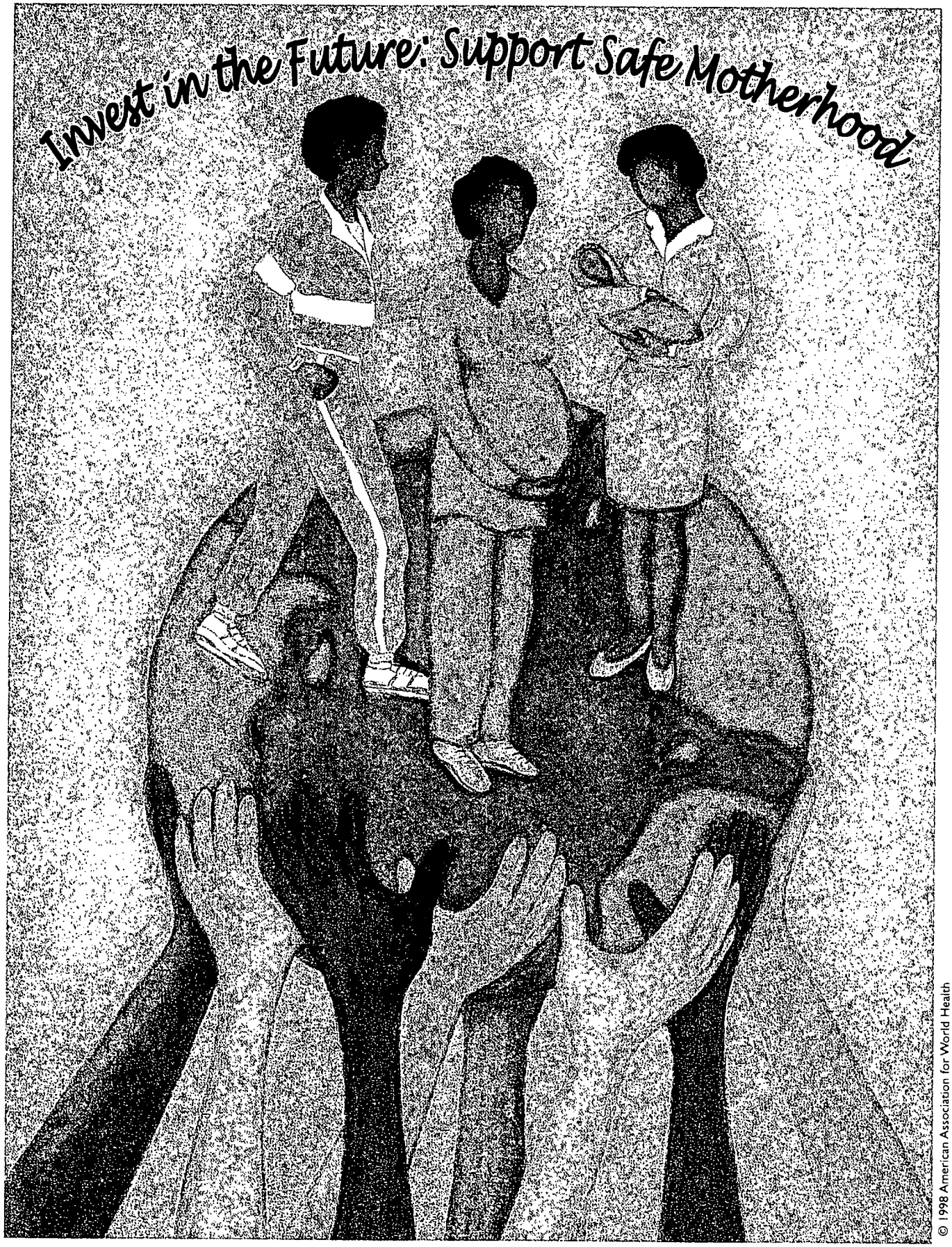


RESOURCE BOOKLET

American Association for World Health
1825 K Street, NW, Suite 1208 • Washington, DC 20006
www.aawhworldhealth.org • (202) 466-5883

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Photo: Carlos Reggero/PAHO

DID YOU KNOW THAT . . .

- Each year almost 600,000 women die from complications of pregnancy and childbirth.
- In many developing countries, maternal deaths account for 25 to 33 percent of all deaths of women of childbearing age.
- At least 40 percent of women who become pregnant each year experience complications that require treatment from a trained provider, and one in 10 requires hospitalization.
- More than one-half of all pregnant women in developing countries are anemic.
- The total cost of saving the lives of a mother or infant through antenatal, delivery and postnatal care is only US $230, while the benefits to families, communities, and countries is immeasurable.
- By improving maternal health and nutrition and immediate postnatal care we could prevent about 75 percent of perinatal deaths, more than 50 percent of infant deaths, and 99 percent of maternal deaths.

For more information please contact:

Human Development Network
The World Bank
1818 H Street N.W., Washington, D.C. 20433

THE WORLD BANK

MAKING MOTHERHOOD SAFER

"How is it possible, that in the midst of unprecedented economic growth and technological breakthroughs, we have managed to allow alarming numbers of young women to continue dying during pregnancy and childbirth?"

James D. Wolfensohn, President, The World Bank

Complications of pregnancy and childbirth constitute the leading cause of death and disability among women 15 to 49 years of age, and 99 percent of these deaths occur in developing countries. The problem is particularly acute in Africa and South Asia, where women's access to maternal health care and family planning is especially limited. Making motherhood safer is fundamental to improving human welfare, reducing poverty and promoting economic development, which are the World Bank's overarching goals.

The World Bank was a co-founder of the Safe Motherhood Initiative, launched in 1987. The Initiative seeks to reduce illness and death related to pregnancy by ensuring that women have the best chance of having a safe pregnancy and delivery and a healthy baby. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, postnatal care, family planning, and good nutrition. Also essential, is information to raise awareness among pregnant mothers and their families about the importance of maternal health care and family planning services.

The Bank's support for safe motherhood has increased substantially over the decade. In 1986, the Bank's overall lending program had less than 10 projects that included maternal health and family planning. Recognizing the magnitude of the problem, the Bank significantly expanded its efforts to make motherhood safer. Today, it is the largest single source of external assistance for safe motherhood, financing some 100 projects that address this issue. A few Bank-financed projects are devoted mainly to safe motherhood. However, most Bank-supported safe motherhood activities are part of broader health projects. These activities employ a variety of strategies, including multi-sectoral approaches and partnerships with other international agencies and non-governmental organizations (NGOs).

Strengthening Maternal Health in Bangladesh

In 1976, the Government of Bangladesh declared family planning a top priority, and the World Bank joined the international community to help Bangladesh achieve its national family planning goals. While primarily focused on family planning, the first World Bank-financed project also included efforts to reduce maternal mortality by training traditional birth attendants and providing maternal and child health kits. Later projects reflected the government's growing commitment to maternal health, and included training of medical staff and expanding access to maternal health services as well as improving the nutrition of pregnant and lactating mothers. The government's 1997 Health and Population Sector Strategy, prepared with Bank support, contributed to the design of a new health and population project, which includes activities to improve antenatal, delivery, and post-natal care, and emphasizes developing basic and comprehensive emergency obstetric care in health centers and hospitals.

Partnerships Bring Progress to India's Urban Slums

The World Bank has a large portfolio of safe motherhood-related projects in India. This includes nine population projects and several nutrition projects. A new, nation-wide reproductive and child health project has just been launched, and a woman and child development project focusing on nutrition will soon be underway. In the poorest and most disadvantaged neighborhoods of Hyderabad, the capital of Andhra Pradesh, a World Bank-financed family welfare project is tackling the city's high maternal and child mortality and fertility rates through an innovative partnership. The women of the slums, NGOs, and government health staff have joined forces to improve the quality and expand family health services in some of Hyderabad's poorest neighborhoods. Experience from earlier programs showed that a top-down, centralized approach to delivering health care and family planning services was not effective. The Municipal Corporation of Hyderabad turned to 24 NGOs to assist in reaching out to the core slum areas not previously covered by maternal and child health services. They educate communities about good maternal and child health practices and family planning, train community link volunteers, organize group savings and community development activities, and are expanding access to maternal and other health care services.

Extending the Reach of Safe Motherhood in Zimbabwe

The World Bank has supported Zimbabwe's health sector since 1987. This support has included efforts to improve the health status of mothers and infants, increase family planning services, and strengthen the government's capacity to plan and manage maternal and child health and family planning services. The first project trained health workers in family planning and midwifery, upgraded health centers, and provided information and education about health and family planning. By project's end in 1994, 48 percent of couples were using contraceptives, more than 90 percent of all women received antenatal care, and 70 percent had a facility-based assisted delivery. The ongoing project, which began in 1991, continues efforts to expand access to basic health, family planning and nutrition services, especially for poorer families. It is also upgrading the youth advisory services which include counseling and a school-based family life education program.

Delivering Safe Motherhood Services in Indonesia

Indonesia launched its "village midwife" program in 1988 with the ambitious target of placing a midwife in every village by the year 2000. The Bank supported training and deployment of these midwives, so that 54,000 are now in place. The Bank has continued its support. Most recently, a new Bank-financed project brings together the powerful and successful community information apparatus of the national family planning program and maternal health and other basic services provided by the Department of Health. Partners in this project include both public and private sector agencies involved in maternal health activities. The project's objectives include creating individual, family and community-level demand; linking the demand with improved quality of services at the community and referral levels; developing sustainable systems to maintain the community midwife program; improving the technical skills of hospital staff to manage obstetric emergencies; and investing in the future through an adolescent reproductive health education program.

Promoting Reproductive Health in the Philippines' Provinces

The Philippines, with World Bank assistance, is implementing a comprehensive, nation-wide reproductive health program, with special emphasis in 41 provinces. Despite a well-developed health system, more than 70 percent of women deliver their babies at home. The Women's Health and Safe Motherhood Project addresses the issues that have prevented women from seeking appropriate care in the past and includes services essential for safe motherhood. Several key factors enabled the government to plan this program effectively and are central to its success. First, a national survey was conducted to carefully assess women's health status. National-level policy dialogue culminated in acceptance of the 1994 International Conference on Population and Development's Program of Action, positioning women's health and safe motherhood as one of six priority health issues. Finally, reorganization of the Department of Health placed family planning, maternal and child health, and nutrition programs under one office and linked that office with hospital administration, which is essential for ensuring care for obstetric emergencies.

Reversing the Tide of Maternal Death in Romania

World Bank support for Romania's health sector began in 1992 with the Health Rehabilitation Project. The project was designed to reverse a long decline in health indicators, including maternal health. In partnership with the European Commission, UNICEF, WHO, and USAID, the project aimed to reduce maternal mortality by improving reproductive health care services; rehabilitating rural dispensaries to expand women's access to health care; and providing equipment needed to improve care for pregnancy complications, as well as for neonatal intensive care. The project provided training and equipment to upgrade 10 reproductive health referral centers at university hospitals and 50 maternal/neonatal referral units in both district and university hospitals. It also set up a network of 240 local family planning units and greatly increased the availability of contraceptives. During this period maternal mortality dropped substantially.

Toward Safer Births in the Villages of Yemen

The World Bank is assisting Yemen in implementing its National Population Strategy through the Family Health Project, begun in 1993. The project is working to reduce unwanted fertility and maternal and infant mortality. These objectives are being met by improving the access to and quality of maternal and child health/family planning services, initially in district hospitals and then at the village level. Special focus is being placed on managing obstetric emergencies, blood banking, and operating theaters. The project provides vehicles for patient referral, as well as fellowships to attract women to train as midwives. At the national level, the project supports the training of health care workers by providing training facilities and technical assistance on curricula development for primary health care and continuing education.

The Safe Motherhood Grants Program

Through its grants program, the World Bank supplements its lending for safe motherhood by providing three to four small grants per year for innovative activities. Examples include development of the Mother-Baby Package and production of a wall chart on "Maternal Health Around the World," through grants to the World Health Organization's Safe Motherhood Program; the "Technical Consultation on Safe Motherhood: 10 years of lessons learned in research and practice," held in Sri Lanka in October 1997; and maternal and reproductive health curriculum development by the Pakistan College of Physicians and Surgeons. Together with the Canadian International Development Agency, the Bank supported the Safe Motherhood Demonstration Project (SMDP), implemented by The Population Council. This research demonstrated the effectiveness of training midwives at the primary and referral levels in life saving skills in Ghana and Viet Nam and medical second opinion for reducing unwarranted cesarean sections in Ecuador.

Future Directions

The Bank is fully commited to making motherhood safer. By working with countries to build a favorable policy environment and help target resources cost-effectively, many lives can be saved. Investments in safe motherhood will have an impact beyond improving women's status and the survival and health of their families. They will also strengthen development capacity and promote sustainable economic growth.

For Further Reading

Measham, Anthony and Richard Heaver, 1996, *India's Family Welfare Program*, Washington, D.C.: World Bank

Tinker, Anne and Marjorie Koblinsky, 1993, *Making Motherhood Safe*, World Bank Discussion Paper 202, Washington, D.C.: World Bank

World Bank, 1998, "Improving Reproductive Health: The Role of the World Bank", Washington, D.C.: World Bank

World Bank, 1998, *Improving Women's Health in Pakistan and Saving Lives*, Washington, D.C.: World Bank

World Bank, 1996, *Improving Women's Health in India*, Washington, D.C.: World Bank

World Bank, 1994, *A New Agenda for Women's Health and Nutrition*, Washington, D.C.: World Bank

SAFE MOTHERHOOD ACTION MESSAGES

1. **Advance Safe Motherhood Through Human Rights**. Defining maternal death as a "social injustice" as well as a "health disadvantage" obligates governments to address the causes of poor maternal health through their political, health and legal systems. International treaties and national constitutions that address basic human rights must be applied to safe motherhood issues in order to guarantee all women the right to make free and informed decisions about their health, and access to quality services before, during and after pregnancy and childbirth.

2. **Safe Motherhood Is a Vital Social and Economic Investment.** All national development plans and policies should include safe motherhood programs, in recognition of the enormous cost of a woman's death and disability to health systems, the labor force, communities and families. Additional resources should be allocated for safe motherhood, and should be invested in the most cost-effective interventions (in developing countries, basic maternal and newborn care can cost as little as US$3 per person, per year).

3. **Empower Women, Ensure Choices**. Governments, community leaders and women's advocates need to address social, economic and cultural factors that limit women's choices and decision-making abilities. Legal reform and community mobilization is essential for empowering women to understand and articulate their health needs, and to seek services with confidence and without delay.

4. **Delay Marriage and First Birth:** Reproductive health information and services for married and unmarried adolescents need to be: legally available, widely accessible, and based on a true understanding of young people's lives. Community education must encourage families and individuals to delay marriage and first births until women are physically, emotionally and economically prepared to become mothers.

5. **Every Pregnancy Faces Risks:** During pregnancy, any woman can develop serious, life-threatening complications that require medical care. Because there is no reliable way to predict which women will develop these complications, it is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies, but especially during and immediately after childbirth when most emergency complications arise. Antenatal care programs should not spend scarce resources on screening mechanisms that attempt to predict a woman's risk of developing complications.

6. **Ensure Skilled Attendance at Delivery**. The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of an emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.

7. **Improve Access to Quality Maternal Health Services**. Health services should be located as close as possible to where women live, and must offer affordable, high-quality care. In order to meet required standards, health systems should have: an adequate number of trained staff; a regular supply of drugs, equipment and supplies; and functioning referral systems. Services should also be respectful of – and responsive to – women's needs, preferences and cultural beliefs.

8. **Address Unwanted Pregnancy and Unsafe Abortion:** Program planners should aim to reduce the number of maternal deaths from unsafe abortion (which are the most easily preventable maternal deaths) by ensuring that all safe motherhood programs include: client-centered family planning services to prevent unwanted pregnancy; contraceptive counseling for women who have had an induced abortion; the use of appropriate technologies for women who experience abortion complications; and, where abortion is not against the law, such abortion services should be safe*. In all cases, women should have access to quality services for the management of complications arising from abortion.

9. **Measure Progress**. Because it is difficult and costly to estimate maternal mortality accurately, alternative ways of measuring the progress and impact of safe motherhood programs must be used. Since maternal mortality is directly linked to the coverage and quality of maternal health services, information on such indicators as who cares for women during childbirth, where the delivery takes place, and the quality of services at health facilities should be collected and analyzed.

10. **Power of Partnership:** Reducing maternal mortality requires sustained, long-term commitment and the inputs of a range of partners. Governments, non-governmental organizations (including women's groups and family planning agencies), international assistance agencies, donors, and others should share their diverse strengths and work together to promote safe motherhood within countries and communities and across national borders. Programs should be developed, evaluated and improved with the involvement of clients, health providers and community leaders. National plans and policies should put maternal health into its broad social and economic context, and incorporate all groups and sectors that can support safe motherhood.

---

*Each of the co-sponsors of the Safe Motherhood Initiative implements these activities according to its specific mandate.

Safe Motherhood: A Matter of Human Rights and Social Justice

For a woman to die from pregnancy and childbirth is a social injustice. Such deaths are rooted in women's powerlessness and unequal access to employment, finances, education, basic health care and other resources. These factors set the stage for poor maternal health even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun.

Making motherhood safer, therefore, requires more than good quality health services. Women must be empowered, and their human rights — including their rights to good quality services and information during and after pregnancy and childbirth — must be guaranteed.

The Powerlessness of Women[1]

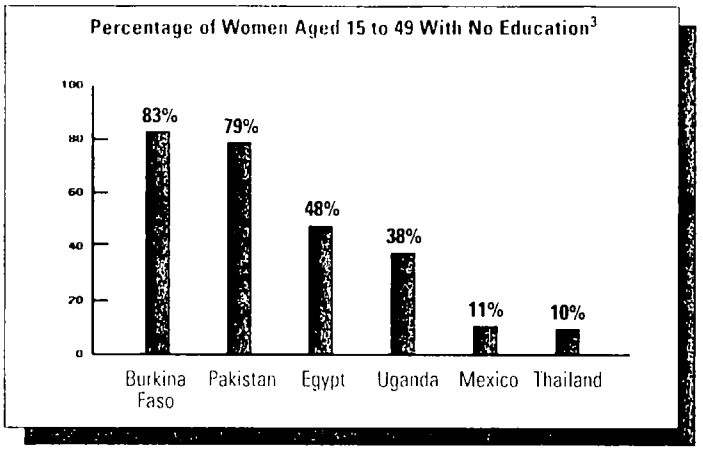
- Millions of women in the developing world do not have the social and economic support they need to seek good health and safe motherhood. Physical and psychological barriers include:

— *Limited exposure to information and new ideas:* In many communities pregnancy is not seen as requiring special care, and women do not recognise danger signs during pregnancy. Even if they are experiencing pain and suffering, they may have been taught that these conditions are inevitable, and therefore do not seek medical care.

— *Limits on decision-making:* In many developing countries, men make the decisions about whether and when their wives (or partners) will have sexual relations, use contraception or bear children. In some settings in Asia and Africa, husbands, other family members or elders in the community decide where a woman will give birth and must give permission for her to be taken to a hospital.

— *Limited access to education:* In much of Africa and Asia, 75% of women age 25 and over are illiterate.[2] When girls are denied schooling, as adults they tend to have poorer health, larger families and their children face a higher risk of death.

— *Limited resources:* Poverty, cultural traditions and national laws restrict women's access to financial resources and inheritance in the developing world. Without money, they cannot make independent choices about their health or seek necessary services.



- **Health services that are insensitive to women's needs, or staffed by rude health providers, do not offer women a real choice:** In many cultures, women are reluctant to use health services because they feel threatened and humiliated by health workers, or pressured to accept treatments that conflict with their own values and customs.

HOW CAN EMPOWERING WOMEN MAKE MOTHERHOOD SAFER?[1]

It enables women to:

- speak out about their health needs and concerns.
- seek services with confidence and without delay.
- demand accountability from service providers, and from governments for their policies.
- participate more fully in social and economic development.

Political Commitment to Safe Motherhood[4]

- National policy-makers can establish a legal and political basis for safe motherhood by defining maternal mortality as a "social injustice", as well as a "health disadvantage". By doing so, they will commit their governments to:

— *Identifying the powerlessness that women face* — throughout their lives as well as during pregnancy — as an injustice that countries must remedy through political, health and legal systems.

— *Ensuring that all women have the right* to make decisions about their own health, free from coercion or violence, and based on full information.

— *Guaranteeing that all women have access* to good quality care before, during and after pregnancy and childbirth.

Using International Human Rights to Advance Safe Motherhood[4]

■ **International human rights treaties can be used to advance safe motherhood (see below). These documents, as well as most national constitutions, guarantee:**

— ***The right to life, liberty and the security of the person.*** These rights require governments to provide access to appropriate health care, and to guarantee that citizens can choose when and how often to bear children.

— ***Rights that relate to the foundation of families and of family life.*** These rights require governments to provide access to health care and other services women need to establish families and enjoy life within their families.

— ***The right to health services (including information and education) and the benefits of scientific progress.*** These rights require governments to provide reproductive and sexual health care to women.

— ***The right to equality and nondiscrimination.*** These rights require governments to ensure that *all* women and girls have access to services (such as education and health care)—regardless of age, marital status, ethnicity or socio-economic status.

■ **Recent international conferences and conventions set explicit goals that support and protect women's reproductive health needs.**

— Governments participating in the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women agreed that women and men have the right to decide if, when and how often to bear children, and should have access to reproductive health services. They also pledged to cut the number of maternal deaths in half by the year 2000, and in half again by 2015. Although these commitments are non-binding, the Committee on the Elimination of Discrimination Against Women, which monitors the Women's Convention (see below), is using them as standards for the 161 countries that signed the Convention.

THE FOLLOWING INTERNATIONAL TREATIES PROVIDE FRAMEWORKS THAT CAN BE USED TO ADVANCE SAFE MOTHERHOOD:[4]

- Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention);
- International Covenant on Civil and Political Rights;
- International Covenant on Economic, Social and Cultural Rights;
- Convention on the Rights of the Child;
- European Convention on Human Rights;
- American Convention on Human Rights; and
- African Charter on Human and Peoples' Rights.

Each is monitored by a group that develops performance standards for member countries and tracks compliance through periodic reports provided by each country.

What Can Be Done

■ **Governments must provide a framework for ensuring safe motherhood by:**

— ***Reforming laws and policies that contribute to maternal mortality*** (e.g. those that restrict women's access to reproductive health services and information) and implementing laws and policies that protect women's health (such as prohibitions against child marriage and female genital mutilation).

— ***Guaranteeing all women access to good quality maternal health care and accurate information,*** and involving women in planning, implementing, monitoring and evaluating health programmes.

■ **Community leaders, women's advocates, private organisations and individuals must:**

— ***Allow women greater freedom*** to make their own health and life choices, encourage them to question unfair practices, and give them opportunities to learn about their rights and health and to develop a feeling of entitlement to medical care and other services.

— ***Help men understand their role in expanding choices for women,*** and in ensuring responsible sexual and family life.

■ **Everyone, including women's health advocates and donors, must:**

— ***Hold governments accountable for effectively protecting the human rights of their citizens*** by reporting any violations to constitutional courts and international monitoring bodies.

Sources:

1: S.J. Jejeebhoy, "Empower Women, Ensure Choices: Key to Enhancing Reproductive Health". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

2: *The World's Women, 1970-1990, Trends and Statistics.* United Nations, New York, 1991.

3: *Women's Lives and Experiences: A Decade of Findings from the Demographic and Health Surveys Program.* Macro International, Calverton, MD, 1994

4: R.J. Cook, "Advancing Safe Motherhood Through Human Rights". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in a more detailed version for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: safe1@familycareintl.org
Web site address: www.safemotherhood.org

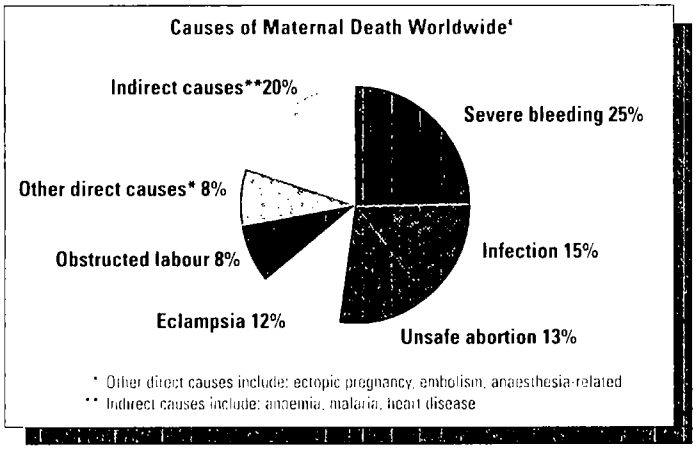
Maternal Mortality

In many developing countries, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. More than one woman dies every minute from such causes; 585,000 women die every year.[1] Less than one percent of these deaths occur in developed countries, demonstrating that they could be avoided if resources and services were available.[1]

In addition to maternal death, women experience more than 50 million maternal health problems annually.[2] As many as 300 million women — more than one-quarter of all adult women living in the developing world — currently suffer from short- or long-term illnesses and injuries related to pregnancy and childbirth.[3]

Maternal Death

■ Every woman can experience sudden and unexpected complications during pregnancy, childbirth, and just after delivery. Although high-quality, accessible health care has made maternal death a rare event in developed countries, these complications can often be fatal in the developing world.



■ Women risk death and disability each time they become pregnant. Women in developing countries face these risks much more often, since they bear many more children than women in the developed world.[1]

Women's Risk of Dying from Pregnancy and Childbirth[1]

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

Country-level differences are even more dramatic: for example, in Ethiopia, 1 out of every 9 women die from pregnancy-related complications, as compared to 1 in 8,700 in Switzerland.[1]

Deaths of Infants and Children

■ Each year, almost 8 million stillbirths and early neonatal deaths (deaths within one week of birth) occur. These deaths are caused largely by the same factors that lead to maternal death and disability—women's poor health during pregnancy, inadequate care during delivery and lack of newborn care.[4]

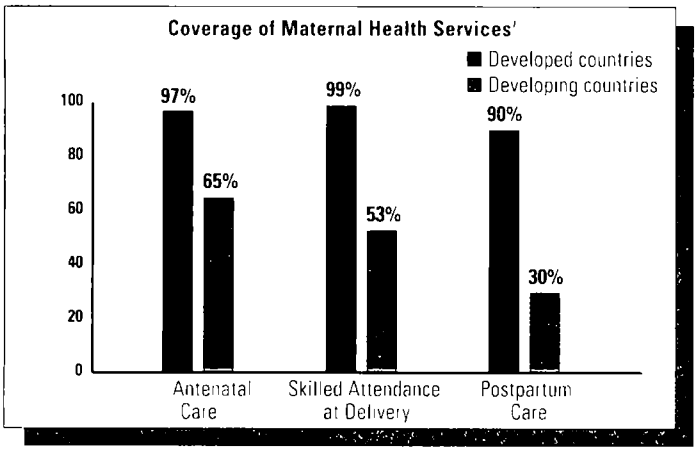
A study in Bangladesh found that a mother's death sharply increased the probability that her children, up to age 10, will die within two years. This was especially true for her daughters.[5]

Maternal Disabilities

■ At least 40% of women experience complications during pregnancy, childbirth and the period after delivery. An estimated 15% of these women develop potentially life-threatening problems.[4,6] Long-term complications can include chronic pain, impaired mobility, damage to the reproductive system and infertility.

Why Are Women Dying?

■ **Most maternal complications and deaths occur either during or shortly after delivery.** Yet many women do not receive the essential health care they need during these periods:



— ***During pregnancy:*** The percentage of women who seek antenatal care at least once is 63% in Africa; 65% in Asia; and 73% in Latin America and the Caribbean. At the country level, however, use of such services can be extremely low. In Nepal, for example, only 15% of women receive antenatal care.[7]

— ***During childbirth:*** Each year, 60 million women give birth with the help of an untrained traditional birth attendant or a family member, or with no help at all. Almost half of births in developing countries take place without the help of a skilled birth attendant (such as a doctor or midwife).[7]

— ***After delivery:*** The majority of women in developing countries receive no postpartum care. In very poor countries and regions, as few as 5% of women receive such care.[7]

Why Do Women NOT Seek Services?

■ **The factors that prevent women in developing countries from getting the life-saving health care they need include:**

— ***distance from health services;***

— ***cost*** (direct fees as well as the cost of transportation, drugs and supplies);

— ***multiple demands on women's time;***

— ***women's lack of decision-making power within the family.***

■ **The poor quality of services, including poor treatment by health providers, also makes some women reluctant to use services.**

What Can Be Done

■ **Ensure access to maternal health services.** Most maternal deaths, many health problems among women and children, and the deaths of at least 1.5 million infants each year could be prevented through:

— ***routine maternal care for all pregnancies***, including a skilled attendant (midwife or doctor) at birth;

— ***emergency treatment of complications*** during pregnancy, delivery and after birth; and

— ***postpartum family planning and basic neonatal care.***

Such care would cost about $3 per person per year in low-income countries. Basic maternal care alone can cost as little as $2 per person.[8]

■ **Improve women's status and raise awareness about the consequences of poor maternal health.** Families and communities must encourage and enable women to receive proper care during pregnancy and delivery.

Sources:

1: "Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF", World Health Organization, Geneva, 1996.

2: "Healthy Pregnancy and Childbearing," in *Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions*, A.O. Tsui, J. N. Wasserheit, and J.G. Haaga, eds. Washington, DC, National Academy Press, 1997.

3: *The Progress of Nations* UNICEF, New York, 1996.

4: "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition", World Health Organization, Geneva, 1997.

5: M.A. Strong, "The Health of Adults in the Developing World: The View from Bangladesh", *Health Transition Review*; 2(2):215-24, 1992.

6: W. Graham, "A Question of Survival? A Review of Safe Motherhood", Ministry of Health, Kenya, 1997.

7: "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition", World Health Organization, Geneva, 1997.

8: "Mother-Baby Package Costing Spreadsheet" (unpublished), World Health Organization, Geneva, 1997.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

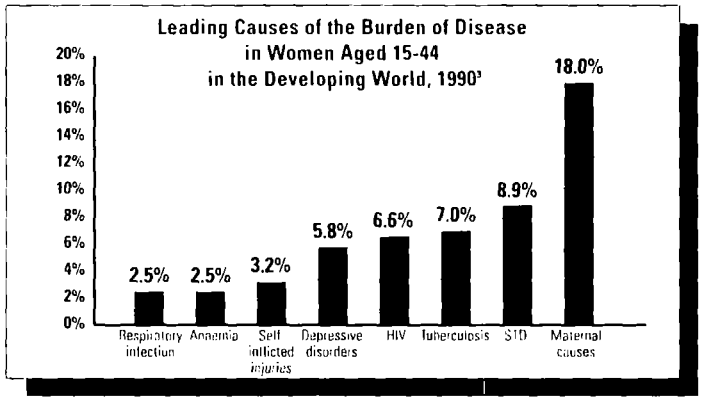
Maternal Health: A Vital Social and Economic Investment

One-quarter of all adult women living in the developing world today suffer from some kind of illness or injury related to pregnancy and childbirth. Each year, maternal health complications are responsible for the deaths of 585,000 women, and contribute to the deaths of at least 1.5 million infants in the first week of life, and 1.4 million stillborn infants.[1] The social and economic cost of these disabilities and deaths — to families, communities, the labour force and countries — is enormous.

The financial cost of basic maternal and newborn health services that could prevent these problems is, on average, only US$3 per person per year in developing countries; the cost of maternal health services alone can be as little as $2 per person.[2] The total cost of saving the life of a mother or infant is approximately $230.

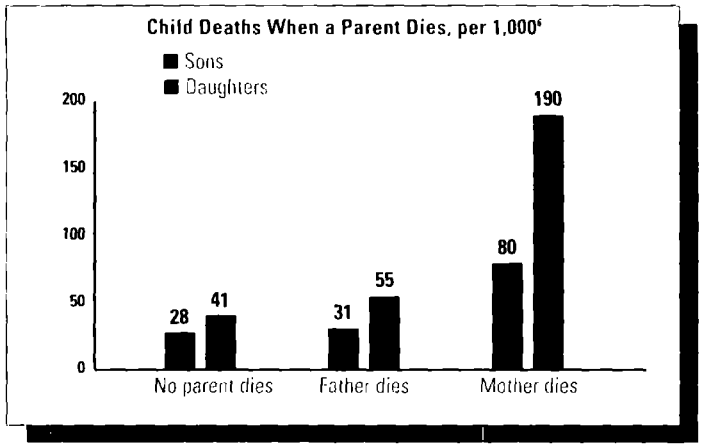
Why Focus on Maternal Health?

- In developing countries, pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age. They account for at least 18% of the burden of disease in this age group — more than any other single health problem.[3]
- Maternal health interventions are among the most cost-effective investments in health.



The Toll on Children

- At least 30 to 40% of infant deaths are the result of poor care during pregnancy and delivery. These deaths could be avoided with improved maternal health, adequate nutrition and health care during pregnancy, and appropriate care during childbirth.[4]
- Poor maternal health and nutrition contributes to low birth weight in 20 million babies each year — almost 20% of all births. These babies die more often than babies of normal weight, and are at greater risk for infection, malnutrition and long term disabilities, including visual and hearing impairments, learning disabilities and mental retardation.[5]
- Motherless children are likely to get less health care and education as they grow up. A study in Bangladesh found that when a mother dies, her children — especially daughters — are much more likely to die than children whose parents are both alive.[6]



The Economic Cost

- Women account for 70% of the 1.3 billion people who live in absolute poverty.[7] When women cannot work because of health problems, the loss of their income, as well as the costs of treatment, can drive them and their families into debt.

  In India, a study found that disability reduced the productivity of the female labour force by about 20%.[8]

- At least 60% of pregnant women in the developing world are anaemic, which reduces their energy — and can depress their incomes.

  Studies in Sri Lanka and China found that anaemia reduced productivity among women tea plantation and

impact of iron supplements.[9]

■ **When women cannot work the consequences can be especially severe for children.** Women are more likely than men to spend their own income on improving family welfare — clothing for young children. When a household is headed by a woman — which is the case for at least 20% of households in Latin America and Africa — her poor health can cause severe problems for the family.[10]

Benefits for Governments and Health Systems

■ **Prevention and early treatment are cost-effective.** Millions of premature deaths, illnesses and injuries can be avoided by helping women prevent unwanted pregnancy and get prompt treatment for reproductive health problems. These steps also help governments avoid the higher costs of treating serious, undetected health conditions, and the costs of providing health care and social services for women with long-term disabilities, and for their families in case of their deaths.

■ **Good maternal health services can strengthen the entire health system.** A health facility that is equipped to provide essential obstetric care — such as blood transfusions, anaesthesia and surgery — can also treat accidents, trauma and other medical emergencies for the community.

■ **Building women's trust promotes preventive care.** Women who receive good care during pregnancy and childbirth are more likely to seek services for children's health, family planning and other health problems, including treatment of sexually transmitted diseases.[3]

What Can Be Done

■ **Governments, non-governmental organisations, international agencies and other funders must make a concerted effort to:**

— ***Acknowledge the social and economic benefits*** of good maternal health, and include efforts to ensure maternal health in all national policies and plans.

— ***Allocate resources to make maternal health services available,*** especially in poor and rural areas. Existing health care resources can be used to support the most cost-effective interventions.

— ***Ensure that every woman has access to a continuum of good-quality safe motherhood services*** offered at the community level, in health centres and in district and regional hospitals.

Sources:

1: A. Tinker, "Safe Motherhood as an Economic and Social Investment". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

2: "Mother-Baby Package Costing Spreadsheet" (unpublished). World Health Organization, Geneva, 1997.

3: *World Development Report 1993: Investing in Health.* World Bank, Washington, DC, 1993.

4: "Perinatal Mortality: A Listing of Available Information". World Health Organization, Geneva, 1996.

5: C. Bellamy, *The State of the World's Children 1998.* UNICEF, New York, 1998.

6: M.A. Strong, "The Health of Adults in the Developing World: The View from Bangladesh". *Health Transition Review* 2(2):215-24, 1992.

7: *Human Development Report 1995.* United Nations Development Programme, New York, 1995.

8: M. Chatterjee, *Indian Women: Their Health and Productivity.* World Bank Discussion Paper 109, Washington, DC, 1991.

9: *A New Agenda for Women's Health and Nutrition.* World Bank, Washington, DC, 1994.

10: United Nations Department of International Economic and Social Affairs, *The World's Women: Trends and Statistics.* United Nations, New York, 1991.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi00@familycareintl.org
Web site address: www.safemotherhood.org

1998

The Safe Motherhood Initiative

When the Safe Motherhood Initiative was launched in 1987, death from the complications of pregnancy and childbirth was a little-known, seriously neglected problem. Ten years later, preventing these deaths is an international priority, and many countries have made significant progress in expanding and improving maternal health services. The global Initiative has become a unique partnership of governments, donors, technical agencies, non-governmental organisations and women's health advocates in more than 100 countries. These partners are now working to protect the health and lives of women, especially during pregnancy and childbirth.

What We Know

☒ **Complications of pregnancy and childbirth are the leading causes of disability and death** among women between the ages of 15 and 49 in developing countries.[1]

☐ **Every woman is at risk.** During pregnancy, any woman can experience life-threatening and unpredictable complications that require immediate medical care.

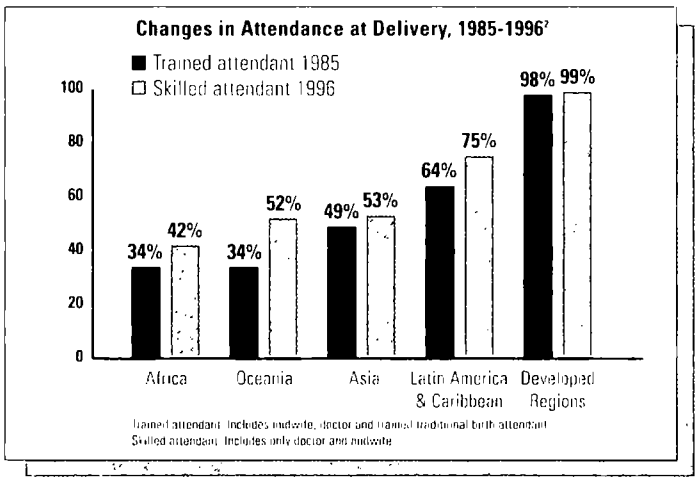
☒ **In order to reduce deaths, good-quality maternal health services must be readily available — and must be used — especially during and immediately after childbirth.** Services should be provided by trained health workers, clinics and hospitals located as close as possible to where women live, and must be linked by an emergency referral and transport system.

☑ **Safe motherhood strategies must be comprehensive.** Even when good quality health services are available, social, economic and cultural limitations can prevent women from using these services. Safe motherhood programmes emphasise the need for action on these root causes, and also on other reproductive health problems, including unwanted pregnancy and sexually transmitted diseases.

The Next Ten Years

☐ **In the last several years, safe motherhood has been embraced by governments all over the world.** They have initiated programmes to reduce maternal death, improve reproductive health services, and protect and promote women's health and well-being, especially during pregnancy and childbirth.

☒ **To help governments and private organisations meet their maternal health goals,** safe motherhood partners from around the world met in October 1997 to identify the most efficient and cost-effective ways to improve maternal health. Participants discussed research results, new technologies, model programmes and lessons learned during the Initiative's first decade. The meeting identified ten essential action messages for improving maternal health (fact sheets on these messages are available for both general and technical audiences), and led to an agreement on the key health services that should be available to make motherhood safer. This package of services is described in the box on the following page.



☐ **A comprehensive package of services for safe motherhood should include:**

— *During Pregnancy:* ***Antenatal care and counselling.***
During pregnancy, health workers should: educate women about how to stay healthy during pregnancy; help women and families prepare for childbirth; and raise awareness about possible pregnancy complications and how to recognise and treat them. Health workers should also identify and manage any complications early and improve women's reproductive health and well-being through preventive measures (iron supplements, tetanus immunisation) and by detecting and treating existing problems (such as sexually transmitted diseases).

— *During Childbirth:* ***Skilled care during labour and delivery.***
During childbirth, every woman should be helped by a health professional who can manage a normal delivery as well as detect and manage complications such as haemorrhage, shock and infection. Skilled attendants should have access to a functioning emergency and transport system so that they can refer women to an appropriate health facility for higher level medical care (such as Caesarean delivery or blood transfusion) when necessary.

— *After Delivery:* ***Postpartum care.***
Following childbirth, women should be seen by a health worker, preferably within three days, so that any problems (such as infection) can be detected and managed early. An additional postpartum visit within the first six weeks after delivery enables health workers to make sure that the mother and baby are doing well, to provide advice and support for breastfeeding and to offer family planning information and services.

— *Before and After Pregnancy:* ***Family planning.***
Family planning counselling and services should be available to all couples and individuals, including adolescents and unmarried women. Family planning services should offer complete information and counselling as well as a wide choice of modern contraceptives, including emergency contraception, and should be part of a comprehensive programme that addresses other sexual and reproductive health needs.

— *Throughout the Reproductive Life Span:* ***Abortion-related care.***
High-quality services for treating and managing complications of unsafe abortion should be available through all health systems. Services require: staff who are trained and authorised to treat complications; appropriate equipment; protocols for care; and effective referral networks. Women with abortion complications should also have access to other reproductive health services, including family planning.

Where abortion is not against the law, safe services for pregnancy termination and compassionate counselling should be available.* Health workers must be informed about the legal status of abortion and protocols for providing it. Appropriate technologies, including new methods such as non-surgical abortion, should be available where feasible.

— *During Adolescence:* ***Reproductive health education and services****.
All young people should have information on sexuality, reproduction, contraception, decision-making skills and gender relations in order to help them make informed decisions about sexuality and to negotiate abstinence or safer sex. Sensitive, respectful and confidential reproductive health counselling and services for married and unmarried adolescents should emphasise the prevention of unwanted pregnancy, unsafe abortion and sexually transmitted diseases (STDs).

— *For Women and Families:* ***Community education.***
Key health topics for women and their families include how to prevent unwanted pregnancy and avoid unsafe abortion; how to recognise complications of pregnancy, childbirth and unsafe abortion and where to seek treatment; and the dangers of certain traditional practices during pregnancy and childbirth. Education is also needed for decision-makers — from husbands to community leaders to national policy-makers — to promote safe motherhood and improvements in women's health and status.

*Each co-sponsor of the Safe Motherhood Initiative implements these activities according to its specific mandate.

Sources:

1: *World Development Report 1993: Investing in Health.* World Bank, Washington, DC, 1993.

2: "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition". World Health Organization, Geneva, 1997.

The Safe Motherhood Co-sponsors

The Safe Motherhood Initiative is led by a unique alliance of co-sponsoring agencies who work together to raise awareness, set priorities, stimulate research, mobilise resources, provide technical assistance and share information. Each of these agencies implements safe motherhood activities according to its specific mandate. The co-sponsors include:

United Nations Children's Fund (UNICEF)
Division of Communication
3 U N Plaza
New York, New York 10017 USA

United Nations Population Fund (UNFPA)
Technical Branch, Technical and Policy Division
220 East 42nd Street
New York, New York 10017 USA

The World Bank
Health, Nutrition and Population
Human Development Network
1818 H Street, N.W.
Washington D.C. 20433 USA

World Health Organization
Maternal and Newborn Health/Safe Motherhood Programme
Division of Reproductive Health (Technical Support)
1211 Geneva 27 Switzerland

International Planned Parenthood Federation (IPPF)
Assistant Secretary General
Sexual and Reproductive Health Technical Support Group
Regent's College, Inner Circle, Regent's Park
London NW1 4NS England

The Population Council
International Programs Division
One Dag Hammarskjold Plaza
New York, New York 10017 USA

For further information and copies of available materials, including additional fact sheets, please contact the Safe Motherhood Initiative secretariat:

Family Care International
588 Broadway, Suite 503
New York, New York 10012 USA
Tel: 212 941-5300 Fax: 212 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

The "Year of Safe Motherhood"

Safe Motherhood is a global effort to increase maternal safety and reduce the number of deaths and illnesses associated with pregnancy and childbirth

Women need not die while giving life to future generations.

Every minute of every day, somewhere in the world and most often in a developing nation, a woman dies from complications related to pregnancy or childbirth. Her death is more than a personal tragedy, although that alone would merit our most serious concern. In addition, her death represents an enormous cost to her nation, her community and her family. Any social and economic investment that has been made in her life is lost. Her family loses her love, her nurturing and her productivity inside and outside the home. Half of all infant deaths can be attributed to poor maternal health. Moreover, the child that survives a mother's death is up to ten times more likely to die within two years than a child with two living parents.

The greatest tragedy is that these approximately 600,000 maternal deaths and over 50 million cases of morbidity that occur each year are largely preventable. A decade of research has proven that surprisingly small and affordable measures can significantly reduce the health risks that women face when they become pregnant.

In 1987 a coalition of the world's leaders in maternal and child health, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Bank, the International Planned Parenthood Federation (IPPF) and the Population Council, joined forces and developed an Inter-Agency Task Force on Safe Motherhood to assess this problem and recommend solutions.

Now it is time to act upon what has been learned over the past ten years of research and model projects, before one more woman loses her life needlessly.

To achieve this goal, World Health Day, 7 April 1998 will kick-off a year-long series of activities to promote Safe Motherhood.

On that day a call to action will be issued to governments, business leaders, policy makers, and citizens of every country of the world. The call to action consists of four simple messages:

1. International aid agencies are urged to provide overseas assistance to programs that promote maternal care as an essential component of reproductive health services.

2. Governments of developing countries are urged to reduce maternal mortality and morbidity by developing and implementing health, nutrition and education programs that promote the health of pregnant women and their infants.

3. Corporations around the world are urged to encourage governments and private organizations in the countries where they do business to provide funds and develop programs that foster safe motherhood, and to support safe motherhood among their employees and customers.

4. Women, men and families everywhere are urged to demand and seek quality prenatal and obstetric care to ensure that no woman dies or suffers long-term complications from childbirth.

www.safemotherhood.org

Safe Motherhood

what's on the site?

www.safemotherhood.org aims to provide visitors with comprehensive and up to date information on the Year of Safe Motherhood and the issue of maternal mortality.

www.safemotherhood.org will be updated throughout the year as new stories, developments, and statistics emerge.

Main Features

What is safe motherhood?
An overview of the principles and components vital to ensuring safe and healthy pregnancies

Introduction
An introduction to the Year of Safe Motherhood, including aims and objectives

Principles of Safe Motherhood
Ten Safe Motherhood action messages

Facts & Figures

* *Data presenting global maternal health issues and causes of maternal death in graph, map and table format*

World Health Day
The Agenda for events surrounding World Health Day - 7th April 1998

Responsible Agencies
The members of the organisations behind the Safe Motherhood Initiative and links to their websites

Forthcoming attractions

Safe Motherhood Success Stories
Case studies of successful programmes to help pregnant women around the world

Visitors Bulletin Board
Comments, questions and opinions from visitors on safe motherhood issues

Inter-Agency Group for Safe Motherhood

UNFPA

UNICEF

WHO

WORLD BANK

IPPF

POPULATION COUNCIL

Chairing Agency:

IPPF

Regent's College, Regent's Park

London NW1 4NS, UK

Telephone: 44 171 487 7864

Fax: 44 171 487 7865

email: psenanayake@ippf.org

Secretariat:

Family Care International

588 Broadway, Suite 503

New York, NY 10012 USA

Telephone: 212 941 5300

Fax: 212 941 5563

email: smi10@familycareintl.org

Safe Motherhood

Inter-Agency Group for Safe Motherhood
UNFPA
UNICEF
WHO
WORLD BANK
IPPF
POPULATION COUNCIL

Corporate Initiative for Safe Motherhood

Statement of Principles

Motherhood 1998

Every day at least 1,600 women die from the complications of pregnancy and childbirth. The remarkable advances in other areas of public health worldwide have not been matched by improved survival for childbearing women. The same factors that contribute to maternal illness and death also lead — each year — to as many as eight million stillbirth and infant deaths within the first week of life. In the developing world, a mother's death leaves her children more vulnerable to illness and death.

The business leaders who have created the *Corporate Initiative for Safe Motherhood* recognize these principles:

- Motherhood represents an unequivocal commitment to the future of humankind.
- As business leaders, we can have a vital role in educating our employees about the simple measures that can prevent needless deaths and injury related to childbirth.
- Our positions of leadership give us an opportunity to raise awareness of Safe Motherhood among our business peers and within the communities in which we conduct our business.
- We recognize the importance of inter-sectoral partnership in addressing the complexity of improving the health of childbearing women and their children.

Chairing Agency:
IPPF
Regent's College, Regent's Park
London NW1 4NS, UK
Telephone: 44 171 487 7864
Fax: 44 171 487 7865
email: psenanayake@ippf.org

Secretariat:
Family Care International
588 Broadway, Suite 503
New York, NY 10012 USA
Telephone: 212 941 5300
Fax: 212 941 5563
email: smi10@familycareintl.org

Safe Motherhood

Inter-Agency Group for Safe Motherhood
UNFPA
UNICEF
WHO
WORLD BANK
IPPF
POPULATION COUNCIL

SAFE MOTHERHOOD ACTION MESSAGES

1. **Advance Safe Motherhood Through Human Rights.** Defining maternal death as a "social injustice" as well as a "health disadvantage" obligates governments to address the causes of poor maternal health through their political, health and legal systems. International treaties and national constitutions that address basic human rights must be applied to safe motherhood issues in order to guarantee all women the right to make free and informed decisions about their health, and access to quality services before, during and after pregnancy and childbirth.

2. **Safe Motherhood Is a Vital Social and Economic Investment.** All national development plans and policies should include safe motherhood programs, in recognition of the enormous cost of a woman's death and disability to health systems, the labor force, communities and families. Additional resources should be allocated for safe motherhood, and should be invested in the most cost-effective interventions (in developing countries, basic maternal and newborn care can cost as little as US$3 per person, per year).

3. **Empower Women, Ensure Choices.** Governments, community leaders and women's advocates need to address social, economic and cultural factors that limit women's choices and decision-making abilities. Legal reform and community mobilization is essential for empowering women to understand and articulate their health needs, and to seek services with confidence and without delay.

4. **Delay Marriage and First Birth:** Reproductive health information and services for married and unmarried adolescents need to be: legally available, widely accessible, and based on a true understanding of young people's lives. Community education must encourage families and individuals to delay marriage and first births until women are physically, emotionally and economically prepared to become mothers.

5. **Every Pregnancy Faces Risks:** During pregnancy, any woman can develop serious, life-threatening complications that require medical care. Because there is no reliable way to predict which women will develop these complications, it is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies, but especially during and immediately after childbirth when most emergency complications arise. Antenatal care programs should not spend scarce resources on screening mechanisms that attempt to predict a woman's risk of developing complications.

Chairing Agency:
IPPF
Regent's College, Regent's Park
London NW1 4NS, UK
Telephone: 44 171 487 7864
Fax: 44 171 487 7865
email: psenanayake@ippf.org

Secretariat:
Family Care International
588 Broadway, Suite 503
New York, NY 10012 USA
Telephone: 212 941 5300
Fax: 212 941 5563
email: smt10@familycareintl.org

6. **Ensure Skilled Attendance at Delivery**. The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of an emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.

7. **Improve Access to Quality Maternal Health Services**. Health services should be located as close as possible to where women live, and must offer affordable, high-quality care. In order to meet required standards, health systems should have: an adequate number of trained staff; a regular supply of drugs, equipment and supplies; and functioning referral systems. Services should also be respectful of – and responsive to – women's needs, preferences and cultural beliefs.

8. **Address Unwanted Pregnancy and Unsafe Abortion:** Program planners should aim to reduce the number of maternal deaths from unsafe abortion (which are the most easily preventable maternal deaths) by ensuring that all safe motherhood programs include: client-centered family planning services to prevent unwanted pregnancy; contraceptive counseling for women who have had an induced abortion; the use of appropriate technologies for women who experience abortion complications; and, where abortion is not against the law, such abortion services should be safe*. In all cases, women should have access to quality services for the management of complications arising from abortion.

9. **Measure Progress**. Because it is difficult and costly to estimate maternal mortality accurately, alternative ways of measuring the progress and impact of safe motherhood programs must be used. Since maternal mortality is directly linked to the coverage and quality of maternal health services, information on such indicators as who cares for women during childbirth, where the delivery takes place, and the quality of services at health facilities should be collected and analyzed.

10. **Power of Partnership:** Reducing maternal mortality requires sustained, long-term commitment and the inputs of a range of partners. Governments, non-governmental organizations (including women's groups and family planning agencies), international assistance agencies, donors, and others should share their diverse strengths and work together to promote safe motherhood within countries and communities and across national borders. Programs should be developed, evaluated and improved with the involvement of clients, health providers and community leaders. National plans and policies should put maternal health into its broad social and economic context, and incorporate all groups and sectors that can support safe motherhood.

---

*Each of the co-sponsors of the Safe Motherhood Initiative implements these activities according to its specific mandate.

BACKGROUND INFORMATION

The World Bank

Making Motherhood Safe

Ten years after the launch of the Safe Motherhood Initiative, more than 1,500 women die every day in the developing world from preventable pregnancy-related complications. Nearly 20,000 pregnancies a day result in stillbirths or infant deaths within the first week of life. The death of a woman of reproductive age translates into substantial economic and social hardship for her family and community. By ensuring that women receive sufficient maternal care, and by providing women with effective family planning services, many of these deaths can be avoided.

A SOCIAL AND ECONOMIC CHALLENGE

Although women's health is vital to sustainable development, it receives little attention in the developing world. Maternal mortality rates, for example, show the widest disparity between industrial and developing countries of any human development indicator. Calculations by the World Bank show that improving health care for women aged 15-44 offers the biggest return on health care spending for any demographic group of adults (men or women). Furthermore, instead of crippling their nations' economies healthy women become productive members of their societies and so do their healthy children. Studies have shown that women are responsible for:

- Providing 70 to 80 percent of the health care in developing countries;
- Heading at least 20 percent of all households in Africa and Latin America;
- Growing 80 percent of the food consumed domestically in parts of Africa and at least 50 percent of export crops; and
- Earning 40 to 60 percent of household income, if home production is valued.

As the World Bank recognizes women's role in eradicating poverty and enabling development, the Bank supports member governments, along with other assistance agencies and non-governmental organizations to develop programs and implement policies that will make pregnancy and birth as safe as possible for women and children. The World Bank now has over 100 projects with women's health components in over seventy countries. Lending has averaged US$490 million over the last three years for reproductive health (family planning, maternal health and STDs/AIDS control) compared to US$170 million in 1990.

WORKING TOGETHER

Safe motherhood is a community responsibility. It can only happen if governments, international development organizations, community-based grass-roots groups, businesses, and private citizens work together. In an effort to reduce the high toll of maternal morbidity and mortality, the World Health Organization, United Nations Children's Fund, United Nations Fund for Population Activities, the World Bank, IPPF, and the Population Council formed the Inter-Agency Group for Safe Motherhood in 1987 and launched the Safe Motherhood Initiative. The initiative was launched in response to the lack of cohesion and information available and the inevitably faltering political and donor commitment to safe motherhood interventions. The goal of the program is to reduce maternal mortality and disability by sharing existing information and establish a consensus on the most effective interventions, revitalize the existing commitments, and to raise awareness among new audiences, specifically businesses and social leaders, about the importance of safe motherhood practices.

SAFE MOTHERHOOD IN ACTION

- In India, the government's Child Survival and Safe Motherhood Initiative, was launched in 1992 with the assistance of the World Bank and UNICEF. The project has contributed to a 20 percent increase in the number of children fully immunized and a steadily rising proportion of pregnant women who receive pre-natal care and deliver their children in hospitals.

Reproductive and Child Health: India

In this unprecedented World Bank-supported project the government is working hand in hand with the community it is trying to help. Consultation with the private sector and the community groups enables the creation of reforms that most directly address the problems of the rural poor. As a result of these consultations, reform targets are focused on providing accessible quality health and information services to the rural poor, in addition to providing contraception information.

- In the fifth of a series of population projects in India, the World Bank has supported the government's goal of improving the availability and quality of family planning and maternal and child health services for poor urban families through the "Fifth Population Project." This project reduced sickness and death for about 2.5 million poor women and children by increasing the availability, quality, and use of temporary birth control methods; by promoting birth spacing; and by supporting child health services.

- The Bangladesh Population and Health Project, financed by a consortium of donors, supports Safe Motherhood by strengthening family planning and other health services, including comprehensive maternal and neonatal care, training of birth attendants, and upgrading health facilities.

- In Indonesia the approach to Safe Motherhood is through partnership. By involving public and private sector agencies and NGOs involved in maternal health, this project seeks to improve the supply and demand for maternal health services, and to strengthen the sustainability of these services at the village level.

- Safe Motherhood goals are being obtained in Morocco by increasing availability to contraceptives, reorganizing prenatal service delivery at the provider and facility level, and by training traditional birth attendants.

Investing in women's health enables women to participate more fully in the process and benefits of development, and is an integral part of the Bank's poverty reducing strategy. By addressing the key problems affecting women throughout their life cycle, governments can improve human welfare *and* national economic efficiency. The international disposition to work towards better women's health is unprecedented. In partnership, governments, other international assistance agencies, and local communities have the power to build on this positive global outlook and on the models and strategies that have been developed locally to improve the health and nutrition of women. Both as a catalyst for, and a partner in development, the World Bank acknowledges that governments and people must make their own decisions about their future and the Bank stands ready to assist them.

RECENT WORLD BANK PUBLICATIONS ON SAFE MOTHERHOOD

1997. *Investing in Young Lives: The Role of Reproductive Health*
1997. *Health, Nutrition, & Population Sector Strategy Paper*
1996. *Improving Women's Health in India*
1996. *India's Family Welfare Program*
1995. *Safe Motherhood Initiative Pamphlet*
1994. *A New Agenda: For Women's Health and Nutrition*
1994. *Population and Development*
1994. *Women's Health and Nutrition: A World Bank Discussion Paper No. 256*

Prepared by External Affairs, February 1998

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

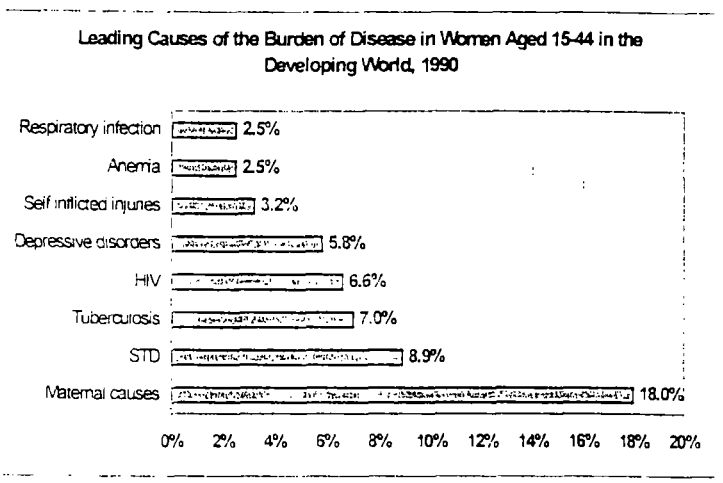
"Year of Safe Motherhood"

FACTS AT A GLANCE

- Every minute of every day, somewhere in the world, a woman dies from complications related to pregnancy or childbirth (defined as a maternal death).

- Approximately 50 million women a year (equivalent to the total population of the countries of Spain and Portugal) suffer maternal health complications.

- In developing countries, pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age:



Source: *World Development Report 1993: Investing in Health.* World Bank, Washington, DC. 1993

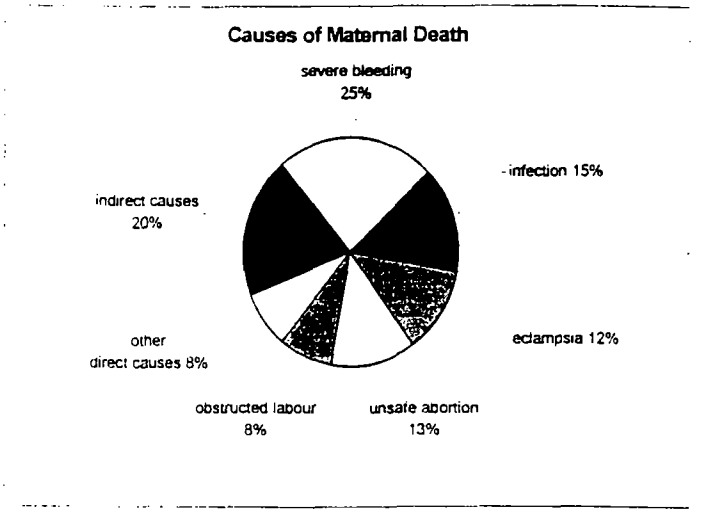
- Worldwide, there are 430 maternal deaths for every 100,000 live births. In developing countries, the figure is 480 maternal deaths for every 100,000 live births; in developed countries there are 27 maternal deaths for every 100,000 live births.

- A woman's risk of dying from pregnancy and childbirth varies widely by region:

Region	Risk of Dying
Africa	1 in 16
Asia	1 in 65
Latin American & Caribbean	1 in 130
Northern Europe	1 in 4,000
North America	1 in 3,700
All developing countries	1 in 48
All developed countries	1 in 1,800

- Country-level differences are even more dramatic: for example, in Ethiopia, 1 out of every 9 women die from pregnancy-related complications, as compared to 1 in 8,700 in Switzerland.

- There are five main causes of maternal death worldwide:



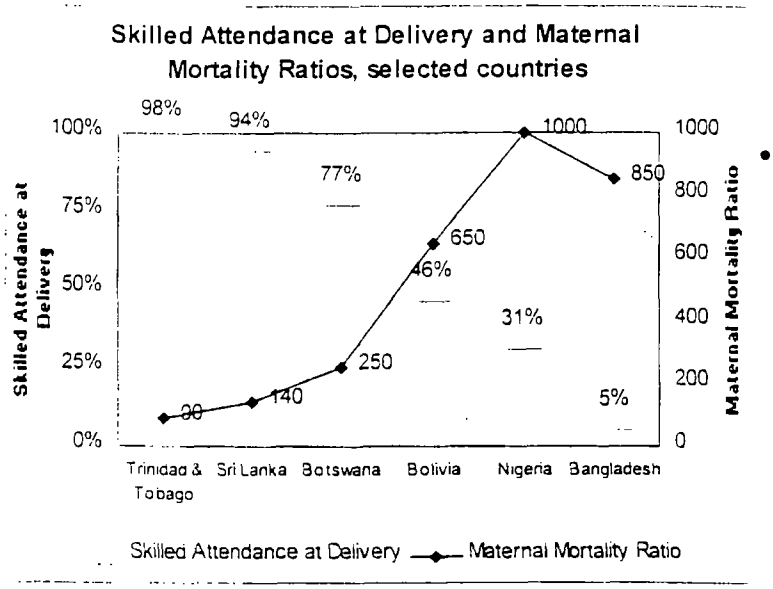
Source: *Maternal Health Around the World*, WHO, 1997

- 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.

Deliveries by Relatives or Alone, Selected Countries

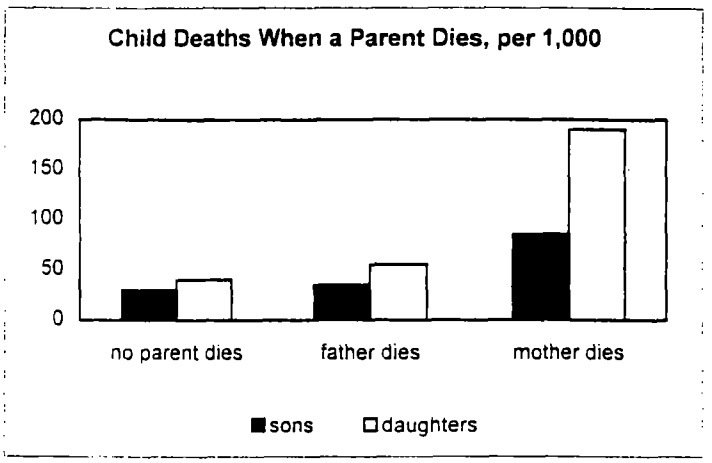
	Delivery by relative/other (%)	*Delivery alone (%)*
Malawi	41	7
Uganda	35	12
Niger	24	17
Nepal	56	11
Pakistan	52	2

Source: Demographic and Health Surveys, selected countries, various years.



- Countries where skilled attendance at delivery is low tend to have higher rates of maternal death and disability. In 1996, skilled birth attendants were present at only 53% of births in the developing world. In developed countries, skilled attendance is nearly universal.

Source: "Revised 1990 Estimates of Maternal Mortality", WHO, 1996 and "Coverage of Maternal Care", WHO, 1997



- Motherless children are likely to get less health care and education as they grow up. A study in Bangladesh found that when a mother dies, her children – especially daughters – are much more likely to die than children whose parents are both alive.

Source: *Mother Baby Package: Implementing Safe Motherhood in countries*, WHO, 1994

- Most maternal deaths, millions of cases of disease and disability, and the deaths of at least 1.5 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 health care services would cost approximately $3 per person per year in most developing countries.

# # #

MEDICUS GROUP Safe Motherhood Initiative "To be a Mother" TV :60 3/11/98

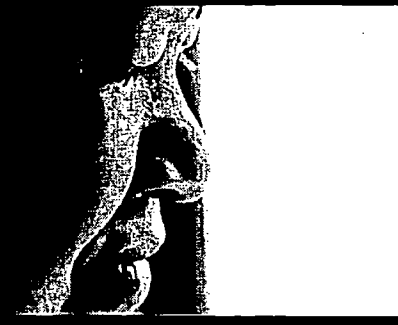
ANNCR VO:
To be a mother, you must know these things.

How to hold your baby.
Feed and care for your baby.
But most important,

how to be there for your baby. If you die while giving birth, you <u>can't</u> be there.

And if you die, chances are your baby will too.

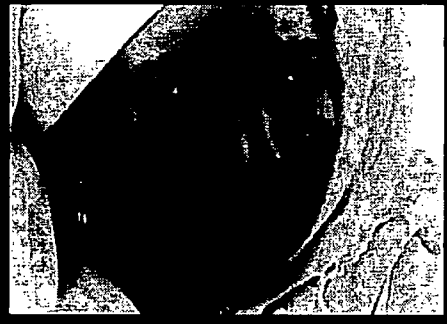
So if you or someone you love is pregnant, see a healthcare worker. And be prepared



to take action if you see any of these signs... Bleeding, severe headache, or fever.

If your waters break, even a little.
If your birth pains last more than a day, get to a healthcare worker immediately.

Because before you can hold and comfort and love, ...



before you can care for your baby, you must first care for yourself.

Safe Motherhood

UNFPA
UNICEF
WHO
THE WORLD BANK
PPF
POPULATION COUNCIL

The Safe Motherhood Initiative.

Because our mothers are our future.

Creative: Lisa Reswick, Paula Raymond, Penny Hawkey – Medicus Group
Producer: Maxine Danowitz
Editor: Alan Eisenberg – Horn/Eisenberg
Sound: Leonard Hospidor – Russo/Grantham - Back Pocket Studios

MEDICUS GROUP Safe Motherhood Initiative "I thought my baby..." TV :60 3/11/98

OVERLAPPING MOTHERS' VO: I thought my baby would look just like me...

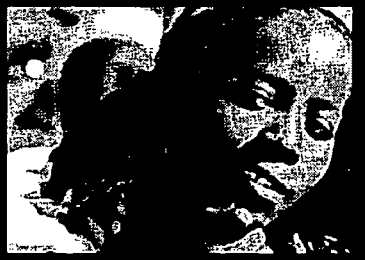
I knew she'd have lots of curly hair...

I thought he'd be strong... The biggest eyes...

Her father's smile...

I thought I'd be there to see it... *(Mothers fade away)*

ANNCR VO: Every minute of every day, a woman dies during pregnancy or childbirth.



Almost 600,000 women each year – a tragic loss of our nation's daughters,

sisters, workers, wives.

And when they die or become ill, their babies often do too.

Yet, more than 90% of these women could be saved

Safe Motherhood
UNFPA
UNICEF
WHO
THE WORLD BANK
IPPF
POPULATION COUNCIL

for as little as $2 per person per year. The Safe Motherhood Initiative has developed

simple, affordable health and education programs save lives.

Safe Motherhood
FCI
P.O. Box 902
NY, NY 10274 USA
www.safemotherhood.org

To find out how your government and community can help, visit our website or write us today.

The Safe Motherhood Initiative.

Because our mothers are our future.

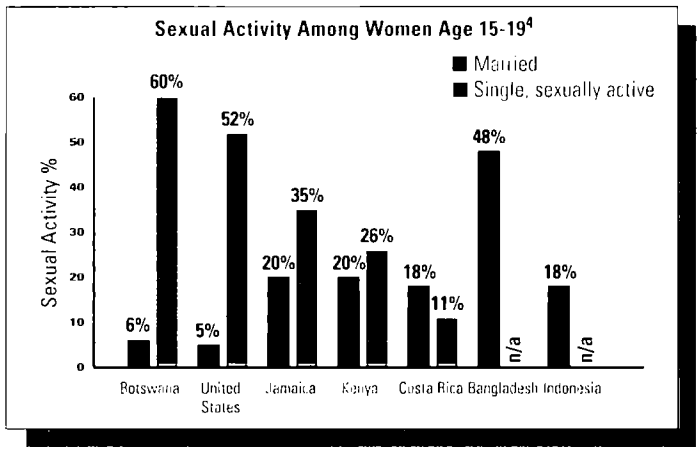
Creative: Lisa Reswick, Paula Raymond, Penny Hawkey – Medicus Group **Producer:** Maxine Danowitz **Editor:** Alan Eisenberg – Horn/Eisenberg **Sound:** Leonard Hospidor – Russo/Grantham - Back Pocket Studios

Adolescent Sexuality and Childbearing

Adolescent pregnancy is alarmingly common in many countries. Every year, adolescents* give birth to 15 million infants.[1] These young girls face considerable health risks during pregnancy and childbirth. Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties; those under age 15 are five times as likely to die.[2] Because early childbearing is so frequent, and carries so many health risks, pregnancy-related complications are the main cause of death for 15-19 year old girls worldwide.[3]

Sexual Behaviour and Childbearing

- **Globally, most people become sexually active during adolescence.** Rates are highest in sub-Saharan Africa, where more than half of girls aged 15-19 in seven countries are sexually experienced.[4]
- **Millions of adolescents are bearing children.** In sub-Saharan Africa, more than half of women give birth before age 20. In Latin America and the Caribbean, this figure drops to one third.[5]



Why Is Adolescent Pregnancy so Common?

- **A lack of information and services:** Adolescents often have poor information about reproduction and sexuality, and little access to family planning and reproductive health services.

  In Sri Lanka, one-third of young adults age 16-24 did not know the duration of a normal pregnancy. Fewer than 5% had discussed reproductive health with their parents.[6]

- **Cultural values:** In many developing countries, female status is equated with marriage and motherhood. Adolescents often marry early; more than 50 countries allow marriage at age 16 or below, and seven allow marriage as early as age 12.[7] Even the youngest brides face immediate pressure to prove that they are fertile.[7]

Health Risks

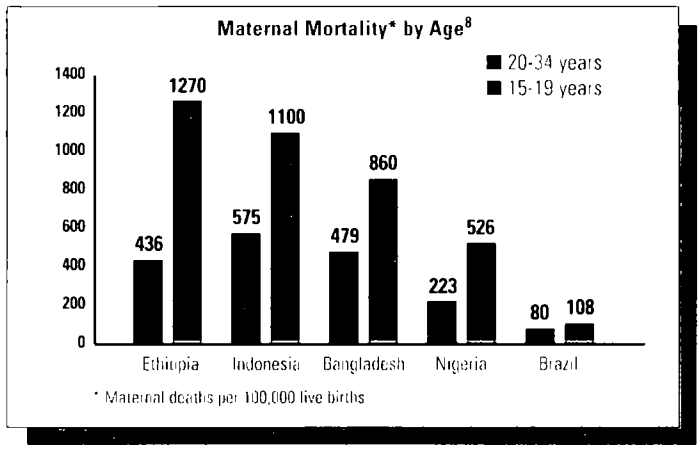
- **Reproductive health problems and deaths are more common among sexually active adolescents than among women in their 20's and early 30's.[4] Physiologically and socially, adolescents are more vulnerable to:**

  — ***Maternal death:*** Girls age 15-19 are up to twice as likely to die during pregnancy or delivery as women age 20-34.[4]

  — ***Infant and child mortality:*** Children born to adolescents are more likely to die during their first five years of life than those born to women age 20-29.[8]

  — ***Sexually transmitted diseases (STDs):*** Each year, 1 in 20 adolescents worldwide contracts an STD (including HIV/AIDS).[9]

  At Kenyatta Hospital in Nairobi, one-quarter of girls age 15-19 seeking antenatal care had an STD (gonorrhoea, chlamydia or herpes).[10]



*The World Health Organization defines adolescence as the period of life between ages 10 and 19.

— ***Violence/sexual abuse:*** Adolescent girls may lack the confidence and decision-making skills to refuse unwanted sex. Girls who are subject to sexual abuse and rape can suffer serious, life-long physical and emotional consequences.

In interviews with adolescents in Peru and Colombia, 60% said they had been sexually abused within the previous year.[11]

— ***Unsafe abortion:*** Each year, girls age 15-19 undergo at least five million induced abortions.[12] Because abortion is legally restricted in many countries, adolescents often resort to unsafe procedures by unskilled providers. Adolescent girls therefore suffer a significant — and disproportionate — share of death and disability from unsafe abortion.[13,14]

Social and Economic Problems

A young mother's ability to meet her own needs and those of her children can be jeopardised by:

- **A lack of education.** Young women are often expelled from school if they become pregnant, and few ever return.

In Kenya, 10,000 girls leave school each year due to pregnancy.[12]

- **A lack of income.** It can be difficult for young mothers, especially those without education or marketable skills, to support themselves and their families financially.

Giving Girls Other Opportunities

- **Age at marriage:** Delaying marriage often delays first birth, and can also reduce the total number of children a woman has, since she will spend fewer years in childbearing.[6]

- **Education:** Women who have some secondary schooling are less likely to give birth during adolescence.[4] On average, women with seven or more years of education marry four years later and have 2.2 fewer children than those with no education.[14]

What Can Be Done

- **Long-term policies and programmes must address the underlying social, cultural and economic factors that contribute to adolescent sexual activity and childbearing. They must improve the status of women and girls and expand their opportunities by:**

— ***Encouraging family and community support*** for delayed marriage and childbearing.

— ***Expanding girls' access to higher quality education and training***, and helping them build marketable skills.

— ***Increasing income-earning abilities,*** opportunities to earn income and access to other resources for adolescent girls and women.

- **More immediately, programmes must make it possible for all adolescents to take responsibility for, and protect, their sexual and reproductive health by*:**

— ***Removing legal, regulatory and cultural barriers*** to sexual and reproductive health information and services for adolescents.

— ***Providing appropriate, accurate sexual and reproductive health education*** for young people, both in- and out-of-school.

— ***Designing and providing sensitive and confidential reproductive health services*** that respond to young peoples' particular needs; help them make informed decisions about sexuality and negotiate safer sex; and emphasise the prevention of unwanted pregnancy, unsafe abortion and STDs.

*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

Sources:

1: "Issues in Brief: Risks and Realities of Early Childbearing Worldwide", Alan Guttmacher Institute, New York, 1997.

2: United Nations Dept. of International Economic and Social Affairs, *The World's Women: Trends and Statistics 1970-90*, United Nations, New York, 1991.

3: "Too Old for Toys, Too Young for Motherhood", UNICEF, New York, 1994.

4: J. Senderowitz, "Adolescent Health: Reassessing the Passage to Adulthood", World Bank Discussion Papers #272, Washington, DC, 1995.

5: J. Hoberaft, notes prepared for the Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

6: "Adolescent Health and Development: The Key to the Future", World Health Organization, Geneva, 1995.

7: N. Sadik, *The State of World Population 1997*, UNFPA, New York, 1997.

8: "The Health of Youth, Facts for Action: Youth and Reproductive Health", World Health Organization, Geneva, 1989.

9: G. Biccgo et al., "Infant and Child Mortality", DHS Comparative Studies, No. 20, Macro International, Calverton, MD, 1996.

10: "Adolescent Reproductive Health in Developing Countries", *CommonHealth: The Bulletin of the Commonwealth Medical Association*, #2, 1995.

11: "Adolescent Reproductive Health", *Network*, 17(3), Spring, 1997.

12: S. Koontz and S.R. Conly, *Youth at Risk: Meeting the Sexual Needs of Adolescents*, Population Action International, Washington, DC, 1994.

13: S. Singh, "Adolescent Childbearing and Pregnancy in Developing Countries: A Global Review", Workshop organized by Alan Guttmacher Institute, New York, 1997.

14: N. Sadik, *State of the World Population 1990*, New York, UNFPA, 1990.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

Every Pregnancy Faces Risks

Every time a woman is pregnant — which happens an estimated 200 million times every year around the world — she risks a sudden and unpredictable complication that could result in her death or injury, and the death or injury of her infant. At least 40% of all pregnant women will experience some type of complication during their pregnancies. For about 15%, this complication will be potentially life-threatening, and will require immediate obstetric care.[1]

Which Women Are at Risk?

- "Maternal risk" is defined as the probability of dying or experiencing a serious complication as the result of pregnancy or childbirth.[2]
- Some groups of women are more likely to develop pregnancy complications than others (for example, if they had a complication during a previous pregnancy). However, it is almost impossible to predict which *individual* woman will develop a life-threatening complication.[3]

What Is "Risk Assessment"?

- Risk assessment is a tool used by health systems that aims to separate women into categories — typically "high risk" and "low risk" — according to certain social, demographic or physical characteristics such as educational status, age, height, and number of pregnancies.[2] Ideally, women who are defined as "high risk" are then given special care to prevent or manage any health problems they may develop. Risk assessment is usually conducted as part of antenatal care during pregnancy.
- Risk assessment was developed to help health providers allocate their time and resources to the women who need them most, especially in communities with limited resources. However, a review conducted for the World Health Organization found that risk assessment has not been an effective strategy for preventing maternal death.[4]

Why Doesn't Risk Assessment Work?

- The broad characteristics used by most risk assessment systems are not precise enough to predict an individual woman's risk.[2,5,6] As a result, a large number of women are identified as "high risk", even though they never develop any complications.

  A study in Zaire found that 90% of women who were identified as "at risk" for obstructed labour ended up not having any problem during delivery.[7]

  — *Most of the women who develop complications do not have any risk factors*, and are therefore classified as "low risk".

  The same study in Zaire found that 71% of the women who did develop obstructed labour did not have any history of problems.

- Even if a woman is correctly identified as being at risk of complications, there is no guarantee that she will get appropriate care. Many health systems cannot provide adequate services. Also, women themselves may be unable or unwilling to seek medical care when they are told they are "high risk". They may lack financial resources to pay fees, be too busy, face opposition from family members or simply not want to go.

When Risk Assessment Fails

- Women may not receive life-saving care. Women who are identified as "low risk" can be lulled into a false sense of security. If this happens, they may fail to recognise the signs of complications, and fail to seek appropriate services.[5]
- Personal cost and inconvenience is high. Women who are identified as "high risk" may waste valuable time and spend scarce funds seeking unnecessary treatment.
- Health systems are overburdened: Misdiagnosing women can create a serious problem for health systems. They may find themselves overloaded and have to spend scarce time and resources on unnecessary treatment for "high risk" women who in fact never develop any complications.[3]
- Since risk assessment cannot predict which women will experience pregnancy complications, it is critical that *all*

women who are pregnant, in labour or recently had a baby have access to high quality maternal health care. This care must include services to manage serious pregnancy complications if and when the need arises.

What Can Be Done

■ **Governments and health providers need to recognise that every pregnancy is special, and should ensure that all pregnant women have access to high-quality maternal health services by:**

— ***Educating women and their families*** about the risk of complications faced by all women, and about actions they should take if and when a problem arises.

— ***Providing adequate care*** as close as possible to where women live. Services should include clean deliveries by health workers who have been trained in midwifery; prompt recognition of complications and appropriate referrals; and treatment of a woman who is experiencing complications until she can be transferred safely to a higher level of care.

— ***Ensuring that a functioning system*** of communication and transportation links health workers who are working in communities, health centres and hospitals so that women with pregnancy complications can receive prompt and appropriate medical care.

— ***Improving women's overall well-being*** and reproductive health through prevention and through screening and treatment for existing problems that contribute to poor reproductive health.

Sources:

1: M. Koblinsky, et al., "Mother and More: A Broader Perspective on Women's Health", in M. Koblinsky, et al., eds., *The Health of Women: A Global Perspective*. Westview Press, Oxford, 1993.

2: B. Winikoff, "Maternal Risk". Paper presented at Berzelius Symposium, Stockholm, Sweden, 1991.

3: W. Graham, "Every Pregnancy Faces Risk". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

4: C. Rooney, "Antenatal Care and Maternal Health: How Effective Is It? A Review of the Evidence" (WHO/MSM/92.4). World Health Organization, Geneva, 1992.

5: E.A. Yuster, "Rethinking the Role of the Risk Approach and Antenatal Care in Maternal Mortality Reduction". *International Journal of Gynecology and Obstetrics* 50(2), 1995

6: J.E. Rhodes, "Removing Risk from Safe Motherhood". *International Journal of Gynecology and Obstetrics* 50(2), 1995.

7: D. Maine, *Safe Motherhood Programs: Options and Issues*. Center for Population and Family Health, Columbia University, New York, undated.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council. FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

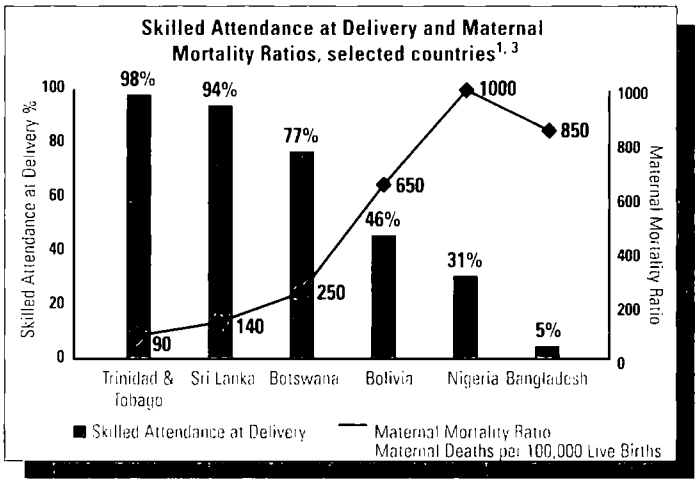
Skilled Care During Childbirth

The single most important way to reduce maternal deaths is to ensure that a skilled health professional is present at every birth. However, there is a serious shortage of these professionals in developing countries. Whether by choice or out of necessity, 60 million women in the developing world give birth each year without skilled help—cared for only by a traditional birth attendant, a family member, or no one at all.[1]

Skilled care during childbirth is important because millions of women and newborns develop serious and hard-to-predict complications during or immediately after delivery. Skilled attendants—health professionals such as doctors or midwives who have midwifery skills—can recognise these complications, and either treat them or refer women to health centres or hospitals immediately if more advanced care is needed.

Unassisted Births Are Common and Can Be Fatal

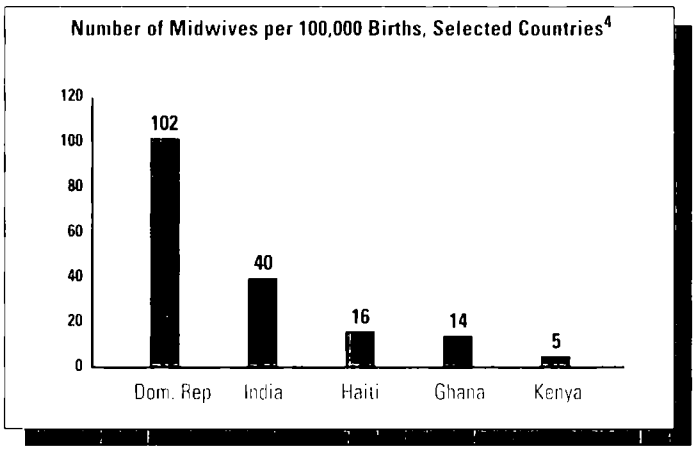
- More than three-quarters of all maternal deaths in developing countries take place during or soon after childbirth.[2]
- In 1996, skilled birth attendants were present at only 53% of births in the developing world.[1] In developed countries, skilled attendance is nearly universal.
- Countries where skilled attendance at delivery is low tend to have higher rates of maternal death and disability.



Who Should Provide Care During Childbirth?

- The best person to provide assistance during childbirth is a health professional with midwifery skills who lives in or near to the community he or she serves.
- Most midwives work in hospitals and urban areas. They are scarce in rural areas — where 80% of developing country populations live.

  In parts of Asia and Africa, there is only one midwife for every 15,000 births.[5]



- Skilled attendants include doctors, nurses, midwives and other health workers with midwifery skills who can diagnose and manage complications during childbirth, as well as assist normal deliveries.[6]
- **Adequate equipment, drugs and supplies are essential to enable skilled attendants to provide good quality care.** In addition, skilled attendants need to be supported by appropriate supervision. When delivery is taking place in the village (at home or in a local health facility), an emergency transport system must be available to take women to facilities that can provide more advanced care.

Care in the Community

- **In developing countries, women commonly seek the help of traditional birth attendants: community members who deliver infants according to local customs and beliefs.** In some — but not all — communities, these attendants may have some training to help them avoid harmful practices, conduct clean deliveries, recognise danger signs and refer women to health facilities if they have any complications. However, without emergency back-up support (including referral to a district hospital), training traditional birth attendants does not decrease a woman's risk of dying in childbirth.[7]

- **In many places, especially in Asia and Africa, women give birth with the help of a relative, or alone.**

Deliveries by Relatives or Alone, Selected Countries[8]

	Delivery by relative/other (%)	Delivery alone (%)
Malawi	41	7
Uganda	35	12
Niger	24	17
Nepal	56	11
Pakistan	52	2

Training Needs

- **As countries try to ensure that a qualified health professional is present at the birth of every child, they face a number of significant problems:**

— ***Existing health workers often lack the skills they need to save the lives of women who suffer emergency complications.*** These skills include the ability to prevent, identify and treat problems such as shock, haemorrhage, infection (sepsis), and eclampsia (convulsions from high-blood pressure), and to manage abortion complications.

— ***Curricula used to teach midwifery skills are often out of date and do not reflect new techniques and research.*** Many of these curricula are adapted from developed country models and do not reflect the limited resources and poor working conditions in developing countries.[4]

— ***Supervision and refresher training in family planning and maternal health are often inadequate.***[4] In Uganda, for example, a study found that only 28% of midwives had ever taken a refresher course.[9]

— ***Many midwives and physicians have no training in traditional belief systems, communication and community organising.***[4] These topics are needed to ensure that a health worker is an accepted part of the community she or he serves.

What Can Be Done

- **Increase the number of health professionals with midwifery skills** in under-served regions, particularly poor and rural areas.
- **Train, authorise and equip midwives, nurses and community physicians to provide all feasible obstetric services** needed within communities, especially emergency interventions, and to prescribe medication. Establish systems for training, supervising and supporting these providers, and for linking them to higher-level health facilities for back-up.
- **Upgrade, establish and expand comprehensive midwifery training programmes** that include life-saving skills for dealing with obstetric emergencies.
- **Create clearly-defined protocols** for routine care and the management of complications.
- **Establish systems for supervising and supporting skilled birth attendants, and for emergency referral and treatment.**

Sources:

1: "Coverage of Maternity Care: A Listing of Available Information, Fourth Edition", World Health Organization, Geneva, 1997.

2: C. AbouZahr, "Improve Access to Quality Maternal Health Services". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

3: "Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF", World Health Organization, Geneva, 1996.

4: "Midwifery Education: Action for Safe Motherhood, Report of a Collaborative Pre-Congress Workshop", World Health Organization, Geneva, October 1990.

5: J. Fortney, "Ensuring Skilled Attendance at Delivery: The Role of TBAs". Family Health International, Research Triangle Park, NC, 1997.

6: WHO/FIGO/International Confederation of Midwives, "Definition of the Midwife", 1992.

7: A. Tinker and M. Koblinsky, *Making Motherhood Safe*. World Bank, Washington, DC, 1993.

8: Demographic and Health Surveys, selected countries, various years. Macro International, Calverton, MD.

9: "Strengthening Midwifery Within Safe Motherhood: Report of a Collaborative ICM/WHO/UNICEF Pre-Congress Workshop", World Health Organization, Geneva, May 1996.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

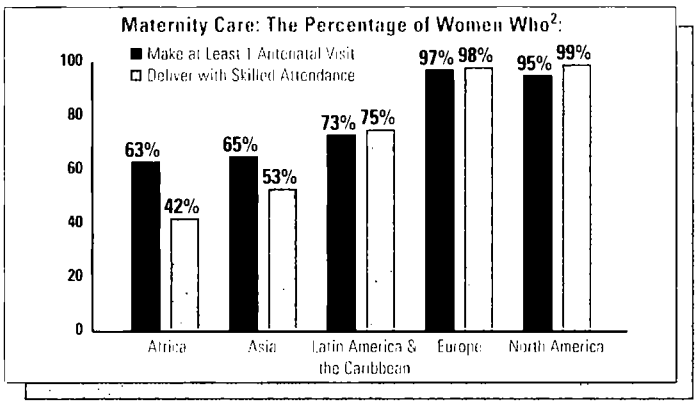
Good Quality Maternal Health Services

Millions of women do not have access to good quality health services during pregnancy and childbirth — especially women who are poor, uneducated or who live in rural areas.[1] Less than half of women in developing countries get adequate health care during and soon after childbirth, despite the fact that most maternal deaths take place during these periods.[1] In contrast, use of maternal health services is nearly universal in developed countries.

Access means that services are available and within reach of women who need them. Good quality services require that health care providers have adequate clinical skills and are sensitive to women's needs; that facilities have necessary equipment and supplies; and that referral systems function well enough to ensure that women with complications get essential treatment.

Many Women Lack Maternal Health Care

- At least 35% of women in developing countries receive no antenatal care during pregnancy, almost 50% give birth without a skilled attendant and 70% receive no postpartum care in the six weeks following delivery.[2] This lack of care is most life-threatening during labour, childbirth and the days immediately after delivery, since these are the times when sudden, life-threatening complications are most likely to arise.



Why Women Do Not Use Available Services

- **No physical access:** Most rural women (80%) live more than five kilometres from the nearest hospital. Vehicle shortages and poor road conditions mean that walking is often the main mode of transportation, even for women in labour.[1]

  In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility, but could not because of distance and the lack of transport.[3]

- **High costs:** Millions of women cannot afford to use maternal health services. Even when formal fees are low or non-existent, women often face hidden fees and expenses for transport, drugs, and food or lodging for the woman or her family members.

Impact of User Fees on Obstetric Admissions, Zaria, Nigeria

	Obstetric services free (1983)	Fees for some services introduced (1985)	Increases in fees (1988)
Obstetric admissions	7,450	5,437	3,376
Deliveries	6,535	4,377	2,991
Maternal deaths	2	1	62

- **Poor information:** Women and community members often do not know how to recognise, prevent or treat pregnancy complications, or when and where to seek medical help.

  In Ghana, 64% of women who died of pregnancy complications sought help from a traditional healer before going to a health facility. Families cited cost and their belief that the woman was not ill enough as the main reasons for not seeking hospital care.[1]

- **Cultural preferences:** Formal health services can conflict with ideas about what is normal and acceptable, including preferences for privacy, modesty and female attendants.

  The Saraguro Indians in Ecuador shun affordable, accessible maternity care because they feel that hospitals violate women's privacy during childbirth and because many health providers are men.[4]

- **Lack of decision-making power:** In many parts of the world, women's power to make decisions is limited, even over matters directly related to their own health.

  In Bangladesh, it is usually the mother-in-law and husband who make the decision to seek (or not seek) care. Studies have found that they are the least likely to know about pregnancy-related complications and their possible fatal consequences.[5]

Health Services Are Inadequate

■ **Poor quality of care is one of the most common reasons women give for choosing *not* to use available maternal health services.** Problems include:

— ***Health facilities in developing countries face chronic shortages of equipment, drugs and basic supplies, including blood for transfusion.*** Families of women in labour may be forced to purchase drugs and supplies to bring to the hospital,[7] which can cause fatal delays.

— ***Health facility staff are often poorly trained.*** They may lack both life-saving and basic clinical skills, and may not observe hygienic practices.

— ***Health workers may be rude, unsympathetic and uncaring,*** so women prefer to use the services of traditional birth attendants and healers.

— *Other factors include:* a lack of privacy; run-down physical facilities; inconvenient operating hours; and restrictions on who can stay with a woman at the health facility.[8]

■ **Delays in referring women from community health facilities to hospitals are one of the most important barriers to life-saving maternal care.**

In Masavingo, Zimbabwe, a significant proportion of maternal deaths were caused by "avoidable factors", including failure by health workers to identify women suffering from serious pregnancy-related complications and to refer them to a higher level of the health care system."

■ **A study of 718 maternal deaths in Egypt found that 92% of them could have been avoided if good quality care had been provided.**[10]

Improving the quality of existing maternal health services is the quickest, most cost-effective way to save women's lives:
Good quality care aims to:[11]

Meet women's needs:

- Services should be provided in health facilities that are as close as possible to where women live and that can provide the services safely and effectively;
- Services should be sensitive to cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers;
- Staff should be respectful, non-judgmental and responsive to clients;
- Women should be treated as active participants in their own health, and offered information and counselling so they can make informed decisions about their health and treatment.

Provide technical competence:

- Staff members should be trained in technical, clinical, management, and interpersonal skills;
- Standards of care and written protocols should be available;
- Physical facilities should be adequate, clean and convenient;
- Necessary drugs, equipment and supplies should be available,
- Comprehensive reproductive health services (including follow up care) should be available on-site or through established linkages to other health facilities;
- A fully functional referral and transport system should exist between all levels of care (home/community, health centres, and district/regional hospitals).

What Can Be Done

■ **Governments and non-governmental agencies must expand services, improve their quality, and tailor them to meet the needs of women and communities by:**

— ***Ensuring that health facilities*** are located close to where women live, have an adequate number of trained staff, a continuous supply of drugs and equipment, and are linked to hospitals by an emergency transport and referral system.

— ***Enforcing standards and protocols*** for service delivery, management and supervision, and using them to monitor and evaluate the quality of services, along with feedback from clients and health providers.

— ***Providing free or affordable maternal and infant health services*** that manage any complications as well as offer routine care.

— ***Educating women and communities*** about the importance of maternal health and appropriate services.

Sources:

1: C. AbouZahr, "Improve Access to Quality Maternal Health Services". Presentation at Safe Motherhood Consultation in Sri Lanka, 18-23 October 1997.

2: "Coverage of Maternity Care: A Listing of Available Information, Fourth Edition". World Health Organization, Geneva, 1997.

3: G. Biego et al., *Survey on Adult and Childhood Mortality, Tanzania.* Macro International, Calverton, MD, 1995.

4: H. Odoi-Agyarko, N. Dollimore, O. Owusu-Argyei, "Risk Factors in Maternal Mortality: A Community-Based Study in Kassena Nankani District". Paper presented at the National Consultative Meeting on Safe Motherhood, Accra, Ghana, January 1993.

5: J. Leslie and G.R. Gupta, "Utilization of Formal Services for Maternal Nutrition and Health Care". International Center for Research on Women, Washington, DC, February 1989.

6: "Safe Motherhood: A Woman's Right to Life, Information Kit". Ministry of Health and Family Welfare, Bangladesh, 1997.

7: S. Thaddeus and D. Maine, "Too Far to Walk: Maternal Mortality in Context." *Social Science Medicine* 38(8), 1994.

8: C. AbouZahr, C. Vlassoff and A. Kumar, "Quality Health for Women: A Global Challenge". *Health Care for Women International*, Vol. 17, 1996.

9: S. Fawcus et al., "A Community-based Investigation of Avoidable Factors for Maternal Mortality in Zimbabwe". *Studies in Family Planning*, Vol. 27, No. 6, November-December 1996.

10: M. Kassas, et al., "The National Maternal Mortality Study of Egypt 1992-1993". *International Journal of Gynecology and Obstetrics*, Vol. 50 (Supplement 2), October 1995.

11: *Mother-Baby Package: Implementing Safe Motherhood in Countries.* World Health Organization, Geneva, 1994.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: sm10@familycareintl.org
Web site address: www.safemotherhood.org

1998

Unwanted Pregnancy

There are an estimated 200 million pregnancies around the world each year. Approximately one-third of these, or 75 million, are unwanted.[1] These pregnancies contribute to maternal health problems in two ways: first, many pregnancies are unwanted for reasons that can threaten the woman's health or well-being; she may have an existing health problem, or lack the support and resources she needs to have a healthy pregnancy and raise a healthy child. Second, where women do not have access to safe abortion services, many unwanted pregnancies are terminated using unsafe procedures that can lead to the woman's death or disability.

Unwanted Pregnancy Can Be Deadly

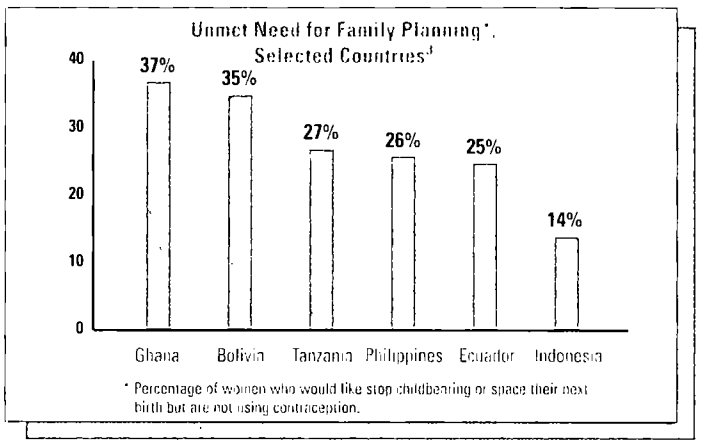
- Every year, approximately 50 million unwanted pregnancies are terminated. Some 20 million of these abortions are unsafe. About 95% of unsafe abortions take place in developing countries, causing the deaths of at least 200 women each day.[2]

Why Do Unwanted Pregnancies Occur?

- Although unwanted pregnancy occurs for many reasons, the most common are non-use of contraception or contraceptive failure:

— *Between 120 and 150 million married women want to stop having children or postpone their next pregnancy, but are not using contraception.* An additional 12 to 15 million unmarried women also want to avoid pregnancy but lack the means to do so.[1]

— *An estimated 8 to 30 million pregnancies each year result from contraceptive failure* — either because the method was used inconsistently or incorrectly, or because the method failed.[4]



Cultural Traditions Can Limit the Use of Contraception

- In many countries women have little control over sexual relations and contraceptive use. Social expectations and pressures define what is or is not acceptable for a woman to do, and can make it difficult for a woman to protect herself from unwanted pregnancy:

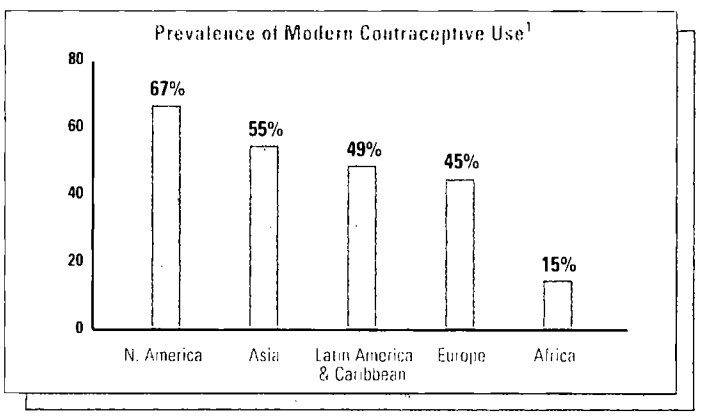
— *Social taboos and unequal power relations between men and women often prevent women from using contraceptives.* Opposition from husbands is one of the most common reasons women give for not using contraception.

— *Between 20% and 50% of women and girls report having been subject to sexual coercion, abuse or rape.*[5] Such women are at high risk for unwanted pregnancy and other sexual and reproductive health problems.

Contraceptives Are Still Out of Reach

- Although nearly 60% of women and men around the world use modern contraceptive methods, 350 million couples do not have access to a full range of family planning methods, services and information.[1]

- Women do not always know where to get family planning services. The proportion of married women age 15 to 49 who know where to obtain a modern contraceptive varies widely within regions: from 22% in Mali to 96% in Zimbabwe; from 45% in Pakistan to 99% in Thailand;



from 61% in Bolivia to 98% in Colombia and 99% in Trinidad and Tobago.[3]

- Use of male contraceptives is low. In Brazil, condoms and vasectomy account for less than 4% of total contraceptive use[6]. Comparative figures in Iran are 6% for condoms and 1% for vasectomy.[7]

EMERGENCY CONTRACEPTION

Emergency contraception [illegible] preventing pregnancy that can be used after unprotected [illegible]. The most common method is for the woman to take a special dose of [illegible] pills called emergency contraceptive pills (ECPs) [illegible] sexual intercourse. ECPs are not considered a method of abortion. Emergency contraception has the [illegible] unwanted pregnancy. However [illegible] available [illegible]

Inadequate Family Planning Programmes

- **Even where family planning services are available, they may not respond to people's needs and preferences.** In many countries, shortcomings in the quality of family planning programmes include:

— ***A focus on quantitative goals*** (such as the percentage of women using a contraceptive method) instead of helping clients achieve their personal goals for the number and timing of their children.[9]

— ***Poor information and counselling.*** Studies in sub-Saharan Africa found only 25-54% of new contraceptive users were informed about side effects.[1]

— ***Promotion of methods that may be inappropriate*** for a particular client.[1] This can happen because facilities have limited contraceptive supplies, or because service providers do not spend enough time discussing clients' needs or decide for their clients what methods they should use.

— ***Poor clinical skills and procedures,*** for example during pelvic exams, sterilisation and IUD insertions, which can cause the client unnecessary pain or infection.[9]

— ***Weak or non-existent links to other reproductive health services,*** including treatment of STDs, that are needed to preserve a woman's health and future fertility.[9]

What Can Be Done

- **Governments and donors need to make programmatic changes to:**

— ***Ensure that all individuals*** – including adolescents and unmarried women – have access to good quality, confidential family planning services which: offer a full range of methods, including emergency contraception; are responsive to the needs and lifestyles of their clients; and enable women and men to have the number of children they want, while protecting themselves against sexual and reproductive health problems.

— ***Ensure that all providers*** of care have the supplies, information, and technical and communication skills necessary for offering high quality care.

— ***Offer reliable information*** and compassionate counselling to all women with an unwanted pregnancy, including information about when and where a pregnancy may be legally terminated.*

Policy-makers need to address regulatory, social, economic and cultural factors within communities and at the national level to:

— ***Ensure that women have control*** over their sexuality and reproduction, rectify power imbalances between men and women, and promote caring, responsible behaviour among men in sexual relations, contraception, pregnancy and childcare.

— ***Address sexual coercion*** and all forms of sexual violence against women.

— ***Address the problem*** of unwanted pregnancy among young people, and modify attitudes that stigmatise pregnant girls.

*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

Sources:

1: N. Sadik, *The State of World Population 1997*. UNFPA, New York, 1997.

2: *Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion*, 3rd edition. World Health Organization, Geneva, 1997 (in press).

3: *Women's Lives and Experiences: A Decade of Research Findings from the Demographic and Health Surveys Program*. Macro International, Calverton, MD, 1994.

4: S.J. Segal and K.D. LaGuardia, "Termination of Pregnancy – A Global View". *Ballière's Clinical Obstetric and Gynaecology*, Vol. 4, No. 2, 235-247, 1990.

5: L. Heise, K. Moore, N. Toubia, "Sexual Coercion and Reproductive Health: A Focus on Research". Population Council, New York, 1995.

6: *Brazil: Programme Review and Strategy Development Report*. UNFPA, New York, 1992.

7: *Islamic Republic of Iran: Programme Review and Strategy Development Report*. UNFPA, New York, 1994.

8: PATH, "Emergency Contraceptive Pills: Safe and Effective But Not Widely Used". *Outlook*, 14(2), September 1996.

9: *Reconsidering the Rationale, Scope and Quality of Family Planning Programs*. The Population Council, New York, 1994.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

Unsafe Abortion

Each year, approximately 20 million unsafe abortions are performed worldwide.* They result in nearly 80,000 maternal deaths and hundreds of thousands of disabilities.[1] In some countries, unsafe abortion is the most common cause of maternal death.[1] It is also one of the most easily preventable and treatable.

Deaths from Unsafe Abortion

■ Every day, 55,000 unsafe abortions take place — 95% of them in developing countries. They are responsible for one in eight maternal deaths. Globally, one unsafe abortion takes place for every seven births.[1]

Unsafe Abortion: Regional Estimates of Mortality and Risk of Death[1]

	Risk of dying after unsafe abortion	% of maternal deaths due to unsafe abortion
Africa	1 in 150	13%
Asia*	1 in 250	12%
Latin America	1 in 900	21%
Europe**	1 in 1900	17%

*Excludes Japan, Australia and New Zealand **Primarily Eastern Europe

Disabilities and Health Problems

■ Between 10% and 50% of all women who undergo unsafe abortions need medical care for complications.[1]

— *The most frequent complications* are incomplete abortion, infection (sepsis), haemorrhage and injury to the internal organs, such as puncturing or tearing of the uterus.[1]

— *Long-term health problems* include chronic pain, pelvic inflammatory disease and infertility.

■ In many African countries, up to 70% of women treated for abortion complications are younger than 20.[2]

— *Younger, unmarried women often have poor access to family planning information and services.* They also have fewer social contacts and less financial means to obtain an abortion safely.[3] Young women are also more likely to delay pregnancy termination until late in pregnancy when the risk of complications is higher.

DANGEROUS METHODS AND PROCEDURES USED TO INDUCE ABORTION INCLUDE:

- Inserting objects (sticks, wires, knitting needles) into the uterus.
- Drinking poisonous or harmful substances (including herbs, bleach and hair dye)
- Taking dangerous doses of over-the-counter medicines
- Douching with poisonous and caustic substances (bleach)
- Inflicting physical abuse (falling down stairs, blows to belly, jumping from heights)

The Cost to the Public Health System

■ Treatment of abortion-related complications often requires several days of hospitalisation and staff time, as well as blood transfusions, antibiotics, pain control medications and other drugs.[1]

■ In some hospitals in developing countries, treating the complications of unsafe abortion consumes as much as 50% of the total budget.[4]

Legislation and Policies on Abortion

■ Pregnancy termination is permitted in more than 131 developing countries (and almost every developed country) — either for broad economic or social reasons, or for more limited health or personal circumstances such as to protect the health of the woman or in case of rape or incest.[5] Definitions of "health risk" vary widely by country.

■ Governments around the world have recognised that unsafe abortion is a major public health issue. At the 1994 International Conference on Population and Development, they called for humane, high quality medical services to prevent unsafe abortion and treat its complications. Participants also called for safe abortion services where not against the law.[6]

*The World Health Organization acknowledges that data on unsafe abortion are scarce and subject to substantial error due to methodological constraints inherent in abortion-related research.

Why Do Women Resort to Abortion?

Most women who decide to terminate a pregnancy are married or live in stable unions and already have several children.[1] Women can find themselves with an unwanted pregnancy for many reasons:

— *Family planning is out of reach:* At least 350 million couples worldwide do not have access to information about family planning and a full range of modern contraceptives.[7]

— *Contraceptive methods fail:* Between 8 and 30 million pregnancies each year are the result of contraceptive failure — either inconsistent or incorrect use of family planning methods, or failure of the methods themselves.[8]

— *Sexual coercion or rape:* In studies around the world, between 20% and 50% of women and girls report sexual abuse, rape or sexual coercion.[9]

— *A variety of social and economic reasons that include:* they are unmarried, have been abandoned by their partners, are adolescents, are in an unstable partnership, have too many children to support, and/or live in poverty.[10,11]

Poor and Unavailable Health Services Make the Problem Worse

■ **Even where legal, abortion is not always available:** In many developing countries, health workers, doctors and nurses do not have adequate training or equipment. Some refuse to perform abortions because they do not understand the laws or because they personally do not support abortion.[12]

■ **Treatment for unsafe abortion is inadequate:** When women have complications from an unsafe abortion, good medical care is often unavailable. Lack of training, equipment and protocols; misdiagnosis; negative attitudes of health workers; and/or overcrowded emergency wards can result in life-threatening and costly delays for women seeking treatment.[3]

■ **Family planning is not always offered to women who have been treated for abortion complications**[12]: In Zambia, for example, 78% of women treated for abortion complications said they wanted information about family planning; 44% wanted to receive a method. However, family planning was discussed with only 33% of the women, and none was offered a method to take home.[11]

What Can Be Done

■ **Ensure universal access to client-sensitive family planning services,** especially for young people and women at risk of sexual abuse, rape and violence.

■ **Offer safe abortion services** by trained, compassionate staff when allowed by law;*

■ **Ensure that high-quality services for treating and managing abortion complications** are accessible through the health system.

■ **Offer family planning counselling and services,** and referrals for comprehensive reproductive health services, to all women who have had an abortion.

■ **Educate communities** about reproductive health and unsafe abortion.

■ **Reform laws and policies** to support women's reproductive health and improve access to family planning, health and abortion-related services.*

*Each of the co-sponsors of the Safe Motherhood Initiative (see below) implements these activities according to its specific mandate.

Sources:

1: *Abortion: A Tabulation of Available Information*, 3rd edition. World Health Organization, Geneva, 1997, in press.

2: *The Health of Young People: A Challenge and a Promise*. World Health Organization, Geneva, 1993.

3: "Care for Postabortion Complications: Saving Women's Lives". *Population Reports*, Vol. 24, No. 2, September 1997.

4: F.M. Coeytaux, "Abortion", in M. Koblinsky, et al., eds., *The Health of Women: A Global Perspective*. Westview Press, Oxford, 1993.

5: "Abortion Laws Into Action: Implementing Legal Reform". *Initiatives in Reproductive Health Policy*. Vol. 2, No. 1. Ipas, Carrboro, NC, January 1997.

6: *Report of the International Conference on Population and Development*. United Nations, New York, 1994.

7: N. Sadik, *The State of World Population 1997*. UNFPA, New York, 1997.

8: S.J. Segal and K.D. LaGuardia, "Termination of Pregnancy - A Global View". *Bailliere's Clinical Obstetrics and Gynaecology*, Vol. 4, No. 2, 235-247, 1990.

9: L. Heise, K. Moore, N. Toubia, "Sexual Coercion and Reproductive Health: A Focus on Research". Population Council, New York, 1995.

10: *Expanding Access to Safe Abortion: Key Policy Issues*. Population Action International, Washington, DC, September 1993.

11: S.N. Kinoti, et al., *Monograph on Complications of Unsafe Abortion in Africa*. Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, Arusha, Tanzania, 1995.

12: *Proceedings: Abortion Matters. International Conference on Reducing the Need and Improving the Quality of Abortion Services*, Stimezo Nederland, Utrecht, Netherlands, 1997.

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

Measuring Progress

During the last decade, governments around the world have pledged to cut maternal mortality in half by the year 2000*. However, accurate figures on maternal death are difficult to gather. Therefore, countries need other, more reliable and cost-effective ways to measure their progress toward reducing maternal mortality.

What Is a Maternal Death?

- "The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the 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]
- Maternal death statistics are usually expressed as:

— *A ratio:* The maternal mortality ratio is the number of maternal deaths per 100,000 live births. It indicates the risk of maternal death among pregnant women and those who have recently delivered.[2,3]

— *A rate:* The maternal mortality rate is the number of maternal deaths per 100,000 women aged 15-49 per year. It reflects both a woman's risk of dying from maternal death and her risk of becoming pregnant.

— *A "lifetime risk":* A woman's lifetime risk of maternal death is the probability that she will die from complications of pregnancy or childbirth at some point during her entire reproductive life-span. It is often used to illustrate the differences in the risk faced by women in developed and developing nations.[3]

Why Is Maternal Death Difficult to Measure?[2]

- **It is under-reported:** People in developing countries often die outside the health system, which makes accurate registration of deaths difficult. Under-reporting can be significant; in some studies, the actual number of maternal deaths was double or triple what was initially reported.[4]
- **It is misclassified:** Health workers may not know why a woman died, or whether she was or had recently been pregnant. Even if the health worker does know, the information is not always recorded. Deaths are sometimes intentionally misclassified, especially if they are associated with clandestine abortions.
- **Methods used to calculate maternal death rates are often complex and costly to use.** The actual number of maternal deaths in a specific place at a specific time is relatively small. Therefore, very large populations must be surveyed in order to get accurate estimates.

Which Estimates of Maternal Mortality Are We Using Now?

- The World Health Organization and UNICEF have developed a new way to estimate maternal mortality that compensates for under-reporting and misclassification. Their estimates, for the year 1990, are generally accepted for countries without reliable data, but they still have wide margins of error. Therefore, they should only be used to describe the general size of the problem in each country in order to:[3,5]

— *sensitise policy-makers, programme-planners and others;*

— *stimulate discussion and action; and*

— *mobilise national and international resources.*

- **Although these estimates can be used to monitor trends over more than a decade, they cannot provide information on short-term progress in reducing maternal mortality.**

What Information Do We Need?

- **In order to reduce maternal deaths, it is more important to understand why women are dying than to know exactly what the level of maternal mortality is.** Such information can be found through:

— *Process indicators,* such as the proportion of births that are assisted by skilled health personnel or that take place in health facilities."[7] Studies have shown that reducing maternal mortality depends primarily on women's use of good quality maternal health services.

*Including at the global Safe Motherhood Conference (1987), World Summit for Children (1990), International Conference on Population and Development (1994), World Summit on Social Development (1995) and Fourth World Conference on Women (1995).

— *Case reviews* of the causes and circumstances surrounding a select number of maternal deaths. There are two types of reviews: those that focus only on what happened once the woman reached the health facility (such as whether the doctor was available), and those that also investigate what happened beforehand (such as whether there was a delay in reaching the facility in the first place).[8] These reviews provide valuable information that can be used to identify and address problems, either with the quality of services or within communities.

EVALUATING OBSTETRIC CARE:

In order to reduce maternal mortality, high quality obstetric services must be available to manage major complications. UNICEF, WHO, and UNFPA have developed a series of process indicators that focus on these essential obstetric services. Data for these indicators can be collected and analysed at health facilities without large-scale community surveys.[7]

This series includes indicators that measure:

- the availability of services;
- the use of services; and
- the performance of health facilities.

More information on this series can be found in "Guidelines for Monitoring the Availability and Use of Obstetric Services", UNICEF, New York, October 1997.

Measuring Maternal Illness and Disability

■ **Pregnancy complications can cause serious, long-term health problems even when they do not result in death.** As such, it is important to try to assess the scope and impact of maternal disabilities, and to understand how they are perceived and dealt with by women and communities.

■ **However, it can be difficult to identify and classify maternal illnesses and disabilities.**[5] Even trained medical personnel may differ in their diagnoses. As such, experts do not recommend using indicators of maternal morbidity as an alternative to maternal mortality as a way to measure the impact of safe motherhood programmes.

What Can Be Done

■ **Decide whether establishing a national maternal mortality figure is the best use of scarce resources.** If an estimate is needed to stimulate attention and action, decision-makers can use the revised WHO/UNICEF figures to indicate the magnitude of the problem.

■ **Use process indicators to develop, implement and evaluate policies and programmes** based on reliable information. Health planners should be careful to select indicators that are easy to collect and are most relevant to the activities being implemented.

■ **Use findings from maternal mortality studies and programme evaluations widely.** Depending on the type of study, clearly-presented results and recommendations for action may be useful to a broad range of audiences, including: policy-makers, health providers, hospitals, medical societies, community groups, and research institutes. Community involvement can be very helpful both in conducting the studies and identifying and carrying out solutions based on the findings.

Sources:

1: *International Classification of Diseases, 10th Revision.* World Health Organization, Geneva, 1992.

2: UNICEF/WHO/UNFPA, "Guidelines for Monitoring the Availability and Use of Obstetric Services". UNICEF, New York, October 1997.

3: "Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF". World Health Organization, Geneva, April 1996.

4: H. Atrash, "Maternal Mortality Surveillance". Presentation at the Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

5: O. Campbell, "Measuring Progress in Safe Motherhood". Presentation at the Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

6: W. Graham and O. Campbell, "Measuring Maternal Health: Defining the Issues". London School of Hygiene and Tropical Medicine, London, May 1991.

7: "Indicators for Monitoring Maternal Health Goals". World Health Organization, Geneva, 1994.

8: J. Ireland and W. Graham, "Conducting a Case Review of Maternal Deaths". Dugald Baird Centre for Research on Women's Health, University of Aberdeen, May 1996 (prepared for WHO Safe Motherhood Needs Assessment).

Prepared by Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). The IAG includes: the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the Population Council; FCI serves as the secretariat.

These fact sheets have also been prepared in more detailed versions for technical audiences. For more information or copies of available materials, contact any IAG member, or the secretariat at:

Family Care International
588 Broadway, Suite 503
New York, NY, 10012, USA
Tel: (212) 941-5300
Fax: (212) 941-5563
Email: smi10@familycareintl.org
Web site address: www.safemotherhood.org

1998

TO: CHRISTY Michael O'Mary 5108

Carol - with some ideas + questions please call ASAP Marks Love

FIRST LADY HILLARY RODHAM CLINTON
TALKING IT OVER
MARCH 31, 1998

The women my husband and I met on our trip to Africa greeted us with song. They sang of their lives. They sang of their hopes for themselves, their families, and a new Africa. They sang for every generation. Whether it's speaking out against oppression or calling out for economic opportunity, the women of Africa have never stopped singing together. uniting their voices in song.

In Ghana, I heard women singing for the chance to become full participants in their country. They were dressed in aqua, orange, yellow and other bright colors, and all united by a common mission. Like the Queen Mother of the Ashanti Stool, who led the Ghanaian people against outside invaders at the end of the last century, these women are leading their country into the Millennium. They showed me the micro enterprises they've created selling jewelry, art, clothing, and other goods. But, nothing made them more proud than their day care center. There, in bright rooms, I saw children being nurtured and cared for while their mothers worked to support their families.

In South Africa, I heard women singing ~~for a chance to build~~ as they built a home and a community. As we approached the Victoria Mxenge Housing Project, we could still see the shanties where a group of homeless squatters – mostly women – used to live. Now, on the other side of the street, there is a vibrant community these women have created by pooling their resources, securing small loans, and building homes together~~, singing all the while~~.

"Strength, money, and knowledge," they sang to me last year, "we cannot do anything without them." When my husband joined me at the village last week, we saw the remarkable changes borne of these three ingredients. [We saw one family's pride as they showed us around their home and shared in others' excitement as we helped lay down the first concrete bricks of a new home.]

Last year, I asked the women of Victoria Mxenge if they believed they would own a home themselves someday. The answer was a resounding "yes." This time, I asked them how many actually owned a home. Hands shot up throughout the group. In just one year, the number of homes in that village has increased from 18 to 109. Roads once made of dirt are now paved. The concrete slab where we gathered last year is now a community center, complete with a day care center and a store. And the women have just bought a whole new plot of land that will provide fertile soil for new businesses, new homes, and the fulfillment of lifelong dreams.

In Rwanda, I heard women singing to rebuild lives ripped apart by genocide. I heard the women in Uganda as they worked to provide education to every boy and every girl. I heard them in Botswana, where women leaders were helping to combat the scourge of AIDS and promote legal rights.

And in Senegal, I heard women singing for their health and their futures. The group of women I met with from the Malicounda Bambara village, had done something remarkable. Although female genital mutilation (FGM) only affects up to 20 percent of women in Senegal, in many villages like Malicounda, it is considered a rite of passage for all girls. What drove them to change all of that? One woman explained that they had "studied human rights and particularly the right to health."

These women decided that FGM had harmed their daughters' bodies and spirits for too long. They decided that it was time to end the hemorrhaging. It was time to end the infections, AIDS, and childbirth complications caused by this tradition. And that's exactly what they did.

Using a skit they showed me, the women of the Malicounda village educated their religious leaders, their husbands, and their neighbors. They banned this practice -- and they are now inspiring others to do the same. Just last month, 13 villages with a combined population of more than 8,000 people joined together to end FGM in their communities. And President Diouf has now called for a new law to abolish it throughout the country.

Success stories like these are being written throughout Senegal and Africa. In Thies, I met a group of parents at the Mode Kane School. They were improving their children's lives by learning to lift up their own education, literacy, and health. And they too were singing a song about their journey. It was called Women's Rights: "All people...have equal rights. The right to education. The right to health. These rights have changed our lives...In our homes, in our neighborhoods and in our country."

With every voice added to this song, the chorus became more powerful. With every voice added, the aspirations of individuals blended into the dreams of generations -- dreams of a new role for women in a new Africa.

As we left Senegal to return home, I thought about how one of that country's greatest authors, Ousmane Sembene, described a group of women from Thies who marched and sang in the name of simple fairness and progress. He wrote "Ever since they left Thies, the women had not stopped singing. As soon as one group allowed the refrain to die, another picked it up and new verses were born...No one was very sure any longer where the song began, or if it had an ending. It rolled out over its own length, like the movement of a serpent. It was as long as a life."

Like women all over the world, the women of Africa will never stop singing.

FAMILY CARE INTERNATIONAL

588 Broadway Suite 503 New York, NY 10012 fci@idt.net Fax 212 941 5563 Telephone 212 941 5300

monday night → Pres/Carpool best people

3P

World Bank

1818 H St

Arrive 6:30

7:15 dinner

9:00

monday night

Safe motherhood

- corporate partner

public service announcements

Wednesday, 1 April 1998

To: Christy Macy

From: Jill Sheffield

Dear Christy,

Attached in two pages are some examples of success stories ... in several of the technical arenas. But they ALL show that with a little ingenuity and a lot of determination, almost anything is possible.

One really super success story (I have the article -- if you were to want it) is from Tanzania. District Hospital with enormously high maternal death rate. Staff decided to find out why and do something...did a complete audit of why each woman died. Compiled a list of what they could do from moving the physician to the hospital compound in the cleaned, painted (quite modest) house, dam up a little river for several hours of auto-clave access per week, ... ordinary, practical things. They had 22 things on that list. Maternal mortality came down by nearly 40% in the two years and at a cost of less than $11,000.

Mupta

Teake Oyelody

Hope you are having some luck. Sounds like they had a good day in Botswana -- even some rest.

Can you come on the 7th? I may be down this Friday. Just so you know. And from Sunday, we'll be staying at the Lombardy Hotel to make things easy.

Have a splendid day...its a wonderful one in NYC!

Hamta

Jill Sheffield

202-473-4486

Best, Jill

473-3691

x 522-2653

PS - Success stories are from the longer versions of our fact sheets.

E mail Jsheff@familycareintl.org

522-2653 (Jan)

SAFE MOTHERHOOD SUCCESS STORIES

IMPROVING ACCESS TO CARE:

Barriers of distance and lack of transport have been reduced by:

- *Assigning health workers trained in midwifery to village-based health facilities, backed up by a functioning referral system.* Such a system has been instituted in **Matlab, Bangladesh,**[18] **Sri Lanka and Cuba**, where maternal mortality has declined.

- *Decentralising care to the lowest level of the health care system* that is able to provide it adequately. In **Mozambique**, nurses have been trained to perform Caesarean deliveries; outcomes are as good as for women who had Caesareans performed by specialist obstetricians.[1]

- *Setting up systems for emergency transport and referral of complications.* The involvement of local community members and leaders in designing and implementing these systems is crucial, as is the support and cooperation of the health system. In **Uganda**, the "Rescuer" project ensures that TBAs have radio communication to call for help, and that local transport can be obtained on short notice.[20] In **Sierra Leone and Ghana**, community leaders were mobilised to collaborate with the local transport workers' union to set up a roster of vehicles for emergency transportation.[19]

- *Establishing maternity waiting homes close to formal health facilities.* Maternity waiting homes can be useful for women living in remote areas or where transport is especially difficult, as in mountainous areas. **Cuba, Ethiopia** and **Mongolia** are using such homes.[21]

- *Providing maternal and infant health services for free and assured through governmental action, improves access for poor women.* Several countries, including **Bolivia, South Africa, Bangladesh and Sri Lanka**, have made this commitment.

QUALITY CARE:

- A generator and blood bank were installed and an unused operating theatre made functional at a hospital in Makeni, **Sierra Leone**. In addition, drugs and supplies were provided through a revolving fund, all for less than $40,000. The number of women seeking care for obstetric complications increased by over 200%, and the case fatality rate among those women dropped from 32% to 5%.

- In **Guatemala**, *protocols were developed* for regional and departmental hospitals to maintain optimal levels of care for patients in out-patient clinics, labour and delivery wards, and those receiving hospital-based postpartum care.

- In **Ghana**, the Ministry of Health has developed *clinical management protocols* for identifying and treating pregnancy-related complications at all levels of the health system. The protocols also set standards for the provision of antenatal care, supervised delivery, postpartum care, family planning and management of abortion complications.

- In **South Africa**, health providers developed a set of recommendations for improving services, including more training for staff, providing a wider range of services, ensuring adequate supplies in all facilities and treating all patients equitably.

- In 1986, **Malaysia** launched a quality assurance system for hospital care. Hospitals are divided into two categories — those with specialists and those without — and compared on the basis of a set of clinical indicators. Those with poor performance are required to investigate the reasons why and take action to improve services. The effect of these measures on quality of care are monitored by state and national quality assurance committees.

ENSURE SKILLED ATTENDANCE:

Policy-makers, physicians, midwives, nurses and community representatives must work together to create a supportive environment that enables health workers to provide at least some components of essential obstetric care.[11]

In **Lesotho**, development of national midwifery protocols was completed by midwives working with obstetricians.[11]

In **Ghana**, midwives trained in life-saving skills now provide emergency obstetric care which had previously been provided only by doctors.[13]

In **Zimbabwe**, where over 30% of deliveries take place without a skilled attendant, the government has launched a national programme to increase the number of nurses trained in midwifery by 50% — by 60% in rural areas.

In **Ghana**, the Ministry of Health has developed clinical management protocols for identifying and treating pregnancy-related complications at all levels of the health system. Designed for midwives, nurses, doctors and public health workers, the manual also sets standards for the provision of antenatal care, supervised delivery, postpartum care, family planning, and management of abortion complications.[15]

Remarks by First Lady Hillary Rodham Clinton
United Nations Economic and Social Council

United Nations Plaza
New York, New York

December 10, 1997

Thank you. Mr. President, your excellencies. I welcome this opportunity to be here as we begin this yearlong commemoration, which is not just a commemoration of the universality of human rights; it is a celebration of the United Nations. I am especially pleased that we are able to gather this morning in the Economic and Social Council, which at its first session in February of 1946, established the Commission on Human Rights.

Forty-nine winters ago the world acknowledged the new common standard for human dignity, a code for the peoples and governments of the world to live by. One of the people who labored to create that code was Eleanor Roosevelt, then the United States representative to the U.N. Commission on Human Rights. The place was Paris. The delegates who came together to craft the language hailed from countries as diverse as Lebanon, Chile, France, China, and Ukraine. The dream was the Universal Declaration of Human Rights, the first international agreement on the rights of humankind.

Some of humanity s greatest lessons emerge only after the deepest tragedies. This Declaration took shape in a world ravaged by the horrors of militarism and fascism. In the wake of the most violent revelations of the depths to which human beings can dehumanize one another, the world as a whole was ready at last to agree upon these standards for human rights.

Let me read a passage from that document:

> *Disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind. The advent of a world in which human beings shall enjoy freedom of speech and belief, and freedom from fear and want, have been proclaimed as the highest aspirations of the common people. Therefore, the General Assembly proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and nations.*

The document goes on to state what should be obvious, but too often is not:

> *All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience, and should act toward one another in a spirit of brotherhood.*

How radically idealistic an act it was at first for the nations of the world to subscribe publicly to this Declaration.

That act did not, however, take place in a vacuum. It was a response to evil, and I use that word deliberately. Those who study the Holocaust know that the Nazis were able to pursue their crimes precisely because they were able progressively to constrict the circle of those defined as humans. From the

moment they came to power, they proceeded step by step to dehumanize, through laws and propaganda, the mentally ill, the infirm, gypsies, homosexuals, Jews those whom they identified as life unworthy of life.

This cold, dark region of the human soul, where people withdraw first understanding, then empathy, and finally even the designation of personhood from another human being, is not, of course, unique to Nazi Germany. This device, this ability to dehumanize, has been witnessed in all times and places. It is precisely this device that the Declaration attempted to help us resist.

Thankfully, in the half-century since the birth of the Declaration, we have, as a global people, managed progressively to expand the circle of full human dignity. Because of this document, individuals and nations alike have a standard by which to measure fundamental rights. Many of the countries that have emerged in the last 50 years have drawn inspiration from the Declaration in their own constitutions. Courts of law look to the Declaration. It has laid the groundwork for the world s war crimes tribunals. It has prompted governments to set up their own commissions to safeguard basic liberties.

At the United Nations Conference on Human Rights in Vienna in 1993, it was the power of the Declaration that inspired the establishment of a High Commissioner on Human Rights. Let me add, how lucky the United Nations and, indeed, the world is that Mary Robinson fills that post.

At the United Nations Fourth World Conference on Women in 1995, it was the strength of this Declaration that enabled us to say for all the world to hear that human rights are women s rights, and that women s rights are human rights.

And yet, in spite of this half-century of progress, we have not expanded the circle of human dignity far enough. There are still too many of our fellow men and women excluded from the fundamental rights proclaimed in the Declaration, too many whom we have hardened our hearts against those whose human suffering we fail fully to see, to hear, and to feel.

Any look back at history shows that every nation has had its blind spots that have kept people out of the promised circle of full humanity. Take the example of my own country. We in the United States have had our own difficult experiences with the selective or unequal application of the rights established in the American Constitution. Even the founding fathers, whose ideas of human dignity were so far ahead of their time, proclaiming that all men are created equal in the Declaration of Independence, inscribed slavery in our Constitution.

It has taken most of our 220 years, some of them bloody, few of them easy, to extend the benefits of citizenship to African Americans, to those without property, and to women. Eleanor Roosevelt herself was 35 years old before she could vote.

Even today, we circumscribe the circle in what we choose not to see. Black South Africans described what it was like to work all day in white environments in which one was literally not seen. In the Balkans, people have willed themselves not to see the humanity of those whose heritage is different from their own. We ourselves in the industrialized world often choose not to see the child labor that goes into our beautiful carpets or our comfortable shoes.

In too many places today what we fail to see are the injustices done to women. We choose not to see the injustice of legal systems around the world that continue to treat women as less than complete citizens. In too many places, female heirs are seeing less inheritance than male heirs. Inequitable divorce

laws compel women to remain in cruel marriages. And some courts of law require the testimony of two women to equal that of a solitary man.

Our vision is limited in other areas as well. We choose not to see the contribution of women to the economic lives of their families and countries. In too many places, women are discriminated against for bank loans and credit, first jobs and promotions. They are denied pay equal to that of men, or any pay at all. They live disproportionately in poverty, making up 70 percent of the world s poor.

We also circumscribe the circle by what we choose not to hear. Freedom and equality for all depend first on whether a citizen truly has a voice. It is telling that even in the drafting of the Universal Declaration, there was a debate about women s voices. The initial version of the first article stated, All men are created equal. It took women members of the Commission, led by Hansa Mehta of India, to point out that all men might be interpreted to exclude women. Only after long debate was the language changed to say, All human beings are born free and equal.

Today, we still choose not to hear the voices of many women. In too many places women are blocked from participating in the political lives of their countries. Just nine days ago in Sudan, 36 women were arrested while attempting to deliver a petition to the United Nations office there in protest of human rights violations in their country. They were arrested, fined, and at least one woman received 40 lashes.

In too many places girls and women never even learn to project their voices. Two-thirds of the 130 million school-age children out of school are girls. Two-thirds of the 96 million people worldwide who can neither read nor write are women. Even now the Taliban in Afghanistan are blocking girls from attending school. Not only that, they are blocking those like Emma Bonino, the European Union Commissioner for Humanitarian Affairs, who would speak out against this injustice.

Freedom of speech and freedom of the press, the rights to petition the government and to assemble all these are essential. Just think how much weaker these rights are in a nation where the majority of young women are illiterate. Rights on paper that are not protected and implemented are not really rights at all.

We further constrict the circle of human rights through what we choose not to feel. As Eleanor Roosevelt put it, When will our conscience grow so tender that we will act to prevent human misery rather than avenge it?

In too many places, the suffering of women is defined as trivial, explained away as a cultural phenomenon. Perhaps it is for this reason that women do not receive proper health care, including access to family planning. Perhaps that is why, in some countries where more than 90 percent of women have undergone genital cutting, the practice continues. Perhaps that is why domestic and sexual violence remains the most serious under-reported and widespread human rights violation in the world.

In almost every country of the world, domestic violence is one of the leading causes of injury and death to women. In my country, 30 percent of female murder victims are killed by current or former partners. As Secretary of State Madeleine Albright has said, domestic violence can never again be dismissed, as it often has in the past, as part of a country s norm or as a set of private assumptions about family life. Let us say it loudly for the entire world to hear

us: We do not believe that violence against women is simply cultural; we believe it is simply criminal.

Perhaps that is why rape and sexual assault continue to be tactics of war. It is the cruelest injustice that so many wars end not in peace for women and their families, but in refugee crises that trap women and children in lives that go from bad to worse. Women and children make up 80 percent of the world s 23 million refugees.

The full enfranchisement of the rights of women is unfinished business in this turbulent century. What meaning does the language of freedom and human rights have for a young woman forced into prostitution and traffic in the commercial sex trade? What meaning can it have for women forced into involuntary servitude as sweat- shop workers or domestic servants? What meaning can it have for a woman forced either to bear a child or abort one? What about the very ingrained practices that undermine the growth and development of girls from their very first years, such as the common practice of feeding them last or less?

As I have been privileged to travel around the world, I have met countless women who know nothing of this Declaration and its promises. They are, however, eloquent in their belief that they deserve respect and better treatment in their families, workplaces, and societies.

Yet some critics continue to dismiss women s sufferings as minor. But are they? In 1958 Eleanor Roosevelt wrote:

Where do human rights begin? In small places, close to home, so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person the neighborhood he lives in, the factory, farm, or office where he worked. Such are the places where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere.

Other critics dismiss human rights violations as harmless. A report released this week by the Carnegie Commission on Preventing Deadly Conflict proves otherwise. According to the report, an upsurge of egregious human rights violations is almost always a powerful warning of dire events to come, including massive refugee flows and civil wars.

Still others say that human rights are a Westerner s luxury not inalienable, but alien. I believe, and the women I ve listened to believe, that human rights are as essential to life as air or water, that they are felt beyond culture and tradition as innate. The women I have met do not feel that human rights are a foreign concept invented by purists. Rather they know in their very hearts and souls, in spite of everything they are told by culture and tradition, that these are God-given rights that they were born with as surely as they were born into the human family.

For if they are not innate, how have people throughout history known to fight for them so valiantly? Paradoxically, the proof of universality lies with the perpetrators of human rights violations themselves. Why would those who have dishonored humanity run to cover their tracks were it not for the knowledge that wrong had been done? The Nazis tried to hide their concentration camps. Communism kept its terrors in the shadow of the Iron Curtain. Scores of bodies are hidden in the hard ground of places like Bosnia and deep in the forests of places like Rwanda.

Throughout my hemisphere, people have disappeared. Why go to the trouble? Because human rights transcend individual regimes and customs. The beliefs inscribed in the Universal Declaration of Human Rights were not invented 50 years ago. They are not the work of a single culture or country. They have been with us forever from civilization s first light.

Sophocles wrote about them 2,500 years ago when he had Antigone declare that there were ethical laws higher than the laws of even kings. P.C. Chang, who helped draft the Universal Declaration, pointed out that Confucious articulated them in ancient China. The belief that we must respect our neighbors as we would respect ourselves resides in the core of the teachings of all the major faiths of this world.

The principles inscribed in the document whose birth we mark today are not constructed, but revealed. Every great religion exposed and taught their truth. If I were to tear up this declaration, its values would abide. If I were to burn this document, its meaning would remain. If I were to forbid someone from hearing its words, they would still ring as loudly as ever in the hearts of men and women.

It is because every era has its blind spots that we must see to our own unfinished business with even greater urgency now while we stand on the threshold of a new millennium. We must rededicate ourselves to completing the circle of human rights once and for all. We must challenge ourselves to see more sharply, to hear more clearly, to feel more fully.

And we must do something else. We must support democracies new and old that work to fulfill the aspirations of this Declaration. As my husband, the President, said last night: Democracy, the rule of law, civil society those things are the best guarantees of human rights over the long run.

It is time for us as a global community to commit ourselves. We have run out of excuses not to. Here we are at the very close of the 20th century, a century that has been scorched by war time and time again. If the history of this century teaches us anything, it is that whenever the dignity of any individual or group is compromised by the derogation of who they are, of some essential attribute they possess, then we all leave ourselves open to nightmares to come.

Conversely, if the century has a lesson for us that is redeeming, it is that by extending the circle of citizenship and human dignity to include everyone without exception, then we have the basis where new worlds of hope can flourish.

So, let us in this year of commemoration walk toward those new worlds. Let us do so knowing that the path will never be easy. These rights may be eternal, but so too is the struggle to attain them. Though the darkness of the human heart may recede, it will never go away. It must be with realistic eyes that we look for human rights. And it must be with open hearts that in this, the 50th anniversary of the Universal Declaration on Human Rights, we rededicate ourselves to its fulfillment.

Thank you very much.

THE WHITE HOUSE
Office of the Press Secretary

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE WOMEN OF ARGENTINA

COLON THEATER
BUENOS AIRES, ARGENTINA

October 16, 1997

Thank you, Mrs. Schiavoni.

To all of you -- Ambassadors, Ministers, Representatives, of the federal and local government, academicians, business women, homemakers, artists, teachers -- to all of you, I thank you for this opportunity to speak before you today. I would like to exte nd a special thanks to the staff of the United States Embassy, but particularly to the National Council of Women and their staff for the outstanding work that was done to make this gathering possible, and I believe we should show appreciation to Mrs. Schi avoni and all associated with the National Council of Women by another round of applause. Thank you.

I also understand I should give a special greeting to all the mothers in the audience, on the eve of Mother's Day, and I do so.

I am, as you may know, an empty-nest mother now, and I called my daughter last night to tell her that I had seen just a small sample of tango, because she loves dance of all forms and wrote a paper in Latin American history on tango and its origins, so I was so pleased to be able to tell her what my husband and I had done on our first night together here in this beautiful city.

I must confess that it is somewhat awe-inspiring to be in this magnificent theater on a stage that has been graced by Domingo and Carusso and Callas. I am almost tempted to sing, but in the interest of preserving warm ties between our countries, I will refrain.

But I would like to talk about voices, powerful voices, the voices of women in this country and my country, throughout our hemisphere and our world, and what we can do to make all of our voices heard. To have our voices heard about our shared commitment to advancing the cause of women's rights, advancing the cause of democracy, and making clear that the two are inseparable.

I can think of no better place to do that than in Argentina. The women of Argentina have long been pioneers on the frontiers of human rights and equality.

From the Argentine Beneficent Society to the National Women's Council to the Grandmothers of the Plaza de Mayo -- with whom I will meet shortly, you and your foremothers have forged a remarkable record of speaking up in your communities, caring for those who cannot help themselves, opening the doors of education to boys and girls, lifting up lives and voices for democracy and human rights.

We are pursuing our goals of equality at a moment in history that is full of hope, a time ripe for positive social change. Countries that were once paralyzed by debt or runaway inflation have embarked on tough reforms and are now on the move.

Economic renewal has been accompanied by democratic transformation. Across the

Americas, military dictatorships have given way to freely elected governments. For the first time in decades millions of people enjoy the right to choose their own leaders, t o engage actively in political life, to speak frankly, to meet in support or opposition to a cause, and to form opinions based on information gathered by a free and inquiring press.

Yet we know that democracy, whether newly rooted or centuries old, is fragile. The process of building and tending democracy is ongoing. Democracy flourishes when its principles are internalized in the hearts and minds of all people, when no one fears t he consequences of standing up or speaking out for justice. And democracy thrives when women are not barred by law, by ignorance, by tradition or by intimidation from making their voices heard at the ballot box, and from pursuing their most cherished dre ams.

In short, empowering ever-more women to seek and claim their rights as citizens and as human beings will ensure that democracies -- yours and mine, old and new -- survive and thrive in the twenty-first century.

The word "empowerment," I am told, does not translate well. But I am sure that every woman gathered here knows its meaning. Empowerment means the right to participate in the political and economic life of our countries. Empowerment means being able to lead lives free of sexual and domestic violence. It means access to justice under law, to education, to health care, to credit and property ownership.

Empowering women makes sure our voices are heard and we are treated as full citizens in our countries.

No nation can hope to succeed in our global economy if half of its people lack the opportunity and the right to make the most of their God-given promise. And, as we can all attest, in too many countries, my own as well, too many rights are still denied a nd too many doors of opportunity still remain tightly closed.

Too many women and children are trapped either in an endless cycle of poverty -- a cycle perpetuated by inadequate health care, poor access to family planning, and limited education -- or they are trapped inside social constructs that impoverish their spi rits and limit their dreams.

Too many women are unable to participate in the economic lives of their countries because they cannot get credit on their own to start small businesses.

Too many women live in fear of violence at the hands of family members. For them, home provides no refuge, the law no protection, and public opinion no sympathy.

Too many women, especially those who are poor and less educated, are unaware of their legal rights in the workplace, of their rights to own and inherit property, of their rights to vote and choose their leaders. While these laws may exist on the books, t oo many governments have not enforced them and too few women have been made aware of them.

Such problems as these may be daunting, but their solutions are in full view. Across the Americas, from Boston to Buenos Aires, there are cutting-edge, common-sense initiatives to give girls and women access to what I call the tools of opportunity: educa tion, decent health care, legal protections, and credit. These efforts prove that women can be empowered to lift themselves, their children, families, and communities out of poverty.

Let me begin with education, for nothing outside the family is more central to advancing the cause of girls and women. And Argentina has long recognized that fact.

Our two nations have a history of warm ties. One of the most notable was the friendship between Horace Mann, the father of public education in the United States, and President Domingo Sarmiento, the father of education in Argentina, who was ahead of his time with

his deeply held belief that girls should attend school.

The fruits of his conviction are there for the world to see today: In Argentina's strong and established system of education. In a literacy rate of 96 percent. And in a primary school completion rate of 90 percent.

Other countries in the Americas are rededicating themselves to improving access to and the quality of education for all their citizens as you have long done. Education will be the centerpiece of the Second Summit of the Americas in Santiago next April, a nd it will highlight models that are working.

Yesterday in Sao Paulo, for example, I saw an elementary school in one of the city's poorest neighborhoods. For years, the school struggled. Many students were not learning and most did not stay in school. Fortunately, the business community, recogniz ing the importance of education, got involved, and created the Institute for Quality Education. Working with the local government, parents, and teachers, they have transformed the school. Teachers who themselves may not have finished high school have no w received additional training. Students were tested. Parents were encouraged to get involved. In less than a year, test scores in mathematics and language went up more than 200 percent. Even in countries like ours, Argentina and the United States whe re we don't face such daunting challenges as Brazil does, we have to do more to improve the quality of education in both urban and rural areas and to ensure that all students have access to information technology. Concentrating on education and insuring that all the children of the hemisphere have a chance to learn will be the most important way that we can enable all of our economies to grow and flourish.

And an economy that grows and flourishes in Argentina or in the United States is good for their citizens and for other neighboring countries' citizens. But if we can create the capital of education in all the other countries in the hemisphere, that too i s good for Argentina and the United States.

Another tool of opportunity is Microenterprise. Microenterprise provides small loans to people, mostly women, who would not otherwise receive them. This concept started in Asia about 20 years ago when it was determined that a very small amount of money , given to a hard-working woman -- who might be landless and totally ignorant, but she had skills that were marketable -- she knew how to sew, she knew how to plant crops, she could do things with a little bit of credit that could bring income into her f amily.

I have seen all over the world how access to such credit sparks a woman's entrepenurial spirit. Just in the last week I have seen two more examples here in our own hemisphere. In Panama I visited a group of women who, with a small grant from the United States Agency for International Development, started a business in a small village growing plants and seedlings to sell in city markets and also to sell to the Panamanian government's reforestation programs.

Now here is something that women have known for the millennia -- how to tend and nurture plant life. Women have held the secrets of medicinal plants and herbs. There are so many women throughout this hemisphere with those kinds of skills. To create a m arket for their product gives them a chance to use their skills to earn income to improve the standard of living of their families, and that is what I saw. Within two years, these women had sold enough orchids, medicinal plants and seedlings to expand t heir business. They had also furnished enough seedlings to restore 48 acres in one of Panama's national parks; and I talked with women who were using their new income to improve their homes and send their children to school.

I met an equally impressive group of women in Caracas. I entered an ordinary-looking building in one of what I was told to be one of the worst neighborhoods in Caracas. And yet, in this very well-kept space, sitting on an open-air, rooftop terrace, talk ing with these women, I was very moved and impressed. The walls were adorned with weavings and art

works that they had made. As a light breeze blew in, one woman told me how she had started a thriving taxi company. She knew how to drive, she was respo nsible and hard-working, there was no transportation adequate to the numbers of people in her community, so she had this idea but no one would give her the credit to purchase the van that she needed until she came to this Microenterprise Institute. She s aid that when she finally got her own business, it was as if "the sky had opened up."

Another woman used a small loan to expand her juice stand that she ran with her husband. Then a few years later she had a restaurant and a butcher shop employing ten people. She had even been able to send one of her children to university -- a woman who had never finished primary school. She said the loan had given her the opportunity "to spread her wings."

Now these are not unique stories. I have met similar women in Nicaragua and Costa Rica, in Bolivia and Chile and Mexico, and I know they are here in Argentina and in my country as well.

Because a real job is the best form of social welfare, microenterprise works for the individual, the family, and society. And the more we can expand credit, to both women and men who appear on the surface to have no collateral, to be poor, but who have s kills that keep them going every day in the hard lives that they face, the more we will create free and broader markets that will enhance the economies of our countries.

Access to quality health care -- especially family planning and reproductive health services -- is also crucial to advancing the progress of women. I have seen first-hand, as I know many of you have, what happens when women are given access to such healt h services.

Just two days ago in Brazil, I witnessed the signing of an agreement between my government and two Brazilian state governments to support a family planning initiative. This came about because two years ago I visited a maternity hospital in Salvador de Bahia, Brazil, and I saw men and women getting the information they would need to enable them to make wise choices about planning their families. I saw mothers cradling their new-born babies in the hallways as they stood in line for their check-ups. I s aw young women, very pregnant, waiting for their pre-natal check-up. I saw infants were getting immunization. I saw parents were being taught what to feed their young children and how to care for them. And I also saw wards of women who were there becau se they had not received good quality health care.

In short, family planning and reproductive health programs were integrated in that hospital into maternal and child health services. And I talked with a number of mothers, as well as with the Minister of Health, who told me that for the first time they felt they could adequately care for the children they had, that they could invest in those children not only their love but other resources as well.

The result of a program like that was that rates of maternal mortality and, importantly, rates of abortion decreased because women received the health care they needed in a timely manner and furthermore, as the Minister of Health, an esteemed medical doct or and university professor, told me, for the first time poor women received the same health services that rich women have always been able to receive for themselves.

This approach of integrating the services and reaching out to poor women and men has proven so successful that it has been adopted as a hemisphere-wide strategy to reduce maternal mortality, and was announced at the First Ladies of the Americas Conference in La Paz last year.

Now the promotion and expansion of women's legal and political rights may, perhaps, be the most difficult challenge we face. And yet slowly but surely we are witnessing the emergence of legal reforms that will raise the status of women in the home and in society.

Domestic and sexual violence against women remains one of the most serious and under-reported human rights violations in the Americas. In country after country, we are finally bringing out into the light of day what has been thought to be a private matte r. In Argentina, women have worked to incorporate domestic abuse issues in police training, and I applaud you. Many countries now have human rights ombudsmen with special offices dedicated to protecting the rights of women. In Panama, legislators ha ve reformed the Family Code to better regulate such matters as alimony, child support and child custody.

And in the United States, we have introduced comprehensive violence against women plans that provide counseling for victims, training for police officers, and prosecution of offenders in all 50 states.

Throughout Latin America, countries are finding ways to open up political participation for women at all levels, from the grassroots to the voting booth, and I understand that there are record numbers of women running for political office here in Argentin a, and I know what a difficult choice that is to put yourself into the electoral system, and I congratulate all the women who are standing for public office or who hold public office because of the courage it takes to do so.

As more women hold office, we have to show that we care about the issues that brought us into the political process. That is especially critical when it comes to human rights.

At the conference in Panama City, I witnessed the signing of another agreement -- this one between USAID and the Inter-American Institute for Human Rights in Costa Rica. The Institute was founded to defend and foster respect for human rights at a time wh en repressive regimes controlled the lives of many people in the Americas. It offered crucial support to brave individuals throughout the region who spoke out against torture and repression at a time when such acts often meant risking one's job, one's ho me -- even one's life.

In 1990, the Institute embarked on a new mission in human rights advocacy: It established a formal program on gender and human rights. When I visited the Institute with Secretary of State Madeleine Albright in May, I had the opportunity to meet and spea k with women who are in the forefront of women's rights issues throughout the Americas. As they said, there is little difference in a woman's life between violence in politics and violence at home. Both dishonor democracy and respect for the God-given i ndividual dignity of each human being. As the Secretary of State said on that occasion, domestic violence can never be excused as cultural. It is criminal and should be treated as such.

There are many examples that I could give you, and you could give me so many more of what you have seen happening in your own lives, in families, in workplaces, in communities and countries. But I have seen, as you have, how efforts such as these in educ ation and health care and credit and in human rights are transforming lives. None of this progress would have happened if women themselves had not spoken out, demanded change, and forced their governments to respond.

Now we must encourage more women to make their voices heard, to join together in both community and national organizations, to press for political change beneficial to all women, to encourage women to vote in local and national elections, to make politics relevant to the lives of women, to send more women into political office.

Only women can make democracy work for ourselves, our children and our families. It is a message that is coming alive throughout the world. Last summer, at a conference in Vienna, Austria, I met with a group of women from the newly democratic countries of Eastern and Central Europe. They had just begun to recognize the power of independent citizen action to address challenges, and they had gathered to share ideas, to renew and strengthen their faith in democratic values and freedoms.

This kind of convening might be beneficial for our hemisphere as well. As our countries continue to expand our political, economic and strategic alliances, as my husband today is speaking with your President about, the women of this hemisphere can lead t he way in building an alliance of democratic values that will strengthen our democracies into the next millennium.

Now many of the issues that are faced throughout the hemisphere and the world may seem far away from the lives of women here and in the United States. Because in many ways, women of Argentina and the United States have a wider spectrum of opportunities t han the women and girls who live in the countries that lie between our own. I was reading in President Sarmiento's book, Life of the Argentine Republic, and I saw this quote which described the lives not just of women in Argentina at the time it was written but of women generally throughout the world, and still describes the lives of most women living on earth today.

Here is what he said: "Women look after the house, get the meals ready, shear the sheep, milk the cows, make the cheese, and weave the coarse cloth used for garments... The boys exercise their strength and amuse themselves...With early manhood comes com plete idleness and ease."

Now I am sure the men in the audience would object to that description, but it is not mine. It is President Sarmiento's. And I am sure that none of us would describe our early adulthood as ones of "idleness and ease" in today's fast paced world, but th e point is still valid that there are too many women whose horizons are very limited, but there are many women like ourselves whose horizons seem to be limitless and yet we, too, face formidable challenges in our own lives and the life of our societies.

I believe we have a responsibility to work on behalf of women who still struggle for the rights we have won. But we also must confront the new question that has edged up to our own front doors.

While the superficial homogenization of the world means that people on every continent wear the same jeans, eat the same fast food, listen to the same music -- these surface similarities do not override a longing for a deeper identity and meaning in our l ives. Despite improving material conditions around the world, many people are not satisfied and families are under new stresses. The gap between the rich and poor grows wider in many places. The social safety net of health care, education, pensions, de cent wages, good jobs -- is in danger of fraying for those less able to navigate this new world. And even for those of us blessed with good health, education, and affluence, we also ask ourselves many questions about the meaning of our own lives.

Questions about how we strike the right balance among our personal roles as wife, mother, homemaker, employed worker, citizen; about how we claim a personal identity in an age of anonymous globalization and high technology; about how families will raise c hildren in the face of pressures from the consumer culture and mass media that undermine parental authority and glorify instant gratification.

This last question is of particular importance to those of us who are mothers concerned about the future of our daughters.

For we have not won our places in society, we have not fought for women's rights to make the choices that are best for them, to stand by while the consumer culture does its best -- in my country and yours -- to objectify women and make girls believe that only their appearances, not their hearts, their minds or their souls, are important.

All the material possessions in the world cannot substitute for a rich and deep spiritual life; all the affluence in my country or yours cannot answer the eternal questions that are posed

by every generation. We cannot permit the pace of our life today, the use of automation and technology, to substitute for what is most important-- the human connections and relationships that are the stuff of what life is made and which are so essential to creating those habits of the heart that every child needs to bel ieve in themselves, to have the confidence to be able to do what they know is right.

This is difficult against the backdrop of this fast paced world in which we live. And I know that life is changing sometimes faster before our eyes than we can even make sense of. But we cannot leave the raising of our children, the inculcating of value s to the mass media and the consumer culture. We have to do a better job through our churches, our families, our civic associations; we have to build up civil society to reach out to all young people to help them understand why so many of you have fought so long and so hard for the values, the rights and the privileges that now in my country can be too easily taken for granted.

Democracy cannot survive unless those values are passed on to the next generation and one of the values has to be that a woman's full humanity is an unshakable, God-given truth, and that democracy itself cannot be fulfilled unless women are treated with d ignity and respect.

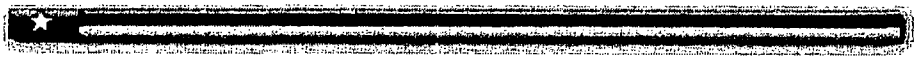
Last year, I participated in a call-in show on the radio for the Voice of America which went all over the world. One male caller asked me very earnestly what I meant when I said, "Women's rights are human rights and human rights are women's rights" at th e Beijing Conference on Women.

I told the caller to close his eyes and think of all the rights and privileges he enjoyed as a man. Then I asked him to imagine a world where every woman enjoyed those same rights. The right to make the choices that fit with that woman's conception of h er future. That means that a woman may choose to be a full-time wife and homemaker and it is a choice worthy of respect. That means that a woman may choose to give herself fully to a professional or business or artistic profession that means she does no t have a place she believes in her life for marriage or children.

That too, should be respected. And for the vast majority of us who attempt to balance our commitment to family with an interest in the outside world and a profession that we care about -- that too should be respected. There should no longer be "one size fits all" prescription for the way a woman's life should be lived. And because we are fortunate to be women at the end of this century with many more years than our grandmothers and great-grandmothers ever could have dreamed, we will have many opportunit ies in our lifetimes to fulfill our various dreams and aspirations.

The acoustics in this hall are famous throughout the world. So what is said here perhaps can carry throughout this hemisphere and beyond if we raise our voices on behalf of women to proclaim that we will not rest until we have repealed discriminatory law s, expelled the mythology about a woman's proper and only role, stared down the forces of physical and psychological intimidation that stifle the potential of women and children, and gives full flower to the belief that a woman has the opportunity and the God-given right to chart her own destiny, and then to work together to provide the tools of opportunity so that every girl and boy in this hemisphere can look with confidence toward the future. That should be our promise to our children for the next cen tury. They, in many ways face, a more difficult life than we did. It does not seem as clear and set as to what direction many of them should take. We have to stand with them and with each other as we create conditions that give each a chance to stand b efore anyone and say "I am a free person, I believe in democracy, and I believe in building a better world for those who come after."

Thank you all very much.




To comment on this service,
send feedback to the Web Development Team.

FAMILY CARE INTERNATIONAL

588 BROADWAY SUITE 803 NEW YORK, NY 10012 fci@idt.net FAX 212 941 5563 TELEPHONE 212 941 5300

Saturday, 4 April 1998

To: Christy Macy

From: Jill Sheffield

Dear Christy,

I know that you are working on THE speech...

* Bottom of p. 2..."A few years ago, I toured..." The group that developed that Safe Home Delivery Kit is a group called PATH. They are for sure going to be in the audience so it would be really a good idea to list them in the USAID, Save list of partners.

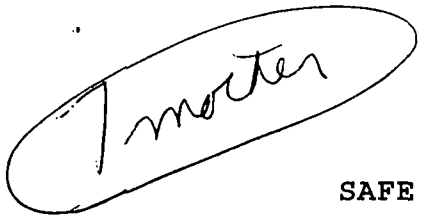
*Page 4..Para that begins "Think about it..." World Bank estimates that by spending $2...not **under** $2.

That's it. I know you are cutting...but in case these stay in...

Looking forward to seeing you Monday p.m. Going to be GREAT. So many thanks!!

Best,

Jill



HILLARY RODHAM CLINTON
SAFE MOTHERHOOD: WORLD HEALTH DAY
THE WORLD BANK
APRIL 7, 1998

It's a great honor and pleasure to be back here at the World Bank, and to join James Wolfensohn and all of you as we celebrate World Health Day -- and recommit ourselves to the global mission of Safe Motherhood. Thank you for giving me this opportunity to speak about a subject so close to my heart -- and of such extraordinary significance to the future of our world.

I want to thank James Wolfenson for being such a powerful voice within the World Bank and throughout the globe on behalf of women, especially his work in raising public awareness that investments in women and girls are the single most important investments nations can make to ensure sustained economic progress and social stability.

I'm so pleased to be joined today by Dr. Crispus Kiyonga, the minister of Health in Uganda, where I have just visited -- and Dr. Siti Hasmah Mohd -- the first lady of Malaysia. Deep appreciation also to the leaders of the Safe Motherhood InterAgency Group -- the World Health Organization, UNFRA (UN Population Fund), UNICEF, the World Bank, International Planned Parenthood Federation, and the Population Council -- who, with the support of Family Care International, lead critical efforts to promote the health and well being of women, children, and families.

I would also like to acknowledge the extraordinary work of the tens of thousands of foot soldiers on the front lines -- the doctors, nurses, midwives and public health workers who are struggling to meet the often overwhelming health needs of women throughout the world -- and who, against formidable odds, save the lives of so many women and children every day. We owe all of them our deepest gratitude.

We are joined here, on World Health Day, by people in cities and communities around the globe, who, like us, are raising our voices in a united chorus to say: no woman should ever die in childbirth. And that all of us -- governments, international agencies, NGOs, and communities -- have a critical role to play in saving their lives, and the lives of their children.

We come together this morning at a time of great promise and hope. I've just returned from an historic trip with my husband to Sub Sahara Africa, and I wish all of you could have joined us to see this great country, not only its pro blems, which are still profound, but the energy and intelligence and determination of the people. Over the past few years, more than 20 nations have broken the chains of authoritarian rule, and begun their journeys

toward economic and social recovery.

Yet in the midst of this time of growth and promise around the world, we still fail to protect our most important citizens -- the mothers of our children. The numbers are shocking, no matter how often you hear them. Every minute, somewhere in the world, a woman dies from complications of pregnancy and childbirth. Every minute, 190 women face an unplanned or unwanted pregnancy; every minute, 110 women experience a pregnancy related complication, ~~and every minute, 40 women have an unsafe abortion~~.

The tragedy that over 600,000 women die every year in childbirth is compounded by the simple yet unbearable truth that the vast majority of those deaths -- and so much of that suffering -- could have been avoided. The other stark truth that we continue to face today: Maternal mortality is 150 to 200 times greater in poorer nations than in our rich ones. And those deaths are directly related to the high level of poverty, and the low status of women, in those countries.

Ten years ago, many of the individuals and agencies here today launched the global Safe Motherhood Initiative, and for the first time, elevated maternal mortality to an international priority. And while many countries, including my own, have not yet met the collective goal of cutting maternal deaths by half by the year 2000, we should all take pride in the strides we are making.

The signs of progress are all around us. In Bangladesh, Sri Lanka, and ~~Cuba~~, health workers trained in midwifery are being assigned to village-based health facilities, and maternal mortality has declined. In Ethiopia and Mongolia, women living in remote areas where transportation is difficult can now go to maternity waiting homes, and get much needed interim care. Last year, I visited health care clinics in Bolivia, where prenatal and family planning services have resulted in safer pregnancies and deliveries, and in some cases, have saved lives.

A few years ago, I toured a small health and family planning clinic in Kathmandu, Nepal, financed by a partnership with USAID, the Save the Children Foundation, and the government. And while I was there, I was given a "Safe Home Delivery Kit" -- like the one I have here today -- that is given to expectant mothers. Inside is a bar of soap, twine, wax, a plastic sheet, and a razor blade. It's purpose is to reduce the two major causes of maternal and neonatal death, tetanus and sepsis, by promoting the "three cleans" principle: clean hands, clean surface, clean umbilical care. The kit was developed by a group called PATH -- who I believe is in the audience here today.

This kit symbolizes for me some of the most important lessons we have absorbed over the past few years. First, we've learned the power of partnerships. In community after community, governments, voluntary agencies, and local leaders are joining forces and resources to develop health care strategies that promote safe motherhood. I was proud to be present at the launching of one of those partnerships in Bolivia a few years ago, when USAID and the Pan American Health Organization and others joined forces to reduce maternal mortality throughout the hemisphere.

We now know, more than ever, that reducing maternal mortality requires sustained, long term commitments from the full range of partners. I know that last night there was an important meeting of new partners in the corporate sector who are joining the World Bank and this Safe Motherhood campaign, and I join all of you in applauding their participation.

But just as importantly, we've also learned that the cost of promoting safe motherhood is often minimal in comparison to the extraordinary rewards in saved lives, improved maternal and child health, and revitalized communities.

Think about it. The World Bank estimates that by spending $2 a year per person for maternal health care, almost all of the 600,000 women who die as a result of complications during pregnancy and childbirth would be alive today. And the lives of 2 million infants would be saved.

We have the resources. We have strategies that work. But we do not yet have the collective will to do what needs to be done. The result is that today, women in every nation in the world -- including my own -- lack basic health care that could save their lives and ensure their health. More attention must be paid to ensure women receive adequate prenatal care, good nutrition, and quality obstetric care, so that childbearing and childbirth is a safe and healthy period of every women's life. We must invest in family planning -- which improves maternal health. Without it, women often turn in desperation to illegal, unsafe abortion procedures that can account for up to half or more of all maternal deaths.

But women can't make progress in either their social or economic status unless they have other opportunities open to them as well. Education is inextricably tied to how women and children achieve progress. We've seen how investments in education have a profound and concrete affect on women's health, as well as the prosperity of their families and their country. So do investments in jobs and credit. I've seen how women's lives have been transformed, and how they've helped lift their families out of poverty, with just a modest loan to start up a small local enterprise. But perhaps most importantly, women must be empowered to participate fully in the decision making and political life of their countries. Democracy requires the active

participation of all citizens, including women.

These are the basic building blocks for a healthy and productive life. These are also the building blocks for social and economic progress, and the spread of democracy around the world.

Three years ago, when I addressed the Women's Conference in Beijing, I said that women's rights are human rights, and human rights are women's rights. The right to health care is a fundamental right for all women. Yet that right is violated every time a woman is denied skilled health workers during childbirth; every time a woman is denied the right to plan her own family; and every time she is subjected to violence in her own home. That basic right is violated every time women are denied the education and the economic opportunities they need to ensure they and their children can lead healthy, productive, and engaged lives.

When this level of social injustice remains commonplace around the world, then the potential of the human family to create a peaceful, prosperous, democratic world will not be realized. But if we can apply the force of international human rights treaties and national constitutions to ensure mothers and children are safe healthy, then, and only then, can every woman be treated with dignity and respect, every child be loved and cared for, and every family have a healthy and strong future. And then, and only then, will communities thrive, and nations flourish.

I want to conclude my remarks this morning with a story from my recent trip to Africa. That trip was an extraordinary opportunity for me and my husband to see the flowers of progress and democracy take root in even the smallest village, nurtured by the songs and the power of women.

In Senegal, a group of women I met with in the Malicounda Biambara village have done something remarkable. They have decided that female circumcision -- considered a rite of passage for all girls -- had harmed their daughters bodies and spirits for too long. It was time to end the hemorrhaging, and the infection, and the AIDS, and the childbirth complications caused by this deadly tradition. And that's what they have done.

Using a skit that they showed me, these women educated their religious leaders, their husbands, and their neighbors. And as a result, they have banned the practice of female circumcision in their village, and now in 13 other villages as well. (I should note that in some Senegalese villages, this practice affects about 20% of the girls -- but in some countries like Mali and Eretria -- that figure is as high as 90%).

When I asked one of the women in this small village what had driven her and others to try to end such a long standing cultural practice, she replied simply: "We studied human rights, and particularly the right to health."

Thanks in large part to the work of so many of you here today, this Senegalese women and so many others around the world now understand that they have a fundamental right to a healthy family, and a better life. Let's renew our vow here during World Health Day -- drawing inspiration and strength from our partners around the world -- to work together to guarantee every woman gains that opportunity for herself and her family. For in doing so, we will fulfill the great promise of prosperity and progress for all people, and for all nations.

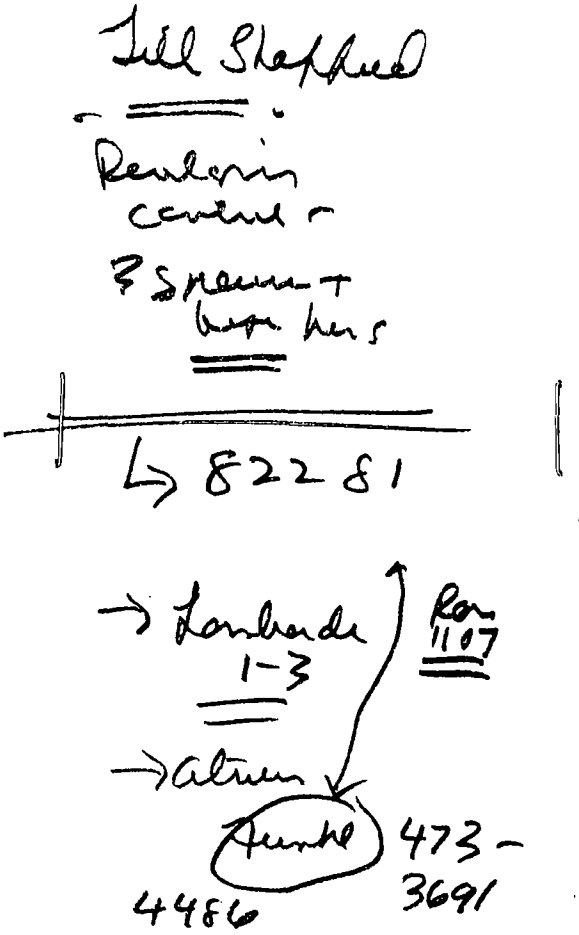
facsimile
TRANSMITTAL

to: Christy Macy
fax #: 202-456-5709
re: Safe Motherhood speech
date: March 25, 1998
pages: 13, including this cover sheet.

As per your phone conversation with Jill Sheffield, attached please find some information on the Safe Motherhood Initiative in general and on World Health Day, specifically. Jill will speak with you again this Friday.

Please call me if you need any additional materials.

Thanks,



From the desk of...

Caryn Levitt
Program Associate
Family Care International
588 Broadway, #503
New York, NY 10012, USA

212-941-5300
Fax: 212-941-5563

10 Themes of Safe Motherhood

1. E**M**power women
2. Kn**O**w that every pregnancy carries risk
3. Reduce **T**eenage pregnancy
4. Guarantee as a **H**uman right
5. Reduce unintended pr**E**gnancy & induced abortion
6. Improve access to quality mate**R**nal health services
7. Utilize t**H**e power of partnerships
8. Measure pr**O**gress
9. Make a social & ec**O**nomic investment
10. Ensure supportive care at **D**elivery

World Health Day 1998 Advisory Committee

American Association for the Advancement of Science
American Association for World Health
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Public Health Association
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Association of Women's Health, Obstetric and Neonatal Nurses
Centers for Disease Control and Prevention (CDC)
City MatCH
Columbia School of Public Health
Congress of National Black Churches
Family Care International
Family Health International
Health Resources and Services Administration
Institute of Medicine
March of Dimes
Maternity Center Association
National Association of Childbearing Centers
National Association of County and City Health Officials
National Association of Local Boards of Health
National Coalition of Hispanic Health and Human Services Organizations
National Council of La Raza
National Institute of Child Health and Human Development
Pan American Health Organization
Population Council
San Diego State University Graduate School of Public Health
Society for Public Health Education
Special Supplemental Nutrition Program for Women, Infants and Children
United Nations Children's Fund
U.S. Agency for International Development
U.S. Conference of Mayors
World Bank
World Health Organization
World Health Organization Collaborating Center in Perinatal Care
Wyeth-Lederle Vaccines and Pediatrics
Yale University School of Medicine

American Association for World Health
1823 K Street, NW, Suite 1208
Washington, DC 20006
202-466-5883 • 202-466-5896 (fax)
AAWHstaff@aol.com
www.aawhworldhealth.org

The American Association for World Health (AAWH) was founded in 1953 as an educational and charitable non-governmental, non-profit membership organization. It serves as a voice of opinion to sustain United States participation in solving international health problems through governmental and voluntary channels. AAWH serves as the U.S. committee to the World Health Organization, based in Geneva, Switzerland, and its western hemisphere affiliate, the Pan American Health Organization, based in Washington, D.C.

World Health Day

Invest in the Future:

Support Safe Motherhood

April 7, 1998

American Association for World Health

World Health Day

What and When is World Health Day?

This international initiative is celebrated every year on **April 7** to promote a forum for information and discussion about health conditions worldwide.

Where is World Health Day?

Everywhere. World Health Day is observed in the World Health Organization's 191 member countries.

Why is World Health Day observed?

The purpose of World Health Day is to encourage people around the world to **think globally and act locally.** It is an opportunity for citizens in both urban and rural communities to learn from our brothers and sisters around the world and gain a better understanding of the challenges we all face. We are not an island. Rather, we are inextricably linked. And it doesn't matter if it's a mother and child in Senegal or a mother and child in Seattle—what we all want is a healthy outcome.

Who can participate?

Everyone.

How can I get more information?

Get your **free resource booklet** by writing or sending electronic mail to the American Association for World Health. You also can view or download the booklet from AAWH's Web site. The booklet will provide you with direction on how to get involved as well as information specific to Safe Motherhood, including reproducible Fact Sheets. It will be available early in 1998.

Invest in the Future: Support Safe Motherhood

The American Association for World Health in conjunction with the World Health Day Advisory Committee has selected the theme "**Invest in the Future: Support Safe Motherhood**" to promote World Health Day 1998 in the United States. In the United States, in nearly two out of every five deliveries, the woman experiences a complication such as high blood pressure, serious lacerations, obstructed labor, hemorrhage, uterine infection, diabetes or Cesarean delivery, and every day two to four women die from pregnancy-related complications.

Maternal Complications during Labor and Delivery in the United States

WHO estimates that about 585,000 women worldwide die per year as a result of complications during pregnancy and childbirth. While in the United States the risk of a woman dying from pregnancy has decreased dramatically over the past 50 years and currently is similar to many other developed countries, experts estimate that many deaths are still preventable. Leading a healthy lifestyle, planning pregnancies, and getting good prenatal, delivery and postnatal care all contribute to healthy outcomes.

Facts to Know...

- Half of all U.S. pregnancies are unintended.
- More than 80% of teen pregnancies are unintended.
- In the United States, two to four women die every day from pregnancy-related complications.
- Sexually transmitted diseases greatly increase the risk for ectopic pregnancies.
- The incidence of ectopic pregnancies has increased dramatically—to more than 100,000 per year.
- An expectant mother with no prenatal care is three times as likely to have a low birthweight baby.
- One third of women in the United States smoke, including 20% of pregnant women.
- About one in five women has serious complications before labor begins.
- U.S. infant mortality rates exceed those of most other industrialized nations.

Maternal and infant morbidity and mortality rates differ sociodemographically, ethnically and regionally. For example:

- African American women are four times as likely to die from pregnancy-related causes as Caucasian women, and mortality rates of African American babies are twice those of Caucasian babies.
- Lack of prenatal care poses a major challenge for the Hispanic—about 30% of pregnant Hispanic women do not receive early prenatal care.

[redacted] Release

PRB

Population Reference Bureau

1875 Connecticut Ave., NW, Suite 520
Washington, DC 20009-5728
Phone: (202) 483-1100
Fax: (202) 328-3937
popref@prb.org
http://www.prb.org/prb/

For Release:
Thursday, March 5, 1998
Contact:
Alene H. Gelbard, 202/483-1100
Lina Parikh, 202/483-1100

The World's Women: Making Gains but Still Widely Disadvantaged

To commemorate International Women's Day (March 8), the Population Reference Bureau (PRB) has just released *1998 Women of Our World*, a wall chart detailing the latest available data on the quality of women's lives in 150 countries.

PRB's *1998 Women of Our World* highlights important gains women have made in recent years: life expectancy has increased 19 years since the 1950s; women's participation in the labor force is up 21 percent since the 1960s; literacy rates have improved 10 percent since the 1970s; and girls' enrollment in secondary school has risen 18 percent since the 1980s.

Despite these gains, data for 150 countries from PRB's new wall chart show that women today still experience major disadvantages in health, education, work, and politics.

Challenges to Health

- **Nearly 600,000 women die every year from causes related to pregnancy, childbirth, and abortion.** The ratio of maternal deaths to live births varies enormously throughout the world—from fewer than 10 maternal deaths per 100,000 live births in many European countries and in North America, to more than 1,400 deaths per 100,000 live births in several countries in sub-Saharan Africa. The majority of maternal deaths (95 percent) occur in Africa and Asia (see figure 4 on wall chart).

- **More than 30 percent of births worldwide are not attended by skilled personnel,** increasing the risk that mothers and their babies may die during childbirth. Tremendous regional variation exists in the percentage of births attended by skilled personnel, from only 33 percent in Eastern Africa to 99 percent in the more developed world (Australia, Japan, New Zealand, Europe, and North America).

- **Worldwide, 56 percent of married women practice family planning.** The percentage of married women practicing family planning varies greatly by region, from 13 percent of married women in Western Africa to 81 percent of married women in East Asia.

Demographic Differences

- **The average number of children that women bear varies significantly around the world,** from less than two children per woman in Europe and North America to more than six children per woman in Western, Middle, and Eastern Africa. Data also show that in regions where family planning use is higher, women tend to have fewer children (see figure 3 on wall chart).

Educational Gaps

- **Worldwide, fewer women are literate than men** (64 percent of women compared with 80 percent of men). The literacy gaps are greatest in less developed regions, such as Western Africa and South-Central Asia, where overall literacy levels are low (see figure 1 on wall chart).

(over)

- **Worldwide, girls are less likely to be in secondary school than boys** (90 girls for every 100 boys enrolled). These figures mask significant regional differences. In Southern Africa, and in Latin America and the Caribbean, more girls than boys are enrolled in secondary school: 119 and 114 girls, respectively, for every 100 boys. In Middle Africa, however, only 61 girls are enrolled in secondary school for every 100 boys.

Work Disparities

- **Women are less likely to work in the formal labor force than men** (54 percent compared with 82 percent of men). The percentage of adult women in the formal labor force varies widely, from 32 percent of all adult women in Northern Africa to 71 percent in East Asia and Eastern Africa.

Political Hurdles

- **Worldwide, women make up a disproportionately small percentage of political decision-makers** (12 percent of national parliaments and 7 percent of ministerial and subministerial-level positions). Regional estimates show a striking contrast in women's participation in the political process. Women make up 19 percent of national parliaments in Northern Europe, Western Europe, and Southern Africa, but they make up only 3 percent of national parliaments in Northern Africa. These regional disparities are even greater at the ministerial level, where women hold 32 percent of ministerial and sub-ministerial positions in North America but less than 5 percent of these positions in Northern and Middle Africa, Western Asia, and Eastern Europe.

In addition, PRB's *1998 Women of Our World* discusses several issues that also have important implications for policy-makers, including:

- **Economic Inequities:** Data show that **women in nonagricultural jobs are paid less than men.** Women's wages as a percent of men's wages range from 60 percent in South Korea to 91 percent in the Philippines. Only in Australia do women make about the same as men (see figure 2 on wall chart).

- **AIDS:** In 1997, almost 6,000 women around the world became infected with HIV every day. Globally, **women account for 41 percent of adults who are living with HIV/AIDS** (see table 1 on wall chart). The proportion of HIV-infected adults who are women varies by region. In sub-Saharan Africa, where 19.8 million adults are infected with HIV (over two-thirds of the world total), women account for one-half of all adults infected with HIV. In most other regions, women account for one-fifth to one-third of HIV-infected adults. Since the beginning of the AIDS epidemic, 11.7 million people have died of AIDS, 4 million of whom were women.

- **Domestic Violence:** Women in **both less developed and more developed countries** are reporting this often hidden violence in **significant numbers** (see table 2 on wall chart).

International Women's Day...

On March 8, 1857, women in New York City's garment and textile industries protested against low wages, long hours, and inhumane working conditions. In 1909, the United States began observing National Women's Day, and in 1910 the Women's Socialist International designated an International Women's Day to mark the garment workers' strike. In 1975, to commemorate the struggle for women's equality, the United Nations began observing March 8 as International Women's Day.

Copies of *1998 Women of Our World* may be purchased for $5 (price includes postage) from PRB by calling 1-800-877-9881; email: popref@prb.org. (Will be available in French and Spanish also.) **Journalists may receive a free copy upon request.**

The Population Reference Bureau is the leader in providing timely and objective information on U.S. and international population trends and their implications. For more information on membership and publications, please contact PRB.

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

Safe Motherhood

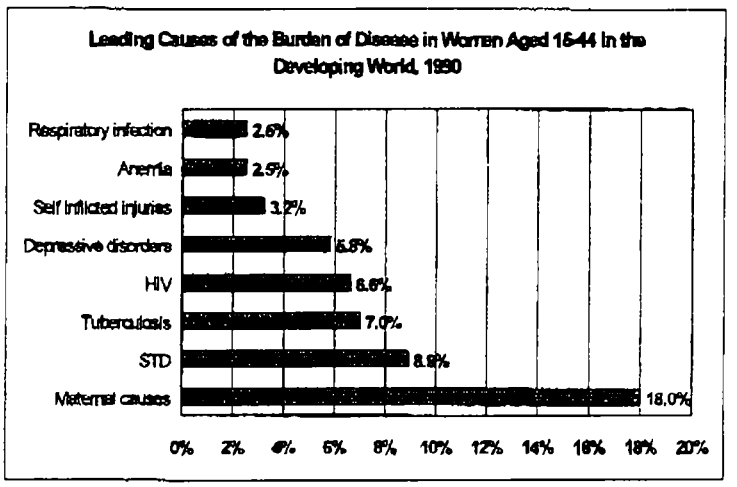
"Year of Safe Motherhood"

FACTS AT A GLANCE

- Every minute of every day, somewhere in the world, a woman dies from complications related to pregnancy or childbirth (defined as a maternal death).

- Approximately 50 million women a year (equivalent to the total population of the countries of Spain and Portugal) suffer maternal health complications.

- In developing countries, pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age:



Source: *World Development Report 1993: Investing in Health.* World Bank, Washington, DC, 1993

- 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.

- A woman's risk of dying from pregnancy and childbirth varies widely by region:

Region	Risk of Dying
Africa	1 in 16
Asia	1 in 65
Latin American & Caribbean	1 in 130
Northern Europe	1 in 4,000
North America	1 in 3,700
All developing countries	1 in 48
All developed countries	1 in 1,800

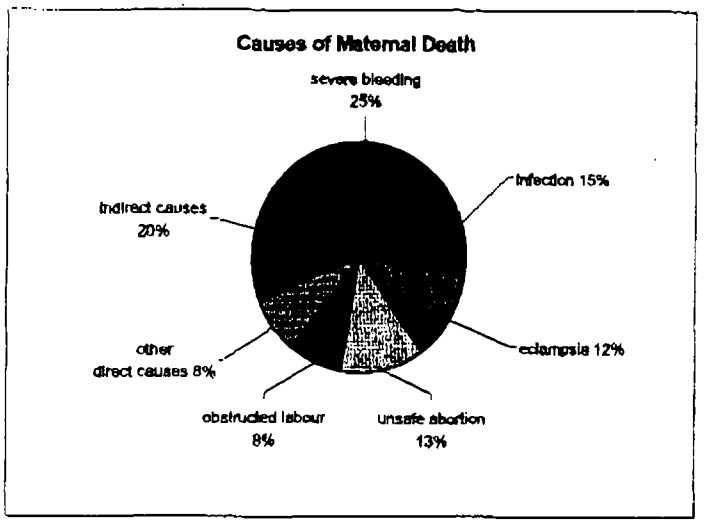
- Country-level differences are even more dramatic: for example, in Ethiopia, 1 out of every 9 women die from pregnancy-related complications, as compared to 1 in 8,700 in Switzerland.

Inter-Agency Group for Safe Motherhood
UNFPA
UNICEF
WHO
WORLD BANK
IPPF
POPULATION COUNCIL

Chairing Agency:
IPPF
Regent's College, Regent's Park
London NW1 4NS, UK
Telephone: 44 171 487 7864
Fax: 44 171 487 7865
email: psenanayake@ippf.org

Secretariat:
Family Care International
588 Broadway, Suite 503
New York, NY 10012 USA
Telephone: 212 941 5300
Fax: 212 941 5563
email: smi10@familycareintl.org

- There are five main causes of maternal death worldwide:



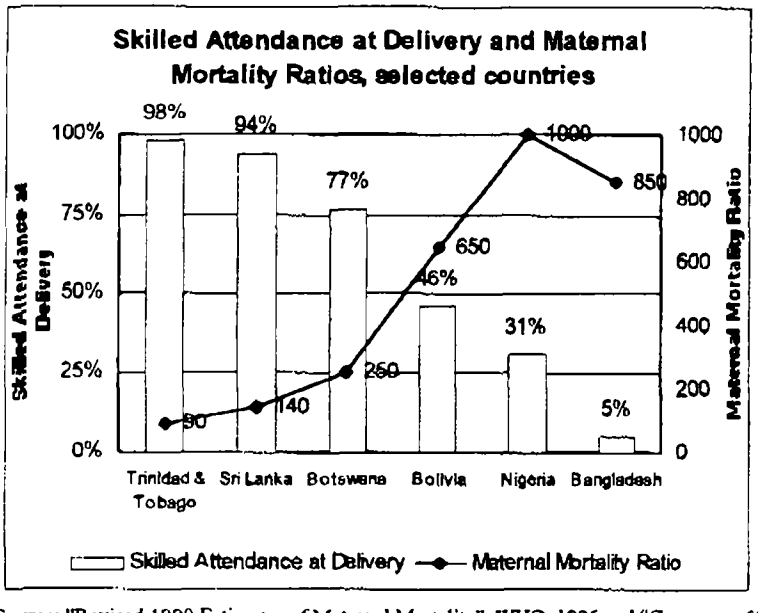
Source: *Maternal Health Around the World*, WHO, 1997

- 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.

Deliveries by Relatives or Alone, Selected Countries

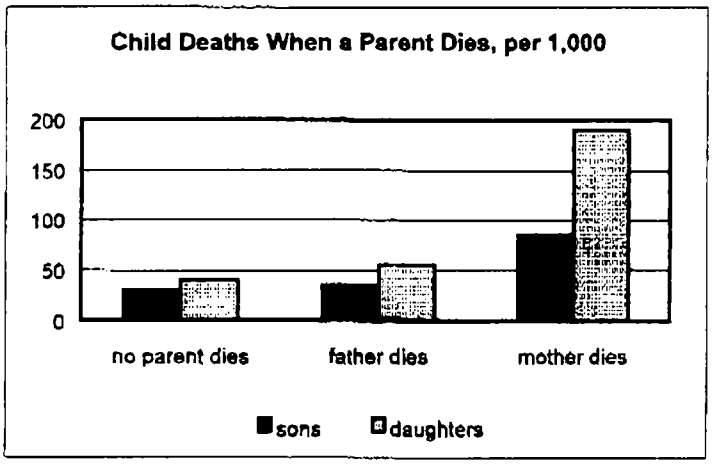
	Delivery by relative/other (%)	*Delivery alone (%)*
Malawi	**41**	**7**
Uganda	**35**	**12**
Niger	**24**	**17**
Nepal	**66**	**11**
Pakistan	**52**	**2**

Source: Demographic and Health Surveys, selected countries, various years.



- Countries where skilled attendance at delivery is low tend to have higher rates of maternal death and disability. In 1996, skilled birth attendants were present at only 53% of births in the developing world. In developed countries, skilled attendance is nearly universal.

Source: "Revised 1990 Estimates of Maternal Mortality", WHO, 1996 and "Coverage of Maternal Care", WHO, 1997.



- Motherless children are likely to get less health care and education as they grow up. A study in Bangladesh found that when a mother dies, her children – especially daughters – are much more likely to die than children whose parents are both alive.

Source: *Mother Baby Package: Implementing Safe Motherhood in countries*, WHO, 1994

- Most maternal deaths, millions of cases of disease and disability, and the deaths of at least 1.5 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 health care services would cost approximately $3 per person per year in most developing countries.

###

05

The "Year of Safe Motherhood"

Safe Motherhood is a global effort to increase maternal safety and reduce the number of deaths and illnesses associated with pregnancy and childbirth

Women need not die while giving life to future generations.

Every minute of every day, somewhere in the world and most often in a developing nation, a woman dies from complications related to pregnancy or childbirth. Her death is more than a personal tragedy, although that alone would merit our most serious concern. In addition, her death represents an enormous cost to her nation, her community and her family. Any social and economic investment that has been made in her life is lost. Her family loses her love, her nurturing and her productivity inside and outside the home. Half of all infant deaths can be attributed to poor maternal health. Moreover, the child that survives a mother's death is up to ten times more likely to die within two years than a child with two living parents.

The greatest tragedy is that these approximately 600,000 maternal deaths and over 50 million cases of morbidity that occur each year are largely preventable. A decade of research has proven that surprisingly small and affordable measures can significantly reduce the health risks that women face when they become pregnant.

In 1987 a coalition of the world's leaders in maternal and child health, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Bank, the International Planned Parenthood Federation (IPPF) and the Population Council, joined forces and developed an Inter-Agency Task Force on Safe Motherhood to assess this problem and recommend solutions.

Now it is time to act upon what has been learned over the past ten years of research and model projects, before one more woman loses her life needlessly.

To achieve this goal, World Health Day, 7 April 1998 will kick-off a year-long series of activities to promote Safe Motherhood.

On that day a call to action will be issued to governments, business leaders, policy makers, and citizens of every country of the world. The call to action consists of four simple messages:

1. International aid agencies are urged to provide overseas assistance to programs that promote maternal care as an essential component of reproductive health services.

2. Governments of developing countries are urged to reduce maternal mortality and morbidity by developing and implementing health, nutrition and education programs that promote the health of pregnant women and their infants.

3. Corporations around the world are urged to encourage governments and private organizations in the countries where they do business to provide funds and develop programs that foster safe motherhood, and to support safe motherhood among their employees and customers.

4. Women, men and families everywhere are urged to demand and seek quality prenatal and obstetric care to ensure that no woman dies or suffers long-term complications from childbirth.

Safe Motherhood

Helping to make women's health

and rights a reality

What is the greatest threat to a woman's life and health in developing countries?

Pregnancy and childbirth.

Every minute:

380 women become pregnant

190 women face an unplanned or unwanted pregnancy

110 women experience a pregnancy-related complication

40 women have an unsafe abortion

1 woman dies

Why "Safe Motherhood"?

Governments and health advocates agree: sexual and reproductive health is essential for national development and personal well-being. And Safe Motherhood is a key component of efforts to improve women's reproductive health and rights. Pregnancy and childbirth are the leading causes of disability and death among women between the ages of 15 and 49, making Safe Motherhood programs essential for women's health and survival. More broadly, commitment to Safe Motherhood can galvanize action on a range of health problems that affect women and their families, including reproductive tract infections, infertility, HIV/AIDS and other sexually transmitted diseases. It can also encourage attention to social issues, like lack of education, discrimination and violence against women, which can lead to, or worsen, women's poor reproductive health.

Death from pregnancy or childbirth is a social injustice that can and must be addressed through political, legal and health systems in every country. More than 99 percent of these deaths now take place in the developing world. Safe motherhood interventions, which are designed to reduce maternal death and disability, are highly cost-effective: basic maternal and newborn care costs an average of US$3 per person in developing countries. The total cost of saving the lives of a mother or infant through antenatal, delivery and postnatal care is only $230, while the benefit to countries, communities and families cannot be measured. Over one-half of all infant deaths could be prevented through these interventions.

The Safe Motherhood Initiative

The global Safe Motherhood Initiative was launched in 1987 to improve maternal health and cut the number of maternal deaths in half by the year 2000. It is led by a unique alliance of co-sponsoring agencies who work together to raise awareness, set priorities, stimulate research, mobilize resources, provide technical assistance and share information. Their cooperation and commitment have helped governments and non-governmental partners from more than 100 countries take action to make motherhood safer. During the Initiative's first decade, these safe motherhood partners developed model programs, tested new technologies and conducted research in a wide range of countries and settings. The essential services they have identified, and the most important lessons they have learned, are summarized here.

Essential Safe Motherhood Services

Safe motherhood services should be readily available through a network of linked community health care providers, clinics and hospitals. The integrated services that policy-makers from around the world have pledged to provide include:

- Community education on safe motherhood;
- Prenatal care and counseling, including the promotion of maternal nutrition;
- Skilled assistance during childbirth;
- Care for obstetric complications, including emergencies;
- Postpartum care;
- Management of abortion complications, postabortion care and, where abortion is not against the law, safe services for the termination of pregnancy*;
- Family planning counseling, information and services;
- Reproductive health education and services for adolescents.

Lessons Learned

Empower women, ensure their choices: Gender inequalities and discrimination limit women's choices and contribute directly to their ill-health and death. Legal reform and community mobilization can help women safeguard their reproductive health by enabling them to understand and articulate their health needs, and to seek services with confidence and without delay.

Every pregnancy faces risks: Every pregnant woman – even if she is well-nourished and well-educated – can develop sudden, life-threatening complications that require high quality obstetric care. Attempts to predict these problems before they occur have not been successful, since most complications are unexpected and the majority of women with poor pregnancy outcomes do not fall into any high-risk categories. Therefore, maternal health programs must aim to ensure that all women have access to essential services.

---

*Each of the co-sponsors of the Safe Motherhood Initiative (see back panel) implements these activities according to its institutional mandate.

Ensure skilled attendance during childbirth: The single most effective way to reduce maternal death is to ensure that a health professional with the skills to conduct a safe, normal delivery and manage complications is present during childbirth. Unfortunately, there is a chronic shortage of these professionals in poor and rural communities in the developing world. Research has shown that even trained traditional birth attendants (TBAs) have not significantly reduced a woman's risk of dying in childbirth, largely because they are unable to treat pregnancy complications. As an interim strategy for settings where TBAs attend a significant proportion of deliveries, program planners may want to provide TBAs with adequate training and support to help them refer complicated cases effectively. In all settings, however, skilled attendance at delivery should continue to be the long-term goal.

Improve access to high quality maternal health services: A large number of women in developing countries do not have access to maternal health services. Many of them cannot get to, or afford, high-quality care. Cultural customs and beliefs can also prevent women from understanding the importance of health services, and from seeking them. In addition to legal reform and efforts to build support within communities, health systems must work to address a range of clinical, interpersonal and logistical problems that affect the quality, sensitivity and accessibility of the services they provide.

Address unwanted pregnancy and unsafe abortion: Unsafe abortion is the most neglected – and most easily preventable – cause of maternal death. These deaths can be significantly reduced by ensuring that safe motherhood programs include client-centered family planning services to prevent unwanted pregnancy, contraceptive counseling for women who have had an induced abortion, the use of appropriate technologies for women who experience abortion complications, and, where not against the law, safe services for pregnancy termination*.

*Each of the co-sponsors of the Safe Motherhood Initiative (see back panel) implements these activities according to its institutional mandate.

Measure progress: Governments around the world have pledged to reduce maternal mortality by 50% by the year 2000. However, maternal mortality is difficult to measure, due to problems with identification, classification and reporting. Therefore, safe motherhood partners have developed alternative means for measuring the impact and effectiveness of programs; for example, by recording the proportion of births attended by a skilled health provider. These indicators can identify weaknesses and suggest programmatic priorities so that maternal deaths can be better prevented in the future.

A Call to Action

Safe motherhood partnerships have been responsible for important international and country-level progress over the last ten years. Collaboration has enabled individual organizations to share their diverse strengths, and to achieve more than they could have alone. During this same decade, however, six million women have died needlessly in pregnancy or childbirth. Your support – and your partnership – can help safe motherhood partners around the world apply the lessons they have learned to save the lives of millions of women before the year 2000. Each minute, each day, in every country.

Please join us.

Printed on recycled paper

With the compliments of

INTERNATIONAL
Programs

Population Reference Bureau, Inc.
1875 Connecticut Ave., N.W., Suite 520
Washington, D.C. 20009-5728
U.S.A.
Phone: (202) 483-1100
Fax: (202) 328-3937

MEASURE *Communication*

Rhonda Smith, MPH
Senior Policy Analyst
Communication Specialist

Population Reference Bureau
1875 Connecticut Ave., NW ▪ Suite 520
Washington, DC 20009-5728 ▪ USA
(202) 483-1100 ▪ Fax (202) 328-3937
E-mail: rhondas@prb.org

MEASURE *Communication*

Rhonda Smith, MPH
Analyste de politiques
Spécialiste en communication

Population Reference Bureau
1875 Connecticut Ave., NW ▪ Suite 520
Washington, DC 20009 ▪ Etats-Unis
(202) 483-1100 ▪ Fax (202) 328-3937
C. élec. : rhondas@prb.org

MEASURE *Communication*

Rhonda Smith, MPH
Senior Policy Analyst
Communication Specialist

Population Reference Bureau
1875 Connecticut Ave., NW ▪ Suite 520
Washington, DC 20009-5728 ▪ USA
(202) 483-1100 ▪ Fax (202) 328-3937
E-mail: rhondas@prb.org

MEASURE *Communication*

Rhonda Smith, MPH
Analyste de politiques
Spécialiste en communication

Population Reference Bureau
1875 Connecticut Ave., NW ▪ Suite 520
Washington, DC 20009 ▪ Etats-Unis
(202) 483-1100 ▪ Fax (202) 328-3937
C. élec. : rhondas@prb.org

On behalf of the Inter-Agency Group for Safe Motherhood
James D. Wolfensohn, President of the World Bank
cordially invites you to attend a special event in honor of World Health Day

SAFE MOTHERHOOD: PROGRESS AND CHALLENGES

on Tuesday, April 7, 1998
from nine thirty in the morning to one o'clock in the afternoon
at the Lewis Preston Auditorium
The World Bank, 1818 H Street, N.W. Washington, DC

RSVP BY MARCH 20, 1998
MAMTA KAUSHAL, THE WORLD BANK
TEL: 202 458-8344; FAX: 202 522-2653

DUE TO SECURITY REQUIREMENTS,
PARTICIPANTS MUST BE
SEATED BY 9:00AM

OR

ANNE TINKER - Director of Safe Motherhood Initiative
[World Bank: (202) 473-3683]

Safe Motherhood: Progress and Challenges

a symposium with:

His Excellency Yoweri Museveni, President of Uganda (invited)

First Lady Hillary Rodham Clinton, United States of America

The Honorable Kofi Annan, Secretary General of the United Nations, (invited)

James D. Wolfensohn, President of the World Bank

and

Mahmoud Fathalla, Senior Advisor, The Rockefeller Foundation

Nafis Sadik, Executive Director, UNFPA

Carol Bellamy, Executive Director, UNICEF

Sir George Alleyne, Regional Director, PAHO

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

Ingar Brueggemann, Secretary General, IPPF

Margaret Catley-Carlson, President, The Population Council

Richard Feachem, Director of Health, Nutrition & Population, The World Bank

Tuesday, April 7, 1998
9:00 a.m.–1:00 p.m.
Lewis Preston Auditorium
The World Bank, 1818 H Street, N.W. Washington, D.C.

- **Family planning is a low-cost way to save lives:** Family planning costs, on average, less than US$2 per capita per year.
- **Governments support family planning:** Governments worldwide are committed to improving the health and survival of women and children through family planning. Approximately three-quarters of the costs of family planning are currently paid for by developing countries.
- **Demand for family planning will continue to increase:** The United Nations estimates that annual expenditures for family planning will have to double by the year 2000, from US$4.8 billion in 1994 to US$10 billion, to meet projected demands. Developing countries will need to increase their expenditures to US$6.7 billion and donors will need to contribute US$3.3 billion to cover these expected costs in the year 2000.

▶ ***More information about the health benefits of family planning can be found in the booklet,* Family Planning Saves Lives *(January 1997), available from the Population Reference Bureau.***

Population Reference Bureau
1875 Connecticut Avenue, NW,
Suite 520
Washington
DC 20009 U.S.A.

Phone:
(202) 483-1100

Fax:
(202) 328-3937

E-mail:
popref@prb.org

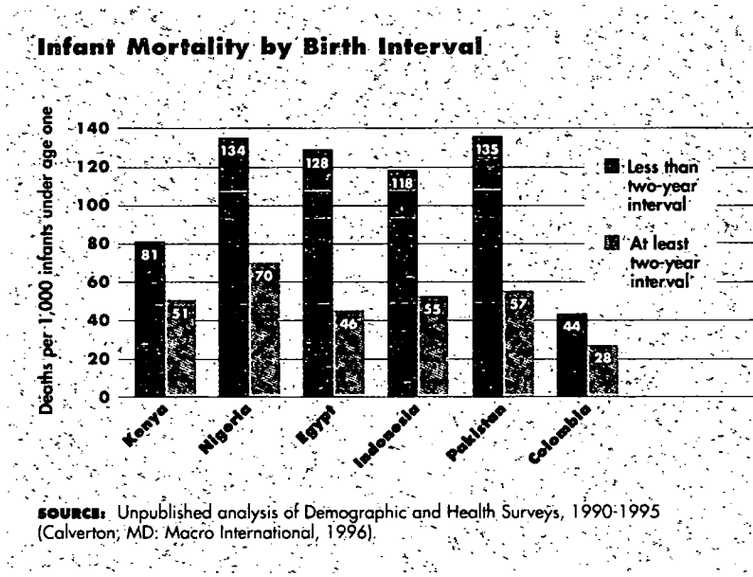
Home Page:
http://www.prb.org

September 1997

How Does Family Planning Save Lives?

Fact Sheet

Every year more than 585,000 women die from complications of pregnancy and childbirth, and at least 11 million children under age five die in developing countries. Family planning can prevent many of these deaths by helping couples avoid childbearing during times of high health risk for mothers and children.



SOURCE: Unpublished analysis of Demographic and Health Surveys, 1990-1995 (Calverton, MD: Macro International, 1996).

Saving Children's Lives

- **Closely spaced births result in higher infant and child mortality:** Babies born less than two years after their next oldest brother or sister are twice as likely to die in the first year as those born after an interval of at least two years.
- **Spacing births can prevent an average of one in four infant deaths:** By spacing births at least two years apart, family planning can prevent an average of one in four infant deaths in developing countries.
- **Children born to young mothers are more likely to die:** Children born to women younger than age 20 are one and one-half times more likely to die before their first birthday as those born to mothers ages 20 to 29.

Saving Women's Lives

- **At least one woman dies every minute from causes related to pregnancy and childbirth:** In developing countries, a woman's lifetime risk of dying from pregnancy and childbirth-related causes is 38 times higher than the risk for a woman in more developed regions.

Women's Risk of Death from Pregnancy and Childbirth

Region	Lifetime risk of death
World	1 in 60
More Developed	1 in 1,800
Developing	1 in 48
Africa	1 in 16
Asia	1 in 65
Europe	1 in 1,400
Latin America/Caribbean	1 in 130
North America	1 in 3,700
Oceania	1 in 26

SOURCE: WHO and UNICEF, *Revised 1990 Estimates of Maternal Mortality, A New Approach by WHO and UNICEF* (Geneva: World Health Organization, April 1996):3, 6.

- **Family planning can prevent at least 25 percent of all maternal deaths:** Family planning can save women's lives by allowing women to delay motherhood; prevent unintended pregnancies and unsafe abortions; protect themselves from sexually transmitted diseases, including HIV/AIDS; and stop childbearing when they have reached their desired family size.
- **Young women and those with pre-existing health problems face higher risks:** Women ages 15-19 are twice as likely to die from causes related to pregnancy and childbirth as women in their 20s. Women who are physically and nutritionally drained, and those suffering from pre-existing illnesses, are also at higher risk of illness and death.
- **Family planning prevents abortions:** An estimated 20 million unsafe abortions take place each year in places where access to safe abortion is limited. Unsafe abortions result in at least 76,000 deaths every year, mostly in developing countries. Family planning can prevent many of these tragic deaths by reducing the number of unintended pregnancies that result in abortions.
- **Family planning is safe and effective:** The risk of dying from use of modern methods of family planning is far less than the risk of death associated with pregnancy and childbirth.

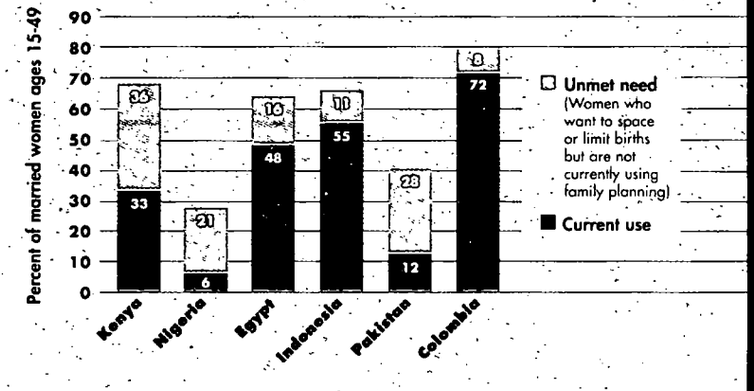
A Cost-Effective Way to Save Lives

More than half of all couples in the developing world are using family planning to achieve their desired family size, and the demand for family planning continues to grow.

- **There is a large unmet need for family planning:** Surveys find that an estimated 150 million women in developing countries are in need of family planning. Meeting just the existing demand for family planning could reduce the number of maternal deaths and injuries by as much as 20 percent.

Demand for Family Planning

(Demand = Current Use + Unmet Need)



SOURCE: Demographic and Health Surveys, 1990-1995 (Calverton, MD: Macro International).

Save the Children.
54 Wilton Rd. Westport CT 06881

FAX FAX

Date: 4/1/98

To: Christie Macy
Fax: 202-456-5709
Phone: 202-456-6266

From: Marianne LeVert
Public Affairs and Communications
Phone: 203-221-4116
Fax: 203-226-6709

Number of pages, including this transmittal sheet: 4

Memo:

Press about The First Lady's trip to Nepal (April 1995).
White House press release: Clean Delivery Kits.
Announcement of First Lady's receipt of Save the Children's Distinguished Service Award at White House ceremony (for background).

Should you need additional information, please do not hesitate to call me at 203-221-4116.

Resend

White House Press Release

NH

THE SAFE HOME DELIVERY KIT

Over 700,000 babies are born in Nepal each year. 650,000 are delivered at home under primitive conditions with most births not assisted by trained attendants. More than 75,000 die within the first year of life, frequently due to tetanus and sepsis caused by unhygienic delivery practices. As a result, Nepal's maternal and infant death rates are among the highest in the world.

The Clean Home Delivery Kit was designed to prevent such deaths. It is the product of two years' research conducted by the Save the Children Alliance/Nepal with support from His Majesty's Government Institute of Medicine and Ministry of Health, funding assistance from UNFPA and UNICEF, and technical assistance from USAID and PATH/US. In 1994, a private company, Maternal and Child Health Products Pvt. Ltd. (MCHP) of Kathmandu, was established with start-up funding and technical assistance from USAID/Nepal through Save the Children/US. This ground-breaking micro-enterprise is owned and operated by Ms. Rukumani Charan-Shrestha (Managing Director), Ms. Sumitra Bantawa, and Ms. Renuka Munakarmi, who each have more than fifteen years' experience in reproductive health care and women's issues, and Ms. Nigma Tamrakar, an experienced businesswoman.

The simple, affordable and easy-to-use kit was designed specifically with the traditional birthing practices particular to Nepal in mind, which included placing the umbilical cord of the newborn on a coin or betel nut while being cut. Rather than trying to change traditions, the kit contains a small, clean, coin-like substitute as well as soap, a new razor blade, clean umbilical-cord ties, and a plastic sheet to provide a hygienic birthing surface. The kit's use will significantly reduce two major causes of maternal and neonatal death, tetanus and sepsis, by emphasizing the "three cleans" principle promoted by the World Health Organization: clean hands, clean surface, clean umbilical-cord care.
Due to the high illiteracy rate among the population all instructions consist of clear, unmistakable illustrations.

Since August 1994, Maternal and Child Health Products Pvt. Ltd. (MCHP) has produced and sold over 100,000 Safe Home Delivery Kits in Nepal, primarily through government and voluntary agencies, and commercial outlets. The First Lady's visit to Kalimati Clinic represents the official launching of the kit which will be sold in drugstores, general stores, and through medical practitioners and community health workers for about Rs. 20 (40 cents). Median income in Nepal is USD 210 per year.

I can update these stats if you need them

The Safe Home Delivery Kit is valuable proof that governments, donor and voluntary agencies, and the private sector can work together constructively to develop innovative health-care products that benefit a large segment of the population and have a high potential for becoming self-sustaining within a short period of time.

WHITE HOUSE PRESS RELEASE

Clinton visits the USAID-assisted International Center for Diarrheal Disease Control in Bangladesh, where oral rehydration therapy was developed.

visit to our program in Nepal April 1995 (so three years ago this month, . . .)

While in Kathmandu, Nepal, Clinton toured a small health and family planning clinic financed by a partnership of USAID, Save the Children Foundation and the government of Nepal. Here the first lady was given a "Safe Home Delivery Kit" for expectant mothers. The primitive kit, consisting of soap, twine, wax, a plastic sheet and razor blade, denotes the extent to which development still remains a challenge to Nepal, one of the poorest countries in the world.

"One lesson the experience of the last several decades teaches us is that where women prosper, countries prosper."

In Bangladesh, Clinton visited the USAID-assisted International Center for Diarrheal Disease Control, which has been key in helping save people suffering from cholera, malnutrition and diarrhea. It was at this center that oral rehydration therapy was initiated and then launched worldwide.

Clinton's last stop was Sri Lanka, the most socially progressive of the countries visited. Here USAID is committed to activities encouraging broad-based economic growth, protecting the environment and building democracy.

"If my visit to other countries in the region highlighted the development challenges and opportunities facing the region, my visit to Sri Lanka underlined the fact that those challenges can be met and just how important health, education and the inclusion of women can be in achieving economic progress anywhere in the world," Clinton noted.

In an article the first lady wrote that ran in The Washington Post on May 14, she praised USAID activities in South Asia: "These projects are proof that American aid — both financial and technical — has provided the tools of opportunity to people and nations who have shown a courageous commitment to democracy and a market economy. Today, that American aid remains critical. Having watched in the last 10 years as democracy has flourished and markets have opened around the globe, we cannot turn our backs on nations struggling to uphold our ideals." ■

VMS
VIDEO MONITORING SERVICES OF AMERICA, INC.
10260 Westheimer
Houston, TX 77042
(713) 780 1635
(713) 780-0980

New York (212) 736-2010
Detroit (810) 352-9220
Denver (303) 861-7162
Los Angeles (213) 993-0111
Boston (617) 266-2121
Hartford (203) 953-1809
Chicago (312) 649-1131
Dallas (214) 644-9696
San Diego (619) 544-1860
Philadelphia (215) 569-4990
Washington (202) 393-7110
San Francisco (415) 543-3361
Miami (305) 576-3581

A BURRELLE'S Affiliate

Transcript

DATE September 18, 1995
TIME 7:00-7:30 PM (CT)
NETWORK CNN
PROGRAM Headline News

Lynne Russell, anchor:

First Lady Hillary Clinton received a Distinguished Service Award from Save the Children at the White House today. The international relief organization commended her efforts to give the less fortunate--especially women and children--a chance, a voice, and a future. She plans to publish a book on children's issues this fall.

# # #

FYI: Save the Children awarded the First Lady the Distinguished Service Award five months after trip to Nepal.

Save the Children.

To: Christie Macy
Office of the First Lady
Fr: Marianne LeVert
Save the Children
Re: Clean Birthing Kit

April 2, 1998

Enclosed please find a sample Clean Birthing Kit and an updated fact sheet about the kit and its use.

The contents of the kit include:

- a fold-out pictorial guide to the birthing process using Nepalese script and women in traditional clothes
- a clean plastic sheet for a sanitary surface for the mother
- a bar of soap with which the birthing attendant should wash her hands
- a clean razor blade to cut the umbilical cord
- a clean plastic disk on which to cut the cord
- a clean string to tie off the cord

Marianne LeVert

Clean Birthing Kit

Contents:

- a pictorial guide to the birthing process using Nepalese script and women in traditional clothes
- a clean plastic sheet for a sanitary surface for the mother during birth
- a bar of soap with which the birthing attendant should wash her hands
- a clean razor blade to cut the umbilical cord
- a clean plastic disk on which to cut the cord
- a clean string to tie off the cord

UPDATED KIT IN 70

Clean Birthing Kit

Nepal is one of the most mountainous and geographically diverse countries in the developing world. Remote villages are perched on the highest mountain ranges, communities are often isolated by the four month monsoon, and there are great distances between poorly equipped government health posts. All of this makes the delivery of health care difficult under the best of circumstances.

In Nepal, over 700,000 babies are born each year. More than 75,000 Nepali children will die within the first year of life, and approximately 539 mothers will die due to pregnancy or delivery each year per 100,000 live births*. Some of these deaths can be attributed to tetanus and other infections arising from delivery under unhygienic conditions. The vast majority of deliveries still take place at home, usually under unsanitary conditions. Births often take place on a floor that has been coated with a mud-dung preparation. Birth attendants are frequently relatives or neighbors who have little experience and no training in clean birth practices. Often, these untrained birth attendants do not wash their hands before assisting with birth, and do not take other hygienic precautions before caring for the cord. For example, the cord is usually cut with a dirty sickle, knife or blade against the surface of an unclean coin or locally available nut (betal nut). In addition, septic substances, typically mustard oil and/or prepared powders, are often applied to the cord.

The World Health Organization (WHO) has firmly supported the principle of the three cleans at delivery: clean hands, clean surface, and clean cord-cutting implement, in conjunction with their Expanded Program on Immunization goal to eliminate neonatal tetanus. Based on the importance of the "3 cleans," and our desire to improve birthing practices in Nepal, Save the Children US, with its Alliance partners Redd Barna of Norway and Save/UK, initiated a research project in 1993, with support from UNICEF, UNFPA, and USAID, to examine the acceptability of the Clean Birthing Kit. In 1994, the Clean Birthing Kit, or in the local Nepali Language, "Sutkeri Samagri" ("Delivery Items"), went in to production. A unique, woman-owned, Nepali-based microenterprise, Maternal and Child Health Products Pvt, Ltd (MCHP), has been marketing and selling the product ever since. To date, over 100,000 kits have been sold, for approximately 27 cents a piece.

The contents of the kit, a small cardboard box only about 3.5 inches long by 2 inches wide, include fold-out pictorial instructions (using Nepali script and pictures of women dressed in traditional clothes) of the actual birthing process; a clean plastic sheet to provide a sanitary surface during birth; a bar of soap with which the birthing helper washes her hands; a clean razor blade to cut the cord; a clean plastic disk on which to cut the umbilical cord; and a clean string to tie off the umbilical cord.

The Clean Birthing Kit, a simple, cost-effective product, has broadened awareness of the importance of "a clean start" throughout many villages of Nepal.

**Nepal Family Health Survey*, 1996, Ministry of Healthfile: C/Kim/Birthkit

Regarding the finding of epidemiologic studies of workers exposed to health and safety hazards:

"Statistics are people with the tears wiped off."

Irving Selikoff, the pioneer who first linked asbestos exposure to the premature deaths of New Jersey insulation workers

Insult, Injury, Asylum: Genital Mutilation Was Only the Beginning

DO THEY HEAR YOU WHEN YOU CRY

By Fauziya Kassindja and Layli Miller Bashir
Delacorte. 518 pp. $24.95

Reviewed BY LORI ROBINSON
a contributing editor of Emerge magazine who is working on a book about sexual assault

Around the world, rituals marking girls' passage into adulthood—Jewish bat mitzvahs, Latin American *quinceaneras*—are joyous occasions. Then there is amputation without anesthesia. What a way to grow up overnight.

An estimated 100 million girls and women have had their genitals sliced or scraped off in a procedure known as female circumcision, cutting or genital mutilation. A tradition practiced in more than 25 African countries and a few Western and Southern Asian countries, it can cause a host of health problems and even death. To be protected from it by family in a culture in which women and men fiercely champion it would be good fortune. But what if to escape cutting meant fleeing into the unknown?

Fauziya Kassindja lived that scenario, landing in the United States at age 17. Her special welcome to this country, compliments of the Immigration and Naturalization Service, amounted to more than a year of imprisonment and consistent human rights abuses. In "Do They Hear You When You Cry," Kassindja, along with one of her lawyers, Layli Miller Bashir, recounts her arduous journey from Togo to detention as an illegal alien, and ultimately to freedom.

Told in Kassindja's voice, this memoir is also a precious lesson about cultures, women's human rights policy and perhaps most important, faith in God and humanity. These elements, fluidly interwoven, create an incredible narrative about an ordinary teenage girl.

Rarely in Western culture do well-rounded accounts of life abroad, particularly in underdeveloped countries, get told. Kassindja's description of her "easy and tranquil" childhood in Togo is refreshing in itself and also serves as vital context for her story. Succinctly depicted, that era of her life sheds light on ethnic groups, Islam and custom, which weigh far more than government or law, and the supreme importance of family. A delightful description of her sister Ayisha's four-day wedding illuminates those values particularly well.

Kassindja's parents followed most tribal traditions but confidently bucked those they found unacceptable. Her father married only one woman, from outside his tribe, provoking vocal disapproval by his siblings. He also defied custom by rejecting female cutting. So deep was his conviction that he said he would never forgive his brother for secretly arranging the cutting of their niece.

When Kassindja's father died, that same uncle became her legal guardian, as mandated by tradition. Soon she was pulled out of school and forced to marry a man with three wives who wanted her cut so she would be "clean" for him. In the most suspenseful chapter, sister Ayisha executes a daring, clever rescue.

After a brief stay in Germany, Kassindja arrived in the United States, where she has relatives, assuming that asylum would be easy to secure. "My teachers at school had said it was a great country. They said people believed in justice in America," she recalled. But within her first hours on U.S. soil, Kassindja was strip-searched twice, left naked in a putrid, freezing holding room, forced to shower in ice-cold water while a guard stared and berated by an immigration official. "I don't know why these people can't stay in their own countries." When she asked where she could put her soiled sanitary napkin, a guard barked, "Why don't you eat it." It got worse.

During 16 months of confinement in one detention center and three prisons, she was tear-gassed and beaten, strip-searched with 11 other women, placed in segregation three times, locked in maximum security wards with criminals, including a cellmate who was a convicted murderer, housed with smokers despite asthma, repeatedly denied access to doctors, misdiagnosed and denied medical treatment for a peptic ulcer disease. Profound chaos and appalling injustices plague detained immigrants, who are disproportionately people of color.

A major disappointment of the book is the hasty retelling of the appeal hearing, arguably the book's most anticipated scene. The authors should have more thoroughly explained the legal arguments made by both sides of the case, as they summarized well the legal and political actions leading up to that moment.

Ultimately, the dramatic legal and media strategies of lawyers, law students, human rights advocates and reporters won Kassindja's freedom, setting legal precedents for future asylum seekers. "You're God's chosen one," was her mother's explanation of the episode after it was over.

The most impressive human accomplishment in "Do They Hear You When You Cry" is Kassindja's strength and graciousness. Though she was disappointed when her mother apologized to her uncle (for the sake of peace in the family) for helping with the escape, Kassindja declares peace herself. "I'm grateful to the American people and government for everything they've done for me, taking me in, giving me shelter, giving me a safe place to live."

BY JOHN EARLE

Fauziya Kassindja escaped the fate of millions of girls worldwide.

[redacted] 11:50:37 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 women 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

Save the Children.
54 Wilton Rd. Westport CT 06881

FAX FAX

Date: 4/1/98

To: Christie Macy
Fax: 202-456-5709
Phone: 202-456-6266

From: Marianne LeVert
Public Affairs and Communications
Phone: 203-221-4116
Fax: 203-226-6709

Number of pages, including this transmittal sheet:

Memo:

As you indicated that less material was better than more and short answers more helpful than long, I am sending you several **short** pieces:
Press about The First Lady's trip to Nepal (April 1995).
One paragraph descriptions of Clean Delivery Kits and of safe delivery programs.
White House press release: Clean Delivery Kits.
Announcement of First Lady's receipt of Save the Children's Distinguished Service Award at White House ceremony.

Should you need additional information, please do not hesitate to call me at 203-221-4116.

when to seek care outside the home, and proper home follow-up care.

Save the Children's community-level programs link volunteers, village health action teams, and local ministry of health systems, among others. We also foster partnerships with residents respected for their traditional health knowledge--including both traditional healers and traditional birth attendants. Common program themes include nutrition education; improved case management for illness and disease; immunization; breastfeeding and family planning--including counseling for HIV/AIDS; safe motherhood initiatives; transport systems for obstetric emergencies; school health programs, and water and sanitation improvements.

Such capacity-building and system-strengthening at the local level means that even when Save the Children's active programs come to a close, the benefits of improved health knowledge and services serve families and communities through future generations.

In Malawi, one community-based program initiated by Save the Children involves village funds for improving access to life-saving drugs. Working with Village Health Action Teams in communities more than five kilometers away from a government medical facility, Save the Children helps set up community pharmacies stocked with five drugs that are essential for treating the four most common childhood infections--fever/malaria, pneumonia, diarrhea, and eye infections. A volunteer designated by the team learns basic assessment and treatment skills, is trained to identify danger signs pointing to the need for hospital care, and keeps records of clientele, diagnosis, drugs and doses, and money received.

The informal pharmacies are typically able to provide anti-malarial treatment for scores of feverish children every month--many of whom may have lost their lives to the disease. In

Clean Delivery Kits (short answer)

Collaborative multi-level program effort in Nepal:

Clean Delivery Kits

Save the Children developed "Clean Delivery Kits" in Nepal to address common unhygienic birthing practices that can cause severe maternal and infant health problems, including fatal infections. To make the kits as useful and culturally responsive as possible, Save the Children collaborated with local organizations on both developing and producing them. In designing and implementing the research for the kits, we worked with a number of local organizations. To produce them, Save the Children collaborated with a local women-owned firm. And to market the kits, we partnered with the Ministry of Health in a social marketing program to publicize availability and carry out ongoing distribution.

REPRODUCTIVE HEALTH PROGRAM PROFILES:

CHOICES FOR A CHANCE

Save the Children's longstanding community-based approach to health gives us a strong foundation to promote participatory reproductive health services shaped by local needs. By developing partnerships and reinforcing networks between local and national groups and government agencies, Save the Children's programs strengthen the health services available to families and communities.

Our reproductive health programs incorporate efforts in five main areas: family planning, safe pregnancy and delivery, sexually-transmitted diseases--including HIV/AIDS, education--especially for women and girls, and community-based economic development.

- Under the umbrella of family planning, Save the Children includes fertility awareness, contraceptive information, education, counseling, and service provision in voluntary programs designed to address local concerns.

- Our safe delivery programs teach women and their families to identify danger signs during pregnancy and delivery and develop a birth plan for accessing emergency obstetric care if needed. We also focus on providing training for traditional birth attendants and village health promoters, strengthening pre- and post-natal care, working with safe birth kits, and establishing village-based referral services.

- To help communities reduce the incidence of sexually-transmitted diseases and improve treatment programs, Save the Children emphasizes education, communications and awareness programs--including community drama presentations; strengthening diagnostic and treatment

Promoting individual and family health, and helping people avoid the personal burdens associated with reproductive and sexual health problems are the goals of Save the Children's reproductive health initiatives. Refining strategies, maximizing resources, and learning from experience is the constant work of our programs around the world.

[NEED? ELABORATE?]

***Women's Education: The poor record of many countries in educating their daughters as diligently as their sons has a generational impact on women, families, and societies. Many studies have clarified the positive, profound and lasting changes engendered by increasing access to education for women and girls. (include fundamental improvements in women's capacity to care for herself and for those who depend on her.)

what safe delivery programs do for women's health.

Clinton visits the USAID-assisted International Center for Diarrheal Disease Control in Bangladesh, where oral rehydration therapy was developed.

visit to our program in Nepal April 1995 (so "three years ago this month,")

While in Kathmandu, Nepal, Clinton toured a small health and family planning clinic financed by a partnership of USAID, Save the Children Foundation and the government of Nepal. Here the first lady was given a "Safe Home Delivery Kit" for expectant mothers. The primitive kit, consisting of soap, twine, wax, a plastic sheet and razor blade, denotes the extent to which development still remains a challenge to Nepal, one of the poorest countries in the world.

"One lesson the experience of the last several decades teaches us is that where women prosper, countries prosper."

In Bangladesh, Clinton visited the USAID-assisted International Center for Diarrheal Disease Control, which has been key in helping save people suffering from cholera, malnutrition and diarrhea. It was at this center that oral rehydration therapy was initiated and then launched worldwide.

Clinton's last stop was Sri Lanka, the most socially progressive of the countries visited. Here USAID is committed to activities encouraging broad-based economic growth, protecting the environment and building democracy.

"If my visit to other countries in the region highlighted the development challenges and opportunities facing the region, my visit to Sri Lanka underlined the fact that those challenges can be met and just how important health, education and the inclusion of women can be in achieving economic progress anywhere in the world," Clinton noted.

In an article the first lady wrote that ran in The Washington Post on May 14, she praised USAID activities in South Asia: "These projects are proof that American aid — both financial and technical — has provided the tools of opportunity to people and nations who have shown a courageous commitment to democracy and a market economy. Today, that American aid remains critical. Having watched in the last 10 years as democracy has flourished and markets have opened around the globe, we cannot turn our backs on nations struggling to uphold our ideals." ■

1 of 1

Resend

White House Press Release

NYU

THE SAFE HOME DELIVERY KIT

Over 700,000 babies are born in Nepal each year. 650,000 are delivered at home under primitive conditions with most births not assisted by trained attendants. More than 75,000 die within the first year of life, frequently due to tetanus and sepsis caused by unhygienic delivery practices. As a result, Nepal's maternal and infant death rates are among the highest in the world.

The clean Home Delivery Kit was designed to prevent such deaths. It is the product of two years' research conducted by the Save the Children Alliance/Nepal with support from His Majesty's Government Institute of Medicine and Ministry of Health, funding assistance from UNFPA and UNICEF, and technical assistance from USAID and PATH/US. In 1994, a private company, Maternal and Child Health Products Pvt. Ltd. (MCHP) of Kathmandu, was established with start-up funding and technical assistance from USAID/Nepal through Save the Children/US. This ground-breaking micro-enterprise is owned and operated by Ms. Rukumani Charan Shrestha (Managing Director), Ms. Sumitra Pantawa, and Ms. Renuka Munakarmi, who each have more than fifteen years' experience in reproductive health care and women's issues, and Ms. Nigma Tamrakar, an experienced businesswoman.

The simple, affordable and easy-to-use kit was designed specifically with the traditional birthing practices particular to Nepal in mind, which included placing the umbilical cord of the newborn on a coin or betel nut while being cut. Rather than trying to change traditions, the kit contains a small, clean, coin-like substitute as well as soap, a new razor blade, clean umbilical-cord ties, and a plastic sheet to provide a hygienic birthing surface. The kit's use will significantly reduce two major causes of maternal and neonatal death, tetanus and sepsis, by emphasizing the "three cleans" principle promoted by the World Health Organization: clean hands, clean surface, clean umbilical-cord care.
Due to the high illiteracy rate among the population all instructions consist of clear, unmistakable illustrations.

Since August 1994, Maternal and Child Health Products Pvt. Ltd. (MCHP) has produced and sold over 100,000 Safe Home Delivery Kits in Nepal, primarily through government and voluntary agencies, and commercial outlets. The First Lady's visit to Kalimati Clinic represents the official launching of the kit which will be sold in drugstores, general stores, and through medical practitioners and community health workers for about Rs. 20 (40 cents). Median income in Nepal is USD 210 per year.

I can update these stats if you need them.

The Safe Home Delivery Kit is valuable proof that governments, donor and voluntary agencies, and the private sector can work together constructively to develop innovative health-care products that benefit a large segment of the population and have a high potential for becoming self-sustaining within a short period of time.

WHITE HOUSE PRESS RELEASE

15/17

VIDEO MONITORING SERVICES OF AMERICA, INC.
10780 Westheimer
Houston, TX 77042
(713) 789-1035
(713) 789-0980

New York (212) 736-2010 | Los Angeles (213) 893-0111 | Chicago (312) 649-1131 | Philadelphia (215) 669-4990 | San Francisco (415) 543-3301
Detroit (810) 352-9220 | Boston (617) 266-2121 | Dallas (214) 844-9696 | Washington (202) 393-7110 | Miami (305) 576-3581
Denver (303) 861-7152 | Hartford (203) 953-1889 | San Diego (619) 544-1800

A BURRELLE'S Affiliate

Transcript

DATE September 18, 1995
TIME 7:00-7:30 PM (CT)
NETWORK CNN
PROGRAM Headline News

Lynne Russell, anchor:

First Lady Hillary Clinton received a Distinguished Service Award from Save the Children at the White House today. The international relief organization commended her efforts to give the less fortunate--especially women and children--a chance, a voice, and a future. She plans to publish a book on children's issues this fall.

# # #

FYI: Save the Children awarded the First Lady the Distinguished Service Award five months after trip to Nepal.

THE WHITE HOUSE

WASHINGTON

OFFICE OF SPEECHWRITING

Fax: (202)456-5709
Phone: (202)456-2777

TO: Jill Sheffield C/O MUMTA

Fax: 522-2653 Phone: 473-3691

FROM: _____

Comments: _____

_____

_____

_____

Date: _____

Number of pages (including cover): _____

HILLARY RODHAM CLINTON
SAFE MOTHERHOOD: WORLD HEALTH DAY
THE WORLD BANK
APRIL 7, 1998

It is a great honor and pleasure to be here at the World Bank, and to join James Wolfensohn and all of you as we celebrate World Health Day -- and recommit ourselves to the global mission of Safe Motherhood. Thank you for giving me this opportunity to speak to you about a subject so close to my heart -- and of such extraordinary significance to the future of our world. I'm so pleased to be joined by Dr. Crispus Kiyonga, the minister of Health in Uganda, where I have just visited -- and Dr. Siti Hasmah Mohd -- the first lady of Malaysia. Deep appreciation to the members of the Safe Motherhood Inter-Agency Group -- the World Health Organization (WHO), UNFRA (UN Population Fund), UNICEF, the World Bank, International Planned Parenthood Federation (IPPF), and the Population Council -- who, with the support of Family Care International, lead such critical efforts around the globe to promote the health and well being of women, children and families.

I would also like to acknowledge the extraordinary work of the tens of thousands of foot soldiers on the front lines -- the doctors, nurses, midwives and public health workers who are struggling to meet the often overwhelming health needs of women throughout the world -- and who, against all odds, have saved the lives of so many women and children over the years. We owe all of them our deepest gratitude.

I want to begin by commending the World Bank for making women's health -- and in particular -- safe motherhood -- a top priority for international agencies and countries around the world. Thanks to your work and leadership, and the tireless efforts of all the international agencies and NGOs here today -- there's a growing understanding of the depth of the challenge women face around the globe. But perhaps more importantly, there's a growing public recognition that investments in safe motherhood initiatives have an impact far beyond improving the status of women and the health of their families. That such investments go hand in hand with social and economic progress throughout a nation, and the building of democracy around the globe.

We gather here this morning at a time of great promise and hope. I've just returned from an historic trip to sub Saharan Africa -- where in just a few years, more than 20 nations have replaced authoritarian rule with free and fair elections, and where even some of the poorest countries are beginning the long road toward economic and social recovery. With the worldwide explosion of technology and information, we are all moving into a global economy, and a truly new world. And we are in the process -- as a community of nations -- of ending the production of the weapons of mass destruction, promoting greater human rights, and ensuring a healthier, cleaner global environment.

Yet in the midst of this time of extraordinary growth and promise -- we still fail to protect the most precious symbol of the future -- the life and health of our mothers. The figures are shocking -- no matter how often they are repeated. Every minute -- 380 women become

pregnant -- 190 women face an unplanned or unwanted pregnancy; 110 women experience a pregnancy related complication; and 40 women have an unsafe abortion. And every minute, somewhere on this globe -- a woman dies from complications of pregnancy and childbirth.

For millions of women around the world, there is no basic primary, reproductive, or emergency care to keep them alive and healthy. For millions of women around the world, life threatening complications from childbirth doom not only their own lives -- but the lives of their children, and the survival of their community. For millions of women around the world, safe motherhood is a far away dream, a distant reality.

Numbers and charts tell us the terrible dimensions of the health problems facing women around the world. But not the personal tragedy and pain of losing one's wife, mother, daughter, sister, or neighbor. As one health care worker admitted: "statistics are people with the tears wiped off." At the Technical Consultation held in Sri Lanka last year, I'm sure many of you heard Dr. Mahmoud Fathalla say that "Maternal mortality is not about statistics... It's about women who have names; women who have faces; faces which we have seen in the throws of agony, distress, and despair." The agony of these deaths is compounded by the simple -- yet unbearable -- truth that the vast majority of them could have been avoided. They should never have been allowed to happen.

We are being joined on this day by people in cities and communities around the globe, who, like us, are raising our voices in unison to say: women need not die while giving life to future generations. Ten years ago, many of the individuals and agencies and NGOs here today launched the global Safe Motherhood initiative, and maternal mortality was elevated -- for the first time -- as an international priority, and goals were set to cut the number of maternal deaths in half by the year 2000. And while many countries -- including my own -- have not yet met our goals, we should take pride in the strides we are making.

The signs of progress are all around us. In Bangladesh, Sri Lanka, and Cuba, health workers trained in midwifery are being assigned to village-based health facilities -- and maternal mortality has declined. In Ethiopia and Mongolia, women living in remote areas or where transportation is difficult can now go to maternity waiting homes, and get much needed care. In Uganda, the "Rescuer's" project ensures pregnant women have radio equipment to call for help. In country after country, national and local health initiatives are helping to save lives, and ensure healthier futures, for women and their families.

A few years ago, I toured a small health and family planning clinic in Kathmandu, Nepal, financed by a partnership among USAID, the Save the Children Foundation, and the government. And while I was there, I was given a "Safe Home Delivery Kit" -- like the one I have here today -- that is given to expectant mothers. Inside is a bar of soap, twine, wax, a plastic sheet and a razor blade. It's purpose is to reduce the two major causes of maternal and neonatal death -- tetanus and sepsis -- by promoting the "three cleans" principle: clean hands; clean surface; clean umbilical care. These kits are made locally in Nepal by a woman-owned micro-enterprise.

This kit symbolizes for me some of the most important lessons we have absorbed over the past few years. First -- we've learned the power of partnership. In community after community, in nation after nation, governments, voluntary agencies, and local leaders are joining forces -- and resources -- to develop innovate health care strategies and tools that promote safe motherhood. We now know -- more than ever -- that reducing maternal mortality requires sustained, long term commitments from the full range of partners in a society. (I know that last night there was an important meeting of new partners in the corporate sector who are now joining the World Bank in this safe motherhood campaign -- and agreeing to a set of principles. I join all of you in applauding their participation.)

But just as importantly, we've learned that the cost of promoting safe motherhood is often minimal -- this kit costs about 40 cents -- in comparison to the extraordinary rewards in saved lives, improved maternal and child health, and revitalized communities. So often, it's these simple, common sense, inexpensive ideas -- like drawing up a roster of vehicles for emergency transportation of women or setting up a revolving fund for drugs and supplies -- that can have the greatest impact on reducing maternal mortality.

Think about it. The World Bank estimates that that by spending under $2 a year per person for health care, almost all of the 600,000 women who die every year during pregnancy or childbirth would be alive today. And the lives of 1.5 million infants would be saved.

The cruel truth is: as much progress as we've made, as many lessons as we've learned, as many conferences as we've held, as many partners as we've gained, we have yet to convince enough of the world's leaders and citizens that maternal mortality is not just a health crisis of extraordinary proportions. It's a social injustice of the highest magnitude -- and the denial of the most basic human rights -- including the right to life itself. Martin Luther King Jr. once said that "of all the forms of inequality, injustice in health is the most shocking, and the most inhumane." I agree.

There is a painful equity in terms of peril for women during childbirth. Forty percent of all women -- whether they live on the upper side of New York city or the shanty towns of Soweto -- have complications. And 15% of all women have life threatening complications. What happens as a result of those complications -- whether a woman or her child lives or dies -- depends not on the content of her character, as Dr. King would have said, but on the neighborhood in which that woman lives, the ethnic group to which she belongs, and the social and economic status of her life. The inequities -- once again -- are shocking. One woman in 4,000 dies of childbirth in the United States. In Eretria -- one woman in eleven loses her life. Here in the U.S., African American women are four times more likely to die from pregnancy related causes than Caucasian women -- and African American babies are twice as likely to die.

When UNICEF released figures that showed infant mortality was ten times greater in developing countries than in the developed ones -- there was a collective outcry. Yet maternal mortality is 150 to 200 times greater in our poorer nations than in our rich ones. And those deaths are directly related to the high level of poverty -- and the low status of women -- in those countries. That is a moral outrage, and must be recognized as such by every nation in the world.

The inequalities in access to health care are the most obvious -- such as who gets to have a skilled practitioner by your side during childbirth. Only a third of the women in East Africa have that luxury, while in most developed countries, it's a universal right.

But these conditions -- and these injustices -- -- are not just in our poor, developing nations. They exist here, in our own backyard -- in our nation's capital, and in inner city neighborhoods around the United States. Infant mortality here in DC is almost double that of the rest of the nation -- and worse than many developing countries. Poor access to health care, and inequalities in health and life expectancies, don't end at national boundaries -- or city limits.

Women everywhere lack basic services that could save their lives, and ensure their health. But more significantly, women and girls don't have equal access to the tools of opportunity that could transform their lives. Education is inextricably tied to how women and children achieve progress -- including better health. And the greatest literacy gaps existing in such places as Western Africa and south-Central Asia -- where there are also some of the highest rates of maternal deaths. It should come as no surprise that children of illiterate mothers are twice as likely to die as those with educated mothers.

But women can't make progress in either their social or economic status unless they have other opportunities as well. For too long, women have been denied the opportunities of jobs and credit, legal protections, and the right to participate fully in the political life of their countries -- all of which are the basic building blocks for a healthy and productive life.

Three years ago, when I addressed the World Health Organization in Beijing, I said that women's rights are human rights, and human rights are women's rights. And I believe that now, more than ever, it is a violation of human rights when women are denied skilled health workers during child birth; that it is a violation of human rights when women are denied the right to plan their own families; that it is a violation of human rights when the leading cause of death worldwide for women between 14 and 44 is the violence they are subjected to in their own homes; that it is a violation of human rights when women can't get the education they need to ensure they and their children can lead healthy, productive, and engaged lives.

As long as these discriminations and inequities remain commonplace around the world, then the potential of the human family to create a peaceful, prosperous, democratic world will not be realized. But if we can apply the the force of international treaties and national constitutions that address basic human rights to ensuring safe motherhood and healthy children -- and if we can demand that governments address these underlying causes through political and legal remedies as well as imposed health initiatives -- then, and only then, will we fulfill the extraordinary promise of this time. Then, and only then, will every woman be treated with dignity and respect, and every child be loved and care for, and every family have a healthy and strong future.

I want to conclude my remarks this morning with story from my recent trip to Africa. That trip was an extraordinary opportunity for me to see the flowers of progress and democracy take root in even the smallest village, in even the poorest of countries. And wherever I went, I

heard the women of Africa singing. They sang as they cared for their children, as they wove their baskets and shawls, as they turned shanties into homes, as they rebuilt their lives.

In Senegal, a group of women I met with from the Malicounda Biambara village, have done something remarkable. They had decided that female genital mutilation -- considered a rite of passage for all girls -- had harmed their daughters' bodies and spirits for too long. It was time to end the hemorrhaging, and the infection, and the AIDS, and the childbirth complications caused by this deadly tradition. And that's what they did.

Using a skit that they showed me, these women educated their religious leaders, their husbands, and their neighbors. They banned the practice -- and are now inspiring others to do the same. Just last month, 13 villages, representing 8,000 people, joined together to end genital mutilation in their communities. And now President Diouf has called for a new law to abolish it throughout the country.

When I asked one woman what drove her and the others to change such a deeply held, long standing practice, she replied simply: "We studied human rights, and particularly the right to health."

Thank you for this opportunity to join you on Women's Health Day, but most of all, for your ongoing work to make safe motherhood a reality for every women and girl, in every nation of the world. For me, the story of these Senegalese women is the story of how much progress has been made in promoting the health and well being of women around the globe, and how far our messages have traveled about the importance of women rights to open and democratic societies. But it is also a stark reminder of how much work remains to be done. I thank you for your accomplishments on behalf of women and children around the world -- but I thank you more for the work that you will do in the months and years ahead to ensure safe motherhood is a universal human right.

JUDY MANN

Safe Motherhood: A First Step in Development

Two significant shifts have occurred in international development efforts.

The first is an agreement reached by major funders and nongovernmental organizations that women are at the center of the development process.

As World Bank President James Wolfensohn put it as part of his remarks during the World Bank conference on Safe Motherhood this week: "If you educate a woman, you educate a woman and a family. If you educate a man, you educate a man."

The second shift has occurred in the capital flow into developing countries. Aid from donor nations fell from $40 billion to $37 billion from 1996 to 1997, as developed countries tightened budgets and cooled to the strategic importance of international development now that the Cold War has ended. The biggest players now are private-sector companies, whose investments went from $247 billion in 1996 to $256 billion last year.

Wolfensohn made it clear that important players in the private sector have joined a 10-year partnership of governmental and nongovernment agencies. Among them are Merck & Co. pharmaceuticals, which has donated Invermectin, a drug that Wolfensohn says "has all but eradicated" river blindness in Africa, and Johnson & Johnson, which recently announced distribution of a drug that fights parasites common in Central America.

What remains lacking is a fundamental political will in many of these countries to make the health of girls and women central to development planning. "People don't care," he said. "As I travel around talking to ministers, conversations about health and safe motherhood are very rare."

Despite a decade of international efforts by such groups as UNICEF, the World Health Organization, the World Bank, the U.S. Agency for International Development, the International Planned Parenthood Federation and the Population Council, maternal mortality is now estimated at between 585,000 and 600,000 a year, an increase from earlier estimates, which were probably unreliable. Current estimates are probably not all that good either, though, since many rural deaths are never officially reported.

Motherhood has been made safe in some places but not others, said Richard Feachem, who directs the health, nutrition and population programs at the World Bank. During the decade-long partnership, he said, "we've learned a lot."

He urged the representatives of organizations involved in the Safe Motherhood effort to think about the objectives as four concentric circles: The outer one involves the empowerment of women in their families, villages and governments; the second one holds the development process in general, the establishment of a country's infrastructure, housing, clean water, sanitation; the third involves the quality, availability and sustainability of basic health services; and the fourth, the core circle, holds maternal health services.

These were patterns that emerged during successful efforts in Malaysia, where women do not have legal barriers, according to Datin Seri Dr. Siti Hasmah, its first lady, who spoke at the conference. Taboos were overcome, and family planning has been stressed during the past decade. Today more than 95 percent of women seek and receive pre- and post-natal care, and 95 percent had births that were assisted by trained personnel.

In another address, Crispus Kiyonga, minister of health in Uganda, noted its successes in increasing contraception use.

He also made the point that the Ugandan parliament has 50 female members, that the vice president is a woman and that there are several women in the cabinet. After the country started to pull itself together in 1986, he said, there was "a deliberate political decision" to encourage women to become involved in the power structure, and the women's vote since then has become particularly influential.

Hillary Rodham Clinton told a wonderful story from her recent trip to Africa. The women of a village in Senegal had joined together to ban female circumcision. "They have decided that female circumcision, considered a rite of passage for all girls, had harmed their daughters' bodies and spirits for too long," she said. "It was time to end the hemorrhaging, and the infection, and the AIDS, and the childbirth complications caused by this deadly tradition.

"Using a skit that they showed me, these women educated their religious leaders, their husbands and their neighbors. And as a result, they have banned the practice of female circumcision in their village, and now in 13 other villages as well.

"When I asked one of the women in this small village what had driven her and others to try to end such a long-standing cultural practice, she replied simply: 'We studied human rights, and particularly the right to health.' "

What is so clear from that story is that the lofty concept of women's rights being human rights—which Clinton articulated in a shot heard round the world at the U.N. conference on women held in Beijing in 1995—has reached the women in remote villages, the women who need this assurance the most.

What was also clear from this week's conference is that some of the most important voices and institutions in the world of development are committed to ending the scourge of maternal deaths from unsafe abortions, lack of family planning, infections, obstructed delivery and other avoidable causes. Whether the resources will be there wasn't clear, but they certainly should be. This is an effort whose time is way overdue.

The Washington Post

FRIDAY, APRIL 10, 1998

THE RELIABLE SOURCE

By Ann Gerhart and Annie Groer

BY TOM ALLEN—THE WASHINGTON POST

Patrick Ewing "in the paint" with 10-year-old Pernell Dongmo.

Knicks Star Patrick Ewing Paints the Town

There was plenty of dribbling going on when **Patrick Ewing** visited the National Museum of American Art yesterday, but it involved paint, not a basketball.

The New York Knicks center, who majored in fine arts while a basketball phenom at Georgetown University, was back in town for a "painting party" with students from the District's Thompson Elementary School, reports The Post's Sylvia Randall.

Ewing plugged the museum exhibit "Time Out! Sports in Art" and his own book, "In the Paint With Patrick," a work-in-progress for young artists and their parents.

"If my mom and dad didn't encourage me, I probably would have stopped," said the seven-footer, who started drawing as a kid in Jamaica.

Ewing, his right wrist wrapped in a blue bandage from a Dec. 20 injury, confessed it had been a long time since he was in a museum: "I'm not really able to enjoy it," he said. "I'd be considered one of the artworks" by fans.

Four Lovebirds Are Having A Ball

Ah, spring. Ah, romance. Love was much in the air at Wednesday night's cocktail kickoff for the Washington Opera Ball.

The fete at Anderson House, off Dupont Circle, was for **Sir Christopher Meyer**, the British ambassador, and his relatively recent bride, **Lady Catherine**, who wed on Halloween. The Meyers will host the June 5 black tie fund-raiser at their Embassy Row home.

"I think this ball may be specially blessed because helping run it are two sets of newlyweds," Ambassador Meyer told some 200 opera lovers, including envoys from the 35 nations who will host pre-ball dinners.

While much of social Washington has met the Meyers, many at this soiree got their first glimpse of another pair of lovebirds: the opera ball general chairman formerly known as **Betty Knight Scripps** and her new husband, investment banker **Jeremy Harvey**.

"I don't know if I should introduce her as Betty, Elizabeth or Mrs. Jeremy Harvey," said artistic director **Placido Domingo**.

For the record, and for the moment, she's Elizabeth Scripps-Harvey and semi-giddy.

"It's wonderful. I've never been so in love in my life," she told The Post's Roxanne Roberts.

BY MARK FORMENSTADT FOR THE WASHINGTON POST

Placido Domingo, in back, shares a laugh with the giddy British ambassador and his wife.

And, perhaps, never so busy. Since their Valentine's Day marriage in the Dominican Republic, they've honeymooned in Hawaii and visited London (Harvey is a Brit). They're booked on an African safari in May, and after the ball it's back to Britain to see the races at Ascot, tennis at Wimbledon and maybe rowing at Henley before a rest in the South of France.

And what might be the secret to such bliss (beyond the obvious means to pay for it)?

"We're both brats," Harvey said, noting that they're only children with much in common. "Tonight we are trying to be grown up, but most days we're somewhere between 11 and 13 years old. It's amazing fun."

The Washington Post

FRIDAY, APRIL 10, 1998

NOW YOU KNOW

■ And now, a multi-culti roundup . . . Opera legend **Luciano Pavarotti** will perform with the **Spice Girls, Celine Dion, Jon Bon Jovi, Stevie Wonder, Natalie Cole** and **Trisha Yearwood** at a benefit concert for Liberian children, Reuters reports.

The June 9 concert for kids affected by a decade of civil war is the third annual benefit for the Pavarotti & Friends Liberian Children's Village. It will be held in his hometown of Modena, Italy.

■ **Hootie & the Blowfish** had lots of family and friends to cheer them on at the Bayou Wednesday night. But they also drew some jocks, including Redskins **Gus Frerotte** and **Dan Turk**, as well as Baltimore Ravens quarterback **Jim Harbaugh** and a clutch of D.C. United players.

■ **President** and **Mrs. Clinton** attended a Wednesday night salute to philanthropist **Paul Mellon** and his late father, **Andrew Mellon**, who helped build the National Gallery of Art. Clinton first came to the museum as a Georgetown University student 30 years ago, and returned as Arkansas governor by playing hooky from National Governors Association meetings here.