

**Whose Agenda?
Cairo and the Unfinished Agenda for Reproductive Health
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A decade ago at the International Conference on Population and Development (ICPD) in Cairo, 179 countries, including the United States, agreed that reproductive rights are human rights. They also recognized that the most pressing international problems of poverty, hunger, disease, environmental degradation, and political instability, can only be solved by securing women's sexual and reproductive health.

Today, the ICPD agenda is vigorously alive. This year, all 179 original governments reaffirmed this watershed agreement. At the same time, nearly 100 current heads of government, along with three dozen Nobel Laureates, corporate and religious leaders, and many others, signed an unprecedented World Leaders' Statement in support of prioritizing the ICPD agenda. Since its presentation to the UN on October 13, even more signatures are being collected—like the ICPD Program of Action itself, this statement is a living document.

For proof that ICPD lives on, however, we need look no further than October 2000, when heads of government who agreed on eight Millennium Development Goals, set these goals in a broader context of commitment to human rights and democratic governance. The ICPD consensus—more than any other agreement of the 1990s—provided the foundation for the Millennium Summit agreements. But in early 2001, when the technocrats convened to streamline the language of the MDGs, and define targets and indicators for each, the core ICPD goal of universal access to reproductive health was not explicitly included. It is, nonetheless, implicit. There is wide understanding that the MDGs cannot be achieved without substantial investment in the sexual and reproductive health and rights agenda set in Cairo.

Ten years after Cairo, what progress has been made? In recent months, we have heard considerable naysaying. I, however, see the glass as half full, not half empty. Granted, we have not made all the progress we hoped for, notably because of underfunding, destabilization caused by warfare and civil unrest, and the ravages of the HIV/AIDS epidemic. But where policies, budgets, and programs reflect Cairo priorities, we see important progress.

More women have access to contraceptives and more girls are in school. In the past decade, contraceptive use has increased from 55 percent of couples to 61 percent. Even in Africa, contraceptive use among married women since the early 1990s has grown from about 15 to 25 percent, and in Asia, from 52 to 66 percent. Between 1998 and 2001, Brazil reduced maternal deaths from roughly 34 to 29 per 100,000 hospital

admissions, through the combined efforts of government and nongovernmental organizations. In Bangladesh, thanks also to a coordinated government and civil society initiative, the percentage of women receiving antenatal care went from 26 percent to 47 percent, female life expectancy increased from 58 to 60 years, and maternal mortality fell from 410 per 100,000 live births to 320, between 1998 and 2002. The mortality rate for children under five in Bangladesh dropped by 24 percent. And, contrary to some assertions, the family planning program there, long a success story, has not faltered.

Progress extends to the policies of UN agencies. Recognizing that reproductive and sexual ill-health accounts for 20 percent of the global burden of ill-health for women, and 14 percent for men, the World Health Assembly adopted a strategy to accelerate progress toward reproductive health last May, based on the Cairo agreements. Remarkably, in June 2003, WHO also published *Safe Abortion: Technical and Policy Guidance for Health Systems*, now being introduced in dozens of countries in a number of languages.

We can find positive examples from most countries, even those generally considered the toughest challenges. Take, for example, Nigeria. After Cairo, a remarkable program for girls was begun by an NGO in southern Nigeria—the Girls' Power Initiative, or GPI. Ten years later, GPI is an internationally recognized organization with a comprehensive program designed to achieve gender equality. By offering information about health and rights, and by helping girls develop the skills to protect themselves from unwanted or coercive sex, and to challenge pervasive inequalities, GPI is changing attitudes and behavior. GPI girls are AIDS-free; they are getting an education instead of getting married young; they have resisted genital mutilation; and they are changing the way their parents, siblings, peers, and communities value young women.

GPI's message of empowerment now reaches another 25,000 students through 28 schools across four states. Based on their success, GPI and colleague organizations across Nigeria are influencing national policies that affect girls' health and rights. The government has adopted a national sexuality education curriculum, and NGOs are helping implement it. In sum:

- We are making strong progress on the sexual and reproductive health and rights agenda agreed upon in Cairo.
- We have political support—the countries most concerned, and their heads of government, reaffirmed their commitment on the 10th anniversary of Cairo.
- The MDG framework encompasses and can promote the ICPD Program of Action.
- We should hold this course.

Bearing these conclusions in mind, let me now turn to priorities for our unfinished reproductive health agenda. I see four: reproductive health and the MDGs; feminization of the HIV/AIDS epidemic; comprehensive sexuality education; and access to safe abortion.

1. First, reproductive health and the MDGs. Reproductive health is a vital foundation investment for achieving all of the MDGs. We are mobilizing and need to do much more to foster alliances across sectors to ensure that sexual and reproductive health and rights figure prominently in the draft global plan to achieve the MDGs. One can make

this case for all eight goals, but I would like especially to emphasize that combating HIV/AIDS, Goal 6, absolutely requires universal access to reproductive health—which leads me to my second priority for the unfinished reproductive health agenda.

2. Feminization of the HIV/AIDS epidemic. These days, evidence on increasingly widespread feminization of the HIV/AIDS pandemic is clear and frequently acknowledged. But action plans and policies have yet to be adopted. The Cairo agreements charted the course we need to take to prevent infection in the vast majority of girls and women, who fall outside the category of core group transmitters. A few salient facts:

- 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.
- Even in Brazil and Thailand, where the epidemics have stabilized in the past several years, evidence is increasing that wives and primary female partners, as well as young girls, are increasingly at risk.

And Nigeria and India will soon have feminized epidemics—unless we change our policy priorities.

The realities of girls' and women's lives that put them at such high risk of infection are the same realities addressed by ICPD. They include: marriage of young girls to older, sexually experienced men who bring infection to the marriage; transactional sex between young girls and older men outside of marriage; violence and sexual coercion inside and outside marriage; husbands who engage in extramarital affairs or visit commercial sex workers; taboos against giving girls factual information about sexuality and reproduction before and after marriage; and lack of condom use in marriage or long-term relationships.

The figures I recounted earlier make clear that the classic epidemiological strategies—outreach to core group transmitters; narrow HIV/AIDS messages that are only about the disease, not sexuality or power or relationships; condom promotion; blood safety; and protection of health workers—have not protected girls and women outside the core groups.

So 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.

We can best reach girls and women outside the core groups by investing HIV/AIDS resources in strengthening and expanding access to programs that girls and women use—namely, comprehensive reproductive health services. Unlike HIV-specific clinics and education programs, which are too often stigmatized, reproductive health services have established community support. They also have a head start of several decades on core staff and management capacities. Resources are needed, both to expand services to reach more girls and women, and to add HIV/AIDS capabilities to reproductive health services.

Reproductive health service providers will need to be trained 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 about their vulnerability; about ways to approach 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.

My third priority in the unfinished reproductive health agenda is:

3. Comprehensive sexuality education that promotes gender equality and human rights. Today's 2 billion young children and adolescents, the majority of whom live in poor countries, will largely determine the growth rate and ultimate size of the world's population, and it is they who are, or soon will be, at major risk of HIV/AIDS. If these young people do not receive adequate reproductive and sexual health care services and education now, if girls do not have equal access to schools, and if both boys and girls foresee a future of unemployment and poverty, both demographic momentum and the HIV/AIDS pandemic will surely continue into future generations.

Our most critical obligation is to help these young people grow up healthy and informed. Comprehensive sexuality education provides factual information, gives social support, and helps 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 of this standard, but the GPI program in Nigeria, and others like it, show the way.

My fourth priority for the unfinished reproductive health agenda is:

4. Access to safe abortion. This may sound crazy in light of this year's election outcomes, but it is not. A remarkable and significant number of countries are moving in the right directions and we must continue to help them to do so. We are working with advocates who work with their governments in more than 15 countries to, for example: ensure access for all women eligible under law; revise regulations and, in several countries, laws; and raise public awareness that unsafe abortion maims and kills.

These four priorities—reproductive health and the MDGs, feminization of the HIV/AIDS epidemic, sexuality education, and safe abortion—pose very substantial challenges. Keeping the Cairo promise, especially to women and the largest ever generation of young people, and achieving the MDGs, will require work with policymakers, and the demographers, epidemiologists, and economists who advise them, to think anew about the underlying dynamics driving population growth, persistent and widespread reproductive health problems, violations of sexual and reproductive rights, and the HIV/AIDS pandemic. It will require engaging 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.

Working together, I believe we can build a diverse and powerful coalition that together mobilizes more resources for sexual and reproductive health services, rights-based youth education programs, and HIV/AIDS prevention approaches that address the realities of girls' and women's lives. At the same time, together we can develop a stronger evidence base on the effectiveness of all these interventions.

Making this alliance will be challenging, at least as challenging as our work for the Cairo paradigm shift. But we must 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. The payoff will be huge—saving millions of lives, both now and in generations to come.

Thank you.