Sexual and Reproductive Health and Rights of Women and Girls Living with HIV: Summary of key issues

Despite the recognition that linking sexual and reproductive health and rights (SRHR) including maternal and child health (MCH) with the HIV response increases overall health outcomes for women and cost efficiencies in service delivery, integrated health services remain unavailable in many countries. Women and girls living with HIV are particularly disadvantaged, with their sexual and reproductive health and rights compromised by discriminatory legal frameworks, rigid health care systems, misinformed medical practices, and stigmatizing attitudes of health care workers.

The criminalization of HIV exposure or transmission, existing in fifty-six countries, deters women from accessing antenatal care or voluntary testing because of fear of an HIV diagnosis, which would expose them to stigma in their communities and violence from their partners. It unjustifiably penalizes women, who, in many settings, are unable to prevent HIV transmission because they have no power to negotiate conditions of sex or to make the decisions whether or not to have children. Fear of prosecution for HIV transmission or exposure adds to already existing barriers to women's access to health information, services, and resources.

Because HIV affects or potentially affects all the dimensions of women's sexual and reproductive health and rights – pregnancy, childbirth, breastfeeding, abortion, use of contraception, exposure to, diagnosis and treatment of STIs – health systems, especially in countries severely affected by HIV, must be adapted to provide skilled sexual and reproductive health services as well as HIV-related treatment, prevention and care distinctly needed by women and girls living with HIV. An integrated approach involves the promotion of their sexual health, while receiving HIV counseling and testing and antiretroviral treatment, so that they can continue to enjoy full quality of life.

Moreover, these services should be grounded on recognition of their rights to full confidentiality, comprehensive information, protection from violence, and non-discriminatory care. Ensuring that the sexual and reproductive health and rights of women living with HIV are met will require that stigma is challenged in all its forms. However, women living with HIV continue to experience poor standards of medical care, including limited options for wanted or unwanted pregnancies and infant feeding, and inadequate regard for the impact of ARV treatment on women's reproductive health, due to discriminatory attitudes or lack of training of service providers.

The rights-based approach adopted by some countries, such as Brazil, Sierra Leone, and Bolivia, has given rise to the prominent role of civil society as watchdogs of violations of women's sexual and reproductive health rights. In Africa, the 2006 Maputo Plan of Action highlighted a comprehensive approach towards integrated HIV sexual and reproductive health and right services, including such neglected issues as unsafe abortion and quality safe motherhood for women living with HIV.

To ensure zero new infections, discrimination, and AIDS-related deaths among women, government and civil society must build on their respective strengths to bring about linkages between HIV and sexual and reproductive health and rights. The empowered participation of women and girls living with HIV, through better information and skills, should lead the SRH-HIV linkages agenda and be a driving force to break through the barriers of violence and stigma and discrimination. Governments must re-align their priorities to support the full sexual and reproductive health and HIV rights and needs of women and girls by providing the needed financial resources, removing legal and regulatory restrictions, and complying with their international commitments.

Sexual and Reproductive Health and Rights of Women and Girls living with HIV

I. Introduction

Women around the world are subject to human rights violations, with unequal access to opportunities and resources that would enable them to exercise their rights. Linked to this is the violation of women's and girls' sexual and reproductive health and rights, which deny women the autonomy, empowerment and skills to make informed decisions that affect their lives, bodies and sexuality, and as such to protect themselves from HIV. Sexual and reproductive rights violations closely linked to HIV include limited access to health care delivery services, forced or coerced sterilisations, violence, stigma and discrimination, loss of inheritance and property rights, as well as mandatory and forced testing. Comprehensive HIV and SRHR services should not only address these violations and contribute to the health of women and girls living with HIV, but should also enable girls and women to protect themselves against HIV infection and related violence, unintended pregnancy, reproductive cancers and other causes of sexual and reproductive ill-health.

As supported by the International Convention for the Elimination of all forms of Discrimination Against Women[1]: and stated in the 1994 International Conference on Population and Development Programme of Action, art 7.2 and 7.3: "reproductive health is a state of complete physical, mental and social well-being… in all matters relating to the reproductive system….". The above definition of reproductive health includes sexual health and implies that "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law….". Reproductive rights" embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic 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, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning……"

The aim of this paper is to provide critical information on the SRHR of women living with HIV, to raise awareness, increase commitment and ultimately advance policies on gender equality and SRHR in the context of the global HIV epidemic at the 55th Session of the Commission of Women in February 2011 and the 2011 UN General Assembly High Level Meeting. The paper presents a brief overview of the findings of SRHR violations of women and girls living with HIV as evidenced in scientific literature and documented by several global and regional civil society organizations, networks and researchers[2]. It

also highlights country responses and future opportunities for addressing SRHR of women and girls living with HIV.

II. The HIV epidemic

The HIV epidemic remains a major global public health and human rights challenge, being the leading cause of death among women of reproductive age (15-49 years)[3]. Of the total estimated 33.4 million people living with HIV worldwide, women account for over half (15.9 million) of adults living with HIV. The vulnerability of women and girls to HIV remains particularly high in sub-Saharan Africa; 80% of all women in the world living with HIV live in this region.[4] In addition, in the majority of countries the epidemic shows the most growth among young women between the ages of 15 and 24; in sub Saharan Africa young women of this age group are up to 8 times more likely to acquire HIV than their male peers. In Asia overall, women account for a growing proportion of HIV infections: from 21% in 1990 to 35% in 2009.

Women living with HIV in most countries have access to antiretroviral therapy and coverage is higher among women (39%), compared with 31% among men. However, there is uncertainty to what extent women are forced to share their medication with their partners, or whether this is a reflection of the expansion of HIV diagnosis and treatment services at antenatal clinics and maternities[5]. Coverage of treatment for prevention interventions is still insufficient. In 2009, an estimated 53% of pregnant women living with HIV in low and middle-income countries received antiretroviral drugs to reduce the risk of transmitting HIV to their infants, compared to 45% in 2008.[6]

Gender inequality, including violence, continues to be both a cause and a consequence of HIV At least one in three women will be beaten, coerced into sex or abused in her lifetime, while women subjected to violence are at higher risk of acquiring HIV, and women who are living with HIV are more likely to suffer from violence.[7]

The critical importance of linking sexual and reproductive health, including maternal and child health, with the HIV response has been well established.[8] However, the availability of integrated HIV and sexual and reproductive health interventions that respect the rights of women and girls is insufficient, impacting on areas beyond HIV, such as maternal health, but such services are increasing [9][10][11]. Despite stark reductions in maternal deaths from 526,300 in 1980 to 342,900 maternal deaths worldwide in 2008 (Hogan et al, 2010; WHO, 2010), scientific reviews also showed that HIV contributed to about 20% of maternal mortality globally and that this decline would have been much more marked in the absence of the HIV epidemic.[12]. A literature review indicates that scientific research primarily focuses on maternity and infant health and vertical transmission of HIV, resulting in lack of data on women and girls living with HIV in different settings and under different conditions. In addition, data points towards negligence of the health needs of women living with HIV. Moreover, the first two elements of comprehensive PMTCT – primary prevention of HIV among women of reproductive age, and prevention of unintended pregnancies in women living with HIV – have been under-programmed. This is also the case for the fourth element of comprehensive PMTCT, treatment, care and support for the mother, her child and family.[13] For example, only an estimated 51% of pregnant women who tested positive for HIV were assessed for their own eligibility to receive ARVs. [14] [15] Programming for all four key elements of prevention of vertical transmission requires a rights-based approach.

Whenever women and girls fear or encounter violation of their rights, they are likely to forego their right to quality health information and services, including family planning services, prevention of vertical transmission of HIV and safe delivery care, thus facing greater risk of maternal and child ill-health[16]. As such, securing availability and access to quality sexual and reproductive health information and services is critical for the protection of women's rights as well as for achieving universal access to HIV services and the health MDGs. International commitments signed by UN member states at the 2006 High-Level Meeting on AIDS[17] reaffirm this by stating: "member states must ensure that pregnant women have access to antenatal care, information, counseling and other HIV services, and to increasing the availability and access to effective treatment to women living with HIV … as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counseling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy…"

However, an analysis of the situation of sexual and reproductive health and rights in southern Africa by ARASA found that laws, systems and services related to SRHR are inadequate despite the number of commitments expressed by governments in international and regional human rights and SRH instruments.[18]

III. Sexual and reproductive health and rights violations

In southern Africa, as in other parts of the world, there is still a wide belief that women living with HIV do not have a right to have children. This often occurs in a broad societal context of rampant violence against women. An analysis of the sexual and reproductive health and right situation in Southern Africa revealed that the related laws, systems and services are inadequate despite the number of commitments expressed by governments in international and regional human rights and sexual and reproductive health instruments. Political will to deal with the issue effectively, if present, is rarely translated into appropriate legislation. In addition, public health systems generally demonstrate limited capacity to respect the dignity and rights of women and girls living with HIV, and to ensure proper counselling and informed consent. This is further compromised by power politics between doctors and patients, where the 'doctor knows best' heightens the context within which the violations of human rights occur.[19]

The following sections will describe some of the major violations.

Stigma and discrimination

Stigma and discrimination of women living with HIV is often associated with the perception that they are vectors of HIV, that they cannot raise children, or somehow don't have family structures deemed adequate to raise and support children[20].

Studies find that many cultures set expectations for women to have children but for women living with HIV, the opportunity to have a child is frequently denied despite the fact that effective ARV treatment is available to protect the unborn child from HIV infection. Often women living with HIV who do get pregnant are considered irresponsible and subject to major stigma and discrimination not just within their communities but also from health care workers. According to WHO, common misconceptions of women living with HIV include misperceptions of promiscuity, blame for bringing HIV into a relationship, and being considered vectors of HIV transmission to their children[21]. There is also lack of confidentiality, lack of counseling and updated information, lack of consent related to HIV testing

and other procedures such as coercion into accepting sterilization or abortion (where it is legal or if defined as a medically indicated). Significantly, studies show that the desire to become a parent is not affected by HIV[22] and that maternity gives meaning to parents' lives and reaffirms social identity – through pregnancy and birth women regain social status lost with learning about their HIV positive status. Furthermore, stigma related to HIV can further marginalize women in their sexual and family relationships.[23]

Health workers' attitudes and behavior

Health workers attitudes and behaviours may hinder women and girls' ability to exercise their sexual reproductive health and rights. Studies demonstrate how pregnant women and girls with HIV are afraid to go for prenatal care because of possible rejection from health professionals and disapproving attitudes. [24] Women are also discouraged or blamed by health professionals when they reveal their desire to have a baby or were pregnant.[25]

As documented in 2008 by the International Community of Women Living with HIV/AIDS (ICW) through study conducted in Namibia, women underwent sterilization against their will and without proper consent[26]. Reported reasons for health professionals to have encouraged sterilization included motives ranging from the woman having prior caesarian sections, miscarriages or having prior children, to being single or widowed, unemployed, having poor health or complications with antiretroviral therapy. In Namibia as in other cultures, having children is an important part of claiming a full and fulfilling life, and of having social status and maintaining a marriage. As such it should be no surprise that the coerced sterilization was reported to cause substantial emotional distress and serious psychological and social consequences to the women.

> *As expressed by a Positive Woman in Namibia - "I have seen a lot of stigma from health workers. I tried to ask something now that I am HIV positive and pregnant, what can I do but they ignored me. Another patient helped me…The nurse said: you are HIV and pregnant, your baby already die".*
>
> Source: The Forced and Coerced sterilization of HIV positive Women in Namibia. ICW 2009 Report

A joint effort by the Federation of Women Lawyers-Kenya and the Center for Reproductive Rights[27] illustrates similar situations in the lack of care for women living with HIV at healthcare centers across Kenya. Women encounter physical and verbal abuse and are subject to discriminatory standards of care. They often cannot access antiretroviral treatment, are denied their right to informed consent and confidentiality during HIV testing and treatment.

Other case studies examined the state of reproductive and sexual health and rights of women with HIV in southern Africa[28]; Chile[29], Argentina[30], and Papua New Guinea[31] which describe women's forced sterilization as a significant violation of rights. The issue was taken up by NGOs and advocacy networks to create public awareness

The Mexican Constitution prohibits discrimination on the basis of health status, and the 2003 Federal Law to Prevent and Eliminate Discrimination dictates measures to guarantee access to medical care and social security, including both negative and positive guarantees of access to reproductive health care. Yet, reports of women, as the one below, are depicted as posing a threat to the health of others by their physicians because of their HIV-positive status and were required to meet special and discriminatory conditions in order to receive medical services. [32]

> When Griselda, a 29-year-old woman with a stable partner also living with HIV, requested a pregnancy test because her menstruation was late, her physician responded with insults and threats: The doctor said: How can you even think about getting pregnant knowing that you will kill your child because you're positive?!!! He threatened not to see me again if I got pregnant. He told me that I was "irresponsible," a bad mother, and that I was certainly running around infecting other people (public hospital, Mexico, 2006).

Criminalization of HIV transmission

Criminalization of HIV exposure or transmission is another major barrier to diagnosis, prevention and treatment of HIV and AIDS. It also may further limit women's ability to decide whether or not, when and with whom to engage in sex – as well as decide 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. Fifty six countries have reported specific laws to criminalize vertical transmission of HIV.[33].

Criminalization of vertical transmission undermines the human rights of women and girls living with HIV[34]. It targets all pregnant women living with HIV as potential offenders, and particularly those more vulnerable as a consequence of poverty, lack of education, gender inequality and absence of health promotion and services. Criminalization of vertical transmission fails to consider the socio-cultural and economic reasons why women may not take all measures to avoid vertical transmission[35]; and the many risks associated with disclosure in an environment where HIV is highly stigmatized undergoing risk of violence, loss of home and livelihood.

> For people living with HIV in situations where in-vitro fertilization and embryo implantation is unavailable or unaffordable (that is, most young people with HIV) the criminalization of vertical transmission imposes on their human right to marry and constitute a family.
>
> Forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for vertical transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent (UNAIDS, 2008b).

IV. Is there medical ground for limiting SRHR of women and girls living with HIV?

Though some studies[36] indicate the possible medical risks of pregnancy for a woman living with HIV, extensive literature reviews confirms that pregnancy does not represent risk with respect to accelerating or intensifying her condition related to HIV or AIDS. The findings only point towards a slightly increased possibility of incurring miscarriages, and problems associated with endometriosis one year after birth.

A 2005 review on maternal health and HIV revealed that the use of antiretroviral therapy can significantly reduce the risk of HIV transmission. In settings where highly active antiretroviral therapy (HAART) is available, vertical transmission rates have been reduced to less than 2%, in the absence of breastfeeding. Even in resource-constrained situations, when obstetric complications and post-partum hemorrhage and post–partum infections occur, they can be reverted with HAART and quality maternal care.[37]

> Findings of a 2008 cross-sectional study with 500 women living with HIV attending child-health clinic in Mombasa, Kenya showed that reproductive and sexual morbidity was high among both HIV-positive and HIV -negative women in the year following childbirth, and that all required access to comprehensive postpartum services. The prevalence of anaemia was particularly high and there was substantial unmet need for contraception. Many of the women had experienced domestic violence, an important determinant of poor health and wellbeing. All women required access to comprehensive post-partum services.[38]

In conclusion, there is no scientific evidence justifying any medical restriction to the sexual and reproductive health and rights of women and girls living with HIV. The health status of women and children will not be compromised by a pregnancy, when she can access adequate health care services, with effective vertical transmission prevention and ARV treatment, free of stigma and discrimination[39] [40].

V. What has been done so far: country level responses

Country experiences show that promotion of sexual and reproductive health and protection of human rights help in building positive attitude towards early diagnosis and treatment of HIV and AIDS. Countries have adopted different approaches to promote and protect sexual and reproductive health and rights, depending on their local context.

The non-governmental organization Instituto para el Desarrollo Humano in Bolivia advocated for legal reform, based on research on the violation of the sexual and reproductive health and rights of people living with HIV. This led to the adoption of Resolution 688, which called for comprehensive health care with full respect for the dignity and rights of people living with HIV, while penalizing discrimination. However, the changes in the legal system did not translate into any change at the societal level as there were very low levels of awareness of among health service providers and people living with HIV. The organization therefore developed the Citizen Observatory which gathered data on the implementation of Resolution 688, in particular identifying barriers to service access and ways to reduce them. The Observatory has fostered close collaboration between people living with HIV and the ministry of health,

the National AIDS Committee and the Global Fund Country Coordinating Mechanisms. The programme is now being rolled-out in Ecuador, Colombia and Peru.[41]

Brazil, a middle-income country characterized by a reasonably organized public health sector and significant levels of social inequality,[42] adopted at an early stage of the HIV epidemic a human rights approach. Strong governmental support for free access to AIDS treatment, together with robust engagement of communities, networks of people living with HIV and social organizations in the decision-making-processes and political agenda, resulted in significant gains in HIV related morbidity and mortality.[43] In 2010, the country developed "Strategies for risk reduction of sexual transmission of HIV in planning for reproduction"[44], taking into account the sexual and reproductive health and rights of women and men living with HIV, including informed decisions. The wide dissemination of information on the availability of these services assisted in guaranteeing the rights of the individual in the public health system, in particular access to unbiased information and services.

In some countries, legal steps have been taken to the detriment of the rights of women living with HIV. In Sierra Leone, for example, a proposed law contained language explicitly criminalizing mother to child transmission of HIV. According to this bill a woman could be fined or jailed for knowingly placing the unborn child at risk of HIV infection. The proposed law has been rescinded - thanks to the advocacy work of the International Community of Women Living with HIV/AIDS ICW[45] - even though drastic transformation in a bill so rapidly is generally quite uncommon.[46]

The African continent has developed an Action Plan to operationalize the Sexual and Reproductive Health and Rights Continental Policy Framework. The 2006 Maputo Plan of Action builds on nine action areas: 1) Integration of sexual and reproductive health (SRH) services into PHC; 2) Strengthening community-based STI/HIV/AIDS/STI and SRHR services; 3) repositioning family planning; 4) developing and promoting youth-friendly services; 5) unsafe abortion; 6) quality safe motherhood; 7) resource mobilization; 8) commodity security and 9) monitoring and evaluation. The Plan is premised on SRH in its fullest context as defined at ICPD/PoA 1994 taking into account the life cycle approach. As such, the elements of SRHR includes Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and newborn care; Abortion Care; Family planning; Prevention and Management of Sexually Transmitted Infections including HIV/AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing mid-life concerns of men and women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counselling; and Health Education.[47]

VI. Current and future Opportunities

As we look forward, it is crucial to strengthen our focus on upholding SRHR in the HIV response, to achieve more effective results which will contribute towards our joint goal of zero new infections, zero discrimination and zero AIDS related deaths. Strengthening programming on the linkages between SRHR and HIV will create opportunities for women and girls' to assert full citizenship and rights in society, which will have a positive effect in changing the sexual, social, political and economical roles of women and girls in society.

While many countries struggle to identify appropriate ways to support the SRHR of women and girls living with HIV, there are several opportunities that can be utilized for shaping policies in the context of the global HIV epidemic and women. Some of these include:

- Firstly, any action to promote and protect SRHR should be part of an integral approach to women's health and empowerment, building on the synergies between MDG 3, 4, 5, and 6. Women and girls living with HIV must be supported with the information and skills that will enable them to have control over their health and body and decide freely without intimidation on matters related to sexuality and reproduction, and have the necessary means to access the highest standard of HIV prevention, treatment, care and support, free of stigma and discrimination. This would include access to comprehensive sexuality education, in particular for young people, which not only enables them to protect themselves against HIV infection, but also equips them to be agents of social change, in terms of gender equality and human rights. Empowered women and girls living with HIV are able to voice their concerns and demand their SRHR needs, when allowed at the decision-making table. Similarly, community-based networks of women and girls, well-equipped to document SRHR abuses, can serve as human rights observers and enable public awareness raising and debate.

- In undertaking these actions, it is crucial to develop, expand and strengthen partnerships with networks of women and girls living with HIV, women's rights organizations and other organizations working towards gender equality, HIV and SRHR. These organizations bring significant knowledge and experience that can contribute to ensuring that responses to HIV are more effective and accessible to women and girls on the ground, in addition to increasing our reach. it is also important to strengthen work across government Ministries, such as the Ministries of Health, Gender, Youth and Finance, and also build on cooperation amongst governments with the support of UNAIDS cosponsors and UN Women. Global partnerships, such as those around the Secretary-General's Global Strategy and the Secretary-General's UNiTE campaign could assist in improving access to high standard HIV diagnosis, prevention and ongoing treatment for women and girls living with HIV, and fostering the linkage with sexual and reproductive health, including MCH.

- Comprehensive SRHR of women and girls living with HIV, including zero tolerance against violence needs to be secured within the wider context of development. National fiscal policies must be assessed to ensure that they are responsive to the needs of women and girls, and translated into well-resources programmes and policies to advance gender equality. In addition, women and girls living with HIV need to be supported in accessing employment and other income generating efforts, as well as resources and land, to enable their economic empowerment.

- Any review of national laws and regulations, should also look at how they impact on the SRHR of women and girls living with HIV, including their enactment to uphold non-discrimination, promote dignity and respect for women and girls living with HIV - including the impact of criminalization of HIV transmission as a barrier to accessing universal HIV prevention and treatment. Such reviews could be part of standard reporting such as the Convention on the Elimination of all forms of discrimination against women (CEDAW), and the Convention on the rights of the Child (CRC). As part of existing accountability and reporting mechanisms, countries could be supported to better monitor violation of SRHR of women and girls living with HIV, to support more efficient national HIV, maternal and child health and women's health responses.

- Any effort to promote social change, could include a specific focus on the SRHR of women and girls living with HIV, and build on high level government commitment in partnership with women and girls living with HIV , so that they can access quality services free of stigma and discrimination . The HIV responses would serve as a conduit to promote all components of Positive Health, Dignity and Prevention to women and girls living with HIV - including sexual and reproductive health services as undeniable elements of prevention.

1 *Convention on the elimination of all forms of discrimination against women*. New York, NY: The United Nations' Division for the Advancement of Women; 1979. Available from: http://www.un.org/womenwatch/daw/cedaw/cedaw.htm [accessed on 2 September 2009]

2 Literature review was conducted on HIV/AIDS and women's issues, sexuality and reproductive health of HIV-positive women. There is a relative abundance of international reviews but a scarcity of peer-reviewed references from specific countries, in particular from the developing world. Review of the literature combined the search of usual databases, e.g. Medline or Scopus, ScienceDirect and local databases, e.g. LILACS (Latin American Literature and Caribbean Social Sciences) and Scielo (Scientific Electronic Library Online). The search was performed for the period of 2000-2011 in the three languages available in such databases (English, Spanish, and Portuguese). Major epidemiological and technical reports from international agencies were consulted. The grey literature used included reports from nongovernmental organizations and networks of people living with HIV in order to extend our comprehension of the complexity of live contexts and settings related to sexual health and reproductive rights of women living with HIV not found in scientific literature.

3 The World Health Organization. Women and health : today's evidence tomorrow's agenda. 2010

4 The Global Report. UNAIDS Report on the Global AIDS Epidemic 2010

5 See http://www.opendemocracy.net/5050/alice-welbourn/more-than-just-pound-of-flesh.

6 Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010. WHO/UNAIDS/UNICEF/UNFPA, 2010.

7 The Global Coalition on Women and AIDS, preventing HIV infection in girls and young women http://data.unaids.org/GCWA/GCWA_BG_preventation_en.pdf

8 The list of related international linkages commitments includes the following: Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (May 2004); New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (June 2004); UNAIDS policy position paper 'Intensifying HIV prevention' (June 2005); World Summit Outcome (September 2005); Call to Action: Towards an HIV -Free and AID S-Free Generation (December 2005); UNGASS Political Declaration on HIV/AID S (June 2006); Consensus Statement: Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services (November 2007)

9 See Duerr et al, 2005 on need for service integration in a multidisciplinary approach for resource limited settings.

10 Druce et al, 2007. Demonstrates benefits for women and children of a comprehensive approach to integrate PMTCT with maternal health, HIV prevention and care, STI services.

11 The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health. http://www.unfpa.org/upload [accessed 17 February2011];

12 Murray, C. et al. Maternal mortality for 181 countries, 1980—2008: a systematic analysis of progress towards Millennium Development Goal 5. The Lancet, Volume 375, Issue 9726, Pages 1609 - 1623, 8 May 2010

13 WHO, UNICEF, UNAIDS, UNFPA November technical meeting on elimination of mother to child transmission, November 2010.

14 Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010. WHO/UNAIDS/UNICEF, 2010.

15 Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010. WHO/UNAIDS/UNICEF, 2010.

16 Hong et al,2007; Delvaux et al, 2007; Coovadia et al, 2007; Fang et al,2009; Mctntyre, 2003; Di Fonzo et al, 2008;Druce etal,2007.

17 2006 High-Level Meeting on AIDS. *Uniting the world against AIDS*. New York, United Nations, 31 May–2 June 2006. (http://www.un.org/ga/aidsmeeting2006/, accessed on 6 February 2011).

(18) member states signed the commitment to implement fully the Declaration of Commitment on HIV/AIDS, entitled "Global Crisis – Global Action", adopted by the General Assembly at its twenty-sixth special session, in 2001; and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases, the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development in 1994.

(21)Emphasize the need to strengthen policy and programme linkages and coordination between HIV/AIDS, sexual and reproductive health, national development plans and strategies, …;

(24) Commit ourselves to overco
ming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

(25). Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary
disclosure of HIV status; and;

(27). Commit ourselves also to ensuring that pregnant women have access to antenatal care, information, counseling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV … as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counseling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy…; (pg4).

18 ARASA. Advoacacy for Sexual and Reproductive Health Rights in Southern Africa. 2009

19 ARASA (2009). *Advocacy for Sexual and Reproductive Health Rights in Southern Africa: seminar report*.

20 Maksud 2003; Morando,1998; Ingram & Hutchinson, 1999; Paiva ,2002.

21 Guidelines on care, treatment and support for women living with HIV/AIDS and their children invresource-constrained settings

22 ACTG 076; Zorilla, 2000; Carvalho and Piccinini, 2006; Sandelowski and Barroso, 2003; Sherr and Barry, 2004.

23 Bell at al (2007). Sexual and Reproductive Health Services and HIV Testing: Perspectives and Experiences of Women and Men Living with HIV and AIDS. Reproductive Health Matters. 2007;15(29, Supplement 1):113-35.

[24] Paiva, V. et al., 2002. [Sexuality of women living with HIV/AIDS in São Paulo]. Cadernos De Saúde Pública / Ministério Da Saúde, Fundação Oswaldo Cruz, Escola Nacional De Saúde Pública, 18(6), 1609-20

[25] Gogna et al. The reproductive needs and rights of people living with HIV in Argentina: health service users' and providers' perspectivesSocial Science & Medicine **69**(6):813-20 (2009)

[26] The International Community of women living with HIV/AIDS.The Forced and Coerced Sterilization of HIV Positive Women in Namibia. ICW, United Kingdon; 2009.

[27] Rights Violations of HIV-Positive Women in Kenyan Health Facilities: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/At20Risk.pdf

[28] HIV/AIDS: Case studies from Namibia and South Africa: http://www.tigweb.org/images/resources/tool/docs/2649.doc

[29] Dignity Denied – Violations of the right to HIV Positive women in Chilean Health facilities – VIVO POSITIVO- Chile. Litigating against the Forced Sterilization of HIV-Positive Women: Recent Developments in Chile and Namibia http://harvardhrj.com/wp-content/uploads/2010/10/223-232.pdf

[30] Defending the sexual and reproductive health rights of women affected by HIV in Argentina: http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1419 (based on a qualitative research by FEIM) Positive Women: Voices and choices (ICW, 2002).

[31] http://www.opendemocracy.net/5050/jennifer-gatsi-mallet-aziza-ahmed/sterilisation-fight-for-bodily-integrity http://www.salamandertrust.net/motherhood/motherhood.swf http://www.southernafricalitigationcentre.org/news/item/South_Africa_HIV_positive_women_sterilised_against_their_will

[32] Reproductive rights violations reported by Mexican women with HIV (2009) Tamil Kendall: http://www.hhrjournal.org/index.php/hhr/article/viewArticle/175/260

[33] Making the law work for the HIV response :a snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support (UNAIDS,2010) reports 56 countries and territories having laws that criminalize HIV transmission, 63 not having these laws, 80 countries not reporting and 10 had contradictory information.

34 (See http://www.athenanetwork.org/assets/files/ReasonsWhyCriminalisationHarmsWomen.pdf.

35 WHO (2010) revised normative guidelines on ARV interventions for PMTCT and HIV and infant feeding which recommend highly efficacious regimens in resource-limited settings. Countries are rapidly adopting the new guidelines. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: 2010 version; WHO (2010) Guidelines on HIV and infant feeding.

[36] Beitune, Duarte, Quintana and Figueiró-Filho (2004),

[37] McIntyre (2006) also points-out that exposure to nevirapine for prevention of vertical transmission can select for resistant virus in the majority of women. While the long-term implications of this are not completely clear, this selection can be reduced by the addition of short courses of postpartum zidovudine and lamivudine

[38] Chersich et al; Maternal morbidity in the first year after childbirth in Mombasa Kenya; a needs assessment. BMC Pregnancy Childbirth. 2009; 9: 51. Published online 2009

[39] ACTG 076; Zorilla, 2000; Carvalho and Piccinini, 2006; Sandelowski and Barroso, 2003; Sherr and Barry, 2004

[40] See also for instance p2 of http://www.pathfind.org/site/DocServer/Pathfinder.PMTCT4-lite.pdf?docID=4041 ; and also http://www.i-base.info/htb/v9/htb9-3-4/Very.html and http://www.salamandertrust.net/resources/WelbournIWDMarch09.pdf

[41] International HIV/AIDS Alliance (2010). *Integration of HIV and sexual and reproductive health and rights: good practice guide*.

[42]Parker et al 2005.

[43]Mocumbi et al 2006.

[44i]Ministério da Saúde do Brasil, 2010. *Consenso para tratamento de adultos. Estratégias de redução de risco de Transmissão Sexual do HIV no Planejamento da reprodução para Pessoas que Vivem e Convivem com HIV ou Aids - Suplemento* http://www.aids.gov.br/sites/default/files/suplemento_consenso_adulto_link.pdf

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

[46] Alice Welbourn, "Desires Denied: Sexual Pleasure In The Context of HIV"(year)

[47] Plan of Action on Sexual and Reproductive Health and Rights, Maputo Plan of Action 2006, African Union