survival, resistance and agency. There are many of us women with HIV who have managed to restore our self-esteem, our deep belief in our fundamental rights to our sexuality and the sexual pleasure and well-being that go with those rights, as there are also many women who have also become rape survivors. I am all the more in admiration of the many women who have had to deal with both in their lives.

In this chapter I will show how Western Judaeo-Christian belief systems have framed a fear of uncontrolled women's sexuality. I go on to illustrate how this Judaeo-Christian belief system formed the basis of Western legal and medical traditions. Through the historical widespread reach of the British Empire especially, (and, more recently of the US regime, also based on the British systemⁱⁱ), these legal and medical systems were exported to many widely spread corners of the world, through the imposition of the British Colonial system of government, legal and health services. Thus these early legal and medical traditions, rooted in the Judaeo-Christian tradition have had international influence. So this is an issue not just for the West. I then go on to explore the consequences of these policies and practices for women with HIV around the world – most of whom are citizens of former British colonies. Finally, I explore how human rights frameworks can change policies and practices of law and

medicine, to help make the good effects which these disciplines can do more common and the bad effects which they can have less common. I conclude that women's rights to sexual and reproductive pleasure – if and when we want it - need to be upheld by and not undermined by governmental, legal and medical frameworks globally.

WOMEN IN THEIR PLACE: Opposite sides of the same coin - forced sex and forced asexuality

When I was diagnosed with HIV, in 1992, no treatment was available. I and my partner (now my husband) assumed that this was a death sentence for me – and for him too. I was pregnant when I had this news, and full of deep joy at the prospect of having another baby. Thus the HIV diagnosis felt like a death sentence not just for me: upon medical advice, I decided to have a medical termination, for fear that going to term would put my own life at risk and leave my older children motherless. Miraculously, we soon learnt that I hadn't passed the HIV to my partner, despite my having become pregnant with him. I was also extremely fortunate in that he took it for granted that he would stay by my side and that we would continue to have a loving fulfilling relationship together, including an active sex life, thanks to the use of condoms and (later) female condoms. Here we are still together, nearly 20 years on, and he is still HIV-negative. We had no more children and I still grieve for the second son I lost. Nevertheless, we have been most blessed with our other children and in other ways in our lives.

One could - and should - argue that this relationship is, in principle, my right. And so it is. But my experience is pretty uncommon. Many positive women have been subjected to violence from their partners upon disclosing their HIV status to them (or, even worse, upon their HIV status being disclosed to their partner by health workers without their own permission). I also know many positive women who are yet to find loving, caring partners whom they so richly deserve, because their positive HIV status has scared the potential partners awayⁱⁱⁱ.

It is also rather more common than I had assumed for women to experience both rape and HIV. In a series of audio interviews which I conducted with 12 HIV-positive women activists from around the world in 2008, some told me about also having been raped. I found this quite shocking, since I had previously been unaware of this additional trauma in their lives. I did already know that in South Africa women have their daughters injected with depo-provera, in anticipation that *when* they are raped, they will at least escape an unwanted pregnancy. Yet I had not realised that levels of rape associated with HIV seem more common elsewhere also.

How do we make the uncommon good things, which I have experienced with my partner and my healthcare, common? How do we make the common bad things, which so many of my positive friends and colleagues around the world have experienced, uncommon?

BELIEF SYSTEMS, SEX AND WOMEN

In all belief systems globally, sex, new life and death are events which are closely linked^{iv}. This is hardly surprising since, without sex, we would (until very recently) have had no life. And childbirth in many countries is still a time of high mortality for women and children

alike. For women, being raped, getting divorced, becoming HIV positive or becoming a widow all seem to be viewed as events of symbolic death for themselves. Some societies promote the practice of sex at these times, others promote *asexuality* in response. For instance, in some societies marriages and funerals are seen as times when it is *good* for people to have sex – with multiple sexual partners also – as a part of the process of the ritual. In some societies, for instance, if a newly widowed woman *refuses* to have sex with the next stranger who enters the community, she is endangering the well-being of that whole community. She must have sex with this particular stranger in order to protect her community (Barnett and Parkhurst 2005). By contrast, in other societies, including the UK, for example, widows are expected to become *asexual*. I have various friends, colleagues and close relatives who have told me of the cloak of *asexuality* which society ascribes to them once they have lost their husbands. It is as if widows^v – and divorcees also – might become rampantly sexual in their new status and might pose a temptation – or threat – to others around them. In the UK as in many other places, widows and divorcees are still seen as potential rivals by other women and quietly excluded from many informal social networks by other women as a consequence. As soon as a woman steps outside the social norms ascribed to her by society in any way (in this case marriage), whether through her choice or not, her sexuality – and her rights to that sexuality – are suddenly in question also. Indeed in the UK just a hundred years ago, a widow was quickly married off to a male relative of her husband, so that she could step back in to the “fold” of “belonging to” a man. This happened to my own paternal great-grandmother when her husband died. She married his male paternal first cousin. This practice is still wide-spread in many parts of the world and women are rarely given a choice in the matter of whom they are remarried to (and I use the passive tense here advisedly). Indeed its very name, ascribed to the practice by social anthropologists, “widow-inheritance” illustrates its roots in the legal obligations of the passing on of possessions from one (male) to another (male).

Other powerful examples of how women’s lives have historically been controlled with regard to their sexuality are rife. Katherine of Aragon, Henry VIII’s first wife, was divorced because she did not produce a son for him who survived early years, thereby causing the break from Rome and Catholicism and the establishment of the Church of England^{vi}. Much more recently were the Magdalena convents in Ireland, for girls who had been raped, or who had become pregnant through relationships before marriage (often with an older, married man in whose house they were serving as a house girl^{vii}). Both the girls and their babies were consigned to the opprobrium of deep disgrace, living in these convents for the rest of their lives – whilst the men involved were untouched. The assumption was always that it was the young women who were at fault and who had led the men astray, rather than any recognition that there might be equal agency, let alone the possibility that a woman had had sex against her will.

Kate Adie’s book, “Nobody’s Child^{viii}” presents another chilling analysis of the history of “illegitimacy”, interwoven with society’s attitudes to “morality”: and the long-term crushing effect that practices had both on the (mainly young) women concerned and their children - in the UK and beyond.

All the attitudes and practices towards women and our sexuality described above from the West are rooted in the Judeo-Christian tradition. There are similar attitudes in other belief

systems. However, the Judaeo-Christian tradition is the one I know best since it is the one in which I was raised. It is also the one which has been exported around the world through the British (and Spanish) Colonial system. Therefore the roots of these attitudes to women in this belief system warrant more analysis, to help us understand and challenge them more clearly.

The image of woman as potential threat to stability is highlighted in the Judaeo-Christian (and Muslim) Creation story - the story of Adam and Eve^{ix}. Eve is seen as the serpent-like temptress of Adam in the Garden of Eden, who seduces him into “biting an apple”, whereupon they realise that they are naked and are banished by God from paradise. This apple is traditionally believed to have been a pomegranate, which is also known in English as a “love apple”. In the Christian tradition, the dichotomous image of a woman either as “perfection” or as a “sinner” is personified by the Virgin Mary, the mother of Jesus Christ, and by Mary Magdalene, whom Jesus “saved from sin”. The Virgin Mary, according to Christian tradition, conceived Jesus immaculately – in this case, without having sex with anyone – and thus without sin^x - and God was Jesus’ father^{xi}. Thus attitudes towards women and asexuality, purity and goodness on the one hand; and women and sexuality, temptation, evil, sin and *badness* on the other, are notions which run very deeply in Christian tradition.

In Britain, from the eleventh century, when England first began to be unified, the Norman kings sought to validate their leadership through identification with the Christian belief system and all that this involved. There are still buildings standing in Britain built at this time: enormous stone churches^{xii}, full of brightly coloured stained glass and other artwork depicting Bible stories.

These stories are also widely represented in the great artwork of Europe, with images such as the Madonna del Prato^{xiii}, and of Mary Magdalene^{xiv}. Indeed, one could best describe mediaeval religious art as the pre-cursor of the modern day multi-million advertising industry. These images adorned churches, monasteries - and places of political power also, since monarchs were keen to validate their supremacy by asserting their close allegiance to the Bible and all it stood for. These images used symbols of colour to enable people to identify quickly key players in the scenes. The Virgin Mary was always depicted wearing a blue robe, whilst Mary Magdalene was shown wearing red – if anything at all. In one fanciful 19th century French painting of Mary Magdalene, she was portrayed languishing naked outside a French cave, where she was reputed to have spent the rest of her days after the events of Jesus’ life. Blue was good, pure, asexual; red was bad, sinful and sexual. What the images conveyed stuck in the minds and psyches of all, just as modern-day advertising does today.

So attitudes towards women and “female sex out of place” have had a strong negative impact on many different aspects of women’s lives. Since medical and legal traditions in the West are both rooted very firmly in Christian principles, in the next section we will explore the strong influences of this religious belief system on these professions. Moreover, the influence of British colonisation of many parts of the world on laws, missionary activities and Western medical practices has a lot to play in this also. For example, homophobic laws brought in by British imperialism are still on the books in many former British colonies^{xv},

although they have thankfully been repealed in India recently, thanks to Justice AP Shah^{xvixvii}. It also seems unlikely that it is merely coincidence that 72% of all women with HIV in the world, in 2005 at least, were citizens of Commonwealth countries (i.e. countries which were formerly colonised by Britain (Welbourn 2005)^{xviii}. Furthermore, with HIV we are talking not just about sexuality but about birth, the spilling of blood and death also. Yet more acts hedged about with ritual in all societies globally. Yet more dangers (Douglas 1988) for society to deal with. Ironically, it was probably a bad idea to have the ribbon which symbolises AIDS coloured red. But then hindsight is always a wonderful thing.

INFLUENCES OF BELIEF SYSTEMS ON THE LAW

Doctors and lawyers may be shocked to read the above and may feel this has nothing to do with them and their practices. This is because the great power of deeply embedded cultural belief systems are that they are *so* deeply embedded that we rarely, if ever, think about or question them. We assume that they *are* the natural order, if we do ever think about them and it is challenging for us to analyse and question them. I still remember the deep shock and amazement I experienced when, as a young student, I first read anthropologist Levi Strauss' slim volume in which he openly questioned the possibility of Mary's immaculate conception. So deeply entrenched had this belief been in my own, what I thought to be relatively liberal, upbringing, that I remember looking up and around me in the university library to check if anyone was watching me, as if I was trying to hide a pornographic magazine under my study books. Yet, if we look at the Magna Carta^{xix}, for instance, signed by King John of England in 1215, and recognised as the pre-cursor of the mother of parliaments, the English parliamentary system, we can see how God and the church were invoked from the very first phrase to support his leadership of England and uphold the legitimacy of the document. We can see also how women's roles in society were firmly placed in legal subordination to men in this document (for example, clause 54). Thus was the subordinate role of women in society explicit in this first document of "modern" law.

As Helena Kennedy has clearly argued in her book "Eve Was Framed", Magna Carta was just the beginning of many centuries of female subordination at the hands of the legal system in England. As Kennedy eloquently explains, the legal system in England and Wales has been framed by male academics and political leaders who have had little or no experience of women's subservient role in our society. This groundbreaking book was at first ridiculed by the legal profession in England – and some older (male) judges still speak very disparagingly of her in private today. Thankfully, however, it has now become a standard textbook for first year law students and Kennedy's views are highly respected by most.

Thus the Western legal profession – and the faith communities also, both steeped in the male hierarchy and traditions of their structures, find challenges to the role of women and women's sexuality deeply threatening to the status quo.

INFLUENCES OF BELIEF SYSTEMS ON MEDICINE AND HEALTH CARE

Medical traditions in England also stemmed from the belief system of Christianity and inevitably inherited its attitudes to women, our sexuality and our role in society. The earliest hospitals were housed in and run by religious communities and were also set up along the Crusaders' routes^{xx}. Most of the London teaching hospitals^{xxi} have saints' names. From the outset the role of women in health care was considered to be one of everyday caring, whilst

the role of physician and healer was considered to be a male role. Even the role of women in childbirth was from early days of the Church seen as a time of women's defilement and, until the mid-20th century, the "Churching of women", in the Book of Common Prayer^{xxii}, was used in England to purify women – even those who were married - after childbirth. This harks back to the assumption that childbirth was associated with sex and is therefore something sinful and dangerous, which has to be redeemed through a religious service.

MEDICAL TRADITIONS, SCIENTIFIC ADVANCES AND THE TYRANNY OF BELIEF SYSTEMS

So what implications do all these traditional connections have for women with HIV in relation to their sexuality? It is now possible for an HIV-positive woman, if she is stable on her medication, has no other sexually transmitted condition, has an undetectable viral load and a good CD4 count, to have unprotected sex with a partner without danger of passing on HIV^{xxiii}. It is also possible for her to conceive and give birth naturally (i.e. without a caesarean) with less than 1 per 1,000 babies being born with HIV^{xxiv}. This is a giant scientific leap – and yet even family doctors in London are as yet unaware of it. A workshop^{xxv} with some of them, by contrast, showed that they were advising women with HIV not to have *any* sexual relationships and that they believed that 50% of all babies born to women with HIV would be HIV-positive. This latter figure is completely wrong, because even without medication, the rate of transmission from a woman to her baby is around 33%. Such is the gulf between scientific advances on the one hand, and belief systems and practices on the other.

A lot of attention is paid to women's reproductive systems globally – rightly, considering the levels of maternal mortality. When it comes to HIV, this is intensified because of the high rates of "vertical" transmission between a mother and her baby without medication. However, while this is a sex-differentiated approach to medical care systems it is a distinctly *gender-insensitive* approach. Pregnant women with HIV are rarely referred to as "women" but rather as "mothers", "patients", "PWAs" – anything to avoid somehow identifying them holistically beyond the immediate clinical issue. Ultimately they are seen as vectors of disease and vessels for producing children. Women's *feelings* about the pregnancy, the shock of a positive diagnosis during pregnancy which, thanks to lack of their own knowledge and lack of any support from medical staff, they think is going to be fatal, just do not appear in medical literature.

An HIV positive diagnosis is an extremely traumatic experience. After trauma, individuals can react in very different ways. Nine months after 9/11 for instance, there was a great leap in the number of babies born in New York City, presumably as an emotional response to the horrors of that day. Not only did people resort to sex for comfort, they were also presumably intending to conceive and bring new life into the world. This was their right. By contrast, I have myself experienced a huge sense of *asexuality* after the trauma of loss of life, a sense which I know to be shared by others also. This can last for weeks or even months, as if having sex is somehow disrespectful to those who have died. Thankfully in my case, my sexuality returned in its own time. But for me at least I had the *choice* to decide if and when to return to being sexually active. This was also my right and I was fortunate in being able to assert it. Yet for many, as I will discuss below, they have no *choice* over whether to express their sexuality with someone else or not, if their HIV status is seen as a cancellation of such rights. It is always important to distinguish between *choice* and *rights*.

I believe this attitude stems, at least in part, from attitudes towards women held traditionally by the medical profession also. In his book “Making Doctors” (Sinclair 1997), which analyses the undergraduate medical teaching at University College Hospital (UCH), London in the early ‘90s, psychiatrist turned social anthropologist Simon Sinclair shows an illustration from Gray’s Anatomy, which portrays a womb with a baby curled up in it, entirely cut off from a torso and missing most of the legs. This image above all other symbolises the professional distancing traditionally imbued in all trainee medical students, in order to objectify those in one’s care as much as possible, as a part of their conditioning towards becoming a doctor – and perhaps also as a part of their distancing from the distastefulness of the sexual act which must inevitably have taken place for the baby to exist. The doctor was seen as master of all he surveyed, whose word and opinion about what was best for a “patient” was law - and beware all those who crossed his path. Sinclair is at pains to add that his participant observation of UCH in the early ‘90s was at the end of an era – and that medical training over the past 15 years or so has transformed beyond recognition and become far more person-focused. Sadly, however, as I discuss below, other health centres in the UK and elsewhere have not yet changed – and we are still left with many senior doctors around the world for whom this tradition of the doctor being the all-knowing seer about what is best for anyone was the normal and the right way to behave towards those in one’s care. Of course, there have always been notable exceptions to this rule, my own consultant being one of them. But the fact that these exceptions exist proves my point all the more – you can still have exceptionally good doctors who are *also* entirely sensitive to one’s needs as a woman, in all manner of respects.

This global medical teaching tradition, in one of its most recent ramifications, has meant that HIV-positive women in Namibia are being coerced whilst in labour into signing documents which give the hospital the right to perform a sterilisation after delivery. Once the women come round to realising what they have signed, the deed is irreversible. The doctors responsible for this in Namibia have openly defended their actions, explaining that “these” women already have too many children and should not be risking the spread of HIV to them. Colleagues in Namibia who have taken the government to court have twice now faced an adjournment^{xxvi}. This practice is not limited to Southern Africa, but has been recorded in Papua New Guinea^{xxvii} and Chile also^{xxviii}.

Another dimension to medical interventions around pregnancy, HIV-testing and women is the likely gender violence that can erupt as a consequence of a woman’s partner discovering her HIV-status^{xxix}. This can take the form of physical beatings, sexual abuse and psychological abuse, including fear of loss of custody of their children. Women are also thrown out of their homes, rejected by their families and communities and may lose out on any inheritance. Yet health care services are not renowned for taking these issues into account, in their pursuit of global “AIDS-free generation” policies^{xxxi}.

When you are a young, pregnant, newly diagnosed, HIV-positive woman, or one who has just given birth and has now been sterilised, and you are also dealing with violence at home, and deep fear for your child’s future well-being, especially if she will now be your last, it is hard to focus on your own rights to sexual pleasure, much as it is absolutely your right to do so.

LEGAL APPROACHES TO ASEXUALITY OF WOMEN WITH HIV

Just in case the negative effects of probably well-intended – but desperately ill-conceived – medical policies and practices are not enough to ruin the quality of life of women with HIV, legal steps have also been taken in many countries in the past three years to add to their challenges. In Sierra Leone, for instance, a proposed law contained language explicitly criminalizing mother to child transmission of HIV. According to this bill a woman could be fined or jailed for knowingly placing her foetus at risk for HIV. Amazingly this provision of the proposed law has been rescinded, thanks to the work of ICW and Aziza Ahmed^{xxxii}. However, to have such drastic transformation in a bill so quickly is extraordinarily rare and is, to date the only example we know of. At the “Living Tomorrow” conference of HIV-positive people in Mexico in 2008, just before the International AIDS Conference, delegates from the USA described how their social workers were advising them, if they wanted to start a new relationship, to take the prospective partner with them either to see their consultant or an attorney, so that they could disclose their HIV-status to this individual with a witness present, in order to avoid potential future legal recriminations. Hardly a great vote-winner compared to a romantic candle-lit dinner. Joking apart, the criminal prosecution of people with HIV – both male and female – for transmission has, once again, struck at the hearts of those of us with the virus. Indeed in a court in Germany in September 2010, (conveniently held two months after the International AIDS Conference in Vienna, the theme of which was human rights), a young popular singer, Nadja B^{xxxiii}, was served an 18-month suspended sentence for exposing someone to HIV when she was 17. She had been very publicly arrested by a posse of armed police officers before a concert and was held in jail for some time before being released on bail. This sentence has since been praised by Western Cape Premier and Democratic Alliance Party leader Helen Zille^{xxxiv} in the South African press. Once more, our sexual pleasure, becomes something scary for us to think about, let alone realise, as it is couched not in terms of what is our right and how we can be supported in this, but in terms of our evilness of intent, as if we *wanted* to go out and spread this virus to others^{xxxv}. For women especially, potential legal prosecution also masks all kinds of reasons why women may not feel that it is safe for them to disclose their status to their partners – and yet, once more, the law acts as a blunt “one size fits all” instrument, unable to distinguish between different issues affecting sectors of a population. The fact that some women may fear that if they *don't* have sex with their partner they may experience gender violence or homelessness for them – and perhaps their children also – does not even enter into the legal equation.

CONSEQUENCES OF THESE POLICIES AND PRACTICES FOR WOMEN WITH HIV

Here are some words from Susanna, a close colleague of mine:

“Sometimes I feel lonely. I feel lonely when in the middle of the night I roll around the bed and the sheets on the other side are cold, the space too wide. I feel lonely when pots look too big for the one person dinner I am cooking. I feel lonely when I realize I have been talking to my cat aloud most of the evening, calling him ‘Amore’” which means ‘Love’ in Italian, my native language, and it is a word that we only use between lovers, or mother and child. I find myself even lonelier in the company of friends with children and long term partners. I wonder how it feels to experience that kind of love and intimacy. I try to cope by making sarcastic jokes, buying far too many high heel shoes, or booking another holiday. Those may

seem all clichés. How many women in their mid 40s are childless and single? Many, right? Why should I blame having HIV for my solitude? “

Susanna goes on to describe how she learnt about her HIV diagnosis and about the massive effect it had on her life. She also critiques the huge gap in support from most medical and social services for younger women especially when they are diagnosed. She continues:

“I think my story highlights some important issues. Women who become HIV-positive are often young vulnerable women, just as I was, with mental health issues, low self-esteem and problematic drug or alcohol use. Once you find out that you have HIV those issues don’t suddenly improve or go away. However society expects you from now on to take all the responsibility of managing your intimate relationships with openness and assertiveness. It was very hard for me to learn, and had I not become part of a collective of women living with HIV I don’t know if I would have even survived. There is much more to living with HIV than swallowing a handful of pills. I have had the privilege of accessing high quality psycho-social services which have not only enabled me to cope with my difficult relationships but have also inspired me to become part of a group of women that challenge stigma around HIV by speaking publicly and by openly advocating for the human rights of HIV-positive women. I am extremely worried that in the current economic climate high quality peer-lead services for women with HIV will not be a priority and will not get funding. Without those services many women will face terrible isolation, poor mental health, poor physical health, and will lack the support necessary to develop the skills and confidence to negotiate safe and pleasurable sex. Without the appropriate support most of those women will remain silent, and society as a whole will lose the contribution of our voices.”

How can Susanna’s fears not be realised? How can we make the uncommon good a common good for HIV-positive women, so that our sexual pleasure can be expressed in all its manifold ways?

HUMAN RIGHTS – REFRAMING THE MEDICAL AND LEGAL LANDSCAPE

Thankfully there is a chink in this armour of repression, a small light guiding us in a way forward. This takes the shape and form of human rights.

Sofia Gruskin and Laura Ferguson^{xxxvi} have argued cogently and persuasively recently for a human rights approach to public health. They spell out clearly how, just because there is not a formal “evidence base” to indicate the immense and complex challenges faced by women with HIV on receipt of their HIV diagnosis, this is no reason to ignore them. They argue clearly that there is no such thing as a “neutral, objective” evidence-base^{xxxvii} and that medicine is as much subject to the views of those who have asked the questions and gathered the data as any other branch of enquiry^{xxxviii}. This is important because it enables us to recognise that it is not enough just to create policies, without also looking long and hard in the “side mirrors” for the juggernaut about to plough you down as you change lanes – as Helena Kennedy puts it. Gruskin and Ferguson also argue that new indicators need to be introduced into public health work, which reflect the human rights implications of policies and practices. They are arguing persuasively that policies and practices that damage the quality of womens’ lives are plain wrong – and that the medical profession – as well as policy makers - should be held accountable for these damages.

Similarly, when it comes to the law, as Helena Kennedy has so eloquently argued:

“There is no hierarchy of human rights and women cannot be relegated to a second division in the protection of their rights; instead the state has a duty to ensure that women are not treated as second-class citizens or subjected to violence even within the private domain of the home. There is no sovereignty of home or nation when abuse is actually taking place....” (Kennedy 2005 p290).

Laws which criminalise women with HIV, for any reason, because of our status are entirely unjust laws. Laws and practices which make us fearful of even thinking about our rights to sexual pleasure, let alone acting on them are unjust and harmful to women.

There are so many extraordinary women like Susanna out there. In the words of Helena Kennedy once more:

“The symbol of justice may be a woman, but why should we settle for symbols?” (Kennedy 2005 p 290). It is high time for both the medical and legal professions to heed the wisdom and compassion of women like Susanna, Gruskin and Kennedy. I believe if they did so, the world would be a better – and safer – place for us all.

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ⁱ Kennedy H. 2005 **Eve was framed** Vintage London

ⁱⁱ For a particularly insightful study of the politics of the AIDS response in South Africa in relation first to British colonialism and more recently to US global politics, see Susser 2009

ⁱⁱⁱ See for instance <http://www.positivelyuk.org/docs/2010summer.pdf>

^{iv} Susser 2009; Coakley 2002; Douglas 1988

^v See Widows for Peace through Democracy website: <http://www.widowsforpeace.org/>

^{vi} Elton 1991

^{vii} Their plight was highlighted by a film in 2002 (Peter Mullan <http://www.imdb.com/title/tt0318411/plotsummary>).

viii Adie 2006

ix Crawford 2007

x In southern Spain visitors to a convent are traditionally greeted with the words “blessed be the Virgin Mary” to which they are supposed to reply “born without sin” See Boyd 2004

xi Similarly, according to Catholic dogma defined by Pope Pius in 1854, the Virgin Mary herself was conceived “immaculately, ie free of “original sin”. This meant that, although Mary’s parents were understood to have had sex to conceive her, she had no “original sin” in her when she was born. This is by contrast with the rest of us, all of whom are believed to be born with “original sin” in us. See [http://www.catholic.com/library/Immaculate Conception and Assum.asp](http://www.catholic.com/library/Immaculate_Conception_and_Assum.asp)

xii <http://www.canterbury-cathedral.org/history/stained-glass.html>

xiii Giovanni Bellini, National Gallery, London: <http://www.nationalgallery.org.uk/paintings/giovanni-bellini-madonna-of-the-meadow>

xiv Mary Magdalene by Carlo Crivelli: <http://www.nationalgallery.org.uk/paintings/carlo-crivelli-saint-mary-magdalene> See also: Paola Tinagli 1997; Lehmann 2009. See also: <http://www.bible-art.info/MaryMagdalene.htm>.

xv <http://aids-freeworld.org/Our-Issues/Homophobia/AIDS-Free-World-Urges-the-Commonwealth-to-End-Its-Silence-on-Homophobia.aspx>

xvi <http://economictimes.indiatimes.com/news/politics/nation/one-giant-leap-for-gay-community/articleshow/4731073.cms>

xvii <http://www.aidsalliance.org/includes/Publication/Enabling-legal-environments-for-effective-HIV-responses.pdf>

xviii <http://www.para55.org/reports/22November05/WelborneNov05.ppt>

xix http://www.bl.uk/treasures/magnacarta/translation/mc_trans.html

xx <http://www.britannica.com/EBchecked/topic/272626/hospital/35526/History-of-hospitals>

xxi <http://www.bartsandthelondon.nhs.uk/aboutus/history/barts.asp>

xxii See <http://cofe.anglican.org/worship/liturgy/bcp/texts/24-thanksgiving-of-women-after-childbirth.html> and <http://www.orthodoxytoday.org/OT/view/wehr-the-churching-of-women>

xxiii <http://www.salamandertrust.net/resources/WelbournIWDMarch09.pdf>

xxiv <http://i-base.info/htb/1865>

xxv Organised by Positively UK in 2009

xxvi <http://www.opendemocracy.net/5050/jennifer-gatsi-mallet-aziza-ahmed/sterilisation-fight-for-bodily-integrity>

xxvii Listen to the audio interview with Maura Mea of Papua New Guinea at <http://www.salamandertrust.net/motherhood/motherhood.swf>

xxviii <http://www.opendemocracy.net/5050/francisca/dignity-denied>

xxix [http://www.sophiaforum.net/index.php/Events/Health and Safety: Women, HIV and gender violence](http://www.sophiaforum.net/index.php/Events/Health_and_Safety:_Women,_HIV_and_gender_violence)

xxx <https://sas.illuminate.com/p.jnlp?psid=2010-10-27.0746.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>

xxxi

[http://www.salamandertrust.net/index.php/Projects/The HIV, Women and Motherhood Audio Project/](http://www.salamandertrust.net/index.php/Projects/The_HIV,_Women_and_Motherhood_Audio_Project/)

xxxii Announced at the satellite session on criminalisation, organised by the ATHENA Network at the Commission on the Status of Women, 2010, New York City Bar Association

xxxiii <http://www.bbc.co.uk/news/world-europe-11097298>

xxxiv *"Zille said the recent court case against a German pop star for failing to disclose her HIV-positive status was an example to emulate."* In **'Charge those who knowingly spread HIV'** Babalo Ndenze The Cape Times, South Africa 13 September, 2010 p3.

xxxv [http://www.sophiaforum.net/index.php/articles/HIV, Women and the Law](http://www.sophiaforum.net/index.php/articles/HIV,_Women_and_the_Law)

xxxvi <http://www.who.int/bulletin/volumes/87/9/08-058321/en/>

xxxvii

<http://www.womeneurope.net/resources/LauraFergusonEvidencebaseslidesWNZTownHallsessionJuly2010.pdf>

xxxviii See also Lakoff and Johnson 1999