

**Realizing the Sexual and Reproductive Health and Rights of Women in the
HIV Prevention Paradigm**

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**“Realizing the Reproductive Health Rights and Needs of People Living with
HIV/AIDS”**

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By now, we all know, but it does not hurt to repeat, that half of all people living with HIV/AIDS worldwide are female, and in sub-Saharan Africa, far more than half. Other, less known facts are that, in newer epidemics, in Russia, India, and China, nearly 40% of people living with HIV/AIDS are already female; and that, in the United States, the number of women living with AIDS increased 15% between 1999 and 2003, compared with a 1% increase in men.

HIV/AIDS affects women and girls in countless ways. They 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 fear of infection. Those living with HIV/AIDS, or whose husbands die of AIDS, 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.

So how did we get here? As you have heard and will hear many times this week, widespread sexual coercion and violence against women; marriage of young girls to much older men; lack of access to HIV information, sexuality education, and reproductive health services all fuel girls' and women's vulnerability. Worldwide, in diverse contexts, women and girls do not have equal access to school, or the power to earn a livelihood, control their relationships, or make their own life choices.

Another major factor that fosters women's disproportionate vulnerability to HIV/AIDS, which is almost never acknowledged, is HIV/AIDS policy itself—and the funding priorities that go with it.

Let me explain what I mean and what we need to do about it, beginning with prevention programs. Prevention has generally been driven by two paradigms. One says that we can contain HIV/AIDS among commercial sex workers, intravenous drug users, and men who have sex with men. This work is vitally important, but has left most girls and women unprotected. Thailand, for example, has been widely celebrated for its success with commercial sex workers and their clients. Yet, in 2004, UNAIDS formally recognized that the greatest need for prevention efforts is now within the context of marriage and “regular relationships.” Brazil faces a similar challenge.

The second dominant prevention paradigm has been ABC—Abstinence, Be Faithful, and use Condoms. Fortunately, more and more people recognize that this framework is irrelevant for most vulnerable 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.

HIV/AIDS is fundamentally a sexual and reproductive health and rights issue for women and girls, and these must be central to our HIV/AIDS prevention paradigm. I'd like to illustrate this point by describing hypothetical experiences of diverse women in the health system, supported by empirical and anecdotal evidence.

First, imagine a pregnant woman seeking antenatal care. If the clinic she visits offers HIV testing at all, it is likely for one of two purposes: either surveillance, or prevention of mother-to-child transmission—not for her own treatment

Imagine that she tests positive for HIV. It is still quite unlikely she will receive MTCT services. Only 9% of pregnant women living with HIV/AIDS globally currently receive antiretroviral prophylaxis. Almost no MTCT programs yet treat the mother herself.

Further, a pregnant woman who tests positive is too often denied health services outright, including safe delivery services. In some instances, she will be “persuaded” to have an abortion.

Imagine, on the other hand, that the woman tests negative for HIV. Quite likely, she will then receive standard antenatal care from overtaxed health workers. What she will not receive is screening for sexually transmitted diseases or any information about how to protect herself from HIV/AIDS or other STDs. She will not be asked whether her husband or partner has other partners or visits sex workers, or if he forces her to have sex against her will, or if he beats her—nor will she be referred to places which could help her in any of these circumstances. She will not be supported to ask her partner or husband to be tested.

These policy and programmatic failures do not happen only to pregnant women. Imagine, now, a woman who seeks reproductive health services because she does not want to have a child. If she is unmarried, she may not even make it past the front door. If she does, she will likely receive contraception, but not help for a sexually transmitted infection. It is highly unlikely that she will have the choice of a female condom. If she can get an HIV test, not yet likely in many family planning settings, and is positive, she may be actively discouraged from having a child, regardless of her dreams and desires—not to mention her rights.

Or imagine a woman who instead accesses the health system through HIV/AIDS services, such as a freestanding testing site. She almost certainly will not receive any family planning or reproductive health services.

The women I have described thus far are relatively fortunate, in that they have access to health services in the first place. Let us not fail to consider those who do not—often, indigenous women, commercial sex workers, young women, women living in dire poverty. These women are generally excluded from public and private health services altogether, especially reproductive health services—and if they access services, they are treated badly.

And now I come to the more constructive element of my remarks—what we can do.

The first area of HIV policy and budget change is comprehensive sexuality education.

Increasing women's control over their sexual lives and reducing their vulnerability to HIV/AIDS requires changing how men and women relate to each other, and that means starting early! It means investing in comprehensive sexuality and gender education, not simply providing full and accurate information about HIV/AIDS. Comprehensive programs also build skills to establish equality in relationships; respect the right to consent in both sex and marriage; and end violence and sexual coercion. These programs need far more money and higher priority than the HIV/AIDS community is currently giving them.

The second policy change must be to include sexual and reproductive health services in special programs which work with marginalized communities. These programs must also have more resources to effectively combat stigma and discrimination, and promote rights and respect.

Finally, our HIV/AIDS policies and budgets must expand access to sexual and reproductive health services rather than 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 care, STD diagnosis and treatment, and contraception. With increased investment, they can provide subsidized female and male condoms, and, eventually, microbicides, as well as HIV/AIDS services, to women and their partners.

This will require significant work to train workers, develop and monitor quality, and provide new services. Both research and advocacy have vital roles to play.