

# How International Health Policy Can Help to Protect the Rights of Women in Asia, with Special Reference to India

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**AIDS in India**  
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Let me tell you about one Indian girl named Kamla, who lives in a remote village in Western Rajasthan state. I met her two years ago in Jodhpur and she told me her story.

Kamla was a young teenager when she was married to a cousin working in Bombay. Unknown to Kamla, her husband was living with HIV and frequently became ill. When he became too ill to work, they returned home to Rajasthan, where he died. Not long after, their 16-month-old child died, too.

Now Kamla is a widow and HIV-positive. She is relatively lucky—her parents have taken her in, but she is often ill. She has no access to life-extending drugs.

In the two years since I met Kamla, her story has gone from rare to increasingly common. Yet only now are the government and world community beginning to recognize what is happening to Kamla and the thousands of young girls like her in India. They had considerable warning.

I visited India for the first time more than 30 years ago, in 1973. Indian colleagues introduced me to women in isolated rural areas and sprawling city slums. Since then I have returned often, focusing on the health, opportunities, and rights of girls and women.

I have always ended these visits optimistic. I have felt buoyed by the slowly increasing awareness of the central importance of improving girls' and women's lives, securing their human rights, and moving toward gender equality.

Yet after my last trip, which took me from villages in southern Rajasthan to the red light district of Kolkata, to primary schools in Mumbai, I came home with a sense of desperation, for the first time.

In the early 80s, when the first HIV/AIDS cases were identified in the United States and Africa, I was living in Bangladesh. As the resident representative of the Ford Foundation, I funded the first ever research on sexually transmitted infections there. I knew, deeply and firsthand, that the circumstances of girls and women across South Asia that made them especially vulnerable to sexually transmitted infections would make them vulnerable to HIV.

I had learned from South Asian women and girls themselves about child brides, about sexual coercion and violence, and about sex discrimination in education and employment. It was clear that the lack of national programs to promote condoms, and to protect women's rights, would only hasten the spread of STIs, including HIV. And I said so. Back then, no officials listened.

In the late 1980s, from the International Women's Health Coalition in New York, again we women foresaw that the HIV/AIDS epidemic would rapidly become a plague for girls and young women everywhere. And again, global leaders did not listen.

Twenty years later, there is a feminized epidemic in all the high prevalence countries of sub-Saharan Africa and the Caribbean. And today, India is on the brink of an unprecedented catastrophe. A large population—soon to be the largest in the world—and inadequate national policies and programs mean that the number of people infected—and affected—by HIV/AIDS could dwarf anything we have yet seen, even in sub-Saharan Africa. India now has at least 5.1 million people living with HIV/AIDS, the second largest number of cases in any one country after South Africa. Richard Feachem, the head of the Global Fund to Fight AIDS, Tuberculosis and Malaria, says a more accurate number would be 5.4 million, making India the nation with the highest number of cases. Other experts, with whom I am inclined to agree, say the number of people living with the virus in India may be as high as 10 million.

Already almost 40 percent of those infected in India are female.

As in most of the high-prevalence countries in Africa and the Caribbean, young people in India are disproportionately at risk, especially girls and young women. In sub-Saharan Africa today, 57% of all those infected with HIV/AIDS are female. Seventy-five percent of HIV-positive young people there are female. Similarly in South Asia, the gender disparity among young people with the disease is growing: Already 62% of HIV positive young people in South Asia are girls.

Why are these girls and young women so vulnerable? I can assure you it is not because they are promiscuous. Early marriages of girls is the norm throughout South Asia. In Rajasthan, India, the median age at marriage for girls is only 16. Thirty-six percent of girls are married by the time they are 15. Eighty percent are married by 18.

Traditionally, child marriages were assumed to protect girls. Instead, child marriage opens a Pandora's box of health problems for girls—pregnancy too early, obstetric fistulas that kill or maim them, and a dramatically increased chance of sexually transmitted infections, including HIV.

We know that worldwide, more than 80% of new HIV infections in women result solely from sex with their husband or primary partner. In Pune, India, for example, a study in one clinic found that 91% of the married women who had a sexually transmitted disease, including HIV, had only one partner—their husband.

Girls in many South Asian societies are still very cloistered. Research shows that South Asian girls have little or no knowledge of sexuality, HIV, or condoms when they marry. Then they learn through experience, and the experience can be devastating. In Bangladesh, for instance, fewer than 20% of married women of all ages have even heard of AIDS.

These young girls are normally married to considerably older, sexually experienced men. Commonly, as adolescents, these men had sex. After marriage, a double standard still applies, and many men engage in affairs or visit commercial sex workers.

Married girls have little power in the relationship because they are so much younger and often less educated than their spouses. When a young girl is totally controlled by her husband and in-laws, knows nothing about sexuality, and certainly not about contraception or HIV, she cannot ask her husband about his faithfulness.

Young married girls also do not have the power within the relationship to ask their husbands to wear a condom. Even if these young girls had access to condoms, using them would be unthinkable, because their most important task is to produce a son as soon as possible. Their marriages – and sometimes their lives – depend on it.

Dr. Suniti Solomon, who diagnosed the first case of AIDS in India and sees at least half a dozen new patients every day, says: “A sex worker can tell a client, ‘Use a condom or get lost. ‘ A housewife in India can never do that.”

What child brides and young women in general face in India is all too similar to what girls face across sub-Saharan Africa. That region now has the world’s highest rates of HIV/AIDS and the highest rates of infected young women.

There’s another similarity. The Indian government, like many sub-Saharan African governments, has not prioritized the health, education, and rights of young girls, even though the world’s nations, including South Asian nations, have repeatedly agreed that such a focus is desperately needed.

In India, advocates for women’s health and rights, community health workers, and a growing number of government, business, and community leaders agree that priority should be given to public health services, especially in rural areas and urban slums, where health facilities, education, and support are weakest, and where young wives are woefully uninformed about health and sexuality. Dedicated workers, like Geeta Sodhi, who is with us today, are seeking ways to reach out effectively, especially to young girls, both married and not married, to help them access health services to prevent early or unintended pregnancy and sexually transmitted diseases, including HIV/AIDS.

Others are working hard to ensure that young girls—married or not—have equal access to education. They are seeking to enforce laws against child marriage. They are leading the way in teaching quality comprehensive sexuality education and training. And they are trying to help parents understand that marriage is not a sanctuary for young girls, but a danger zone of life-threatening health complications.

Well over one quarter of all the adolescents—the 10-to-19-year-olds—in the world live in South Asia. How they learn, what they learn, and what they do about sex will substantially determine the course of the epidemic.

Across India, the epidemic is also driven by poverty, drought, or other conditions that force men to migrate in search of work. Away from home, they have sex with women in brothels, or along the truck routes, or on construction sites. They return home to infect their wives and their babies. Other girls and women are at risk from sexual violence, or unsafe health services, or ignorance. As elsewhere, most people in South Asia living with HIV do not even know they have it.

How are we in the global community—citizens, health policy makers, and donors—going to help India meet these challenges? Global actors are mobilizing to support interventions like those used in Africa early in the epidemic—promoting condom use by sex workers and their clients, protecting blood supplies, and working with IV drug users. More recently, they have begun to fund HIV/AIDS counseling, testing, and treatment. These are all important. But global and national agencies also need to invest HIV/AIDS resources in building reproductive health services and basic health systems—the only way to reach the 70-90% of girls and young women in India who are poor and live in rural areas. They should also invest in comprehensive sexuality education—in school and out of school—that not only provides facts but also helps young people build skills and value relationships based on gender equality and respect for human rights.

All epidemics are tackled through a three-pronged approach of prevention, testing, and treatment, and HIV/AIDS should be no exception. But, increasingly, the resources going to prevention and treatment are out of balance. In its \$15 billion HIV/AIDS initiative, for instance, the current U.S. Administration is so preoccupied with treatment, that it is slighting the most critical prevention strategies. Treatment is vital. It is also understandably appealing to politicians because delivery of drugs is humane, measurable, and good for headlines. But emphasis on treatment to the detriment of prevention is disastrously short-sighted. It ignores the critical question: If treatment is available, but most people don't change their behavior, won't the epidemic grow unabated?

Although no country in South Asia receives funds from the President's AIDS initiative, the U.S. government, as the largest donor and the world's sole Superpower, has inordinate impact on international strategies. The White House and Congress have severely limited funds for two of the most important means of prevention: condom distribution and comprehensive sexuality education programs.

Other donor governments, and national governments as well, are also neglecting the most effective strategies to lower the risk of HIV/AIDS to the girls and young women of India. They are not yet sufficiently supporting universal access to sexuality education for adolescents. They are also leaving that "taboo" task to creative, but overburdened, nongovernmental organizations.

These short-sighted policies are in effect because no one is asking three key questions. One I have already touched on: What is the reality of girls' —and boys'—day to day lives? The second is this: How can we reach girls and young women promptly, effectively, and sensitively? Thirdly, who is reaching them now? The answer is schools and reproductive health services, but these are desperately underresourced. We need to persuade policy makers to invest far more in these institutions which, unlike HIV-specific clinics and education programs, are not stigmatized and have community support.

Unless we improve the status and opportunities of girls and women in South Asia and protect their human rights, there is no hope of controlling HIV/AIDS. Unless we give young people information on how to protect themselves, they will not be able to do so. Unless we invest in effective prevention as a top priority. India's economic and social progress will, at best, be slowed, and, at worst, reversed. National and international support for effective prevention strategies will prevent HIV/AIDS in India from having "a women's face," as it now does in too many African nations.

Our greatest hope, in India and worldwide, lies with young people.

Comprehensive sexuality and health education that promotes gender equality and human rights encourages equality within relationships, the right to consent in sex and marriage, and the right to be free of violence and coercion. When all young people, everywhere, have these tools—before marriage—they can change the underlying engines fueling not only the HIV epidemic, but also poverty and injustice.

Thank you.