

With Women Worldwide: Sexual and Reproductive Rights and Health to End HIV/AIDS

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Good morning. Today, I'll discuss women and HIV/AIDS; what my organization, the International Women's Health Coalition, is doing to address girls' and women's vulnerability; and how our solution can and must be expanded globally.

I feel a special responsibility this morning, having just returned from Botswana and South Africa. Rates of HIV infection there are the highest in the world. I'd like you to imagine HIV/AIDS in Botswana. Nearly 40% of adults have HIV or AIDS. This means that, on the street, in restaurants, hotels, and offices, two of every five people you see are likely to be living with HIV or AIDS.

In South Africa, I met young men and women who have less than a 50% chance of living until they are 60. Just last week, a new report estimated that 90% of all new infections among young South Africans—those between the ages of 15 and 24—occur in girls and women.

Botswana and South Africa are the epicenter of the pandemic, but societies worldwide are facing the devastating impacts of HIV/AIDS—especially women and girls. Half of all people living with HIV/AIDS worldwide are female, up from 41% in 1997 and 35% in 1985. In sub-Saharan Africa, far more than half are female and young. In some parts of Botswana, 70% of women who come in for antenatal care test positive for HIV. In newer epidemics—in Russia, India, and China—nearly 40% of people living with HIV/AIDS are already female. Here in the United States, the number of women living with AIDS increased 15% between 1999 and 2003, compared with a 1% increase in men. In Thailand, widely celebrated for its success controlling HIV in commercial sex workers and their clients, the greatest need for prevention is now in marriages and “regular relationships.” Brazil faces a similar challenge.

In addition, women and girls are the caretakers of husbands, partners, children, grandchildren, parents, siblings, friends, and neighbors living with HIV/AIDS. They worry about how to protect the baby they want to have, or their growing children from HIV/AIDS. Those who are not infected live at risk and in fear of infection. Those living with HIV/AIDS, or whose husbands die of AIDS-related diseases, are wrongly accused of transmitting the disease. They are beaten, lose their property, are forced to marry their brothers-in-law, or are cast out of their communities and spurned by their families.

Why? The answer is simple: despite numerous global agreements and national laws, women continue to be treated unspeakably. Worldwide, in diverse contexts, women and girls do not have equal access to school, the skills to earn a livelihood, or the power to control their relationships and make their own life choices. Sexual coercion and violence against women are rampant inside and outside marriage. The World Health Organization

estimates that one of every three to five women will experience some type of violence or abuse in her lifetime. In Botswana, six in ten women will experience severe violence. What does gender inequality have to do with HIV/AIDS? Girls and women are already biologically twice as likely as men to become infected with HIV during sexual intercourse with an infected partner. Research from South Africa suggests that a violent partner dramatically increases the woman's risk. It also obliterates any protective action she might otherwise take. Violence or the fear of it inhibits women from negotiating condom use or talking with partners about their risky behaviors, such as having multiple partners.

Each year, an estimated 10 million young girls are married to older men—men who demand frequent and unprotected sex from brides too disempowered to resist. Marriage, far from being a safe space, can be very dangerous. In Ghana, for example, married women are almost three times more likely to be HIV-positive than women who have never been married.

In general, failure—often refusal—to provide HIV information, sexuality education, and reproductive health care to girls and women condemns them to infection and death.

What have HIV/AIDS agencies and programs done to address these realities? Almost nothing. In the HIV world, prevention means focusing on people most likely to transmit the virus—men who have sex with men, commercial sex workers, and IV drug users. Girls and women have not been a focus because, as one senior scientist recently wrote, “In this pandemic, girls and women are an epidemiological dead end.” In other words, policymakers don't invest in them because they are relatively unlikely to transmit the virus.

Further, the bulk of attention by far has gone to testing and treatment—which is vitally important, but cannot succeed on its own. U.S. global HIV/AIDS assistance, known as PEPFAR, allocates 55% of its funding to treatment. The Institute of Medicine's just-released analysis of PEPFAR states, and I quote: “The only way to eventually control this pandemic is by preventing new cases... Proud as we should be of PEPFAR's success in providing medication to many of those already ill, it needs to urgently put the accent on prevention measures of proven efficacy on a much larger scale.”

Those funds which PEPFAR does devote to prevention are limited to an ABC approach—Abstain, Be Faithful, and Condomize. ABC has, more often than not, also been adopted by others because of the power of the U.S. government. Fortunately, more and more experts—most recently the Institute of Medicine—recognize that this framework is far too narrow. Moreover, it is irrelevant for women and girls. Four-fifths of women living with HIV/AIDS worldwide are infected by their husbands or primary partner. They cannot abstain, they are already faithful, and they cannot negotiate condom use.

We must put these women and girls at the center of HIV prevention policies and programs. During the 1990s, the International Women's Health Coalition, or IWHC, collaborated with women leaders and other constituencies to transform population policies and budgets. Today, as a result, these policies prioritize the reproductive health and rights of individuals, not just national demographic goals for fertility control.

Similarly, in the third decade of HIV/AIDS, we are determined to make the global HIV/AIDS response work for women and girls. Our strategy—as in the past—is to bridge

two worlds: global movements for women's and young people's health and human rights, and governments and global institutions that control health policies and budgets. This time, our "bridging" strategy consists of three main elements:

- First, working with women and youth leaders from around the world to develop a concrete action agenda for HIV policy;
- Second, funding these leaders to pursue this agenda in their own communities and countries; and
- Third, simultaneously, taking the agenda, together with our partners, to the United Nations and international donors that have major influence on the design and implementation of national HIV/AIDS programs.

In Bangkok, in November 2005, IWHC convened 28 women from 22 countries, united by our commitment to change HIV/AIDS policy. We reflected wide geographic and professional perspectives, decades of expertise in HIV/AIDS, sexual and reproductive health, gender and development, human rights, and the experiences of women living with AIDS, as well as young people. Together, we produced "With Women Worldwide: A Compact to End HIV/AIDS."

We agreed on a fundamental principle: the HIV/AIDS prevention paradigm must be changed to reduce and eliminate, as a central priority, girls' and women's vulnerability to HIV.

The Compact has three priority actions:

First, to reach girls and women, HIV/AIDS policies and budgets must expand access to sexual and reproductive health services, not just build separate HIV facilities. Reproductive health services are established and accepted by families and communities. They have critical core capacities we can build on to provide the full range of reproductive health services, including quality pregnancy and delivery care, STD and HIV diagnosis and treatment, male and female condoms, and other contraceptives. By investing in these services, we will strengthen national health systems as a core foundation to meet all public health goals.

Our second priority is to raise new generations to treat each other differently. A major avenue for this is comprehensive sexuality and gender education—that not only provides full and accurate information about HIV/AIDS, but also helps young people build skills for equality in relationships; respect the right to consent in both sex and marriage; and end violence and sexual coercion. Such programs provide girls with safe spaces, free from harassment and discrimination; alternatives to early marriage; and activities to help build their self-esteem and confidence. These programs help boys learn to take responsibility for their own behaviors and understand that violence and coercive sex are neither their birthright, nor proof of masculinity.

Research shows that this approach to sexuality education empowers young people for safer sex, but these programs need far more money and higher priority than the HIV/AIDS community currently gives them.

Third, we must increase investment in technologies which put the power for prevention in women's hands. This means subsidizing universal access to female condoms so that

they are affordable and available to all women and girls. It means doubling research and development financing for microbicides, and continued funding for vaccine development.

Beyond these three priorities, the Compact also emphasizes that women, who know women's realities, must be included in decision-making and in leadership at all levels and in all sectors. The Compact promotes the setting and monitoring of gender equality goals in all sectors—to secure the laws, economic opportunities and resources, education and social recognition—that will empower girls and women.

This agenda is not just for and by women. Supporters have grown from 28 women from 22 countries to more than 260 organizations from 50 countries, including leading global and national HIV and positive people's organizations, human rights defenders, youth, women's rights, and faith-based groups. More than half are from the global South, and the remainder are either from the global North or internationally based. Men's and women's interests alike are well represented. Governments, UN agencies, and international organizations have also signaled their support.

The With Women Worldwide agenda benefits everyone. It proposes HIV/AIDS prevention by all, for all, through policies, laws, and programs that respect human rights and foster zero tolerance for discrimination, stigma, and violence.

So, our action agenda is developed and widely supported. IWHC has been working for two decades on the second element of the strategy: helping build local organizations to implement the Compact in their countries.

For example, we have supported the Girls' Power Initiative, or GPI, in Nigeria since its inception in 1994. GPI's comprehensive program educates young people in four Nigerian states about their health and rights. Program participants get an education instead of getting married young; they resist genital mutilation for themselves and their sisters; and they are changing the way their parents, siblings, peers and communities value young women. In Cross River State, where HIV prevalence has reached 12% among sexually active individuals, GPI girls have the skills and the knowledge to protect themselves. In addition to the 1,500 girls directly involved in the program, GPI's message of empowerment reaches another 25,000 girls in 28 schools. GPI and our other colleagues across Nigeria are now also influencing national health and education policies to better protect the health and rights of all Nigerian girls.

Today, GPI is an internationally recognized organization. This month, they are receiving an award for Excellence & Innovation in Sexuality Education from the World Association for Sexual Health (WAS). GPI's truly innovative approach exemplifies how basic lessons on rights, empowerment, and self-esteem can be coupled with health information to shape a new generation of young leaders—and a better future for us all.

A continent away, in India, we support SANGRAM, which implements the With Women Worldwide agenda in very different ways. Through its District Campaign, SANGRAM trains rural women as peer educators to raise awareness in their villages—particularly among women—about sexual and reproductive health and HIV/AIDS. By taking advantage of informal social networks, SANGRAM has reached thousands of women with life-saving information. SANGRAM is increasingly involving students in its education programs—today the campaign has more than 1600 youth volunteers. SANGRAM also trains social workers to become advocates for women in the health system, so that

physicians and other health practitioners become more attuned to the specific needs and rights of women in the context of increasing risk for HIV/AIDS. Finally, SANGRAM is the national secretariat for a nationwide alliance of 12 non-governmental organizations, or NGOs, working to strengthen national HIV/AIDS policy to empower women and girls. As we sit here, they are raising their voice against last week's decisions by three Indian states to prohibit sex education in public schools.

Bene Madunagu and Grace Osakue, co-founders of GPI, and Meena Seshu, the head of SANGRAM, were with us in the earliest days of shaping the Compact and the strategy to achieve its goals. They are engaging with local and national government officials, as women on behalf of women—another goal of the Compact—and they are helping us take the With Women Worldwide Compact to global gatekeepers and power brokers.

With Women Worldwide was originally conceived for use at a critical global negotiation at the United Nations in June 2006. We knew that the outcome document from that negotiation—called a Political Declaration—would serve as a new framework for the AIDS response of national governments, donors, and global agencies like UNAIDS. Our sustained advocacy before and at the meeting resulted in strong action commitments in the Political Declaration, including investment in sexual and reproductive health services and comprehensive education programs. You can see how closely this commitment mirrors the With Women Worldwide priorities I shared with you before. The agreement also prioritizes the human rights of women and young people, and the involvement of men and boys in work for gender equality. I assure you, these are major victories. We—and our partners around the world—now have a means of holding governments accountable to women and girls everywhere.

The With Women Worldwide alliance has used the Compact as a foundation for concerted global and national action since the UN meeting last summer. We worked with UNAIDS to integrate gender equality and sexual and reproductive rights into new guidelines on HIV prevention for governments, which have just been released. Compact supporters around the world will work to ensure that these guidelines are used effectively at local and national levels. Further, we are working with donor governments and UN agencies to identify concrete ways that their HIV/AIDS funding can help empower women and girls, and we aim to work with corporations as well.

To underscore how important this work is, I'd like to end where I began—in Botswana. Average life expectancy in Botswana is now 30. In the absence of HIV/AIDS, it would have been around 70. As I left the country, the beautiful young immigration officer took extra time looking at my passport. As she handed it back to me, she said with certainty that she would not live to be my age—60. I said: 'Yes you will. I promise you.' She has a chance to live because her country provides antiretroviral treatment. But let us remember, she should not have been infected in the first place. Together, we must ensure that the vast majority of girls and women who are negative stay that way, free of violence, sexual coercion, and discrimination. Thank you.