

# **Women's Health, Women's Lives: Rallying Communities of Faith in Support of the MDGs**

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**Consultation on the Role of American Religious Communities in Achieving  
the Millennium Development Goals (MDGs)  
June 8, 2005, UN Church Center, New York, NY**

Good afternoon. I am delighted to have the opportunity to share ideas with all of you today. I was invited to talk about the Millennium Development Goals for Maternal and Child Health, which I will do. But we can only save the lives and protect the health of millions of girls and women if we simultaneously work on the goals for gender equality, women's empowerment, and combating major diseases like HIV/AIDS, tuberculosis, and malaria—all of which fall particularly heavily on girls and women.

None of these goals can be achieved unless we give priority to sexual and reproductive health and rights—issues that are inextricably and deeply linked with how societies and individuals perceive and value faith and morality.

I begin by telling you about a remarkable organization working in Nigeria. The Community Life Project—CLP for short—was started in 1992 by a Nigerian feminist named Ngozi Iwere. Ngozi is a deeply spiritual person living in an area of Lagos where most people are active believers of many faiths—whether Roman Catholic, Protestant, evangelical, Muslim, or animist. At a time when issues of religion, sexuality, and human rights are increasingly politicized, CLP seeks to engage the entire community in promoting individual and family health, as well as respect for human rights, within religious groups and in the community as a whole. CLP's remarkable program works effectively with both community leaders, including religious leaders, and couples, on normally taboo issues, including "patriarchy," sexual pleasure, infertility, and interpersonal communication. By partnering with churches, mosques, trade associations, schools, hospitals, and families, CLP builds a sense of inclusion and ownership for their work to end sexual coercion and violence against women; to prevent HIV/AIDS; to change norms about divisions of responsibility in family life; and to engender hope.

Let me give you an example. Roman Catholic couples in CLP's community are required to take pre-marriage classes based on a standardized Church curriculum. CLP made close relationships with local priests to establish the trust needed to establish new ways of working with couples, and the priests have adapted their curriculum as a result. Instead of teaching women that they must acquiesce to their husband's desire for sex, courses now discuss ways for couples to talk to each other about their sexual relationship, and to help each other experience pleasure in the healthiest possible way. Instead of teaching couples that "natural" family planning is their only contraceptive option, the courses educate couples on all modern contraceptive methods—including the periodic abstinence promoted by the Church. Indeed, they include extensive information on Church teachings—but encourage the couples themselves to make the best decisions for their health and their relationships.

As Ngozi says of CLP, “That’s why people in the community, regardless of their beliefs, come to us when they have a crisis or a problem and ask for our help and our support. We operate based on the principle that freedom of conscience and belief is everybody’s basic right.”

Surely, this is a principle we all support.

Women leaders like Ngozi all over the world are creating and implementing effective programs to address HIV/AIDS, end death and ill health related to pregnancy, eradicate violence against women, and promote and protect young people’s health and rights, including in relation to sexuality. During the 1990s, my organization, the International Women’s Health Coalition, collaborated with these women leaders and other constituencies worldwide—including faith-based groups—to transform global and national policies directed toward the world’s women and children. Today, these policies prioritize the health and rights of individuals, not just national goals. This is a basic humanitarian approach which we in the women’s movement share with most communities of faith.

We have no prospect of achieving the Millennium Development Goals unless we support approaches like that of Ngozi and CLP—comprehensive, community-based approaches that build on each community’s beliefs to promote and protect the sexual and reproductive health and rights of all individuals. We will not achieve Millennium Development Goals 4 and 5, to reduce child mortality and improve maternal health, or Goal 6, to combat HIV/AIDS, tuberculosis, and malaria, or the goals on poverty, hunger, and education—without strong actions to achieve Goal 3, gender equality and women’s empowerment. And vice versa.

Consider Goal 3 more closely. For women to achieve education, employment, and financial independence, and to contribute to political processes in their countries, they must be able to decide whether, when, and with whom they have sex and bear children. They must be able to live free of sexual violence, coercion, and discrimination. Indeed, as the Gender Equality Task Force report concluded, “Sexual and reproductive health and rights are central to women’s abilities to build their capabilities, take advantage of economic and political opportunities, and control their destinies.”

Let us look at Goal 6, combating HIV/AIDS. The world seems to have forgotten that HIV/AIDS is fundamentally an issue of sexual and reproductive health and rights. Current narrow programs have failed utterly to protect women and girls, and their HIV infection rates are rising in every single region of the world. Four-fifths of all women living with HIV/AIDS worldwide—that’s 80%—are infected by their husbands or primary partners, not by their own behaviors. We know what to do—invest in sexual and reproductive health services and education for all women and girls, protect sexual rights, and help boys and men to be responsible in their own sexual behavior, and to respect women. Only in this way will all people have the skills, and the social support, to protect themselves and each other from this deadly virus.

In recognition of all these realities, the MDG Project report issues a call to bold action on women’s health and rights, with strong support from the reports of the task forces represented here today. The report identifies expanding access to sexual and

reproductive health information and services, as one of the Project's 17 Quick Win solutions projected to yield major results in the next three years. Guaranteeing sexual and reproductive health and rights was also one of the top seven priorities of the Gender Equality Task Force report, and a linchpin of the Maternal and Child Health Task Force Report. The UN Secretary General's response—his own report, "In Larger Freedom"—endorses these commitments.

What do these commitments promise women and girls? Access to the basic health information and services that most of us take for granted—things like care before, during, and after pregnancy and childbirth; access to contraceptive options and safe abortion services; and testing and care for sexually transmitted infections, including HIV and AIDS. These interventions are striking in their simplicity, and they are relatively inexpensive. They do not require new technologies or scientific breakthroughs. They do require political will—and it is the moral obligation of all of us to generate that will.

It is inexcusable that more than half a million women still die from complications pregnancy or childbirth every year—all but 1 percent of them in developing countries—and that at least 20 times that number, 10 million women each year, suffer severe harm, because we have not invested in the simple, low-cost reproductive health services that save women's lives, and enable them to protect their families. It is inexcusable that in sub-Saharan Africa, 76% of young people 15-24 living with HIV/AIDS are female—76 percent. We will see more of this pattern in Nigeria, India, China—even Brazil and Thailand—unless we achieve universal access to sexual and reproductive health services, and protect the sexual rights of women and young people.

Unfortunately, today, the world's women and youth have been deserted by a critical global partner—the United States government. We here today, committed to religious freedom and social justice, must bring the U.S. government back. We must work to change current U.S. government policies which endanger the lives of women and young people in the world's poorest countries.

Let us look more closely, for example, at the \$15 billion U.S. global AIDS initiative—the President's Emergency Plan for AIDS Relief, or PEPFAR. The effectiveness of this unprecedented financial commitment is imperiled by several counterproductive provisions. One of those is that one-third of prevention funds must go to "abstinence-only-until-marriage" programs.

Let me be clear. We work with hundreds of health professionals, teachers, and religious leaders from all over the world. Whatever our personal background or beliefs, we all support abstinence for young people until they have full information and feel ready for relationships based on mutual respect. Unfortunately, too many of the world's young people—especially girls—don't have the choice, or the chance, to wait, and our policies to prevent HIV/AIDS must account for that fact. Otherwise, we are, in essence, sentencing these children to death, and the world to a long festering, if not overwhelming, epidemic.

The abstinence-only-until-marriage approach, for example, assumes that the majority of sexually active young people are not married. For girls in the developing world, this is an inaccurate and life-threatening assumption. In the next ten years, more than 100 million girls living in the developing world will be married as children, usually to older men. In Mozambique, for example—a PEPFAR country—57% of girls are married by age 18.

And in a survey of adolescent girls in 31 developing countries, 80% of unprotected sexual encounters occurred in marriage. For these young brides, these children, abstinence is not an option.

Further, the abstinence-only approach assumes that young people can choose whether to have sex. In South Africa, 30% of girls say their first intercourse was forced, and 71% have experienced sex against their will. Adolescent boys and young men in many places also report that they were forced—physically, or by social or cultural pressures—to have sex before they were ready. We cannot tell such young people to just say no. We must not disregard and deny the circumstances they face. We must invest in programs that empower women and girls, men and boys, with the knowledge and skills needed to practice mutual respect—with the short-term goal of protecting them from HIV and unwanted pregnancy, and the longer-term goal of eradicating gender inequality, including sexual violence and child marriage. This is not a radical agenda—it is something we can all support.

As U.S. citizens, we should be asking the government where are tax dollars are going: who is being funded by our government—in our own communities and overseas—to teach children about sexuality, a vital dimension of human development and fulfillment. In contexts where rates of HIV infection, unintended pregnancy, and child marriage are high—including communities in the United States—adolescents' ability to make informed decisions about their sexual lives, based on accurate information, is a life and death matter. Yet, recent research has found that most U.S.-based abstinence-only grantees use curricula that contain false, misleading or distorted information on reproductive health, and many of them are promoting stereotypes about boys and girls as scientific facts. Such curricula are being exported to other countries by our government.

PEPFAR funds are also going to groups that have limited or no experience working with people living with HIV/AIDS in the most affected countries and communities. One group received \$10 million from the U.S. government to promote abstinence, even though it had been deemed “not suitable for funding” by an expert panel. Simultaneously, groups with years of experience in comprehensive sexuality education, including abstinence, are sidelined. One of these is Population Services International, which promotes all aspects of PEPFAR's own “ABC” prevention approach to HIV prevention—“Abstinence, Be Faithful, and Use Condoms.” After years of U.S. government funding for their reproductive health programs worldwide, their budget has suddenly been cut.

Pressure from extremists has warped well-intentioned U.S. foreign policies like PEPFAR. Due to exactly this type of pressure, the MDG framework does not explicitly include access to sexual and reproductive health services, or comprehensive sexuality education for young people, or protection of sexual and reproductive rights. In the next few months, we have the chance—and, indeed, the moral responsibility—to remedy that.

All of us committed to human rights, and to achieving the MDGs, must ask world leaders at the Millennium Summit in September to unequivocally commit themselves to sexual and reproductive health and rights. We must demand substantially increased, and better programmed, foreign assistance. This means, for example, that global HIV/AIDS funds must be reprogrammed to reach girls and women. It means that the health sector—and finance ministers—must prioritize reproductive health services to end deaths and injuries related to pregnancy. It means sufficient investment to ensure universal access to subsidized female and male condoms, and development of microbicides.

The MDGs are not numerical targets that exist in a vacuum devoid of faith, compassion, and religious commitment. Quite the contrary. Everywhere, most people—including those who framed the MDGs—are people of faith. Implementing the MDGs presents a tremendous opportunity for moral and religious leadership—passionate, purposeful, and persistent—on issues of sexual and reproductive health and rights. Over the years, religious communities have made great strides in delivery of health services to some of the world’s most vulnerable people. Today, more than ever, we need these leaders, and advocates, to convince policymakers that reproductive health services, comprehensive sexuality education, and programs to eradicate sexual coercion and violence, are life-affirming and life-saving.

As my friend and colleague Ngozi Iwere said recently, “The main business of living is to reduce the harm that we do to each other as we live our beliefs.” I hope that communities of faith will join with the worldwide women’s movement to live our shared beliefs in the value of life, dignity, and human rights for all.

Thank you.