



Half the Sky: Turning Oppression Into Opportunity for Women Worldwide

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Geoffrey Dabelko:

The book is rich in citing reports and statistics and the stuff that many of these practitioners and policymakers in the audience here consume on a daily basis, but the two of you really used the stories of women who have suffered and who have overcome to bring these issues forward. Can you talk about some of those women and the lessons that they can teach us and then how you see those being best connected back to those, many times, faceless numbers and reports that we deal with so often here in Washington?

Sheryl WuDunn:

Well, we really tried to blend the importance of statistics and research with the reality of what's on the ground, and so we saw women who had been through so much. They're stories were just so compelling to us that we just couldn't not share them with readers.

And so we talk about women who have been raped. Some of this is extremely hard to stomach. You both know what it's like on the ground. We talk about women who have died needlessly early in childbirth because they didn't have access to healthcare, issues that you know very, very well from research. But we also talk about how some of them have survived.

One of the people that we really were moved by was Mahabuba [*spelled phonetically*]. She is in Ethiopia. At the time of, the event that happened to her, she had a terrible situation. She was raped when she was something like 13, and she ended up having the baby on her own. No one was there to help her because she was abandoned by her family, and she obviously was so young that in the end she actually had obstruction in labor, and the baby died. And she suffered an injury, an internal injury called an obstetric fistula, which is a terrible injury



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that leaves a woman incontinent as well as almost incapacitated, unable to move.

Obviously she ended up not being able to control herself, and so she was very smelly and no one wanted to be near her. So they put her in a hut at the edge of a village, and they ripped off the door so that the hyenas would get to her. So, in the middle of the night, she was grasping a stick. She took that stick and she fought off hyenas with that stick. This girl was only 14. The next day she crawled to a nearby village where she knew there was a missionary, a Western missionary, who took her in and then got her to a clinic and to a hospital where she was actually operated on. These fistulas can be operated on if you get access to healthcare. And he actually was able to basically save her; the hospital saved her, and now she's a wonderful woman who's actually now a nurse at that hospital. So she's a fully productive asset.

These are the stories that we talk about in *Half the Sky*, so they are really sort of the face of all those statistics that we read about.

Nicholas Kristof:

I think one of the larger problems, actually, which we try to address is that, in general, I think the humanitarian community, whether it's the UN or NGOs or journalists, we haven't done a great job in calling attention to humanitarian issues, partly because we believe in them so much, and as a result, I think we're often not as effective as we should be in getting non-believers to pay attention to them.

And it always sort of disturbs me that if a company is introducing some product that doesn't matter at all, if it's introducing a new brand of toothpaste, then so much energy goes into marketing this toothpaste to try to get people to buy it, while when there are millions of lives at stake, then very little creativity or thought goes into the marketing and message of that issue. And I think that's one reason why, for example, maternal mortality has been on the agenda now for several decades and yet has made remarkably little progress. And over the last 20 years in Africa, for example, the number of women dying in pregnancy or childbirth has actually increased, and globally it's been pretty much stagnant for the last 25 years.

And there has, in fact, been some interesting work in the field of social psychology about precisely this issue, about what builds empathy and gets people to care. And we briefly talked about some of the lessons of that. Let me just briefly explain it because I think it informs, kind of, our thought on this. One of the things is we know intellectually that people





don't really care about a group; they care about an individual, but, you know, we never really thought about how big the group is before people begin to get turned off. It turns out that it's when the group gets to be simply two people, that if you ask people to donate, and there's one victim, if you will, one individual, then they will empathize with that individual; they will try to help. The moment you have two people and they become a class, then empathy drops and efforts to help them drops. In addition, there is quite a bit of evidence that people want to be a part of something successful, so they're much more willing to help save, for example, 50 lives out of 100 than they are to save 500 lives out of 100,000, even though it's much less cost-effective.

And, you know, the kind of messaging the humanitarian community tends to do are, at first, "There are a million people suffering from such-and-such," and that -- you know, we present it on a cosmic scale that you're going to save so many lives, but it doesn't seem so great. And I think as a result, a lot of our messaging on these issues doesn't connect. And I think it's one reason why a lot of these issues haven't gotten more traction over time. And that's one reason why *Half the Sky* is chockablock with stories, you know, and the whole panoply varies. You try to build that connection and then talk about them at a more intellectual and borrow from studies and so on, but to try first to build an emotional connection with the issue. We'll see whether it works.

Geoffrey Dabelko:

Let me follow up on that form of communication on this and reporting. You both received the kind of pinnacle award for your profession in journalism, the Pulitzer Prize. What does that allow you to do that your column or your reporting doesn't necessarily do? And then perhaps also, Sheryl, I noticed that some of what you're doing is really trying to also go forward with a kind of a social market -- not necessarily social marketing, but some of the variety of online mechanisms to plug into different audiences and communicate on this. Can you talk about how the form of this is part of your hopes for how to reach some of these audiences?

Nicholas Kristof:

Well, my column in *The New York Times* is about 790 words, and, you know, so twice a week I churn out that many, and you're counting every last word, trying to, you know, use "can't" instead of "cannot" to save two characters here and there. And the truth is that all these issues are interconnected and that if you're writing about maternal health, for example, which is so much of a topic today, then it's hard to talk about that in isolation and not





mention girls' education, for example. And all these issues, because they are interconnected, it felt to us that it was very important to try to approach this in a more integrated fashion and to be able to tell stories but also, you know, borrow from some really important academic research. And the field of development, I think, has become much more rigorous in recent years and there are a lot of insights that we can borrow from. So, you know, for somebody who's used to writing 790 words, it is such a treat to be able to then flip the book on everybody.

Sheryl WuDunn:

But the other reason is that we also know that everybody has their own personal experiences and different backgrounds, and different things move, you know, different people. And so, when you have a variety of things in a book like that, although they're all interconnected, something will speak to someone. And so, we just hope that people will pick up on the strand or the path that really speaks to them.

Geoffrey Dabelko:

Let me pick up on one of Nick's points and toss it to Aparajita and to Jeremie, which is, why is it that we've seen so very little progress on maternal health and the MDG 5? Because, as Nick cited, there have been some efforts, obviously not enough. But that's one of the ones where there hasn't been movement and some backsliding. So, from your perspectives in working in the field, what is it that you see are the real barriers that we need to overcome?

Aparajita Gogoi:

Okay. First of all, maternal health is such an issue that there is no solution, no one-size-fits-all. There are localized problems, and you have to implement localized solutions. There's no magic bullet. However, we know what can prevent women and children from dying needlessly. What we are not doing is actually implementing those solutions. And the reason for this is different in different countries. Some countries are in conflict. In some countries, there is no political will at all.

Maternal mortality or women's health do not feature in the political agenda. So there are so many, many reasons. In countries like mine, in some communities, women's life is not just worth saving. Families would watch and stand and look at a woman undergoing labor for 28 hours, 29 hours, bleed to death, watch life bleed out of her but just not make the decision of taking her to a health facility where her life can be saved. So there is a multitude of reasons why maternal mortality has literally remained where it is. There are islands of excellence.





There are many countries which have really done well, and I think the world needs to look at what has worked in similar situations and really implement that in their own countries.

Geoffrey Dabelko:

And in the Indian context, what are some of the things that have been successful that you would want to highlight, particularly to an audience that is in the business of working on these kinds of programs?

Aparajita Gogoi:

You know, women are dying not just because they don't have access to health facilities. It's also because of a lot of societal causes: status of women in society, lack of education, lack of women's decision-making power. Fifty percent women in my country cannot even make a decision that she should go to the market to go shopping; she has to take someone's permission. She obviously has no right to take decisions over how many children she should have, when she should have children, where should she have children, does she want to have children at all, one after another.

So, it has to come from within countries; it has to come from within societies. When we talk of empowering women, we cannot just look at the women and forget her society. Reaching that woman is like reaching the core of the onion; you have to peel away layers of communities, of families, of religious beliefs, of traditions, and only then can you get to it. And that's the reason why we advocate that when you look at a problem like girls' education or maternal mortality or reproductive rights, you really have to take a holistic view.

Geoffrey Dabelko:

Jeremie, you're in Rwanda and Burkina Faso, obviously, but other places where you're working? What do you see as the big impediments for why we haven't made more progress?

Jeremie Zoungrana:

I think we have to see it as a holistic problem because it's not just about having access to quality of services, the big problem is access, but at which level. If we have the woman who has a problem and first, [doesn't] know that there is a problem, and when this woman decides to go to the health system facility, they don't have transportation system in place. And when this woman reaches the health system, at this level there is no scrip provider, there is no equipment -- there are many barriers. The bad things will happen.





So, for me, most of the time we focus on decision making, the policy, but we forget one part: to make the quality of services ready. And when these quality of services are ready, we are not ensuring that we are increasing the demand based on the social reality at the country level. So we have to consider all aspects and not focus only on one intervention. I think this is the problem.

And if I have to consider the case of Burkina Faso, I can see that women don't have access to health services because they are not available, in terms of number, in terms of quality. And women also don't know that they need these kinds of services. We have the traditional norm that doesn't allow women to go to the health facility. We have also the economical barrier. We know that when we talk poverty, we talk about women. So all these things are linked. In addition to that, when you analyze the budget of our Ministry of Health you will realize that it's less than 15 percent. And this is far from the need. The same thing for all countries in Africa, I can say.

And one thing that I have to say is the international context. Now, when we have a meeting to talk about health issue, we are talking about only one disease, and we forget all the rest. You know, I don't want to talk about this disease, but only one disease. And when you analyze a lot of programs, you see that more than 50 percent of this budget goes to this problem. And what about maternal mortality? You have to say, "Okay, if we finish to resolve this problem, we'll talk about maternal mortality." And I think this is one of the visions. If not, we can talk and talk and find more.

Nicholas Kristof:

I think there's actually one lesson, perhaps, from America's own experience about why we haven't gotten more traction in maternal mortality. If you look at the history of American health and public health, then throughout the 19th century we made incredible strides economically, in education, and including girls' education, for example. And yet, maternal mortality rates in the U.S. showed remarkably little progress.

And then in World War I -- one of, to me, the most shocking statistics -- more American women during World War I actually died in childbirth than American men died at war. And yet it's just something that we -- you know, it's always happening.

And then, finally, what actually made a difference, wasn't just the generally rising economy,





it wasn't rising education standards, it wasn't more urbanization as such, although probably all those helped a little bit. But when women got the right to vote, then you began to see some quite remarkable strides in reducing maternal mortality. And it wasn't exactly so simple as, "Okay, women get the right to vote and are all of a sudden they're passing measures," but it does seem to be some broader sense that women had become more valued members of the community, more respected, as well as a sense among politicians that women wanted more public spending on healthcare. And some combination of those factors seemed to be the main reason why, in the U.S., we were able, after a long stagnation, to actually reduce maternal mortality rates here in the U.S.

Geoffrey Dabelko:

You've all touched on the fact that the kind of critical shortfall in the availability in services, but said, at the same time, that's necessary but not sufficient to get there. So a lot of the comments in the course of many of the themes of the book are rooted in this notion of the power disparities and the fact that women are challenged in so many of these contexts to have voice, to have decision-making power.

So, from the stories that you have told and the experiences that you have working in the field, what are the models or maybe a particularly inspiring story that suggest the ways that we start to break those links? Because you stress the importance of women being part of the solution or driving the solutions, so where do you see these success stories that we can build from and draw lessons from?

Sheryl WuDunn:

One of the areas that I have seen that really has come a long way is in China. You know, my grandmother's feet were bound. So, three generations ago, look where women were in China. A lot of women had their feet bound. And now, partly because Chinese women were allowed to be educated -- basically China said, "Everybody can be educated, including girls." In other words, they didn't prevent girls from going to school; they welcomed them to go to school along with boys. But while that is necessary, it is not sufficient because the other important thing is that a society has to allow women to work, to be absorbed into the labor force.

And so the women in my ancestral village, they were educated, but then they were also allowed to leave their village to go to the county seat to go work at factories. Now, we may call them "sweatshops," and, believe me, I think they are terrible places to work. I wouldn't





want my kids to work there. But when a woman is faced with the decision, do I spend my life in the rice fields and the rice paddies where I'm not really as strong as the men, or do I work in a factory, where American's call them "sweatshops"? Welcome the factory.

It's because they earn an income, which they weren't doing in the rice paddies, and they send that income back to their families at home in the village. Their status just goes way up because they're a breadwinner in the family. And that's the beginning of change in dynamics of the relationship between men and women. And so, the clothes we wear now, the shoes we wear, the bags we carry, a lot of them are made by Chinese women in factories. Those women helped jumpstart the Chinese economy.

Now, across Asia that happened as well, and if one can sort of replicate that in other places of the world, that's great. And it's not going to be exactly the same; each country will find their own way of doing something like that, but the key is empowering women and bringing them into the workforce.

Aparajita Gogoi:

I just want to carry on from where you left off and talk about maybe what we can call "social empowerment." You talked about economic empowerment.

You know, if you look at the issues that we all are working on, which is maternal mortality or lack of access to better healthcare services, who are the women who are being affected? It's definitely not women in this room. It's not me; it's not you. It's women who are poor, who are not educated, who do not have decision-making power. And I think when we talk of looking at the light at the end of the tunnel, we have to realize that these are the women that we have to reach out to.

And I want to give you an example. And we organize public hearings in India where we tell women just to come and talk about their experiences, what they faced when they went to deliver in a health facility or what went through her mind when she was lying in labor, waiting for her husband to come back from work and take a decision whether to take her to a hospital or not. And we organize public hearings where we bring in government officers, we bring in policymakers, ministers, members of parliament, we bring in health service providers, and we create a very safe space where the women can talk in a very non-threatening atmosphere. It's not always non-threatening, but we try.





When we went and told the women that, “Come and talk about what you have experienced, good, bad, ugly,” the women first laughed and giggled and said, “What makes you think anyone is interested in knowing about my experiences?” which was really, really surprising for us. They said, “Why should I talk? Nobody cares. Nobody cares whether I die, I survive, or what.” And it took us a lot of information dissemination when we talked to women about your right to health: “There are policies; there are programs under which you are entitled to certain things. If you go to a hospital for a delivery, you’re not supposed to pay for your drugs or the procedures. It’s provided free by the government.”

And, finally, when the women came and spoke, I mean, that was very, very moving, not for us because we work with them and somehow we are so attuned to all of this, but for the policymakers it was a thousand times more effective than people like us going into talk all to the policymakers and all the government officials. Because they came and spoke about some very good experiences where a health worker went out of their way to help someone or experiences where they watched their neighbor or their sister just die, you know, being rushed from one hospital to another, ambulance being there but no fuel. And I think what we tried to do is we really tried to get the stories out from the people who are affected because we feel that that’s the very honest way of conveying the real issue.

Nicholas Kristof:

I’m curious; you guys -- Aparajita and Jeremie -- you guys are in the field. One of the things that strikes me as an impediment -- maybe more in Africa, but over and over, and most recently in Sierra Leone, which has the highest maternal mortality ratio in the world -- women don’t want to go to the clinics or hospitals; they want to go to the TBA, to the traditional birth attendant.

You go and see the traditional birth attendant, and you shudder. I mean, somebody who’s completely uneducated, has learned things from their mother, doesn’t really know what she’s doing, kills women right and left, and and as far as I can tell, it was basically that the TBA might not know what she was doing, might be utterly incompetent, but had a great bedside manner. And the doctors, in contrast, were rude; they were arrogant; they often humiliated women. There was no market reason for them; they were just overwhelmed.

And so the women responded, quite naturally, by staying away from the hospitals that might save their lives and going to the TBAs, which were killing them. Now, is there some truth to





that, generally? I mean, do you see that? And how does one get around that?

Jeremie Zoungrana:

Yes, this is true because the TBA is woman from the village, but usually the health provider is someone who came from another country. So it's not clear or sure that they know the culture of this country. You can also send the young lady who is midwife to deliver older than her.

You are right, but I just want to share some success stories about what we are doing at the field. With the White Ribbon Alliance, we try to link the community to the decision-maker with what we are doing. And the good example is when we have some health area, catchment area, to train provider. For example, one of our programs with Jhpiego in the field is really to make sure that providers are skilled. And I have to thank USAID for that because it's through their program that we are able to bring the technology that we have from university here at the field level.

So when you train providers, you have to add this cultural part to make sure that they're able to be competitive as TBA, traditional birth attendant, to be able to welcome well people, to let the woman decide what kind of position she wants to use for delivery because they traditionally allowed women to choose, et cetera.

So, in addition to that, we have to educate even the high-profile level because when you talk about maternal mortality, you say, "Do you know that every three hour in my country, a woman died?" The First Lady will tell you, "Really? I never know that." She is counting how much money we have in the budget, how many roads we have in the country, but how many women died. This is not the problem. So we try to have this kind of link, give the floor to the women to talk about the issue. And also, allow the First Lady and [unintelligible] if we could talk about this issue.

And we have many kind of success that the White Ribbon Alliance has been able to do in the world with government, with parliament, to build a very strong system that ensures that the quality of services are technically good but also in terms of satisfaction of the client.

Geoffrey Dabelko:

So with a couple, I think, excellent examples of how to respond to this challenge of the power disparities, I'd like to ask you about what you've seen in terms of this kind of





integrated picture that you've given us, both in terms of problem but then also on the solution side.

And one of the challenges, clearly, that we can all recognize, and many of these people face day-to-day from the donor side, or developed countries trying to help assist on these issues, is the notion of the stovepipes and the bureaucracies and the funding sources that go for one but not for the other. Jeremie alluded to this in terms of lots of attention for one disease but forgetting others and the implications of that.

From the research and the reporting you've done for the book, have you run into this problem in the field? And then what are your reflections -- and since we're sitting in the building that literally houses the U.S. Agency for International Development, for example -- about the challenge of doing single-sector in a multi-sector world, where we live truly integrated lives?

Sheryl WuDunn:

Well, there are certainly certain things about maternal mortality that are isolated. I mean, really you need to focus, you need specialists, and you need, someone who knows how to deliver a baby, which is different from what you would need to combat sex trafficking, where you need policemen to sort of crack down on brothels. So to some degree there is separation, but in reality there's also a lot of necessary integration because ultimately it comes down to the status of women and women's rights, just the right to speak up and, as Aparajita and Jeremie have said, just the right to say, "I want to be able to deliver at a health clinic."

It's really giving the woman the confidence in some of these places to be able to ask for just basic needs. And so I guess in terms of integration, a woman's life is not sort of compartmentalized. Maybe it's serial. When she's in her childbearing years, she'll be demanding certain things, and that's when you step up on the maternal health. But there's also the idea that a lot of things are very integrated, and overall you just need policies that will support women's rights.

Nicholas Kristof:

Yeah, Jeremie was absolutely right. He was diplomatic earlier when he talked about disease, but, there is a great deal of frustration about the way so many resources have gone to HIV and AIDS, and often the upshot has been that you get very talented health workers who leave positions where they're actually dealing with people and are hired by NGOs to be





administrators and are sort of taken out of the front lines.

And so, sometimes spending actually undermines other areas, and maternal mortality, I think, in some ways has been a loser from a focus on AIDS in particular. And that's why, most recently, when PEPFAR was renewed, there was, indeed, an effort to create a broader, systemic approach. And I think that was absolutely right.

And if you look at the places where there have been successes, whether they be China, as Sheryl alluded earlier, Sri Lanka has managed to reduce maternal mortality by about 90 percent since the 1930s quite steadily. And Kerala in India has also; the numbers are a little fuzzier, but it's made great progress in maternal mortality as well. It does also seem to be a real, systemic approach that does include educating girls, valuing them more broadly, looking after reproductive health in general.

I mean, one part of reducing maternal mortality is also improving family planning so that people are actually having fewer births as well. The stovepiping approach, you know, it really can get in the way of making progress on this issue, I think.

Geoffrey Dabelko:

You mentioned family planning, which has a chapter devoted to it. It is one of the solutions that is cost effective and part of this kind of integrated approach. You introduce the term, at least the new term to me, in terms of talking about the "God gulf," and in some ways we're still focused on the politics here rather than the politics overseas. Do you want to talk about what that is and how you see bridging it as critical to really being as supportive as we could and should be on these issues?

Nicholas Kristof:

We look at examples in the past where there really have been successes, and it seems to us that we're really going to make progress on issues like women's rights globally not so much just by passing laws from above and not just by recruiting presidents and prime ministers but by really having a broad, grassroots social movement and changes of priorities. And when people lead, politicians will follow.

And maybe the best example of that was the British abolitionist movement in the 1780s, which is an extraordinary story. In 1780, essentially slavery wasn't even on the agenda. There were a few Quakers who were jumping up and down about it; nobody else paid any





attention. By the late 1780s, you had more people in Britain who had signed a petition against slavery, for ending the slave trade than were entitled to vote at that time. You had millions of people who were boycotting sugar, and eventually it led to the abolition of slavery in areas controlled by Britain and laid the groundwork for the end of the transatlantic slave trade. Britain lost an average of 1.6 percentage points of GNP for 60 years, lost 5,000 troops because of that. It was a real commitment. And one of the reasons why it succeeded, I think, was that it encompassed both quasi-Jacobins on the left, people who were real leftists, and evangelicals on the right, and it managed to really be an extraordinary coalition.

In this country, that is something that is enormously lacking from this area. If you look at sex trafficking, there are a lot of liberal feminists who are very active on this and have done great work on it. There are a lot of evangelical conservatives who have done great work on this area and have pushed it. There is such distrust in America right now that there's very little cooperation between the two sides. And because there are some areas of disagreement, then there isn't cooperation on what everybody agrees on, which is, you know, that 15-year-old girls shouldn't be locked up in brothels. And that "God gulf," this real disagreement between -- and distrust between -- more secular, more liberal people on the coasts and evangelical Christians more in the center has, I think, really hobbled our ability to make more progress on sex trafficking and on maternal mortality, which is difficult. There are obviously going to be disagreements about abortion, all kinds of things, but I think that if one's going to register progress, there has to be greater effort to try to get all sides in the room and working on areas that have common agreement.

Sheryl WuDunn:

They really should borrow from the corporate world and form strategic alliances just around a certain area, but they can have their own areas of separation.

