Keynote address at Plenary: "State Policy and Planning for Gendered Economic Security"

by Nafis Sadik, M.D.

UN Secretary-General's Special Envoy
for HIV/AIDS in Asia and the Pacific

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Gender, Poverty & Human Development

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Thank you for inviting me to speak today. You have called this meeting at a critical point in India's history, when it seems that sustained economic growth is a reality at last. But as we have already seen, the creation of wealth brings its own problems. Poverty is relative as well as absolute: economic growth as such offers no assurance that the poor will benefit. Wealth may widen gaps between rich and poor: economic growth may exclude specific groups, driving them even further into poverty. As the title of this summit reminds us, women and their children are most at risk.

There are many experts here to help in your discussions. I want to make only a few brief points:

First, inequality can be as pernicious as poverty itself. We live in a world where the three richest men are wealthier than the 41 poorest nations; where half the world exists on less than $2 a day, and where the number of the absolutely poor remains at 1.2 billion.

Conditions in India reflect and magnify these inequalities. According to the 2001 census and this year's Human Development Report, India has 16 per cent of the world's population but a third of the world's hungry; one in six of the world's women, but one in four of its maternal deaths.

Inequality has a specific gender dimension. Discrimination against women starts even before birth: it is distressing to learn that sex-selective abortion is widening the gap against women in India's gender ratio. Girls in India are still less likely to go to school than boys and they are much less likely to stay in school. Nearly half of India's women are illiterate compared with only a quarter of men. Women are still subject to violence in the home, ill-treatment in the workplace and harassment on the street; and women in many communities are still controlled as if they were children.

Discrimination extends to health care: India's maternal mortality rate is the second highest in the world, and family planning is available to only half of India's women. The move towards a totally voluntary

family planning programme is still not complete: while the Union Government has made great strides, policies such as excluding from the *panchayat raj* women with more than two children are coercive in effect. So is allowing service providers to set their own targets for new family planning acceptors: a quota is a quota, whoever decides the level. Poor women are especially at risk from coercive policies: we must insist on total respect for freedom of choice.

Sex-selective abortion, high maternal mortality rates, low literacy, sexual harassment and coercion in family planning are all manifestations of lack of respect for women. We must demand respect, and we must demand equality.

Second, exclusion is a particularly corrosive aspect of poverty. Poor women will do whatever they can to improve their condition: but today's complex world demands the ability to move outside one's community; not only money but training, skills, confidence; the very qualities that poor women lack. And at every point, the bonds of tradition; the expectations of families and communities; and their own modesty and misgivings, hold women back. The world is changing, but change often shuts out poor women.

And that brings me to my third point—only a community that includes everyone can ensure security and well-being for everyone, men or women; rich or poor; urban or rural.

The goal is completely practical. Some of the elements are already in place, in the form of the laws and constitution of this country and its component states. The aim must be to put flesh on the legal bones, to ensure that women have in practice the equality they are guaranteed by law. Other elements are still lacking—women lack guarantees of equal pay for equal work for example; they lack practical training to permit them to join in the technological revolution; they lack effective protection from harassment and sexual violence. I hope this session will illuminate some of these dark corners and show some ways to make progress.

I hope we will also note the great progress made by women, not only through the legal and administrative process but through their own economic efforts. The micro-credit movement shows what women can do for themselves, once a few of the major obstacles are removed. How much more could they do, if their efforts found encouragement rather than opposition!

I hope we will also remember that women's economic security begins with the social fundamentals – education and health care, including reproductive health. In this age of HIV/AIDS, women's health is more than ever at risk.

My final point is that India is not alone. International agreements on social development have identified gender equality and inclusion as development goals in themselves, as well as contributions to the broader goal of halving poverty by 2015.

During the 1990s the member states of the United Nations reached consensus agreements on many aspects of social development, including the environment, human rights, population, gender, and social cohesion. These agreements formed the basis for the Millennium Development Goals which world leaders adopted in 2000.

Each part of this agenda interlocks with the others. Achieving it calls for action by all nations and all segments of society. And action on the social agenda calls for parallel action on trade, debt and other economic issues, and for the necessary finance from all sources. Today we have an agenda for building a global community—the social counterweight to economic globalisation.

Social Investment Promotes Development

The experience of the last 30 years shows that economic security is based on social investment. Better primary health care and education, increase women's autonomy and widen their range of choice. Primary health care includes voluntary family planning – women in charge of their own fertility are closer to controlling their own lives and escaping from poverty. They also have smaller, healthier families.

These investments pay off in terms of economic growth. About a third of economic growth in South-east Asia can be attributed to lower fertility. Reproductive health is the point where development meets demography.

The returns on social investment far outweigh the cost. There are three distinct benefits:

- ***First, better health and higher literacy overall.*** **Health is the key to quality of life. Poor women themselves say that falling ill is their single biggest fear. A long illness or a bad injury to a wage earner can tip families into poverty and drive poor families into destitution. For women, infections and injuries associated with pregnancy and childbirth are the single biggest threat to their health. They need reproductive health care, including family planning, to avoid infection and unwanted pregnancy. Women need care in pregnancy, in childbirth, and very importantly, after childbirth. More than half of maternal mortality is the result of infection after giving birth. Literacy offers women especially the opportunity to control their lives and lift themselves out of poverty. Women with some education are much more likely to choose family planning. They and their families are more likely to be healthy;**

- ***Second, slower population growth.*** **When women can choose whether and when to become pregnant, they have smaller families, and population growth is slower. Countries then have a wider range of policy choices and more time in which to make them.**

- ***Finally,*** **lower fertility means a smaller group of younger dependents. For the same investment, countries can improve the quality of children's health care and education. More resources are available for other kinds of investment, and for creating the conditions for faster economic growth. This "demographic window" closes after a generation because of an increase in the proportion of older dependents who need care and services. But while it lasts it is a unique opportunity in a country's demographic history.**

The demographic window was the key to the economic success of the south-east Asian countries. India now has the same opportunity, because fertility has fallen to moderate rates in the last decade.

Investment in education, reproductive health, and gender equality starts to show its value immediately, in terms of fewer unwanted pregnancies and lower maternal mortality. In the longer term, it will pay off many times over, not only in economic growth overall, but in closing the wide gap between the richest and the poorest in society.

HIV/AIDS: the Threat to Women, the Threat to Development

Compared with the cost of other anti-poverty measures, social investments are very modest. They would command attention in any circumstances. But there is one factor that makes them essential – the growing threat of HIV/AIDS.

India is fortunate in that HIV/AIDS infection rates remain relatively low. Yet over 500,000 new cases were reported last year, and there is evidence that HIV/AIDS is breaking out from the high-risk groups into the wider community.

In many recent visits to Asian countries, including India, I still find the belief that so-called "Asian values" will somehow protect us. I am not sure what these Asian values are: as far as I know, HIV/AIDS passes from person to person in exactly the same way, whether you are Asian or African.

Asian values seem to imply that "our girls are not like that" or "India's wives are faithful to their husbands". Quite right – it is not India's women who are spreading HIV/AIDS, but India's men. In rural India almost 60 per cent of girls are married before they are 18. Nearly 60 per cent of married girls bear children before they are 19. If some of these girls are HIV positive, the husband is responsible. In the cities, young women marry later—but some are sexually active outside marriage. If they have the infection, a man has passed it on to them.

I am making no moral judgments here: I am making a realistic assessment, as a specialist in public health. And that is what we must do. Everyone must look clearly at the threat of HIV/AIDS, and accept their responsibility for preventing it. We simply have no time for hypocrisy: India faces impending disaster. Please remember that India's levels of infection today are as low as African countries' were, only 12 years ago.

There is no cure for HIV/AIDS and as yet no vaccine against it. Treatments are partially successful, and the manufacturers have greatly reduced their prices – but whatever the cost, drugs are out of the reach of most of India's women; and, on the scale needed, they are out of the reach of government health services.

The only way to stop the AIDS pandemic in India is to prevent the HIV infection spreading. This is a huge task, but there is a beacon of hope in the success of prevention efforts in such countries as Uganda and Thailand, and in some Indian states. We can discern three elements in a successful prevention strategy.

First is to reach out to high-risk groups: intravenous drug users; sex workers; people who have multiple partners, and men who have sex with men. We do not make judgements about their behaviour; but we recognise the part they play in spreading infection, and we try to mitigate it.

Second, we must not allow association with high-risk groups to stigmatise everyone living with HIV/AIDS. Removing the stigma of HIV/AIDS is the single most difficult obstacle to an effective prevention programme, but it can be done. It calls for leadership above all; a willingness to confront and openly discuss sensitive matters, such as sex among unmarried young people. Fully half of all new infections are among people 15-24. Young women are especially at risk—and marriage does not protect them. Our message must be that HIV/AIDS can happen to anyone. Everyone must understand the importance of responsibility for protecting themselves and those they love. Men must understand that women are not blame for the disease.

And we must promote and support women's power to speak out and to make their own decisions. Women run a higher risk of infection than men. Yet women lack the means to defend themselves. They cannot always refuse sexual contact. They often lack the power to negotiate the use of condoms, even with their own husbands. We must put in women's hands the means of their own protection and empower their use. We must educate women, and we must educate men to treat them as equals.

Countries must find their own ways to confront the HIV/AIDS pandemic. But the richer countries bear a heavy responsibility to help the poorer ones, and the poor within each country. I have to say that despite all efforts, the overall record of the richer countries in coming to the aid of the poorer ones is not good.

I hope this will change. Meeting the Millennium Development Goals, halving extreme poverty by 2015, building the global community, is a matter of altruism, of doing the right thing: but it is also a matter of security and self-interest. Poverty, gender inequality, poor reproductive health and the spread of HIV/AIDS threaten us all, wherever we live.

The Government's Role

There is much that women can do and are doing, to help themselves. But there are a series of tasks that properly belong to government:

- **to ensure education and health care, including reproductive health care, for all women and girls;**
- **to implement constitutional protections for gender equality, and press for new measures in the same spirit;**
- **to support and encourage women's efforts for greater economic power;**
- **to offer leadership and action in the fight against HIV/AIDS;**
- **to call on the international community to act in the global interest, and in particular to make good on their pledge to cut poverty in half by 2015.**

I hope this Summit will energise policymakers at all levels with a new sense of their responsibility; but also of the great rewards of successful action. I wish you a most successful session.