

## From population control to human rights

Women's health activist Adrienne Germain talks to Sarah Cumberland about the revolution that has changed the world's approach to reproductive health.

**Q: Why did you start your work in family planning?**

**A:** During the 1970s and 80s I spent a lot of time with women in Africa, Asia and Latin America. Fear of death in childbirth, child marriage, family violence, pain, poverty and resignation were common themes. Health information and services were woefully inadequate. I chose to work in family planning because it is a vital reproductive health resource and the only one that was available to poor women in developing countries.

**Q: Why were reproductive health services so poor in developing countries back then?**

**A:** Governments did not feel that reproductive health other than family planning was worth investing in. Data about women's reproductive health were sparse and maternal deaths were estimated, not counted, while morbidity was ignored. This neglect was based on the argument that preventing pregnancy was a better way to prevent these deaths than providing obstetric services. Sexually transmitted infections in females and induced abortion were subjects people refused to deal with, even though abortion, nearly always unsafe or fatal, was being used as a means of birth control. This was evident from the few statistics that were available and from my experience working with these women.

**Q: Can you recall an incident that illustrates the consequences of this neglect?**

**A:** One strong image illustrates the lack of services and basic human rights for women who had abortions. In Cameroon I visited a sparkling new maternity hospital on a hill. Down below, in what was often a sea of red mud, was a dilapidated building where women with complications of "backyard" abortions were often left lying by the door by family members too ashamed to be seen with them. Only one doctor worked there, in terrible conditions with almost no equipment or drugs. The women were put on rusty gurneys with a dirty sheet and, after treatment, housed in "rooms" the size of closets, each with three tiers of wooden shelves, not beds.



Adrienne Germain

Courtesy of Adrienne Germain

Adrienne Germain, President Emerita of the International Women's Health Coalition has worked for women's health and human rights for 42 years. Following 14 years with the Ford Foundation, including four as the country representative in Bangladesh, she led the Coalition's work on international health and population policy with local organizations in Africa, Asia and Latin America.

In one I saw one woman, "Rose", dying. The fancy maternity hospital on the hill could have saved her but refused to serve women who had had unsafe abortions.

**Q: In Asia in the 1970s, many countries had strong population control programmes that provided family planning services. Didn't women in these countries receive better care than women in countries where contraception was not supported by the government?**

**A:** While contraception was an essential and desired service, too little attention was given to service quality because the goal was to promote acceptance of contraceptives. In India, for example, a lot of intrauterine devices (IUDs) inserted during periodic "camps" were not fitted properly and led to unwanted pregnancies. The women involved often ended up having unsafe abortions because abortions were rarely available in health-care facilities, especially in rural areas, even though it had been legalized in 1972 for pregnancies up to 10 weeks. This is still the case in rural areas. Although abortion services are now more widely available in urban areas, especially from private, for-profit providers, low-income urban women must still resort to unsafe procedures. IUDs remain unpopular in India. Other contraceptive choices were very limited and services then, as now, were often poor, yet women were blamed for not wanting to use them. In Indonesia, contraceptive services were often delivered to villages by the military. Women were given no choice in contraception-related matters; they were not offered support or information on dealing with

its side-effects or guidance in choosing alternative methods. Again, the drive to increase acceptors trumped interest in service quality.

**Q: During the late 1980s, you witnessed a feminist revolution that differed from one in high-income countries during the 1960s and 1970s. What were these activists fighting for?**

**A:** This movement in developing countries had its roots in the fight for broader social justice. Many of the leaders had developed their political skills fighting against military dictatorships in Latin America or trying to eradicate poverty in Asia. They wanted women to be treated as human beings with sexual and reproductive rights. They knew that protecting these rights had to go hand in hand with work towards achieving gender equality and women's empowerment. They called for a change to the existing policy paradigm, from one centred on controlling population growth to policies centred on sexual reproductive health and rights from the perspective of the women themselves.

**Q: The United Nations International Conference on Population and Development, held in Cairo in 1994, changed governments' approaches to population and development. What did you and other activists at the conference ask governments to do?**

**A:** We called for good quality comprehensive sexual and reproductive health services, including contraception, safe abortion, maternity care, and diagnosis and treatment of sexually transmitted infections, bolstered

by comprehensive sexuality education and protection of human rights. We also called for better access to women's health services. Ultimately, the core tenets of this platform, which became known as "Reproductive health and justice: the Rio Statement" (because it was developed at a meeting in Rio), were adopted by 179 governments at the Cairo conference.

*Q: Can you give an example of a country that changed its national policy to reflect a rights-based approach to reproductive health?*

A: Bangladesh has had a very strong family planning programme in place since the early 1970s. Following the Cairo conference, the International Women's Health Coalition worked with government, civil society and donors to add obstetric services to the existing contraceptive and menstrual regulation services. Programmes were initiated for prevention of sexually transmitted infections including HIV [human immunodeficiency virus], reproductive health education for young people, and contraceptive information for newlyweds. Five years after the new National Health and Population Programme started in 1998, maternal deaths had fallen by nearly 25%. By 2008, they were down 40%.

*Q: What will help to bring about change in countries?*

A: A demand from the countries themselves will help bring about integrated sexual and reproductive health services, comprehensive sexuality education and protection of sexual and reproductive rights. Fortunately, a younger generation of activists with their own visions and skills is emerging. They are committed to action in their countries but need more support. The world should support these young people and foster their leaders.

*Q: As a member of the Global Task Force on Women and HIV and AIDS, what challenges did you want to see addressed?*

A: Despite all the attention and resources invested in HIV and AIDS, little progress has been made on integrating HIV services with other sexual and reproductive health services for women and girls. This failure, whose severe consequences for women and children are

known, motivated us to seek a paradigm shift in HIV policy. Again, we face a major political and practical challenge that involves making everyone, from researchers to advocates, understand that women's vulnerability to HIV stems primarily from our failure to protect their sexual and reproductive rights. Further, living with HIV is dramatically more difficult when services are not integrated. We've made the case over and over again: HIV belongs with sexual and reproductive health and rights. Finally, in December 2009 a global agenda for accelerated action for women and girls in the context of HIV was approved with sexual and reproductive rights at its core. However, much remains to be done at both national and international levels to transform this agenda into concrete, fully funded programmes.

**In 40 years I have never seen as strong a commitment to women's health.**

*Q: Why the widespread resistance to integrating HIV and reproductive health services?*

A: There are many reasons, including disease control models that emphasize risk, not vulnerability; competition for scarce resources; narrow disciplinary training that encourage health professionals to work separately rather than collaborate across subjects and services; and gender bias among others. Research shows that women's health has definitely suffered from the separation of HIV information and services from other components of sexual and reproductive health care. A clear example is the inability of most HIV services in sub-Saharan Africa to provide contraceptives, safe abortion, treatment and referral following sexual coercion or violence, or human papillomavirus (HPV) screening to women living with HIV. When people have to go to different places on different days to get different services, many can't or won't do so for good reasons and we lose opportunities to educate and to provide preventive services.

*Q: What sort of hope do you hold for women's health?*

A: In 40 years I have never seen as strong a commitment to women's health as we have right now at the global level. The United Nations Secretary-General and the President of the United States have both announced important initiatives for women's health. We've never before had such leadership. These major global health initiatives – the United Nations Global Strategy for Women's and Children's Health and the United States Government's Global Health Initiative – are highly conducive to progress. Their political weight bolsters other global initiatives and donors to finance and strengthen health systems with an emphasis on women and children. The UNFPA has new leadership and a revised strategic plan that focuses on integrated sexual and reproductive health services, as well as adolescent health and development, reinforced by promotion of gender equality and human rights. Many of the leaders behind these major global efforts are men. As more men in positions of importance (including ministers of finance) speak out and act, especially at the national level, progress will be faster.

*Q: Making political commitments is all very well but are politicians actually delivering?*

A: The rhetoric has improved, but most politicians act only in their interests and/or when they are pressed to do so. In most countries, women and children don't have a strong political voice, although in some they have gained considerable ground over the last decade or so. Health professionals have been less supportive than they should be and need to be educated about how the sexual and reproductive rights and health services approach will help them achieve their own goals. We must promote and applaud global champions such as those I've mentioned, as well as highly experienced and effective policy-makers and programme managers from countries that are making progress. We must invest in both local and international advocates whose main task today is to persuade those with power and resources to transform their rhetoric into action. ■