



11:30:37 AM

Record Type: Record

To: Christine N. Macy/WHO/EOP

cc:

Subject: MRS. CLINTON URGES FOCUS ON MATERNAL HEALTH

I should have thought to send this to you yesterday - sorry.

----- Forwarded by Neera Tanden/WHO/EOP on 04/08/98 11:53 AM -----



TANDEN_N @ A1

04/07/98 03:58:00 PM

Record Type: Record

To: Neera Tanden

cc:

Subject: MRS. CLINTON URGES FOCUS ON MATERNAL HEALTH

Date: 04/07/98 Time: 14:51

MMrs. Clinton urges focus on maternal health

WASHINGTON (AP) In the time it took Hillary Rodham Clinton to deliver her World Health Day speech, she said, an estimated 15 women died around the globe from pregnancy complications or unsafe abortions.

``No woman should ever die in childbirth," Mrs. Clinton declared Tuesday, calling for renewed global attention to maternal health. ``The vast majority of these deaths and so much of that suffering could have been avoided."

Nearly 600,000 women and girls, most in developing nations, die each year while pregnant or in labor due to complications, including self-induced abortions, according to the World Health Organization and UNICEF.

Breaking down the statistics, Mrs. Clinton said that every minute, a woman or girl dies, 40 have unsafe abortions, 110 experience a pregnancy-related problem and 190 face an unplanned pregnancy.

Mrs. Clinton, speaking to several hundred health care professionals and private and public policymakers at World Bank headquarters, said countries should develop better family-planning and education programs for women and children to combat maternal mortality.

On that point, she criticized conservative members of Congress who each year try to block U.S. government money for international family planning, which critics contend lead to abortions.

``Without it (family planning) women often turn in desperation

to illegal, unsafe abortion procedures that can account for up to half or more of all maternal deaths," Mrs. Clinton said.

"I would like to stress that point because there are some in our Congress and in our country who do not understand how providing family-planning services helps reduce the rate of abortion."

Mrs. Clinton, who last week returned from a 12-day tour of sub-Saharan Africa with President Clinton, noted that she and her husband visited projects promoting women and children to underline U.S. support for "human rights and particularly the right to health."

Supporting Mrs. Clinton at the World Health Day celebration, Malaysia's first lady, Siti Hasmah Mohd Ali, called for the elimination of "cultural and social taboos" that often prevent women and girls from making their own reproductive decisions.

"Safe motherhood is a basic human right," she said.

Carol Bellamy, executive director of the United Nations Children's Fund, said her visit last week to Afghanistan, where women suffer harsh discrimination under Taliban rule, demonstrated to her that women without equal human rights are in mortal danger.

"It is no coincidence that Afghanistan ... is distinguished both by severe economic and social restrictions on women and by the highest maternal mortality rate of any developing country 1,700 deaths per 100,000 live births a truly shocking number," Bellamy said.

In the United States, by comparison, from 10 to two dozen women die for every 100,000 live births, according to various federal surveys.

Bellamy and Mrs. Clinton said simple hygienic handling of mother and baby can save lives at an estimated cost of \$3 per person per year.

APNP-04-07-98 1450EDT



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FOR IMMEDIATE RELEASE
December 2, 1996

Contact: Vicky Jaffe
or Ann Kittlaus

USAID-Funded Initiative Will Save Mothers' Lives

On December 4 in La Paz, Bolivia, at the Sixth Conference of Wives of Heads of States and Governments, First Lady Hillary Rodham Clinton will announce a U.S.-funded hemispheric partnership to reduce maternal mortality. The Maternal Mortality Reduction Initiative is designed to improve emergency obstetric care across the western hemisphere and contribute to the goal of reducing maternal mortality by 50 percent of 1990 levels by the year 2000.

The U.S. Agency for International Development (USAID) will fund this initiative to be implemented by the Pan American Health Organization (PAHO) and the USAID-funded MotherCare and Quality Assurance projects. USAID will provide a grant to PAHO for \$2.25 million, of a \$4.5 million dollar effort, for regional activities of the Maternal Mortality Reduction Initiative. This is in addition to support for the MotherCare project and the Quality Assurance project as part of the same initiative.

Mark Schneider, USAID assistant administrator for Latin America and the Caribbean and PAHO Director George Alleyne will sign the agreement, which will foster an improved health policy environment for emergency obstetric care.

Maternal mortality is a critical problem in the western hemisphere, with an average maternal mortality ratio of 140 deaths per 100,000 live births. (In the United States, the ratio is 12 deaths per 100,000 births.) Major causes of mortality include hemorrhage, hypertension related to pregnancy, sepsis and obstructed or prolonged labor. These conditions can largely be prevented or controlled by increasing use of family planning, prenatal care, clean delivery, postpartum services and better care for obstetric emergencies.

In addition to the support for the \$4.5 million regional Maternal Mortality Reduction Initiative, USAID also sponsors regional initiatives in Latin America and the Caribbean on vaccinations, care of sick children and other health care services. These programs are directed, for the most part, to women in rural areas where health care services are less than optimal.

USAID is the U.S. government agency that administers economic and humanitarian assistance worldwide.

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Bolivia

FACT SHEET ON MATERNAL MORTALITY GRANT

Background: It is estimated that 23,000 women die from pregnancy-related causes each year in Latin America. From community-based studies in developing countries, it has been shown that 80% of maternal deaths can be attributed to hemorrhage, sepsis, hypertensive disorders of pregnancy, obstructed/prolonged labor and ruptured uterus, and septic abortion. These conditions are treatable with available technology. But in environment where resources are scarce and poorly organized, women continue to die. Some of the barriers to safe motherhood in the Americas include: the lack of complication recognition, the inability of women to seek care due to low status in society, the dearth of accessible and affordable health care, poorly trained and/or culturally insensitive health care workers, shortages of medical supplies, and a lack of reliable transportation.

The reduction of maternal mortality and the improvement of maternal health care in the Americas have become major issues in the past few years, with new initiatives being launched at the Summit of the Americas' Symposium on Children and at the Summit itself. To address the problem of maternal mortality, USAID has developed a Regional Maternal Mortality Initiative to support and advance a strategic approach for more effective delivery of selected health services. The regional initiative takes a three-pronged approach, aimed at improving service delivery through improved community response, better quality of care at the first referral, and policy reform aimed at improving the overall policy environment which encourages these types of analysis and promotion of legislation and policies to reduce maternal mortality.

Description of Maternal Mortality Grant: The Regional Maternal Mortality Initiative will be implemented by a partnership between two USAID-funded projects, the MotherCare Project at John Snow International and the Quality Assurance Project at the University Research Corporation, and the Pan American Health Organization (PAHO). The Initiative represents the regional program portion of US Government support to the countries of the Americas in their effort to achieve the Summit of the Americas' goal of reducing maternal mortality by one-half of 1990 levels by the year 2000. PAHO will take the lead on advising countries on the policy changes needed for the intensive implementation of the Basic Emergency Care aspects of the Regional Plan for the Reduction of Maternal Mortality. PAHO's work will include revising and reaffirming the 1990 Regional Plan; strengthening the regional and country Interagency Coordinating Committee which brings together relevant ministries at a country level and all interested parties at a regional level; analysis and promotion of legislation and policies to reduce maternal mortality; and building high-level political support for reduction of maternal mortality, including support

for developing follow-up action by the First Ladies of the region.

The MotherCare Project will focus on community response to increase the capability of selected PVO networks and Ministries of Health to identify and respond to community efforts to reduce maternal and neonatal mortality, including training and educational campaigns. The Quality Assurance Project will take the lead in the area of quality of care at the first level of referral -- developing, testing, evaluating and disseminating approaches to enhance use of protocols, standards and guidelines at the first level of referral.

The Initiative will be implemented from December 1996 through December 2001. It has a working budget of \$4.5 million, of which \$2.5 million will be granted to PAHO.

Corporate Initiative for Safe Motherhood

The World Bank Atrium
Monday, April 6, 1998

Welcome

David de Ferranti
Vice President, Human Development Network, The World Bank

The Power of Partnership

James D. Wolfensohn
President, The World Bank

Safe Motherhood Public Service Announcements, Premiere

Glenn J. DeSimone
Chairman and Chief Executive Officer, Medicus Group International

The Corporate Initiative

Russell C. Deyo
Vice President Administration, Member of Executive Committee, Johnson & Johnson

Statement of Principles

Vendela Thommessen
UNICEF International Spokesperson
with
Russell C. Deyo and James D. Wolfensohn

Closing Remarks

David de Ferranti

This evening is made possible by a generous grant from Johnson & Johnson

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Let's work together for Safe Motherhood

Daniel Epstein

Washington, DC, April 7, 1998 - For World Health Day, observed this year on 7 April, the Pan American Health Organization (PAHO) has selected the theme Lets Work Together for Safe Motherhood, to call attention to the need for men, women, and families to work together to make motherhood safe and healthy. The challenge for all is to ensure that pregnancy, birth, and the postpartum period occur under the best possible conditions for the mother, child, and family, according to Dr. George Alleyne, Director of PAHO.

We can make motherhood safe and healthy, said Dr. Alleyne. In Latin America and the Caribbean, the risk of a woman dying from pregnancy-related complications is one in 130; in North America it is one in 3,700. This is a troubling difference. Most maternal deaths can be prevented if women have greater freedom to determine their own health and life choices within families and communities and if society provides the means to ensure that pregnancy and childbirth are as free of risks as are humanly possible.

Reducing inequalities in social and economic policies, and protecting and promoting women's rights, choices and autonomy are critical to reducing maternal deaths and ill-health, achieving the goals of the Safe Motherhood Initiative, and bringing about sustainable, equitable development for women and men. On this World Health Day, and throughout the year, our challenge is to advance safe motherhood. Let us work together to ensure that every woman participates in the planning and decisions that affect her body, her health, and her future and has access to the necessary services so we can avoid needless risks and ensure that all members of society reap the benefits of safe, healthy motherhood, concluded Dr. Alleyne.

World Health Day, observed in 191 member countries of the World Health Organization, aims to encourage everyone to think globally and act locally on a specific issue of global importance for public health. Every minute, somewhere in the world, a woman dies as a consequence of complications of pregnancy, 100 hundred women suffer from pregnancy-related complications, 300 women conceive an unwanted or unplanned child, and 200 women acquire a sexually transmitted disease.

In the countries of Latin America and the Caribbean, reduction of maternal mortality rates and the achievement of safe motherhood continue to be challenges. In the Americas, 63 women die every day as a consequence of complications of pregnancy, childbirth, and the postpartum period.

The most important causes of maternal death in the Region are hemorrhage, pregnancy-induced hypertension, secondary infections associated with pregnancy, abortion performed in unsafe or unhygienic conditions, or difficulties during delivery, such as

contracted pelvis or presentation of the baby in a position that hinders the normal delivery process. Approximately one out of every five pregnant women experience complications such as high blood pressure, hemorrhage, obstruction during delivery, or uterine infections. All these situations can be regarded as obstetric emergencies requiring the attention of skilled personnel. More than 50% of maternal deaths could be prevented through a healthy lifestyle, access to quality health services staffed by skilled personnel, and timely care, especially in cases of complication.

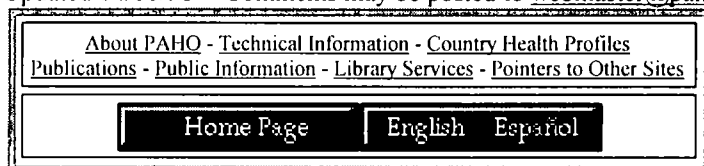
What should mothers do? Go to a health service for prenatal care at the first sign of pregnancy. Get vaccinated against tetanus. Go to the closest health center or hospital at the first sign of alarm or danger during pregnancy, childbirth, or after childbirth and postpartum. Maintain good hygiene during pregnancy, delivery, and after delivery. Go to a health center or seek the assistance of a skilled birth attendant when it is time to give birth. Take iron supplements during pregnancy. Plan their families. Start using a reliable method of contraception as early as possible after delivery.

Communities can work together with the health services to be well informed about maternal health care, danger signs during pregnancy, childbirth and when and where to seek assistance; determine the location of the most appropriate health care facility for a woman with a high-risk pregnancy to receive prenatal care and attention during childbirth.; facilitate transportation of mothers who show danger signs; organize community committees for the support of pregnant women and the prevention and surveillance of maternal mortality; and support political leaders and authorities in prioritizing the prevention of maternal mortality.

Countries can recognize that reproductive health and maternal health programs are among the health interventions that have proven most cost-effective. Investing in the health of women can yield huge benefits for countries. They can also ensure that the prevention of maternal deaths is defined not only as a public health problem but also as a social justice issue, and establish the legal and political basis for guaranteeing care during pregnancy, and seek to identify the multiple inequities associated with pregnancy and childbirth that need to be remedied through the political, legal, and health systems.

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Last Updated 04/06/98 -- Comments may be posted to webmaster@paho.org





World Health Day '98 "Safe Motherhood"



by
George A. O. Alleyne
Director

*World Health Day '98
Washington, D.C., 7 April 1998*

The health of the people of the world should be a concern to the people of the world every year, every month, and every day. But this year and this day are very special because in this year we celebrate the 50th anniversary of the World Health Organization and it is particularly significant that the theme for this special day of this special year is Safe Motherhood. The call to a wide range of individuals, agencies and organizations to focus on this serious problem, is an indication of our firm belief in the value of partnerships as the most effective way to find a solution.

In this 50th year of WHO's existence it is fit and proper that we rejoice in the achievements in health many of the traditional indicators show improvement. Fewer children die of preventable diseases, more families have access to safe water, and in many other ways the world is healthier. It is this progress, and earnest of progress that shames us into looking squarely at one vital health problem that is still with us, and reflects the gross inequity that

affects women in particular. The difference between the poor and the rich countries is stark -the lifetime risk of maternal death is almost 40 times higher in the former. I do not have to paint the horrible consequences of maternal mortality and morbidity for this audience. You are only too well aware of the accounts of young women dying of obstructed labor, ruptured uterus, septicemia, eclampsia, or hemorrhage. You know of the consequences of maternal deaths to societies and families the almost irreparable damage in physical and behavioral terms to those children who survive.

I would refer to the fact that much of maternal mortality and morbidity is a manifestation of the extent to which women are deprived of their basic rights. They do not have those sanitary and social measures relating to food, clothing, housing and medical care, that are enshrined in the American Declaration of the Rights and Duties of Man. However, I am optimistic that we can advance, and that optimism is based in part on some answers to the questions posed earlier. I will address three of these:

the knowledge we now have about the dimensions of the problem and its impact;
the experience we have acquired about the interventions needed to address it and how they can be implemented in the service settings where the problem is most acute; and,
the partnerships now available to put these interventions into place.

Let me take each of these in turn.

Knowledge derived from information is a prerequisite for action. Relatively recently, in the 1980s, as a result of the studies undertaken by WHO with UNFPA, the world community came to appreciate the dimensions of the problem of maternal mortality, its causes, and determinants. Each maternal death remained a private tragedy, borne in silence by those it affected. These first studies resulted in the establishment of the Safe Motherhood Initiative, in Nairobi in 1987, with WHO as a cosponsor along with UNFPA and the World Bank, joined by UNICEF, UNDP, IPPF, and the Population Council. Today, new methods have been developed to help national authorities and local groups estimate the scale of the problem and determine the effectiveness of the interventions that are being applied.

During the first ten years of the Safe Motherhood Initiative, our knowledge about the scale, medical causes, and socio-economic and cultural determinants of maternal mortality has increased significantly. Much remains to be done; in particular, developing countries need to further strengthen their vital registration and health information systems. Communities need to be more involved in analyzing the causes of maternal deaths in any particular setting and quality care must become the standard. Indeed, we are now aware that in the absence of true community involvement in both the identification of the nature of the problem and the development and implementation of programmes to address it, progress will be slow. I am also convinced that the increasing involvement of NGOs and womens groups will accelerate progress.

A second area which gives cause for hope is the experience we have acquired about the interventions needed to address maternal mortality and how they can be implemented in settings where the problem is most acute. The lessons learned from the first ten years of the global safe motherhood initiative were recently discussed at an international technical consultation which took place in Sri Lanka in October last year. We now have clear evidence about the effectiveness of different prenatal, intranatal, and postpartum interventions. For example, it is now clear that every pregnant woman faces the risk of developing sudden and serious complications most of which cannot be predicted or prevented. Some 15% of pregnant women develop serious complications. All women must have access to life-saving care as a matter of urgency when such complications arise. Rationing health care by trying to identify women most likely to develop problems will not work.

We now know that the single most important intervention for ensuring safe motherhood is the presence of a skilled health care provider at every delivery, wherever it takes place. Achieving this will be a challenge because currently we do not have enough of the people with essential midwifery skills in the places where women live and give birth. Thus there is urgent need for training and retraining of these personnel. It is essential to detect abnormal conditions in mothers and children to be able to carry out emergency measures and know when referral is necessary. Traditional birth attendants are no real permanent substitutes for skilled attendants, although in some countries circumstances have forced a liaison between the two, as an interim measure, recognizing the need for referral to the trained professional.

We have been able to identify the barriers that prevent women from having access to the quality health care they need. Surprisingly, these barriers turn out to be similar the world over. Distance is one such barrier, but it is by no means the most serious. Equally important if not more so are barriers such as cost of services (overt and hidden costs) and the poor quality of the interactions between providers and women and their families. Again, evidence is now accumulating from around the world about the kinds of interventions that can help

overcome such barriers. They include community-based transport and insurance schemes, decentralization of the care, establishing maternity waiting homes, and participatory workshops bringing women and health care providers together to discuss how services can be more in tune with women's needs and perceptions. Barriers such as these are by no means limited to the developing world. In developed countries, too, increased attention is currently focused on the need to humanize medical care during pregnancy and childbirth as well as on the importance of ensuring access for all, including the most disadvantaged sectors of society.

Cost should not be the major barrier to provision of services. Safe and effective interventions can be provided at marginal extra cost even in the most resource-limited settings. For as little as an additional US\$ 1 to 3 per person per year, the essential interventions for safe motherhood can be put into place in the health services of the poorest countries. The outstanding results of the African Prevention of Maternal Mortality Project show quite clearly that it is possible to mount successful emergency obstetric care services and save the lives of women with complications even in situations with limited financial and human resources. Many of the interventions needed to save lives can be provided by people with midwifery skills working within communities as long as they have the back-up and support of a functioning referral system. There is no need in most cases for expensive technologies; indeed the overuse of such technologies can be counterproductive and harmful.

It is impossible to speak of the interventions needed to reduce maternal mortality and quality of care issues without also mentioning one of the major causes of maternal death complications due to abortion. Millions of women each year turn to unqualified practitioners working in inappropriate settings to terminate an unwanted pregnancy. There are many reasons why women do not wish to carry a particular pregnancy to term. They may not have been using a reliable method of contraception or the method they were using may have failed. They may have been forced into unwanted and unprotected sexual relations or they may simply have not known how to protect themselves from an unwanted pregnancy or how to persuade their partner to let them do so. Whatever the reason, they often risk their health and lives by resorting to abortion. These women need care when complications arise and they are as deserving of compassion and humane care as is any person who turns to the health care system. Today we know that one of the most effective interventions to reduce maternal mortality is to address the causes and consequences of abortion by ensuring that all women have access to family planning information and services, and compassionate care including postabortion family planning in those cases that come to the health services when complications arise. Improving the quality of perinatal and maternal care involves the conjuncture of many of the points raised today. We need information, health care systems that involve the community, functioning supervision and referral systems, skilled attendants, and approaches that respect the dignity of the woman.

The interventions I have mentioned up to now have been those interventions that are mainly the prerogative of the health care system. But safe motherhood is not the responsibility of the health sector alone. It is a societal responsibility to ensure that girls and women are, from the earliest age, valued as highly as boys and men for their contribution in the many spheres of human endeavor. Gender discrimination even in its subtle forms can militate against women in their whole life cycle but more importantly for this forum, as they carry out their reproductive roles.

The third recent development that gives me cause for optimism, as I stated in the beginning, is a renewed sense of global, regional, national, and local partnership around this issue. Over the past ten years of the international Safe Motherhood Initiative, a growing body of national authorities; national, international, and local NGOs; and multilateral and bilateral cooperation agencies, have come together to pool their efforts and collaborate to implement the strategies needed to address the problem. Such collaboration is important not only because of the attention it focuses on the issue, but also because it permits the identification and mobilization of the necessary resources at international and national levels.

In this connection, it gives me particular pleasure to note that on this World Health Day 1998, WHO is joined by an impressive array of partners with the same goals and objectives in mind. World Health Day 1998 is being celebrated not just by national authorities and the World Health Organization at the national, regional, and global levels, but also by the World Bank, UNICEF, UNFPA, IPPF, and the Population Council and major bilateral donors and key actors in the world of business, the NGO community, and many parts of our growing civil society.

All these developments whether in the field of the operational interventions, the strategic approaches or in the power of partnership give me cause for hope.

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Last Updated 4/6/1998 Comments may be posted to webmaster@paho.org

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Opening Address at
Safe Motherhood Matters: Ten Years of Lessons & Progress
Technical consultation in Colombo, Sri Lanka
23 October 1997

Safe Motherhood at Ten: Looking Back, Moving Forward
by Dr. Mahmoud Fathalla

Thank you very much, Madam Chairperson.

In the professional career of an obstetrician, there is no more tragic event than a maternal death. Our colleagues in developed countries probably end their careers without ever having to witness such a death. But for obstetricians and midwives practicing in developing countries, maternal mortality is not about statistics. It is about women; women who have names, women who have faces. Faces which we have seen in the throes of agony, distress and despair. Faces which continue to live in our memories and continue to haunt our dreams. Not simply because these are women in the prime of their lives who die at a time of expectation and joy; not simply because a maternal death is one of the most terrible ways to die – bleeding to death, convulsions, severe sepsis, the unbearable pains of obstructed labor or the trauma of unsafe abortion – but above all because in retrospect almost every maternal death is an event that could have been avoided, and should never have been allowed to happen.

The organizers asked me to prepare a historical perspective of the journey to safe motherhood. In doing this I will have to take you along three historical roads in this journey. The first is the road to Nairobi; the second is the road from Nairobi to Colombo; and the last and most important is the road ahead.

The road to Nairobi started when the world woke up to the reality of major tragedy. This was no new epidemic; throughout the ages women have died from complications of pregnancy and childbirth. But it was not until this time that three factors converged to awaken us. One factor was the accumulation of data from epidemiological research which showed that half a million women were dying every year as a result of pregnancy and child birth, and several million more were suffering from severe morbidity. The second factor was the realization that this suffering did not need to happen. Maternal mortality is largely avoidable, and in developed countries it has become something of the past. The third factor which was also very important was the increasing status of women. The lives of women came to mean more and it was considered that they were worth saving.

The road to Nairobi was the road to make the case that motherhood *should* be made safe. The road from Nairobi to Colombo was not about the “should” but about the “could”: can we make motherhood safe, and how can we do so? It was not easy, but ten years along the road we know that motherhood **can** be made safe. We know about the interventions that can make a difference, and we have learned some hard lessons along the way. I would like to briefly share with you first an outline of the interventions which we are going to discuss in the next few days, and then I want to spend some time on the hard lessons which we learned on the road from Nairobi to Colombo.

We know that there are three categories of interventions which can have an impact on safe motherhood. In my classes I use the letters A, B, C, D, E and F to specify these interventions. The first category contains interventions that are needed by all women and that are justified on their own, irrespective of their potential impact on safe motherhood. These are:

A for Advancement of women and

B for Birth spacing.

The second category includes the interventions needed by all pregnant women, irrespective of whether they are liable to develop a life threatening complication. These are:

C for Community-based prenatal care and

D for Delivery by a trained birth attendant.

The third category consists of interventions that are needed by women experiencing a life threatening complication. These are:

E for Emergency obstetric care and

F for Facilities for referral.

We are going to hear a lot about these interventions and our experiences with them over the past decade.

I want to spend some time on the hard lessons we have learned – and I say hard lessons because they are lessons that in one sense or another defy conventional wisdom. Women die during pregnancy and childbirth because there are life-threatening complications which can develop. The first piece of conventional wisdom we defy is that prevention is better than cure. Unfortunately in this field we know that life threatening complications of pregnancy and childbirth are for the most part not preventable. In fact, we can only prevent two of the major causes; one is unsafe abortion, if we have the courage to make it safe, and the other is puerperal sepsis, which we can prevent by good care at delivery.

Another overturned piece of conventional wisdom is the risk approach, a good public health approach for the rational allocation of resources: we identify from the outset the people who are at risk, and then target interventions and resources to these people. Unfortunately, most of the complications of pregnancy and childbirth are not predictable. Every woman is at risk.

It is also conventional wisdom that primary health care is the right approach to achieve health care for all, by an equitable allocation of resources and by emphasizing the low-cost interventions that will benefit the majority rather than the high-cost interventions directed to the few. For those of us who have put our faith in primary health care, it came as a shock that as far as safe motherhood is concerned, primary health care alone is not enough. We can detect complications of pregnancy and childbirth at the primary care level, but their management will need to be done at a higher level.

The last bit of conventional wisdom I need to dispel for you is a particularly hard lesson. We believe that development is the solution and that poverty is at the root of all health problems in the Third World. This is correct, but where safe motherhood is concerned it needs a qualification. A well-off woman in the city is as likely to develop a placenta previa and serious antepartum hemorrhage as a poor woman in a village. The only difference is the access to quality health care. The important lesson here is that pregnancy and childbirth are a risky business. Every woman is at risk and every woman should have access to the right health care if the need arises.

Now if the road to Nairobi was about “should,” and the road from Nairobi to Colombo is about “could,” the road ahead is the “should” and the “could” backed by the wallet. And I submit to you that there are three requirements to sustain this notion of safe motherhood. The first requirement is to raise the level of the issue of safe motherhood from being simply a health issue to being a human rights issue. Maternity is not a disease, maternity is a privilege, and women have a basic right to be protected when they undertake it. The second requirement for this phase is the support of the women’s movement, and we need more of that support than we are getting now. It is true that women in the North have probably forgotten what a maternal death is; but for their sisters in the South, the journey of pregnancy and childbirth is still a dangerous one from which many do not return. Women’s right to life should be an issue around which all women can mobilize and act.

But the will without the wallet will not move us ahead in the road after Colombo, and so that is the third requirement. The question will be “Can we afford to do it?” and my answer is we can. We can, because we have learned from our experience of the last decade that in many cases the marginal cost to add and improve services in some type of existing infrastructure has succeeded in saving women’s lives. We can, because before

we make a decision, let us recall the faces of our mothers and then answer the question “How much are mothers worth?”

Before I conclude, I want to leave you with a message. It is not a message from me, but a message from the young women who have died because of pregnancy and childbirth. By the time we conclude this opening ceremony, about one hundred young women will have died. By the time we conclude our meeting here probably ten thousand young women will have died. I belong to an ancient culture that believes in a life hereafter and I can almost feel the presence of the thousands of souls of young women cut down in the prime of their lives, victims of social injustice. They will be with us here in Colombo today and throughout the conference. Their souls will be roaming in the space of these white halls of this hotel. They will be blessing us, they will be praying for us, they will be hoping that our commitment and action which missed them will help save the lives of their sisters in years ahead. Let us hear their message and say we will.

Thank you.

APX-1

THE WORLD BANK
INTERNATIONAL FINANCE CORPORATION
MULTILATERAL INVESTMENT GUARANTEE AGENCY

3.10.98

Patty,

Per our conversation last week and my
voice mail today, information for the
April 7 event is enclosed.

We are re-working the events so we
can work with Mrs. Clinton's schedule.
(1015-1030 arrival)
I will check back with you after
we have met to discuss the re-scheduling.

Thank you,

Gina Cicatelli



WORLD HEALTH DAY: PRELIMINARY AGENDA OF SPEAKERS

- 9:15-9:30 Safe Motherhood video reports
- 9:30-10:30 Chair: **James Wolfensohn** (5 minutes)
- 58 minutes
- **James Wolfensohn**, Welcoming address (10 minutes)
 - **Head of State/First Lady/Midwife**, SM experience in a developing country (10 minutes)
 - * - **Hillary Clinton**, Expression of concern (15 minutes)
 - **Kofi Annan**, Keynote speech (possible video or *Louise Frechette, DSG*; 10-15 minutes)
 - **Public Service Announcement** (3 minutes)
 - **Question and Answers Removed**
- 10:30-11:00 Closed press conference with above 4 speakers in a separate press room, followed by individual interviews.
- 10:30-10:45 Coffee/Tea for all other participants (*Safe Motherhood video reports*)
- 10:55- 1:00 Chair: **George Alleyne** (5 minutes)
- 90 minutes*
- **Mahmoud Fathalla**, Highlights and Challenges of Safe Motherhood (15 minutes)
 - IAG heads of agencies responding to Fathalla (with 2 key messages)*
 - George Alleyne**, PAHO (8-10 minutes)
 - Nafis Sadik**, UNFPA (8-10 minutes)
 - Carol Bellamy**, UNICEF (8-10 minutes)
 - David de Ferranti**, World Bank (8-10 minutes)
 - Ingar Brueggemann**, IPPF (8-10 minutes)
 - Margaret Catley-Carlson**, Population Council (8-10 minutes)
 - **Richard Feachem**, the World Bank, closing remarks (5 minutes)
 - **Questions and Answers** (15-20 minutes)
- 1:00-1:30 Closed press conference for speakers in second part of event (possibly followed by individual interviews)
- 1:00-2:00 *Lunch cancelled*

* In responding to Fathalla, IAG heads will be informed beforehand to reply to one to two of Fathalla's points and put it in their organization's context.

**The AAWH/PAHO event will begin at 1:00 p.m. We have pledged to end as close to 12:30 as possible although they recognize there may be unanticipated delays. The allotted time for the second part of the agenda is 2 hours in case the event goes over time.

Draft: March 9, 1998



FOR MORE INFORMATION
CONTACT: Benna Holden
(202) 973-0369

Year of Safe Motherhood

FACTS AT A GLANCE

Inter-Agency Group
for Safe Motherhood

UNFPA

UNICEF

WHO

WORLD BANK

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POPULATION COUNCIL

- Every minute of every day, somewhere in the world, a woman dies from complications related to pregnancy or childbirth.
- Approximately 50 million women a year (equivalent to the total population of the states of California and Texas) suffer serious maternal health complications annually.
- Worldwide, there are 430 maternal deaths for every 100,000 live births.
- In developing countries, the figure is 480 maternal deaths for every 100,000 live births; in developed countries there are 27 maternal deaths for every 100,000 live births.
- The highest maternal mortality figures are found in Eastern and Western Africa; the lowest recorded figures are in Northern Europe.
- According to the American Association for World Health, 300-500 deaths a year are reported in the United States; however, it is estimated that these U.S. figures represent less than half of the actual deaths from pregnancy.
- Women's lifetime risk of dying from pregnancy:

<u>Region</u>	<u>Risk of Dying</u>
Africa	1 in 16
Asia	1 in 65
Latin American & Caribbean	1 in 130
Europe	1 in 1,400
North America	1 in 3,700
All developing countries	1 in 48
All developed countries	1 in 1,800

- Common causes of maternal death: severe bleeding (25%), infection (15%), unsafe abortion (13%), eclampsia (12%) and obstructed labor (8%).
- Each year, 60 million deliveries take place in which the woman is cared for only by a family member, an untrained traditional birth attendant – or no one at all.
- Most maternal deaths, millions of cases of disease and disability, and the deaths of at least 1.7 million infants each year could be prevented through:
 - ⇒ basic maternal care for all pregnancies, including a skilled attendant (doctor or midwife) at birth;
 - ⇒ prevention and treatment of complications during pregnancy, delivery and after birth; and
 - ⇒ postpartum family planning and basic neonatal care.

These healthcare services would cost about \$2 per person per capita in most developing countries.

###

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SAFE MOTHERHOOD MATTERS: MARKING THE INITIATIVE'S TENTH ANNIVERSARY

In 1987, when the Safe Motherhood Initiative was founded, maternal mortality was a serious – and seriously neglected – problem. In most countries, data were not even available to make accurate estimates of maternal death and disability. Ten years later, the Initiative has proven that pregnancy-related deaths are preventable, and has secured a high priority place for safe motherhood on the international development agenda. The body of research that has been conducted on maternal mortality and morbidity is significant, and innovative approaches to address the immediate and root causes of poor maternal health are being tested in a variety of economic circumstances around the world.

Unfortunately, however, the last decade's progress cannot be measured in lives saved. Based on improvements in data collection and analysis, the World Health Organization now estimates that 585,000 women die from pregnancy and childbirth every year; while in some countries maternal mortality rates have decreased, in many they remain at unacceptably high levels. Women's poor health, and the inadequate care they receive during pregnancy and delivery, also contribute to an estimated seven million perinatal deaths annually.

At the most basic level, maternal mortality persists largely because:

- **Knowledge and information about maternal death and disability – and strategies to address them – were inadequate ten years ago.** Conclusive data on the impact and effectiveness of different interventions have only recently become available. Even now, organizations working at the country and community level are often unaware of relevant pilot programs, appropriate technologies and guidelines, and the technical resources available to them. As a result, national activities sometimes include strategies that are not cost-effective and do not have a measurable impact on maternal mortality, such as risk screening during antenatal care.
- **Political commitment has not been sustained.** Although decision-makers have supported safe motherhood in theory, in practice they often view it as too expensive, and do not consider its social and economic impact or its links to other health and development issues when they are allocating scarce resources. Further, the public in developing and donor countries has not forcefully advocated support for safe motherhood programs and financial assistance, partly because people are not aware of the magnitude of poor maternal health and partly because women's contributions to society have not been recognized and valued.
- **Resources have been inadequate and misallocated.** Currently, the vast majority of maternal/child health resources (excluding family planning) are spent on children; governments and donor agencies have also placed more emphasis on expanding community-based services than on improving the facility-based care that we now know is necessary to reduce maternal death. Further, donors sometimes earmark funds without considering national priorities or the relative cost-effectiveness of different reproductive health interventions. In one African country, for example, the head of the Ministry of Health's Maternal Child Health/Family Planning Unit says that the funds it received between 1993-1996 (\$3 million for safe motherhood, \$5 million for STDs/HIV, and \$22 million for family planning) were inversely proportional to its priorities.

The Tenth Anniversary

To mark the tenth anniversary of the Initiative, and to address the obstacles outlined above, the Safe Motherhood Inter-Agency Group (IAG) is planning a two-year program of action intended to revitalize national action and galvanize international support for safe motherhood among existing and new audiences. Its objectives are:

- To share existing information and lessons learned, and to develop a consensus on the best and most effective interventions, for use by **program-planners** around the world. In addition, to provide them with technical and informational resources they can use to implement national programs.
- To help **policy-makers** make their political and financial commitments to safe motherhood *explicit*, and mobilize and allocate necessary resources.
- To broaden international commitment to safe motherhood by raising awareness among **new audiences** – including business and societal leaders globally, and the general public in developed countries – through the media, celebrities and spokespersons, and special events. In addition, to gain their individual support and their support for government and corporate donations.

Why Now?

During the last decade, effective strategies for safe motherhood – including appropriate management of pregnancy and delivery; life-saving essential obstetric care when complications arise; and the prevention and management of the complications of unsafe abortion – have been identified and evaluated systematically *for the first time*. As a result, we now know which interventions have the most impact and are the most cost-effective, knowledge that is essential given our scarce resources. At the same time, participants at a series of global conferences this decade, including the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (FWCW), have declared that reproductive health, including safe motherhood, is integral to population, development, and human rights. These two milestones offer an unprecedented opportunity to translate the on-going but amorphous good will that exists into effective and immediate action for women – and their families. They also raise an important issue that needs to be explored and clarified, namely, the role of safe motherhood as the cornerstone of reproductive health (as measured by its contribution to improved women's health, infant and child health, and population and development) and the relative priority of maternal health in the continuum of reproductive health and rights.

A. The Program of Action

To mobilize the support and commitment of each of our main target audiences, the Safe Motherhood Inter-Agency Group (IAG)* is now planning a program of activities and events that are linked by a multi-faceted strategy to stimulate awareness and action. The three main elements include:

- A **technical consultation** for program-planners worldwide in October 1997;

*The members of the IAG are: the World Bank, the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, the Population Council, and the International Planned Parenthood Federation, which is currently chairing the group.

- **Safe Motherhood Day** on World Health Day in 1998, where selected heads of state, business leaders, opinion-makers, celebrities, and activists will recognize achievements and call for action on safe motherhood; and
 - A **communications strategy** that unites these events and builds support for safe motherhood. The products and resources developed will include materials for the technical consultation and the Safe Motherhood Day events, as well as a strategy 'package' reflecting international consensus on the elements necessary for country-level action. A public information campaign will also be organized to gain the support of new audiences who could press for action during the Year of Safe Motherhood, 1998.
-

ANNEX ONE:

Safe Motherhood Action Messages for the Technical Consultation

1. ***Establish Safe Motherhood as a Human Right***
Topics will include: national and global commitments to safe motherhood as embodied in international agreements and conventions; women's right to make decisions about their own health free of coercion or violence and based on full information; women's right to have access to quality services before, during and after pregnancy and childbirth; and the obligation of governments to ensure the provision of safe motherhood care.
2. ***Safe Motherhood is a Vital Economic and Social Investment***
Topics will include: the multiple benefits of safe motherhood for mothers, children, and communities, and its impact on women's productive and reproductive roles; and the contribution of safe motherhood to broader reproductive health, women's overall health and status, and national development.
3. ***Empower Women: Ensure Choices***
Topics will include: educating girls and women and increasing their decision-making power about pregnancy and reproductive health; raising women's awareness about the danger signs of complications and actions they can take; promoting good nutrition, self-care and the appropriate use of resources; encouraging women to demand the kind of services they want; and mobilizing family and community support and resources, with special attention to the role of men.
4. ***Delay Marriage and First Birth***
Topics will include: the impact of early pregnancy on the health and well-being of girls and women; the linkages between age at marriage and age at first birth; approaches to providing health information and services to young people, including key topics such as reproductive physiology, responsible sexual behavior, life planning skills and family planning.
5. ***Every Pregnancy Faces Risks***
Topics will include: the need of all women for care during pregnancy; service delivery strategies that are designed to give each woman the level of care she needs; the difficulty of predicting complications for individual women and the consequent notion that **all** women are at risk; the problem of "risk screening" strategies for services to pregnant women; the distortions of quality of care created by the emphasis on "high risk".
6. ***Ensure Skilled Attendance at Delivery***
Topics will include: definition of skilled attendant; the evidence for the importance of skilled attendance; the role of the professional birth attendant (doctor, midwife, nurse) in managing normal deliveries and detection and management (including referral) of obstetric complications; numbers and deployment of skilled attendants (living and working conditions); allocation of responsibilities; training needs (basic and in-service); supervision: curricula.
7. ***Improve Access to Quality Maternal Health Services***
Topics will include: overcoming barriers that limit women's access to services; the definition, provision and monitoring of quality services (clinical, interpersonal and logistical aspects); design of services that are sensitive to clients' needs, taking into account gender and socio-cultural

issues; decentralization of services; and avoiding inappropriate use of technologies and interventions, including the overmedicalization of pregnancy and childbirth.

8. ***Address Unwanted Pregnancy and Unsafe Abortion***

Topics will include: the public health importance of unwanted pregnancy and unsafe abortion; universal access to family planning information and services, including emergency contraception, with special attention to the needs of young people and marginalized groups; managing contraceptive failure; provision of postabortion family planning care; access to safe abortion within the limits of the law; and management of abortion complications safely and humanely.

9. ***Measure Progress***

Topics will include: the selection of appropriate ways to measure maternal mortality and monitor and evaluate progress; the need for and uses of data on maternal morbidity; the role of data on service utilization rates and qualitative information on knowledge and attitudes; the challenge of measuring quality of care.

10. ***The Power of Partnership***

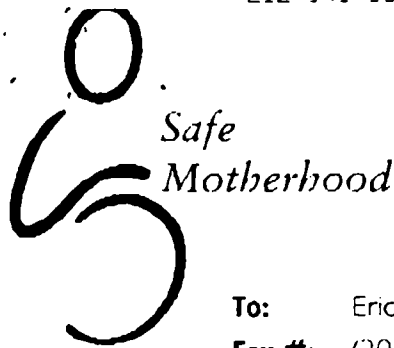
Topics will include: collaboration between government, non-governmental and multi-lateral organizations; the role of the private sector, the role of health professional associations; links with sectors outside health; how best to use available resources (including cost, cost-effectiveness and financing); and how to maximize opportunities and increase resources.

THE FIRST APRIL 7 LADY'S SCHEDULING OFFICE

PLEASE DELIVER TO:

- 1.) Jody K
- 2.) File April '98
- 3.) _____
- 4.) _____

ORGANIZATION	Safe Motherhood / The World Bank	
EVENT	World Health Day Celebration	
DATE OF EVENT	April 7, 1998	
LOCATION	Washington, DC	
EVENT DESCRIPTION	Invitation to Participate in Panel Discussion	
CONTACT		
RECOMMENDED BY		
STATUS	ACCEPT _____ REGRET _____ PENDING ☒	LETTER _____ VIDEO _____
NOTES	File March File April yes 4/7 ~~9:30 am~~ 10 am	



Inter-Agency Group
for Safe Motherhood

UNFPA

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POPULATION COUNCIL

To: Eric, Office of the First Lady
Fax #: (202) 456 5309
Re: Invitation to Mrs. Clinton
Date: October 10, 1997
Pages: 2, including this cover sheet.

FACSIMILE

Dear Eric:

Further to our conversation last week I am writing to you to follow up regarding the invitation from James Wotensohn of the World Bank to the First Lady Hillary Clinton to open a special event to celebrate World Health Day on April 7, 1998. Please find enclosed for your reference a copy of the invitation.

While we have been informed that it may not be possible to confirm her attendance earlier than a couple of months prior to the event, I am following your suggestion of contacting your office once more. We are further delighted to inform you that there has been a strong indication from Mr. Kofi Annan, Secretary General of the United Nations, that he will accept our invitation as key speaker of the event.

Thank you very much for your kind assistance, and please do not hesitate to contact us should you require any further information.

Sincerely,

Asa Jonsson
 Family Care International

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The World Bank
Washington, D.C. 20433
U.S.A

JAMES D. WOLFENSOHN
President

August 13, 1997

First Lady Hillary Rodham Clinton
The White House
Old Executive Office Building, Room 100
Washington, DC 20500

Dear Mrs. Clinton: *My dear Hillary -*

It is my pleasure to invite you to open a special event at the World Bank on April 7, 1998, from 8:30 to 10:30 a.m., in celebration of World Health Day and the Year of Safe Motherhood. This "Call to Action for Safe Motherhood" will be sponsored by the World Health Organization, United Nations Children's Fund, United Nations Population Fund, International Planned Parenthood Federation, Population Council, and World Bank. The event will be the centerpiece of a year-long campaign, on the tenth anniversary of the Safe Motherhood Initiative, to support maternal survival and family well-being.

You will be joined on the panel by other distinguished leaders and opinion-leaders. Others who have been invited to lend their support include the Secretary General of the United Nations, the Presidents of Sri Lanka and Uganda, the chairman of a coalition of business leaders for safe motherhood, and the head of the Pan American Health Organization. Live satellite reports from selected sites around the world will demonstrate what safe motherhood or the lack of it means to millions of people worldwide, and international media will cover the event. ←

The heartfelt support of prominent leaders such as yourself who care about and work for humanitarian causes and equitable development will make a difference to women and their families worldwide. It would be an honor and a pleasure to have you join me and other invited guests at this special event.

Warm regards
Sincerely yours,

Jim

James D. Wolfensohn

encl.

The World Bank
Washington, D.C. 20433
U.S.A

JAMES D. WOLFENSOHN
President



August 13, 1997

Handwritten notes:
#2
Melanne
Fill April 9

First Lady Hillary Rodham Clinton
The White House
Old Executive Office Building, Room 100
Washington, DC 20500

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Warmest wishes
Sincerely yours,

Jim

James D. Wolfensohn

encl.

Teen
← pregnancy

1997.09.11: (Fact Sheet) Preventing Teenage Pregnancy

<http://www.hhs.gov/cgi-bin/waisgat...6626645+16+0+0&WAISection=retrieve>

Date: Thursday, September 11, 1997

FACT SHEET

Contact: HHS Press Office (202) 690-6343

Nicole - There will be a new fact sheet out in a couple days @ updated budget numbers -- everything else is current.
-E

PREVENTING TEENAGE PREGNANCY

Overview: Despite the recent decline in the teen birth rate, teen pregnancy remains a significant problem in this country. Most teen pregnancies are unintended. Each year, approximately one million pregnancies occur among American teenagers aged 15-19. And almost 200,000 teens aged 17 and younger have children. Their babies are often low birth weight and have disproportionately high infant mortality rates. They are also far more likely to be poor. About 80 percent of the children born to unmarried teenagers who dropped out of high school are poor. In contrast, just 8 percent of children born to married high school graduates aged 20 or older are poor.

In his 1995 State of the Union Address, President Clinton challenged "parents and leaders all across this country to join together in a national campaign against teen pregnancy to make a difference." A group of prominent Americans responded to that challenge, forming the National Campaign to Prevent Teen Pregnancy. As the President's Senior Advisor on Teen Pregnancy and Youth Issues, Dr. Henry Foster serves as liaison to the National Campaign.

On January 4, 1997, President Clinton announced a comprehensive effort by his Administration to prevent teen pregnancy in this country. The new initiative, led by the Department of Health and Human Services, responds to a call from the President and Congress for a national strategy to prevent out-of-wedlock teen pregnancies and to a directive, under the new welfare law, to assure that at least 25 percent of communities in this country have teen pregnancy prevention programs in place.

Building on the variety of efforts already underway, the national strategy works to prevent out-of-wedlock teen pregnancies and encourage adolescents to remain abstinent. The strategy sends the strongest possible message to all teens that postponing sexual activity, staying in school, and preparing to work are the right things to do. It will strengthen ongoing efforts across the nation by increasing opportunities through welfare reform; supporting promising approaches; building partnerships; improving data collection, research, and evaluation; and disseminating information on innovative and effective practices.

Recent Trends

After rising steadily from 1986 to 1991, the birth rate for teens aged 15-19 declined for the sixth straight year in 1996, from a high of 62.1 per 1,000 teens aged 15-19 in 1991 to 54.7 in 1996. The decline was 12 percent between 1991 and 1996 and four percent from 1995 to 1996. All 50 states had a sustained decline in their teen birth rates between 1991 and 1995, and 21 of these states had declines of more than 10 percent over this period. In addition, from 1991 to 1992, the pregnancy rate for 15 to 19 year olds fell three percent. Recent declines in both birth and abortion rates indicate that teen pregnancy rates are continuing to fall.

The National Strategy to Prevent Teen Pregnancy

Building on our current efforts to prevent teen pregnancy, the national strategy announced by President Clinton on January 4, 1997 is designed to strengthen the national response to prevent out-of-wedlock teen pregnancies and support and encourage adolescents to remain abstinent:

Implementing New Efforts Under Welfare Reform. Under the welfare law signed by President

Clinton on August 22, 1996, unmarried minor parents are required to stay in school and live at home, or in an adult-supervised setting, in order to receive assistance. This approach was proposed by President Clinton in 1994, and incorporated into numerous state demonstration projects approved by the Administration prior to the new welfare law. The law also supports the creation of Second Chance Homes, which will provide **teen** parents with the skills they need to become good role models and providers for their children, giving them guidance in parenting and in avoiding repeat pregnancies. The welfare law also provides \$50 million a year in new funding for state abstinence education activities, beginning in FY 1998. Finally, the new welfare law includes the tough child support enforcement measures President Clinton proposed in 1994, which will send the strongest possible message to young girls and boys that they should not have children until they are ready to provide for them.

Supporting Promising Approaches. The Clinton Administration continues to support innovative **teen pregnancy** prevention strategies tailored to the unique needs of communities. HHS-supported programs in this area already reach about 30 percent, or 1,410 communities in the United States. New funding in 1997 has built on these efforts. The Community Coalition Partnership program provided additional support for comprehensive **teen pregnancy** prevention programs in 13 communities with high rates of **teen pregnancy**. In addition, the Adolescent Family Life Program provided an additional \$9 million in new funding to enable communities to develop and implement 66 abstinence-based education and demonstration projects throughout the country. President Clinton continues this commitment in his FY 1998 budget plan, including \$14 million for the Adolescent and Family Life Program and \$14 million for the Community Coalition Partnership Program. HHS programs are based on five principles: parental and adult involvement; strong messages of abstinence and personal responsibility; clear strategies for young people's futures; involvement by all facets of the community; and a sustained commitment to young people.

Building Partnerships. The strategy will build partnerships among national, state, and local organizations. HHS will work with national youth-serving organizations to use their networks to promote activities that provide girls and boys opportunities for the future, including encouraging abstinence; with organizations working on behalf of teenagers with disabilities; and with the National Campaign to Prevent **Teen Pregnancy**, the private-sector group that has responded to President Clinton's challenge on this issue.

Improving Data Collection, Research, and Evaluation. The national strategy will work to improve data collection, research, and evaluation to further our understanding of the magnitude, trends, and causes of **teen** pregnancies and births; to develop targeted **teen pregnancy** prevention strategies; and to assess how well these strategies work.

Disseminating Information on Innovative and Effective Practices. Sharing information about promising and successful approaches is critical to expanding **teen pregnancy** prevention efforts across the country. Through the national strategy, HHS will continue to work with its partners to highlight innovative practices at the federal, state, and local levels and to disseminate new research and evaluation findings. The Department will also disseminate new information on the developmental needs of youth and on the use of broad-based activities to help teenagers avoid risky behaviors leading to **teen pregnancy**.

Sending a Strong Abstinence Message. The national strategy will place a special emphasis on encouraging abstinence, especially among 9- to 14-year-old girls, through HHS' Girl Power! campaign. The Girl Power! abstinence education initiative will engage all HHS **teen pregnancy** prevention and related youth programs in sustained efforts to promote abstinence among 9- to 14-year-old girls, and it will create a national media campaign to involve parents and caring adults in sending a strong abstinence message across the country.

- ③ The national strategy will also focus on boys and young men, by working to increase understanding of motivations for both abstinence and fatherhood and by developing effective prevention strategies for boys. These efforts will include working with the Administration's Fatherhood Initiative to ensure that men, including pre-**teen** and teenage boys, receive the education and support necessary to postpone fatherhood until they are emotionally and financially capable of supporting children. The strategy will

also build on existing HHS efforts, such as the Title X Adolescent Male Initiative, that promote responsible behavior among teenage boys.

On May 1, 1997, Secretary Shalala announced two new community grant programs to prevent **teen pregnancy** and promote responsible behavior. One program will be aimed at teenage girls and the other at teenage boys. Both programs are part of the National Strategy to Prevent **Teen Pregnancy**, announced by the Clinton Administration in January 1997. The grant program for girls is also part of the Secretary's Girl Power! campaign. Each of the grant programs will total about \$1 million per year, and will involve public-private partnerships organized by individual communities.

Current HHS Programs

- **The Community Coalition Partnership Program for the Prevention of Teen Pregnancy** is one of HHS's most comprehensive and innovative **teen pregnancy** prevention programs. In 1995, the Centers for Disease Control and Prevention awarded grants to community-wide coalitions in communities with high rates of **teen pregnancy**. CDC awarded approximately \$250,000 per year for two years to 13 communities in 11 states to help these communities mobilize and organize their resources to support effective and sustainable **teen pregnancy** prevention programs. For FY 1997, a total of \$13.7 million was made available to help the 13 community coalition partnerships implement their action plans and evaluate their impact, as well as to support related data collection, evaluation, and dissemination activities. President Clinton's FY 1998 budget plan includes \$14 million for this program.
- **The Adolescent Family Life Program (AFL)**, created in 1981, supports both research and demonstration projects. Approximately one-third of total AFL funds support research into the causes and consequences of adolescent **pregnancy**. Of the remaining funds, approximately two-thirds are used to support demonstration projects that provide health, education, and social services to pregnant and parenting adolescents, their children, male partners, and families. The remainder supports prevention programs aimed at promoting abstinence among pre-adolescents and adolescents as the most effective way of preventing adolescent pregnancies, sexually transmitted diseases, and HIV/AIDS. In FY 1997, AFL supported 17 projects in 14 states, and these will be continued in FY 1998. AFL also received an additional \$9 million to support abstinence education demonstration programs utilizing the definition of abstinence education contained in the welfare law. Of these funds, AFL awarded \$1 million in one-year pilot grants to 22 grass roots/community agencies in 19 states and the District of Columbia, and \$8 million in one-year grants to 44 public and non-profit groups for larger abstinence education demonstration projects. During FY 1998, AFL will be supporting a total of 83 demonstration projects.
- **Reproductive Health and Family Planning Services** (under Title X of the Public Health Service Act) are provided to nearly 5 million persons each year, nearly one third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients. The program has also launched an adolescent male initiative called the "Young Men/Family Planning Partnership Training Program." Under this initiative, Title X clinics employ male high school students as interns while also providing training in clinic operation and peer education; assisting in identifying career paths in allied health and related occupations; and increasing their use of services in a family planning setting. A second effort in this initiative is outreach beyond the traditional family planning provider network to organizations committed to working with young men. As part of this effort, the HHS Office of Population Affairs supported research grants in FY 1997 for male-oriented organizations that wish to add family planning education services for young men in their existing programs.
- **Healthy Schools, Healthy Communities**, a Health Resources and Services Administration program created in 1994, has established school-based health centers in 26 communities in 20 states to serve the health and education needs of children and youth at high risk for poor health, **teenage pregnancy**, and other problems.
- **The Social Services Block Grant (SSBG)** (under Title XX of the Social Security Act) provides

funding to prevent, reduce, or eliminate dependency; achieve or maintain self-sufficiency; prevent neglect, abuse, or exploitation of children and adults; prevent or reduce inappropriate institutional care; and provide admission or referral for institutional care when other forms of care are inappropriate. SSBG Grants are made directly to the 50 states, the District of Columbia, and Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands to fund social services tailored to meet the needs of individuals and families residing within each jurisdiction.

- **The Community Services Block Grant**, which operates in all 50 states, the District of Columbia, and the territories, enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services.
- **The Independent Living Program**, run by the Administration for Children and Families, provides funds to states to support activities ranging from educational programs to programs that help young people who are making the transition from foster care to independent living to avoid early parenthood. This program supports activities in all 50 states and the District of Columbia.
- **Youth Programs** including Runaway and Homeless Youth Programs, Transitional Living Programs, and the Youth Sports Program, address a wide range of risk factors for **teen pregnancy**. Together, these programs operate in 620 communities in 50 states and the District of Columbia.
- **The Community Schools Program** was created by the 1994 Violent Crime Control and Law Enforcement Act to support activities during non-school hours for youth in high-risk communities. Funds are awarded to public-private partnerships of community-based organizations to provide a broad spectrum of supervised extracurricular and academic programs after-school and during evenings, weekends and school vacations. Grantees also train teachers, administrators, social workers, guidance counselors, and parent and school volunteers to provide concurrent social services for at-risk students. The Administration for Children and Families awarded \$10.15 million in grants to 54 communities in 1997 under this program.
- **HRSA's Healthy Start** has 62 demonstration projects to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.
- **Maternal and Child Health Services Block Grant (Title V)** funds support a variety of adolescent **pregnancy** prevention activities in over 55 states and jurisdictions that include adolescent **pregnancy** prevention programs, state adolescent health coordinators, state prenatal hotlines, family planning, technical assistance, and other prevention services. Approximately 85 percent of the block grant funds are distributed under a formula which requires a match by the states. More than \$1 billion is generated under this federal-state partnership. Through the block grants, approximately 610 school-based and school-linked centers are supported. In addition, the Maternal and Child Health Bureau administers a program of discretionary grants using 15 percent of the Block Grant appropriation. In FY 1995-96, the Bureau awarded approximately 166 discretionary grants to support adolescent health programs each of which impacts directly or indirectly on the problems of **teen pregnancy**.
- **Empowerment Zones and Enterprise Communities** in 105 rural and urban areas in 43 states and the District of Columbia have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage **pregnancy** prevention and youth development.
- **Health education in schools** supports the efforts of every state and territorial education agency to implement school health programs to prevent the spread of HIV and sexually transmitted diseases

(STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

- **Community and Migrant Health Centers**, including family and neighborhood health centers, operate in 3,032 community-based sites through 685 center grantees in all 50 states, the District of Columbia, and six territories. The centers provide primary and specialized health and related services to medically underserved adolescents. Some centers include special hours or clinics for adolescent patients.
- **Indian Health Service (IHS)** provides a full range of medical services for American Indians and Alaska Natives. IHS supports projects targeted at preventing teenage **pregnancy**, and its prevention and treatment programs also have a special emphasis on youth substance abuse, child abuse, and women's health care.
- **Drug Treatment and Prevention Programs** include services to prevent first time and repeat pregnancies among teenagers. One hundred twenty-two residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services in 39 States, the District of Columbia, and the Virgin Islands. Also, 25 programs to prevent substance use and other adverse life outcomes serve high-risk female teens in 13 States and the District of Columbia.
- **Health Care and Promotion** under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- **The Medicaid program** also funds family planning services at an enhanced match rate for states. The federal government pays 90 percent of state expenditures for Medicaid family planning services, while the state funds the remaining 10 percent. The enhanced match encourages states to fund family planning programs which include patient counseling and education concerning **pregnancy** prevention and reproductive health.

Evaluation and Research

HHS has conducted research, surveillance, demonstrations, and evaluations on an ongoing basis to gather and provide information and technical assistance on the magnitude, trends, and causes of teenage **pregnancy** and on prevention programs and approaches that work, including:

- **"Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood"** is a two-volume comprehensive review completed for HHS by Child Trends, Inc. in June, 1995 of the most recent literature on **teen** sexual behavior, **pregnancy** and parenthood and the effectiveness of **teen pregnancy** prevention programs.
- As part of its **Youth Risk Behavior Surveillance System**, CDC helps states monitor critical health risk behaviors among teenagers, including sexual risk behaviors that result in HIV infection, other STDs, and **teen pregnancy**. In 1995, 40 states and territories and 16 large cities collected comparable data.
- The 1995 **National Survey of Family Growth**, released in May 1997, provides the latest and most comprehensive national data on fertility, contraception, marriage and cohabitation, infertility, adoption, maternity leave, medical services, breast-feeding, smoking and other factors that impact both teenage and adult women, and the health and well-being of their children. The study updates key trends, includes many new topics, and has significant new findings on teenagers. The findings of the 1995 survey showed that the long upward trend in **teen** sexual activity may finally have stopped with a slight decline between 1990 and 1995 in the percentage of teenagers who have had sexual intercourse. The survey also found a dramatic increase in the use of contraception at first intercourse.

- The **National Longitudinal Study of Adolescent Health (Add HEALTH)** is a comprehensive study of adolescent health funded by HHS' National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health and other HHS agencies. The study provides information about risky behaviors and resiliency factors in adolescents and about environmental influences, including parents, siblings, peers, schools, neighborhoods, and communities. Preliminary results of the study, released in September 1997, indicate that a feeling of personal connection to home, family, and school is crucial for protecting young people from a vast array of risky behaviors, such as cigarette, alcohol, and marijuana use, violent behavior, suicide, and sexual activity. The **National Survey of Adolescent Males**, supported by NICHD, OPA and other HHS agencies, will also provide relevant information on the behavior of young men and women.
- National Institutes of Health also conducts research and evaluation studies of promising interventions, including the "Adolescent **Pregnancy** Prevention Program", "Preventing Problem Behavior Among Middle School Students" program, and the "Research on Sexually Transmitted Diseases, Violence, and **Pregnancy** Prevention" (RSVPP) project.

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← pre-natal
care

Date: Thursday, Sept. 11, 1997

FOR IMMEDIATE RELEASE

Contact: Jeff Lancashire or Mary Jones (301) 436-7551 paoquery@cdc.gov

Vital Statistics Report Shows Significant Gains In Health

Broad gains in the nation's health, including a dramatic decline in the AIDS death rate as well as continued decline in the teen birth rate, was reported today by HHS' Centers for Disease Control and Prevention. The annual report, showing preliminary birth and death statistics for the United States in 1996, indicates that:

- HIV/AIDS mortality declined 26 percent between 1995 and 1996, falling from the leading cause of death among 25-44 year-olds to the second leading cause of death in that age group
- the teen birth rate declined for a fifth straight year
- a new record low was achieved in the infant mortality rate
- the number of women obtaining early **prenatal** care continued to increase.

"There is a wealth of good news in this report, and I'm particularly encouraged by the progress we are making against AIDS," said HHS Secretary Donna E. Shalala. "In 1993, this Administration began a sustained prevention, treatment, and research effort that continues to pay off today in ways we scarcely dared to hope. The 26 percent decline in deaths from HIV/AIDS in a single year reported by CDC today is truly a remarkable achievement." The report shows the national age-adjusted death rate from HIV/AIDS dropped an estimated 26 percent between 1995 and 1996, from 15.6 deaths per 100,000 population in 1995 to 11.6 in 1996. HIV infection, previously the leading cause of death for those 25-44, now ranks second behind accidents and adverse effects and just ahead of cancer. Earlier this summer, preliminary findings from another CDC survey had reported a similar pattern of decline in AIDS deaths over the first nine months of 1996. HIV/AIDS mortality had increased an average of 16 percent per year between 1987 and 1994, before leveling off in 1995. The new report, "Births and Deaths, United States: 1996," is prepared each year by CDC's National Center for Health Statistics. "This report contains good news for 1996, and more important, it shows positive trends continuing over an extended period of time," said CDC Director David Satcher, M.D., Ph.D. "The investments we have made in education and prevention programs are paying real dividends -- healthier babies, fewer teen pregnancies and births, and a reduction in the tragic human toll from HIV and AIDS. With a sustained commitment, our national partnership can continue to improve." This new vital statistics report contains preliminary data based on over 90 percent of birth and death records reported to states. The report reveals a number of other encouraging findings as well:

- The age-adjusted homicide rate dropped an estimated 11 percent in 1996, from 9.4 homicides per 100,000 population in 1995 to 8.4 in 1996.
- The age-adjusted suicide rate dropped an estimated 4 percent in 1996, from 11.2 to 10.8.
- Life expectancy reached an all-time high of 76.1 years in 1996, up from 75.8 in 1995. Record high life expectancies were reached for white and black males (73.8 and 66.1 years, respectively), and for black females (74.2). The gender gap in life expectancy narrowed from 6.4 years in 1995 to 6.0 years in 1996, while the race differential between the white and black populations narrowed from 6.9 years to 6.5 years.
- Infant mortality reached another new low of 7.2 deaths per 1,000 live births. The white infant mortality rate declined 5 percent (from 6.3 to 6.0), while the black rate declined 6 percent (from 15.1 to 14.2). An estimated 15 percent decline in mortality rates from Sudden Infant Death Syndrome (SIDS) explains approximately a third of the 1995-96 decline in total infant mortality.
- The teen birth rate for 15-19 year-olds dropped 4 percent in 1996, from 56.8 to 54.7. The teen birth rate has declined by 12 percent since 1991. In 1996, the birth rate for teens ages 15-17 dropped 6 percent while the rate for 18-19 year-olds dropped 3 percent. Among black teens 15-17 years of age, the rate fell 7 percent between 1995 and 1996 and 23 percent between 1991 and 1996.
- Unmarried childbearing remained essentially level in 1996, with a slight decline in the birth rate

1997.09.11 : Vital Statistics Report Shows Significant Gains In <http://www.hhs.gov/cgi-bin/waisgat...4426968+10+0+0&WALSaction=retrieve>

for unmarried women.

- The proportion of mothers beginning care in the first trimester (82 percent) improved again in 1996 (from 81 percent in 1995). Early care improved among white (84 percent), black (71 percent), and Hispanic mothers (72 percent) in 1996.
- The cesarean delivery rate declined for the seventh consecutive year (20.6 percent for 1996).

The report contained some less positive findings as well:

- The percent of babies born low birthweight increased slightly from 7.3 in 1995 to 7.4 in 1996, the highest level reported in more than two decades.
- Although they have declined for the total population, homicide and suicide remain the second and third leading cause of death respectively among young persons ages 15-24.

Data from this report come from birth and death certificates filed in the states and provided to the federal government through the National Vital Statistics System. The report can be downloaded from the NCHS Home Page on the Internet at <http://www.cdc.gov/nchswww/nchshome.htm>.

Note: HHS press releases are available on the World Wide Web at: <http://www.hhs.gov>.

Date: Tuesday, March 17, 1998

FACT SHEET

Contact: HHS Press Office (202) 690-6343

HHS CHILD CARE PROGRAMS: INVESTING IN OUR FUTURE

Overview: *The Clinton Administration has made ensuring safe, accessible, and affordable child care a top priority. The Department of Health and Human Services (HHS) leads the Administration's child care activities, coordinating federal child care assistance for families through the Child Care Bureau at the Administration for Children and Families. The Child Care Bureau works closely with states, territories and Native American tribes to improve child care delivery and to design programs that meet local needs.*

All across America, HHS' child care programs provide vital support for working families. This year, HHS child care programs, with a budget of \$3.1 billion, will provide child care services for more than one million children. The pioneering Head Start program, along with the new Early Head Start program, will provide services to approximately 830,000 children with a budget of \$4.4 billion.

To help plan future improvements, the first-ever White House Conference on Child Care was held on October 23, 1997. Conference participants discussed strategies for meeting the three key child care challenges: availability, affordability and assuring safety and quality.

Using lessons learned from the conference, President Clinton in January 1998 announced an historic initiative to improve and expand access to child care for America's working families. The President's FY 1999 budget includes approximately \$20 billion over five years for child care, approximately \$15 billion of which will go toward HHS child care programs and Head Start. This is the largest single investment in child care in the nation's history. The President's proposal will help working families pay for child care, build the supply of good after-school programs, improve the safety and quality of care, and promote early learning.

INCREASING OUR INVESTMENT

An Historic Child Care Initiative. President Clinton's FY 1999 budget proposal includes approximately \$20 billion over five years for child care. This historic investment would put us on track to double the number of children receiving child care subsidies to more than two million by the year 2003 by increasing funding for the Child Care and Development Block Grant by \$7.5 billion over 5 years. Additionally, the initiative increases tax credits for three million working families to help them pay for child care and provides after-school care for up to half a million children per year. Addressing the need for quality in child care, the President also proposed a new Early Learning Fund to enhance early childhood development; additional funding for stronger enforcement of state child care health and safety standards; a Child Care Provider Scholarship Fund to provide 250,000 scholarships over five years to students working toward a child care credential; and a Research and Evaluation Fund to expand the range of knowledge about our child care system, particularly the issues facing low income parents. In March 1998, HHS released a new report showing that states are pursuing innovative strategies to improve child care quality. However, states need more resources to help working families afford child care. The President's plan would provide much needed child care funds to states, allowing them to expand child care services and to help more families who are eligible for federal child care assistance but not currently served.

Increased Funding. As a result of the President's efforts, federal child care funding has increased by 68 percent since 1993, and now HHS child care programs provide child care services for over 1 million

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the Most Out of School Time project and on community programs that are using volunteer service participants in school-age programs. The initiative is also designed to encourage children and youth to participate in community service activities. The President has also proposed an \$800 million increase in the 21st Century Learning Fund administered by the Department of Education as part of his comprehensive child care initiative.

Child Care Research. HHS launched the Child Care Policy Research Consortium to study child care needs, opportunities, constraints, utilization patterns and outcomes for low income families, as well as systemic issues which affect subsidized child care. Established in 1995, the consortium consists of five new partnerships including universities, state agencies, resource and referral programs, and other organizations. A child care research symposium was held in June 1996 to advance understanding of current knowledge and its practical applications for state-level child care policymakers. In addition, HHS recently funded a national study of low-income child care. The President has proposed a \$150 million Research and Evaluation Fund as part of his child care initiative in order to expand the range of knowledge about our child care system, particularly the issues facing low income parents.

Serving Special Populations. The Clinton Administration has made a commitment to meeting the needs of special populations and children with special needs. HHS has initiated a special initiative to assist ten states to develop and implement effective plans aimed at improving and expanding their child care service delivery system. The project, "Map to Inclusive Child Care" will expand to other states over the next three years. The Child Care Bureau also provides targeted technical assistance to Native American child care programs across the nation.

SUPPORTING THE HEAD START PROGRAM

Increased Funding. Under the Clinton Administration, funding for Head Start has doubled, increasing from \$2.2 billion in FY 1992 to \$4.4 billion in FY 1998. These additional funds have enabled Head Start to serve more than 116,000 more children and their families, enhance the quality of Head Start services, launch a new initiative to serve infants and toddlers, and improve program research. In FY 1998, Head Start will serve an estimated 830,000 children and their families. President Clinton's FY 1999 budget provides \$4.7 billion for Head Start -- an increase of \$305 million over FY 1998. This funding will enable Head Start to serve an additional 30,000 to 36,000 children in FY 1999, bringing total Head Start enrollment to 860,000 to 866,000 children and their families. This investment also sets the course for reaching the President's goals of serving one million children in Head Start and doubling the number of infants and toddlers in Early Head Start to nearly 80,000 by 2002.

Creating the Early Head Start Program. The landmark Head Start Act Amendments of 1994 established the new Early Head Start program, which expands the benefits of early childhood development to low income families with children under three and to pregnant women. Currently there are 173 Early Head Start programs in the 50 states, District of Columbia and Puerto Rico. In FY 1998, funding for Early Head Start totals \$279 million, and approximately 39,000 children will be served by Early Head Start programs across the country. President Clinton's FY 1999 budget includes \$350 million for Early Head Start, allowing the program to serve nearly 50,000 infants, toddlers, and their families.

Linking Head Start and Child Care. In March 1997, HHS announced that Head Start expansion funds will be used for the first time to build partnerships with child care providers to deliver full-day and full-year Head Start services. Through these new expansion grants, Head Start and child care agencies will combine staff and funds to provide high quality services. Children will stay in one place all day, rather than attending Head Start for half a day and then moving to child care for the remainder of the day. In addition, the expansion funds will provide for increased Head Start slots for children.

Assuring Head Start Quality. In November 1996, HHS published revised Head Start Program Performance Standards, developed with the consultation of over 2000 experts from the fields of child development, early childhood education, health, family support services, social services, Head Start grantees and parents. These revised, more user-friendly standards remove rigid and prescriptive requirements, integrate infants and toddlers into the Head Start program, and promote collaboration with other community programs.

ENSURING HEALTH AND SAFETY IN CHILD CARE

Launching the Healthy Child Care America Campaign. In May 1995, HHS launched the Healthy Child Care America Campaign to promote partnerships between child care and **health** agencies to ensure that children in child care are in safe and healthy environments and receive the **health** services they need. In October 1996, HHS awarded \$2.5 million in grants to 48 states, the District of Columbia, Puerto Rico and the Republic of Palau to support and encourage the development of statewide strategies and planning for healthy, safe child care programs. The award of these grants is the product of a collaborative effort between two agencies in HHS: the **Health** Resources and Services Administration's Maternal and Child **Health** Bureau, which will administer the grants, and the Administration for Children and Families' Child Care Bureau. The activities of the projects include formation of statewide Healthy Child Care Campaigns, investments in systems and services to increase child care capacity, programs to address children with special needs and the training of child care providers in **health** and safety. The projects are funded for three years.

New Child Care Regulations. On July 23, 1997, President Clinton proposed new child care regulations that will help more children in child care receive the immunizations they need on time. The proposed rule requires that all children receiving federal child care assistance be immunized according to state public **health** agency standards. This regulation will particularly affect those children in child care arrangements that are legal but exempt from state licensing requirements.

Health and Safety Protections. Under the Child Care and Development Block Grant (CCDBG) Act, states were required to establish **health** and safety standards for the prevention and control of infectious diseases, including immunizations; building and physical premises safety; and minimum **health** and safety training for providers accepting CCDBG funds. Under the new welfare law, all child care providers serving children funded by CCDF must meet the **health** and safety requirements set by States and Tribes.

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Date: Thursday, September 11, 1997

FACT SHEET

Contact: HHS Press Office (202) 690-6343

PREVENTING INFANT MORTALITY

Overview: Thanks to an intensified national commitment to giving babies a healthy start in life, the U.S. infant mortality rate, which is the rate at which babies die before their first birthday, is at an historic low of 7.2 deaths per 1,000 live births in 1996, and the proportion of mothers getting early **prenatal** care is at a record high of 82 percent. We've also seen declines in some of the risk factors for low birthweight and infant mortality: teen births dropped for the fifth straight year in 1996 and smoking among pregnant women has been decreasing in recent years. Nevertheless, the United States continues to have unacceptably high infant mortality rates with significant disparities among racial and ethnic groups.

The Clinton Administration supports a comprehensive national strategy to increase access to **prenatal** care and to help families care for infants. Early and continuous **prenatal** care helps prevent low birthweight and identify conditions and behavioral factors that often cause or aggravate low birthweight, such as smoking, drug and alcohol abuse, inadequate weight gain during pregnancy, and repeat pregnancy in six months or less.

To further help assure that women have proper **prenatal** care, HHS in February 1997 announced the nation's first toll-free referral and information service to help women obtain proper **prenatal** care throughout their pregnancies. Callers in all 50 states can now call 1-800-311-BABY (2229) for pregnancy and **prenatal** care information, including referral to local clinics and physicians. A separate phone number is available for Spanish speakers: 1-800-504-7081. The toll-free service is supported by the Healthy Start program in HHS' Health Resources and Services Administration.

HHS Initiatives

The Administration's strategy is reflected in all of HHS' infant mortality prevention activities. For example:

- The public-private "Back to Sleep" campaign has contributed to a nearly 40 percent decline in the death rate from Sudden Infant Death Syndrome (SIDS) in the U.S. between 1992 and 1996. Led by the National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and other HHS agencies, and co-sponsored by the American Academy of Pediatrics and other groups, the campaign encourages caregivers to place babies on their backs to sleep to reduce the risk of SIDS.
- Based on emerging evidence from epidemiological and clinical studies, including studies funded by the Centers for Disease Control and Prevention (CDC) and NIH's National Institute of Child Health and Human Development (NICHD), in September 1992, the Public Health Service issued a recommendation that all women of childbearing age consume 400 micrograms of folic acid daily to reduce their risk of having a pregnancy affected by a neural tube defect (e.g., spina bifida or anencephaly). To aid in implementing this recommendation, HHS' Food and Drug Administration promulgated regulations to require the mandatory addition of folic acid to all cereal grain products labeled as enriched (e.g., breads, pastas, rice) and authorized the use of a health claim that communicated the relationship between dietary folate and risk of neural tube defects on foods that were good sources of folate. Neural tube birth defects affect about 4,000 pregnancies each year.
- HRSA's Healthy Start Initiative, a demonstration effort in 62 communities with high infant mortality rates in 32 states and Puerto Rico, has developed promising replicable models for

collaborative community-based interventions to reduce infant mortality.

- HHS has expanded perinatal services and service hours at community health centers in communities with the highest infant mortality rates through programs administered by HRSA's Healthy Start Initiative and Bureau of Primary Health Care. These programs also provide counseling on the dangers of cigarette smoking, drinking alcohol, and substance abuse during pregnancy, and smoking cessation services.
- HHS has expanded Medicaid eligibility and services for pregnant women and their infants. Individual states have tailored the implementation of these expansions to their residents' needs, adding, for example, provisions for outreach and perinatal/parenting education, more providers, and streamlined application procedures to facilitate early and continuous prenatal care. Families are encouraged and offered assistance to obtain well-child screenings that can identify and treat health problems and further reduce infant mortality.
- HHS provides information to women and their physicians on HIV testing and treatment with the anti-HIV drug zidovudine (AZT) to reduce transmission of HIV from mother to child. New guidelines and educational materials have been produced by HHS, in collaboration with the Columbia University School of Public Health.
- HHS helps fund high-quality treatment programs for pregnant and postpartum women through the Center for Substance Abuse Treatment (CSAT) in the Substance Abuse and Mental Health Services Administration and HRSA's Maternal and Child Health Bureau. Of the women who completed treatment in CSAT-funded programs in 1996 for whom there are outcome data, 98 percent remained drug-free for at least 30 days post-treatment, and 81 percent remained drug-free for four to six months.
- HHS supports the provision of reproductive health and family planning services through the Title X program. Each year, some 5 million persons receive Title X- supported services, nearly a third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients. HHS also encourages states to provide a wide array of family planning services under Medicaid by reimbursing states for 90 percent of the costs expended on these services.
- HHS also supports medical research to prevent birth defects, premature birth, sudden infant death syndrome and other life-threatening conditions. For example,
 - The wider use of corticosteroid treatments during premature labor, a clinical practice endorsed by the NIH Consensus Development Conference based on research supported by NICHD, has reduced deaths of premature infants, respiratory distress syndrome, and internal hemorrhage in the infant.
 - Treatment with surfactant, discovered and developed through research supported by NICHD and the National Heart, Lung and Blood Institute, has also reduced deaths of premature infants from respiratory distress syndrome.
 - NICHD-supported research has shown that treatment of a common condition known as bacterial vaginosis with specific antibiotics can reduce the risk of a premature delivery. Clinical trials are in progress to determine which precise treatment would be most effective.
 - The CDC is examining sociocultural, behavioral, and environmental factors, including stress and social support, related to preterm births among African-American women in Harlem, New York and Los Angeles, California.

HHS also works in partnership with many civic and business organizations in efforts to reduce infant mortality, including Johnson & Johnson, March of Dimes, Robert Wood Johnson Foundation, Colgate Palmolive, Carnegie Corporation, Kellogg Foundation, and many more.

Recent Trends

Due in part to long-standing medical research and social services supported by HHS, infant mortality has declined considerably in recent decades. Over the past twenty-five years alone, the infant mortality rate has dropped from 20 deaths per 1,000 live births in 1970 to less than 8 deaths per 1,000 live births in 1996.

- Infant mortality dropped to 7.2 deaths per 1,000 live births in 1996, down 4 percent since 1995 and nearly 22 percent since 1990. Declines occurred among both neonates (infants under 28 days of age) and postneonates (infants aged 28 days to 12 months).
- Between 1995 and 1996, the white infant mortality rate declined 5 percent, to 6 deaths per 1,000 live births, while the black infant mortality rate declined 6 percent, to 14.2 deaths per 1,000 live births. While the gap did not widen in 1996, the black infant mortality rate remains more than twice as high as the white infant mortality rate.
- Compared to the white infant mortality rate, the American Indian/Alaska Native infant mortality rate is 70 percent higher, and the Asian/Pacific Islander rate is 11 percent lower. The infant mortality rate for Hispanic-origin infants is nearly 3 percent higher than for non-Hispanic white infants (based on linked birth/infant death data from 1989-91).
- In 1996, the leading causes of infant mortality in the U.S. were: congenital anomalies, disorders related to immaturity (short gestation and unspecified low birthweight), SIDS, and respiratory distress syndrome.
- In 1996, a record-high 82 percent of mothers began **prenatal** care within the first trimester of pregnancy, the seventh consecutive year of increase from 75.5 percent in 1989. However, in 1995, the most recent data available, about a third of teen mothers ages 15 to 19 (33.7 percent) did not begin **prenatal** care in the first trimester.
- Disparities in the timely receipt of **prenatal** care between white mothers and black and Hispanic mothers still exist, but have narrowed. From 1989 to 1996, first trimester **prenatal** care increased 19 to 21 percent for black and Hispanic mothers (to 71 percent and 72 percent, respectively) and 6 percent for white mothers (to 84 percent).
- The incidence of low birthweight increased slightly in 1996, from 7.3 percent to 7.4 percent in 1996, the highest level reported in more than two decades.
- Cigarette smoking during pregnancy declined for the fifth consecutive year in 1995, to 13.9 percent of mothers. Over 12 percent of births to smokers were low birthweight (less than 2,500 grams or 5 pounds 8 ounces) compared with almost 7 percent of births to non-smokers.
- Among industrialized countries in 1993, the U.S. had the 25th lowest infant mortality rate, down from the U.S. rank of 22nd in 1992.

Promoting Healthy Children

At HHS, infant mortality prevention is part of our overall early childhood strategy, which includes a number of initiatives to help protect and support young children.

- In 1995, the Clinton Administration launched the "Early Head Start" program to expand the proven benefits of early childhood development to low-income families with children under three and to pregnant women. Using FY 1997 funding, the program served nearly 27,000 children and their families.

- The Clinton Administration's comprehensive Childhood Immunization Initiative, combined with resource increases for immunization and outreach, is beginning to pay off. Today, the number of two-year-olds properly immunized in the United States is at an all-time high of 78 percent and vaccine-preventable diseases are at record lows.
- Through Clinton Administration efforts to ensure that parents have access to reliable and affordable child care, child care funding has increased by approximately 68 percent since 1993. HHS also launched the Healthy Child Care America Campaign to improve the health and safety of child care programs and to provide child health education to child care providers and parents.
- In 1994, HRSA's Healthy Schools, Healthy Communities Initiative was launched to provide easy access to comprehensive primary care, including mental and dental services, for homeless and low-income children who are at risk for both poor health and school failure. This initiative funds 26 school-based health centers in 23 states and the District of Columbia. This year, these health centers will provide over 24,000 children with vital preventive and curative services, as well as teaching them skills to keep them healthy for life.
- On August 21, 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996, improving the availability of health insurance to working families and their children by providing important new protections for an estimated 25 million Americans (approximately 1 in 10) who move from one job to another, who are self-employed, or who have pre-existing medical conditions.
- At President Clinton's urging, the Balanced Budget Act of 1997, signed into law by the President on August 5, 1997, provides the largest increase in funds available for health insurance for low-income children since the creation of Medicaid in 1965. The \$24 billion set-aside for children will allow states to extend health coverage to millions of uninsured children by expanding their current Medicaid programs or by creating new health insurance plans.

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For more information on Healthy Start, contact HRSA's Maternal and Child Health Bureau at (301) 443-0543. For more information about the Back to Sleep campaign contact Ruth Dubois at (301) 496-5133. For more information about the use of folic acid to prevent neural tube defects, contact Judith Foulke at (202) 205-4144. For consumer information materials on the risks and benefits of AZT therapy during pregnancy, call the HIV/AIDS Treatment Information Service (ATIS), toll free, at 1-800-448-0440 or 1-800-243-7012 (TTY service for the deaf). Information about substance abuse treatment programs for pregnant and postpartum women is available through the National Clearinghouse for Alcohol and Drug information (NCADI), at 1-800-729-6686.

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Closing Address at
Safe Motherhood Matters: Ten Years of Lessons & Progress
Technical consultation in Colombo, Sri Lanka
23 October 1997

by Dr. Fred T. Sai

Distinguished ladies, gentlemen, friends, and colleagues for safer motherhood:

Introduction

We came here today with many thoughts, feelings and expectations; some agonizing, some sad. By now I think all of us have a certain level of anger, which I hope will become creative anger in the time to come. To reflect back on the emotionally charged evening on which we started, there are probably souls and spirits of many, many women surrounding us as we sit here today, egging us on, praying for us, and hoping that we will not fail the next generation. May I, in all humility, ask you all to stand up for one minute of silence for all of the women of the world whom we have failed in the last ten years.

I thank you very much. Now why did we start this Safe Motherhood movement? When did we start it and why? It was in 1987, when we were made aware of the magnitude of maternal mortality. These data, which showed such disparity between developed and developing countries, created outrage in many of us. Many international agencies were concerned that a problem – a problem which affects one half of mankind, a problem for which the technologies were available, for which the knowledge was available – could be allowed to create so much hardship among women. And therefore, we decided to launch this initiative and call the world to action.

Ten years ago in Nairobi, 32 countries were represented; here today we have 65. Half of the participants then were physicians; today, only one quarter are physicians. Then 60 percent were male; today 60 percent are female. Ten years ago we discussed the causes of maternal death and we highlighted the need for action. Many of us have been wondering this week why are we here *today*? We are here today because we know that maternal mortality is still rampant. We know that while it is difficult to measure, and therefore our data are not exact, maternal mortality it has proven more difficult to bring down than we thought ten years ago.

We were shocked when WHO and UNICEF came out with a statement that instead of 500,000

maternal deaths each year, there are in fact 585,000. There have been questions as to the accuracy of these statistics but, despite that, we know that this is a very high and unacceptable figure: 1,600 maternal deaths per day. But even more unacceptable is that 99 percent of these are occurring in the developing world.

Only 53 percent of women in the developing world are attended at delivery by a skilled health worker, compared to 99 percent in the more developed world. Only 30 percent of women in the developing world receive at least one postpartum care visit, compared to 90 percent in the more developed world. The majority of maternal deaths occurs in the postpartum period – 61 percent. More than half of these occur within one day of delivery. Unsafe abortion accounts for a significant proportion of our maternal deaths, almost 80,000 a year. In some countries, the goal we set 10 years ago of reducing maternal mortality by 50 percent would have been achieved wholly by eliminating deaths to due unsafe abortions.

But despite these gloomy statistics, I believe that we have achieved something that might not have been achieved if the Initiative had not started. The issue of making motherhood safer is finally on the international agenda – although it wobbles occasionally, and it requires constant vigilance from all of us to keep it there. Sexual and reproductive health has become the accepted term and the accepted approach. However, a closer look at many SRH programs reveals that in fact, reproduction is often left out – just as ten years ago, Alan Rosenfield and his colleagues noted that the “M” was often missing from “MCH” programs. When we argue for an integrated, holistic approach, we must ensure that safe motherhood receives the priority and the support that it deserves.

We also must not forget that safe motherhood itself is integrally linked with a background scenario that includes empowerment of the woman and development from infancy and childhood of the girl child, as emphasized at the Beijing and Cairo conferences as well as the World Summit on Social Development and the World Conference on Human Rights. When advocating for safer motherhood to governments, we must not focus exclusively on the technical interventions and forget the larger background scenario of development, which difficult as it is, must be achieved if our work is to be done. When corpses are coming down a river and you keep picking them out, you will be failing if you did not go up river to see why they are dying up there. One of our obligations is to be sure that this full development agenda is kept very much to the forefront.

Safe Motherhood: Lessons Learned

While we must accept the reality that maternal mortality has not declined significantly on a global level, we **can** still point to the achievements of the Initiative over the past ten years. Our agenda this week was structured around several key messages, both technical and political, that reflect the knowledge we have gained. Technically, we have learned a great deal, and one lesson we have learned — and must address directly and emphatically — is that some of the strategies we were recommending ten years are not necessarily the most effective.

For example, we have learned that **every pregnancy faces risks**. Some of these risks can be predetermined, others cannot. But because the complications of pregnancy and childbirth are difficult to predict, the risk approach as a basis for rationing health care is not effective and can, in fact, lead to potentially life-threatening inequities and inefficiencies in the provision of maternal health care.

Since risk-screening has heretofore been a major component of antenatal care, existing antenatal care services must be fundamentally re-oriented and integrated with other maternal health services. The aim, which should be clearly stated, is to identify and manage any health problems that a woman may have. There are countries in this world where the antenatal visit may be the only contact a woman may have with the health system, and we should use the opportunity to identify the care that she needs and give her that care. It is an opportunity to educate not just the mother herself, but also her husband, her family, indeed her whole community about the needs of pregnancy and childbirth. We should not simply condemn antenatal care as purposeless activities during the antenatal period. Let us have defined purposes for this care to help us come to terms with how much, how often, and when.

We have learned that **skilled attendance at delivery is essential**. Having a health worker with midwifery skills present at childbirth is both a key indicator of progress and the most important goal for the Initiative for the next ten years. Who that skilled attendant is will, of course, vary by country. While we had high expectations ten years ago of training programs for traditional birth attendants (TBAs), we have no evidence that attendance at delivery by TBAs without a variety of other backstopping mechanisms reduces maternal mortality. In some communities where the use of TBAs is strongly rooted in local customs it may still be beneficial to train TBAs to recognize and refer complications, and to strengthen linkages between TBAs and the formal health system. In other words, where TBAs exist they have a role as community health service linkage personnel. They have a role as transmitters of some of our knowledge in a context that the people will find comfortable. The main emphasis, however, should be on ensuring that there are providers trained in midwifery available to attend deliveries at the community level. These providers also must be able to recognize danger signs and must be able to refer

cases promptly and safely.

We have also realized how important it is to **improve access to quality maternal health services**. We have learned that women face many barriers in seeking care: physical barriers of poor roads and long distances; financial barriers which may increase due to structural adjustment policies or public expenditure policies that result in unaffordable fees; or problems with the quality of services, including poor provider attitudes. We have also learned that the barriers can be overcome with practical, low cost solutions developed by and with the community itself. Poorly functioning health systems deny health workers the ability to provide considerate service women want and need.

We have learned that **prevention of unwanted pregnancies** is reasonably easy and necessary. Understanding clients' perspectives and needs is the key to providing family planning services in a way that will enable them reach their reproductive goals in a healthful manner. This implies addressing gender inequities in society as well as practical changes in how family planning services are provided and evaluated.

And we have learned that however contentious the issue, we must not and cannot ignore the issue of **unsafe abortion** when talking about Safe Motherhood. To aim for a unified stance on this issue is perhaps a pipe dream, but it is shameful that abortion is still either completely ignored or hotly debated — but rarely addressed, despite the fact that abortion-related deaths are the most preventable cause of maternal mortality today. Irrespective of the law, abortions take place everywhere in the world in large numbers. The more restrictions there are, the more deaths there are following covert abortions unsafely performed. Even in countries where abortion is legal, women have difficulty accessing safe and humane abortion services, and still die because of lack of knowledge or lack of access. In legally restricted settings, women who seek clandestine abortions are often subject to physical and financial abuse. Providers are not subject to regulations or standards, nor is there any mechanism for training in clinical as well as vital counseling skills. Providers and policy makers need to take responsibility for providing safe abortion to the full extent allowed by law, and in all settings we must manage the complications of unsafe abortions when they occur. To treat women who are suffering the complication of unsafe abortions worse than we treat criminals is a shame, and an affront to our humanity.

Now how do we **measure progress**? We have come to the conclusion that collection of data on maternal mortality to determine ratios is difficult and expensive, and the resulting estimates are imprecise and cannot be used to assess program impact. We therefore need to focus instead on identifying tools to assess program impact and quality, such as maternal death audits and case reviews,

as well as process indicators.

Finally, we have talked throughout this meeting on the **power of partnership**. Access to good quality care for safer motherhood is a human rights issue, and safe motherhood should be a priority program for governments, for policy makers, health providers, and for civil society at large. We want to convince them that it is in their own interest, and ours as well, that alliances to be formed. We need the human rights and women's rights advocates, and we need men's groups and religious groups. We need the NGOs, we need donors and we need various sectors of government for resources. Finally, we noted this morning that today's world is the world of communications, therefore we need the communications people and the media. We want them to be with us, we want them to take the message and package it so that people who **should** listen **will** listen. The Safe Motherhood Inter-Agency Group has itself demonstrated in a very practical way that inter-governmental, governmental and non-governmental organizations can work together and work together well.

Emerging Issues for Safer Motherhood

Because this was a technical consultation, we have focused much of our discussion on extracting lessons from the past ten years of research and programmatic experience. That has meant, however, that we may not have focused on other important issues that are critical to safe motherhood but where we do not yet have enough research findings or experience to come to definitive conclusions. This does not mean that these issues are not important, and that we cannot do something about them in the meantime. They include:

- ▶ Violence against women, which often increases during pregnancy and can contribute to unwanted sex and unwanted pregnancy;
- ▶ HIV/AIDS and other sexually transmitted diseases, which we know are a major killer of women, pregnant and non-pregnant;
- ▶ Nutrition and micronutrients supplementation: the vitamin A issue has not been settled, and we need to be able to come to closure on this;
- ▶ Male responsibility and male partnership.

Conclusion

Ladies and gentlemen, we have traveled a long road together, a road some of us have traveled long before we came to Nairobi. From here we have perhaps an even more tortuous road in front of us,

but we have hope, we have courage, we have knowledge, we have good will — and we have a clear and urgent goal.

We must define maternal mortality as a social injustice that reflects society's failure to value and protect women. Women should not die just because they are women. Governments must recognize their responsibilities to provide for the special care that women need, starting from birth, continuing through childhood and adolescence, and particularly during pregnancy and childbirth. The social, cultural, legal, and other inequities faced by women throughout their life cycles must be identified and fought. Education and improved status gives the girl-child more autonomy, so we must increase women's ability to make and act on decisions regarding sex and birth, particularly first births. Safe motherhood is a key to social and economical growth. Women's contributions sustain the family, community and nation. Investing in their survival and well-being makes economic sense as well as being a moral imperative.

There are times when people look at the gigantic world, the power politics of the world, and we ask ourselves, what can we do? We are in a battle where everyone can contribute. I would like to share with you a Methodist hymn I learned as a boy:

Do not wait until some deeds of greatness you may do,

Do not wait to spread your light afar.

To the many duties ever near you now be true

Right in the corner where you are.

Each and every one of us has a role to play in his home, in his work or community. Let us seize the opportunity. Women are, inevitably, charged with the responsibility of replenishing the human resource base. We cannot accept that in performing this task, society should make them put their lives on the line, when the methods for making it a safe, joyful, and rewarding experience are available. Thank you.

Making Pregnancy and Childbirth Safer

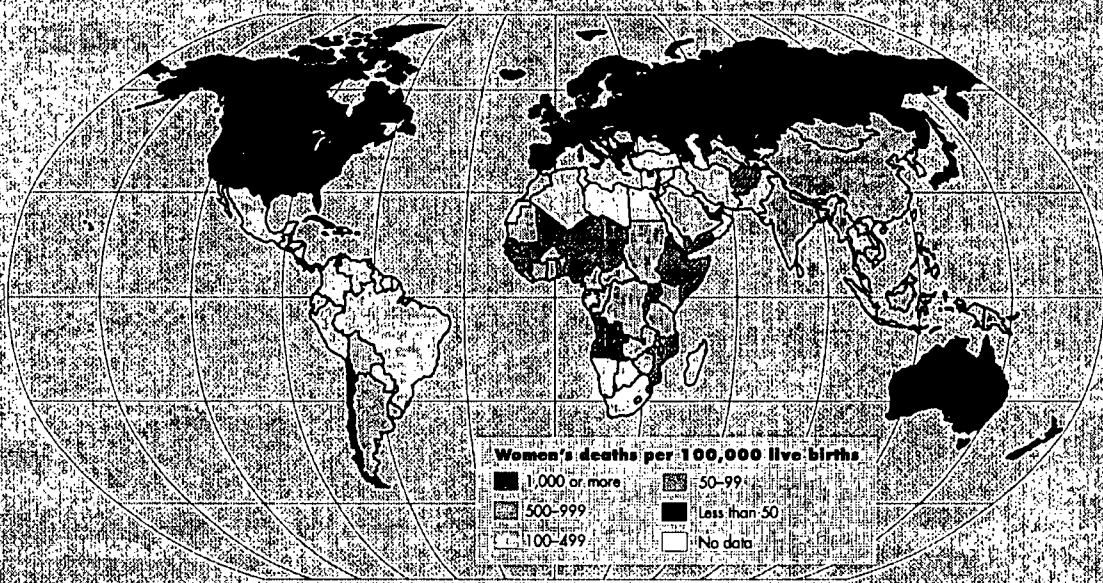
Nearly 600,000 women die of pregnancy-related causes each year. Ninety-nine percent of these deaths occur in the developing world. Many of these deaths can be prevented, however, with increased awareness of the problem and appropriate interventions.

A woman's lifetime risk of dying from pregnancy-related complications or during childbirth is one in 48 in the developing world, versus only one in 1,800 in the developed world. The risk of dying from pregnancy-related causes is highest in Africa, both because African women are pregnant more often than women on other continents and because risks are greater with each

pregnancy (see Figure 1). Because of the much larger population, however, each year the majority of maternal deaths take place in Asia.

Interventions can improve the chances of women's survival and can also save many of the 3 million to 4 million babies who die annually in the first month of life. Existing health services have contributed to dramatic declines in infant mortality over the past 30 years, but maternal mortality rates have not improved. The majority of complications that cause maternal deaths cannot be averted simply by improving women's overall health or nutritional status.

Figure 1
WOMEN'S DEATHS RELATED TO PREGNANCY AND CHILDBIRTH BY COUNTRY



Source: Population Reference Bureau, 1997; World Population Data Sheet, 1997

Making Pregnancy and

What causes maternal deaths?

Maternal deaths have both direct and indirect causes. About 80 percent of maternal deaths are due to direct causes, which include obstetric complications such as severe bleeding, infection, unsafe abortion, hypertensive disorders, and obstructed labor. Women also die of indirect causes such as malaria, diabetes, hepatitis, and anemia (see Figure 2). These causes are aggravated by pregnancy.

The environment in which women live influences maternal health. Maternal deaths are strongly associated with substandard health services and the unavailability of medical supplies at the time of labor, delivery, and immediately after birth. Women may also delay or not seek treatment because of logistical, social, or cultural barriers.

Most births in developing countries—about 60 percent—take place outside health facilities. Births at home need not be unsafe,

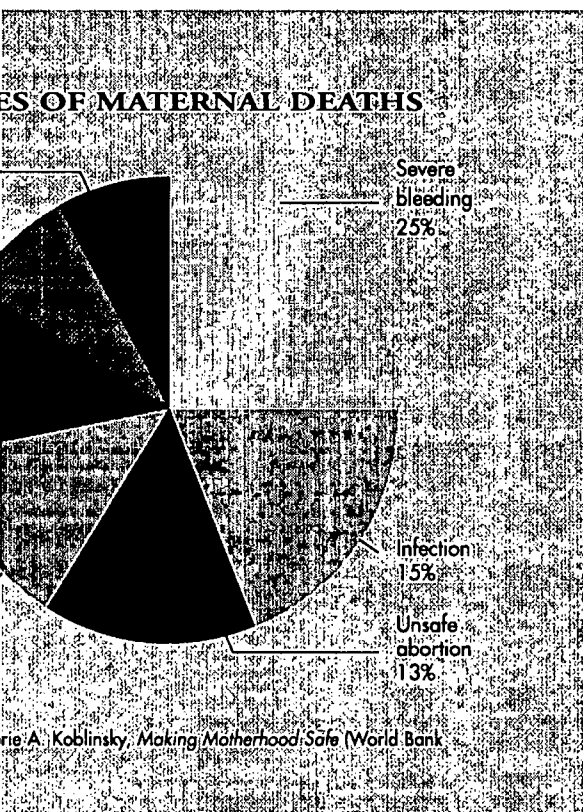
provided that a woman's family and her birth attendant can recognize the signs of labor and delivery complications and, if complications occur, move her to a facility where trained professionals can provide adequate care. In far too many cases, however, women are not brought to facilities in time. The warning signs of complications may not be recognized, or families may fear being treated badly, charged high fees, or receiving substandard care at such health facilities. Even deliveries in health facilities may be needlessly risky, because the quality of obstetric care is inadequate.

What are the consequences?

A mother's death has profound consequences for her family: In some developing countries, if the mother dies, the risk of death for her children under age 5 is doubled or tripled. In addition, because these women are stricken during their most productive years, their deaths have a profound impact on society and the economies of their nations.

Furthermore, for every maternal death, many more women suffer from injuries, infections, and disabilities related to pregnancy and childbirth. Studies show that women bear injuries as distressing as ruptures of the uterus, pelvic inflammatory disease, and fistula—damage to the reproductive tract, which can lead to incontinence if not repaired—as a consequence of childbirth. The World Health Organization (WHO) estimates that more than 15 million women per year fall victim to untreated injuries that occur during pregnancy and childbirth.

The World Bank and WHO estimate the cost per person of disability and untimely deaths in order to measure the cost-effectiveness of various health interventions. "Disability-adjusted life years," or DALYs, are the measure used to express how a healthy life is affected by disease. This measure combines the loss of healthy life from



Childbirth Safer

premature death with the loss of healthy life from disability. Women in the developing world lose more DALYs—28 million—to maternal causes than to any other cause (see Figure 3).

What can be done to make pregnancy and childbirth safer?

Maternal deaths can be prevented with existing knowledge and technology. Because all pregnant women face some unpredictable risks—15 percent of pregnant women will require medical care in order to avoid death or disability—they need to be able to recognize the symptoms of complications and have access to medical care when complications arise. Governments that wish to make pregnancy and childbirth safer can take some basic steps.

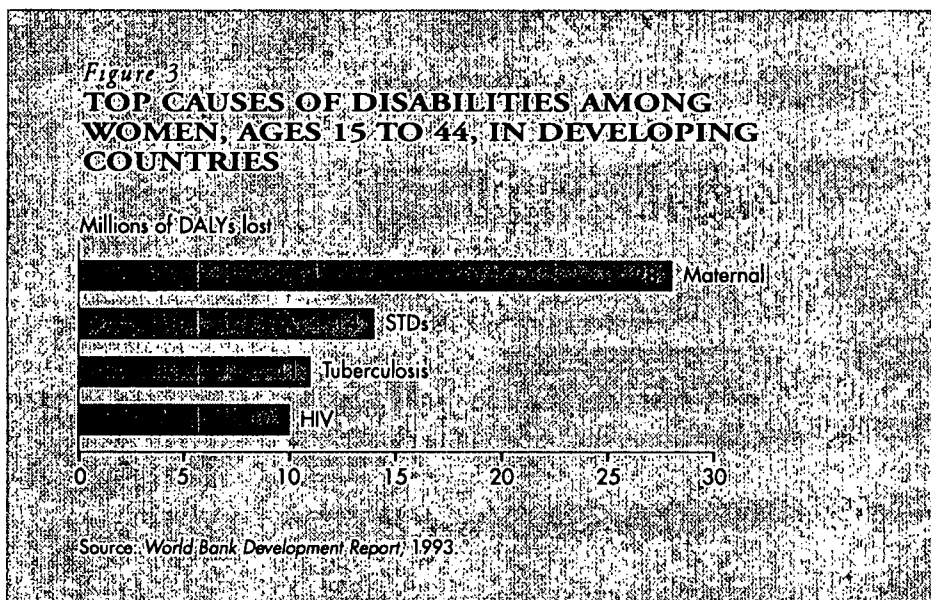
Increase access to family planning

methods. Family planning can prevent many maternal deaths by helping women prevent unintended pregnancies and by reducing their exposure to the risks involved in pregnancy and childbirth. Family planning allows women to delay motherhood, space births, prevent unsafe abortions, protect themselves from sexually transmitted diseases—including HIV/AIDS—and stop childbearing when they have reached desired family size.

Improve the quality of prenatal care.

Most women in developing countries now receive some kind of health care during pregnancy, but this care is not always effective. Prenatal care should include screening and treatment for STDs and anemia, as well as detection and treatment of pregnancy-induced hypertension. Recent studies suggest that taking vitamin A supplements during pregnancy can reduce maternal mortality. Prenatal counseling also gives women information about appropriate diet and other healthy behaviors and about where to seek care for pregnancy complications.

Ensure recognition of complications of pregnancy and delivery. Many women, especially in rural areas, live far from sources of adequate obstetric care. Families and birth attendants need to be aware of the warning signs of complications and must act quickly



to get women in need to health facilities. Wherever possible, communities should have specific plans for transporting women who suffer complications during childbirth.

Ensure access to essential obstetric care. Trained midwives can manage or stabilize some complications—for example, by providing women with antibiotics for infections or with injections to prevent excess bleeding. Midwives can also have an important role in community education and providing referrals to health facilities.

To deal with the most serious complications, a facility should be able to provide most or all of the elements of “essential obstetric care,” which includes the ability to perform surgery and provide anesthesia, blood transfusions, management of problem pregnancies (for example, women with anemia or hypertension), and special care for newborns. This care requires adequately trained professional staff, logistical support

A mother's death has profound consequences for her family and for society.

Making Pregnancy and Childbirth Safer

(to make sure intravenous drugs and other supplies are available when needed), and good supervision. Standard protocols for managing complicated deliveries can guide and coordinate the actions of health professionals.

Provide post-abortion care. Many women die of complications related to unsafe abortions. Unsafe abortion accounts for about 13 percent of maternal deaths worldwide, and in some countries, the percentage is much higher. Even in countries where abortion is legal, the services are often difficult to obtain because of the stigma attached to abortion, and because of the cost of the services. Women who have unsafe abortions need access to care to treat complications, such as infections, incomplete abortions, hemorrhages, and injuries to the cervix and uterus.

Provide postpartum care for mother and baby. Immediate postpartum care can detect and manage problems arising after delivery, such as hemorrhage, infection, and problems with breastfeeding.

Raise awareness of safe motherhood. Implementing a safe motherhood program requires commitment in the public and private health sectors, as well as at the community level. A lack of political commitment at either the national or local level can undermine efforts to strengthen safe motherhood programs. The Safe Motherhood Initiative, launched in 1987 by UNFPA, the World Bank, and WHO, seeks to raise awareness about maternal mortality and to find solutions. This initiative, which has since been joined by UNICEF, UNDP, IPPF, and the

Population Council, sponsored a technical meeting in 1997 to reaffirm the commitment to reducing maternal mortality.

Pregnancy and childbirth can be safer.

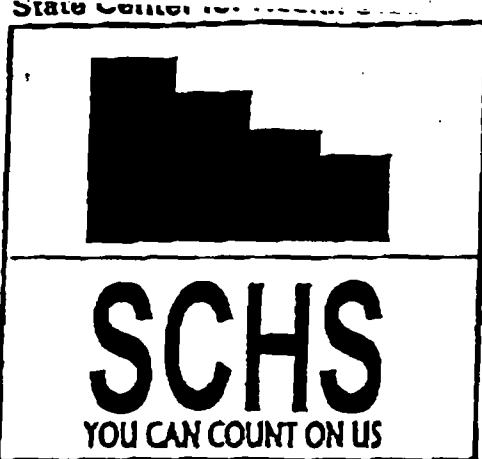
Implementing the steps outlined above requires resources and sustained effort, but can result in many saved lives. In Sri Lanka, for example, the maternal mortality ratio dropped dramatically—from 555 deaths per 100,000 live births in the 1950s, to 240 in the 1960s, to 30 in 1994. A nationwide extension of the health care system and expansion of midwifery skills are credited with this decline. Sri Lanka has had a major increase in the proportion of births attended by trained personnel, and in 1996, over 94 percent of births occurred in local hospitals. In a rural area of Bangladesh, maternal deaths declined significantly when a research project provided a combination of interventions. The project increased women's access to midwives in rural clinics, community health workers, maternal and child health professionals, a larger district hospital, and emergency transportation. The midwives and community health workers taught families about the warning signs of complications, and how women could be transported for care in cases of emergencies. Boats served as ambulances to bring women with serious complications to facilities staffed by physicians 24 hours a day. Women who required surgery were referred to obstetric facilities at the district hospital. In many other countries, improvements in health services are being linked with community education about maternal health.

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BRIEFING PAPER
ON THE 1996 INFANT MORTALITY RATE
FOR THE
DISTRICT OF COLUMBIA

Prepared by

**The State Center for Health Statistics
Department of Health
September 29, 1997**

**Government of the District of Columbia
Marion Barry, Jr., Mayor**

Final

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SCHS 9/29/97

BRIEFING PAPER ON THE 1996 INFANT MORTALITY RATE

Statistical Overview

In 1996 there were 8,377 live births and 121 infant deaths to District of Columbia residents (Table 1). This resulted in an infant mortality rate of 14.4 deaths for every 1,000 live births. This is the lowest infant mortality rate in the District's reporting history.

In 1995 there were 8,993 live births and 145 infant deaths. The infant mortality rate for 1995 was 16.1 deaths per 1,000 live births. There was a 10.6 percent decrease in the infant mortality rate between 1995 and 1996. This represents 24 fewer infant deaths in 1996 than in the previous year. There were 616 fewer births to District women in 1996 which is a 6.8 percent reduction from the 1995 total.

There has been an overall declining trend in the infant mortality rate over the past six years (1991 to 1996) as shown in Table 1. During the six-year period the number of infant deaths declined from 235 in 1991 to 121 in 1996. There were 114 fewer infant deaths in 1996 compared to 1991, representing a decline of 48.5 percent. There were 3,273 fewer births, during this period reflecting a decrease of 28.1 percent over this period.

Table 1 presents a six-year summary of these statistics.

Table 1: Six-Year Infant Mortality Trends District of Columbia Residents, 1991-1996			
Year	Births	Infant Deaths	Infant Mortality Rate*
1991	11,650	235	20.2
1992	10,939	200	18.3
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4

* Per 1,000 live births

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1

1995 and 1996 Comparisons

- The number of infant deaths dropped from 145 in 1995 to 121 in 1996.
- The overall infant mortality rate for the District declined by 10.6 percent to a record low of 14.4 per 1,000 live births for 1996.
- The infant mortality rates declined in wards 4, 5, 7 and 8.
- The District's infant mortality rate has fallen 28.7 percent since 1991.
- Deaths to infants younger than 28 days has declined by 19.7 percent in 1996 as compared to 1995.
- More women received adequate or early and frequent prenatal care in 1996 as compared to 1995.
- The infant death rate for black babies declined from 19.7 per 1,000 live births in 1995 to 17.2 per 1,000 live births in 1996.
- The infant death rate for white babies increased marginally from 9.1 per 1,000 live births in 1995 to 10.6 per 1,000 live births in 1996.
- Births to teenage mothers increased slightly from 15.5 percent of the total in 1995 to 16.8 percent of the total in 1996.

Of the 121 infant deaths that occurred in 1996, 82 (68 percent) occurred during the neonatal period (before 28 days of life). The neonatal death rate declined by 19.7 percent from 12.2 per 1,000 live births in 1995 to 9.8 per 1,000 live births in 1996 (Table 2). The neonatal period is important relative to efforts to reduce infant mortality because most infant deaths (in this case 68 percent of the total) occur during the neonatal period. The postneonatal death rate (deaths occurring from 28 days to under one year of age) was 4.6 per 1,000 live births in 1996 compared to 3.9 per 1,000 live births in 1995.

Table 2: Neonatal and Postneonatal Deaths Among District of Columbia Residents, 1995 and 1996		
	1995	1996
Neonatal Death Rate	12.2	9.8
Postneonatal Death Rate	3.9	4.6

Factors Contributing to Infant Mortality

Low birthweight babies and lack of prenatal care are major influences upon infant mortality. The percentage of low birthweight infants (those weighing under 2,500 grams, 5.5 pounds) was 14.2 percent in 1996 compared to 13.5 percent in 1995 (Table 3), representing a 5.2 percent increase. For blacks the increase was 3.7 percent compared to a 24.5 percent increase for whites.

Table 3: Low Birthweight* Babies by Race District of Columbia, 1995 - 1996			
Race	1995	1996	Percent Change
All Races	13.5	14.2	5.2
Black	16.2	16.8	3.7
White	5.3	6.6	24.5

* Under 2,500 grams.

The percentage of low birthweight infants born to mothers under 20 years of age increased by 13.8 percent from 13.0 in 1995 to 14.8 in 1996 (Table 4). The percentage of low birthweight babies born to mothers 20 years of age and over increased by 5.7 percent, from 80.6 percent in 1995 to 85.2 percent in 1996.

Table 4: Low Birthweight* Babies by Age of Mother District of Columbia Residents, 1995 and 1996			
	1995	1996	Percent Change
< 2,500 Grams	13.5	14.2	5.2
Mothers < 20 Years of Age	13.0	14.8	13.8
Mothers ≥ 20 Years of Age	80.6	85.2	5.7
Unknown Age of Mother	6.4	0	-

*Under 2,500 grams.

Note: Percentages may not add to 100 due to rounding.

Adequate prenatal care, as defined by the Institute of Medicine (Kessner et al., 1973), is care initiated in the first trimester with a minimum of nine prenatal visits. Care is considered to be inadequate if initiated in the third trimester and consisting of less than four prenatal visits. Any other combination of prenatal care and number of visits is considered to be intermediate care. Figures computed for the adequacy of prenatal care, based on these definitions, revealed an increase in the percentage of women receiving adequate prenatal care in the District. In 1995 51.1 percent of the women who gave birth received adequate prenatal care, where as, in 1996 that figure increased by 5.1 percent to 53.7 percent. In 1996 the number of women receiving inadequate prenatal care decreased by 4.8 percent to 17.9 percent from 18.8 percent in 1995. The number of women who were in the intermediate prenatal care category decreased by 7.5 percent, from 30.7 percent in 1995 to 28.4 percent in 1996 (Table 5).

Table 5: Adequacy of Prenatal care District of Columbia Residents, 1995 and 1996			
	1995	1996	Percent Change
Adequate	51.1	53.7	5.1
Intermediate	30.7	28.4	-7.5
Inadequate	18.8	17.9	-4.8

Consistent with the 4.8 percent reduction in the number of women receiving inadequate prenatal care and the 5.1 percentage increase in the number of women receiving adequate prenatal care, the infant mortality rate has fallen from 16.1 in 1995 to 14.4 in 1996.

Geographical Distribution

Compared to 1995, there was a decrease in the number of infants born in all Wards of the city in 1996. The infant mortality breakdown by Ward for 1996 (Table 6) also shows a decline in the infant mortality rate for in Wards 4, 5, 7, and 8. However, the infant mortality rate increased in the other four Wards (1,2,3 and 6). In two of the four wards that had increased rates for 1996, Wards 2 and 3, the actual number of infant deaths were the same as the 1995 figure. However, because there were fewer births in these two Wards in 1996, the infant mortality rate increased. The number of infant deaths increased only in Ward 1, where there were three more infant deaths compared to 1995. The largest decrease in infant mortality among the Wards occurred in Ward 5 where there was a 45.7% reduction in the rate from 29.3 in 1995 to 15.9 in 1996.

Table 6: Births, Infant Deaths and Infant Mortality Rates by Ward District of Columbia Residents, 1995 and 1996						
	Births		Infant Deaths		Infant Mortality Rate*	
Ward	1995	1996	1995	1996	1995	1996
1	1,306	1,255	15	18	11.5	14.3
2	889	865	8	8	9	9.2
3	756	731	3	3	4	4.1
4	1,003	997	14	13	14	13.0
5	1,092	1,005	32	16	29.3	15.9
6	1,033	905	15	14	14.5	15.5
7	1,249	1,070	27	22	21.6	20.6
8	1,621	1,549	31	27	19.1	17.4
Unknown	44	0	0	0	-	-
Total	8,993	8,377	145	121	16.1	14.4

* Infant deaths per 1,000 live births.

A statistical overview of each Ward is shown in Table 7 for 1996 and Table 8 for 1995. Ward 3 had the lowest infant mortality rate of 4.1 and Ward 7 had the highest infant mortality rate of 20.6.

Table 7: Statistical Overview by Ward District of Columbia Residents, 1996						
Ward	Births	Infant Deaths	IMR*	LBW**	Teen Births	LBW to Teens
1	1,255	18	14.3	152	186	18
2	865	8	9.2	103	118	13
3	731	3	4.1	46	5	0
4	997	13	13.0	137	159	19
5	1,005	16	15.9	180	207	21
6	905	14	15.5	135	150	19
7	1,070	22	20.6	177	244	33
8	1,549	27	17.4	257	337	52
Total	8,377	121	14.4	1,187	1,406	175

* IMR means infant mortality rate per 1,000 live births.

** LBW means low birthweight (under 2,500 grams).

**Table 8: Statistical Overview by Ward
District of Columbia Residents, 1995**

Ward	Births	Infant Deaths	IMR*	LBW**	Teen Births	LBW to Teens
1	1,306	15	11.5	141	200	23
2	889	8	9.0	120	106	11
3	756	3	4.0	31	6	1
4	1,003	14	14.0	116	148	16
5	1,092	32	29.3	183	196	28
6	1,033	15	14.5	151	167	15
7	1,249	27	21.6	217	257	28
8	1,621	31	19.1	249	311	35
Total	8,993	145	16.1	1,214	1,392	158

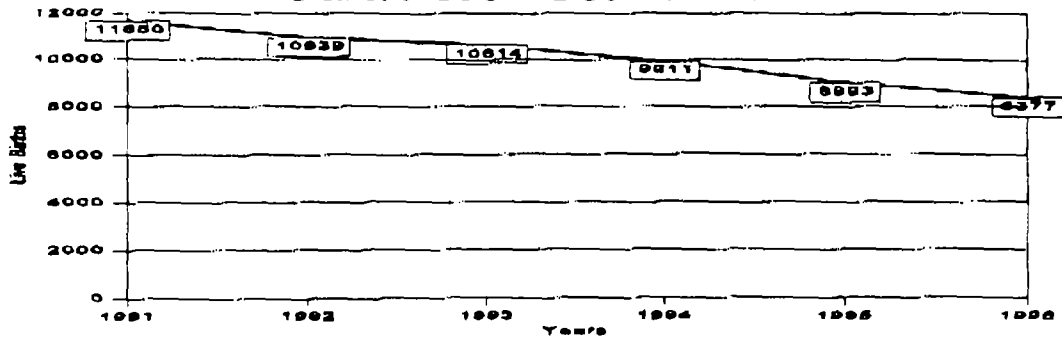
* IMR means infant mortality rate per 1,000 live births.

** LBW means low birthweight (under 2,500 grams).

SIX YEAR TRENDS

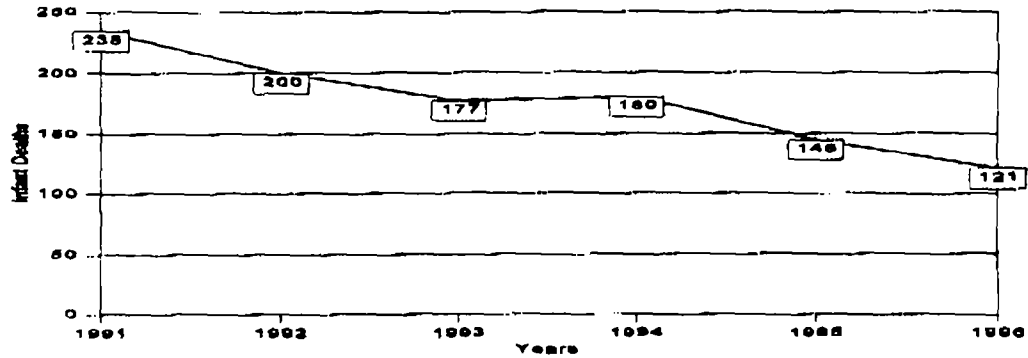
Live Births, 1991-1996

District of Columbia Government



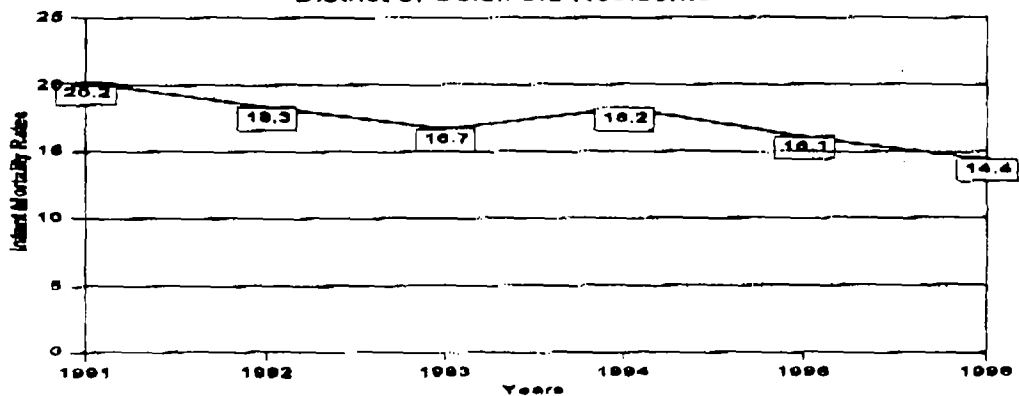
Infant Deaths, 1991-1996

District of Columbia Residents



Infant Mortality Rates, 1991-1996

District of Columbia Residents



SCHS 9/29/97

8

STATISTICAL NOTE

REPORTED PREGNANCIES AND PREGNANCY RATES IN THE DISTRICT OF COLUMBIA, 1991-1995

**Department of Health
D.C. State Center for Health Statistics**

**Government of the District of Columbia
Marion Barry, Jr., Mayor**

February 1997

Reported Pregnancies and Pregnancy Rates in the District of Columbia, 1991 - 1995

by Sara T. Glendinning

Introduction

This report provides statistics on the pregnancies of District of Columbia women which were reported to the Department of Health during the five year period of 1991-1995. The pregnancy outcome categories included in this report are live births, induced abortions, and fetal deaths of at least 20 weeks gestation. Fetal deaths under 20 weeks gestation and abortions not reported to the Department of Health are not included. Abortion reporting is voluntary in the District of Columbia. The Department of Health does not receive reports on abortions performed in private physicians' offices. Also, abortions performed on District residents outside Washington, D.C. are not included. Therefore, the actual number of pregnancies of District of Columbia women during this five year period is greater than that reflected in this report.

Annual pregnancy rates were calculated using U.S. Census Bureau mid-year population estimates for July 1991 through July 1995. Unknown cases were distributed according to the reported age proportions.

Pregnancies

Reported pregnancies decreased 26 percent and pregnancy rates decreased 14 percent between 1991 and 1995. Pregnancy rates decreased each year during the five year period. The 15,680 pregnancies reported to the Department of Health in 1995 were 12 percent less than the 17,903 pregnancies reported in 1994 (Table 1). The pregnancy rate decreased eight percent between 1994 and 1995, going from 123.5 pregnancies per 1,000 women aged 15-44 years in 1994 to 113.6 in 1995. Pregnancy rates decreased between 1994 and 1995 in each age group under 40 years of age. The pregnancy rate of 15-19 year old women decreased 12.5 percent while the pregnancy rate of women 40 years and older increased eight percent between 1994 and 1995.

Live Births

The number of live births to District of Columbia residents decreased each year during the five year period, 1991-1995. The 8,993 births in 1995 were 23 percent less than the 11,650 births in 1991 and nine percent less than the 9,911 births in 1994 (Table 1). The fertility rate also decreased each year, going from 72.9 per 1,000 women aged 15-44 years in 1991 to 70.8 in 1992, 70.7 in 1993, 68.4 in 1994, and 65.1 in 1995 (Figure 1). Fertility rates decreased between 1994 and 1995 for women in each age group under 35. The fertility rate of women 15-19 years old decreased seven percent between 1994 and 1995. Seventeen percent of the 1995 live births occurred to mothers under 20 years of age. Mothers aged 20-29 accounted for almost half (48 percent in 1995) of the births.

Induced Abortions

The number of reported induced abortions to District of Columbia residents decreased each year during the five year period, 1991-1995. Reported induced abortions decreased 17 percent between 1994 and 1995 and 29 percent between 1991 and 1995 (Table 1). The abortion rate in 1995 was 47.8 per 1,000 women aged 15-44 years. Nineteen percent of the 6,604 abortions reported in 1995 occurred among teenagers and 59 percent were performed on women in their twenties. Between 1994 and 1995, reported abortions decreased 19 percent for women under 25 and 14 percent for women 25 years and older.

Fetal Deaths

The 83 reported fetal deaths of at least 20 weeks gestation in 1995, four percent more than the 80 reported in 1994, were 47 percent less than the 156 fetal deaths reported in 1991 (Table 1). During this five year period, 1995 had the second lowest number of reported fetal deaths. Fifty-three percent of the reported fetal deaths in 1995 occurred among women in their twenties and 26.5 percent occurred among women in their thirties.

Summary

In 1995, 57.4 percent of the reported pregnancies ended in live births, 42.1 percent ended in induced abortions, and 0.5 percent ended in fetal deaths of at least 20 weeks gestation (Table 2). Figures 2a and 2b, depicting the percentage of reported pregnancies ending as a live birth or induced abortion, show slightly higher percentages of the reported pregnancies of women under 20 and women 20 years or older ending in a live birth and slightly lower percentages ending in abortion in 1995 than in 1991 and 1994. The proportion of reported pregnancies ending in a live birth in 1995 varied from 49.4 percent for women 20-24 years old to 72.3 percent for women 35-39 years old (Figure 3).

Table 1. NUMBER OF REPORTED PREGNANCIES AND PREGNANCY RATES BY OUTCOME OF PREGNANCY AND AGE OF WOMEN: DISTRICT OF COLUMBIA, 1991-1995

Age of Women	Reported Pregnancies					Live Births					Induced Abortions					Fetal Deaths				
	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Total.....	21,161	19,365	18,726	17,903	15,680	11,660	10,939	10,614	9,911	8,893	8,355	8,291	8,008	7,912	6,604	156	135	104	80	
Under 15 years.....	190	169	136	197	125	97	80	82	88	74	92	87	52	107	48	1	2	1	2	
15-19 years.....	3,816	3,113	3,272	3,149	2,685	1,953	1,717	1,766	1,601	1,454	1,941	1,377	1,483	1,538	1,220	22	19	13	10	
20-24 years.....	6,395	5,819	5,543	5,602	4,672	3,128	3,045	2,823	2,791	2,306	3,233	2,741	2,697	2,789	2,340	34	33	23	22	
25-29 years.....	5,069	4,961	4,418	4,018	3,573	2,890	2,650	2,526	2,169	1,979	2,136	2,266	1,662	1,842	1,676	41	25	30	15	
30-34 years.....	3,517	3,285	3,172	2,058	2,816	2,257	2,169	2,063	1,970	1,879	1,222	1,087	1,091	1,071	918	38	29	16	17	
35-39 years.....	1,676	1,646	1,739	1,521	1,428	1,067	1,042	1,087	1,058	1,033	569	584	635	455	392	19	22	17	10	
40 years and older.....	399	370	447	360	381	258	236	267	246	268	140	129	178	110	110	1	5	2	4	
Rate per 1,000 women																				
Total.....	132.4	125.4	124.8	123.5	113.6	72.9	70.8	70.7	68.4	65.1	68.5	63.7	63.4	64.6	47.6	1.0	0.9	0.7	0.6	
Under 15 years.....	13.6	12.1	9.7	14.2	9.4	6.8	5.7	5.9	6.3	5.6	6.6	6.3	3.7	7.7	3.6	0.1	0.1	0.1	0.1	
15-19 years.....	232.3	214.3	238.7	233.6	204.3	115.8	118.2	128.8	118.8	110.7	115.1	94.8	108.9	114.1	92.6	1.3	1.3	0.9	0.7	
20-24 years.....	202.2	192.3	198.2	223.7	218.6	98.9	100.6	100.9	111.5	106.9	102.2	90.8	96.4	111.4	108.5	1.1	1.1	0.8	0.9	
25-29 years.....	154.9	154.0	140.4	131.3	119.3	88.3	82.3	80.3	70.6	66.1	65.3	71.0	69.2	60.2	62.6	1.3	0.8	1.0	0.5	
30-34 years.....	119.2	112.6	109.4	107.1	102.7	76.5	74.3	71.1	69.0	68.5	41.4	37.2	37.8	37.5	33.5	1.3	1.0	0.8	0.6	
35-39 years.....	65.4	65.2	69.3	61.5	69.6	41.7	41.2	43.3	42.7	43.3	23.0	23.1	25.3	18.4	16.4	0.7	0.9	0.7	0.4	
40 years and older.....	17.0	16.1	19.6	15.9	17.2	11.0	10.3	11.7	10.9	12.1	5.9	5.6	7.8	4.9	5.0	0.0	0.2	0.1	0.2	

1/Unknown cases were distributed according to the reported age proportions. Rates were calculated using Bureau of the Census July 1991 - July 1995 population estimates.

2/Abortion reporting is voluntary in the District of Columbia. Only abortions performed in D.C. and reported to the D. C. Department of Health are included in this table.

3/Includes only fetal deaths of at least 20 weeks gestation.

4/Computed by relating the number of events to women of all ages to women aged 15-44 years.

5/Computed by relating the number of events to women under 15 years to women aged 10-14 years.

6/Computed by relating the number of events to women aged 40 years and over to women aged 40-44 years.

Department of Health, D.C. State Center for Health Statistics

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SENT BY: VITAL RECORDS OFFICE ; 3-26-

Table 1. NUMBER OF REPORTED PREGNANCIES AND PREGNANCY RATES BY OUTCOME OF PREGNANCY AND AGE OF WOMEN: DISTRICT OF COLUMBIA

Age of Women	Reported Pregnancies					Live Births					Induced Abortions ²				
	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
All women	21,161	19,365	18,726	17,903	15,680	11,650	10,939	10,614	9,911	8,993	9,355	8,291	8,008	7,912	6,604
Under 15 years	190	169	135	197	125	97	80	82	88	74	92	87	52	107	48
15-19 years	3,916	3,113	3,272	3,149	2,685	1,953	1,717	1,766	1,601	1,454	1,941	1,377	1,493	1,538	1,220
20-24 years	6,395	5,819	5,543	5,602	4,672	3,128	3,045	2,823	2,791	2,306	3,233	2,741	2,697	2,789	2,340
25-29 years	6,069	4,981	4,416	4,016	3,573	2,890	2,650	2,526	2,159	1,979	2,138	2,286	1,862	1,842	1,576
30-34 years	3,517	3,285	3,172	3,058	2,816	2,257	2,169	2,063	1,970	1,879	1,222	1,087	1,091	1,071	918
35-39 years	1,875	1,648	1,739	1,621	1,428	1,067	1,042	1,067	1,056	1,033	589	584	635	455	392
40 years and older	399	370	447	360	381	258	236	267	248	268	140	129	178	110	110
Rate per 1,000 women															
All women	132.4	125.4	124.8	123.5	113.6	72.9	70.6	70.7	68.4	65.1	58.5	53.7	53.4	54.6	47.8
Under 15 years	13.5	12.1	9.7	14.2	9.4	6.9	5.7	5.9	6.3	5.6	6.6	6.3	3.7	7.7	3.6
15-19 years	232.3	214.3	238.7	233.6	204.3	115.8	118.2	128.6	118.8	110.7	115.1	94.8	108.9	114.1	92.8
20-24 years	202.2	192.3	198.2	223.7	216.6	98.9	100.6	100.9	111.5	106.9	102.2	90.6	96.4	111.4	108.5
25-29 years	154.9	154.0	140.4	131.3	119.3	88.3	82.3	80.3	70.6	66.1	65.3	71.0	59.2	60.2	52.6
30-34 years	119.2	112.6	109.4	107.1	102.7	76.5	74.3	71.1	69.0	66.5	41.4	37.2	37.6	37.5	33.5
35-39 years	65.4	65.2	69.3	61.5	59.8	41.7	41.2	43.3	42.7	43.3	23.0	23.1	25.3	18.4	16.4
40 years and older	17.0	16.1	19.6	15.9	17.2	11.0	10.3	11.7	10.9	12.1	5.9	5.6	7.8	4.9	5.0

Unknown cases were distributed according to the reported age proportions. Rates were calculated using Bureau of the Census July 1991 - July 1995 population estimates. Abortion reporting is voluntary in the District of Columbia. Only abortions performed in D.C. and reported to the D. C. Department of Health are included in this table. Includes only fetal deaths of at least 20 weeks gestation. Imputed by relating the number of events to women of all ages to women aged 15-44 years. Imputed by relating the number of events to women under 15 years to women aged 10-14 years. Imputed by relating the number of events to women aged 40 years and over to women aged 40-44 years.

Table 2. PERCENT OF REPORTED PREGNANCIES ENDING AS A LIVE BIRTH, INDUCED ABORTION, OR FETAL DEATH, BY AGE OF WOMEN: DISTRICT OF COLUMBIA, 1991-1995

Age of Women	Live Births					Induced Abortions ²					Fetal Deaths ³				
	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Total.....	55.1	56.5	56.7	55.4	57.4	44.2	42.8	42.8	44.2	42.1	0.7	0.7	0.6	0.4	0.4
Under 15 years.....	51.1	47.3	60.7	44.7	59.2	48.4	51.5	38.5	54.3	38.4	0.5	1.2	0.7	1.0	2.0
15 - 19 years.....	49.9	55.2	54.0	50.8	54.2	49.6	44.2	45.6	48.8	45.4	0.5	0.6	0.4	0.3	0.4
20 - 24 years.....	48.9	52.3	50.9	49.8	49.4	50.6	47.1	48.7	49.8	50.1	0.5	0.6	0.4	0.4	0.4
25 - 29 years.....	57.0	53.4	57.2	53.8	55.4	42.2	46.1	42.1	45.9	44.1	0.8	0.5	0.7	0.4	0.4
30 - 34 years.....	64.2	66.0	65.0	64.4	66.7	34.7	33.1	34.4	35.0	32.6	1.1	0.9	0.6	0.6	0.6
35 - 39 years.....	63.7	63.2	62.5	69.4	72.3	35.2	35.4	36.5	29.9	27.5	1.1	1.3	1.0	0.7	0.6
40 years and older.....	64.7	63.8	59.7	68.3	70.3	35.1	34.9	39.8	30.6	28.9	0.2	1.4	0.4	1.1	0.6

1/Unknown cases were distributed according to the reported age proportions.

2/Abortion reporting is voluntary in the District of Columbia. Only abortions performed in D.C. and reported to the D.C. Department of Health are included in this table.

3/Includes only fetal deaths of at least 20 weeks gestation.

Department of Health, D.C. State Center for Health Statistics

Munpha Cashell: world bank 473-3691
boss: funke

acnolwedlge: mr. wolfenson; interagency group for safe motherhood;

Jill sheffield: 212-941-5300

maternal health: major global concern;

basic fact sheets: background; global safe motherhood initiative; more than 1 women every minute; 600,000 deaths of women each year; all related to pregnancy and childbirth; y far greatest threat to women in

in u.s.: riks of dying one in 3600 in ereirea: one in 11; I know what 11 looks like; statistic fact of it; unfair; in countries of north and south; differential up to 200 times greater; we get heated up when infant mortality is ten times greater; this is 200 times greater; find ourselves able to look past it; safe motherhood; 5 principle causes; we know what they are; we know how much it costs to avert one of those deaths; \$2. The initiative; partnership of 6 internaitonal agencies; with lots of other government and groups; learned some lessons; spending a lot of effort to get those out; 10th anniversary; we know a lot more than we used to; first step; information and development of political will; if that's not there, rest of it doesn't matter: April 7; world health day; focus on safe motherhoood; around the owrld; wonderful confluence;

hrc: she went to meeting of first ladies in Bolivia; second lady in bolivia good friend of hrc; wants to come; big impression; family planning; maternal health clinics; strong statements;

speak about: we know that countries around the world; but in our biggest cities, the inner cities hae very high maternal mortaltiy rates; in some; as high as in some deeloping countries; DC terrible; new york, chicago, los angeles; our work is truly international; don't have facts; american assn of world health; domestic; half of all us pregnancy unintended; 204 women die very day from pregnancy rleated; aids; ectopic pregnancy -- more than 100 ; no prenatal care; 1/3 women smoke; on front porch:

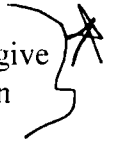
we learned: 40% of all pregnant women -- in DC or Nirobi: have complication siwth pregnancy; 15% of all women hae life trehatening complications; reason less likelty to die if in dc than wagadoodoo; get care; more quickly land trained people; so acrosws globe; our nutrition isn't better; we are going to have this too;

it takes a global village to ensure that women have healthy and safe p regnancies; one of points we make in this material; helping women through child birth safely is responsbiltiy of her family and her neighborhs; not just her jobs; each of us has to help her get that help; signals of complications; global village;

govt has job /part to play;

*It's a
big
problem
but it
happens
every
day in
our
plan-*

hrc could take on social justice issue; dramatic case of social injustice to women; no one can give us right to live -- but can give right to health; shri lanka -- this is a social justice; impression from trip to latin america;



the will to do something; we can make a difference; doesn't cost the earth; doesn't cost nothing; not a huge outlay; has to start with willingness to do something on behalf of women and families; if a woman dies in labor and delivery and baby survives; 95% of those babies dead within 12 months; children under 5 at great risk; they will also die; that woman is important to family and other children; if she dies; outlook for everyone else is very bleak -- in agricultural societies; women do all the work;

12-15 minutes; max;

The World Bank

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street N.W.
Washington, D.C. 20433
U.S.A.

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March 6, 1998

Ms. Melanne Verveer
Assistant to the President of the United States &
Chief of Staff to the First Lady
Room 100
Old Executive Office Building
Washington, DC 20500

Dear Ms. Verveer:

I am very pleased to hear that Mrs. Clinton has accepted Mr. Wolfensohn's invitation to participate in the World Health Day event, honoring *Safe Motherhood* to be hosted by the World Bank on April 7th, 1998 from 9:30 a.m. to 11:00 a.m.

Enclosed is some background information on the Safe Motherhood Initiative and a copy of the draft agenda for your review. The event will begin with a call to action for Safe Motherhood by Mr. James D. Wolfensohn, President of the World Bank. The First Lady, Hillary Rodham Clinton, has been invited to close the session with a discussion of the necessary roles of governments to implement safe motherhood actions and commitments. A press briefing will follow the event and the First Lady will have an opportunity to discuss the activities that President Clinton's administration is implementing to help improve maternal health care and save women's lives.

We are ready to accommodate any timing issues which the First Lady may have regarding the agenda.

Safe Motherhood is an important issue affecting the lives of everyone's mothers, sisters, daughters and children. We hope to use World Health Day to raise awareness about the fact that a woman's health and well-being is not simply her responsibility but that of her entire family. The First Lady's participation will most certainly enhance and strengthen our message.

*Americas speech
on children (12/84).*

Nick

Ms. Melanne Verveer

-2-

March 6, 1998

I look forward to talking to you further about this event, and will be in contact with you to discuss the First Lady's role in the World Health Day event. Thank you.

Sincerely,

Funke Oyewole
Funke Oyewole
External Affairs Officer
The World Bank

Encl.

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202-473-3691

**WORLD HEALTH DAY:
PRELIMINARY AGENDA OF SPEAKERS**

9:30- 10:30 Chair: **Mr. James D. Wolfensohn**
 - **James Wolfensohn**, Opening Remarks
 ✱ - **Hillary Clinton**, Expression of Concern
 - Public Service Announcement

10:30- 11:00 Press briefing with above speakers
 - Opportunity for Q&A's with the press
 - followed by individual interviews.
 Coffee/Tea for all other participants

(this part of the agenda is just FYI)*

*11:00- 1:00 Chair: **George Alleyne**
 - **Mahmoud Fathalla**, Highlights and Challenges of Safe Motherhood
 - IAG Heads of Agencies responding to Fathalla (with 2 key messages)
 Nafis Sadik, UNFPA
 Carol Bellamy, UNICEF
 George Alleyne, PAHO
 David de Ferranti, World Bank
 Ingar Brueggemann, IPPF
 Margaret Catley-Carlson, Population Council
 - **Business Chair, Johnson & Johnson**, statement on corporate
 commitment to Safe Motherhood
 - **Richard Feachem**, the World Bank, closing remarks
 - *Four video reports from SM troubled spots (sprinkled between speakers)*
 - Questions and Answers

1:00-1:30 Closed press conference for speakers in second part of event (possibly
 followed by individual interviews)

* In response to Fathalla, IAG heads will be informed beforehand to reply to one to two of Fathalla's points and put it in their organization's context.

Safe Motherhood Action Messages

1. ***Establish Safe Motherhood as a Human Right***
Topics include: national and global commitments to safe motherhood as embodied in international agreements and conventions; women's right to make decisions about their own health free of coercion or violence and based on full information; women's right to have access to quality services before, during and after pregnancy and childbirth; and the obligation of governments to ensure the provision of safe motherhood care.
2. ***Safe Motherhood is a Vital Economic and Social Investment***
Topics include: the multiple benefits of safe motherhood for mothers, children, and communities, and its impact on women's productive and reproductive roles; and the contribution of safe motherhood to broader reproductive health, women's overall health and status, and national development.
3. ***Empower Women: Ensure Choices***
Topics include: educating girls and women and increasing their decision-making power about pregnancy and reproductive health; raising women's awareness about the danger signs of complications and actions they can take; promoting good nutrition, self-care and the appropriate use of resources; encouraging women to demand the kind of services they want; and mobilizing family and community support and resources, with special attention to the role of men.
4. ***Delay Marriage and First Birth***
Topics include: the impact of early pregnancy on the health and well-being of girls and women; the linkages between age at marriage and age at first birth; approaches to providing health information and services to young people, including key topics such as reproductive physiology, responsible sexual behavior, life planning skills and family planning.
5. ***Every Pregnancy Faces Risks***
Topics include: the need of all women for care during pregnancy; service delivery strategies that are designed to give each woman the level of care she needs; the difficulty of predicting complications for individual women and the consequent notion that **all** women are at risk; the problem of "risk screening" strategies for services to pregnant women; the distortions of quality of care created by the emphasis on "high risk".
6. ***Ensure Skilled Attendance at Delivery***
Topics include: the definition of skilled attendance; the evidence for the importance of skilled attendance; the role of the professional birth attendant (doctor, midwife, nurse) in managing normal deliveries and detection and management (including referral) of obstetric complications; numbers and deployment of skilled attendants (living and working conditions); allocation of responsibilities; training needs (basic and in-service); supervision; curricula.

7. ***Improve Access to Quality Maternal Health Services***

Topics include: overcoming barriers that limit women's access to services; the definition, provision and monitoring of quality services (clinical, interpersonal and logistical aspects); design of services that are sensitive to clients' needs, taking into account gender and socio-cultural issues; decentralization of services; and avoiding inappropriate use of technologies and interventions, including the overmedicalization of pregnancy and childbirth.

8. ***Address Unwanted Pregnancy and Unsafe Abortion***

Topics include: the public health importance of unwanted pregnancy and unsafe abortion; universal access to family planning information and services, including emergency contraception, with special attention to the needs of young people and marginalized groups; managing contraceptive failure; provision of postabortion family planning care; access to safe abortion within the limits of the law; and management of abortion complications safely and humanely.

9. ***Measure Progress***

Topics include: the selection of appropriate ways to measure maternal mortality and monitor and evaluate progress; the need for and uses of data on maternal morbidity; the role of data on service utilization rates and qualitative information on knowledge and attitudes; the challenge of measuring quality of care.

10. ***The Power of Partnership***

Topics include: collaboration between government, non-governmental and multi-lateral organizations; the role of the private sector, the role of health professional associations; links with sectors outside health; how best to use available resources (including cost, cost-effectiveness and financing); and how to maximize opportunities and increase resources.

SAFE MOTHERHOOD MATTERS: MARKING THE INITIATIVE'S TENTH ANNIVERSARY

In 1987, when the Safe Motherhood Initiative was founded, maternal mortality was a serious – and seriously neglected – problem. In most countries, data were not even available to make accurate estimates of maternal death and disability. Ten years later, the Initiative has proven that pregnancy-related deaths are preventable, and has secured a high priority place for safe motherhood on the international development agenda. The body of research that has been conducted on maternal mortality and morbidity is significant, and innovative approaches to address the immediate and root causes of poor maternal health are being tested in a variety of economic circumstances around the world.

Unfortunately, however, the last decade's progress cannot be measured in lives saved. Based on improvements in data collection and analysis, the World Health Organization now estimates that 585,000 women die from pregnancy and childbirth every year; while in some countries maternal mortality rates have decreased, in many they remain at unacceptably high levels. Women's poor health, and the inadequate care they receive during pregnancy and delivery, also contribute to an estimated seven million perinatal deaths annually.

At the most basic level, maternal mortality persists largely because:

- **Knowledge and information about maternal death and disability – and strategies to address them – were inadequate ten years ago.** Conclusive data on the impact and effectiveness of different interventions have only recently become available. Even now, organizations working at the country and community level are often unaware of relevant pilot programs, appropriate technologies and guidelines, and the technical resources available to them. As a result, national activities sometimes include strategies that are not cost-effective and do not have a measurable impact on maternal mortality, such as risk screening during antenatal care.
- **Political commitment has not been sustained.** Although decision-makers have supported safe motherhood in theory, in practice they often view it as too expensive, and do not consider its social and economic impact or its links to other health and development issues when they are allocating scarce resources. Further, the public in developing and donor countries has not forcefully advocated support for safe motherhood programs and financial assistance, partly because people are not aware of the magnitude of poor maternal health and partly because women's contributions to society have not been recognized and valued.
- **Resources have been inadequate and misallocated.** Currently, the vast majority of maternal/child health resources (excluding family planning) are spent on children; governments and donor agencies have also placed more emphasis on expanding community-based services than on improving the facility-based care that we now know is necessary to reduce maternal death. Further, donors sometimes earmark funds without considering national priorities or the relative cost-effectiveness of different reproductive health interventions. In one African country, for example, the head of the Ministry of Health's Maternal Child Health/Family Planning Unit says that the funds it received between 1993-1996 (\$3 million for safe motherhood, \$5 million for STDs/HIV, and \$22 million for family planning) were inversely proportional to its priorities.

The Tenth Anniversary

To mark the tenth anniversary of the Initiative, and to address the obstacles outlined above, the Safe Motherhood Inter-Agency Group (IAG) is planning a two-year program of action intended to revitalize national action and galvanize international support for safe motherhood among existing and new audiences. Its objectives are:

- To share existing information and lessons learned, and to develop a consensus on the best and most effective interventions, for use by **program-planners** around the world. In addition, to provide them with technical and informational resources they can use to implement national programs.
- To help **policy-makers** make their political and financial commitments to safe motherhood *explicit*, and mobilize and allocate necessary resources.
- To broaden international commitment to safe motherhood by raising awareness among **new audiences** – including business and societal leaders globally, and the general public in developed countries – through the media, celebrities and spokespersons, and special events. In addition, to gain their individual support and their support for government and corporate donations.

Why Now?

During the last decade, effective strategies for safe motherhood – including appropriate management of pregnancy and delivery; life-saving essential obstetric care when complications arise; and the prevention and management of the complications of unsafe abortion – have been identified and evaluated systematically *for the first time*. As a result, we now know which interventions have the most impact and are the most cost-effective, knowledge that is essential given our scarce resources. At the same time, participants at a series of global conferences this decade, including the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (FWCW), have declared that reproductive health, including safe motherhood, is integral to population, development, and human rights. These two milestones offer an unprecedented opportunity to translate the on-going but amorphous good will that exists into effective and immediate action for women – and their families. They also raise an important issue that needs to be explored and clarified, namely, the role of safe motherhood as the cornerstone of reproductive health (as measured by its contribution to improved women's health, infant and child health, and population and development) and the relative priority of maternal health in the continuum of reproductive health and rights.

A. The Program of Action

To mobilize the support and commitment of each of our main target audiences, the Safe Motherhood Inter-Agency Group (IAG)* is now planning a program of activities and events that are linked by a multi-faceted strategy to stimulate awareness and action. The three main elements include:

- A **technical consultation** for program-planners worldwide in October 1997;

*The members of the IAG are: the World Bank, the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, the Population Council, and the International Planned Parenthood Federation, which is currently chairing the group.

- **Safe Motherhood Day** on World Health Day in 1998, where selected heads of state, business leaders, opinion-makers, celebrities, and activists will recognize achievements and call for action on safe motherhood; and
- A **communications strategy** that unites these events and builds support for safe motherhood. The products and resources developed will include materials for the technical consultation and the Safe Motherhood Day events, as well as a strategy 'package' reflecting international consensus on the elements necessary for country-level action. A public information campaign will also be organized to gain the support of new audiences who could press for action during the Year of Safe Motherhood, 1998.

**PRESIDENT CLINTON:
BETTER, HEALTHIER LIVES FOR CHILDREN**

March 24, 1998

Today, President Clinton announces a series of initiatives designed to underscore the new US-African partnerships, particularly the desire of African nations to invest in a better and healthier future for its children.

Included in today's announcement are three new initiatives to improve educational standards and access to technology, ensure adequate food and agricultural production for proper nutritional balance, and fight deadly infectious diseases that claim the lives of too many African children.

Promoting Better education. The *Education for Development and Democracy Initiative* seeks to further African integration into the global community by improving the quality of, and technology for, education in Africa. The President's announcement is centered around three principal strategies: community resource centers, public-private partnerships, and educating and empowering girls. Key components include:

Primary and Secondary Education

- Pilot schools will be selected as community resource centers to provide educational materials and serve as bases to improve local teachers preparation and training for out-of-school youth.
- School-to-school partnerships between the United States and Africa and among African schools will be promoted through access to computer technology and from exchanges.
- Improving girls education through leadership identification and scholarships, raising community awareness and support for educating girls, strengthening school nutrition and lunch programs and mentoring by older girls and women.

Higher Education

- U.S.-African linkages at the university-to-university level will be strengthened through assistance with curriculum development aimed at training in labor-market relations, business, health, science, math, technology and engineering studies.

Professional Training and Civil Education

- The education initiative will fund partnerships between U.S. and African government institutions and civil society organizations, designed to better promote understanding, cooperation and integration of public-private efforts.

Ensuring Better Nutrition. A key part of the President's announcement today is ensuring that while we improve the educational standards of Africa's children we also ensure adequate and proper nourishment and provide assistance to enhance agricultural production. The Africa Food Security Initiative (AFSI) is designed to assist African nations to strengthen and protect agriculture and food security.

Promoting Stronger Health Care. The third element of the President's program of investing in the future of Africa's children is combating the infectious diseases that claim so many young lives. To help

combat malaria, which accounts for 1.5 - 2.5 million deaths per year, the President announces an additional \$1 million grant to the National Institutes of Health in order to provide further assistance to the Multilateral Initiative on malaria (MIM). This effort will complement an ongoing Infectious Disease Initiative for Africa that focuses on surveillance, response, prevention, and building local resistance capacity for infectious diseases throughout the continent.

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Health security for women

The articles appearing in this issue of *World health statistics quarterly* seek to demonstrate the need for women's health to be considered in a holistic rather than a fragmented manner. In particular, it is essential to take a lifespan perspective, since health conditions in one phase of a woman's life not only affect subsequent stages of her own life but also have an impact on future generations.

Underlying all the contributions is a concern for women's "health security", a concept that encompasses all aspects of the basic human right to the highest attainable standard of health.

Some of the articles address reproductive health issues, others consider the greater vulnerability of women to infection (as well as the different impact of some diseases on women), while a number of articles examine the special health needs of specific groups of women.

This issue seeks to provide health professionals and other interested persons throughout the world with new and critical data and information that may be useful in continuing endeavours to improve the health of women across age-groups and across borders. Many of the articles echo issues addressed in the historic *Beijing Platform for Action*, adopted at the conclusion of the September 1995 Fourth World Conference on Women.

Sécurité sanitaire pour les femmes

Les articles dans ce numéro du *Rapport trimestriel de statistiques sanitaires mondiales* cherchent à montrer qu'il faut envisager la santé des femmes de manière globalisée plutôt que fragmentée. Il est notamment essentiel d'adopter une perspective portant sur la vie entière, car l'état de santé d'une femme au cours d'une des phases de sa vie n'affecte pas seulement les stades ultérieurs de sa propre vie, mais a également un impact sur les générations futures.

A la base de toutes les contributions se trouve le souci de la sécurité sanitaire des femmes, notion qui englobe tous les aspects des droits fondamentaux jusqu'au niveau de santé le plus élevé possible.

Certains articles traitent de la santé reproductive, d'autres examinent la vulnérabilité plus grande des femmes vis-à-vis de l'infection (ainsi que l'impact différent de certaines maladies sur les femmes), tandis qu'une série d'autres articles étudient les besoins de santé spécifiques de certains groupes de femmes.

Le présent numéro cherche à fournir aux professionnels de la santé et à d'autres personnes intéressées, au fil des travaux, des données essentielles et nouvelles et des informations pouvant être utilisées à l'occasion des tentatives qui sont faites en permanence pour améliorer la santé des femmes à travers les âges et au delà des frontières. Un grand nombre de ces articles se font l'écho des questions qui ont été abordées dans la *Plate-forme d'action de Beijing*, document historique adopté à l'issue de la Quatrième Conférence mondiale sur les femmes de septembre 1995.

As this special issue of the *World health statistics quarterly* demonstrates, a great deal of information on all aspects of women's health is now available. This knowledge and information has been indispensable to the continual assessment of the situation of women throughout the world and in all periods of their lives.

Women's overall health and well-being has improved. Life expectancy indicators illustrate a general trend for women to live longer. This is especially the case where women have enjoyed the fruits of development, have had access to services, have benefited from a physical and cultural environment containing few health risks and have acquired the information necessary to enable them to make informed choices.

There is also no doubt that the greater involvement of women in the workforce and in the socioeconomic and health arenas has contributed substantially to a different vision of women's health, not only as care-providers, but also as decision-makers. Problems such as violence against women have existed throughout time, but it is women who have had the vision and commitment to bring to light the terrible health consequences of this violence, and to ensure that the silence around gender-based violence is broken.

In addition to ensuring that the knowledge base on women's health problems continues to grow, the unflagging commitment and work of individuals, institutions and organizations working in the area of women's health have provided particularly useful lessons. In looking for and applying solutions, we are now able to draw upon the wealth of experience already gained, both positive and negative, in order to build on what has been achieved, guard against repeating past mistakes, and prevent wasting precious resources.

Among the most significant lessons is the realization that health must be considered in a holistic way. This applies to the health of all human beings – men and women – at all ages. As far as women's health is concerned, there has been a tendency in the past to deal with health care needs through separate programmes related to particular health issues. An example of this has been the overemphasis on the reproductive aspects of women's health, often with subsequent neglect of other areas. At both international and national levels there is now a movement which adopts a more humane approach and provides integrated services to women in a holistic fashion.

Another lesson learned is that, in looking at health issues affecting women, it is essential to take a lifespan perspective, since health conditions in one phase of a woman's life not only affect subsequent phases of her own life, but also have an impact on future generations. This inter-generational link is a characteristic unique to women.

In spite of the overall improvement in women's health and the lessons learned the situation is still highly unsatisfactory. Today there is a certain restlessness among those who have been actively working at all levels for so many years to improve women's health. The right words have been said in all the right places. General consensus has been reached on the steps which need to be taken to make a measurable difference in so many areas of women's health across age groups and borders. And yet action is still lagging and the measurable differences remain elusive.

The following statistics are testimony to the fact that so much more needs to be done:

In the area of violence against women –

- Studies worldwide indicate that between 20 and 50% of women have been beaten by a male partner, with wide-ranging physical and mental health consequences.
- Violence against women in conflict and refugee situations is also a serious health issue, with women and children representing the majority of civilian victims worldwide.

Maternal morbidity and mortality continue to be unacceptably high –

- 99% of the 585 000 deaths from pregnancy-related causes in 1990 took place in developing countries. In other words, 1 woman in 50 in the developing world dies as a result of pregnancy-related complications compared to 1 woman in 8 000 in the developed world.
- The number of maternal deaths represents only a small fraction of the total burden of disease associated with pregnancy and childbirth. Conservatively estimated, the submerged fraction of the iceberg amounts to some 20 million cases of morbidity and disability each year, ranging from acute and devastating injuries such as obstetric fistula to chronic, debilitating conditions such as severe anaemia, reproductive tract infections and uterine prolapse. Some one-third of all women in the developing world have suffered such problems at some time in their lives.

With respect to HIV/AIDS –

- While women were under-represented among those suffering from HIV infection in the 1980s, this trend is no longer discernible. In 1995, almost half of all newly-infected adults throughout the world were women. Women in developing countries, notably in areas of the world where the pace of HIV infection is growing at an especially alarming rate, have been particularly affected. In 1995, 35% of all new infections affecting women were found in South-East Asia.
- Seven million women have already contracted HIV. By the year 2000 this number will have climbed to 13 million, and 4 million of these women will have already died.

While statistics do not tell the whole story, when appropriately used, they are very revealing of the inequities that continue to take their toll on the health of women. How can we provide a guarantee that this scenario becomes a relic of the past in a brighter health future for today's infant girl?

One answer is to spare no effort in supporting and moving forward the cause of women's health. Another complementary strategy is to ensure that women's health issues remain firmly on the political and developmental agenda at all levels.

The World Health Organization is firmly committed to both of these avenues. WHO has mainstreamed women's health in all relevant programmes and strengthened these components in order to address all aspects of women's health and well-being throughout their entire lives. In addition, the Global Commission on Women's Health was created as an essential expression of the commitment of WHO to forging ahead with positive and effective measures at all levels for improving women's health, and carrying out international and national advocacy on behalf of women's health concerns. It has been said by many people that neither men nor women can enjoy their human rights until they enjoy the most fundamental human right of all – the right to health. The right to health is best expressed in the notion of "health security" throughout the lifespan. Health security traces the entire lifespan of a woman from the time *in utero* through to old age. It encompasses all aspects of the basic human right to health: the right to freedom of choice and personal security; the right to food in sufficient quantity and of good quality; the right to live and work in environments where known health risks are controlled; and the right to education, information and decent housing.

Health security also encompasses the principle of universality in health care, so that all human beings – men or women – may live with the knowledge that they can seek and receive quality health care which is also accessible and affordable. Health security, therefore, seeks the empowerment of people through various forms of societal and eco-

nomic support and fuller knowledge and awareness, thus enabling people to make the right choices, cope with the changing patterns of vulnerability and keep healthy. Women will only enjoy the right to health once progress is made in finally overcoming persistent barriers to equity, choice and participation.

The World Health Organization and the Global Commission on Women's Health have adopted women's right to health and the enjoyment by women of health security throughout their lifespan as the platform for advocacy efforts and actions. In this way, the attention which is so necessary to improving women's health across age groups and borders will continue to occupy the spotlight in all arenas and at all levels.

Every woman has the right: to know that she is free from the threat of gender-based violence both inside and outside her home; to reap the benefits of education in both formal and informal environments which are themselves free from health risks; to know that everything that **can be done will be done** to ensure that she does not die, or become ill as a result of pregnancy and childbirth; and to the social, political and economic empowerment that will allow her to protect herself from HIV/AIDS and other sexually transmitted diseases. Finally, every woman has the right to accessible and affordable health care services and to gender-sensitive interventions delivered by providers who adhere to the highest ethical standards.

We are all accountable for guaranteeing these health rights to all women throughout the world. We can fulfil our responsibilities by expanding our partnerships to strengthen our individual and collective actions and efforts. Unceasing advocacy, concrete actions with measurable outcomes and solidarity across all barriers will make the difference in providing for a better health future for today's infant girl, tomorrow's girl and woman.

This special issue of the *World health statistics quarterly* contains a series of articles which present the wide range of issues that are critical to achieving health security for women. Women's reproductive health is comprehensively addressed. The article on maternal mortality presents new data which reveal that the scale of the problem is much greater than earlier believed. Options for expanding the contraceptive choices available to underserved women who wish to regulate their fertility, and the adverse repercussions on health status resulting from the limited range of contraceptives made available in some contexts are presented in the article on the contraceptive method mix. In "Combating female genital mutilation: an agenda for the next decade", the author reports that this phenomenon continues to be a problem in many African countries and proposes actions to accelerate progress in eliminating it.

Another group of articles addresses women's differential vulnerability to infection, the differential impact of diseases on women, and differential treatment rates by sex. Articles on HIV/AIDs address women's increased vulnerability to HIV. Critical areas for action by policy makers and the health care profession are identified. The article "Women and tuberculosis" underscores the fact that women's lower propensity to seek diagnosis and treatment has devastating consequences for their health. It has been found that gender plays a large role in the impact of leprosy. Gender-sensitive strategies for improving disease control are laid forth. "Women and smoking" makes it clear that, although smoking is seen largely as a male problem, it leads to a number of killer diseases in women. Recommendations for research, public policy and education are made.

Several other articles examine the special health needs of specific groups of women. The article on aging women reinforces the importance of addressing women's health throughout the entire lifespan in order to avoid certain health conditions in their

old age. One author points out that migration poses a major public health problem for women.

Health security for women cannot be divorced from broader ethical concerns. The article "Ethics and reproductive health: a principled approach" points out that women must be treated as competent partners and participants when formulating medical decisions. The piece on sexual abuse among health practitioners furthers knowledge on the barely explored field of the sexual exploitation of female patients by health care professionals in positions of trust.

It is hoped that this special issue of the *World health statistics quarterly* will provide health professionals and lay people in all regions of the world with new and critical data and information which will be of use in their continuing endeavours to improve women's health across age groups and political borders.

Aleya El Bindari Hammad
Executive Administrator
for Health Policy in Development,
World Health Organization, Geneva

ral of obstetric complications before they become life-threatening emergencies.

Any woman, even if she is healthy and well-nourished, can unexpectedly develop obstetric complications. Such complications often happen suddenly and dramatically, requiring medical intervention quickly if death or serious disability is to be avoided. Providing access to essential care for obstetric complications will help to reduce case fatality rates among women experiencing complications and thus reduce maternal mortality. Services for the management of complications should be available as close as possible to where women live. Whereas certain interventions such as caesarean delivery or blood transfusion require the skills and equipment normally available only at the first referral or district hospital, many other life-saving interventions, such as management of eclampsia, haemorrhage, abortion and sepsis, can be delivered at health centres staffed by people with appropriate midwifery skills. A description of the interventions needed at different levels of the health care system – community, health centre or district hospital – has recently been issued.^e

New estimates of maternal mortality

Although the interventions needed are well-established, ascertaining progress in reducing maternal mortality is extremely difficult for two reasons: maternal mortality is difficult to measure; and the information available at country level does not generally permit the establishment of good baseline data.

In order to address these problems WHO and UNICEF worked with Cynthia Stanton and Kenneth Hill of Johns Hopkins University to develop a new approach to estimating levels of maternal mortality in developing countries. The new approach has the dual objective of generating improved estimates for countries with inadequate or no national data on maternal mortality, while at the same time providing improved estimates for countries with data by adjusting for problems of under-reporting and misclassification. A full description of the strategy will be published separately.^f

The new WHO/UNICEF approach to estimating maternal mortality

Assessing levels of maternal mortality at the national level requires knowledge about deaths of women of reproductive age (15-49 years), the cause of death and also whether or not the woman was

pregnant at the time of death or had recently been so. Yet few countries count births and deaths; even fewer register the cause of death; and fewer still systematically note pregnancy status on the death form. Broadly speaking, countries fall into one of three categories:

1. Countries with no reliable system of vital registration where maternal deaths – like other vital events – go unrecorded;
2. Countries with relatively complete vital registration in terms of **numbers** of births and deaths but where **cause of death** is not adequately classified; cause of death is routinely reported for only 78 countries or areas, covering approximately 35% of the world's population.⁽⁴⁾
3. Countries with complete vital registration and good cause of death attribution – although even here, misclassification of maternal deaths can arise for a variety of reasons.

Maternal mortality can be measured by incorporating questions on pregnancy and deaths into large-scale household surveys. The disadvantage of such approaches is that they require large sample sizes and are extremely expensive and time consuming⁽⁵⁾.^g A more cost-effective approach is the *Sisterhood Method* which adds on to existing household surveys a few simple questions about whether or not the sisters of the respondent are still alive. Smaller sample sizes are needed because each respondent can provide information on a number of sisters. However, the results do not provide a current estimates but give an idea of the levels of maternal mortality roughly ten years earlier. There is some evidence that the method may underestimate pregnancy-related mortality^(6,7).

The best way of measuring maternal mortality in the absence of vital registration is to identify and investigate the causes of all deaths of women of reproductive age: the *Reproductive Age Mortality Survey (RAMOS)*. Multiple sources of information – civil registers, health facility records, community leaders, religious authorities, undertakers – are used to identify all deaths⁽⁸⁾. Subsequently, interviews with household members and health care providers and facility record reviews are used to identify maternal deaths. RAMOS studies are time consuming and complex to undertake, particularly on a large scale and only ten developing countries have carried out RAMOS or household studies to estimate maternal mortality at the national level.

Methodology for the new estimates

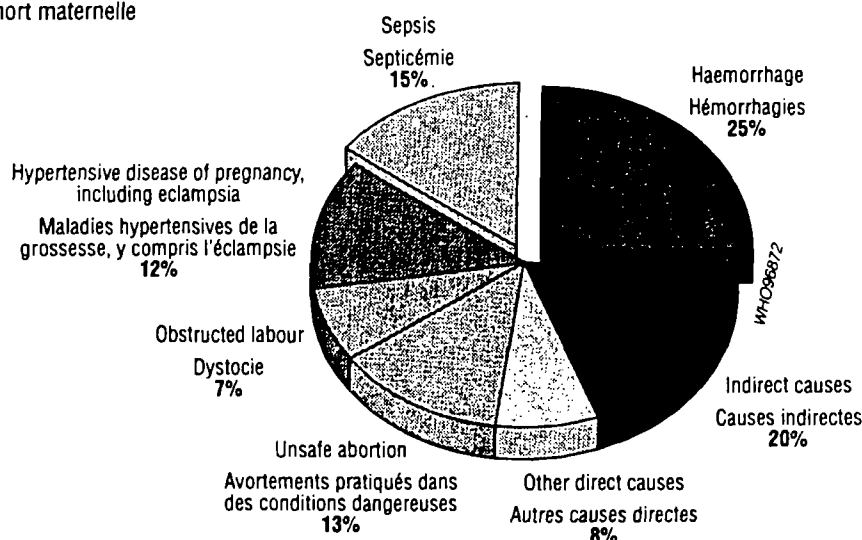
The new estimates were developed using a dual strategy: existing national maternal mortality esti-

^e World Health Organization. *The mother-baby package: implementing safe motherhood in countries*. Maternal Health and Safe Motherhood Programme, Geneva, 1994 (WHO/FHE/MSM/94.11).

^f World Health Organization and United Nations Children's Fund. *Revised 1990 estimates of maternal mortality: a new approach by WHO and UNICEF*. Geneva & New York, 1996 (WHO/FHE/MSM/94.11 – UNICEF/PLN/96.1).

^g For example, a sample of nearly 10,000 pregnancies in Addis Ababa, Ethiopia, yielded 45 deaths and an estimated maternal mortality ratio of 480. At the 95% level of significance this gives a sampling error of around 30%, that is, the ratio could lie between 370 and 660. (Source: *Ref.: Ref. 7*)

Fig. 1
Causes of maternal deaths
Causes de mort maternelle



difficult to make. Some deaths from external causes—for example, suicide or homicide—may be attributable to the pregnancy itself (2). This phenomenon is common to both developed and developing countries. A study in the United States found that several deaths of pregnant or recently pregnant women were the result of physical violence related to the fact of pregnancy and that had they been included as maternal deaths the overall maternal mortality ratio would have increased by 8% (3).

The medical causes of maternal death represent only the most visible dimension of a multi-layered problem. In reality it is often logistic or health service factors that determine whether a woman with pregnancy-related complications lives or dies. Lack of access to skilled health care for complicated pregnancies or for emergencies is often the root cause of death. Barriers to such access can be physical (distance, lack of transport), economic (lack of resources to pay for the needed transport, care or drugs), or sociocultural (low status which impedes women's ability to take decisions to seek care and which may impose restrictions on their mobility).

Even when a woman reaches a health facility a variety of health service factors can prevent her from receiving appropriate care in a timely manner. These include, for example, shortages of drugs and equipment, lack of safe blood supplies for blood transfusion, and shortages of skilled personnel. In some cases, a woman may not receive care simply because providers fail to realize the gravity of her condition and act appropriately (2).

Actions needed to reduce maternal mortality

The actions needed to attain the goal of reducing maternal mortality have been known and understood for many years. Because women's status is often a determinant of their access to education, health care and nutrition, it is a foundation upon

which improvements in maternal health care must rest. However, improving women's status will necessarily remain a long-term objective. In the short term, there are three essential interventions that will help to reduce maternal deaths:

- reducing the number of high risk and unwanted pregnancies;
- reducing the numbers of obstetric complications; and
- reducing deaths among women who develop complications.

Ensuring access to family planning so as to avoid births that are too early or too late in a woman's life, too close together or unwanted, is an important pathway for the prevention of maternal deaths. Unwanted and mistimed pregnancies are associated with a higher risk of maternal death. It has been estimated that ready access to family planning for all women could reduce the numbers of maternal deaths by some 20%.

Once a woman is pregnant, however, she needs care throughout pregnancy and delivery, including essential care for the management of obstetric complications. The number and severity of obstetric complications can be reduced by ensuring that all women have access to basic maternal care – good-quality antenatal, delivery (clean and safe) and postpartum care. Basic maternal care is an opportunity to provide women and their families with information on how to take care of themselves throughout pregnancy and childbirth, to inform them about danger signs and symptoms, and to advise on what to do if complications arise. Such care should include the prevention and management of conditions which can lead to complications – such as anaemia or sexually transmitted diseases – or diseases aggravated by the physiological effects of pregnancy – such as malaria, diabetes, tuberculosis or cardiovascular diseases. Of particular importance during basic maternal care is the early detection and prompt management or refer-

Maternal mortality

Carla AbouZahr^a, Tessa Wardlaw^b, Cynthia Stanton^c & Kenneth Hill^d

Introduction

Levels of maternal mortality in industrialized and developing countries show a greater disparity than any other public health indicator, far exceeding differences in infant mortality rates which are most often taken as the measure of comparative disadvantage. Although there have been significant declines in infant mortality rates in recent years, the available evidence indicates that the same is not true for maternal mortality. As the end of the 20th century approaches, in the developing world 1 woman in 50 still dies as a result of pregnancy-related complications and the figure rises to 1 in 10 in many parts of Africa. By contrast, the figure for developed countries can be as low as 1 in 8 000.

Maternal mortality as an indicator of development

Maternal mortality is a particularly sensitive indicator of inequity; it offers a litmus test of the status of women, their access to health care and the adequacy of the health care system in responding to their needs. Information about the levels and trends of maternal mortality is needed, therefore, not only for what it tells us about the risks of pregnancy and childbirth, but also for what it implies about women's health in general and, by extension, their social and economic status.

The importance of maternal mortality as an indicator of women's health and status, and by extension of human development, is reflected by its inclusion in the goals of international conferences, such as the Nairobi Safe Motherhood Conference in 1987, the World Summit for Children (WSC) in 1990, the International Conference on Population and Development (ICPD) in 1994, and the Fourth World Conference on Women (FWCW) in 1995. The goal common to all these conferences is reduction of maternal mortality to half the 1990 levels by the year 2000. Related goals include increasing access to antenatal care, ensur-

ing that all women deliver with a skilled birth attendant and improving the nutritional status of girls and women.

Definition and causes of maternal mortality

The *Tenth revision of the international statistical classification of diseases (ICD-10)* defines a maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (1). Thus, like infant mortality, maternal mortality is, in part, a time-of-death indicator. Unlike infant mortality, however, measuring maternal mortality requires knowledge not only of the timing of death but also of the cause of death.

Maternal deaths should be divided into two groups:

Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

Indirect obstetric deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but was aggravated by physiological effects of pregnancy.

The direct causes of maternal mortality are the same around the world; haemorrhage, sepsis, eclampsia, obstructed labour and abortion complications account for around 80% of all maternal deaths. Although the distribution of causes differs somewhat from region to region, globally the biggest proportion of deaths (25%) is due to haemorrhage, most of which occurs during the postpartum period. Sepsis accounts for around 15% of the total, obstructed labour for 7%, eclampsia for 8%, and unsafe abortion for 13%. Other direct obstetric causes, including ectopic pregnancy, embolisms and anaesthesia accidents, account for a further 8% of direct maternal deaths. Indirect causes of maternal death such as anaemia, malaria, cardiovascular diseases, hepatitis and diabetes, account for some 20% of all maternal deaths. (Fig. 1)

Deaths from "accidental or incidental" causes have historically been excluded from maternal mortality. However, in practice, the distinction between incidental and indirect causes of death is

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mates were adjusted to account for under-reporting and misclassification; and a simple model was developed to predict values for countries with no data. The model uses two widely available independent variables – general fertility rates and proportion of births that are assisted by a trained person – to predict maternal mortality.

Maternal mortality estimates for individual countries can be divided into 5 categories (these categories are used in *Table 1*):

- A. *Developed countries with complete vital registration systems and attribution of cause of death.* For these countries the maternal mortality ratio is the reported number adjusted by a factor of 1.5 to account for misclassification of maternal deaths (9,10).^h
- B. *Developing countries with good death registration but poor or non-existent attribution of cause of death.* The model is used to predict the proportion of deaths of women of reproductive age that are maternal. This proportion is then applied to the deaths of women of reproductive age actually registered to obtain the number of maternal deaths and the maternal mortality ratio.
- C. *Countries with RAMOS type estimates of maternal mortality.* The maternal mortality ratio derived from the RAMOS study is used directly without any adjustments.
- D. *Countries with Sisterhood estimates of maternal mortality.* Several recent studies have found that the Sisterhood Method under-estimates total female adult mortality, and presumably, maternal mortality as well (6, 7). However, the Sisterhood Method, in addition to providing an estimate of maternal mortality, also provides estimates of the **proportion** of all deaths of women of reproductive age that are maternal.ⁱ Therefore, for these countries, this **observed proportion** was applied to the total number of deaths of women of women of reproductive age generated by the United Nations Population Division's population projections (1994 revision)^j for the year 1990 since these are believed to be better estimates of female adult mortality.
- E. *Countries with no estimates of maternal mortality.* For countries without accurate information on numbers of deaths and without direct or indirect estimates of maternal mortality, the model is used to predict the proportion maternal of all

deaths of women of reproductive age and this proportion is applied to the 1990 United Nations projections of adult female deaths to derive the maternal mortality ratio.

The results of the new approach indicate that globally, there are some 585 000 maternal deaths, 99% of them in developing countries.^f This is around 80 000 deaths more than earlier estimates have suggested and indicates a substantial underestimation of maternal mortality in the past. Moreover, the number of deaths represents only a small fraction of the total burden of disease associated with pregnancy and childbirth. Conservatively estimated, the submerged fraction of the iceberg amounts to some 20 million morbidities and disabilities each year, ranging from acute and devastating injuries such as obstetric fistula to chronic, debilitating conditions such as severe anaemia, reproductive tract infections and uterine prolapse. Some one-third of all women in the developing world have suffered such problems at some time in their lives.

In developing countries as a whole, maternal mortality ratios range from 190 per 100 000 live births in Latin America and the Caribbean to 870 per 100 000 in Africa. Extremely high ratios of over 1000 per 100 000 live births are found in Eastern and Western Africa (*Table 2*).

Differences between these revised estimates and previous estimates of maternal mortality

The maternal mortality ratios derived from this new approach differ from earlier estimates, both in terms of global numbers of maternal deaths, and in terms of the regional breakdowns. In particular, estimates for Africa are generally much higher whereas those for Asia and Latin America as a whole are broadly comparable to the earlier figures (*Table 3*).

These new estimates differ – in some cases considerably – from official figures or from figures derived from other sources such as Sisterhood studies. For example, the figures quoted for developed countries are based on official figures inflated by a factor of 1.5 to account for misclassification of maternal deaths. As already noted, this new approach results in systematically higher estimates of maternal mortality than Sisterhood studies due to the fact that the Sisterhood estimates appear to underestimate adult female mortality and have been adjusted accordingly.

Using the new estimates

The new WHO/UNICEF approach to estimating maternal mortality is primarily intended to be of use in countries with no estimates of maternal mortality or where there is concern about the adequacy of officially reported estimates. The intention was to draw attention to the existence and likely dimensions

^h The 1.5 adjustment factor is based on evidence from several studies. See, for example, *Ref.-Ref. 9 & 10*.

ⁱ In so far as the *Sisterhood Method* identifies all pregnancy-related deaths which may include some due to fortuitous or accidental causes, it may over-estimate maternal mortality. However, the method is likely to miss some early maternal deaths such as those related to abortion or ectopic pregnancy. It has been assumed that the two biases cancel out.

^j **United Nations Population Division, *World population prospects: the 1994 revision***, New York, United Nations, 1995 (ST/ESA/SER.A/145).

Table 1 (continued)

Tableau 1 (suite)

Suriname ^a				
Swaziland	560	160	29	E
Sweden – Suède	7	10	6 000	A
Switzerland – Suisse	6	5	8 700	A
Syrian Arab Republic – République arabe syrienne	180	950	75	C
Tajikistan – Tadjikistan	130	270	120	A
Former Yugoslav Republic of Macedonia – Ex-République yougoslave de Macédoine ^a				
Thailand – Thaïlande	200	2 300	180	E
Togo	640	1 000	20	E
Tonga ^a				
Trinidad and Tobago – Trinité-et-Tobago	90	25	360	B
Tunisia – Tunisie	170	380	140	E
Turkey – Turquie	180	3 000	130	C
Turkmenistan – Turkménistan	55	70	350	A
Turks and Caicos Islands – Îles turques et Caïques ^a				
Tuvalu ^a				
Uganda – Ouganda	1 200	11 000	10	E
Ukraine	50	320	930	A
United Arab Emirates – Emirats arabes unis	26	10	730	E
United Kingdom of Great Britain and Northern Ireland – Royaume-Uni de Grande-Bretagne et d'Irlande du Nord	9	70	5 100	A
United Republic of Tanzania – République-Unie de Tanzanie	770	8 700	18	E
United States of America – Etats-Unis d'Amérique	12	480	3 500	A
Uruguay	85	45	410	B
Uzbekistan – Ouzbékistan	55	380	370	A
Vanuatu	280	15	60	E
Venezuela	120	680	200	B
Viet Nam	160	3 300	130	E
Yemen – Yémen	1 400	8 100	8	E
Yugoslavia – Yougoslavie ^a				
Zaire – Zaïre	870	16 000	14	E
Zambia – Zambie	940	3 500	14	E
Zimbabwe	570	2 300	28	E

^a For these countries it was not possible to calculate maternal mortality ratios using this methodology in the absence of independent variables. – Pour ces pays, il n'a pas été possible de calculer les rapports de mortalité maternelle à l'aide de cette méthode à cause de l'absence de variables indépendantes.

^b Categories explained in text. – Les catégories sont définies dans le texte.

Sources: World Health Organization and United Nations Children's Fund. Revised 1990 estimates of maternal mortality: a new approach by WHO and UNICEF. Geneva & New York, 1996 (WHO/FHE/MSM/94.11 – UNICEF/PLN/96.1).

of the problem of maternal mortality. The estimates should be taken as indicating orders of magnitude rather than precise estimates and are not necessarily what governments consider most appropriate. The standard errors associated with the predicted maternal mortality ratios are very large. They cannot, therefore, be used for regular monitoring of trends. The figures pertain to the year 1990 and should be seen as a recalculation of the earlier 1991 revision rather than as indicative of trends since then.

The results for each country should serve as a stimulus to action and to help mobilize national and external resources to this end. The nature of such action will be determined in large measure by the social and economic conditions of the country but must include increased access to high quality care during pregnancy and childbirth for all women.

Other ways of monitoring trends in maternal mortality

Where current vital registration systems underestimate maternal mortality due to misclassification of maternal deaths, there is room for improvement through the establishment of a system of confidential inquiries which not only result in better estimation of the dimensions of the problem but also, in so far as they identify the causes of misclassification and analyze the management of each case, lead directly to improvements in case management and reductions in substandard care (11).

National-level confidential enquiries are primarily of value in settings where the majority of deaths of women of reproductive age are officially registered. Where this is not the case, similar approaches can be used at the facility level to gener-

Table 3

Maternal mortality – New regional estimates compared with previous estimates

Tableau 3

Mortalité maternelle – Nouvelles estimations régionales comparées aux estimations précédentes

UN Region – Région des Nations Unies	Maternal mortality ratio (Maternal deaths per 100 000 live births) – Taux de mortalité maternelle (décès maternels pour 100 000 naissances vivantes)	Maternal mortality ratio (Maternal deaths per 100 000 live births) – Taux de mortalité maternelle (décès maternels pour 100 000 naissances vivantes)	Maternal deaths (000s) – Décès maternels (pour 1 000)	Maternal deaths (000s) – Décès maternels (pour 1 000)
	Old estimates – Anciennes estimations	New estimates – Nouvelles estimations	Old estimates – Anciennes estimations	New estimates – Nouvelles estimations
WORLD – MONDE	370	430	509	585
MORE DEVELOPED REGIONS – RÉGIONS PLUS DÉVELOPPÉES	26	27	4	4
LESS DEVELOPED REGIONS – RÉGIONS MOINS DÉVELOPPÉES	420	480	505	582
AFRICA – AFRIQUE	630	870	169	235
Eastern Africa – Afrique orientale	680	1060	60	97
Middle Africa – Afrique centrale	710	950	21	31
Northern Africa – Afrique septentrionale	360	340	17	16
Southern Africa – Afrique australe	270	260	4	3.6
Western Africa – Afrique occidentale	760	1020	66	87
ASIA – ASIE^a	380	390	310	323
Eastern Asia – Asie orientale ^a	120	95	30	24
South-central Asia – Asie méridionale et centrale	(570) ^b	560	(224) ^b	227
South-eastern Asia – Asie du Sud-Est	340	440	42	56
Western Asia – Asie occidentale	280	320	12	16
EUROPE	(23) ^b	36	(1) ^b	3.2
LATIN AMERICA/ CARIBBEAN – AMÉRIQUE LATINE/CARAÏBES	200	190	25	23
Caribbean – Caraïbes	260	400	2	3.2
Central America – Amérique centrale	160	140	6	4.7
South America – Amérique du Sud	220	200	17	15
NORTH AMERICA – AMÉRIQUE DU NORD	12	11	1	0.5
OCEANIA – OCÉANIE^c	600	680	1	1.4

^a Excluding Japan. – A l'exclusion du Japon.^b Direct comparisons are not possible because of the redistribution of parts of the former USSR between the two regions. – Les comparaisons directes sont impossibles à cause de la répartition de certaines parties de l'ancienne URSS entre les deux régions.^c Excluding Australia and New Zealand – A l'exclusion de l'Australie et de la Nouvelle-Zélande.**Note:** Figures may not add to totals due to rounding. – Il se peut que le total ne corresponde pas tout à fait aux chiffres donnés, ceux-ci étant arrondis.**Sources:** World Health Organization. *Maternal mortality ratios and rates: a tabulation of available information*. Third edition. WHO/MCH/MSM/91.6.World Health Organization and United Nations Children's Fund. *Revised 1990 estimates of maternal mortality: a new approach by WHO and UNICEF*. Geneva & New York, 1996 (WHO/FHE/MSM/94.11 – UNICEF/PLN/96.1).

pathways leading to maternal deaths and examine the coverage and quality of services for the management of obstetric complications.¹ Process indicators can help to identify the most appropriate

mix of interventions and to assess progress towards improved coverage and quality of care.

The use of process indicators does not imply the abandonment of efforts to measure impact, that is, maternal mortality ratios. However, it is unrealistic to expect that all countries will be able to establish the kind of ongoing monitoring systems needed for a regular appraisal of maternal mortality. Nor would it be appropriate to direct scarce resources to such

¹ UNICEF & World Health Organization. *Maternal mortality: guidelines for monitoring progress (draft)*, 1996.

an undertaking at the expense of programmes to deal with the problem at its source.

Implications for the future

Despite its limitations in terms of monitoring, this approach represents a substantial improvement on earlier efforts to estimate maternal mortality at regional and global levels, but more particularly at the national level. At regular intervals, WHO and UNICEF will update and expand the data set and re-estimate maternal mortality.

The use of such strategies to estimate maternal mortality is a short-term solution to the problem of measurement. In the long term, accurate information about maternal mortality is dependent on improvements in vital registration systems and their incorporation into all national health information systems. This must be the ultimate objective of all national authorities and of multilateral and bilateral development agencies.

In the meantime, the information now available on probable levels of maternal mortality (Table 2) should serve to stimulate greater action on the part of national authorities and international assistance agencies to reduce the toll of disease, death and disability associated with pregnancy and childbirth.

Summary

A new approach to measuring maternal mortality indicates that there are some 585 000 maternal deaths, 99% of them in developing countries. This is around 80 000 deaths more than earlier estimates have suggested and indicates a substantial underestimation of maternal mortality in the past. There is a greater disparity in levels of maternal mortality between industrialized and developing countries than in any other public health indicator. While significant progress has been made in reducing infant mortality, the same is not true for maternal mortality. Although the actions needed to reduce maternal mortality have long been known, 1 woman in 50 is still dying as a result of pregnancy-related complications and the figure rises to 1 in 10 in many parts of Africa. By contrast, the figure for developed countries can be as low as 1 in 8 000.

Résumé

Mortalité maternelle

Une nouvelle approche de la mesure de la mortalité maternelle indique qu'il y a environ 585 000 décès ma-

ternels, dont 99% dans les pays en développement. On compte donc environ 80 000 décès de plus que le nombre suggéré par les estimations précédentes, ce qui indique que l'on a sous-estimé considérablement la mortalité maternelle dans le passé. L'écart est plus important dans les niveaux de mortalité maternelle entre les pays industrialisés et les pays en développement que dans tout autre indicateur de santé publique. On a réalisé des progrès considérables concernant la réduction de la mortalité infantile, mais cela n'est pas vrai en ce qui concerne la mortalité maternelle. Bien que l'on sache comment réduire la mortalité maternelle depuis longtemps, 1 femme sur 50 meurt encore de complications liées à la grossesse, et ce chiffre passe à 1 sur 10 dans de nombreuses régions d'Afrique. Par contre, le chiffre relatif aux pays développés est bas et n'est parfois que de 1 sur 8 000.

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