Spring 2010

POSITIVELY WOMEN

Behind Closed Walls

Women in Prison and HIV

The only magazine for positive women written by positive women

contents

3-5 Experience, Strength and Hope

6-8 Interview – Baroness Jean Corston

9 HIV, Prison and Positively Women

10-11 Sarah

12 Government Policy

14-15 The Demonised Other: Sex Work and HIV

16-18 10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women

20-21 Health Care and Support for Positive Women in Holloway Prison

22-23 Healthcare in Prison

24-25 Yarl's Wood

27 Asylum Aid

28 In Memoriam of Z

30-31 Violence Against Women and HIV

32 Cate's Column

33 HIV News

Hello Readers,

This issue is particularly close to my heart due to similarities in my own life experience. To be asked to be part of this edition was an absolute privilege. I ask that when reading this magazine, you try to keep your mind and heart open.

'Behind Closed Walls' gives us a very intimate account of the experiences some incarcerated women have had to endure because of one common denominator; they have HIV. The ramifications of their experiences have affected these women in many different ways, but ultimately the punishment continues. Persecution, ridicule, rejection, deportation, and exposure to their peers and families are but a few of the fears people with HIV run the risk of living through.

I would personally like to thank the women who have demonstrated incredible strength and courage to share their stories with you, to shed light on a true picture of how HIV is still not addressed appropriately and effectively in our society, starting at government level.

Following the interview with Baroness Corston (see page 6), the question about whether the government is actively working to address the recommendations of the Corston report remains open. Beyond that, the Corston report fails to address or even note any mention of HIV in the review process. One relevant question that remains open is 'what level of priority is given when addressing the need for implementing policy around HIV in prisons?' The NAT's publication 'Tackling Blood Bourne Viruses in Prisons' highlights a framework for best practice, stating that prisoners are some of the most vulnerable people in the UK, and evidence shows higher rates of BBV's amongst those received into the prison system.

Contributions to this edition have come from a variety of professionals, and we are very grateful for their perspectives and experience. In this issue, we explore how changes in future policy making are fundamental if we are going to hope for a shift in the pandemic prisons and detention centres clearly face. I believe the term pandemic is appropriate, as in one prison we visit, 1% of the population are receiving support around their diagnosis.

Positively Women currently visits three prisons inside and outside of London, and there is a vital need for our service. You only have to read our articles to see how variable that need is, as dealing with a diagnosis can be devastating for some and a relief for others. Overall, it's clear that it can't be dealt with in isolation – especially not in an environment where discrimination is a daily occurrence.

Within the pages of this issue, you will notice that the word criminalization is used. Positively Women would like to make it clear that we do not support the use of this term. We feel using this term puts HIV positive people at greater risk of stigma and discrimination.

I hope you find this magazine both informative and enjoyable, and that it gives rise to new thoughts or at least questions in your mind.

Please do not hesitate to contact us, via email, phone, or freepost should you have any comments, suggestions or if you would like to contribute an article for the magazine in the future.

Best wishes
Sophie

Positively Women
347-349 City Road, London EC1V 1LR
Helpline 020 7713 0222
Admin 020 7713 0444
Fax 020 7713 1020
Email info@positivelywomen.org.uk
Website www.positivelywomen.org.uk
Positively Women is a national organisation providing support services to women living with HIV and their children
Charity reg: 1007685

Experience, Strength and Hope

'You are fucking joking!' I screamed four times back at the Health Advisor; these were the first words to pass my lips after being given my HIV diagnosis, followed by 'Jesus wept'. I remember being given a cigarette, and then I was back in my cell; it felt surreal. I'd gone for a routine screen, not worried about HIV as a previous test six months earlier had come back negative.

I vividly recall the terror as I went through the gates, ignorant to the events that would unfold during my stay and how, upon leaving, my life would never be the same again

I was remanded in Holloway prison in early 2000, I vividly recall the terror as I went through the gates, ignorant to the events that would unfold during my stay and how, upon leaving, my life would never be the same again. I spent eight months in prison, remanded for drug-related offences and a string of outstanding warrants. I was in a bad way, both physically and mentally. For the previous two years I'd slept rough, and I had experienced violence and physical assaults.

For my own protection, for this article, I remain anonymous, not through shame, but I believe it would only cause harm to myself to reveal my identity, I try to share from a place of experience, not as a victim. Writing this does not come easy. Memories of my time in Holloway come up, and then it disappears again, I have had support in putting this together from the Health Advisor who gave me my diagnosis. I bumped into her in a clinic not so long ago and asked her if she would help me, as I had little recollection of what I was like then... I blocked it all for no reason other than self-preservation.

I received my diagnosis and then very shortly afterwards found out that my then partner had lapsed in to a coma and had been unconscious in hospital for the last month. Their condition was not good; cerebral lesions and lesions on their lungs presented evidence of advanced stages of HIV. Interestingly enough my first question was had I infected him? I automatically took responsibility, something women do, for the following six weeks, it was all about him, every day I was convinced he was going to die. I caused merry-hell in the prison, I was refused compassionate leave, and this only served to highlight my loss of liberty and freedom. Every time I saw an officer I would pull them to one side asking when would I get to see my partner, when would I get my phone call; the hospital wouldn't give any information as I wasn't family.

The stress was beginning to present itself in the form of Alopecia (whilst inside I eventually lost three quarters of my hair). When my cell was spun one day, the officers removed the many bags of hair I had been keeping in my drawer. I was stripped naked in my cell, I didn't understand why. I had the bags of hair on my bed, and they discovered reading material I had on HIV, which I'd only just plucked up the courage to take up to my cell; I felt violated in every sense of the word, never have I felt so intimidated and frightened. I was in pieces, sobbing, then I was called into the office with five officers standing there asking me what was going on, I couldn't speak, I just kept sobbing.

The stigma and discrimination around HIV in prisons is horrific, and as much as I felt completely isolated with it at times, that was the safer option. The wings are not somewhere you would take this stuff. I was so angry, raging, not solely because of health issues, but because I felt completely helpless and powerless about all the other things that were presenting themselves. I entered prison on what's called a 20/52 (suicide watch) after being held in police custody for a few days, and even though I knew

The copy deadline for the next issue is 15 June 2010

Managing Editor
Lucy Osman

Design/Layout
Intertype.co.uk

Print
Stephens & George

Editorial Team
Angelina Namiba, Bex, Carole Sturdy, Cate Jacobs, Claire, Janine, Julie, Maggie, Maureen, Mona, Silvia Petretti, Sophie Strachan, Susan and Tina.

Proof Readers
Maureen and Sophie Strachan.

Subscriptions
subscriptions@positivelywomen.org.uk

Send letters to the editor and unsolicited manuscripts to

Positively Women
Freepost RLYJ-ULRT-CEEC
Positively Women
347-349 City Road
London
EC1V 1LR

Or email losman@positivelywomen.org.uk

Please submit articles of no longer than 1400 words, indicate what name you would like to use and supply photos (which can be returned to you). While we respect the individual's point of view, we will not print anything we deem to be discriminatory.

The Positively Women magazine is a public document. We cannot guarantee confidentiality for the stories on these pages or for any assumptions that may be made. Please be aware of this when considering making a contribution. No material in this publication may be used without permission from Positively Women. Views expressed by individual contributors are not necessarily those of the editor or Positively Women.

I had been caught bang to rights I still looked for ways to not see the truth. I did not intend to kill myself; it was due to my vulnerable state and it got worse as the news continued to pour in until I was offered a job to get me out of the cell.

Being banged up for 23 hours a day was pure hell. The year I was detained at her majesty's pleasure there was a huge staff shortage and we would frequently miss exercise time, or 'free-flow' due to there being no staff. There was also a heat wave, the prison had metal shutters as windows that didn't allow free airflow which was inhumane in the heat, I would lay in bed at night full of resentment towards the other women as they slept, cursing, saying, 'How the hell can you sleep?!!' I felt incredible isolation and shame.

I knew of women trying to commit suicide in the dorms we were put in. It was so traumatic, and officers would ask me to keep an eye on them, which was inappropriate considering I was nothing but a number to them. I fought against every restriction, defiant to the end, but eventually I engaged with a psychologist in the prison. This was my first introduction to art therapy, and I cried and cried as I let go of the anger. It was a rollercoaster of emotions, in and out of grief, sadness and loss, and betrayal, I felt such betrayal around my then partner, who refused to talk to me about anything to do with our HIV status, and who then gave QE (Queen's Evidence) against me and walked free from prison after five months.

As I write this, it becomes more apparent just how utterly out of control I and my life had become. For me, prison was about survival; every day I felt scared – the uncertainty and upheaval each time I was to appear in court, having to pack up my few belongings and come back to a different wing with people I didn't know and officers who got off on the misuse of power. I remember trying to manipulate my solicitor to get me bail so I could get away for just a moment to use drugs. Eventually, I used drugs while in prison, and learned it was easier inside than out on the street. I still recall the day I was called into the lounge by an officer who attempted to blackmail me with tobacco and canteen if I was willing to 'inform' them of drug taking on the wing. That was just another nail in the coffin for me; prison is unsafe, even the officers aren't to be trusted.

Day after day I felt desperately lonely, unsafe and not believing I could trust a soul. I remember a family member coming to visit me and part of me wanted to break down and tell her about my fear. I was terrified, 'What if the officers read my lips in the visiting room?' Nowhere outside of health care did I feel safe. I was devastated at receiving my diagnosis, and it's only been years later that I accept I have the virus. I spent a long time in complete self-rejection and it was a very confusing time. I would see my health advisor at least three times a week, just to get out of my cell. I was desperate for answers; it was my way of trying to gain control of events, trying to grasp some hold on the mess I had created.

This is also where Positively Women came in, I was introduced to a female caseworker who came to see me once a week I think, speaking and listening to her was the first time I felt any hope for a long time, especially around my new status. Initially I spent that time talking about everything else other than my status, the focus was still on my partner and looking at possible treatment centres to address my addiction. It was so much easier to look outward than inwards, and accept my part in all the mess.

The case worker and me had similarities in where we where coming from, those visits were a lifeline to me, and I received guidance and support, in and out of prison. She was there to support me after a court appearance and my confidentiality was breached around my status (that's how a family member learnt of my diagnosis). Once again I lost faith in a system, which fails many.

Once again I lost faith in a system, which fails many

I'll never say I didn't deserve to go to prison, I was causing harm to society with my addiction, and the intervention of prison served me, I was opened up to a different way of life, I just needed the right interventions. Yet prison doesn't work in many ways, they medicate the inmates as a way of containment, they don't have appropriate pathways in place that supports the high level of mental health care needed, and the staff are not trained appropriately, HIV awareness is just one of many areas where training is lacking. I came out of prison with a diagnosis of post-traumatic stress disorder, which today can still be triggered. It was the most traumatic experience of my life and trust me, I've had a few.

Over three years of psychological support from the Royal Free Hospital has been of significant assistance to me in gaining some acceptance and allowing me to grieve. I no longer seek desperate validation through others to tell me I'm okay, too many rejections from other people have taught me I need to love myself.

In the early days, I would give so much power to the virus; it would consume me day and night, filling me with terror, keeping me silent for the first year, afraid to open my mouth and make it real. I have learned in hindsight that I sought comfort in denial, a natural path in the grieving process.

One aspect of my grieving process was doing some 'family of origin' work and realising that illness has never been addressed truthfully in my family, where it has never been OK to be ill. This is not to apportion blame, rather to help me find some compassion for myself. I could never give myself permission to honour the enormity of what it meant to be HIV positive, instead minimising it and marching on – my own personal martyrdom. I have learned that in order for me to embrace my status I have to practice compassion for myself, because I regularly encounter people or situations that would harm me if I weren't prepared. For example, there was a time I was living in shared housing and having flatmates (alleged friends) bleach their cups and cutlery, ask me to bleach the bathroom each time I'd use it, one housemate who physically threatened me calling me a 'dirty HIV bitch' just because I had the virus. I have learned through making mistakes how much consideration needs to be given when anyone thinks about disclosing. I was in a treatment centre at the time the above incidents occurred, and it was the first time I'd ever disclosed to anyone other than health professionals. At the time, I was experiencing my first episode of shingles, I was freaked out, my anonymity and confidentiality were broken within minutes of my disclosing, and people just stopped talking to me. It was horrible. I lost all hope again and felt angry that this is what we as HIV positive people have to deal with.

Over the years, I have learned that stigma is a state of the mind, and I feel the Government has a very long way to go in working toward overcoming the stigma that is still attached to this virus. I have also had to look at the prejudices I carried and the stereotyping that had been imprinted on my mind of other HIV positive people, so I truly understand that ignorance is a common ground for some people. It was all fear driven.

Part of my self-empowerment has come from receiving education about the virus and asking questions that will help dissipate my fear and anxiety. That has taken time, too. Currently I am discussing treatment options with my consultant, and while it's not what I want, I'm aware that self led me to prison and today I know that living with untreated HIV is of more concern for me than starting treatment and dealing with possible side effects. This is remarkable progress for me, I couldn't discuss treatment for almost five years, couldn't read anything, I literally had a complete block around it. Last week I said to my consultant, I could be having the same conversation with you in 10 years, just delaying the inevitable, but I know what I need to do. There is also the very real fact that until now, I was in no place to start treatment emotionally or mentally, and my psychologist has given me assurances of support when I do start, thank God. Words fall short of expressing how grateful I am for the support I receive at the Ian Charleson Day Centre and the Royal Free Hospital. I have a consultant who listens and supports me, nurses who are always friendly and supportive, and I feel safe, heard, seen, and treated like a human being. Debbie, my psychologist, created a space safe enough for me to disclose my deepest fears, my pain, disappointments, devastations, sorrow, rejections, and my ongoing journey around boundaries, both internal and external. A space that held me when I was falling apart inside and a relationship where I learnt to place trust in another.

Positively Women provide a unique service in supporting women and families affected by HIV, they visit three prisons currently and have no funding to sustain this service, without their support whilst in prison and long after I don't know what my journey would have been like.

I'm a keen activist today and am off to Vienna in July to give voice to women living with HIV, at the 2010 world AIDS conference, if someone had said this would be my path all those years ago, I'd have told them to fuck off... What doesn't break us makes us a stronger person.

Jane

Mental Health in Prison

More than 70% of the prison population has two or more mental health disorders. Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners 35 times more likely than women in general Social Exclusion Unit (2004) quoting, Psychiatric Morbidity Among Prisoners In England And Wales, (1998)

The suicide rate in prisons is almost 15 times higher than in the general population. In 2002 the rate was 143 per 100,000* compared to 9 per 100,000 in the general population.**

* The National Service Framework For Mental Health: Five Years On, Department of Health (2004)

** Samaritans (2004) Information Resource Pack (2004)

Only one in 10 prisoners has no mental disorder www.mentalhealth.org.uk

The following organisations have been selected to provide information and other sources of support around an HIV diagnosis or mental health. Please note that the list is by no means exhaustive.

Positively Women
020 7713 0222 – info@positivelywomen.org.uk

Samaritans
0845 790 9090 – www.samaritans.org.uk

Narcotics Anonymous
0845 373 3366 – www.ukna.org

Interview – Baroness Jean Corston

I think anyone is shocked at the first sight of a baby in prison

Can you please introduce yourself?

My name is Jean Corston. I am now a member of the House of Lords, a Labour member, before that I was a Labour Member of Parliament for 13 years sitting for Bristol East. I was the first woman to be elected to Chair the Parliamentary Labour Party, the person who's responsible for all of the business of Labour MPs in the House of Commons. I am a granny; I've got six grand-children, a son and a daughter. I was primarily interested when I was in the Commons in Human Rights, in women's rights, disability – those kinds of issues.

Why are you interested in women and prison issues?

I first visited a women's prison, I went to Holloway, early in the 1990s and was shocked to hear the life stories of the women there and I think anyone is shocked at the first sight of a baby in prison. That was when I was a member of the Home Affairs Committee at the House of Commons. The reason why I've become particularly identified with it now is that at end of 2005 I was asked by ministers in the Home Office if I would conduct a review of women with particular vulnerabilities in the criminal justice system, not just prison and look at the routes into prison and the well-springs of women's criminality.

What is the Corston report and why does it exist?

It arose from a review, at the time in one particular year 13 women took their own lives. You can't say they committed suicide because they may not have intended their deaths, but that's what happened, they died at their own hands and considering the size of the female population and what the numbers had been before, it was very high. There were also very high rates of self-harm in women's prisons. I was asked to do it by the Government. It contained 44 recommendations 41 of which were accepted, sometimes with varying degrees of enthusiasm, but it's my job to make sure the enthusiasm doesn't wane. The core of what I said, which seems obvious to many women, is that women and men are equal but they're different and to treat them the same doesn't guarantee equality of outcome.

Can you give an example of any of those recommendations that have been put in place?

At the end of it all, I remember saying to the Home Office official who worked with me on the report that if I achieved only one thing from the report I would like to be able to say that I had abolished routine strip-searching in women's prisons. Women were strip-searched on reception, but they could be and were strip-searched, before they went to court and when they came back from court despite the fact they'd been under the eye of official people the whole time. It's what's done to men, because men supposedly hide weapons on themselves, whether they do, I don't know.

In view of the fact that a very large proportion of women in prison have been abused and often abused sexually when they were children, I thought it was a terrible thing to do, it was unnecessary, it was degrading and it under-mined relationships between staff and prisoners. It's an exercise of power, it's 'we will do this because we can'. I would go around prisons when I was doing this report and I would say: Can I see your search book? What do you find? Because I knew what the answer would be, it was we don't find anything. I'm proud and this almost brings tears to my eyes when I think about it that as of April 1 last year, so it's a year, routine strip-searching in women's prisons in England and Wales was abolished. Now what happens is they are searched on reception, except they are allowed to keep their underwear on, which they weren't before. From then on, they are only search on

an intelligence basis, for example if a member of staff thinks a woman's behaviour is a bit suspicious and I think it's been entirely successful.

When you were researching the report, did anything around HIV come up?

It was raised with me as a health issue, just that there were some people in prison, apparently quite a small number for whom this was a complicating factor – that they were HIV positive. Apart from that, no, it was never brought up with me in any other way, other than prison staff referring to it.

Why do you think the numbers of women in prison continues to rise?

Just recently, I was told they were going down. I think my report was a wake-up call. I think a lot of judges and magistrates had no idea whether there were any other alternatives to custody in their areas, because they'd never been to look or never asked, because there are alternatives to custody, admittedly it's patchy. In some areas it's absolutely brilliant and in other it is non-existent but there are, all over the country, alternative programmes for women and community centres where women can go as part of an order and I think that's had an affect in that women are now being given an opportunity to have a different kind of disposal. In Yorkshire there is a pilot programme where women who are facing what would be arrest for an offence are given a caution on the condition that they attend a women's centre for an assessment to see whether that woman is going to co-operate with an assessment. Those kind of initiatives are happening now and they are happening all over the place – there's a new one in Wales called Turnaround which as it's name implies is about giving women the opportunity to turn their lives around so that is a growing phenomenon.

What do you feel is the impact of putting women in prison on children and on women-headed households?

When men go to prison the advice they are often given by staff is, put your head down, get on with your sentence and forget about the outside world. Now that may or may not be good advice but it's fine if there's somebody keeping the home-fires burning, it's fine if there's somebody bringing up the children and it's fine if there's somebody who can arrange for the rent to be paid. If that person isn't there, the effects are catastrophic. The majority of male prisoners' children are looked after within the family, only

Women and men are equal but they're different and to treat them the same doesn't guarantee equality of outcome

Baroness Jean Corston with Sophie Strachen at the House of Lords

Parliamentary copyright images are reproduced with the permission of Parliament

I know that the majority of women who are in prison are troubled rather than troublesome

10% of women prisoners children are looked after by the children's father or the women's partners. So they go to other family members or they are taken into care. Then frequently the women don't get those children back and time and again I would say to women prisoners; what do you want? I know, I'm a mother and they always said the same thing; I want somewhere for me and my kids to live. Generally, even if they are arrested and remanded, and over a third of those on remand don't get a sentence in prison, 28 days in prison is long enough to lose home and children and you never get either back. Unsurprisingly those women keep having babies because they'd like to keep one and it's amazing how often they are taken away, it's a tragedy.

I think there is also research to show that the children of women who go to prisons are much, much more likely than the general population to end up in prison themselves. I met a woman in Style prison who had given birth in prison and she herself had born in that prison. Every year about 15,000 children are affected by their mother's imprisonment. A further complicating factor in trying to maintain anything like a family relationship is that there are only 13 women's prisons. I say that's still too many, but if you think about the geographical spread, in order to have a family visit people have to travel a very long way to see a mother, a daughter, a sister, an aunt...

Those are all reasons why imprisoning mothers particularly of young children is catastrophic for them and for their children.

What would you like to see happen to the prison system?

I've never held a view that no woman should be in prison, I believe that prison is there in the interests of public safety and to uphold the rule of law. I'm not one of these people who just says that no woman could ever commit a crime that could cause her to be in prison. But I know that the majority of women who are in prison are troubled rather than troublesome and that not only do they not need to be there but it's a complete waste of resources both physical and human and emotional to keep them there. So I would like there to be a nationwide network of women's centres like ones I've seen in Glasgow, Halifax, Worcester where women who are in trouble, who've come to the attention of the police or the courts, can be sent to turn their lives around, to develop self-confidence. I have never met a short-term women prisoner who I could honestly say was self-confident. I would like them to have the opportunity to like them selves and for their children to be proud of them because that's what they want and it isn't rocket science.

Interview by Sophie

HIV, Prison and Positively Women

It was clear in the course of our interview that HIV hadn't been an issue merited with any importance in the Corston review to even warrant comment; HIV isn't mentioned once in the report itself. There is no comprehensive policy on HIV in prison in the UK and as you can see from the example below – there should be.

We as an organisation are unique in our service within prisons supporting women whether they have been diagnosed in prison or are HIV positive and back in prison through the 'revolving door' syndrome. We have just started going into HMP Bronzefield and initially we went there to see one lady, who was receiving no support. Our caseworker ended up spending the whole day there and saw six women.

There's no funding for us to provide this service, and no one is taking responsibility to fund our service when there is clearly a need. Positively Women go into three prisons and there are many women waiting to see us. The needs of women living with HIV in prison are not being met and predominantly this is due to funding or rather the lack of it.

The problem is that there's so much silence about HIV within the prison; it's of paramount importance that your confidentiality around being HIV positive is maintained. As opposed to looking for peer support about the care of your children or your housing needs, you're not going to look for peer support in the case of being HIV positive because you are living in fear of anyone else knowing. We think that's one of the reasons that HIV didn't come up as an issue in the course of the Corston report.

If you think about a prison like Bronzefield there are about 570 women incarcerated there – it's the biggest women's prison in Europe – but six women have come forward and told their health worker they're HIV positive. That's six out of 570. The proportion of people who are HIV positive in the prison system is far higher than the normal population. The proportion is 1% of the prison population and that's an estimate, but it's confirmed by the cases we have seen.

The complexity of issues women present with is enormous we can note a recent trend which is an increase in younger HIV positive women presenting, we have two caseworkers going into Holloway to the young offenders institute there. Another common issue for HIV positive people in prison is around treatments.

One particular example we highlighted with Jean Corston was around treatments. One of the women Positively Women supports in Bronzefield is taking a drug (Retonavir). This is a booster drug so that if helps her other drugs work effectively, you can keep this drug out of the fridge for up to 28 days. The prison pharmacy is refusing to let the women take the drug back to the cell because they maintain it has to be refrigerated, which means she can't take the drugs at the time that she needs them. There is a need for education in dealing with women in prison as the Corston report states, but there's a huge need for education around HIV.

When we discussed this issue with Jean and she suggested we raised it with Maria Eagle who is the Government minster responsible for prisons in the UK. We have written to Ms Eagle and at the time of printing are yet to have heard a response.

Sophie and Lucy

Sarah

Sometimes you take the wrong turn in life; you can get lost, hopefully you find or work yourself back on track, it's taken nine years and cost me my liberty, job, mental, physical, and emotional health, plus a year away from my son's life.

My name is Sarah I was diagnosed with HIV in 2000 and literally shut down. Who am I? Sarah Porter or Sarah Jane Porter as I was portrayed in the press.

I lost my freedom and anonymity in this world, which still has repercussions. Will it all rear its ugly head again one day? Will somebody remember? This is my biggest fear. 'Criminalization' increases stigma and punishes vulnerability by assuming the worst about people it victimises.

The investigation surrounding my case felt like a personal mission on behalf of the police and one officer in particular. The intrusion into my home and the way I was treated by the investigating officer was vindictive and uncompassionate and to this day leaves a bitter taste in my mouth.

The investigating officer leaked my story to the media; this led to him being taken off the case. However, he still felt driven enough to show up at court on the day of my conviction. The force need more training in understanding and handling of cases of HIV transmission.

HIV 'criminalization' is the far-reaching consequences, there is no protection for your family. I was forced to disclose my status to my son because of malicious gossip that started in the school playground at a time when we were just re-adjusting to life together and at an age, I felt, he was too young to have to deal with this information, though I am happy to say he coped very, very well.

Going to prison was the most alien thing I had ever had to do in my life. Leaving my son tore my heart apart; it left me feeling guilty and eventually redundant as a mother. What if something happened to him whilst I was locked away? I should have been protecting him and I just felt so hopeless. I would wake in a panic asking myself what if he lost that bonding with me? I felt as though I was drowning. In the meantime my child was growing up without me, losing his first tooth, learning to tie his shoe laces...

Like so many others behind bars I believe that I would have achieved so much more by being given a community sentence and getting the correct support and help. However, the vindictive nature of current political legal thinking combined with media frenzied hysteria demanded incarceration; it seems to have made the knee-jerk reaction an art form; following rules and regulations that cannot be supported by logic.

There is little of the prison service that makes any sense to me, it's a 'one size fits all' policy, but common sense tells you this cannot possibly be the case. 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.

I want people to know that losing your liberty is so much more. I want people to know that being sent to prison is to enter a world of fear, anxiety, and daily uncertainty. I remember finding my control, something that only I could switch on and off and not the officers not the prison, not the system and it felt so good... I pushed my fingers further and further down my throat and at last I had learnt how to make myself sick. It was such a release and felt so good! They had destroyed my soul, my relationship with my son and I hated them for the pain.

Having my life constantly in the media made me feel exposed and vulnerable. I was stripped of everything. When inmates gossiped, I felt hounded by the pack mentality, when people do not know the truth they can be very cruel and ignorant it's a very scary place to be locked in amongst people with ill feelings towards you.

I was rigid with fear at times each day having to try to justify myself to people. I felt I was going insane, totally isolated. Sometimes there were no words for the dark spaces between breaths. Grief was a blanket that enveloped me and nearly suffocated me.

I was luckier than some high profile cases and I soon began to make friends and be accepted on the wing. My relationship with the officers was good and when stories were leaked to the newspapers, they managed to halt the delivery at the gate, although as much as they tried, magazines, newspapers still managed to circulate, without a total ban on these things it is impossible to detect every story.

What was extraordinary is how much strangers cared. The letters of support poured in. It was touching, but confusing and slightly frightening. It is a big responsibility to return so much affection. To know that people you've never met and never will can feel so warmly towards you.

I am happy to say that it was fairly easy to re-adjust to being home and outside again and I had the opportunity to have weekend leave before my release which quashed a lot of fear around the media and my being recognised. Before my release I made sure that I had support networks in place, I had a brief stay at the Mildmay Hospital, I reconnected with my counsellor and most of all I had Sophie at Positively Women. Sophie had supported me all through my prison sentence. I also made referrals to an eating disorder clinic to tackle the demon I had bought home with me, bulimia. My friends were supportive and with me all the time for the first month.

Sophie was a lifeline for me in and out of prison. I do not believe I could have coped as well without her support it was so precious, without Positively Women I sometimes wonder if I would still be here today! Sophie gave me hope, strength and a way of looking forward instead of continually going backwards. Those were small steps but were to be very powerful steps, knowing that there was support, people whom cared and believed in me helped me to start believing in myself again.

The visits were also a welcome relief from the boring existence of prison life they made me feel like a person again and not 'that criminal'. I did not like myself feeling down and ugly with HIV and here was a person who took the time and patience to help put me back together again.

When the day of my release arrived, I was scared, excited, sad and unsure. My first few days were spoilt by media intrusion trying to get my story, getting in my face whilst out on a school trip with my son. I could not believe that they would sink so low, but nothing could take away my son again and this was the best feeling in the world! I lost a year of my son's life, how do you give that back? Through guilt and trying to make sure he wants for nothing!!!

Life today revolves around my son. I still have dark times where I allow the HIV to have power over me, the days I despise it and question 'why me?' Days I think I will never be the same again, days that I have under the duvet and wish that by some miracle it was all a mistake!

I appear confident on the outside but inside there is still a battle raging with low self-esteem and confidence. I lost my job at a company I loved to work for and still miss so very much. I wonder when I will feel confident enough to go out and face the interview process and CRB checks. Until then I try to focus on the positives that have come out of my situation, the family that are back in my life, my adoring and very talented son, my trusting and loyal friends and the fact that I am alive and I am FREE.

Sarah

Sarah Jane Porter, was convicted of grievous bodily harm through the reckless transmission of HIV, and was sentenced to 32 months in prison in June 2006.

Government Policy

Women in Prison

What is the Government's policy on women's imprisonment? Has anything been learnt from the 2007 Corston Review on vulnerable women in the criminal justice system?

The Government accepted most of the recommendations of the Corston Report – but what has it actually done? New policy has been introduced for women's prisons and guidance for offender managers working with women in the community and money has been invested in projects to divert women from custody. But still far too many women are being sent to prison and as the stories in this magazine show there continues to be huge unmet need amongst women in prison, particularly in terms of healthcare and support.

Post-Corston Policy Making

Following the Corston Report the Government introduced a new Prison Service Order on treatment of women in prison (PSO 4800). This PSO highlights gender differentiation in a number of areas and provides guidance on working with women and lists the measures each prison will be assessed against. In relation to health this states:

There must be an effective partnership between the woman's prison and the PCT, which ensures that each partner fulfils their respective functions in relation to securing and maintaining the health of their women prisoners.

Some specifics are outlined but these mainly relate to detoxification and no mention is made in the entire document about women with HIV.

There is also an Offender Management Guide to Working with Women Offenders, similarly, there is no specific reference to HIV and the guidance on healthcare is general, for example:

One of the most important interventions offender managers can probably make is to ensure that women offenders have a GP and access the normal mainstream health services.

Gender-Specific Pathways

The National Offender Management Service (NOMS) arranges its work around pathways to reduce re-offending the original seven pathways have been expanded to include two gender-specific pathways:

Supporting women who have been abused, raped or who have experienced domestic violence

Supporting women who have been involved in prostitution

This means that every women's prison should be providing specialised support in these two areas.

Diverting Women from Custody

The Government's policy focus now is on diverting women from custody – to this end they have funded 30 projects working with women in the community to provide support to lower the risk of a custodial sentence. Women in Prison is working in London and Manchester with women on short sentences (under six months) trying to stop the revolving-door syndrome and provide support in prison, through the gate and in the community that will give women choices and enable women to stay out of prison. Women involved in the project are also encouraged to get involved in Women in Prison's campaign group Women Moving Forward.

Small Custodial Units

The most far reaching and radical of Baroness Corston's recommendations have not been followed through. Dismantling the women's prison estate and replacing it with small, local, custodial units that are not under Ministry of Justice control seems no closer. By keeping women closer to home and better connected to local mainstream services, including health and education these units, would have the capacity to provide coherence and continuity of support and care. Hopefully, this would provide the improvement in treatment for women in custody with HIV that is needed.

The post-Corston policy developments should be used as a starting point for improving policy and practice for specific groups of women in prison, including women with HIV.

Women in Prison is part of the Supporting Women – Against Prison (SWAP) Campaign calling on all parties to commit to halving the number of women received into prison each year. To find out more and get involved see www.womeninprison.org.uk

Laurel Townhead
Policy and Campaigns Manager
Women In Prison

"We were a little apprehensive about it at first – I felt a little embarrassed and clumsy inserting it, although, once it was in, it felt fine and we forgot about it, for the rest of what was, a highly pleasurable afternoon, thank you!"

"I like the female condom as I often have issues with negotiating safe sex with my partner. With the female condom I can take control and I feel more confident."

"My experience has been a good one. Me and my husband can feel more sensation when we use the female condom. My husband is not positive and he feels more comfortable if I use a female condom..."

The Female Condom

The new Female condom is

- more affordable
- safe and effective

The Female Condom gives women control and choice over their own sexual health.

Let us know what you think!

www.femalehealth.com
www.postalcondoms.co.uk

The Demonised Other:
Sex Work and HIV

It is a well known fact that the British are obsessed with sex in all its colourful guises of sensual love making (under a 13.5 tog duvet to keep warm); passionate fucking, the furtive alcohol-pop induced gropes of losing one's virginity, extra-marital liaisons consummated in a nearby motorway motel, or the boring sexual trysts of celebrities. Our obsession, like most obsessions, is unhealthy. Rather than being the self-liberating sort of sexual curiosity experienced by the likes of Brigitte Bordot, ours borders on prudish, straight-jacketed and self-righteous heterosexual dogma. This readily lends itself to the delineation of people into the good cop – bad cop version of normal and deviant sexualities. Our desire to categorise a person's moral worth according to their sexual behaviour did not spring up overnight. In large part, we have our Victorian forebears and their neuroticism to thank for that.

The discovery of 'unnatural' sexualities around the 1850s occurred at a time when the medical profession was expanding and medical statistics were being collected to determine the health of the nation. The figures revealed a serious health hazard; venereal disease in the civilian and military populations. Immediately, the figures were harnessed by the state and the church as another excuse to bolster the dominant sexual ideology of the time; the virtues of marriage and reproduction. Swiftly sex outside the confines of matrimony became a metaphor for danger and disease; homosexual acts were condemned as ungodly and perverted, but it was prostitute women who felt the full force of the political, moral and medical sledgehammer. Indeed, our modern day obsession with prostitute women and sexually transmitted infections was sealed with the passing of the draconian Contagious Diseases Acts of 1864, 1866 and 1869 to control venereal disease among enlisted men in selected garrison towns and ports.

The Acts provided that a plainclothes policeman could accost any woman he suspected of being a 'common prostitute' and place her name on a police and medical register before forcibly subjecting her to fortnightly internal examinations by an appointed doctor – these became known as 'rape by speculum' examinations. Should she refuse to submit voluntarily, she would go before the magistrates to defend her name – that she did not have sex with men (with or without payment) – if she failed, imprisonment loomed. What's more, should she be found to have gonorrhoea or syphilis, she would be forcibly interned in a certified lock hospital for up to nine months. This sexual double standard ensured that prostitute women were defined as the primary source of disease and because men's sexual lust was deemed natural, they were neither questioned about buying sex nor subjected to invasive and often brutal bodily examinations. While the Acts were successfully abolished before the close of the nineteenth-century, there remains embedded in our culture a pervasive belief that prostitution and disease go hand in hand. During the Victorian period, public and medical anxiety found a fulcrum around the spread of syphilis, gonorrhoea and chanchroid. Today, it is HIV.

In our society, prostitution is one of the most dangerous professions. The danger, we are informed, stems from irresponsible prostitutes, strung out on drugs and engaging in unprotected sex with countless men. Indeed, the press and the media's incessant and wholly unfounded portrayal of

prostitute women as harbingers of HIV not only constructs the sex worker as a 'deviant' 'unhygienic' character, deserving social banishment and legal punishment, but it also directs attention away from the real threat. British sex workers are twelve times more likely to die from violence than other women of a similar age. The polarisation therefore between the female sex worker as deviant as opposed to victim is sadly misconstrued. The average Joe on the street is disinterested in the extreme violence meted out against female sex workers, seeking instead to believe the tabloids, which demonise prostitutes for conspiring in their own downfall into a netherworld of multiple sexual partners, degrading sexual acts and disease.

Such a stereotypical view could not be further from the truth. Many independent escorts actually enjoy their career choice and sex workers in the UK have lower rates of STIs than the general population. To some this latter fact is clearly bizarre, even baffling, and yet on closer inspection the reason is glaringly obvious. The general population tend to engage in unprotected casual sex with little or no medical knowledge of STIs. Sex workers, on the other hand, are generally better informed about HIV, hepatitis or chlamydia (the list could go on), and consequently take appropriate measures, such as using condoms and having regular sexual health checks. Indeed, numerous sociological studies have found that sex workers regard the condom as an integral protective tool when selling commercial sex. In other words, using a condom is an individual responsibility not to be dispensed with during penile penetration because the medical risks far outweigh any financial benefit.

We should not forget that sex work is stratified according to social, economic and geographical factors. Women are either independent and self employed entrepreneurs or they work for establishments. In the UK, most women engage in commercial sex in private residences, hotel rooms or massage parlours, while a small proportion of women seek male trade on the open streets. Historically, there has always been a world of difference between the life chances of those women working as independent escorts indoors and those women working the streets or the colloquial 'red light district'. The lives of the latter are typically characterised by social and economic exclusion, drug addiction, male coercion and often extreme violence. It is here that criminal markets collide and hard drugs, such as crack cocaine and heroin, deflate the monetary value of buying sex; £10 – £20 being the norm for sexual intercourse in the North West of England. For these marginalised women, the risks of HIV and other STIs, along with rape, robbery and death are far greater.

While most sex workers strive to protect their own health as well as the health of their male clients and any innocent third party (i.e. the wives and partners of the client), the same cannot be said of the actual client, some of whom seek to circumvent the strict rules of condom use irrespective of the health consequences. The sex industry is a deeply masculinised area and high levels of risk taking are sought by some clients seeking 'bareback' sex or sex without a condom. Because pleasure tends to override any safety concerns, it is also male clients who fuel the practice of 'oral without' – fellatio and cunnilingus without a condom or barrier. Thus, while most clients accept that condoms will be used during vaginal and anal penetration the same cannot be said of oral without; a service accepted as standard and should it not be offered, men tend to vote with their feet and the sex worker loses business to her competitor. The risk of contracting HIV through oral sex may be low, but it certainly is not risk free; gonorrhoea, syphilis and herpes, however, pose a greater threat.

HIV might be the new kid on the block as far as sexually transmitted infections go, but our society's readiness to condemn prostitute women as a major source of sexual infection has its roots in the Contagious Diseases Acts. Whether one morally agrees (or not) with a woman's decision to use her body as a commercial object, the fact remains that sex workers in the UK have lower rates of STIs than the general population. Rather than condemn such women as morally deviant and sexually irresponsible, perhaps we ought to celebrate their positive attitude towards practicing safer sex. After all, men who buy sex use condoms because the sex worker encourages them. The same might not be true if the men engaged in a quick sexual liaison after a few pints down the pub. Perhaps the blame culture surrounding prostitute women and how best to criminalise and punish them should be replaced with more rational dialogue on how best to bring the general population's knowledge of safe sex up to the higher standards associated with the independent escort.

CMc

To see the research material this article is derived from, email clairemcqclaire@yahoo.co.uk

10 Reasons

Why Criminalization of HIV Exposure or Transmission Harms Women

Recently, laws that specifically criminalize HIV transmission and exposure have been enacted, or are pending, in parts of Africa, Asia, Latin America, and the Caribbean. At the same time, particularly in Europe and North America, existing criminal laws are increasingly being used to prosecute people for transmitting HIV or exposing others to HIV. In addition to criminalizing the transmission of HIV, these laws sometimes call for mandatory HIV testing of pregnant women, as well as for non-consensual partner disclosure by healthcare providers; further exacerbating the impact of such legislation on women. The call to apply criminal law to HIV exposure and transmission is often driven by a well-intentioned wish to protect women, and to respond to serious concerns about the ongoing rapid spread of HIV in many countries, coupled with the perceived failure of existing HIV prevention efforts. While these concerns are legitimate and must be urgently addressed, closer analysis reveals that criminalization does not prevent new HIV transmissions or reduce women's vulnerabilities to HIV. In fact, criminalization harms women, rather than assists them, while negatively impacting on both public health needs and human rights protections.

10 Reasons to Oppose the Criminalization of HIV Exposure or Transmission, a document released in December 2008 by a broad coalition of HIV/AIDS, human rights, and women's organizations, provides ten reasons why criminalizing HIV exposure or transmission is, generally, an unjust and ineffective public policy. This document further expands on one of these ten reasons, by detailing how applying criminal law to HIV exposure or transmission – far from providing justice to women – endangers and further oppresses women.

Applying criminal law to HIV exposure or transmission does nothing to address the epidemic of gender based violence or the deep economic, social, and political inequalities that are at the root of women's and girls' disproportionate vulnerability to HIV. On the contrary, for the 10 reasons identified below, criminalization is likely to heighten the risk of violence and abuse women face; strengthen prevailing gendered inequalities in healthcare and family settings; further promote fear and stigma; increase women's risks and vulnerabilities to HIV and to HIV-related rights violations; and have other negative outcomes for women.

1 Women will be deterred from accessing HIV prevention, treatment, and care services, including HIV testing:

Many women fear violence and rejection associated with disclosure and an HIV positive diagnosis. The criminalization of HIV transmission or exposure may generate additional obstacles to healthcare for women. Prevailing stigma, discrimination and other violations of rights, including the lack of assured confidentiality, already pose a barrier to HIV prevention and testing services. The fear of an HIV positive diagnosis and the potential of subsequent prosecution is already discouraging pregnant women from accessing antenatal care, for fear that they will test positive and be exposed to abuse. Criminalizing HIV exposure or transmission also potentially undermines the effectiveness of child health, maternal health and perinatal HIV transmission programs, as women may choose not to access these services, due to fear. Thus, women are essentially being prevented from accessing available treatment and care services, for themselves or their children.

2 Women are more likely to be blamed for HIV transmission:

Women are often the first to know their HIV positive status; particularly as governments move towards provider-initiated HIV testing and counselling in pre-natal settings. Thus, women are more likely to be blamed by health staff, by their intimate partners, their partners' families, and their communities for 'bringing HIV into the home'. This blame and stigma can result in eviction, ostracism, abandonment, loss of property and inheritance,

and loss of child custody. Laws criminalizing HIV exposure or transmission would only provide another tool to oppress women. This is especially true insofar as apportionment of blame is still an important part of both customary and formal legal systems in relation to divorce and inheritance.

3 Women will be at greater risk of HIV-related violence and abuse:

While violence increases women's risks of HIV transmission, women's HIV positive diagnosis also increases the risks of violence. The fear of violence deters women from disclosing their HIV status. Research indicates that young positive women are ten times more likely to experience violence and abuse, than their HIV negative counterparts. There are also increasing reports of women being killed by their partners for 'bringing HIV into the family'. Criminalizing HIV exposure or transmission is likely to increase incidences of violence and abuse against positive women, as women may feel forced to disclose their positive HIV status to avoid prosecution, while risking violence and abuse at the hands of partners and family.

4 Criminalization of HIV exposure or transmission does not protect women from coercion or violence:

Sexual violence and rape, including marital rape, place women worldwide at risk of HIV transmission. Laws against sexual violence, where they exist, are often poorly enforced. Similarly, government policies and guidelines that call for providing sexual violence survivors with necessary medical treatment, including emergency contraception to prevent pregnancy and post-exposure prophylaxis to prevent contracting HIV, are often not implemented. Criminalization of HIV exposure and transmission does not protect women from sexual violence and rape, nor from unwanted pregnancy. Instead, it will increase women's risk of 'secondary criminalization', as rape survivors who have been infected with HIV could be found potentially liable for prosecution of HIV exposure and transmission.

5 Women's rights to make informed sexual and reproductive choices will be further compromised:

The patriarchal context of society undermines the power of many women to make informed choices, including sexual and reproductive choices. As a result, women are often not in a position to negotiate the conditions of sex, including whether or not to engage in sex, as well as to negotiate condom use. Women also often have limited access to sexual and reproductive health and rights information to inform their choices, and to access nondiscriminatory and unbiased sexual and reproductive healthcare services. Criminalization of HIV exposure or transmission may further limit women's ability to choose whether or not, how, when and with whom to engage in sex – as well as to choose whether or not to have children – due to the risk of being prosecuted for exposing and/or transmitting HIV to a partner and/or child. Further, criminalization undermines the promotion of sexual and reproductive health and rights of HIV positive women.

6 Women are more likely to be prosecuted:

Since women are more likely to know their HIV status, they are also more likely to be prosecuted for HIV exposure and transmission, since knowledge of one's HIV positive status is often a necessary element for prosecution. At the same time, women are least likely to have access to legal services and, thus, a fair trial. The burden of proof and the biased application of the law further increase women's risks of being charged, prosecuted and found 'guilty' of HIV exposure or transmission.

7 Some women might be prosecuted for mother-to-child transmission:

Some laws criminalizing HIV transmission or exposure are drafted broadly enough to include transmission during pregnancy or breastfeeding. For millions of women, living with HIV – but often denied access to family planning, reproductive health services, or medicines that prevent perinatal transmission of HIV – this effectively makes pregnancy, intended or not, a criminal offense. Further, it is increasingly recognized that in many middle and low-income settings, breastfeeding is the best option for child survival and well-being, despite the possibility of HIV transmission. There are many more effective ways to prevent perinatal transmission of HIV, beginning with supporting the rights of all women to make informed decisions about pregnancy and providing them with sexual and reproductive information and services; preventing HIV in women and girls in the first place; preventing unwanted pregnancies among all women; and providing effective medication and healthcare services to prevent perinatal transmission for HIV positive women, who wish to have children, or who are pregnant.

8 Women will be more vulnerable to HIV transmission:

Existing barriers limiting women's access to information, resources and services, including gender inequalities and inequities, will be compounded by the fear of prosecution for HIV exposure or transmission. The gendered access to health information and services, combined with the fear of being criminalized for exposing or transmitting HIV to someone, will place women in an even lesser position of power to negotiate conditions of sex, as negotiating condom use may be perceived as 'proof' of knowledge of an HIV positive diagnosis.

9 The most 'vulnerable and marginalized' women will be most affected:

'Vulnerable and marginalized' women, such as women in same-sex relationships, and women sex workers and drug users, often lack adequate access to HIV prevention, testing, treatment, care, and support services, primarily as a result of their existing 'criminalized' status. The criminalization of HIV exposure and transmission is likely to further stigmatize already 'criminalized' women and to constitute yet another barrier to healthcare and other services by posing a threat of double prosecution – prosecution for engaging in 'criminal behavior' and for HIV exposure or transmission.

10 Human rights responses to HIV are most effective:

Now, more than ever, greater attention to human rights is needed in the response to the global HIV epidemic. Criminalizing HIV exposure and transmission compromises human rights, undermines public health initiatives, and increases especially women's risks and vulnerabilities.

Rather than responding to HIV by creating fear through criminalization, human rights emphasize protecting the dignity – including the sexual rights – of all people, and create conditions in which people can make free and informed choices about their health and their lives.

These conditions include:

- The right to unfettered information, to the tools and technologies of HIV prevention; and to the right to make informed decisions about intimate matters, such as sex and sexuality, as well as pregnancy;
- Freedom from all forms of violence, from assaults on bodily integrity, from marital rape and all forms of sexual coercion;
- Freedom from arbitrary arrest, detention, and prolonged incarceration under laws criminalizing sex work, drug use, and same-sex relationships;
- Equal access to property and inheritance, so that women are not driven into poverty and higher HIV vulnerability by the death of their spouse or through dissolution of marriage.

When conditions such as these are met – when all people have equal control over their sexual lives and are in the position to make free and informed decisions about all forms of HIV prevention options – the criminalization of HIV exposure or transmission will be a thing of the past.

Both Sophie Strachan and Silvia Petretti contributed to this document.

Copyright © 2009 by the ATHENA Network. All rights reserved.

Putting

Patients 1st

Real faces, real stories, real lives

Gilead believes in supporting people living with HIV. That is why we have created a series of booklets to help patients make the most appropriate choices to maintain their health. If you would like to receive copies of these booklets, **please contact your healthcare professional.**

GILEAD
Advancing Therapeutics.
Improving Lives.

Health care and support

for positive women in Holloway prison

Last year we audited our throughcare work with positive women in the Women's Health Clinic (WHC) at Holloway Prison. For those of you unfamiliar with the term, throughcare is the process by which the medical, psychological and social needs of individual prisoner clients are assessed and organised. It involves liaison and referral with agencies such as probation, housing, social services, voluntary groups, drug teams and hospitals; in addition to advocacy, counselling, advice and pre-release planning. This work is a central part of our role as Health Advisers in the clinic.

In the audit, we looked at our work over a three month period, with the aims of:

- Describing the characteristics of positive women using the clinic
- Describing our throughcare work with each woman
- Looking at how well we met each woman's self-identified priority needs in prison
- Describing the details of the pre-release plans we made
- Making recommendations for improving throughcare

Audit findings

Seventeen HIV positive women were resident in Holloway between 1 January 2008 and 31 March 2008. They ranged in age from 23 to 43, with a mean age of 33. Their ethnic background was as follows:

White-British	2
White-Irish	1
Black-Caribbean	2
Black-African	11
Mixed race	1

Before they came into prison, they were living in a variety of accommodation:

Permanent / rented	10
Temporary	1
Supported housing	1
Psychiatric hospital	1
NFA	4

As well as being homeless, or living in very insecure accommodation, many women also had complex psychological and social problems:

- 8/17 (48%) had a serious addiction to drugs (usually crack and heroin) and/or alcohol
- 7/17 (41%) had a severe and enduring mental health problem (eg: depression, schizophrenia, ADHD)
- 5/17 (29%) had a dual diagnosis
- 10/17 (59%) had immigration issues

Their stay at Holloway ranged from 9 days to 515 days (1 year, 5 months), with an average stay of 121 days. Six women have returned to prison once or more times since the audit.

Throughcare work

All 17 women were assessed by a Health Adviser (HA), usually within a few days of their admission to Holloway. However, one woman was not seen for 41 days. This unacceptable delay happened for a number of reasons – a breakdown in the referral system between the reception doctor and the WHC, the woman's lack of knowledge about the support available to her (it was her first time in prison), and her anxiety about her confidentiality.

Treatment issues are very dominant in our work, and often an urgent priority when a woman is admitted to prison. This is illustrated by the audit findings:

- 11/17 (65%) women were irregular or non-attenders at their specialist treatment centres prior to their admission to Holloway
- 15/17 (88%) should have been taking anti-retroviral therapy
- On admission, 6/15 (40%) were actually taking ARV treatment
- Of the six women on treatment, four came in without a supply of their medication
- Health Advisers arranged a new supply of medication in all four cases (from their treatment centre or via a relative)
- The number of days interruption in treatment ranged from 0 to four days
- During their admission, two women started ARV treatment for the first time
- Three women restarted their ARV treatment, having not been able to take it whilst outside prison
- After HA interventions, 11/15 (73%) of the women who should have been on treatment were successfully adherring to their anti-retroviral therapy whilst they were resident at Holloway

During the three month audit period, the Health Adviser team assessed nine new positive prisoner clients, and our weekly caseload varied from six to 12 women.

All 17 women were offered ongoing support and counselling by one of the HA team, with 16/17 (94%) taking up this offer. The number of weekly sessions provided to each woman varied from one to 39, with an average of 10 sessions. Appointments lasted from 30 minutes to an hour. The liaison, referral, advocacy and pre-release planning work generated from each appointment took up to two hours of HA time.

We liaised with and/or made referrals to a wide variety of agencies: HIV treatment centres, Positively Women, probation, Social Services, immigration solicitors, housing, Refugee Legal Centre, Drug Strategy, local DIP (drugs in prison) teams and drug projects, sex worker projects, TB and HIV CNS (community nurse specialists), CMHT (community mental health teams) and Assertive Outreach Team.

We also carried out advocacy work on behalf of 11/17 (65%) women, with a focus on the following areas:

- Accessing HIV medication reliably and confidentially on their residential units
- Writing supporting letters for housing and immigration
- Accessing medical and psychiatric care in prison

The link between the Women's Health Clinic and Positively Women (PW) is longstanding, and one of the key services provided to positive women whilst they are in prison. A PW worker comes in every fortnight and gives one-to-one support to women referred by the HA team. This is a lifeline to many women, who are often making touch with PW for the first time. Some women have been able to sustain their relationship with PW, and have gone on to use PW's services after their release.

During the audit period, 14/17 (82%) women were offered an appointment with a PW worker. Five women declined, and two women were not able to see a PW worker during their short admission. So in total seven women saw a PW worker between one to seven times during their time at Holloway.

Priority needs

During our assessments we ask women to identify their priority needs. The audit revealed women's psychological, social and medical priority needs for throughcare work. These were remarkably consistent: Accessing HIV medical care, Finding somewhere to live, Immigration issues, Coming to terms with their HIV diagnosis, Addressing addiction, Coping with being in prison

Perhaps not surprisingly, addiction and immigration needs were the most difficult to meet. Accessing HIV medical care once they were released was directly related to their addiction and/or mental health difficulties.

Pre-release planning

Pre-release plans were made in relation to the following: housing, benefits, hospital appointments, HIV medication, outside support, multidisciplinary team meetings, subutex and methadone scripts and prison or detention centre transfer.

We arranged a multidisciplinary team meeting (MDT) for two clients during the audit period. An MDT meeting enables detailed co-ordinated planning for release, throughcare and aftercare, and can be very empowering for clients who are present and active in the meeting. They are useful when a range of professionals are involved in the client's care and she has a multitude of needs.

A detailed pre-release plan was made for only 8/17 (48%) of clients. The reasons why no pre-release plan had been made were:

- Unexpected transfer to a Detention Centre
- Released from court unexpectedly
- Transferred to another prison
- Client declined support from WHC and did not attend appointments

Recommendations for improved throughcare

We found the audit very useful – both in providing a detailed snapshot of our clients and our work, and in highlighting areas for improvement.

We made a number of recommendations, which included the following:

1. Clearer updated assessment and pre-release forms.
2. Commence pre-release planning at assessment.
3. Use peer and clinical supervision to systematically consider what HA interventions would be useful to promote engagement with our service and motivation to change.
4. Improve referral to the Health Advisers of positive patients, to reduce potential treatment breaks and allow timely access to specialist medical care.
5. Rewrite throughcare protocol to reflect audit findings.
6. Repeat audit of HIV throughcare.

Dawn Whittaker and Karen Luke
Health Advisers, Women's Health Clinic, HMP Holloway

References

Jarrett, S., and Del Rio, C. (2004) Working in prisons. *The Manual for Sexual Health Advisers*. Society of Sexual Health Advisers. London.

Fox, A., Khan., Briggs, D., Rees-Jones, N., Thompson, Z., and Owens, J. (2005). *Throughcare and aftercare: approaches and promising practice in service delivery for clients released from prison or leaving residential rehabilitation.* Home Office. London.

Prison Reform Trust and National AIDS Trust. (2005). *HIV and hepatitis in UK prisons: addressing prisoners' healthcare needs*. A report by the Prison Reform Trust and National AIDS Trust. London.

Healthcare in prison

By law, prisoners are entitled to the same standards of healthcare as other people. So in theory, being in prison shouldn't be a barrier to accessing the right HIV treatment and support. However, in practice the quality of healthcare provided can vary from prison to prison. Some prisoners have difficulties getting prompt access to medical treatment, had delays in being taken to external hospital appointments and experienced barriers to getting hold of HIV prevention resources such as disinfectant tablets.

There is no comprehensive official policy on HIV in prisons. Because of this, individual prisons are left to interpret the various regulations (often known as Prison Service Orders) that should shape practice in prisons and form their own approach. This article tries to help prisoners and their advocates by explaining what these regulations say.

According to Prison Service Order 3200, all prisoners are entitled to the same standard of healthcare as that available in the wider community:

'The Prison Service in partnership with the NHS has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS. This means that prisons should already provide health education, patient education, prevention and other health promotion interventions in that general context.'

What's more, each prison's healthcare services must be listed in a 'clear and observed' policy statement detailing what services are available and who provides them. A prisoner can ask to see the policy statement for their prison (Performance Standard 22).

Entering prison

For prisoners living with HIV the reception process is very important, since it should be used to highlight their specific healthcare needs. Under Prison Service Order 3050, all prisoners must be given a healthcare assessment within 24 hours of their arrival in prison.

According to the order, this assessment must be designed to detect:

- Immediate physical health problems
- Immediate mental health problems
- Significant drug or alcohol abuse
- Risk of suicide and/or self-harm.

A follow-up health assessment should also be completed in the prisoner's first week.

Although many prisoners are reluctant to disclose their HIV status at this stage, not doing so means that there can be no continuity of medical care, including provision of anti-HIV drugs.

The prison healthcare staff should try to make contact with the prisoner's previous doctor and GP, but must have the prisoner's consent to do this.

Accessing healthcare

Healthcare facilities differ from prison to prison, but in general, a prison healthcare manager will be in charge of healthcare staff, including doctors, nurses and dentists. If a prisoner feels unwell, they can request to see a member of the healthcare team. Prison staff must record this request and pass it on promptly to the healthcare team (Prison rule 20(2)).

The needs assessment carried out at reception will form the basis of the healthcare services prisoners receive. If the prisoner has disclosed their HIV status, healthcare staff can organise regular appointments with an HIV clinician, who may prescribe anti-retroviral therapy and other medication.

The Department of Health publication *A pharmacy service for prisoners* recommends that all prisoners should have access to pharmacy staff, and that wherever possible, prisoners should be responsible for storing and administering their own medication. However, if the medication is considered to present a security risk (sedative drugs that could be sold on to other prisoners, for example) then it will be supervised by healthcare staff.

The HIV clinician may visit the prison, or the prisoner may be taken to an outside hospital. Depending on their security category, a prisoner may be escorted to external appointments, or released with temporary license (Prison rule 9). In cases where escorts are thought to be necessary, prisoners can experience delays in attending hospital appointments. The need for escorts can also clash with the need for confidentiality.

The standard escort arrangement for prisoners from closed prisons is that two officers accompany the prisoner. Handcuffs or other restraints will be used unless there are medical objections. Handcuffs should normally be removed during medical consultations and reapplied once the consultation has finished.

If a prisoner's healthcare needs cannot be dealt with fully at the prison where the sentence is being served, they may be moved to another prison where different facilities are available. This may mean being taken to a prison even further away from friends, family and other support networks.

Transfers

The prison population can be highly mobile as prisoners will often be transferred to other institutions during their sentence. According to Prison Service Order 3050, when a prisoner is transferred from one prison to another healthcare staff have a duty to provide continuity of care. A new healthcare assessment should be made every time a prisoner is transferred and medical records should be passed on.

In some circumstances, healthcare staff can place a prisoner on 'medical hold', which prevents the prisoner being moved if their healthcare would be disrupted. NAT (National AIDS Trust) has set out a best practice framework for prison healthcare staff. Along with other useful information, it suggests five key questions healthcare staff should answer before a transfer takes place:

1. Is it in the prisoner's best interests to suggest a 'medical hold' to preserve continuity of HIV treatment?
2. Are the prisoner's medical records up to date regarding their needs/treatment?
3. How will any outstanding test results be communicated following the move?
4. If the prisoner is taking complex medication, have prior arrangements been made with the new prison to continue this without disruption?
5. If the prisoner is accessing disinfectant tablets (or condoms), will they be able to obtain them in the new prison?

Drug use

During the reception process, prison staff will assess a prisoner's need for drug misuse treatment. At some prisons, this may involve taking obligatory blood or urine tests. Each prison is expected to provide clinical services for drug and alcohol problems, such as detoxification, and is expected to work closely with NHS specialist drug misuse services (Prison Service Order 3550).

Although injecting drug use is widespread in prison, no prisons in England, Wales and Northern Ireland provide needle exchanges. As a result, the sharing of syringes is common, leading to a greater risk of transmission of HIV and hepatitis C.

A pilot needle exchange scheme is being organised in Scotland. The Scottish Executive is committed to needle exchange programmes in prisons, although there has been heavy opposition from prison service workers who are concerned that needles may be used as weapons.

On the other hand, prisons in England, Scotland and Wales have been instructed to provide disinfectant tablets to decontaminate needles. Although these tablets are not fully effective in eliminating HIV from used syringes, they represent the best available protection for injecting drug users in prison. They should be available on request from prison staff (Prison Service Instruction 34/2007). They are not available in Northern Ireland.

Confidentiality

Healthcare staff, and other prison staff, have a duty of confidentiality towards prisoners. Prison Service Order 3500 states that: 'Health information is normally collected from patients in confidence, and the common law duty of confidence prohibits the use and disclosure of such information without consent of the individual.'

Also, Prison Service Order 8460 states that prison staff must not: 'Give prisoners or ex-prisoners personal or other information about staff, prisoners or their friends and relatives which is held in confidence.'

Conclusion

The can often be a divergence between the official regulations and actual practice in prisons. While the regulations are only one part of the picture, knowledge of them may help prisoners and advocates argue for better treatment.

More detailed information on these issues will be published in a NAM publication, *Social and legal issues for people with HIV*, due to be published this summer.

for hiv information
nam

Yarl's Wood

Living with HIV and being an asylum seeker in detention is what I call a double tragedy. I was taken from my home in Manchester in 2005 to be detained at the notorious detention centre Yarl's Wood. It's an experience I want to put to an end and I hope this will be the last time I talk about it. It makes me angry, frustrated, and I can't stop asking myself why as human beings we have to pass through this horrendous experience? I wonder if we have a kind of a curse that can never leave us to be happy and proud of our continent in our continent Africa and I hope one day I will get an answer. This does not mean that there are no other detainees from other continents but the truth is that the majority are from Africa.

It was early morning in 2005; I had just washed my hair and applied a conditioner to my hair. I had not had my breakfast when I saw 10 huge men outside my door that came in two vans to arrest me. Two police personnel and about eight immigration officers. By the way, I'm not that huge a woman that I need ten people to arrest me. I had known that I was a wanted person since I received my refusal from Home Office and had just appealed. My lawyer had informed me that she would forward my appeal to Home Office and I needed to be careful. I did not know how careful I was supposed to be. In 20 minutes I was in a police cell with hair conditioner still in my hair, which I did not wash out until four days later. I literally looked like a rat that had fallen in a jug of milk. When I was leaving my house I told the immigration officer that I was on HIV treatment and my tablets were in the fridge, they picked them up and put them in my bag. I could not do it myself and was not allowed to hold my bag because I was a detainee, I did not realise that as we left the house the bag was then thrown back into my flat. In short, I did not have medication with me.

While in the police cell, I remember other criminals or asylum seekers making a lot of noise, shouting and swearing. I was constantly crying until I lost the energy and the voice to cry. I was so tired and hungry that I could not even swallow a drop of water. I could not stop thinking of my unknown destination, the uncertain future without medication. I was diagnosed in 2002 in London and by 2005 I had already accepted my diagnosis of HIV but that day, I realised how vulnerable I was, I knew that with my immanent deportation, my lifeline of anti-retrovirals was coming to an end. I was detained because my application for remaining in the UK was turned down. I am a Rwanda national who grew up in Uganda I went back to Rwanda in 1996 after the genocide of 1994. I had nothing to go back to, as I had no source of income, home and family.

After two days in a police cell, I was taken to Yarl's Wood in Bedfordshire. A doctor, who confirmed that I was ok to

fly to Rwanda, examined me; all this time I had not taken my medication. After four days in detention, I was taken to Bedfordshire hospital HIV clinic unfortunately they did not have the medication I was on. Part of my combination was newly licensed in the USA, but not in the UK so it was not easily accessible in many hospitals unless they had many patients on it. I was taken back to the detention centre as they ordered for my medication from another hospital. By the time I got it I realised that it was an under-dose because I was taking more milligrams than I had received. It was not the right milligram and was only four days worth. When I told them about the wrong dose I was told to take an over-dose which I refused because it was not the right option, I also realised that if I took an over-dose it was going to last me two days instead of four days before they could get the right dose. Meanwhile, I was not on medication. The medical team had to arrange to get my medication from my hospital in Manchester, which took almost a week.

Now that I had the right treatment there was another hurdle of keeping one of my medications in the fridge which I had to take with food. I would take my medication at 9pm at home but in the detention centre it was to change. They had to keep it in their fridge, I needed an escort to take me to the clinic and swallow my tablet but most of the time the clinic was closed at that time, and sometimes there were no escorts to take me there. I was used to taking my medication with my last meal at 9pm, the last meal in the detention centre is served as early as 5pm. I talked to the nurse about the time difference but she told that I had no choice but just to change the time of taking my medication that suits the dinning time. I was ready to change but I needed to do it gradually. I suggested that I could get a sandwich, which I would eat at 9pm in order to take my medication. The nurse agreed to arrange for me to get it but it caused me more problems as I was accused of wanting more food than others. I lost weight because my stomach could not tolerate the food I was given. I would get sick as soon as I ate food. I depended only on milk and a banana as far as I can remember. That was the only food that would stay in my stomach. One time a lady from Jamaica had to stand up for me because she realised how the kitchen staff and officers were mistreating me because of a sandwich. It looked like I had stolen it. Many times officers would arrest the sandwich. I know this sounds weird but is true. This lady told them blank that it was the most embarrassing thing to happen to someone she did not even know. She demanded to know when I will get out of the dinning area without being questioned about the sandwich. The truth is that I hate cold food and a sandwich is not one of my favourite foods. I was not greedy as they thought, I just needed something to take with my medication.

Every day I went to take my medication, every patient in the clinic knew, there was no privacy. One time an escort asked me why I was taking the 'bloody big tablet' which looks like a bullet (Retonavir). Another time a lady saw my tablets and said that we had the same problem; I never commented.

The nurses and doctors had no idea on HIV treatment, confidentiality, adherence and more. They thought I was as ignorant as they were, but I made sure that I told them what an expert patient I am. I could not be misled by their lack of HIV knowledge. It helped because they stopped messing around with my treatment. They would ask me before they could order for my medication.

I remember another woman who was HIV positive. She asked me to keep her medication because she did not want her roommate to see her medication which I did but caused me more problems. There is what they call 'spot check' in the detention centre. They can decide to strip your room inside out checking for illegal belongings like money or anything that is not registered under your name. It was my time with my roommate. They emptied everything from my wardrobe to my bed in front of my roommate and I was asked to explain why I had medicine which was not mine plus my own medication. I had to tell them that it was for HIV treatment. My roommate looked shocked, after two days she moved to another room.

I was released without an explanation and without my medication. When I asked why I could not get my medication, one of the detention officers asked whether I wanted to stay in the detention or if I wanted to go home. I was told to go to my GP and get my treatment. These ignorant people had no clue that a GP would not prescribe my medication. After all I was not going back to my old address and National Asylum Seeker Support (NASS) had stopped my support. This means I had no GP where I was going to live. I was released at 2.30pm by the time I got to Manchester from Bedfordshire, it was after six in the evening which means that by all means it was almost impossible to get treatment from Manchester that evening. Anyway all I wanted was to go back home so I gave up the medication and walked away empty handed. I spent a total of two months in Yarl's Wood but it was like two years in hell. It's more difficult if you are HIV positive and on medication. Thank God recently I got indefinite leave to remain in the UK.

Hope from Manchester (name changed)

For help around detention visit www.medicaljustice.org.uk and see www.bhiva.org/DetentionRemovalandPeople.aspx

YOU WANT
TO GET ON BUT OTHER PEOPLE'S FEAR WON'T LET YOU

LET'S TALK

HIV STIGMA

The person depicted in this advert is a model.

Talking to people who understand your concerns can really help. Contact one of the groups below (or your local HIV community organisation) for friendly confidential advice.

w: nat.org.uk **t:** 020 7814 6767
w: ahpn.org **t:** 020 7017 8910
w: tht.org.uk **t:** 0845 122 1200
w: positivelywomen.org.uk **t:** 020 7713 0222

THT Direct 0845 12 21 200

POSITIVELY WOMEN

Asylum Aid

The recent allegations of mistreatment towards female hunger strikers at Yarl's Wood Detention Centre near Bedford, and the Early Day Motion put forward by John McDonnell MP on 23 February, which 'condemns the detention of victims of rape and other torture, of mothers separated from their children and anyone who does not face imminent removal; believes that such detention flouts international conventions and UK immigration rules' underline the urgent need for a change of culture designed to produce a genuinely gender sensitive asylum system.

Cecilia's preference of prison to a detention centre is based on her own experiences. In *Every Single Woman*, a film and briefing published in December 2009 by the *Charter of rights of women seeking asylum*, she gives a more detailed comparison,

'When they search my room in prison... The female officer comes and first warns you they are going to search your room. They really do take care of the children. They would take you out of the cell. They would give you something to do. They'd give you a job – something to get a certificate – something to do in the community.

In the detention centre when they search your room it's male officers. There are many more male officers. They just come in. There is no privacy. The men come and search your room. They search your bras and underwear. They do what they want to do. They don't ask you. I find it very hard because of what happened to me in Africa. I think, another one, here it is again.'

In recent years, there has been a significant attempt to respond to the particular sensitivities related to women serving time in UK prisons. The 2007 Corston Report, reviewing vulnerable women within the criminal justice system, estimates that one in three women in prison have suffered sexual abuse. As a result, HM Prison Service produced a Prison Service Order stating that the appropriate gender ratio for women's prisons is generally considered to be 60:40 female to male staff as 'women who have been abused by men may feel safer in a predominantly female environment' and 'there are also issues of decency and security that need to be dealt with by female staff.' There is no ratio in place for Detention centres.

The major difference between women in prison and women being held in detention centres is that women in detention have committed no crime. While both are detained however, they should receive, as a minimum, a comparable standard of treatment and facilities. A recent inspection of Tinsley House Detention Centre by HM Inspector of Prisons was damning. It stated:

'When we last visited, we expressed serious concerns at the plight of the small number of children and women held in this largely male establishment. On our return conditions had generally deteriorated and the arrangements for children and single women were now wholly unacceptable... The small number of single women felt intimidated and rarely left their rooms.'

The UK Border Agency (UKBA) could learn from the improvements made by the Prisons Service, and others introduced across the criminal justice system, and transfer this learning to introduce similar standards of treatment within the asylum system. The recent appointment of Matthew Coats as gender champion at the UKBA is a step in the right direction. It is to be hoped that other measures to ensure that women asylum seekers receive a comparable standard of treatment to women in similar situations who are settled in the UK will soon follow.

For more information on the *charter of rights of women seeking asylum* and to read the *Every Single Woman* report, please go to www.asylumaid.org.uk/charter.

'Rather than going to a detention centre, it's good for me to be in prison for the rest of my life.'

Cecilia, Cameroon

In Memoriam of Z

This is the most difficult article I have ever had to write. I cannot use the name of the person. I cannot say where she was from. Her family has given me the permission to write an obituary about her as long as she can not be identified. When I need to hide the identity of people I write about I often use letters of the alphabet. In this case I will use Z: the last letter of the alphabet, to reflect how we, as a society, had left her last for most of her short life.

I first met Z during one of my first outreach visits to prison when I first started working at Positively Women nine years ago. She was then a blond and bubbly twenty something, who, already, had been diagnosed with HIV and HCV for a few years. She had grown up in one of the poorest parts of the UK, in a family already deeply affected by drugs and alcohol addiction and sexual abuse: an unoriginal tale for a woman who ends up in prison.

I saw Z frequently for many years. She had a voracious drug addiction and committed petty crimes to feed it. Z was in and out of prison, usually staying for a few weeks, sometimes months. I met her twice on her release at the prison gates to give her support in her struggle to be assigned accommodation from the homeless unit. Z had a learning disability and could hardly read or write, so she needed a lot of help. At the homeless unit, we spent our time queuing up, filling forms, begging, and quarrelling with housing officers. I remember I would become discouraged easily, but Z was extremely tenacious and resourceful and would continue insisting when I was ready to give up. Obviously it was her accommodation that was at stake, but it gave me a glimpse of a side of her which was very different from that of a powerless, desperate, drug addict. There was a real force in her. How would you survive on the streets for years and feed a very expensive addiction if you weren't tough, ingenious, and able to use any meagre opportunity you are presented with?

Both times we went to the homeless unit she was assigned some form of accommodation. We were so excited we had succeeded in getting a place. The first time we travelled all the way to the outskirts of north London by bus, carrying two bin bags with Z's belongings. When we arrived the place was a cold and squalid studio flat, without furniture, just a bed without sheets or a duvet. I felt sad when I left her, as if I was abandoning her. The Health Adviser had given her a piece of paper with a written plan for the whole week: names and numbers for Detox day-clinic, probation, hospital, Positively Women etc. I promised to contact her the following day, but I couldn't find her, her mobile phone went directly to answer phone. I saw her a few weeks later, in prison. She told me that she had gone out to get fish and chips, but she had become disoriented and couldn't find her way back. I didn't blame her. I wouldn't have wanted to find my way back to that bare and lonely place myself.

The second time Z got accommodation from the homeless unit was a hostel filled with other addicts. That time too when I left her I felt totally hopeless. The accommodation and support on offer was totally inadequate to support her. This meant that she couldn't properly take care of her health. It felt like her life was not worth much.

In the last couple of years Z changed. Her hair had become darker, her natural shade, her cheeks sank in, she was aging quickly. Every time she was arrested she arrived, drawn, skinny with a CD4 count not in double digits. Her bubbly side quietened. When I saw her in prison I felt a sense of relief. I knew that it was the only time she would have medication, food and a secure roof on her head. After a few weeks, she would start looking better and putting weight on. The last Christmas of her life she spent it in prison. She told me that she committed a crime so she could be arrested, and be safe behind bars. She couldn't bare spending Christmas in the streets. Z had changed a lot, she was more thoughtful, she really wanted to quit drugs and had made contact with her teenage daughter, she hadn't seen her since she was a baby, and she was being looked after by other relatives. Z was dreaming of cleaning up and visiting her.

Z was offered a place in a rehab in a rural area. But it didn't work, somehow her status was disclosed and she experienced humiliating discrimination. Her plates and cutlery were separated and people avoided her for fear of infection. She ran away, back to the streets of London and I saw her a few weeks afterwards in prison.

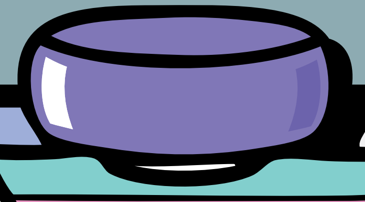
Z died of an overdose, on her own, in a homeless hostel, a year ago.

Silvia

CAN'T LET MY MEDS MESS UP MY NIGHT. THEY CAN WAIT

If you don't take it, talk about it.

Hot date or not, side effects shouldn't come between you and your anti-HIV medication. Your doctor or nurse can help you deal with problems or make changes to your prescription. Find out more at **www.yourstoryyourscript.co.uk**



Bristol-Myers Squibb

YOUR STORY, YOUR SCRIPT

August 2009, HIV/0509/2906

Violence against Women and HIV

As a woman living with HIV, and as somebody who has worked for the past 10 years at Positively Women[1] supporting countless women through the correlated traumas of an HIV diagnosis and domestic violence and abuse, I was elated to be invited to a Sophia Forum[2] event that focussed on the topic of Gender Violence and HIV. In spite of the overwhelming evidence worldwide of the connection between those two phenomena, the link is rarely discussed here in the UK.

Professor Charlotte Watts opened the evening by setting the context. She highlighted how poverty, gender inequity and power inequality, make it impossible for women to challenge and overcome social and cultural norms that condone violence as well as making it harder for women to access HIV services for prevention testing or treatment. Poverty, gender inequity and power inequality are common to many countries with high HIV prevalence. Professor Watts highlighted that perpetrators of violence against women are much more likely to partake in high-risk behaviours (such as unsafe sex with multiple partners and drug-abuse) and therefore are more likely to be HIV infected. Finally, she highlighted that as forced sex is physically traumatic and since it is carried out without condoms, it is more likely to transmit the HIV virus. In reality, this means that in high prevalence countries, like South Africa, women with a violent partner are over 50% more likely to be HIV positive[3].

Women access more health services, and are often tested for HIV during pregnancy, so they are the ones who have to go back home and break the news to their partners. It is not uncommon for women to be accused of 'bringing HIV into the home' and this can exacerbate existing or initiate new abuse and violence. We know very well here at Positively Women that an HIV diagnosis can be the trigger that generates violence and can make escaping from it much more complex. In Tanzania research showed that women living with HIV are 10 times more likely than HIV negative women to experience violence in the home, in the UK those figures are unknown. The fear that the partner may reveal their status to the wider community is often an insurmountable obstacle to escape domestic violence, as exemplified by this quote from one of our service users:

policeblue999

Steve Bowbrick

I was taken to A&E for head injuries after he had punched me and I passed out. I could not tell anybody because he kept threatening to tell friends and family about my HIV status so I remained with him and the abuse[4]...

The second speaker Rahila Gupta, writer and leader of Southall Black Sisters, who spoke about gender violence for the Black and Ethnic Minorities in the UK and strongly highlighted how the British culture and 'The State' collude to ensure violence against women continues. An example is the 'two years law'. If an immigrant is married to a British citizen, legally she needs to wait for two years probation before she is given citizenship. This can effectively lock women into abusive relationships. If you put HIV in the mix, things become even more complex. Leaving an abusive marriage for an HIV positive migrant woman in the UK could lead to loosing access to life-saving HIV medication. Southall Black sisters have been campaigning for changing this law since 2004[5].

Violence, immigration law and HIV create a bleak picture for many women in the UK. I recently visited an HIV positive woman in Holloway prison; I will call her Olu (not her real name). Olu came from a West African country and she was in her early 20s, she had been arrested for working with false papers. Olu's tale was horrific. She had been smuggled in this country to be a domestic help. Her boss raped her repeatedly and also forced her to have sex with some of his friends. Olu somehow managed to escape but didn't have a passport, so she got some false papers to use to work as a cleaner. Olu was arrested while trying to open a bank account, once arrested she was diagnosed HIV positive in prison. I only saw her once. From prison she was moved to a detention centre and then deported back to her country where lack of medication and support means she will probably die. While the UK government promotes 'Universal Access to HIV Treatment', many HIV positive people are forcibly deported to countries where treatment is not available.

In the UK the number of women living with HIV has been steadily growing since the beginning of the epidemic. Newly diagnosed women were only 20% of the new infections in 1996, and over 40% in 2007[6]. There are now more the 25,000 HIV positive women in the UK and not much is known about the correlated effect of HIV and violence on our lives. Our actions and interventions as women living with HIV are severely limited by the fact that gender and gender violence are totally ignored by the nine-year-old HIV and Sexual Health Strategy. If HIV and gender are not prioritised in the most important piece of national policy around HIV, organisations like Positively Women and others, who offer support to women vulnerable or infected with HIV, have to struggle under-funded and under-staffed. It is very difficult for us to develop a strong campaigning strategy within this context and network more efficiently with other women's groups around common issues such as gender violence.

Silvia

1. www.positivelywomen.org.uk
2. www.sophiaforum.net
3. www.lse.ac.uk/collections/LSEAIDS/pdfs/Watts%20Violence%20and%20HIV%20LSE%209th%20July2006.pdf
4. Patience PozFem UK report *'Women HIV and Sexual Health'* www.poz-fem-uk.org/resources.html
5. www.southallblacksisters.org.uk/campaigns.html#oneyear
6. www.hpa.org.uk

Life and death moments

Cate's Column

It is not often that someone's death can be seen as a cause for celebration! And before you all think I'm evil – let me explain.

Reg was HIV positive and a long term survivor. He'd been around since the early days when there weren't effective treatments or much hope for the newly diagnosed. He was also one of very few heterosexual men and if I'm honest, white colonial, with all the stereotypical attitudes and prejudices that that brings. We never did see eye to eye and were often at loggerheads with each other. I think he saw me as a 'gobby-git' or a 'feisty feminist' – he certainly wasn't used to women who had an opinion, weren't afraid to express it and fight their corner; but nevertheless we were still peers.

He was very kind to me when my partner died of HIV and spoke of Martin fondly. Over the years our paths, and swords, crossed less and less. He was often working abroad and I moved out of the area for a while. Life happens!

It seems silly to say, that the next time I saw Reg, I was shocked at how much he'd aged, as he wasn't a young man when I'd first known him and now he was a pensioner. He was quite frail and living in a home for the elderly.

I saw him a couple of times at our local support centre; he joked that only the good die young, laughed at our survival and praised the effectiveness of treatments. I felt gentle affection for him in his advancing years – we had little left to argue about and anyway what would be the point!

He died in early February. It was a turning point in the HIV community. Reg died of an AGE related illness, not an HIV-related illness. It was a first for us. An important day that proved that it is possible to have a normal life expectancy with HIV! Reg was living and dying proof of that, which is cause for celebration.

My own ageing process is something I have welcomed and celebrated as a mark of my survival. I let my hair go grey. Smiled at the appearance of crows feet and laughter lines. But my old age is not something I feel ready for. When I was first diagnosed I abandoned any ideas of having a career. It never occurred to me set up a pension plan; there didn't seem much point.

All that has changed; what was a distant dream is now more of a certainty and creeps ever closer. Unless I take after my grandmother who lived to be 96 – there are probably more years behind me than ahead – it has always felt so through every year of my diagnosis, except now it takes on a different meaning. One day I am going to be an old woman and I never expected that! I am often surprised by my reflection in the mirror – it catches me unawares. Some days I simply don't recognise the woman who looks back at me. In my minds eye I have long curly auburn hair, exuberant energy and young children. I'm stuck at 32. In my minds eye I didn't age from the day I was diagnosed; I didn't expect too.

The truth is grey hair, grown children and grandchildren. Yes that's grandchildren plural! My eldest son and his partner are expecting their first child in September.

The joy in my heart is immense as I celebrate life and death moments. Moments of hope and tomorrows, prompted by the death of a friend, and the awaiting life of my second grandchild.

HIV News

Positively Women Mark International Women's Day

To mark International Women's Day Positively Women gave out hundreds of Female Condoms at Speaker's Corner in Hyde Park, London. The Female Condom 2 (FC2) was launched in 2009 and generously donated for this event to Positively Women by the Female Health Company.

Positively Women were inundated with requests for demonstrations and questions about the female condom from the general public and event participants. The female condom is hardly used at all in the UK despite it's growing popularity in the developing world. The FC2 is a woman-initiated method of preventing both pregnancy and STIs, including HIV. Using the female condom increases a women's sense of empowerment.

The aim of the event was to raise awareness about the female condom and promote sexual health. Positively Women will promote the FC2 this year with a free female condom to be included with the next issue of the magazine as well as further promotional events planned.

MAC Cosmetics VIVA GLAM campaign 'From Our Lips' at Positively Women

The MAC AIDS Fund launched their new MAC Cosmetics VIVA GLAM campaign 'From Our Lips' at Positively Women recently – by introducing the new voices of the campaign, Cyndi Lauper, who hit the music industry at the beginning of the HIV epidemic in the 1980s and Lady Gaga, who is explosively popular with young people today. In honour of all women living with HIV, and those working to curb its spread, the MAC AIDS Fund announced a donation of $2.5 million to fund model programmes that address the vulnerabilities and inequalities that place women at increased risk of HIV/AIDS.

A grant from the MAC AIDS is funding a new project for Positively Women: From Pregnancy to Baby and Beyond which will provide education, information and emotional support for women living with HIV in all aspects of conception, antenatal and post-natal care. In the UK, Positively Women were one of the recipients of the donation receiving a one-year grant for £50,000.

Baby starved to death under health services care

A serious case review has been ordered into the death of a seriously malnourished baby boy in London despite the involvement of nine different health professionals with both the child and his mother.

The boy was found dead in a flat in St John's Wood, north-west London, on 8 March. Two days later, his mother, who was HIV positive, died in hospital. A second child has been taken into care.

According to the Daily Mail – which obtained a leaked internal report from one of the two health trusts involved, Central and North West London – the Eritrean mother refused an interpreter in January because she was afraid members of her own community might find out about her HIV status.

www.guardian.co.uk

Two leading UK HIV activists overdosed on meds

Two leading UK HIV activists who had not been informed about recent dosing changes to their meds. Both have spent months overdosing on HIV drugs.

One activist reported taking twice the dose of the protease inhibitor atazanavir (Reyataz) for six months; the other took 1200mg of darunavir (Prezista three tablets once daily) for ten months. The story highlights the need for everyone with HIV to double check their medicine with a pharmacist, especially if your drugs are being home delivered.

This article has been reproduced by kind permission of Baseline. For your free e-copy of the magazine please contact: editor4baseline@hotmail.co.uk or call 0121 449 4405.

Cyndi Lauper with the Positively Women team at the launch of the new VIVA GLAM campaign

WHAT'S HAPPENING AROUND THE UK?

BIRMINGHAM

Universal Women's Group and is on the last Friday of every month.

Contact Alex on 0121 622 6471 or email alexbergman@abplus.org.uk

Terrence Higgins Trust Birmingham provides support or advocacy services for women living with HIV.

For more information contact Michaela on 0121 694 6440

BRIGHTON

The Sussex Beacon run a Women's Group and provide one-to-one support in Brighton. The group is run once a month from 10:30am - 3:30pm.

Contact Paula Evenden on 01273 645698 or e-mail paula.evenden@sussexbeacon.org.uk

BRISTOL

Terrence Higgins Trust multicultural women's group. Monthly on Saturdays.

Contact Bonnie on 0117 955 1000, 11.30am-3pm

CARDIFF

Terrence Higgins Trust. African women last Thursday of every month 1-4pm, women and carers group – 2nd Monday 11am-1pm, parents group.

Contact on 02920 666 465

CORNWALL

Kernow Positive Support (KPS) has a new peer support group meeting monthly. Tuesday 10am-1pm drop-in for HIV positive women.

Contact KPS on 01208 264866 or visit www.kpsdirect.com

COVENTRY

Terrence Higgins Trust. Peer support service is available for HIV positive women. Women's social events are also organised.

Contact Kate and the Community Support Team on 02476 229 292

DUNDEE

Body Positive Tayside – Care and support group offering a range of services for people with a blood borne virus. Women's group meets regularly.

Contact Kim on 01382 461424 www.sol.co.uk/b/bptayside

EAST ANGLIA

PLP – Support group for HIV positive women.

Contact 01502 537 985 or email info@plpea.org.uk

Women Living Positively runs a monthly support group for infected and affected women.

Contact Joe on 01473 692 616 for more details

EAST SUSSEX

Terrence Higgins Trust. African positive women's groups meet monthly in Eastbourne and Hastings.

Contact Caroline 01323 649927

EDINBURGH

ISIS – a group for women living with or affected by HIV – continues to meet every Tuesday from 1.00 – 3.30pm at Waverley Care, 1 – 3 Mansfield Place, Edinburgh EH3 6NB

Contact Maro on 0131 558 1425 or email fphealth@waverleycare.org

Waverley Care – Offers a number of services providing practical and emotional support to people living with HIV in Scotland and to their partners and families.

Contact on 0131 661 0982 or visit www.waverleycare.org

Positive Help – Practical support for people affected by HIV and AIDS.

Contact on 0131 558 1122

ESSEX – SOUTHEND-ON-SEA AND THURROCK

Terrence Higgins Trust Safe Haven African Women's group monthly.

Contact Winnie on 01702 340 791 or 07766 428 355

GLASGOW

Phace Scotland – Provides a range of services for people who are HIV positive.

Contact on 0141 332 3838 or visit www.phacescotland.org

Body Positive Strathclyde women's support group. Weekly, Friday 5-8pm.

Contact on 0141 332 5010

HAMPSHIRE

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345 019 or email info@positiveaction.org.uk

HERTFORDSHIRE

Herts Aid holds a HIV positive women's support lunch monthly – the 3rd Tuesday of each month from 1pm-3pm.

Contact on 01920 484784

INVERNESS

Terrence Higgins Trust Scotland Highland Services. Free and confidential HIV, HepB, HepC testing, HepB vaccination. Welfare rigths support, one to one support and monthly support group for HIV positive people.

Contact Agnes on 07816 064 752

LEEDS

One-to-one emotional support. Every 2nd Monday 6-8pm, children welcome.

Contact Becki on 0113 236 4720

WHAT'S HAPPENING AROUND THE UK?

LIVERPOOL

Sahir House hold a monthly mentor-led women's peer support group.

Contact Serena on 0151 708 9080 or email info@sahir.uk.com

LONDON

Str8Talk – Islington. A multi-cultural self-help group for heterosexual HIV positive men and women.

Contact Str8Talk on 020 7812 1777

Riverhouse – Hammersmith, Weekly groups for HIV positive women 11am-4pm.

Call 020 8753 5190 for details

LUTON/BEDFORDSHIRE

Bbpositive HIV positive women's support group. Wednesdays 4-6pm. Food and refreshments available.

Contact Kirsten or Chrissie on 01582 484 499 or 01582 485 448 or visit www.bbpositive.com

MANCHESTER

George House Trust HIV positive women's support group and African Service. Alternate Tuesdays.

Contact Lynda on 0161 274 4499

Body Positive North West women's support group. Weekly, Friday mornings.

Contact on 0161 873 8100

SOUTHAMPTON

Ribbons Centre HIV positive women's group. Monthly, Wednesdays.

Contact Ginny on 0238 022 5511

STOKE ON TRENT

Espirit Women's Group for HIV positive women. Fortnightly on Wednesdays from 11.30am-4pm.

Contact Rosie on 01782 201279

WOLVERHAMPTON

Terrence Higgins Trust – Support for African women who've been diagnosed HIV positive, monthly on Thursday afternoon.

Contact Jane on 01902 711 818

SURREY

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345019 or email info@positiveaction.org.uk

SWANSEA

AIDS Trust Cymru. Monthly women's group 11am-3.30pm. Usually the first Wednesday of the month.

Contact Silvia on 01792 461 848 or visit www.AIDStrustcymru.org.uk

Please get in touch if you know of a group or service that can be included. Call 020 7713 0444 or email losman@positivelywomen.org.uk

LONDON – POSITIVELY WOMEN'S SERVICES

Support Groups:

Cara – Ladbroke Grove

Weekly groups for HIV positive women. Every Thursday 11am-3pm

Call 020 7243 6147 for details

Positively Women – Islington

Monthly support groups:

- HIV positive women's group every first Thursday of the month, 4-8pm
- Lesbian, bi-sexual and transgender HIV positive women's group every second Thursday of the month, 5-8pm
- Parenting groups for HIV positive parents every last Wednesday of the month 11.30am-2pm
- Caribbean Group last Saturday of every month 2-5pm

Call 020 7713 0444 for details or créche booking. Or see www.positivelywomen.org.uk/supportgroups.html

Riverhouse – Hammersmith

Weekly one-to-one sessions and groups for HIV positive women. Mondays 3-8pm.

Call 020 8753 5190 for details

One-to-one sessions:

- General support
- Newly diagnosed support
- Immigration support
- Evening and daytime sessions

PW – call 020 7713 0444

Outreach one-to-one sessions:

Homerton – call 020 8510 7996

Royal Free Hospital – call 020 7794 0500

Complementary therapies:

Weekly appointments for Shiatsu, Cranio-Sacral Therapy and Hypnotherapy.

New Yoga class is drop-in term time, (outside school holidays) 11-12.30 on a Friday.

PW – call 020 7713 0444

YOU WANT
TO KEEP QUIET ABOUT YOUR HIV

LET'S TALK

BODY CHANGES

The person depicted in this advert is a model.

Talk to your doctor if you are concerned about how HIV and
HIV-related therapy may affect your physical and mental well-being.

THT Direct 0845 12 21 200

POSITIVELY WOMEN