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As the HIV Epidemic among Young Women Grows, Can We Look to the SDGs to Reverse the Trend?

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Abstract

To end the growing HIV epidemic among young women, human rights violations must be addressed. The Sustainable Development Goals have the potential to help, but only if political barriers are overcome and a rights-based approach is integrated.

Introduction

We have long known that biomedical interventions alone will not curb the HIV epidemic among young women and girls in sub-Saharan Africa. The history of the global response to HIV is ripe with political failures to address deep-seated human rights violations. Gender inequality—which ranges in its manifestations from persistent failures to recognize the sexual and reproductive health and rights of women to economic injustices perpetuated through law—allows HIV to flourish among young women and girls. This correlation between human rights violations and poor health outcomes for women and girls was not addressed by the Millennium Development Goals (MDGs), which were aimed at eradicating poverty and did not adequately measure the drivers of HIV among young women. The promise of the Sustainable Development Goals (SDGs), in this respect, is to reduce the interrelated factors that cause or contribute to gender inequality, while also reducing gender inequality's impact on health and HIV.

This paper attempts to interrogate the promise of the SDGs, specifically SDG 5. SDG 5 presents us with an opportunity to better address the challenges that contribute to women's and girls' vulnerability to HIV, for by zeroing in on these

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indicators through a legal framework, we can generate action and accountability around the human rights of young women and girls.

The paper also describes our experience developing a proposed methodology for SDG indicator 5.6.2. This indicator—which measures the number of countries that have laws and regulations guaranteeing access to sexual and reproductive health care, information, and education for women and girls—is unique in that it represents the first attempt to measure the number of countries in compliance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action. As such, it presents an opportunity to better address the challenges that contribute to young women's and girls' vulnerability to HIV by zeroing in on the existence of laws and policies that directly or indirectly affect the health of this population. This has the potential to generate action and accountability by states and other relevant actors vis-à-vis young women and girls affected by HIV—assuming that the process is not hampered by methodological flaws.

We begin with a discussion of the environmental factors that enable the spread of HIV among young women and girls in sub-Saharan Africa. We then briefly discuss the missed opportunities associated with the MDGs. Next, we show that the human rights framework is critical to the promise of advancing the sexual and reproductive health of women and girls, before moving on to a lengthier discussion of the SDGs, particularly SDG indicator 5.6.2. We conclude with a discussion of the political dynamics of the SDG process and proposals aimed at securing comprehensive and accurate data on the indicators.

Factors that drive the HIV epidemic among young women and girls

The HIV epidemic has been devastating for young women and girls. The root causes of this devastation are complex, multifactorial, and interrelated—and include converging epidemics such as sexually transmitted infections (STIs), sexual and physical violence, and drug addiction, as well as more macro-level issues such as economic injustice, structural inequalities, inadequate political participation, and the widespread failure to recognize and protect reproductive rights. For example, in the early years of the United States' HIV epidemic, women and girls living with HIV were overlooked and neglected both politically and medically; the situation improved only after prolonged advocacy efforts.[1] In other parts of the globe, health systems have frequently violated women's rights rather than addressing their needs, with coercive practices such as forced sterilization and abortion documented in Kenya, South Africa, China, and Cambodia.[2]

This is all the more tragic because the burden of HIV, particularly in sub-Saharan Africa, falls disproportionately on young women and girls, who not only have greater biological vulnerability to the disease but are also affected by a lack of access to preventive and medical services, as well as by the relative powerlessness that stems from restrictive gender norms and diminished legal status. Moreover, as the global epidemic has progressed, its toll on young women has become particularly apparent. In 2015, UNAIDS estimated that 2.3 million women between the ages of 15 and 24 were living with HIV worldwide—making this population 60% of all young people (aged 15–24) living with HIV. This trend can also be observed in new infection rates, which are particularly dire in sub-Saharan Africa: in 2015, women accounted for 56% of new infections among adults 15 years and older, with women aged 15–24 making up 66% of new infections among young people.[3] The remainder of this section provides a brief overview of the overlapping inequalities that drive the HIV epidemic among women and girls.

Gender inequality and its effects on economic security, educational access, and health

Despite the widespread ratification of international treaties and conventions that promote gender equality, gender inequality persists in sub-Saharan Africa and around the world. This has obvious economic ramifications—for example, the gender wage gap in sub-Saharan Africa is among the highest in the world, and women hold diminished status in many economies in this region.[4] While this alone increas-

es the vulnerability of women and girls by making them dependent on male relatives for financial support, its impact becomes even more severe when one considers the ripple effects on educational access. Education is important: not only do women with higher educational attainment tend to delay sexual debut and marriage, but increased educational attainment is also linked to increases in self-efficacy, economic stability, and negotiation of safe-sex practices.[5] And because all of this is considered protective against HIV, the fact that many families from the low-income states of sub-Saharan Africa do not have the financial means to send their daughters to school is troubling from a health perspective.

There is also an endogeneity effect at work: women's unequal status in the labor market relegates them to caregiving work (also considered their traditional role in some states), but the HIV epidemic has now made the burden of caregiving so great that its physical, social, and psychological impacts make women more vulnerable to HIV. Women and girls account for 66–90% of all AIDS caregivers worldwide and two-thirds of all caregivers for people living with HIV in southern Africa—with the burden of this caregiving exacerbated in rural and resource-poor settings.[6] The effects of this distribution of care work are tremendous: young girls who may otherwise have been fortunate enough to attend school are now often absent because they are needed at home; when the economic demands of caregiving become particularly acute, some of these girls may resort to work outside of the formal economy in order to provide for their families. Still others may turn to sex work or transactional sex, placing them at an even higher risk of contracting HIV.[7] In this way, then, the severe burdens of caretaking can themselves contribute to propagating the epidemic.

Gender inequality and its more direct effects on women's health

Gender inequality also has more direct effects on health, with one of the clearest examples being the pervasive problem of violence against women and girls. According to the World Health Organization, approximately 35% of women worldwide report having experienced sexual or physical violence over the course of their lifetimes, and about one-third of women in relationships report that their partner physically or sexually abuses them.[8] Regularly experiencing violence decreases women's ability to negotiate safe-sex practices and seek HIV testing or counseling—and, unsurprisingly, studies in India and Tanzania have shown an association between intimate partner violence and the prevalence of HIV infection among women (though it is important to note that other studies have demonstrated that this finding holds true only in some settings).[9] In addition, many women who are HIV positive are reluctant to disclose their status to their partners for fear of reprisals.[10]

Various studies demonstrate additional connections between gender inequality and women's health. For example, a recent study in Tanzania demonstrated that some men's perception of women as sexual objects encouraged them to demand sex from their wives, while frequently engaging in extramarital sex—behaviors that put married women at increased risk of contracting HIV from their husbands.[11] Moreover, the same norms that encourage sexual submission in women also result in women having less autonomy to mediate safe-sex practices—and this dovetails in unfortunate ways with reliance on male-controlled prevention methods such as condom use.[12] Only recently have promising advances been made in the field of microbicides, which have the potential to become an effective female-controlled prevention strategy.[13]

Gender inequality in health systems

When health systems reflect prevailing gender norms, this creates further inequities. This can be seen in a number of contexts, including in the mistreatment that women experience during facility-based childbirth (a consequence of, among other things, the insidious ways in which patriarchal norms contort the doctor-patient relationship).[14] But for our purposes, it is most clearly illustrated by the practice of coerced sterilization, which is typically justified by either the prevention of vertical transmission or the discriminatory belief that women with HIV are unfit to be mothers.

These kinds of rights violations have been documented in Namibia and South Africa and tend to affect women who are marginalized and living in places with weak or nonexistent surgical consent laws. Common practices include sterilizing women who are undergoing other procedures, requesting their consent during labor, obtaining consent from male relatives, withholding treatment until consent is given, and offering cash or nutrition in exchange for undergoing sterilization. In some settings, women are also subject to breaches of confidentiality (for example, disclosure of their HIV status to governmental authorities) and to open hostility from health care workers, who are rarely held responsible for their actions.[15]

While these are some of the most dramatic examples of health system failures, there are other, subtler examples as well, including an overemphasis on programs designed to prevent mother-to-child transmission of HIV. These programs have been extremely successful at preventing vertical transmission but often neglect the health care needs of women living with HIV, especially once the window for vertical transmission has closed. Nor are these programs immune to the problems discussed above, as they, too, often undermine women's rights by failing to respect confidentiality, obtain informed consent, or provide adequate medical treatment.[16]

In a broader sense, these kinds of health system failures—which are not only failures of care but also acute human rights violations—reinforce the need for states to adopt laws and regulations that safeguard the sexual and reproductive health and rights of women.

The promise of international human rights in advancing the sexual and reproductive health of women and girls

Ensuring the realization of sexual and reproductive rights is a fundamental aspect of achieving sustainable development. Sexual and reproductive rights are grounded in a constellation of fundamental human rights guarantees, including the rights to life, health, privacy, information, freedom from discrimination, and freedom from cruel, inhuman, and degrading treatment, among others.[17] These rights are found in national laws and constitutions, as well as in foundational and universally accepted human rights documents; they are also defined and expanded on in later international and regional human rights treaties, interpretive statements, and political consensus documents.[18]

Global and regional human rights treaties—including the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa—provide for specific protections of the human rights of women and girls. Further, a series of documents adopted at United Nations (UN) conferences, most notably the 1994 ICPD Programme of Action, link governments' duties under international treaties to their obligations to uphold sexual and reproductive rights.[19] Under international human rights law, states are required to take steps to progressively achieve the full realization of the right to sexual and reproductive health. As highlighted in the Committee on Economic, Social and Cultural Rights' General Comment 22, "States parties must move as expeditiously and effectively as possible towards the full realization of the highest attainable standard of sexual and reproductive health … using all appropriate means, particularly including, but not limited to, the adoption of legislative and budgetary measures."[20] States are obliged to ensure that laws and policies are in place to guarantee access to sexual and reproductive health and rights. There is, therefore, a direct connection between human rights law and what SDG indicator 5.6.2 seeks to measure: laws guaranteeing access to sexual and reproductive health care.

The Beijing Platform for Action builds on the 1994 ICPD consensus, which was agreed on by 179 states and renewed most recently at ICPD+20, in 2014.[21] The Beijing Platform for Action guarantees women the right to sexual and reproductive health services and information and, in its robust description of what that entails, defines a baseline of adequate sexual and reproductive health care,

information, and education. The Beijing Platform for Action also aims to improve women's sexual and reproductive health and education through a number of recommended policy changes, including increases in the education and training of women; increases in women's access to appropriate, affordable health care services and information; and initiatives to improve women's STI and HIV care and education.

These international consensus documents and subsequent jurisprudence and commentary from human rights mechanisms have elucidated the parameters of the right to sexual and reproductive health care, education, and information. This right extends throughout the woman's life cycle—including in connection with pregnancy and childbirth, contraception and family planning, abortion and post-abortion care, comprehensive sexuality education, and sexual health and well-being.

Notably, UN treaty monitoring bodies—which are committees of independent experts appointed to monitor states' implementation of the core international human rights treaties—have developed strong human rights standards on women's and girls' right to safe pregnancy and childbirth, situating it within the rights to life, health, equality and non-discrimination, and freedom from cruel, inhuman, and degrading treatment. This guarantee encompasses women's rights to the full range of services in connection with pregnancy and the postnatal period, as well as the ability to access these services free from discrimination, coercion, and violence.[22] Additionally, women and girls must be able to exercise reproductive autonomy in determining the number and spacing of their children, have adequate information about maternal health care, and be empowered to utilize maternal health services.[23] As a result, states have a duty to prevent and address maternal and perinatal mortality by guaranteeing antenatal, perinatal, and postpartum care; combat early and high-risk pregnancy and early marriage; provide prevention services, testing, and treatment for HIV/AIDS during pregnancy; and ensure access to education and employment for pregnant women and girls, while also ensuring access to infertility information and services to all women.[24]

Moreover, human rights treaty monitoring bodies have consistently found that women and adolescents have the right to access contraceptive information and services and have recognized the correlation between the unmet need for contraception and high rates of teenage pregnancy, abortion, and maternal mortality.[25] These bodies have also noted the obstacles to ensuring women's access to contraception information and services, including unaffordability, third-party authorization requirements, and restrictions on access on the basis of marital status or age.[26] They have recognized that these barriers amount to potential violations of the rights to non-discrimination and health and have mandated that states ensure women's access to a full range of high-quality contraceptive and family-planning information and services.[27]

The right to abortion requires states to guarantee access to safe and legal abortion information and services, including post-abortion care. Treaty monitoring bodies have consistently recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality.[28] As a result, they have called on states to decriminalize abortion, at a minimum, in circumstances in which pregnancy poses a risk to a woman's life or health, is the result of rape or incest, or involves severe fetal impairment.[29] Moreover, they have recognized that bans on abortion are incompatible with human rights guarantees.[30] Additionally, treaty monitoring bodies have indicated that legal abortion services must be accessible in practice and that the denial of such services or the imposition of barriers to access undermines women's reproductive autonomy and can amount to violations of the rights to health, privacy, non-discrimination, and freedom from cruel, inhuman, and degrading treatment.[31] In this light, they have urged states to establish clear guidelines that indicate the conditions under which abortion is legal and to eliminate barriers to access, including third-party authorization requirements (such as spousal consent), mandatory waiting periods, and biased counseling requirements.[32] Moreover, states should regulate conscientious refusals of care to ensure that they do not limit women's access to reproductive health

services and should ensure that such refusals can be invoked only by individuals and not institutions.[33] Treaty monitoring bodies have also indicated that states must guarantee the availability of confidential and adequate post-abortion care and must ensure that such care is not conditioned on the patient's admitting to having procured abortion services illegally (which can later be used to prosecute the patient). Such circumstances may amount to cruel, inhuman, and degrading treatment.[34]

Comprehensive sexuality education—which includes education about STI and HIV prevention—is embedded in these foundational rights. Notably, the right to health requires states to remove all barriers interfering with access to health education and information, including all barriers to sexuality education, such as parental consent requirements.[35] UN treaty monitoring bodies have recognized that sexuality education contributes to the prevention of HIV/AIDS, teenage pregnancy, unwanted pregnancies, abortions, and maternal deaths.[36] They have also established that states should ensure adolescents' access to information on sexual and reproductive health by implementing sexuality education programs in schools, as well as in other settings in order to reach children who are not in school.[37] Additionally, treaty monitoring bodies have indicated that sexual and reproductive health information should be comprehensive and scientifically accurate.[38] Notably, sexuality education programs should include information on preventing unwanted pregnancy, sexual and reproductive health and rights, the risks of unsafe abortion, the legality of abortion, and the prevention of STIs, including HIV.[39] They should also aim to transform cultural views and taboos about adolescent sexuality and gender equality and should address other topics relating to sexual and reproductive health and well-being.[40] Related to the SDGs on health (SDG 3) and education (SDG 4), comprehensive sexuality education is critical because it allows individuals to make informed decisions relating to reproduction and sexuality, enabling their autonomy.

Moreover, human rights standards indicate that adolescents and youth are entitled to special measures of protection to ensure that they are able to exercise their human rights, including their sexual and reproductive rights.[41] The Convention on the Rights of the Child acknowledges that adolescents have the evolving capacity to make decisions about their own well-being, and adolescents with the capacity to make intelligent decisions about their health must be given the autonomy and "freedom to seek, receive and impart information and ideas of all kinds."[42] The convention avows that states should grant children the right to consent to sexual health interventions—including education and services for STIs and HIV, contraception, and safe abortion—without parental guidance; these commitments have recently been reaffirmed in the Committee on the Rights of the Child's General Comment 20, which discusses the evolving standard for consent in matters related to adolescent health.[43] Moreover, human rights treaty monitoring bodies have called on states to ensure adolescents' access to sexuality education and information, eliminate third-party consent requirements in connection with sexual and reproductive health information and services, remove laws criminalizing consensual sexual behavior between adolescents, and prohibit harmful traditional practices that affect the right to health, such as female genital mutilation and early marriage.[44]

Taken together, the multitude of treaties and documents guaranteeing sexual and reproductive rights also protects the right to enjoy sexual experiences autonomously and free from coercion. This includes freedom from gender-based violence. The interconnectedness of violence and sexual and reproductive health is addressed in both the ICPD Programme of Action and the Beijing Platform for Action, the latter of which affirms the right to make reproduction-related decisions free from discrimination, coercion, and violence.[45] Measuring the degree to which UN member states have incorporated policies against gender-based violence into law is crucial for determining the level of sexual and reproductive health guarantees for citizens. Together, these norms and principles provide a framework on which to anchor the vision and goals for global development. SDG indicator 5.6.2

measures the number of countries with laws that guarantee access to these defined rights.

The Millennium Development Goals and women's rights: A missed opportunity

As things stand now, it is clear that global efforts to measure progress on women's rights have shed little light on the mechanisms driving the current HIV/AIDS epidemic among young women and girls in sub-Saharan Africa. At the Millennium Summit in 2000, UN member states developed eight quantifiable and time-bound targets—the MDGs—to operationalize the Beijing Platform for Action and related UN General Assembly commitments. These targets were developed to drive and measure progress at the national level.[46] MDG 3 focused on gender equality and women's empowerment but was mainly measured by gains in enrollment in primary education and the number of women holding elected office; it made no attempt to measure violence against women or address discriminatory laws.[47] Similarly, MDG 6, which focused on HIV/AIDS, malaria, and other diseases, pledged to halt and start reversing the spread of HIV/AIDS by 2015; to achieve, by 2010, universal access to HIV/AIDS treatment for all those in need of it; and to halt by 2015 and start to reverse the incidence of malaria and other major diseases. The only three indicators related to adolescence were to reduce HIV prevalence among populations aged 15–24 years; increase condom use during sexual intercourse with non-regular partners; and increase the proportion of the population aged 15–24 with comprehensive correct knowledge of HIV/AIDS. Overall, then, the MDGs did nothing to support collective efforts to close the glaring gap around adolescent data on health or the structural drivers of HIV in young women and girls.

The MDGs measured complex, interrelated issues (such as HIV and maternal and child health) as separate "silos," while failing to address other areas, including universal access to sexual and reproductive health.[48] They did not measure human rights advances or violations, or the effectiveness of governance and accountability measures in ensuring progress.[49] Nor did they adequately measure inequalities: child mortality and maternal mortality targets and indicators measured average reductions and not quintiles, despite the fact that measuring the latter would have revealed the overarching failure to improve the situation of women in the fourth and fifth quintiles in any context.[50] Despite the mobilization they generated at the time, the MDGs represented a disregard for the lived experience of the most disadvantaged. Donor, outcome-based programming resulted in incentivizing health services only for those who were less marginalized and easier to engage.[51]

The Sustainable Development Goals: Will they do better?

After the expiration of the MDGs, the international community sought to adopt a more comprehensive set of goals. UN General Assembly Resolution 70/1, entitled Transforming Our World: The 2030 Agenda for Sustainable Development, sets out 17 goals and 169 targets over the next 15 years to achieve sustainable development.[52] The 2030 agenda's vision of sustainable development, and the actions required to achieve it, are grounded in universal respect for international law, human rights, the rule of law, justice, gender equality, and the empowerment of women and girls.[53] The agenda emphasizes the responsibilities of states, in conformity with the UN Charter, to respect, protect, and promote human rights and fundamental freedoms for all, without distinction as to race, color, sex, language, religion, political or other opinion, national or social origin, birth, disability, or other status—and recognizes that gender equality and the empowerment of women and girls will make a crucial contribution to progress across all goals and targets.[54]

The global indicator framework. In line with the agenda, the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (IAEG-SDGs) developed 230 global indicators to assist in measuring progress in the implementation of the SDG targets.[55] The indicators were considered at the 47th session of the Statistical Commission, which

convened in March 2016. During the session, the commission also recognized that the development of the indicator framework is a technical process that will need to continue over time, making use of expertise in related fields.

The tier system. In its report to the Statistical Commission, the IAEG-SDG proposed that the global indicators be grouped into three "tiers," based on their level of methodological development and the overall availability of data. Tier I indicators would be those for which an established methodology exists and data are widely available; tier II indicators would be those for which a methodology has been established but data are not easily available; and tier III indicators would be those for which an internationally accepted methodology has not yet been developed.[56] During the 48th session of the Statistical Commission, the IAEG-SDG reported on progress made in developing the global indicators, as well as plans to develop methodologies for tier III indicators (including work on definitions and standards), to be agreed on at the international level to guarantee international comparability. UN Women and the World Health Organization then sought experts to help develop the methodology for SDG 5. At the time we became involved in this process (and at the time of writing), SDG 5 was a tier III indicator.

SDG 5. SDG 5 aims to achieve gender equality and empower all women and girls. Its nine interrelated and mutually supportive targets are in service of this goal. These gender equality objectives also underpin the SDG Declaration and all other goals and targets, which place the elimination of inequality and discrimination at the center of the development agenda.[57] (See, in particular, SDGs 3, 4, 10, and 16—though it is important to note that there are inter-linkages and synergies among all the goals and targets, which are global in nature and universally applicable.[58]) It should also be noted that while SDG 3—which is to ensure healthy lives and promote well-being for all at all ages—is clearly relevant to the struggle against HIV, achieving SDG 5 is no less crucial to preventing the spread of this disease. As discussed at length above, gender inequality contributes, in many overlapping ways, to the spread of HIV in sub-Saharan Africa; this linkage makes it abundantly clear how much is at stake, in health terms, in empowering women and girls.

Target 5.1 of SDG 5 is to "end all forms of discrimination against all women and girls everywhere." The indicator proposed by the IAEG-SDG to track progress in the implementation of this target over the next 15 years is "whether or not legal frameworks are in place to promote, enforce, and monitor equality and non-discrimination on the basis of sex."[59] As noted above, gender discrimination and acute human rights violations also occur within health systems, making this focus on legal frameworks equally vital for the sexual and reproductive health of women.

Indicator 5.6.2 attempts to address this by aiming *to increase the number of states with laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information, and education*. Because of our expertise in sexual and reproductive health and rights and HIV, we agreed to work on the methodology for this tier III indicator.

Indicator 5.6.2 is integral to the achievement of all of SDGs. The principle of universality within the 2030 agenda calls on states of all income and development levels to take action to achieve sustainable development and, in so doing, address issues ranging from poverty and hunger to climate change and inequalities—both within and beyond their borders.[60] Without laws and regulations that guarantee access to sexual and reproductive health services, information, and education, this commitment will remain unmet. It is clearly critical to the elimination of HIV/AIDS in women.

Target 7 of SDG 3, the health and well-being goal, mandates that states ensure universal access to sexual and reproductive health care services, including for family planning, information, and education, and also requires the integration of reproductive health into national strategies and programs.[61] The health goal also includes targets related to maternal mortality, HIV/AIDS, and harmful practices such as genital mutilation and

child, early, and forced marriage (targets 3.1, 3.3, and 3.7, respectively). SDG 4, on education, requires that education promote gender equality, that all girls complete primary and secondary education, that women have equal access to tertiary and vocational education, and that states eliminate gender disparities in education (targets 4.7, 4.1, 4.3, and 4.5, respectively). Reproductive and sexual rights are necessary components of these objectives as well.

All of that being said, in developing a methodology with which to measure laws and regulations, we must pay special attention to states with plural or multiple legal systems that allow various sources of law to govern simultaneously.[62] Plural legal systems may include customary law, religious law, and tradition or practice. Customary and religious laws enjoy the status of binding sources of law or practice in the vast majority of countries in Africa, and in a number of countries in Asia and the Americas as well.[63] Legal pluralism can, in certain circumstances, permit religious, traditional, and customary law or practice to contradict national or civil law. Of course, common and civil law can also be discriminatory. States avoid compliance with international law in various ways, including reservations to international conventions or the failure to domesticate international law. States may also enact constitutional protection for plural legal systems. For example, national legislation may set the age of marriage at 18, while constitutionally protected religious and customary laws may set lower age limits. We therefore included questions in our methodology—discussed in more detail below—intended to capture these legal loopholes. There are also some countries with gender discrimination in civil or national law related to marriage, adoption, and inheritance.[64]

As noted by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), launched by the UN Secretary-General in 2015 to create a roadmap for achieving the health-related SDGs, it is critically important for us to develop a methodology that can effectively measure member states' legal commitments to guaranteeing sexual and reproductive services and education.[65] While a number of sources and databases exist to measure individual components of sexual and reproductive health care within states, few have built-in engagement with states—meaning that most existing sources would be inadequate without substantial revisions to, and expansions of, their data collection processes. Although country-level research on the components of SDG 5.6.2, validated by qualitative interviews and analysis of law and policy, might be the soundest approach, the SDG process has limited financial resources and requires that member states buy in to the methodology. A survey that can be administered to member states in a timely way and that provides usable and reliable results may therefore be the most acceptable method by which to track SDG progress. We were asked to develop such a survey while simultaneously exploring other paths. In the following section, we discuss the survey methodology we proposed to effectively measure these outcomes among member states.

Our proposed methodology for SDG indicator 5.6.2: The number of countries with laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information, and education

Our work in developing a methodology for indicator 5.6.2 revealed the challenges of integrating a rights-based approach into the SDGs. The process was hampered by weak and ineffective coordination and collaboration mechanisms among the UN agencies responsible for developing indicators—and there was also an overemphasis on "silo-ing" these SDG indicator development processes, despite the avowed inter-relatedness of the SDGs. Similarly, despite the obvious need to incorporate human rights standards into the indicators, there was a clear preference for measuring procedural guarantees rather than implementation or access (indicator 5.6.2 was confined to measuring the existence of laws and regulations rather than evaluating their implementation in practice). These limitations were communicated to us by UN representatives, who cited limited resources, a lack of cooperation from other UN agencies, and the likelihood that

too onerous a methodology would be rejected by member states.

More specifically, there was also a strong preference by UN representatives for a "yes/no" survey administered only to member states. This was problematic on at least two levels. First, a binary survey instrument of this kind—while simpler to administer and methodologically more sound in terms of data analysis—is constitutively incapable of capturing the breadth and complexity of the issues at stake and cannot yield adequate or accurate information. This is particularly true in this indicator's case, given the lack of operationalization of key terms (for example, "regulations," "guarantee," "address"), the politicization of crucial information (for example, the unwillingness to include information about abortion), and other serious validation challenges. Second, the richest source of information on how states are complying with the international standards addressed herein is not the states themselves but reports and commentary by human rights bodies and civil society organizations. The myriad ways that member states avoid compliance with laws guaranteeing access to sexual and reproductive health care, information, and education can be discovered in treaty body comments and questions, as well as in the concomitant shadow reports prepared by members of civil society. Excluding these voices from the reporting process, we argued, would be a serious mistake.

We sought to propose a more effective strategy for compiling and validating data—and, in so doing, made several recommendations, including for an expert panel and the inclusion of voices from civil society. Our original questionnaire—which covered the breadth of ICPD issue areas (including implementation)—was quickly deemed unmanageable by UN representatives. They stated that member states would reject the indicator if we pressed forward with a "burdensome" process. By the time we had finished our work, the UN questionnaire had been reduced to five issue areas: (1) pregnancy/childbirth, (2) contraception/family planning, (3) abortion, (4) sexuality education/information, and (5) sexual health/well-being (all of which, it should be noted, are clearly relevant to the ongoing struggle against the HIV epidemic in sub-Saharan Africa). Other, more specific questions about HIV were deemed to be already covered by other SDGs, despite our stated concern that other indicators did not take into account the existence of relevant laws. Our questions on marginalized and vulnerable groups, adolescents, and gender-based violence were cut. We argued strenuously for the inclusion of questions examining the status of ratification of relevant rights treaties, as well as relevant observations and commentary.

To ensure the reliability of the survey across states, we recommended that staff with comparable positions in similar government entities provide answers to the questions. UNFPA would identify categories of country-level staff appropriate for survey completion and do the same for nongovernmental organizations and civil society groups on the ground. Then, UNFPA staff would administer the survey, working in conjunction with country-level staff and civil society groups to provide complete answers. In order to accurately assess validity, we proposed an expert panel like the one that has been established for the Global Strategy for Women's, Children's and Adolescents' Health to further the 2030 agenda.[66] In that case, the World Health Organization set up a nine-member panel whose participants represent diverse regions and backgrounds—ranging from human rights to humanitarian work to statistics—to "monitor and review" progress in connection with the Global Strategy for Women's, Children's and Adolescents' Health. We suggested establishing an analogous panel here that includes a similarly diverse group of experts on sexual and reproductive health, information, and education, all of whom are knowledgeable about human rights standards. This expert panel would assess the validity of the survey's content and review all questions for clarity before the administration of the survey.

To measure "construct validity"—or the extent to which the results of the study are found to be consistent with existing data—the expert panel, in conjunction with UNFPA staff, would also

compare findings from the survey with existing data from states. For example, spikes in adolescent maternal mortality might correspond with regions governed by plural legal systems. Additionally—given that many states have a patchwork of laws and regulations on sexual and reproductive health issues, which can be confusing and contradictory and which may prevent clear or accurate answers to the questions in the survey—civil society groups would also participate in the survey.

Though there are existing data sets that match sections of our survey, nothing exists that comprehensively covers the substance of this indicator. This survey would therefore represent the "gold standard" of what a state would need to do to achieve progress on the target. In the survey analysis, a grading system would be established based on this "gold standard," and each state would be assigned a grade representing its level of compliance with the human rights obligations connected to this indicator. The expert panel would also assess whether the state took the necessary measures to ensure compliance; this assessment would include a review of any concluding observations, decisions, communications, reports, and recommendations issued by UN and regional treaty monitoring bodies. The "gold standard" would be satisfied if the state can provide evidence that it has taken all necessary measures to address the concerns raised by UN and regional human rights bodies.

We exited the indicator's development process toward the end of 2016. We understand that the indicator is still tier III, that boys and men have been added, and that there are now 33 questions in the survey. We also understand that UNFPA is piloting the survey through six of its offices. The process, however, taught us about the tensions between the SDG objectives and reality, particularly in the realm of human rights. The historic inclusion of an SDG indicator to measure the existence of legal protections is a step in the right direction; however, the methodology, as it currently stands, might weaken the reliability of the results. Every component of this proposed indicator refers to an important dimension of the human rights and future of young women and girls affected by HIV. Without the guarantees this indicator seeks to measure, we will not stem the epidemic of HIV among young women and girls.

Conclusion

The HIV epidemic has been devastating for women and girls—and, as things stand now, global efforts to measure progress on the rights of women and girls have shed little light on the causes of the current HIV epidemic among young women and girls in sub-Saharan Africa. The SDGs have the potential to do better, but our work on indicator 5.6.2 illustrates the real difficulties of integrating a rights-based approach into the SDGs. One of the clearest hurdles—seen in the preference for collecting solely procedural information, and only from member states—is the lack of an effective accountability mechanism for ensuring state compliance with SDG commitments. What we urgently need, then, is to overcome these political barriers so that we can incentivize a response to HIV prevention and eradication that prioritizes the human rights of women and girls.

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