

International Family Planning Makes a World of Difference

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I will begin by asking all of you—men as well as women—to observe a minute of silence. In this minute, imagine you are pregnant, or that your partner is. How would you care for yourself or your partner? What health services would you expect? What hopes and fears would you have?

During the minute just ended, at least one woman died somewhere in the world because there was no one to help her through childbirth or to provide a safe abortion. Perhaps 30 more women suffered severe injury or infection for the same reason. These women will be chronically ill, or infertile, for the rest of their lives as a consequence.

Who was the woman who died and how did she die?

- She could have been Hanatu, a girl of 12 in Northern Nigeria, the second wife of a much older and very conservative man. It is likely that Hanatu, small-statured and physically immature, died after 24 or 48 hours in the agony of obstructed labor and, finally, a ruptured uterus. Her mother-in-law would not give her permission to go to a health center.
- The woman who died could have been Salma, a 28-year old, rural Bangladeshi woman in her fourth pregnancy. She might have died in the throes of eclamptic convulsions or massive hemorrhage. Although a health facility is half an hour away by bus, she did not have the bus fare. In any case, chances are the clinic would not have had staff trained and equipped to provide the emergency obstetric care she needed.
- Or, the woman who died might have been Betania, a middle-class teenager in Recife, Brazil, pregnant not by choice, but by rape. She drank pesticides and had a friend push her down a flight of stairs in a desperate attempt to abort herself. Though eligible for a safe abortion under Brazil's very strict abortion law, the municipal hospital refused to serve her. She died terrified and alone.

About 600,000 women die every year in these sorts of circumstances, and some 18 million are left disabled or chronically ill, 99 percent of them in Asia, Africa, and Latin America. Why does this happen? We have the knowledge and the technology to prevent most of these deaths and ill health. Here in the U.S. most doctors face only a tiny risk of losing a patient to maternal causes. Few of them will see the complications of an unsafe abortion, thought that could change if anti-abortionists gain the upper hand.

Given existing knowledge and technology, our failure to reduce death and suffering related to pregnancy—at home and abroad—is one of the gravest social injustices in the world today—a fundamental violation of women’s basic right to life and health. Several factors are responsible.

First is lack of political will and, therefore, low budget priority. The magnitude of these deaths is not known to the broad public: Maternal deaths attract no headlines, even though the global numbers are equivalent to four jumbo jets crashing every day. Compared to the 12 million children under five who die each year in developing countries, 600,000 deaths of women apparently seem minor to legislators and policymakers. But are they minor?

The second factor behind our failure to reduce maternal death and illness is discrimination. The majority of women affected are poor or young, of low social status, with no public voice or political power. They are invisible – even in the U.S. How many of you know that the U.S. ranks 21st among nations in women’s lifetime risk of maternal deaths. The relatively high risk of maternal death in the U.S. is primarily because poor women of color do not have adequate pregnancy care. For example, from 1982 to 1996, maternal deaths among African American women ranged from 18 to 22 per 100,000 births, compared with 5 to 6 per 100,000 births for white women. More than half of these maternal deaths could have been prevented or treated with routine pregnancy care.

There is similar discrimination in many other countries. In Perú, for example, only a fraction of the poorest women are attended by a doctor, nurse or trained midwife during childbirth; but almost all of the richest women have skilled attendants. Such divergence between rich and poor is not seen for other health services such as childhood immunization.

Discrimination against the poor and disadvantaged within countries is repeated across countries. Worldwide, the largest gap in human well-being between rich and poor countries is in maternal mortality ratios. Women in Africa and South Asia, for example, are 200 times more likely than women in the U.S. to die from causes related to pregnancy.

The third factor militating against maternal health is inadequate strategy. In the U.S. and Europe, historically, maternal mortality ratios declined dramatically when midwifery care was improved and expanded and, later, new techniques became available, including antibiotics, caesarian sections and blood transfusions, along with systems to monitor quality of care and ensure access. Saving women’s lives today—the lives of Hanatu and Salma—also requires a functioning health system and skilled health care providers capable of treating obstetric complications and emergencies. But international agencies and public health decision-makers have tried to get away with cheap fixes. They trained traditional (usually illiterate, community-based) birth attendants in basic hygiene and management of normal deliveries; and provided simple birth kits. More than a decade after a global safe motherhood initiative started promoting these interventions, no change has occurred in the level of maternal mortality.

Policy makers also have yet to give sufficient resources to contraceptive services. Worldwide, an estimated 150 million married couples who want to regulate their fertility lack access to a method of contraception that is safe and acceptable to them. But the real numbers of women without access are even larger. Young, unmarried people are not included in estimates of unmet need for contraceptives—and are also widely excluded from services—leaving them at risk of sexually transmitted diseases, unwanted pregnancy, and botched abortion.

The fourth reason that maternal death and illness remain high is sexism—in families, communities, the health professions, government agencies, legislatures, and the courts. Today, most international agencies and national governments, cowed by anti-abortion politics, run primarily by men, and faced with archaic laws, refuse to provide one of the simplest, lowest cost, life-saving interventions—that is, early, safe abortion. As a result, half the estimated 40 million abortions worldwide annually are unsafe. They cause 13-15 percent of all maternal deaths, and in some countries, 35-50 percent of deaths. Think about it—we could save the lives of at least 80,000 women every year, and spare millions untold suffering, with a very modest investment in training and equipment. But we are not doing it. Someone said years ago, “If men got pregnant, abortion would be a sacrament.” But men do not get pregnant. In this country, 77 percent of anti-abortion legislators are men, and, as the recent pro-choice education project points out, 100 percent of them will never face an unwanted pregnancy.

Sexism also includes oppression of women, violation of their human rights, and constraints on their access to health services, in the name of religion, or morality, or “culture.” Most of you have probably heard of female genital mutilation, a so-called cultural practice, justified in the name of Islam, but actually an expression of patriarchy. You have no doubt read about the extremist Taliban in Afghanistan who have put the health and survival of all girls and women, in grave jeopardy for similar reasons. These are extreme examples. More commonly, at the policy level around the world, men throughout history impose proscriptions on women’s access to fertility regulation—they have legislated against contraception and safe induced abortion in some circumstances; and for forced abortion and forced sterilization in others, depending on their own predilections.

The reproductive health problems I have already described are just some of the health risks associated with sexuality, gender power imbalances, sexism and sex discrimination. A women’s well-being begins at home, yet home is hardly a safe haven. Men routinely beat women for any number of reasons—for failing to have dinner on the table, or for asking to use condoms during sex, or for expressing their own opinions—and frequently for no reason at all. Rape and domestic violence in developed and developing countries account for one out of five healthy days of life lost to women ages 15 to 49.

The majority of women beaten by their men around the world do not have a forum for redress, support services or a place of refuge, not even the homes of their own parents. In South Asia, for example, women who are beaten by their husbands and seek shelter with

their parents are told that such violence is a part and parcel of marriage. More often than not, they are ordered to be “obedient” wives and return to their assailants.

Other dangers stemming from sexuality and the power imbalance between the sexes have just as much potential to injure and kill. Trafficking in women and sexually transmitted diseases cross all borders. When men who have sex with multiple partners refuse to use condoms, the women in their lives often end up with sexually transmitted diseases, including HIV. The World Health Organization estimates that 330 million new sexually transmitted infections occur annually, at least half among young people. Girls and young women are particularly vulnerable.

In poor sections of Washington, D.C., villages of Uganda, and cities of India, young women are infected at higher rates than men their age. These young women are especially vulnerable, not only biologically, but also because they lack sex education, have poor access to health care, and commonly face violence and intimidation from men. In parts of Africa, for example, men who believe that sex with a virgin can cure AIDS, are spreading HIV to girls as young as five or ten years old.

Sexual harassment degrades and threatens girls and women in school and at work around the world, with serious consequences for both physical and mental health. Here again, extreme cases illustrate the extent to which women’s bodies and sexuality are considered the property of men. In South Asia, rejected suitors commonly throw acid in the faces of the women they desire so that no other men will want them. In the Arab world and, until recently, parts of Latin America, male “honor” is justification for murdering wives and sisters who are accused of adultery. Some 12 Latin American countries exonerate rapists if they marry their victims. Across a great part of the world, male privilege is also reflected in the preference for sons in health care, in sex-selective abortion, and even in female infanticide.

- Death in childbirth
- Botched abortions
- Sexually transmitted diseases and HIV/AIDS
- Violence
- Coercion
- Poverty
- Discrimination
- Sexism
- Oppression

Intractable problems? Only if we accept them!

Why should you care? Because, if these things happen to one woman anywhere, they can happen to women everywhere.

Can anything be done? The answer is a resounding yes.

In 1994 in Cairo, and again in 1995 in Beijing, the world's governments agreed on sweeping, 20-year agendas to address the injustices I have described. And, rich countries, including the U.S., pledged to provide funds. Five years after these agreements were made, UN reviews have shown many examples of progress. In the same three countries where I described women dying due to lack of health care in pregnancy, new programs and policies are emerging. Let me briefly describe three of these which my organization, the International Women's Health Coalition, supports.

In Nigeria non-government groups across the country have developed remarkable sexuality education programs for adolescents. In 1995, Action Health Incorporated (AHI), one of Nigeria's most effective NGOs working for sexual and reproductive health and rights, opened a reproductive health clinic for young people. Responding to adolescents' needs, including alarmingly high rates of HIV infection—62 percent of AIDS cases from 1986 to 1995 were among young women aged 15 to 29—the clinic provides counseling, testing, treatment, and referral for contraception, pregnancy, sexually transmitted diseases (STDs) including HIV/AIDS, and sexual violence. Their work, and that of several other Nigerian organizations, includes not just health services but programs that build girls' self-esteem and that work with boys and girls to learn how to build respectful, responsible relationships, and to work for gender equality. Nike Esiet, AHI's founder reports: "We are helping make Cairo a reality by empowering young people to take charge of their lives in ways they never would have before."

In 1998, after three years of intensive work, Bangladesh completed their first comprehensive national health and population sector program, based on the definition of reproductive health used in the Cairo *Programme of Action*. Recognizing that maternal mortality in Bangladesh is as high today as it was 25 years ago, the government, civil society, international agencies, and donors agreed to augment a narrowly focused family planning program with a more comprehensive approach to reproductive health care, including essential obstetric services, continued access to early abortion, improvements in the quality of contraceptive services, and programs for young people.

In Brazil, the law allows abortion only in the case of rape, incest or to save the life of the woman. Yet an estimated 1.4 million women have clandestine abortions annually. In 1997, over 250,000 of them were hospitalized with serious complications. The national women's health movement has blocked a right-to-life amendment to the constitution. As remarkable, they have persuaded more than 16 hospitals in 14 cities to provide abortion services to women eligible for them under the law.

In addition to these country-specific examples, there are two very significant general examples of progress. The first is:

Expanding work on technology development and distribution

Considerable progress has been made on the development of microbicides—substances used intravaginally to protect against sexually transmitted diseases—and more governments are subsidizing access to female condoms in Africa and Latin America. The U.S. Food and Drug Administration has approved emergency contraception to prevent

pregnancy after unprotected intercourse, and also RU 486 for early abortion—which means that they can be made more easily available worldwide. Work is progressing to develop less expensive means to diagnose and treat STDs.

The second general area of progress is:

Women mobilizing for change

When I began international work 30 years ago, women’s organizations in Africa, Asia, and Latin America were few and scattered. They had not coalesced into movements with social and political force, nationally or internationally. They were particularly absent from the health and family planning arenas. After 30 years organizing at the grassroots level, women all over the globe are now playing an increasingly vocal, visible, and vital role in helping to shape the policies and programs that determine their health and well-being. Significantly, these women are joined every day by more and more men who have begun to realize that they and their communities will benefit. Together, we shaped the agendas set in Cairo and Beijing and reaffirmed them in the UN’s five-year reviews in 1999 and 2000. The international women’s health movement—with roots now in almost every country—is gaining strength and political momentum.

As encouraging as these examples are, an enormous amount remains to be done. The opposition—primarily, well-funded and highly skilled fundamentalist groups and governments influenced by them—are mounting ever stronger campaigns to roll back progress on women’s health and rights. In national parliaments and in the corridors of the UN the opposition:

- Asserts that condoms do not protect against HIV—only abstinence does.
- Argues that women should not have access to abortion for any reason.
- Says that abortion causes breast cancer.
- Urges governments not to support the global Safe Motherhood Initiative, asserting it is a cover for abortion on demand—would that it were.
- Adamantly opposes sexual health information and services for young people.
- Defines emergency contraception to be abortion and works to withhold it, even from women who have been raped, including refugees like those from Kosovo.

This litany has too often reverberated in the U.S. Congress—affecting both domestic and international health and family planning policy.

For years, Congressmen who relentlessly oppose women’s right to protect their health and control their fertility play international and domestic policy initiatives off against one another. For example when *Roe vs. Wade* made abortion legal in the U.S., that same year the foreign assistance act was amended to prohibit use of U.S. funds for legal abortion overseas. Failing to completely gag U.S.-funded providers in this country, in 2000, anti-abortion proponents imposed a “global gag rule” that denied U.S. funds to nongovernmental groups in other countries who speak or write about the dangers of restricting access to safe abortion or about the need to change abortion laws and policy—a gag that would be unconstitutional here at home. Last week, that gag rule was lifted but

its effects—including the deaths of poor women around the world—will continue at least until October next year. [Editor’s note: President Bush reinstated a global gag rule January 22, 2001.] Anti-abortion restrictions cast a global chill on access to safe abortion and even on access to contraception, because the U.S. is the largest international funder of family planning. The UN system, nongovernmental organizations, and even sovereign governments are afraid even to do research, publish or debate, let alone advocate or provide abortion.

This is just the tip of the iceberg of the opposition that we in the international sexual and reproductive rights and health movement face. We here today know only too well—what too few others do not yet see—the opposition is not only anti-abortion and ‘anti’-contraception. They also oppose gender equality and free speech. They cut across national boundaries and are among the most effective negotiators at the United Nations. The stakes are thus very high—as high as they have ever been. Three actions are imperative:

First - Vote today—and urge your friends to vote—with the clear knowledge that your vote will make a difference to reproductive freedom across the globe. Only one candidate for President and one for Senator stands for reproductive choice and women’s rights. Only one party would increase foreign assistance.

Second - Support Planned Parenthood locally and globally. They have taken an exceptionally forthright stand on this election, and are part of a worldwide institution that protects women’s lives and health.

And third - Learn more, educate others, and contribute as much as you can to the work of the global women’s health and rights movement. My organization, the International Women’s Health Coalition, supports women across the globe to organize and advocate on their own behalf, and on behalf of their families and communities. The Coalition’s colleagues around the world know, if we lose our struggle here in the U.S. they will suffer severe consequences. They stand in solidarity with us... and we with them. We must move forward together to save the lives and health of millions of women like Hanatu, Salma, and Betania. This is a global task, requiring global mobilization—now.