

# **Reproductive Health and Rights: A Vital Strategy in the Fight Against HIV/AIDS**

**Delivered by Adrienne Germain**

**President, International Women's Health Coalition**

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**[Expanded version of delivered remarks]**



Thank you very much, Chris, for inviting me to PATH. I am delighted to have an opportunity to share ideas and debate strategy with all of you.

Ten years ago, at the International Conference on Population and Development (ICPD) in Cairo, 179 governments agreed that sexual and reproductive health and rights, women's empowerment, and gender equality should be at the center of the global development agenda. This agreement has been strengthened and reaffirmed at least 10 times since, including by the United Nation's Summit on HIV/AIDS in 2001.

Also in 2001, UNAIDS announced that more than half of the people living with HIV/AIDS in sub-Saharan Africa were girls and women, most considerably younger than men living with HIV/AIDS. These days, evidence on increasingly widespread feminization of the HIV/AIDS pandemic is clear and frequently acknowledged. I will talk today about what we can do to prevent infection in girls and women who are not the so-called core group transmitters, i.e., commercial sex workers who already have the attention of HIV/AIDS policy makers. The Cairo agreements charted the course we should take. What I hope we can do is move forward—together—and much faster, to make these agreements reality.

First, I'll briefly review the feminization of the epidemic, and why it's happening. HIV/AIDS rates in general, and for girls and young women in particular, are soaring. Nearly 50% of the 38 million people living with HIV/AIDS around the world are female, up from 41% in 1997. Young women now account for 62 percent of persons ages 15 to 24 living with HIV/AIDS worldwide. In sub-Saharan Africa, 75% of infected young people are female. For every 10 young men living with HIV/AIDS in Kenya and Mali, there are 45 young women. In many other high prevalence countries, adolescent girls are four to six times more likely than boys their age to be living with HIV/AIDS.

Even in Brazil, where the epidemic has stabilized in the past six years, in 2001 and 2002 the number of cases in girls under 20 was six times higher than the number of cases in boys that age. And in Thailand, also considered an HIV/AIDS success story, evidence is now mounting that HIV has spread to the primary partners of sex workers' clients, and that casual sex is increasing among girls who, unlike boys, were not sexually active in earlier years. These dynamics are a recipe for resurgence of the epidemic. They were predictable.

Evidence is also emerging, in too many places, that girls and women have even less access than men, and present later, to health services for counseling, testing, care, and ARV treatment. Women experience significantly more stigma than men, as well as twice the level of violence when their HIV/AIDS status becomes known. Women and girls generally bear the brunt of home-based care. All this was predictable.

HIV/AIDS leadership and the wider community, recognizing the feminization of the epidemic, increasingly acknowledge the realities of girls' and women's lives that put them at such high risk of infection. The list of these realities—the same realities addressed by the Cairo conference 10 years ago—is long, but let me name six of the most harmful:

**1. Marriage of young girls to older, usually sexually experienced men.** In 50 of the least developed countries, 38% of young women currently aged 20-24 were married before they reached 18. In Rajasthan, India, 36% of girls are married by the time they are 15, and 80% are married by 18. A child bride is typically totally controlled by her husband and in-laws, knows nothing about sexuality, contraception, or HIV, and is expected to demonstrate her fecundity immediately. She is in no position to ask her husband about his sex life, let alone condom use.

**2. Sex between young girls and older men outside of marriage.** Girls 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. 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 access with protective information and services.

**3. Violence and sexual coercion inside and outside marriage.** As we all know, girls and women are biologically two times more likely than men to become infected 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 lesser conflicts, including family or tribal feuds, is all too common in today's headlines. But how many of us know that in schools across Africa, getting the grade that good work deserves requires sex with your teacher—if you are a girl?

**4. Husbands 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 have sex with women in brothels, or along truck routes, or on construction sites. They return home and infect their wives and, in turn, their babies. In even the most outwardly sexually conservative societies, such as India and Indonesia, boys and men have sex with each other—secretly—and then marry.

**5. Taboos against giving girls factual information about sexuality and reproduction before, and even after, marriage.** Girls across Asia, the Middle East, and Africa are supposed to be not only virginal, but ignorant of sex when they enter marriage. They commonly have no knowledge of sexuality, reproduction, HIV, or condoms. A study in 2001 found that only 70 percent of women in India had even heard

of AIDS. Is it any wonder then that prevalence rates there are soaring? In countries that already have generalized HIV epidemics, more than 80 percent of young women 15-24 have insufficient 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 partners. And most of their primary partners either do not perceive they are at risk from their husbands, or they do not ask their husbands to use condoms for fear of violence or rejection. Dr. Suniti Solomon, who diagnosed the first case of AIDS in India and sees new patients every day, said just this summer: "A sex worker can tell a client, 'Use a condom or get lost.' A housewife in India can never do that."

For these reasons and countless more, girls and women cannot, on their own, protect themselves from unwanted, unsafe, violent, or coercive sex, across highly disparate societies where HIV/AIDS has already taken off or is about to, as in India and Nigeria. Both of these countries have many of the factors—the "realities" I listed earlier—that have led to feminized epidemics in sub-Saharan Africa and the Caribbean. Already almost 40 percent of those infected in India are female. In still other countries, even recognized "successes"—Brazil and Thailand—we are seeing increasing risk for girls and women.

How can we prevent and reduce feminization of the epidemic? First, I suggest it is important to consider how we define the problem we want to address. In this regard, I see striking parallels in the nature of intellectual leadership in the population field and the HIV/AIDS field.

Before ICPD, the population field focused mainly on fertility control; demographers were its primary experts; and family planning was the main solution. For years, women activists who knew women's realities argued for a wider paradigm. And the 1994 Cairo conference provided an opportunity for debate and a new consensus. While recognizing family planning is essential, the Cairo Program of Action says it should be delivered through a broader reproductive health and rights approach, together with investment in programs to achieve gender equality, women's empowerment, human rights, and poverty alleviation. We also acknowledged in Cairo that, going forward, securing and fulfilling adolescents' rights to sexuality education and health services would have to be a high priority.

What about HIV/AIDS policies? As I have experienced it, the problem definition (controlling a communicable disease) has been determined primarily by classic principles of epidemiology, together with the understandable desire for economically efficient strategies. This has resulted in a focus on outreach to core group transmitters; narrow HIV/AIDS messages about disease, as opposed to sexuality or power or relationships; and condoms as primary means of prevention, with additional attention to such matters as blood safety and protection of health workers. The statistics I've recounted above indicate that these interventions have been woefully inadequate to protect girls and women outside the core groups.

Had we invested in gender equality 30 years ago, as the first world conference on women agreed—or in equality, youth empowerment, and sexual and reproductive rights and health, as the Cairo conference agreed 10 years ago—I believe the HIV/AIDS epidemic would not have become feminized, and possibly, not generalized. If we

seriously invest in gender equality, youth empowerment, and sexual and reproductive health and rights going forward, I suggest we'll make better progress—and also reap the many additional benefits to families and societies that come with these investments.

What is the way forward? Ten years after the ICPD paradigm shift in population policy, we need another paradigm shift—this time in HIV/AIDS policies—to better prevent infection in girls and women, and also to ensure their equitable access to effective testing, care, and treatment. On the prevention end, various agencies and initiatives are working on such key areas as women's economic empowerment, education, and human rights. I focus today on the need for wider and sustained investment in sexual and reproductive health and rights, as defined in Cairo, by the HIV/AIDS community specifically.

I would suggest two primary shifts in HIV/AIDS policies. The first is to broaden HIV/AIDS strategies to encompass sexual and reproductive health and rights services for the vast majority of girls and women who are not core group transmitters. The second is to promote and support comprehensive sexuality education, not just HIV/AIDS education. Both of these are vital to help today's girls and women protect themselves. They will also be fundamental in preparing communities, individuals, and health and education systems for the crucial processes of testing, developing, and ultimately introducing microbicides and vaccines meant for all populations, not just the core groups. These two investments aim to achieve not only short term outcomes, but also long term social changes in gender relations and in respect for human rights, including, centrally, sexual and reproductive rights.

Going to the first shift, we can best reach girls and women outside the core groups by strengthening and expanding access to programs they use—namely, comprehensive reproductive health services. These already serve many women and girls, but need to reach many more. Unlike HIV-specific clinics and education programs, which are too often stigmatized, reproductive health services have community support and a head start of several decades on core staff and management capacities. At the same time, however, reproductive health services are under-financed.

We should provide substantially more resources (drawn from multiple sources, including HIV/AIDS funds) both to reach more girls and women, and to add HIV/AIDS capabilities to reproductive health services. If we invest wisely, especially at primary and secondary levels, we will at the same time fundamentally strengthen weak public health systems, and thereby contribute to improved absorptive capacity for other vital HIV/AIDS interventions and health services for all.

We need many more reproductive health service providers and we need to train them in HIV/AIDS testing and treatment; in prevention of vertical transmission; in care and treatment of opportunistic diseases and illnesses; and in procedures to protect themselves. As important, their counseling skills, information materials, and interpersonal skills need to be upgraded so that they can talk with all patients and partners not only about HIV/AIDS, but also about other STDs and such issues as sexual coercion and violence; about how to talk with their children and their partners; and about negotiating condom use, including when using another contraceptive method. We must ensure on a priority basis that all reproductive health services have adequate supplies of both male and female condoms, emergency contraception, and, when proven, microbicides.

Investments in services should be complemented by health education and outreach, not just to provide information on HIV/AIDS, but also to inform husbands, partners, and families about, and encourage their support for, sexual and reproductive health and rights overall. Finally, substantially increased funds should be made available on a priority basis to develop and bring to market helpful new technologies, such as improved female condoms and microbicides.

The second policy shift going forward concerns young children and adolescents, over 2 billion of them, the majority of whom live in countries where the numbers of HIV/AIDS cases, especially among girls and young women, are rising dramatically. If these young people do not receive adequate reproductive and sexual health care services and information now, if girls do not have equal access to schools, and if both boys and girls foresee a future of unemployment and poverty, the HIV/AIDS pandemic will surely continue into future generations.

We and our colleagues know, based on experience, that comprehensive sexuality and health education that promotes gender equality and human rights can make a significant difference in young people's lives. These investments provide factual information, give social support, and help young people build skills to establish equality within relationships, respect the right to consent in sex and marriage, and end violence and sexual coercion. Effective programs provide safe spaces for girls, free from harassment and discrimination, an alternative to early marriage, and activities to help build their self-esteem and confidence. Current adolescent programs typically fall far short in this regard.

Although we do not yet have strong empirical evidence of the effectiveness of such programs, especially for behavior change, we must invest in them for their own sake, and for two fundamental, practical reasons. First, until substantial investment is made, including in monitoring and evaluation, we will not generate the data we need to demonstrate efficacy. Second, an HIV/AIDS vaccine, the only preventive that could work in the absence of behavior change, is at least 20 years from availability, and most expect it will fall significantly short of 100 percent effectiveness.

The only way we can protect today's young people, and those born in the next 10 to 20 years, is to provide factual information, skill building, and condoms (and microbicides, when available). Such investments likely will not protect all of today's young people, but surely will help reduce the numbers at risk. At the same time, these investments will build social and political acceptance for long-lasting change, and an end to the underlying engines of the HIV epidemic, the same engines that drive unwanted pregnancies, maternal mortality, and wider injustice.

The Girls' Power Initiative, GPI for short, in Nigeria, is a strong example of the progress that can be achieved by working with young people. Bene Madunagu and Grace Osakue founded GPI in 1994 to build girls' confidence, knowledge, skills, and self-esteem. Working with parents and community leaders, and learning from the girls themselves, they are helping the girls, school principals and teachers, and parents to understand that early marriage is a danger zone, not a sanctuary, for young girls, and that factual information on sexuality and skill-building prevents unwanted and unsafe sex.

GPI's example, and the example of others across Nigeria, have already dramatically influenced national policies. They inspired a national sexuality education curriculum, adopted by the federal government in 2001, and are now helping train the teachers who will implement the curriculum in ten states. At the same time, GPI inspired a pioneering program for young men, the Conscientizing Male Adolescents program, CMA for short. Eddie Madunagu, CMA's founder and Bene's husband, says, "the social transformation necessary to free women from domination, exploitation, oppression, abuse, and indignity requires the efforts not only of women but also of men." CMA educates boys and young men to critically assess gender inequalities and to combat them in their personal lives, as well as in their broader struggle for democracy and citizenship.

Watching GPI girls and CMA boys testify, debate, sing, laugh, listen, and support one another, I have been struck by the power and potential they represent for Nigeria—as they go, so will the country.

Keeping our promise to this largest generation ever of young people, and achieving this crucial HIV/AIDS policy paradigm shift, requires work with policymakers, and the epidemiologists and economists who advise them, to think anew about the underlying dynamics driving the HIV/AIDS pandemic. It will require engaging our currently separate communities in partnership: the HIV/AIDS community, women's health advocates, human rights activists, and the reproductive health/population field. It will also require leadership, time, and resources. The payoff will be huge—saving millions of lives. But we have two main challenges to overcome.

First, **the underlying politics**. At countless meetings of all kinds on sexual and reproductive health issues, one rarely sees HIV/AIDS professionals; and the obverse is also true. In the 1980s and 90s, the family planning and population community resisted allying with HIV/AIDS groups because the issue was controversial, and, they felt, stigmatizing. Today, the HIV/AIDS community resists reproductive health for the same reason, among others. Developing alliances between and among the reproductive health and rights field, women's health and rights advocates, and the HIV/AIDS community thus requires resolving actual or perceived differences in goals and values, and finding common ground. It also requires that we take advantage of fundamental political arithmetic – the bigger, the broader, the more organized a constituency, the more effective it will be. In politics, two plus two can equal five.

This is as true in the global South as it is in the North. Take the case of Brazil, a country with very strong, very mobilized HIV/AIDS, reproductive health, and feminist movements. Just last month, the originator of the National AIDS program there, Paulo Teixeira, told a large audience in New York that continuing progress to end HIV/AIDS in Brazil, and to stop feminization of this phase of their epidemic, requires these communities to join forces. As he said, we all need to reach the women and adolescents who are increasingly at risk or infected with HIV, endure preventable mortality and morbidity related to pregnancy, and face substantial discrimination in health services, along with violations of their sexual and reproductive rights. Think of how much could be done if our movements worked together!

Our second and related challenge is to reconcile **competing demands for HIV/AIDS funds**, which are still inadequate. We cannot allow ourselves to compete with one another. Working together, I believe we can build a diverse and powerful coalition that agrees to broaden interventions to address the rapidly expanding infection rates among

girls and women outside the core groups. We can work together to mobilize adequate resources for VCT, care, treatment, conventional prevention approaches, and for reproductive health and youth programs, as well as for female condom and microbicides research and development. At the same time, together we can develop a stronger evidence base on the effectiveness of these interventions.

Making these changes will be challenging, at least as challenging as the Cairo paradigm shift was. Now—more than ever—girls' and women's lives are at stake. Building on the remarkable consensus reached at Cairo, I am confident that we can do this.

I look forward to hearing your views—pro and con—and your ideas on how to move forward together. Thank you.