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**Reproductive Rights and Reproductive Health, with Special Reference to HIV/AIDS**

Mr. Chairman, Distinguished Delegates, Ladies and Gentlemen: It is a distinct honor to serve as a special discussant and I thank you for the privilege.

The Population Division's *World Population Monitoring Report* for 2002 focuses on reproductive rights and reproductive health and appears two years short of the decade anniversary of the landmark International Conference on Population and Development held in Cairo. The report makes a substantial contribution by empirically advancing our understanding of this population subarea. It summarizes recent information on the "behavioral epidemiology" of reproductive health, reviewing global trends in key events of the reproductive life cycle and examining the risks associated with adverse levels and outcomes. In particular, repeated exposure of individuals to the dual risk of unwanted pregnancies and sexually transmitted infection (STI) from unprotected sexual intercourse can be followed by harmful sequelae, such as unsafe abortion, life-threatening pregnancy complications, male or female infertility, HIV transmission to partners and newborns, and mortality.

This behavioral epidemiology seen in a single person's life course begins with his or her conception, when fetal nourishment is increasingly found to have lifetime consequences for cognitive development and healthy aging. It progresses into the individual's adolescent years when a healthy entry into sexual and reproductive life can be protected by adequate schooling, non-harmful rites of passage, nutrition, family life education, productive employment and a supportive communal and familial environment. Unfortunately a high percentage of youth in developing countries, who as a group represent some 40% of the population, do not experience these protections due to them from society. Once sexually active, the risk of unwanted conceptions and infections is present with each sexual encounter in the absence of effective measures, such as condom use, abstinence, or contraception. As sexual activity frequents our daily lives, lifetime exposure to such risks is high, especially in the young adult years. Except in a few countries, the *World Population Monitoring Report* shows that the total need for contraception is satisfied for less than half of couples and STI prevention is marginal. The annual worldwide incidence of STI at 340 million relative to the 2.4 billion or so who are sexually active suggests as many as 1 out of 7 will be infected in a given year. STIs, including HIV/AIDS, are often introduced to women by male partners. If positive cases go untreated and pregnancies subsequently occur, the man and woman are each individually exposed to significant morbidity risks, such as infertility and reproductive organ cancers, and for newborns, blindness and congenital abnormalities. Lifetime and recurring exposure to ST infection, unplanned pregnancy, as well as a number of other health assaults – malaria, tuberculosis, respiratory infection, and malnutrition – whose levels are unacceptably high in poverty-stricken areas – compromise the individual's right to a healthy existence and to enjoy his or her life relatively free of the burden of disease.

The behavioral epidemiology of reproductive health is not the exclusive property of females but applies to males as well. It represents a fundamental progression of life through entry into and exit from sexual and reproductive behavior that is treated with sanctity by nearly all cultures, societies, religions, communities and governments.

I detail the course of sexual and reproductive life to highlight two points that I wish to make. The first relates to the macro-level development implications of improved reproductive health and the second to the issue of national responsibility for the right to health--reproductive and otherwise.

In 1974, almost three decades ago, the first World Conference on Population was held by the UN in Bucharest, Romania, in which 135 countries participated. That Conference's historic legacy was to position population as an integral factor of social and economic development efforts. International policy discourse at Bucharest and the subsequent Mexico City population conference in 1984 continued to raise the spectre of population issues – their relevance, content and influence – as a macrolevel force. Population growth, composition, and distribution were examined in relation to economic development, social change, and environmental impact, with attendant policies focused on influencing the fertility and mortality transitions. Population policy, unfortunately, over time became synonymous with fertility management policy, and in terms of content viewed contraceptive service delivery programs as the policy instrument of choice, given the close empirical connection between levels of contraceptive use and fertility. Today the varying pace of fertility transitions in the developing and developed regions has generated a diverse set of associated demographic issues, including very young and very old age structures, rapid urbanization, and international and internal voluntary or involuntary population movement. The Cairo Conference was exceptional, however; it shifted the extant focus of global discourse to microlevel concerns for reproductive rights and to the relationship between reproduction and health. Unfortunately at that time there was little or no empirical basis to support the underlying tenets of reproductive health's relationship to national development. A large part of that empirical basis has been supplied today by the *World Population Monitoring Report*.

I have personally lamented the divergence between directions of population policy discourse at Bucharest and Mexico City and those of Cairo, enough to have mulled writing an essay as to whether in 2004 we will be at "Bucharest+30" or "Cairo+10", pluses being used frequently these days to signify presumed progress. My own frustration with the Cairo agenda has been its highly gendered and microlevel arguments. After much reflection, though, I would like to suggest to this distinguished audience that Cairo+10 is in fact Bucharest+30. By this I mean that the global community increasingly believes that investing in health is an investment in development. Poor health outcomes are strongly correlated with poverty (Subramanian et al., 2002). The two conditions are reinforcing and reciprocal, where countries burdened by disease tend to have low and unstable economic growth. Income inequality is also associated with health inequalities, both across and within populations. The WHO (2000) and World Bank have emphasized this connection in their disease- and poverty-reduction efforts, advocating policies aimed at improving health and strengthening health systems through implementation of essential health packages, that include sexual and reproductive health care. The embracement of reproductive health care as a component of

essential health services in the context of poverty reduction reflects commitment to investing in health as a means to improving human capital and economic welfare. The connectivity between the micro aspects of reproductive health and the macro issues of development is now established. The WHO *World Health Systems Report*, the World Bank's *Poverty Reduction Strategy Papers* and the UN's *World Population Monitoring Report* offer a trilogy of knowledge and insight that instates population health, and its reproductive dimension, as a macro force essential for human and national development. We should not forget the demographic bonus, the consequence of fertility transitions as occurred in Asia and the West, accelerated by the expansion of and access to contraceptive services.

Economist and philosopher, Amartya Sen has argued that the process of development should be conceptualized in terms of people's ability to do or be, placing the notion of human freedom at the center of the development agenda (1999). Positive freedom is what a person can actually do. Whether for man or woman, positive reproductive freedom is the person's ability to actualize his or her reproductive goals. Good health, Sen proposes, is the freedom from premature mortality and morbidity. Reproductive rights might be interpreted in this developmental context.

The liberalist tradition of international relations (Mearsheimer, 2001) provides the rationale for today's 35<sup>th</sup> Population Commission and other UN assemblies, viewing nation states as operating and cooperating optimistically with each other for a larger common good.. The liberalist perspective suggests nation states have and can exercise the responsibility to develop the capabilities of their populations and in this regard, enable their rights to health.

Four days ago on March 28th, the government of Malawi disseminated its first Reproductive Health Policy (February 2002). The policy supports comprehensive reproductive health care, addressing each event in the behavioral epidemiology sequence. Developed as "an integral part of the national development policy", the document identifies reproductive health as a major component of the government's poverty reduction plan. My suggestion to this distinguished audience is that Malawi, an impressively poor and disease-afflicted country, has managed to connect the micro to macro concerns of reproductive health and national development. I am confident that other governments represented here have or will soon follow this course of legislation. Reproductive health and rights is about human development and freedoms.

Thank you for your attention.

## REFERENCES

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