



**Making Progress:
An International Agenda to Secure and Advance
Sexual and Reproductive Rights and Health**

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Good morning. Thank you all for dedicating your time this week to such a vitally important topic. I'm particularly grateful to the Ministry for inviting me to participate.

The experiences of the countries from which you have come reflect the complexity of sexual and reproductive health and rights worldwide. In some places, the greatest challenge that girls and women face is access to family planning and contraception. In others, those services are well established, but women have little access to safe abortion or help in childbirth. In parts of the world, rates of sexually transmitted diseases, including HIV/AIDS, are currently very high among girls and women; in others, the rates are low, but increasing. Regardless of particular circumstances, there is one certainty: sexual and reproductive health and rights are a vital aspect of the lives of all people, male and female, young and old, especially now in the face of new estimates that 40 million people are currently infected with HIV/AIDS, and the number is growing every day. The conference organizers have chosen a most appropriate title—HIV/AIDS and sexual and reproductive health truly are everybody's business.

I begin today by reviewing the evolution of the concepts of sexual and reproductive health and rights, progress made, and major challenges that remain. Then, I will propose actions to take at country level to strengthen health systems. Finally, I will close with some points for global and regional advocacy.

I. Definitions of sexual and reproductive rights and health (SRRH)

More than a decade ago, at the International Conference on Population and Development (ICPD) in Cairo, 179 countries agreed that:

- all couples and individuals have the right to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so; and that
- all decisions concerning reproduction should be made free from discrimination, coercion, and violence.

The Fourth World Conference on Women in Beijing in 1995 further agreed that the human rights of women include their right to decide freely and responsibly on matters related to their sexuality:

"The human rights of women include their right to have control over and decide freely on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between

women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.

At Beijing, governments also recognized that entrenched patterns of social and cultural discrimination are major contributors to sexual and reproductive ill health, along with lack of information and services. The ICPD Programme of Action calls for and defines reproductive and sexual health care to include:

- Family planning
- Antenatal, postnatal, delivery, and postpartum care
- Access to safe abortion and post abortion care
- Prevention, care, and treatment for HIV/AIDS and other STIs
- Prevention, surveillance, and care for violence against women and other action to eliminate traditional harmful practices

A major breakthrough at ICPD, reaffirmed repeatedly since, is that these services are essential for all people, married and unmarried, including adolescents.

Six years after ICPD, fired with the hope and enthusiasm of a new millennium, world leaders met at the United Nations and committed their countries to achieving eight Millennium Development Goals. The 2005 World Summit in September explicitly reaffirmed—in one of the strongest ever intergovernmental affirmations of sexual and reproductive rights and health—that universal access to reproductive health is critical to achieving the MDGs.

In 2002, Secretary-General Kofi Annan created the Millennium Project to develop concrete recommendations for achieving the MDGs. The Project report, published earlier this year, issues a call to bold action on women's health and rights, emphasizing sexual and reproductive health. Moreover, the Project also defined 17 Quick Win Solutions that could yield major results in the next three years. Expanding access to sexual and reproductive health information and services is one of them.

In addition to the 2005 World Summit affirmation, in the fall of 2004, over 300 current heads of state, Nobel Laureates, business and religious leaders and many others, signed an unprecedented statement in support of prioritizing the ICPD agenda. Since the presentation of the statement to the UN on October 13, 2004, the sponsors have collected even more signatures. Like the ICPD Programme of Action, this statement is a living document that reaffirms the global commitment to sexual and reproductive rights and health. The statement is available at <http://www.icpdleadersstatement.net>.

There has also been progress in the policies of UN agencies. For example, the World Health Assembly, in May 2004, adopted the first global strategy—based on the ICPD agreements—designed to accelerate progress toward reproductive health worldwide. The strategy, based on a human rights framework, focuses on five key action areas: strengthening health systems capacity; improving information for priority setting; mobilizing political will; creating supportive legislative and regulatory frameworks; and strengthening monitoring, evaluation and accountability.

So—we have a great deal of both political and public health affirmation for the central importance of sexual and reproductive health and rights. What about progress?

Assessing where we are, how far we've come, and how far we have to go is a matter of science, empirical evidence, and the art of political interpretation. It is not simply a matter of supportive international statements and public rhetoric, but also realities in countries.

What about changes in women's health and daily lives? Where policies, budgets and programs reflect ICPD priorities, we see important progress. With respect to reproductive health we could say that the glass is half full, not half empty. More girls are in school, for example; more women have access to contraceptives; and many countries, including China, Egypt, Honduras, Indonesia, Jamaica, Jordan, Mexico, Mongolia, Sri Lanka, Tunisia, Thailand, and Brazil have reduced maternal mortality thanks to investments in skilled birth attendants, referral systems, and basic/comprehensive emergency obstetric services.

Importantly, reproductive health improvements in Brazil are the result of strategic collaborations between the government and nongovernmental organizations, especially the Brazilian women's movement. In Bangladesh, too, thanks to a coordinated government and civil society initiative, important gains have been made in the proportion of women receiving prenatal care and in female life expectancy, along with drops in maternal and child mortality. Contrary to the fears of some, the family planning program there, long a success story, has not faltered with these additional initiatives on maternal health. Substantial progress has also been made in increasing contraceptive use among married women in sub-Saharan Africa, where contraceptive prevalence is generally lowest.

Although there has been progress, much remains to be done. This is where the glass is still half empty. Sexual and reproductive ill health accounts for an estimated one-third of the global burden of illness and early death borne by women of reproductive age, and 20% for all people worldwide.

I will focus on three main dimensions of sexual and reproductive health that need significantly increased priority in policies and budget allocations at the health systems level. These are: pregnancy and delivery; contraception and safe abortion; and STDs, including HIV/AIDS.

1. First, pregnancy and delivery.

More than half a million women still die from complications of pregnancy or childbirth every year—all but 1 percent of them in developing countries—and at least 20 million women each year suffer severe harm because we have not invested in basic reproductive health services, such as skilled birth attendants, that save women's lives and enable them to protect their families. The World Bank has estimated that if all women had access to interventions needed to address complications of pregnancy and childbirth, especially emergency obstetric care, 74 percent of maternal deaths could be averted.

Country-level data from WHO illustrate the magnitude of the challenge before us. Disparities in access to care during pregnancy and childbirth remain vast—between rich and poor countries, and among countries of the developing world. For example, in sub-Saharan Africa, the proportion of women experiencing direct obstetric complications who actually get obstetric care can be as low as 5 percent. This situation characterizes 19 of

the 20 countries with the highest maternal mortality ratios worldwide, including Burkina Faso, Kenya, Zimbabwe, Mali, Tanzania, and Mozambique.

On the other hand, as previously noted, countries such as Thailand, Egypt, and Honduras that have made sustained investment in ensuring access to midwives and skilled attendants, a functioning referral system, and emergency obstetric care have seen significant drops in maternal mortality over the past few decades. These interventions are striking in their simplicity, and relatively inexpensive. They do not require new technologies or scientific breakthroughs. They do require political will.

2. Second, contraception and abortion.

In 1999, at least 300 million married women worldwide lacked access to modern contraception—pills, IUDs or condoms. If we include voluntary sterilization as a choice, nearly 400 million lacked a full range of contraceptive choices. As I stated earlier, there has been encouraging progress over the past few decades—but contraceptive prevalence rates in many countries, including Afghanistan, Benin, Mozambique, Nigeria, Mali, Burkina Faso, and Ethiopia remain under 10%.

Further, the gap between projected total demand for contraception and current use of all contraceptive methods is still very wide. It can be closed by:

- Ensuring sufficient supply of commodities, currently a significant challenge;
- Extending full contraceptive services to young and unmarried people; and
- Strengthening health service capacity to ensure availability to all.

Given the high levels of unmet need for contraception in some countries, which often result in unintended or unwanted pregnancies, and also the large numbers of deaths and health problems caused by botched abortions, the ICPD recognized that unsafe abortion is a major public health concern. The five-year review of progress toward ICPD goals reaffirmed the need to address this problem and declared that where legal, abortion must be safe. A significant number of countries have since taken action to amend laws and regulations to achieve this end. More information is available at http://www.reproductiverights.org/wn_abortion.html.

Increasingly, governments, NGOs and health professionals are using WHO's 2003 publication, *Safe Abortion: Technical and Policy Guidance for Health Systems*, to train health care providers, inform program managers and policymakers, and educate the public in every region. The guidance is available at: http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf.

Despite progress in this area, many women eligible for pregnancy termination under the laws of their countries still do not have access to safe services. Every year, 19 million unsafe abortions take place around the world. The complications resulting from these procedures lead to at least 68,000 deaths, 99% of them in developing countries, and uncounted injuries or serious infection.

3. Third, HIV/AIDS and other STDs in girls and women

Today, nearly half of all people living with HIV/AIDS around the world are female, up from 41% in 1997. In every region, a significant portion of adults living with HIV/AIDS

are women, and infections among girls and women are increasing in almost every region. Among young people, 62% of those 15-24 living with HIV/AIDS worldwide are female. In sub-Saharan Africa, the statistics are even more grim. There, 57% of all those living with HIV/AIDS are female, and among young people 15 to 24, 76%—three of every four—are female.

U.N. Secretary-General Kofi Annan clearly articulates why this is happening: “It is a shocking fact, and one of which I as an African man feel ashamed, that a girl in [some countries of] sub-Saharan Africa is **six times** more likely to be infected than a boy. There are many reasons, ranging from abuse and coercion by older men and men having several partners, to lack of awareness and empowerment among girls and women.” Women also are biologically more vulnerable than men, and the younger the woman or girl, the higher this risk is, especially if she is married young to an older man.

Evidence is emerging in many, but not all, places that girls and women have even less access than men do and present later to health services for information, counseling, testing, care, and antiretroviral treatment. In these same places, women experience significantly more stigma than men, as well as twice the level of violence when their HIV/AIDS status becomes known. Women also carry the extra burden of care when family members are sick, dying, or orphaned.

Now let’s consider interventions. The current popular slogan on prevention for the population at large is ABC—Abstain, Be faithful, Use Condoms. ABC does not work for the most vulnerable women and girls. Abstinence is not an option for women and girls who face violence and sexual coercion; for whom sex is the only means of survival; who are married to men who do not let them use condoms or say no to sex; or for whom a pregnancy is desired. Most often, these women are faithful, but their partners are not. In fact, eighty percent of all women living with HIV/AIDS are infected by their husbands or primary partners, not by their own behaviors.

It is vital that we bring HIV/AIDS policies closer to women's realities. United Nations bodies have proposed an “ABC *Plus*” approach, focusing on the ICPD principles of educating and empowering women, and securing their health and rights. The ABC Plus approach includes health services, comprehensive sexuality and life-skills education in schools, youth programs for both young women and men, and economic empowerment of women and girls that will better enable them to protect their own health and lives and those of their children.

II. Health Systems: Challenges and priority actions

Achieving progress toward sexual and reproductive rights and health, including HIV prevention, treatment, and care, requires a strong, functioning health system in every country, especially at the primary and first referral levels. Our approach to meeting three health system challenges will likely determine our future success—or failure. To my mind, the most significant challenges of our time with respect to health systems are:

- Health sector financing and sector-wide approaches (SWAps)
- Decentralization of health systems
- Verticalization of (usually) disease-centered programs and services

First, health systems financing. Overall, health systems are substantially under-financed and crumbling in the countries facing the greatest problems of sexual and reproductive rights and health, including HIV/AIDS. As donors and national governments move toward modalities such as sector-wide approaches (SWAs) and direct budget support, special attention must be paid to sexual and reproductive health to ensure that it is a priority. Similarly, as increasing emphasis is placed on cost recovery, including service fees, and on privatization, special care must be taken to ensure that these mechanisms do not pose barriers to women's and young people's access to care.

Second, increasingly widespread decentralization of health systems (a policy promoted by governments and donor agencies to bring services closer to the people in need) means that sexual and reproductive rights and health may fall off the budget priority list altogether if local authorities are not informed and interested—and experience has shown that they often are not. In this instance, programs for democracy and good governance, as well as health sector investments and support for the participation of civil society and NGOs in setting health priorities, can help to ensure local political support by providing training, outreach, and advocacy for sexual and reproductive rights and health.

Third, paradoxically, while donors emphasize SWAs, we are also seeing separate, vertical programs for malaria or tuberculosis eradication, or for HIV/AIDS, among other specific health interventions, along with enormous amounts of global funding. Far from strengthening overall health system capacity, these programs often divert health system resources and personnel to combat one particular disease, rather than helping to build and fortify the system as a whole.

Taking into account these three interrelated phenomena—financing, decentralization, and vertical programs—and considering the pivotal importance of sexual and reproductive health and rights, widespread feminization of AIDS epidemics, and basic health system capacity, we propose that priority action should be taken in three key areas: financing for sexual and reproductive health and rights, accountability, and investment in young people.

First, with regard to financing for reproductive health, we propose that both global and national HIV/AIDS budgets and policies include concrete action plans and policies, and significant resource allocations, to prevent infection in girls and women through expanded and strengthened sexual and reproductive health services, including STI testing and treatment, to reach all women, including adolescents. This is not currently the case.

We also urge that more HIV/AIDS funds be invested in the development and provision of prevention methods that put the capability for prevention in women's hands. Subsidized access to female condoms should be greatly scaled up, for example, and UNFPA has a program, their Comprehensive Condom Campaign, to do just that. In addition, funding is urgently needed to develop and bring to market microbicides—substances that women can apply in the vagina to reduce transmission of HIV and other STIs. An estimated \$1 billion in the next five years will ensure that final clinical trials of five potential products can be completed expeditiously.

Let me move now to the second action area, accountability of the health system. Civil society engagement at local and national levels is fundamental to setting health sector priorities, and vital to ensuring that governments and donors are held accountable to

their commitments. Take the example of Bangladesh. In the late 1990s, Bangladesh formulated its first Health and Population Sector Strategy (HPSS) and Health and Population Sector Programme (HPSP), with the main goal of “improving the health of women, children, and the poor.” Integrated reproductive health services were the centerpiece. Government and international donors were committed to involving civil society in the design phase, partly because the ICPD Programme of Action mandated civil society participation—and also because they knew that integrating health services and family planning would be a highly political issue, and they would need broad-based support.

For two years, the government and donors allocated time, funds, and personnel to work with civil society, and consulted with 34 stakeholder groups. This process resulted in strong government and stakeholder support of the policy, and a shift from a narrow focus on family planning to more comprehensive reproductive health services. Health outcomes improved noticeably. For example, between 1998 and 2002:

- The proportion of women receiving antenatal care increased from 26% to 47%.
- Female life expectancy increased from 58 to 60 years.
- Maternal mortality decreased from 410 to 320 deaths per 100,000 live births.
- The child mortality rate dropped by 24%.

Unfortunately, however, neither government nor donors continued to support stakeholder and broad civil society participation as planned. When a new government came to power, the program was politically vulnerable, implementation stalled, and the key ingredient—unification of health and family planning services—was reversed.

WHO’s 2005 World Health Report concludes, “Experience from Bangladesh in the mid-1990s shows that time and money invested in mobilizing [civil society] constituencies is well worth it; failing to do so can have serious negative consequences.” The Bangladesh example illustrates the following key points for fostering health systems development and accountability:

1. Changing policy and sustaining its implementation requires a popular base.
2. Constituency and alliance-building require sustained funding to civil society groups, not just for advocacy projects, but for long-term capacity-building.
3. Popular mobilization must be led by civil society organizations for credibility and staying power.
4. Governments and donors must allow civil society organizations access to decision-making documents and processes, program implementation, and evaluation, while respecting their autonomy.

International donors have a critical role to play in identifying non-governmental organizations and other civil society groups, and in facilitating their involvement in donor/government processes. I cannot emphasize enough how critical this role is, especially in countries where local governments are not yet experienced in or may not be very receptive to working with NGOs, and/or where NGOs are just developing.

The third and final action area is investing in young people. Half the world’s people are under 25. Many young people have been and are vulnerable to unwanted sex, unwanted pregnancy, botched abortion, and STDs. Now they are also extremely vulnerable to HIV infection – 7,000 young people are newly infected every day. If young

people do not receive adequate reproductive and sexual health services and education now, if boys and girls cannot obtain condoms or contraception without discrimination and stigma, if girls do not have equal access to schools, if we do not make sexual coercion and violence against women unacceptable, and if both boys and girls foresee a future of unemployment and poverty, both the demographic momentum of early and high fertility in some countries and the overwhelming force of the HIV/AIDS pandemic will surely continue into future generations.

The ICPD recognized that sexual and reproductive health and rights, including HIV/AIDS prevention, are not just about access to health services, but changing social norms and behaviors, achieving gender equality, and protecting human rights, especially of girls and women. Nations truly committed to sexual and reproductive rights and health, including the prevention and eradication of HIV/AIDS as a matter of national policy and budget priorities must therefore also:

- a. Ensure that all girls, as well as boys, complete middle and secondary school.
- b. Foster youth employment and livelihoods programs equally for girls and boys.
- c. Pass and enforce laws against sexual coercion, violence, and discrimination against women, including harmful practices such as child marriage.

Investing in young people has gained momentum since ICPD. Major efforts have been made to develop programs for both married and unmarried youth, male and female. Yet in many parts of the world, adolescence is barely recognized as a significant period of life. We must work everywhere to recognize young people as major stakeholders in the promotion of sexual and reproductive health and rights, including HIV/AIDS prevention; in political life; and in national development. We must ensure universal access for young people to comprehensive sexuality education, within and outside of schools, which:

- Includes abstinence as one important option;
- provides full and accurate information;
- gives social support and helps young people to:
 - build skills to establish equality within their relationships,
 - respect the right to consent in sex and marriage, and
 - end violence and sexual coercion.

Such programs should provide girls with safe spaces, free from harassment and discrimination; alternatives to early marriage; and activities to help build their self-esteem and confidence—consistent with the UN's ABC-plus model. They should help boys be responsible for their own behavior and understand that violence and coercive sex are not their birthright. Such programs were mandated at ICPD and have been reaffirmed many times since.

Young people must also be guaranteed access to health services, not necessarily through separate services, which will often be impractical, but at least through appropriately trained staff, adjusted hours of service, and “youth-friendly” outreach. Provision of basic services and referral can also be developed in many places where young people congregate.

III. Realities of girls' and women's lives

HIV/AIDS epidemics around the world are primarily driven by heterosexual sex. HIV/AIDS is thus essentially a sexual and reproductive health and rights issue, especially for girls and women. The realities of girls' and women's lives that violate their sexual and reproductive rights and undermine their health are the same realities that put them at serious risk of HIV/AIDS—and that impose disproportionate burdens on them once they are infected and/or caring for others who are. The list of these realities is long, but let me name six of the most harmful:

1. Marriage of young girls to older, usually sexually experienced men. Of the 331 million girls currently aged 10–19 in the developing world—excluding China—163 million will be married by their twentieth birthday. In many countries, girls are still married before their fifteenth birthdays. In Mozambique, for example, 21% of women currently aged 20–24 were married before age 15, and 57% before age 18. One-quarter (24 %) of young women in Mali were married by age 15, and two-thirds by 18. In Nicaragua, 13% of young women were married or living with their partners by age 15, and 43% by 18. In South Asian countries such as Bangladesh and India, a child bride is sexually inexperienced, knows little or nothing about contraception or HIV, and is expected to demonstrate her fertility immediately, i.e., she is required to have frequent and unprotected sex, resulting in high-risk pregnancies. Marriage, far from being a safe space, can be very dangerous.

2. Sex between young girls and older men outside of marriage. Girls in some social settings are driven to transactional sex through an array of needs—family survival, transportation, school fees, food—and sometimes enticements—clothes, a night out, or a cell phone. Transactional sex crosses income groups, but everywhere seems to be primarily between older men and younger women, including girls. In a study conducted in Soweto, South Africa, for example, among nearly 4,000 pregnant women ages 15 to 44 years, transactional sex was associated with HIV seropositivity. Girls and young women who are sold, or enticed, or tricked into transactional sex end up not only in brothels or red light districts, but also in countless informal settings impossible to track or to reach with protective information and services.

3. Violence and sexual coercion inside and outside marriage. Girls and women are biologically twice as likely as men to become infected with HIV during sexual intercourse with an infected partner. A violent partner dramatically increases the woman's risk and obliterates any protective action she might otherwise take. Rape as a weapon of war, or even of lesser conflicts such as family or tribal feuds, is all too common. In some countries, between 20 and 48 per cent of young women aged 10–25 years have experienced forced sex. And today we witness the horrors of international and national sex trafficking in young women and in children of both sexes.

4. Husbands or primary partners who engage in extramarital affairs or visit commercial sex workers. Premarital and extramarital sexual activity are widely condoned, or even encouraged, for adolescent boys and men as a demonstration of masculinity. Men who work far from home often have sex with women in brothels, along truck routes, or on construction sites. They return home and infect their wives and, in turn, their babies with a range of sexually transmitted infections. In Thailand, this is clearly an emerging challenge: In 1991, 90% of HIV transmission in Thailand was through sex work, and 5% through heterosexual transmission of cohabiting partners. By

the end of 2002, 15% was through sex work, and 50% through heterosexual partners. In even the most outwardly sexually conservative societies, such as India and Indonesia, boys and men have casual sex with each other—secretly—and then marry.

5. Taboos against giving girls factual information about sexuality and reproduction before, and even after, marriage. All too often, social norms dictate that girls are not only virginal, but also ignorant of sexuality, reproduction, HIV, contraception, and even condoms when they enter marriage. UNAIDS reports that in 24 sub-Saharan African countries, including Cameroun, Kenya, Nigeria, and Uganda, more than two-thirds of young women ages 15-24 lack comprehensive knowledge of HIV.

6. Lack of condom use in marriage or long-term relationships. By now it is common knowledge that few men use condoms with their primary female partners. And most women who are primary partners either do not perceive that they are at risk from their boyfriends or husbands, or they do not ask them to use condoms for fear of violence or rejection, or because they want to get pregnant. Dr. Paulo Teixeira, Senior Adviser to the HIV/AIDS program in Sao Paulo, Brazil, has repeatedly expressed concern that adult middle class women in stable relationships do not perceive that they are at risk for infection. Those in what they perceive to be a monogamous relationship—that is, 92% of Brazilian women—use condoms only 21% of the time. Yet the epidemic in Brazil is spreading 9 times faster among women than men. In India, Dr. Suniti Solomon sums up the plight of women in her country: “A sex worker can tell a client, ‘Use a condom or get lost.’ A housewife in India can never do that.”

IV. SRRH and HIV/AIDS are not separate challenges

For these reasons and countless more, girls and women cannot, on their own, protect themselves from unwanted, unsafe, violent, or coercive sex which translates into unwanted pregnancy, maternal mortality and HIV/AIDS. There is much to be done, and much that each of you can do. As a starting place for discussion, I recommend three areas for your consideration.

First, I urge you to work with governments, donors and civil society at national, state, and provincial planning levels to:

- Make sexual and reproductive health services, and comprehensive sexuality education, two central priorities in national health plans and budgets, including national HIV/AIDS plans and budgets;
- Ensure that national development plans and development assistance projects aim for specific gender equality outcomes;
- Systematically increase investments in education, health services, and income earning skills development and opportunities for young people.

Second, it is critical that you facilitate cooperation and alliances between the people and organizations who work on sexual and reproductive rights and health and those who work on HIV/AIDS—both in and outside governments, and in your embassies—by:

- Financing joint work by women’s, youth, and HIV organizations;
- Facilitating their participation in policy development processes, and accountability processes and mechanisms;

- Supporting progressive sexual and reproductive rights and health initiatives, especially to compensate for other donors' interventions that have negative impacts on, or do not help secure, the health and rights of women and girls.

Finally, in your own public speaking, as often as possible, and, when you can, persuade colleagues and national leaders in their public speaking to:

- Call for zero tolerance of sexual coercion and violence against women and *commit to specific actions*;
- Promote gender equality in all aspects of life and *demonstrate your commitment through action*;
- Remind your audiences that *HIV is a sexual and reproductive rights and health issue*; that girls and women must have information and health services to protect themselves; that boys and men must be educated and encouraged to be responsible and respectful for their own sexual behaviors; and that these are fundamental questions of human rights and social justice, not simply medical expertise.

Thank you very much.