

## The Women Who Gave Birth to the Six Billionth Person

*Remarks by Adrienne Germain, President, International Women's Health Coalition, at a Symposium convened by the U.S. Department of State: "Six Billion World Citizens: Choosing Our Global Future," October 12, 1999.*



For weeks, we've been discussing the arrival of the six billionth person in the world. My mission today is to draw our attention to the woman who gave birth to that six billionth person. The UN has chosen a woman in Kosovo. But she might have been in Africa. If so, there is a one in twenty chance that she is dead.

She might, for example, have been Hanatu, a 12 year-old girl living in northern Nigeria, the second wife of a 60-year old man who believed that his religion required him to keep his child bride secluded in the household compound. When Hanatu started to hemorrhage after giving birth, her husband would not allow the family to take her to a nearby hospital. She bled to death.

If the woman who gave birth to the six billionth person lived, we might be inclined to consider her lucky. But is she? Not if she was one of the 18 million women severely injured each year because they do not have skilled help in childbirth, or access to a safe abortion, or care after childbirth.

Consider Devaki, a 26-year-old woman I met on a village road in northern India. After giving birth to her fourth child—the fourth girl, itself a tragedy for an Indian woman—Devaki suffered uterine prolapse. That is, her womb now hangs outside her body and she must carry it in her hands. Devaki's life is in ruins—because of the prolapse and because she bore no sons. Her husband cast her out and her own parents would not take her in. She begs on the road to survive.

We tend to think death and injury in childbirth happen to other women in other countries. But the U.S. has one of the highest levels of maternal mortality among industrialized countries and the level has not budged in 15 years—primarily because poor women of color do not have adequate access to pregnancy care. For example, when I was a volunteer in the emergency room of Bellevue Hospital in New York City, Wilen was rushed in by paramedics in the last stages of labor.

She was in her seventh pregnancy, she had had no prenatal care, and she was diabetic. The emergency team slaved all night to save her. She was one of the "lucky ones". She lived but was severely disabled. I was a volunteer 30 years ago. The situation has hardly changed since then. Too many poor women, in the U.S., still do not get prenatal care.

In Cairo in 1994, the U.S. Government led the world's governments in designing a new population and development agenda to prevent tragedies like this from happening anywhere in the world. In the cities and poor rural communities of the U.S., as in the cities and villages of Nigeria, India and Brazil, we must do a better job in at least three arenas in the next century. These are:

- Providing access to health services for pregnancy;
- Linking contraception and prevention of sexually transmitted diseases (STDs); and
- Generating zero tolerance for gender discrimination and violence against women.

Let us look briefly at each of these:

First, we must make sure that all women have access to skilled people and well-equipped facilities for pregnancy care. For \$2 to \$3 per person per year in most poor countries, using existing technologies, we can reduce significantly the 600,000 deaths related to pregnancy that occur every year.

We can—and we must—also ensure access to safe abortion. About 80,000 women die needlessly from unsafe abortion every year. For example, Betania, a middle class teenager in Recife, Brazil, pregnant by rape and HIV positive, was eligible for an abortion under Brazil's very restrictive law. But the doctors at the municipal hospital did not know that and refused to serve her. She died terrified and alone after a desperate attempt to abort herself. Thousands of miles away, Becky, a teenager in Indiana died from a clandestine abortion. She was afraid to talk to her parents under the parental notification law. Restrictions on abortion mean death for women. They do not prevent abortion.

The second area in which intensified action is needed is the link between contraception and STDs – including HIV/AIDS. The World Health Organization estimates that 330 million new STD infections occur annually, half of them among young people. Yet, until very recently, contraceptive researchers, family planning service providers and budget allocations have focused on contraception. We can no longer think about or talk about contraception without saying STD prevention in the same breath. Service providers must always provide information about STDs and promote both male and female condoms.

Young people, who are at such high risk, need special attention. But in this country and around the world, we deny them the information and technologies that we know would protect them. Ensuring services for young people was one of the hardest fought battles during the UN's International Conference on Population and Development, and again during the five-year review of its implementation. Thanks to the leadership and tenacity of the Mexican delegation, supported by the U.S. and, ultimately, most other governments, the world affirmed last June that sex education and services should be available to young people.

While we can and must do better with the knowledge and information we currently have, technologies for STD/HIV prevention and treatment are terribly deficient. We desperately need to develop methods that women control that will protect against infection, with and without protection against unwanted pregnancy. Developing such methods should be the highest priority for contraceptive researchers and budgets. Promising research is underway but funding—by NIH, USAID, and the pharmaceutical industry—is woefully inadequate.

The third priority area for action is promoting women's rights and encouraging men's

responsibility to end gender discrimination and violence against women. Across the world, one out of every five healthy days of life lost to women is lost because men beat or sexually abuse women. In the U.S. alone, four million women are battered every year. In South Africa, two women are raped every minute. Women subjected to violence, and women who fear such violence—as most of us do—women who are less educated than their partners, or who do not have their own income, are not in a position to negotiate condom use, or insist on contraception, or demand health care, or have a say in the laws and policies that affect their lives.

The men who do have power—in households, legislatures, the White House and the UN—have the responsibility to act. Some have. For example, President Clinton has led the way on domestic violence legislation in this country. Other world leaders should be supported and encouraged to do likewise. James Wolfensohn, President of the World Bank, has instituted special lending programs for girls' education and has committed the Bank to gender equality. The heads of all development banks should do likewise. Prime Minister Mocumbi of Mozambique is himself spearheading work on safe motherhood in the national health system. If every head of state, every minister of finance—and every U.S. congressman—did likewise, in partnership with women, we would be far closer to meeting the promises we made in Cairo, and reaffirmed just last June at the United Nations.

We know what to do and how to do it. What we need is the political will and, relatively speaking, a very modest financial commitment. While I am not a Washington insider, I know that Congress is currently debating an increase in the Pentagon budget for fiscal year 2000. The increase under discussion is \$17 billion. \$17 billion happens to be the amount that the UN estimates is needed to ensure universal access to reproductive health services. I say—invest that money in women, not arms. You'll get much more peace for your money—and you will relegate to history the kinds of tragedies that befell Hanatu, Devaki, Wileen, Betania, and Becky.