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INTEGRATING INTERVENTIONS ON MATERNAL MORTALITY AND MORBIDITY AND HIV: A HUMAN RIGHTS-BASED FRAMEWORK AND APPROACH

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ABSTRACT

Maternal mortality and morbidity (MMM) and HIV represent interlinked challenges arising from common causes, magnifying their respective impacts and producing related consequences. Accordingly, an integrated response will lead to the most effective approach for both.

Shared structural drivers include gender inequality; gender-based violence (including sexual violence); economic disempowerment; and stigma and discrimination in access to services or opportunities based on gender and HIV. Further, shared system-related drivers also contribute to a lack of effective access to acceptable, high-quality health services and other development resources from birth forward. HIV and MMM are connected in both outcomes and solutions: in sub-Saharan Africa, HIV is the leading cause of maternal death, while the most recent global report on HIV identifies prevention of unintended pregnancy and access to contraception as two of the most important HIV-related prevention efforts.¹ Both are central to reducing unsafe abortion—another leading cause of maternal death globally, and particularly in Africa.

A human rights-based framework helps to identify these shared determinants. A human rights-based approach works to establish the health-related human rights standards to which all women are entitled, as well to outline the indivisible and intersecting human rights principles which inform and guide efforts to prevent, protect from, respond to, and provide remedy for human rights violations—in this case related to HIV and maternal mortality and morbidity. The Millennium Declaration and Development Goals (MDGs) help to both set quantifiable goals for achieving the components identified within the human rights-based framework and document the international consensus that no single goal—such as those addressing HIV and MMM—can be achieved without progress on all development goals.

INTRODUCTION

Recent United Nations documents affirm the importance of addressing women's health—including maternal mortality and morbidity (MMM) and HIV—as a human rights concern. For example, the groundbreaking 2009 U.N. Human Rights Council resolution on preventable maternal mortality and morbidity and human rights recognized that “the unacceptably high global rate of preventable maternal mortality and morbidity is a health, development and human rights challenge,” and thereby called on “all States to renew their political commitment to eliminating preventable maternal mortality and morbidity at the local, national, regional and international levels, and to redouble their efforts to ensure the full and effective implementation of their human rights obligations.”^{2,3,4}

At the same time, the 2011 UN General Assembly Political Declaration on HIV/AIDS: *Intensifying Our Efforts to Eliminate HIV and AIDS*, recognized that HIV disproportionately affects women and girls, and “that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic, and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation.”^{5,6} Member states pledged to “eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection,” including by ensuring “that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence.”⁷ In addition, the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol) obligates member states to “ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”⁸

Thus, some progress has been made, particularly at the level of political commitments. However, there remains a long way to go to reach the targets of the HIV- and MMM-related Millennium Declaration and Development Goals (MDGs).⁹ While maternal mortality rates dropped by 34% from 1990 to 2008, this represents only a 2.3% annual average decrease, falling far short of the MDG target of a 5.5% annual decrease.¹⁰ Furthermore, this figure overlooks the fact that for every one maternal death, an estimated 20 additional women suffer pregnancy-related injury, infection, or disease.¹¹

The HIV situation is similar. While efforts to halt and reverse the HIV epidemic are beginning to reduce the number of new infections, serious challenges persist. Importantly, for every two people who begin treatment for HIV, five are newly infected. In 2009, more than 1.2 million women were newly infected.¹² At the same time, while women and men are being treated with antiretroviral drugs (ARVs) roughly in proportion to their disease burden, women now comprise more than half of all people living with HIV globally. In many African countries, women are infected at a ratio of 5:1 or 6:1, and the majority of new infections

are found among young women and adolescents. The most recent UNAIDS report demonstrates that HIV incidence among women aged 15-49 declined only marginally between 2009 and 2011.¹³

Traditionally, HIV and MMM issues have been treated separately, with a disease-specific approach long dominating the programming response of the public health field and understandably focusing on alleviating immediate practical problems, such as ensuring adequate supplies of ARVs and providing emergency obstetric facilities. Unfortunately, this approach creates non-integrated, siloed, and disease-specific programs that fail to strengthen the overall health system and neglect to respond effectively to the fundamental determinants of a range of health outcomes. A non-integrated approach may also foster inequities and even competition in the allocation of health resources at all levels of the system (primary, secondary, tertiary), which in turn can compromise effectiveness at all levels.¹⁴

This article argues that a sustainable approach must be anchored in human rights and gender equality in order to tackle immediate health and rights concerns while addressing the structural drivers that underlie HIV and MMM. As the recent report from the Global Commission on HIV and the Law notes, “access to HIV and reproductive health services could substantially reduce both vertical transmission of HIV and maternal death.”¹⁵ While we primarily emphasize health-related rights, it is important to keep in mind that human rights issues arising in the context of MMM and HIV are not restricted to health-related rights, but rather encompass the full range of human rights and fundamental freedoms. These include, significantly, those elaborated in the core international human rights norms and standards (with special emphasis on the UN Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW]). They also include both the definition of the highest attainable standard of health and the human rights principles which should guide efforts to achieve those standards.

To create sustainable and lasting solutions, the structural and system-related drivers of both MMM and HIV must be addressed together. Both HIV and MMM are complex social phenomena. They arise from, and impact, a wide spectrum of circumstances touching all dimensions of a woman’s life. Significantly, gen-

der inequality, gender-based violence, economic disempowerment, and HIV stigma and discrimination drive both—as evidenced by their disproportionate impact on women and girls. Gender-disaggregated statistics have made the latter evident only in the last decade. Statistics still obscure discrimination-based inequities within and across countries; for example, within most countries, a poor woman is four times more likely to die in childbirth than her wealthier counterpart. In North America, a woman’s lifetime risk of death (across all her pregnancies combined) was estimated at one per 3,700 live births; in Africa, that risk is one death per 16 live births.¹⁶ Africa is also home to a disproportionately large percentage of women and girls living with HIV.¹⁷

To be as effective as possible, HIV and MMM prevention efforts should be enacted in tandem due to the overlap in structural drivers. We propose a human rights-based framework and approach that integrate strategies to combat HIV and MMM linked to the larger gender equality agenda. A human rights-based framework calls attention to the impact of gender-based and HIV-stigma-based discrimination and rights violations. It brings focus to the unique obstacles facing most women and girls—exacerbated for the most vulnerable by discrimination based on factors such as age, occupation, sexual orientation, gender identity, and social status. A human rights-based approach directs attention to building legal literacy, economic empowerment, and women’s capacity to exercise and enjoy rights. It calls for the development and use of diverse mechanisms and tools for holding duty bearers (those responsible for ensuring access to services and to justice) to account.¹⁸

THE RELATIONSHIP BETWEEN HIV AND MATERNAL MORTALITY AND MORBIDITY

The relationship between HIV and MMM is increasingly evident, and the benefits of addressing the two together are increasingly clear.¹⁹ Women living with HIV hold an increased risk of maternal death because of weakened immune systems and disease interactions.²⁰ HIV infection may increase the risk of maternal death due to obstetric complications such as anemia, hemorrhage, or problems during caesarean section.²¹ According to most recent evidence, 18% of global MMM is attributable to HIV.²² The likelihood of MMM increases by 1.5% to 2% for a woman living with HIV.²³

Globally, the number of women with HIV who die from pregnancy-related causes declined by more than 20% since 2005, but regional variations show uneven progress with rates remaining very high in some sub-Saharan African countries.²⁴ The close correlation between HIV and MMM is most severe in sub-Saharan Africa, where HIV rates are the highest in the world, especially among women and girls.²⁵ In southern Africa, HIV has offset annualized reductions in MMM by at least 4% to 7%, resulting in a net increase in maternal mortality.²⁶

Complications arising from HIV infection and mortality have seriously impeded efforts to reduce maternal mortality.²⁷ In 21 of the 22 UNAIDS priority countries, AIDS remains the leading cause of maternal death, representing 90% of maternal deaths.²⁸ Nonetheless, nearly 74% of deaths not attributable to HIV could be prevented if women receive services necessary to protect their right to life.²⁹ Significant efforts are needed to realize maternal, reproductive, and sexual health. Sexual health is itself a critical consideration: while one possible outcome of pregnancy is delivery, other outcomes include miscarriage, stillbirth, infant death, unsafe abortion, or lifelong morbidity.³⁰

The massive scale of HIV in some countries has undermined health, social, and community systems’ capacities to address MMM, as well as other health, development, and human rights issues. For example, the spread of HIV may reduce the availability of safe blood to be used for blood transfusions needed during anemia-related pregnancy crises and obstetric emergencies. Physical space in health facilities may be limited, and overcrowding due to extended treatment of the growing number of patients with HIV and related opportunistic infections may limit the availability of care for maternity and delivery services.³¹

SHARED STRUCTURAL DRIVERS

Biological connections and related health system failures only provide a partial explanation for the strong association between HIV and MMM.³² Human rights violations increase a woman’s risk of HIV and maternal death. Such violations also obstruct global efforts to address these critical health issues. Moving beyond care and outcomes in pregnancy and delivery or following HIV infection, a “life course” human rights-based framework considers the compound-

ing impact of lifelong gender-based discrimination, and the additional impact of discrimination against subgroups of girls and women on the basis of e.g. health status, ethnicity, race, origin, caste, religion, economic status, sexual orientation, and gender identity.³³ At the root of these human rights violations lie four main shared structural drivers common to HIV and MMM: gender inequality, gender-based violence, economic disempowerment, and HIV-related stigma and discrimination.

Gender inequality

Violations of women's rights to equality and non-discrimination drive MMM and the gender dimensions of HIV. An uneven power dynamic often prevents women from being able to negotiate for voluntary, non-coerced, protected sex; as a result, sex often puts women at increased risk for unintended pregnancies and HIV. These in turn increase the potential for unsafe abortion or high-risk pregnancy and delivery. Unprotected sex is the single leading risk factor for death and disability in women of reproductive age in low- and middle- income countries.³⁴ Gender inequalities also limit women's access to education, thereby depriving them of basic literacy and numeracy skills needed for economic independence, as well as fundamental sexuality and health information—all of which are needed for girls and women to make informed, independent decisions about their sexual lives.

The gendered impact of discriminatory laws and policies can also exacerbate women's risk of HIV and maternal mortality. For example, legal systems that fail to criminalize marital rape and do not protect women from intimate partner violence institutionalize and reinforce barriers to women's sexual autonomy.³⁵ Laws requiring HIV testing of pregnant women, or laws that do not protect patient confidentiality and informed consent to medical procedures (including sterilization) may dissuade pregnant women from seeking maternal care out of fear that a positive test result may trigger rights violations within the health facility and/or violence, abandonment, or ostracism from their family or community.³⁶

Young women and girls may face even greater gender inequalities and in turn, heightened vulnerability to HIV and maternal mortality. Access to health services is especially limited for young women due to the culture of silence that often surrounds sexual and repro-

ductive health services and education for women and girls. Gendered social norms about sexual activity, lack of access to education and health opportunities, and power imbalances also reduce young women's and girls' ability to make autonomous health decisions.³⁷ Moreover, as Dr. Geeta Rao Gupta recently stated in a plenary speech at the XIX International AIDS Conference, it is critical to acknowledge that girls are sexual beings and that they should be a visible part of the solution.³⁸ However, even when girls are able to access services, health care providers often discourage them from using contraception or refuse to provide it because of their age or unmarried status.³⁹ Laws defining the age of consent to sex and consent to health services can be an additional barrier to HIV and family planning services for girls.

Forced marriages of girls to older men exacerbate existing gender power imbalances.⁴⁰ Early marriage increases girls' vulnerability to HIV for several reasons: girls may lack of knowledge of sexually transmitted infection (STI) protection and they may be unable to refuse sex or demand that protection be used. Girls who are married early are typically more exposed to sex with older partners; the older partners' sexual experience with multiple partners makes them more likely to be living with HIV.⁴¹ Younger girls may also face pressure to start a family quickly, resulting in increased risk of obstetric complications and maternal death during pregnancy.⁴²

Gender-based violence

Gender-based violence (GBV) deserves particular attention, as it is an explicit manifestation of discrimination. GBV can take many forms, including battery by partners and other family members, marital rape, and female genital mutilation (FGM), all of which can increase the risk of HIV and maternal mortality. Women who experience physical and/or sexual violence are less likely to be able to negotiate condom use due to coercion and the psychological impact of repeated abuse. Because HIV is primarily transmitted sexually, special attention must be paid to sexual violence. Forced sex may cause abrasions or cuts, which facilitate HIV transmission.⁴³ Unequal power between women and men intersects with age to place girls at a heightened risk of abuse by older men, including family members.⁴⁴ In fact, GBV may be accepted or tolerated according to particular myths or norms. For example, some men believe sexual intercourse with

young virgins will cure HIV.⁴⁵

Harmful practices such as FGM also increase the risk of both HIV and maternal death. FGM increases the risk of HIV if unsterilized knives are used to perform the procedure. The procedure also increases the likelihood of tearing and bleeding during intercourse, which facilitates HIV transmission.⁴⁶ Similarly, FGM increases the likelihood of MMM due to obstetric complications during labor.⁴⁷

Other types of violence may increase vulnerability to HIV and maternal mortality. Pregnant victims of GBV face greater risk of maternal death and can experience infections and labor complications as a result of the violence.⁴⁸ It is more difficult for women living with HIV to access health services and stay healthy through pregnancy when gender inequality and fear of violence are pervasive.

Women living with HIV are at increased risk of all forms of violence.⁴⁹ In Kenya, for example, 20% of women living with HIV report experiencing physical, psychological, and sexual violence after revealing their status to their male partner.⁵⁰ Women are typically blamed for HIV even if their partner is also positive. Fear of violence dissuades women from getting tested and discourages women from accessing health services where there is a likelihood of mandatory testing.⁵¹ The risk of disclosure-related violence is especially high for young women living with HIV.⁵²

Economic disempowerment

Women face significant inequality vis-à-vis men in access to employment, income, asset accumulation, credit, and other forms of ensuring economic security and autonomy. This is the case even when controlling for differences of race, ethnicity, language, geographic location, and other factors associated with economic disempowerment.⁵³ Research suggests that unemployment increases mortality and morbidity fourfold.⁵⁴ Disempowerment in turn limits women's access to the resources, information, social networks, and tools to protect themselves and reduce their dependence on male partners, which inhibits their ability to negotiate sex and therefore increases their risk of HIV and unwanted pregnancies which may lead to MMM.^{55,56}

The poorest and most marginalized women in the poorest countries and communities have even less access to adequate information about HIV transmission, fewer economic opportunities, and less access to sexual, reproductive, and maternal health services.^{57,58} In resource-constrained households, and where men control the distribution of limited family resources, health care is often rationed based on gender: women's health expenses are not deemed a priority, and girls receive less or poorer quality care.⁵⁹ The same pattern may result in denying girls education. These decisions exacerbate girls' and women's economic disempowerment and vulnerability to HIV and maternal mortality and morbidity.⁶⁰

HIV-related stigma and discrimination

HIV-related stigma and discrimination reduce the quality and accessibility of health, social, and legal services and limit access to justice. Women living with HIV may be treated as though they are "beyond help or undeserving of services" by health care workers or community members.⁶¹ Individual, community, institutional, and "legally based" discrimination may result in hospitals and health workers denying treatment, access to essential medicines, and information about sexual and reproductive health services, including contraceptives or childbearing in the context of HIV. Forcing or coercing women living with HIV to have abortions or to undergo sterilization can compromise women's health.⁶² Moreover, it can have the effect of causing women, particularly those living with HIV, to avoid health services for fear of stigma and discrimination, including treatment that may violate their sexual and reproductive rights and their right to found a family.⁶³

Gender inequality magnifies the impact of HIV-related stigma, for example, social ostracism, isolation, and inability to access health care, which further exacerbate structural drivers of MMM and HIV.⁶⁴ Widows living with HIV may be socially and economically marginalized and stripped of their rights to family property.⁶⁵ Laws that criminalize sex work may increase stigma thereby discouraging sex workers' efforts to seek care and limiting their access to health, social and legal services, including contraception and sexual and reproductive health care.⁶⁶

DEVELOPMENT OF A RIGHTS-BASED

FRAMEWORK AND APPROACH

This section focuses on the human rights standards and operational human rights principles that can effectively guide attention to both HIV and MMM.

The rights-based framework

A rights-based *framework* identifies the interrelated structural inequalities that result in women's differential ability to access health, social and legal services and other development opportunities throughout their lifetimes, particularly for marginalized women and girls subject to additional discrimination on the basis of factors such as caste, class, sexual orientation, gender identity, race, and language.⁶⁷ This results in poor health outcomes and limited enjoyment of their general human rights. It highlights the transformative potential of fostering equality and empowering women, men, transgender persons, and young people to effectively assert their rights to good health and legal empowerment as well as quality services. The framework points to the need for holistic and integrated solutions linking diverse public sector services and strengthening of the health system—a critical element at all stages.

International consensus has coalesced around legal obligations and standards for human rights, women's rights, sexual and reproductive rights, including the right to the highest attainable standard of health, and gender equality.^{68,69,70} These cover freedoms and entitlements, and the obligations of the state and other duty bearers to respect, protect, and fulfill all human rights. These obligations include assuring availability, accessibility, acceptability, and quality of both health services and other services and programs addressing the “underlying determinants of health.”⁷¹

The rights-based approach

A rights-based *approach* highlights the human rights principles of accountability, participation, empowerment, equality and non-discrimination, transparency, sustainability and international cooperation that should guide efforts to address the structural and health-system inequities. Actions to reverse gender-based and other discriminatory laws and practices, pursue integration of sexual and reproductive health and rights interventions with HIV prevention, treat-

ment, care, and support, and improve the availability, accessibility, acceptability, and quality of health, social and legal services must hold state and non-state actors accountable for providing the range and quality of mandated public sector services and programs which meet the state's commitments under national and international law.^{72,73}

These principles are indivisible and integrally connected.⁷⁴ Therefore, any rights-based approach should embrace all principles, even if this includes giving priority to some principles based on specific conditions or the type of violation. For example, accountability demands transparency and sharing of information regarding practice and outcomes, as the resulting information is the basis for holding individuals and programs responsible for commitments, good practice, and respect for their clients' rights and choices. The latter is best accomplished through effective participation of clients and communities in all stages of programming. This is particularly true regarding community or client oversight mechanisms on quality of care or service outcomes. The latter most often requires empowering women with information and the self-confidence, and sense of solidarity and support, which gives them the base from which to engage. It also requires accountability from international actors providing funding and technical guidance for these services.⁷⁵

APPLICATION OF A RIGHTS-BASED FRAMEWORK AND APPROACH TO THE SHARED DRIVERS OF HIV AND MATERNAL MORTALITY AND MORBIDITY

As we have noted, adopting a holistic and rights-based framework for addressing HIV and MMM will lead to an integrated solution to both. This concept is in line with a growing concern for building stronger linkages between sexual and reproductive health and HIV policies, programs, and services.⁷⁶ The results can arise indirectly—for example, by strengthening health care systems overall through increased funding, or directly—for example, by integrating services using those entry points in the system that best protect women's rights: interventions related to family planning, voluntary counseling and testing (VCT) for HIV, and expanded programming for prevention or elimination of mother-to-child transmission of HIV (PMTCT).

Where solutions have been integrated, results have

begun to shed light on the reciprocal benefits and synergies of linking HIV and MMM. For example, the recent global scale-up of HIV services may have benefitted health systems in general, and correspondingly, may have contributed to improving maternal health.⁷⁷

An approach focused on “combination prevention” connecting biological links with structural and social factors can offer more sustainable solutions to addressing causes as well as consequences.⁷⁸ A rights-based approach calls attention to the particular obstacles to health and rights faced by women at increased risk of or vulnerability to HIV and MMM, such as young people, sex workers, transgender women, and migrants.⁷⁹ Effective implementation and the policy and program implications of such a framework are complex, requiring a multisectoral approach and significant national coordination across government, civil society, donors, and the UN system.⁸⁰ In pursuing such approaches, program actors must remain true to key human rights principles.

MMM and HIV as rights issues

Shifting away from sole reliance on technical interventions and trainings, the human rights community has supported the health community in reframing MMM as a human rights issue.⁸¹ Similar efforts have been under way for some time around human rights and HIV.⁸² Such recharacterization enables stakeholders, whether community, clients, or advocates, to more comprehensively address all drivers of MMM and HIV. At the field level, this has progressed to pursuing rights-based performance standards for practitioners, as well as setting in place judicial, political and social accountability mechanisms for pursuing both redress and systemic change from duty-bearers who fail to safeguard women’s health.

For example, based on a complaint filed in Kenya by the Federation of Women Lawyers-Kenya and the Centre for Reproductive Rights-USA regarding “systematic violation of women’s reproductive health rights in Kenyan health facilities,” the Kenyan Commission on Human Rights conducted a broad public inquiry on services around the country. The findings documented the need for provider-friendly formal guidelines and standards of practice reflecting the globally agreed-upon performance standards and operational rights principles as well as greater trans-

parency such as tracking of facilities’ performance based on global indicators and measures for assessment (for example, those produced for emergency obstetric care).⁸³ In a subsequent major initiative to reduce maternal death, The Kenyan Skilled Care Initiative expanded beyond simple technical training, and instead trained maternal health care workers in both technical standards *and* a human rights-based approach to provision of services. The program included a basic review of key rights principles drawn from Kenya’s own ministerial guidelines and regulatory frameworks which helped foster greater accountability.⁸⁴

Individual health professionals are also well-positioned to refer women living with HIV to community support groups and to encourage them to advocate for their rights. Protections to secure confidentiality of health status and the right to privacy and bodily integrity are especially necessary to encourage women living with HIV to seek and access care. For example, when integrating VCT and ARV services into existing sexual and reproductive health programs, Family Health Options Kenya (FHOK) developed specific policies to ensure client confidentiality and informed consent in the context of HIV and integrated the services so that all clients used the same waiting rooms and entrance areas to prevent recognition of those using the HIV-related services.⁸⁵

Application to structural drivers

Each of the four structural drivers addressed above find corresponding integrated action points in the rights-based approach to HIV and MMM: fostering gender equality, modifying services for gender-based violence, combating HIV stigma and discrimination, and empowering economic opportunities for women and girls.

Revamping health systems to foster gender equality

In KwaZulu-Natal, South Africa, an existing antenatal and postpartum care program offered men the option to participate in counseling sessions with their female partners. The women provided informed consent. Clinical staff was also trained to recognize and address abusive situations and provide support and referral to domestic violence services. Evidence suggested that male partners were more helpful and supportive after the counseling sessions and that couples

increased their communication about topics raised in counseling.⁸⁶

In order to generate greater support from male partners at the clinic in Nakuru, Kenya, efforts focused on increasing the numbers of men accompanying their female partners to the clinic. This had the effect of decreasing the number of women who left their appointment cards at the clinic for fear that their partners would know that they were using contraceptives—positive outcomes for both HIV and prevention of unintended pregnancy.

These efforts directly address the many ways in which health and social systems have evolved to conform to and reinforce the harmful gender norms and inequalities that drive both HIV and MMM. This includes social norms limiting women's ability to participate in decisions and represent their concerns regarding their care but also norms constructing childbirth as a "women's issue" limiting the involvement of and perhaps failing to hold responsible household members with the power and resources to access quality care.

Modifying services for GBV survivors to accommodate an integrated approach to women's health

In Haiti, the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO) has effectively integrated support for victims of sexual violence within broader programming for sexual and reproductive health and HIV services, including same day test results and counseling, syphilis screening, and an appointment with a doctor.⁸⁷ The program was the first to offer post-exposure prophylaxis (PEP) for rape survivors arriving within 72 hours of the exposure. Such services have now expanded to other VCT centers.⁸⁸

In Kenya, the NGO Liverpool VCT (LVCT) is implementing a post-rape care program that addresses health and legal issues arising out of sexual assault. At the same time, they influenced the development of the Kenya National AIDS/HIV Strategic Plan (KNASP III) and its first National Plan of Operations (NPO) to include strategies for supporting rights of women and vulnerable communities, including survivors of sexual violence and women living with HIV.⁸⁹

These examples address GBV survivors' need for services to address the health implications of violence (such as services to prevent unwanted pregnancy and

HIV infection), as well as the psychological, legal, and social support to overcome the disempowering effects of GBV, hold perpetrators accountable, avoid future exposure to GBV, and participate in efforts to change the harmful gender norms that manifest in GBV and other rights violations. They also offer promise for greater participation of clients in program planning.

Combating HIV-related stigma and discrimination to facilitate greater access to care

HIV adds important dimensions to the human rights-based approach by putting a spotlight on stigma and discrimination as significant barriers to an effective HIV response. It calls attention to the impact of punitive laws and policies while also calling health and social service workers to provide services in a non-stigmatizing, non-discriminatory manner. For example, in 2010, the Fiji Network for People Living with HIV and AIDS (FJN+) conducted a survey designed to measure and analyze HIV-related stigma, called the *People Living with HIV Stigma Index*.⁹⁰ The survey findings were based on a sample of 45 people living with HIV in Suva and Lautoka on the Island of Viti Levu and in Labasa on the Island of Vanua Levu. The survey found high levels of self-stigma, including guilt, blame, and low self-esteem. In response, FJN+ has strengthened the counseling services for people living with HIV, and has used evidence from the Index to successfully advocate for the inclusion of clauses on stigma and discrimination and confidentiality in a 2010 HIV decree that aims to safeguard rights.⁹¹ The data revealed key gaps in the response to people living with HIV and informed the development of service-related standards to which all providers can both refer and be held to account. Looking to the community at large, addressing stigma and discrimination can also foster the changes in attitude and improved health practices to simultaneously combat HIV and maternal mortality.⁹²

Fostering women's economic empowerment to enhance individual autonomy

A rights-based approach to HIV and maternal health includes an emphasis on a woman's ability to acquire and control financial resources through education, access to work, and/or independent income generation. Access to resources has the potential added benefit of reducing pressure to make choices which

put them at risk of HIV or MMM and may improve women's decision-making power. A 2011 study in Nepal demonstrated that "reduction in fertility changes in education and wealth, improvements in development, gender empowerment and reduction of anemia each contributed substantially to a decline in maternal deaths."⁹³ Evidence from Indonesia suggests that where women had more economic autonomy with respect to household assets, uptake of maternal health care services increased.⁹⁴ Directly addressing nutrition can also impact maternal health since inadequate nutrition can increase complications with pregnancy, maternal ill-health and can retard early childhood development.⁹⁵ Finally, a study in Malawi on a program using cash incentives to maintain girls' enrollment in or encourage their return to school demonstrably reduced early marriage, teenage pregnancy, and self-reported sexual activity after just one year and increased school retention by a factor of four.⁹⁶ Numerous studies across regions show a positive correlation between education and the use of maternal health services and contraception.⁹⁷ Such interventions have multiplier effects and can help foster greater sustainability of services when women are able to pay.

CONCLUSION

Making real progress on HIV and maternal mortality and morbidity requires thinking beyond isolated health interventions. The MDGs provide a powerful and strategic platform for mobilizing resources, intensifying political will, and increasing momentum and action for a comprehensive approach to both HIV and MMM. In many regions, HIV obstructs progress toward MDG 5 on MMM, underscoring the urgent need for a comprehensive response to both issues.⁹⁸ Moreover, safeguarding women's rights and promoting gender equality (MDG 3) and human rights is central to achieving all the MDGs. As recognized in the UNDP's "MDG Breakthrough Strategy," gender equality and women's empowerment have "multiplier effects" across all MDGs.⁹⁹ Securing human rights, including gender equality, ensures that women can access the services they need to protect themselves from MMM and HIV, and to enjoy lives that reach and surpass the aspirations underpinning the Millennium Declaration and its goals. An integrated rights-based approach must tackle immediate health needs while addressing the structural drivers that underlie HIV and MMM, as well as other health and development issues. In particular, it is necessary

to address the human rights violations that create and sustain poverty and increase the risk of HIV and MMM for women.

A human rights-based approach also adheres to key human rights principles in solving these problems. The key principles of accountability, participation, empowerment, equality and non-discrimination, transparency, and sustainability/international cooperation safeguard human rights within interventions and programs and also contribute to the effectiveness and sustainability of a holistic, integrated, and client/community responsive intervention approach. Further, they encourage engagement of a broader range of stakeholders who can provide technical expertise, resources and political support, foster policy change, and bring to bear the expertise and authority of internationally agreed standards regarding the right to health. These principles also help ensure that domestic and international actors supporting such efforts are themselves held to the same operational human rights principles.¹⁰⁰

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68. Ibid. This includes "assuring the sexual and reproductive rights of young people to make informed choices and protecting and providing access to safe termination of unwanted pregnancy (as well as) a) the right to life; b) the right to the highest attainable standard of health; c) the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; d) the assurance of equality and non-discrimination in provision of services and information in both the formal and informal mechanisms and practitioner choices related to provision of care ; and e) the enabling of individuals effective participation in decisions impacting their sexual and reproductive health. In addition, the substantial documentation of the mistreatment of women in delivery-whether through neglect and non-response or even abusive treatment at the hands of health staff or providers--highlights the added concern in the case of maternal mortality of f) the right to be free from cruel, inhuman or degrading treatment."
69. Ibid. The key consensus documents, all of which helped develop the justification for an overall right to health, include the World Health Organization Constitution (which defines health as physical, mental, and social well-being); the International Covenant on Economic, Social and Cultural Rights, Art. 12.1, 12.2; International Covenant on the Elimination of All Forms of Racial Discrimination, Art. 5(e)(iv); the Convention on the Elimination of All Forms of Discrimination Against Women, Art. 11(f), 12; the Convention of the Rights of the Child, Art. 24; the Convention on the Rights of Persons with Disabilities and key reports from the UN Office of the High Commissioner for Human Rights, the Human Rights Council and the UN Special Rapporteur on the right to health which have refined the definition of the right to the highest attainable standard of health as well as rights pertaining specifically to maternal mortality and morbidity.
70. This is encompassed by the Convention on the Elimination of All Forms of Discrimination Against Women, but also included in all human rights norms and standards as applied to gender equality and the human rights of women and girls.
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Brazil's public health system increasing access to oral contraceptives demonstrates these efficiencies. Brazil's success from 1996-2006 in increasing oral contraceptive access and use across all regions from 55% to 68% benefited from strong family health planning counseling access, integration between sectors and integration of reproductive health issues into local planning strategies.

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