WOMEN DELIVER

Invest in women - it pays

GLOBAL CONFERENCE

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Overview: Why *Women Deliver*? Why Now?

Every minute of every day, a woman dies needlessly in pregnancy or childbirth, most in the developing world. Ten million women are lost in each generation – our mothers and sisters, daughters and grandmothers, wives and partners, friends and neighbors.

Fully 42 percent of all pregnancies worldwide suffer complications, and in 15 percent of all pregnancies, the complications are life-threatening.[1]
Huge disparities exist in women's survival rates between rich and poor countries, and between the rich and the poor in all countries.[2]

- In the ten top-ranked countries, where women are guaranteed good-quality health and family planning services that minimize their lifetime risk, fewer than one in 16,400 women will die from complications of pregnancy and childbirth.
- One in 4,800 women will die of these causes in the United States. The rate for black U.S. women in 2000 was nearly four times that for white non-Hispanic women.[3]
- In sub-Saharan Africa, where high fertility multiplies the dangers women face over their lifetimes, one in every 22 women will die in pregnancy or childbirth.
- In Niger such complications kill *one in every seven women.*

2007 is a critical year for advancing the health and rights of women.

- *Women Deliver* marks the 20th anniversary of the launch of the global Safe Motherhood Initiative. Its research led to impressive gains in many places.
- We now know how to save the lives of most of those who die needlessly worldwide. But maternal and newborn health still receives inadequate attention and funding.
- In 2000, world leaders agreed on Millennium Development Goal #5: improve maternal health (and its target of cutting maternal mortality by 75 percent by 2015).
- This is often called the heart of the MDGs, because if it fails, so will the other MDGs.
- In 2005, world leaders and the UN Secretary General recommended to the General Assembly another target for Goal #5: Achieve universal access to reproductive health by 2015. *Women Deliver* comes at a point halfway to 2015.
- The numbers of women who die in pregnancy and childbirth (more than 536,000 per year) and of newborns who die before they are one month old (about 4 million per year) – mainly from preventable causes – have not dropped significantly in 20 years, in large part due to lack of political will.

The leading killers:

- *Haemorrhage*: uncontrolled bleeding can kill a healthy woman in two hours. Most developing countries lack adequate supplies of safe blood, especially in rural areas.
- *Eclampsia* (high blood pressure): this condition is often undiagnosed until too late.

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The Eight Millennium Development Goals

Goal #1: Eradicate extreme poverty and hunger.
Smaller families and wider birth intervals from reproductive health care, including contraceptive use, allow families to invest more in each child's nutrition and health. When a woman is too ill, anaemic or hungry to work, her household economic situation deteriorates and poverty increases; her children are less likely to attend school. A woman's death in childbirth deprives her family and community of her contributions.

Goal #2: Achieve universal primary education.
Every year of education for girls and women improves their families' health and nutrition and raises their economic output. Families with fewer children can afford to invest more in their education, making it more likely that girls will be sent to and stay in school.

Goal #3: Promote gender equality and empower women.
Women who can plan the timing and number of their births and count on safe motherhood will have greater opportunities for work, education and civil involvement. Discrimination and violence against girls and women not only abuse their human rights, but also rob society of critical energy, economic production and creative talent.

Goal #4: Reduce child mortality.
Care for the health of mothers is inseparable from the health of newborns. Those whose mothers die are three to 10 times more likely to die within two years than those whose mothers survive. Young girls married off at puberty bear children at risk: babies born to girls under 15 are five times as likely to die as those born to women in their 20s.

Goal #5: Improve maternal health.
Improving maternal health – by cutting maternal mortality by three-quarters by 2015 and guaranteeing universal access to reproductive health – is often called the heart of the MDGs, because if it fails, the other MDGs will too. Investment in reproductive health care, education, emergency obstetric services and skilled care at delivery will enable women to deliver – not just the next generation but also paychecks and productivity -- everything development advocates work to achieve.

Goal #6: Combat HIV/AIDS, malaria and other diseases.
Comprehensive sexual and reproductive health care includes preventing and treating HIV/AIDS and other sexually transmitted infections. Antenatal and post-natal care facilities can bring mothers and their families into the health care system, encouraging diagnosis and treatment of many other illnesses for many more people.

Goal #7: Ensure environmental sustainability.
Helping women avoid unintended pregnancies and to stay healthy and economically productive through pregnancy and motherhood helps stabilize rural areas, slows urban migration and balances natural resource use with the needs of the population.

Goal #8: Develop a global partnership for development.
Healthy and economically productive women can be half of every country's engine for growth and development. Affordable prices for drugs, global economic stability and a secure supply of commodities would greatly advance reproductive health programmes, and are especially needed in developing countries.

Maternal Mortality Scorecard

New Figures for 2005

On October 12, 2007, an unprecedented joint UN agency working group released new estimates, the first in five years, on maternal mortality worldwide.

The World Health Organization; UNFPA,the United Nations Population Fund; UNICEF (the United Nations Children's Fund); the UN Population Division; and The World Bank together developed a new approach to estimating maternal mortality that seeks both to generate estimates for countries with no data and to correct available data for under-reporting and for misclassification.

Inconsistency in data on deaths and on classification of those deaths creates broad uncertainties in many places, even in developed countries. But all estimates almost certainly understate the problem. The 2005 approach differs from those used in 1990, 1995, and 2000, so the new figures cannot be reliably compared to previous estimates.

However, the task force conducted two kinds of trend analysis to supply information on progress toward achieving the Millennium Development Goal 5 target of reducing maternal mortality by 75 percent by 2015. Both these analyses showed declines in maternal mortality ratios since 2000 that are insufficient to achieve the MDG goal.

The assessment of risk given below takes into account both the probability of becoming pregnant and the probability of dying as a result of that pregnancy in 171 countries with populations of more than 250,000, cumulated across a woman's reproductive years. This is the **lifetime risk of maternal death.**

The New Country Rankings

Among the ten top-ranked European and other industrialized countries, where women are guaranteed good-quality health and family planning services that minimize their lifetime risk, fewer than one in 16,400 will die from complications of pregnancy and childbirth. At the other end of the scale are ten countries where high fertility and shattered health care systems raise women's lifetime risk so that more than one in every 15 women will die of pregnancy-related causes.

Rank by lifetime risk of death from pregnancy-related causes

1. Ireland	1 in 47,600 will die and in…
2. Bosnia and Herzegovina	1 in 29,000
3. Italy	1 in 26,600
4. Greece	1 in 25,900
5. Austria	1 in 21,500
6. Germany	1 in 19,200
7. Czech Republic	1 in 18,100

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8. Denmark	1 in 17,800
9. Sweden	1 in 17,400
10. Spain	1 in 16,400
11. Slovenia	1 in 14,200
12. Slovakia	1 in 13,800
12. Switzerland	1 in 13,800
14. Australia	1 in 13,300
14. Hungary	1 in 13,300
16. Iceland	1 in 12,700
17. Japan	1 in 11,600
18. Canada	1 in 11,000
19. Poland	1 in 10,600
20. Croatia	1 in 10,500
21. Netherlands	1 in 10,200
22. Kuwait	1 in 9,600
23. Finland	1 in 8,500
23. Latvia	1 in 8,500
25. Malta	1 in 8,300
26. United Kingdom	1 in 8,200
27. Belgium	1 in 7,800
27. Israel	1 in 7,800
27. Lithuania	1 in 7,800
30. Norway	1 in 7,700
31. Bulgaria	1 in 7,400
32. France	1 in 6,900
33. The former Yugoslav Republic of Macedonia	1 in 6,500
34. Cyprus	1 in 6,400
34. Portugal	1 in 6,400
36. Singapore	1 in 6,200
37. Republic of Korea	1 in 6,100
38. New Zealand	1 in 5,900
39. Ukraine	1 in 5,200
40. Luxembourg	1 in 5,000
41. Belarus	1 in 4,800
41. United States of America	1 in 4,800
43. Serbia and Montenegro*	1 in 4,500
44. Barbados	1 in 4,400
45. Republic of Moldova	1 in 3,700
46. Mauritius	1 in 3,300
47. Chile	1 in 3,200
47. Romania	1 in 3,200
49. Brunei Darussalam	1 in 2,900
49. Puerto Rico	1 in 2,900
49. Estonia	1 in 2,900
52. Qatar	1 in 2,700
52. Russian Federation	1 in 2,700
52. Bahamas	1 in 2,700
55. Uruguay	1 in 2,100

56. Costa Rica	1 in 1,400
56. Cuba	1 in 1,400
56. Uzbekistan	1 in 1,400
56. Saudi Arabia	1 in 1,400
56. Trinidad and Tobago	1 in 1,400
61. China	1 in 1,300
61. Bahrain	1 in 1,300
63. Georgia	1 in 1,100
64. United Arab Emirates	1 in 1,000
65. Armenia	1 in 980
66. Turkey	1 in 880
67. Sri Lanka	1 in 850
68. Mongolia	1 in 840
69. Azerbaijan	1 in 670
69. Mexico	1 in 670
71. Venezuela	1 in 610
72. Belize	1 in 560
72. Malaysia	1 in 560
74. Argentina	1 in 530
74. Suriname	1 in 530
76. Tunisia	1 in 500
76. Thailand	1 in 500
78. Albania	1 in 490
79. Jordan	1 in 450
80. Oman	1 in 420
81. Brazil	1 in 370
82. Kazakhstan	1 in 360
83. Libyan Arab Jamahiriya	1 in 350
84. Iran	1 in 300
85. Colombia	1 in 290
85. Lebanon	1 in 290
85. Turkmenistan	1 in 290
88. Viet Nam	1 in 280
89. Panama	1 in 270
90. Jamaica	1 in 240
90. Kyrgyzstan	1 in 240
92. Dominican Republic	1 in 230
92. Egypt	1 in 230
94. Algeria	1 in 220
95. Syrian Arab Republic	1 in 210
96. Maldives	1 in 200
97. El Salvador	1 in 190
98. Ecuador	1 in 170
98. Namibia	1 in 170
98. Paraguay	1 in 170
101. Fiji	1 in 160
101. Tajikistan	1 in 160
103. Morocco	1 in 150

103. Nicaragua	1 in 150
105. Democratic People's Republic of Korea	1 in 140
105. Peru	1 in 140
105. Philippines	1 in 140
108. Botswana	1 in 130
109. Cape Verde	1 in 120
109. Swaziland	1 in 120
111. Myanmar	1 in 110
111. South Africa	1 in 110
113. Solomon Islands	1 in 100
114. Indonesia	1 in 97
115. Honduras	1 in 93
116. Guyana	1 in 90
117. Bolivia	1 in 89
118. Pakistan	1 in 74
119. Iraq	1 in 72
120. Guatemala	1 in 71
121. India	1 in 70
122. Bhutan	1 in 55
122. Papua New Guinea	1 in 55
124. Gabon	1 in 53
124. Sudan	1 in 53
126. Comoros	1 in 52
127. Bangladesh	1 in 51
128. Cambodia	1 in 48
129. Ghana	1 in 45
129. Lesotho	1 in 45
129. Mozambique	1 in 45
132. Haiti	1 in 44
132. Eritrea	1 in 44
134. Zimbabwe	1 in 43
135. Kenya	1 in 39
135. Yemen	1 in 39
137. Madagascar	1 in 38
137. Togo	1 in 38
139. Djibouti	1 in 35
139. Timor-Leste	1 in 35
141. Lao People's Democratic Republic	1 in 33
142. Gambia	1 in 32
143. Nepal	1 in 31
144. Equatorial Guinea	1 in 28
145. Côte d'Ivoire	1 in 27
145. Ethiopia	1 in 27
145. Zambia	1 in 27
148. Central African Republic	1 in 25
148. Uganda	1 in 25
150. Cameroon	1 in 24
150. United Republic of Tanzania	1 in 24

152. Burkina Faso	1 in 22
152. Congo	1 in 22
152. Mauritania	1 in 22
155. Senegal	1 in 21
156. Benin	1 in 20
157. Guinea	1 in 19
158. Malawi	1 in 18
158. Nigeria	1 in 18
160. Burundi	1 in 16
160. Rwanda	1 in 16
162. Mali	1 in 15
163. Democratic Republic of the Congo	1 in 13
163. Guinea Bissau	1 in 13
165. Angola	1 in 12
165. Liberia	1 in 12
165. Somalia	1 in 12
168. Chad	1 in 11
169. Afghanistan	1 in 8
169. Sierra Leone	1 in 8
171. Niger	1 in 7

* Serbia and Montenegro became separate entities in 2006.

Real Stories About Women and Girls: Putting a Face on *Women Deliver*

Targeted investments can save the lives and improve the health of real women, mothers and newborn babies around the world – real people like these:

Leonora Pocaterrazas and Albina Chambe, Bolivia
In Bolivia, indigenous tradition often means women give birth at home, fully clothed, squatting on the floor, with only family members to help. When Albina Chambe, 15, went into labour in a poor suburb of La Paz, her fiancé Grover, only 18 himself, wanted to take his wife to a hospital. But Albina's mother had delivered 13 children at home, without skilled assistance, and argued that Albina should follow tradition.

Soon, however, Albina's pains worsened, so Grover half-carried Albina on a 20-minute uphill climb to the nearest dirt road. He spent more than a day's pay for a taxi to the hospital. There a medical team safely delivered Luz Belen, the couple's new baby girl.

Leonora Pocaterrazas, 21, was not so lucky. When she went into labour in the high mountain village of Columpapa Grande, weeks ahead of schedule, her husband wasn't ready. "She told me she was in pain. I gave her a massage and then I went to ask my sister for help," he told visitors. "When I got back she had already had the baby."

The sister couldn't stop Leonora's bleeding, and the baby wasn't breathing. "The baby was too small. He died half an hour later," the husband said. Leonora died as well, leaving three other children behind.

For lack of measures against such risks over their lifetimes, one in every 89 Bolivian women will die in pregnancy or childbirth – one of Latin America's highest rates. UNFPA, the United Nations Population Fund, supports Bolivian government efforts to integrate skilled midwives and healthcare providers into the country's health system so that women at risk, like Leonora, are brought to hospitals in time for emergency care that can save their lives – and those of their newborns and their other children.

Fatima M., Afghanistan
Fatima's story illustrates the dire consequences a mother's death has for her family and her community. She and her husband Ahmed already had nine children and were barely surviving on his salary as a security guard when she became pregnant again. He nearly lost his job taking care of the family during her difficult pregnancy. Then Fatima died giving birth to twin boys in a Kabul hospital. Because Afghanistan's shattered health care system multiplies their lifetime risks, one in every eight Afghan women will die in this way, from complications of pregnancy and childbirth.

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Fatima's hospital expenses put Ahmed deeper into debt, so he took their 13-year-old son out of school to work. The twins had to be fed on goats' milk and expensive infant formula and they were often ill with diarrhea or acute respiratory infections, the most common killers of infants worldwide. The family's 11-year-old daughter was taken out of school to care for them. At seven months, the smaller twin died of a respiratory infection.

Ahmed remarried, adding to his debt and poverty, so he married off his oldest daughter when she turned 13. She became pregnant at 15, before her body was ready, and suffered an agonizing obstructed labour. Her baby was born brain-damaged and she was left with an obstetric fistula, an opening between her vagina and bladder that made her incontinent. The resulting wetness and odor caused her acute humiliation. Her husband abandoned her, and she had to return to her father's home to continue a life of poverty.

Kakenya Ntaiya, Kenya

Kakenya Ntaiya's story shows how education can change all the cards in the hand a young girl is dealt at birth. The oldest of eight children of a Maasai tribal family, she was engaged to be married when she was five years old. She grew up caring for cattle and her siblings in a small village 20 miles from the nearest paved road. She often was the only person to help her mother give birth in their hut. She was expected to undergo ritual circumcision at puberty, leave school and marry the man her parents had chosen.

Kakenya had other ideas. She told her father she would undergo the circumcision only if she could stay in school. Her father agreed, and at 13 she joined the estimated 2 million women who have suffered female genital cutting worldwide.

Undeterred, Kakenya finished high school with top marks and decided she wanted to attend college – in the United States. No girl in her village had ever done that. So she negotiated again, this time with the village elders. If they let her go, she promised, she would come back and help build a school and a maternity hospital.

It worked. The village women united to raise the money to send Kakenya to the United States. They knew pregnancy in Kenya often means death: one in every 39 women will die there of complications in pregnancy and childbirth, one of the world's highest rates.

Kakenya graduated from Randolph-Macon Women's College in 2004, and her mother came from Kenya to attend the ceremony. Kakenya went on to a PhD program in education at the University of Pittsburgh, determined to become a leader in helping others get an education in Kenya. She has now raised more than US$75,000 toward the school she promised to build in her village.

Kakenya's success has inspired millions of people. She has been the subject of a *Washington Post* series, a BBC documentary and many magazine articles. She married in 2006 and is expecting her first child in September 2007.

"Now all the village women want their daughters to stay in school," she tells audiences throughout the world.

Glossary of terms

AIDS orphan – A child under 18 who has lost one or both parents to AIDS. There are more than 15 million AIDS orphans in the world today, 12 million of them in sub-Saharan Africa. UNAIDS projects that the total will be 25 million by 2010.[1]

Anti-retroviral drugs (ARVs) – Drugs taken to fight HIV. They inhibit reproduction of the human immune-system retrovirus (HIV) that causes adult immune-system deficiency syndrome (AIDS). Short courses of anti-retroviral drugs during pregnancy, delivery and post-delivery reduce the risk of mother-to-child transmission of HIV/AIDS.

Child survival – A goal of programs aimed at preventing or treating common diseases of children.

Emergency obstetric care – Consists of skilled medical personnel with the antibiotics, sedatives, blood transfusions and other equipment they need to deal with complications of pregnancy and childbirth, including obstetric surgery if necessary.

Family planning – The conscious effort of couples or individuals to plan for the number of their children and to regulate the spacing and timing of their births, through contraception and the treatment of involuntary infertility.

Female genital cutting – All procedures involving partial or total removal of the external female genitalia, or other deliberate injury to the female genital organs, whether for cultural, religious or other non-therapeutic reasons. Often called "female genital mutilation" or "female circumcision," it has been inflicted on an estimated 130 million living women, usually with crude instruments and without anaesthesia.[2]

Fistula (obstetric) – An opening or rupture linking two areas such as the vagina, rectum, bladder and/or abdominal cavity, usually caused by obstructed labour, unsafe abortion or traditional practices such as female genital cutting. The result is uncontrollable leakage of urine or faeces, odor, infections and usually social ostracism for the woman or girl.

Gender bias – Any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights. While the term technically refers to discrimination against either males or females, in practice the near-global preference for boys leads to sex-selective abortions, abandonment or neglect of girl infants and children, and restrictions on the feeding, health care, education, legal rights and social and political participation of girls and women. Elimination of gender bias is increasingly seen as both a human rights issue and as a precondition for, and indicator of, sustainable, people-centered development.

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Gender-based violence – Violence that targets women or men, girls or boys on the basis of their gender or sexual orientation. It includes, but is not limited to, sexual assault and domestic violence, and is often used as a weapon of war.

Gender-disaggregated data – Facts and figures that break out data by gender. Use of this data allows decision-makers to focus on issues of particular relevance to women and men, girls and boys, and their different roles and positions in society. Statistics on household distance from water or fuel, for example, have different implications for women and men since women usually collect these necessities.[3]

Human rights – The rights people have simply because they are human beings, held inalienably, universally and forever. Citizenship, nationality, race, ethnicity, language, gender, sexuality and abilities are irrelevant. Human rights only become enforceable when they are codified as conventions, covenants or treaties, or as they become recognized as customary international law.[4]

Maternal death – A woman's death due to complications of pregnancy or childbirth, usually restricted to deaths of women pregnant within 42 days before death. Some definitions specify a woman be pregnant within three to 12 weeks before death.[5]

Maternal mortality rate – The number of maternal deaths per 100,000 women of reproductive age (15 to 49).[6]

Maternal mortality ratio – The number of maternal deaths per 100,000 live births during the same time period.[7]

Maternal-newborn health – The health of newborn babies is so intimately linked to the health and survival of the mother that the World Health Organization (WHO) now refers to newborns' health only in this way.[8]

Micro-enterprise – A manufacturing business with four or fewer employees, or a firm in trade with 10 or fewer employees, and little working capital. Such businesses account for an estimated half of all businesses in many countries, more than 80 percent of those in Latin America and the Caribbean.[9]

Millennium Development Goals (MDGs) – An eight-point agenda for reducing poverty and improving lives worldwide, agreed upon by world leaders at the Millennium Summit in 2000. For each goal, one or more targets have been set, most for 2015, using 1990 as a benchmark. The eight goals are: 1. Eradicate extreme poverty and hunger; 2. Achieve universal primary education; 3. Promote gender equality and empower women; 4. Reduce child mortality; 5. Improve maternal health; 6. Combat HIV/AIDS, malaria and other diseases; 7. Ensure environmental sustainability; and 8. Develop a global partnership for development.[10] Following the 2005 World Summit, universal access to reproductive health was added as a target under Goal #5 in 2006.

Morbidity rate – The number of individuals who become ill with a particular disease within a susceptible population during a specified time period.[11]

Mortality rate – The ratio of the number of deaths from a particular disease to the total number of cases of that disease.[12]

Neonatal – Referring to the first four weeks of a child's life.

PMCT – Abbreviation for programmes to Prevent Mother-to-Child Transmission of HIV/ AIDS. Such programmes administer anti-retroviral drugs to newborns, and less often to their mothers and siblings. The most successful programmes provide two ARV doses to both mothers and newborns and also offer confidential HIV counseling and testing.[13]

Reproductive health – The state of complete physical, mental and social well-being – not merely the absence of infirmity – in all matters relating to the reproductive system and to its functions and processes.

Safe motherhood – A family, community and social environment that allows women to experience a pregnancy to full term without unnecessary interventions, and delivery of a healthy infant into a postpartum period of medical and social support for the physical and emotional needs of the woman, infant, and the entire family. Safe motherhood begins before conception with proper nutrition, health care and a healthy lifestyle for the mother, and continues with appropriate antenatal care, the prevention of complications when possible, and the early and effective treatment by trained medical personnel of complications, if any, followed by post-natal medical care for mother and child.[14]

Safe Motherhood Initiative – A global campaign launched in 1987 by WHO; UNICEF; UNFPA, the United Nations Population Fund; the World Bank; Family Care International and other organizations, to ensure all pregnancies are wanted, all women can go safely through pregnancy and childbirth, and infants are born alive and healthy.[15]

Safer sex – Any sexual practice that aims to reduce the risk of unintended pregnancy and of passing HIV and other sexually transmitted infections from one person to another. Examples are non-penetrative sex or vaginal intercourse with a condom. During unsafe sex, fluids that can transmit HIV and other STIs (semen, vaginal fluid or blood) may be introduced into the body of the sex partner.[16]

Sexual and reproductive health care rights and services – The full spectrum of education, information, affordable and effective supplies and services necessary to allow all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to attain the highest standard of sexual and reproductive health. These rights also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[17]

Sexual rights – The rights of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to the following: sexuality, including access to sexual and reproductive health care services; the right to seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of sexual partner; the decision to be sexually active or not; consensual sexual relations; consensual marriage; the decision of when and whether or not to have children; and to pursue a satisfying, safe and pleasurable sexual life. These
rights are already recognized in national laws and international human rights and consensus documents.[18]

Son preference (or boy preference) – A desire to have male rather than female children. This is usually due to the perception that sons contribute more to their families and/or cost the family less than girls, through remunerative work, continuing the family line and carrying out family rites and rituals, and providing security to the parents in old age.[19]

Unsafe abortion – A procedure for terminating unintended pregnancy, either by persons lacking the necessary skills or in an environment lacking minimal medical standards, or both.[20]

Women of reproductive (or childbearing) age – Women age 15 to 49, according to WHO.

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Conference Organizers

The conference core planning group includes the Department for International Development, UK (DFID); Dutch Ministry of Foreign Affairs; Family Care International (FCI); International Planned Parenthood Federation (IPPF); Norwegian Agency for Development Cooperation (Norad); The Partnership for Maternal, Newborn & Child Health; Save the Children; Swedish International Development Agency (Sida); UNFPA, the United Nations Population Fund; UNICEF, the United Nations Children's Fund; The World Bank, and the World Health Organization (WHO).

Family Care International (FCI): FCI works to ensure that women and adolescents have access to life-saving services and information to improve their health, experience safe pregnancy and childbirth and avoid unintended pregnancy and HIV infection. www.familycareintl.org

Department for International Development, UK (DFID): DFID, part of the UK government, manages Britain's aid to poor countries and works to eliminate extreme poverty. www.dfid.gov.uk

Dutch Ministry of Foreign Affairs: The Ministry of Foreign Affairs is the channel through which the Dutch Government communicates with foreign governments and international organizations. It coordinates and carries out Dutch foreign policy. www.minbuza.nl/en/ministry

The International Planned Parenthood Federation (IPPF): IPPF is a strong global voice safeguarding sexual and reproductive health and rights for people everywhere. www.ippf.org

Norwegian Agency for Development Cooperation (Norad): Norad is a directorate under the Norwegian Ministry of Foreign Affairs. Its most important task is to contribute to international cooperation to fight poverty. www.norad.no

The Partnership for Maternal, Newborn & Child Health: The Partnership is a membership organization of 150 groups concerned with Millennium Development Goals (MDGs) #4 and #5. It resulted from a merger among the Partnership for Safe Motherhood and Newborn Health, the Child Survival Partnership and the Healthy Newborn Partnership. www.who.int/pmnch/en

Save the Children: Save the Children is an independent global organization creating change for children in need. It works with families to define and solve the problems their children and communities face while employing a broad array of strategies to ensure self-sufficiency. www.savethechildren.org

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Swedish International Development Agency (Sida): Sida is a governmental agency providing technical assistance and funding throughout the world. www.sida.se

UNFPA, the United Nations Population Fund: UNFPA is the lead United Nations agency supporting reproductive health care in 150 countries worldwide. It works to prevent women from dying in pregnancy and childbirth through technical, political and financial assistance. Activities range from providing family planning, advocating health reforms and upgrading health facilities, training midwives and doctors, mobilizing communities and promoting women's rights. All activities are undertaken in close partnership with national governments, sister United Nations agencies, civil organizations and The World Bank. www.unfpa.org

UNICEF, the United Nations Children's Fund: UNICEF is mandated by the United Nations General Assembly to advocate protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. www.unicef.org

The World Bank: The World Bank is a vital source of financial and technical assistance to developing countries around the world. It provides low-interest loans, interest-free credit and grants for education, health, infrastructure, communications and many other purposes. www.worldbank.org

World Health Organization (WHO): WHO is the authority for health within the United Nations system. It provides leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. www.who.int/en

The *Women Deliver* organizing committee includes more than 40 NGOs. Family Care International is the organizing partner. The NGOs include:

- Action Aid, Johannesburg, South Africa
- Action Canada for Population and Development (ACPD), Ottawa, Canada
- Advocates for Youth, Washington, D.C.
- Asian-Pacific Resource and Research Centre For Women (ARROW), Kuala Lumpur, Malaysia
- Asian Forum of Parliamentarians on Population and Development, Bangkok, Thailand
- Averting Maternal Death and Disability (AMDD), New York, NY
- CARE, Atlanta, GA
- CEDPA – The Centre for Development and Population Activities, Washington, D.C.
- CHANGE – Center for Health and Gender Equity, Takoma Park, MD
- DSW – German Foundation for World Population, Hannover, Germany
- EngenderHealth, New York, NY

- Federation of Obstetrics and Gynecology (FIGO), London, United Kingdom
- Feminist Majority Foundation, Arlington, VA
- Global Health Council, Washington, D.C.
- The Guttmacher Institute, New York, NY
- Human Rights Watch, New York, NY
- The Hunger Project, New York, NY
- IMMPACT – Initiative for Maternal Mortality Programme Assessment, Aberdeen, United Kingdom
- Inter-European Parliamentary Forum on Population and Development (IEPFPD), Brussels, Belgium
- International Center for Research on Women (ICRW), Washington, D.C.
- International Community of Women Living with HIV/AIDS (ICW), London, United Kingdom
- International Council of Midwives (ICM), Hague, Netherlands
- The International Rescue Committee, New York, NY
- International Women's Health Coalition (IWHC), New York, NY
- Ipas, Chapel Hill, NC
- Japanese Organization for International Cooperation in Family Planning (JOICFP), Tokyo, Japan
- JHPIEGO, affiliate of Johns Hopkins University, Baltimore, MD
- Latin American & Caribbean Women's Health Network (LACWHN)/Red de Salud de las Mujeres Latinoamericanas y Caribe ñas (RSMLAC), Santiago, Chile
- Partners in Population and Development, Mohakhali, Bangladesh
- Population Action International, Washington, D.C.
- PATH, Seattle, WA
- Rainbo, London, United Kingdom
- White Ribbon Alliance, Washington, D.C.
- The Womens' Commission on Refugee Women and Children, New York, NY
- Y-Peer – the Youth Peer Education Network, New York, NY
- The Youth Coalition, Ottawa, Canada

Why So High?
USA Facts on Maternal Mortality

Americans tend to be complacent about pregnancy and childbirth. Most believe it is now more or less routine and no longer the deadly risk it was for their grandmothers. This is true for most U.S. women, but by no means for all.

Maternal mortality is a continuing US problem

- About six million U.S. women become pregnant every year, and about four million give birth. Miscarriage and abortion account for the rest.[1]
- In 2004, a total of 540 U.S. women were reported to have died of maternal causes, the highest number in decades, according to the Centers for Disease Control.
- When a UN agency working group calculated the risk of death from complications of pregnancy and childbirth over a woman's reproductive lifetime, it found that one in 4,800 U.S. women will die from these causes.[2]
- This 2005 figure puts the U.S. 41st among 171 countries in the latest UN list.
- The overall U.S. maternal mortality ratio is now 11 deaths per 100,000 live births, one of the highest rates among industrialized nations.
- The level is thought to reflect both more detailed reporting on the causes of women's deaths and rising U.S. rates of obesity, high blood pressure and diabetes.
- U.S. maternal deaths have remained roughly stable since 1982 and have not declined significantly since then – 25 years ago.[3]
- The Centers for Disease Control estimates that the true level of U.S. maternal deaths may be 1.3 to three times higher than the reported rate.
- The major direct causes of U.S. pregnancy-related deaths are embolism, haemorrhage, complications of medical conditions, and hypertensive disorders of pregnancy (eclampsia and pre-eclampsia).[4]
- Goals of the *Healthy People 2000* project of the U.S. Department of Health and Human Services, launched in 1990, included lowering the U.S. maternal mortality ratio to 3.3 deaths per 100,000 live births. Only three states met that goal, and the target was revised upward to 4.3 for *Healthy People 2010.*[5]
- In the U.S., women over age 35 have higher pregnancy-related deaths than younger women. Women age 35-39 are 2.5 times more likely and women over age 40 are 5.3 more likely to experience a pregnancy-related death.[6]

Major disparities persist

- Maternal mortality among black women in 2000, the latest date for which figures are available, was almost four times the rate among non-Hispanic white women (34.7 per 100,000 live births vs. 9.3 per 100,000 live births).[7]
- The white-minority disparity holds true even across income levels and regardless of the level of antenatal care they receive.
- American black women are at rising risk of suffering premature deliveries and low birth-weight babies.[8]

- more -

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Complications are widespread

- For every woman who dies, several thousand suffer disability. One in five U.S. women experiences major complications during pregnancy and one in four will have serious complications during and after delivery.[9]
- About 43 percent of U.S. deliveries (1.7 million per year) experience some kind of maternal morbidity (defined as any illness or injury caused or aggravated by, or associated with, pregnancy or childbirth).[10]

Eclampsia is the most common

Eclampsia (toxemia, or pregnancy-induced hypertension) or pre-eclampsia is the most common complication for pregnant U.S. women, affecting 4,000 women per year.[11]

- Pre-eclampsia leads to about 18 percent of all U.S. maternal deaths, compared to 15 percent worldwide.
- Risk factors include multiple pregnancies, obesity, diabetes, or a history of high blood pressure, kidney disease or connective tissue disease (like arthritis or lupus).
- The U.S. incidence of pre-eclampsia has risen 40 percent in the last decade.

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[1] Except where otherwise noted, this section from Centers for Disease Control and Prevention (CDC), "Deaths: Final Data for 2004," National Vital Statistics Reports, Vol 55 #5, Aug. 21, 2007, pp. 12-13 and 102-103 .
[2] World Health Organization, UNICEF (United Nations Children's Fund), UNFPA (United Nations Population Fund), the UN Population Division, and The World Bank, *Maternal Mortality in 2005,* World Health Organization, Oct. 12, 2007, p. 27.
[3] Geller, Stacie E. et al, "Morbidity and Mortality in Pregnancy: Laying the Groundwork for Safe Motherhood," University of Illinois, Chicago, IL, 2006, p. 176.
[4] Geller, Stacie E. et al, "Morbidity and Mortality in Pregnancy: Laying the Groundwork for Safe Motherhood," University of Illinois, Chicago, IL, 2006, p. 178.
[5] Centers for Disease Control and Prevention, "Maternal, Infant and Child Health," Midcourse Review, Healthy People 2010, Health and Human Services Administration, Atlanta GA, 2005, p. 20.
[6] Geller, Stacie E. et al, "Morbidity and Mortality in Pregnancy: Laying the Groundwork for Safe Motherhood," University of Illinois, Chicago, IL, 2006, p. 178.
[7] Minino, A.M., et al., "Deaths: Final Data for 2004," National Vital Statistics Report, Centers for Disease Control, Atlanta GA, Vol. 55 No. 19, Aug. 21, 2007, pp. 12-13.
[8] Centers for Disease Control and Prevention, "Maternal, Infant and Child Health," Midcourse Review, Healthy People 2010, Health and Human Services Administration, Atlanta GA, 2005, p. 20 .
[9] Geller, Stacie E. et al, "Morbidity and Mortality in Pregnancy: Laying the Groundwork for Safe Motherhood," University of Illinois, Chicago, IL, 2006, p. 178-179.
[10] Geller, Stacie E. et al, "Morbidity and Mortality in Pregnancy: Laying the Groundwork for Safe Motherhood," University of Illinois, Chicago, IL, 2006, p. 177.
[11] This section from the Preeclampsia Foundation, "Preeclampsia Fact Sheet," "Statistics" and "Frequently Asked Questions," http://www.preeclampsia.org/ (accessed June 20, 2007).

The Road to *Women Deliver*

1948: United Nations Universal Declaration of Human Rights spelled out for the first time a global agreement that every woman, man and child had certain rights merely because they were human beings. No exceptions for "cultural practices," "national traditions," "family matters" or "religious teachings." No exceptions for gender, skin color, ethnicity, political views, religion or nation. No exceptions.

1968: International Conference on Human Rights, Teheran, affirmed that couples "have a basic human right to determine freely and responsibly the number and spacing of their children."

1975: First UN World Conference on Women, Mexico City, set three goals: full gender equality and elimination of gender discrimination; integration and full participation of women in development; and increased contribution by women to strengthening world peace. Delegates called for an international covenant to protect women's rights.

1976-1985: United Nations International Decade for Women (IDW), a product of the 1975 conference, led to establishment of UNIFEM, the UN Development Fund for Women. Two-thirds of UN member states adopted some form of national "plan" for women.

1979: CEDAW, the Treaty for the Rights of Women, approved at the UN. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) is the most comprehensive international agreement on women's basic rights. Ratified by more than 180 countries (but not the United States), it has become an important tool for ending human-rights abuses and promoting the well-being of women and girls worldwide.

1980: Second World Conference on Women, Copenhagen, identified three priorities: equal access to education, employment opportunities and adequate health care.

1985: Third World Conference on Women, Nairobi, recognized that relatively few women had benefited from progress so far and that the need for gender equality pertained to all areas of human activity. It set categories for assessing progress: in constitutional and legal measures, social participation, and political participation and decision-making.

1987: Safe Motherhood Conference, Nairobi. The enormous toll of women dying in pregnancy and childbirth worldwide led WHO, the World Bank and UNFPA (the United Nations Population Fund) to spearhead the research and advocacy Safe Mother Initiative to promote investment in measures to save women's lives. In its 20-year history, the SMI has made reduction of maternal mortality an essential health goal for the global community.

- more -

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1992: UN Conference on Environment and Development ("Earth Summit"), Rio de Janeiro, recognized the vital role of women in sustainable and social development and affirmed the rights of adolescents.

1993: UN International Conference on Human Rights, Vienna, declared that women's rights are human rights, condemned violence against women as human rights abuse, and led to the naming of a UN Special Rapporteur on women's situation worldwide.

1994: International Conference on Population and Development (ICPD), Cairo, said meeting reproductive health and other needs of individual women and men was the best path to development and slowing population growth. Leaders of 179 countries reached consensus on a 20-year Programme of Action – the "Cairo Consensus" – that called for investments in women of $21.7 billion per year by 2015.

1995: United Nations Fourth World Conference on Women, Beijing, spelled out in its Platform for Action 12 critical areas of concern for achieving equality, development and peace. It set targets and explained measures that governments, donors, multilateral agencies and non-governmental organizations should take to meet the goals.

2000: Millennium Declaration and Millennium Development Goals (MDGs), New York. At a global summit meeting, world leaders agreed on eight broad development goals for achievement by 2015, along with related targets and indicators for progress. The goals are: 1) Eradicate extreme poverty and hunger; 2) Achieve universal primary education; 3) Promote gender equality and empower women; 4) Reduce child mortality; 5) Improve maternal health; 6) Combat HIV/AIDS, malaria and other diseases; 7) Ensure environmental sustainability; and 8) Develop a global partnership for development. In 2006, the UN General Assembly agreed to add universal access to sexual and reproductive health and rights to the list as a target under MDG #5.

2002: World Children's Summit, New York, called for essential and emergency obstetric care before, during and after pregnancy and delivery as the best way to save the lives of women and children worldwide.

2002: World Summit on Sustainable Development, Johannesburg, focused on economic and financial approaches to development rather than on women's role or rights-based policies.

2004: Global Roundtable Countdown 2015, London, assessed progress on sexual and reproductive health and rights in the decade since the Cairo Consensus of the ICPD. More than 700 activists, parliamentarians and world leaders expressed disappointment at the pace of investment and policy change but committed themselves to renewed action on behalf of girls and women worldwide – especially in integrating reproductive health with HIV/AIDS initiatives and in bringing young people into policy-making councils.

2005: Commission on the Status of Women 10-Year Review and Appraisal, New York, found that the 1995 Beijing Platform for Action had sparked major improvements for women in some places although reaction had worsened conditions in others. Promises were not being kept.

Invest In Women – It pays![1]

Healthy women deliver for their families, communities and nations.

- Women's unpaid household, caregiving and farm work worldwide equals about a third of the world's Gross National Product.
- Women's income is more likely than men's to go for food, education, medicine and other family needs.
- Death or disability of a mother raises death and illness rates for children, destroys families, takes children out of school and lowers household and community economic productivity.
- Women are the sole income earners for 25 to 33 percent of all households.
- In 2001, the U.S. Agency for International Development estimated the global economic impact of maternal and newborn mortality at US$15 billion in lost potential production per year – half associated with women and half with newborns.

The return on investment in women is enormous.

- Investment in educating girls one extra year beyond the average boosts their eventual wages 10 to 20 percent.
- Investment in female secondary education yields returns in the form of higher wages that range from 15 to 25 percent, according to Yale economist Paul Schultz.[2]
- Credit extended to women increases household consumption about twice as much as men's borrowing.
- Providing emergency obstetric services and equipment to save women's lives also creates the capacity to perform operations and transfusions for accidents and other emergencies.
- Investing in family planning services lowers the rate of unintended pregnancies, which reduces unsafe abortions, which reduces health care costs.
- In some low- and middle-income countries, hospitals spend up to half their obstetric and gynecological budgets to treat women with complications from unsafe abortions.
- A 1993 World Bank study found that antenatal and delivery care and family planning were among the six most cost-effective health interventions for low-income countries.

Investment in women creates a "virtuous circle"

- Educated, employed and economically productive women are more likely to use health care systems.
- One study found that unemployed women have more than four times the chance of maternal death than employed women, and a greater chance of maternal health complications and illness after childbirth.

- more -

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- Women who use maternal health services are more likely to use other reproductive health services, such as HIV/AIDS testing and treatment, and family planning.
- Women who use maternal health care services are also more likely to obtain vaccinations for themselves and their children.
- Job status is more important to improving maternal health than overall household economic status, perhaps because paid work increases women's power over household resources.

The necessary investment is well within reach.

- Several reports estimate that the package of services essential to make significant improvements in maternal health would cost less than US$1.50 per person in the 75 countries where 95 percent of maternal deaths occur.
- The World Health Organization estimated that international development assistance for maternal and newborn health totaled US$530 million in 2004. WHO estimated it should be an additional ten times as much ($5.5 billion per year) to achieve MDG#5 by 2015 in the 75 countries where 95 percent of maternal deaths occur.
- Projections suggest that such funding requirements could be met if countries invested 15 percent of their national budgets in health and if official development assistance climbed further towards 0.7 percent of Gross National Income in the OECD countries.
- That sum is only 0.016 percent of global GNP and 2 percent of aid, well within the grasp of donor countries. And it would return three times as much in the maternal and newborn productivity that would otherwise be lost.

---

[1] Figures in this fact sheet, except where indicated, from K. Gill, R. Pande and A. Malhotra, "Women Deliver for Development," International Center for Research on Women, Washington DC, July 24, 2007, pp. 37-41.

[2] These two points on education from B. Herz & G. Sperling, "What Works in Girls' Education: Evidence and Policies from the Developing World," Council on Foreign Relations, New York, 2004, pp. 3-6

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Women Deliver When They are Educated

Educating girls raises lifetime incomes for them, their families and their countries.[1]

- The World Bank found in a study of 100 countries that every 1 percent increase in the proportion of women with secondary education boosted a country's annual per capita income growth rate by about 0.3 percentage points.
- Girls who have one more year of education than the national average earn 10 to 20 percent more, on average – even more than the increase for boys.
- Crop yields in Kenya could rise up to 22 percent if women farmers had the same education and inputs (such as fertilizer, credit, investment) as men farmers.[2]

Educating girls and women fosters democracy and women's political activity.[3]

- A Bangladeshi study found educated women three times more likely to take part in political meetings than those without schooling.
- Educated women are more likely to resist abuses such as domestic violence, traditions like female genital cutting, and discrimination at home, in society or the workplace.

Educating girls and women saves children's lives.[4]

- Every year of education delays a girl's marriage and reduces the number of children she has.
- Educated women are less likely to die in pregnancy or childbirth and more likely to send their children to school.
- If mothers have a primary school education, the mortality rate for their children under 5 is halved: they provide better nutrition and health care and spend more on the children.
- Children of uneducated mothers are half as likely to attend primary school as those whose mothers attended primary school themselves.[5]

Educating adolescents and young people is critical for development.

- Young people under 25 – half the world's 6.5 billion people[6] – need vocational and life skills and access to sexual and reproductive health information and services, if they are to take full part in their countries' development and contribute to it.
- Secondary and higher education, especially for girls, provides high returns for poverty reduction, economic growth and reproductive health.
- Enabling young couples to choose when to marry and have children leads to smaller families, slower population growth, increased productivity and rising incomes.

- more -

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Girls' education still lags behind schooling for boys.

- Of 163 million illiterate youth in the world, 63 percent are female.[7]
- Of the 104 million children 6 to 11 not in school, 60 million are girls. Nearly 40 percent of those girls live in sub-Saharan Africa and 35 percent in South Asia.[8]
- Although the gap is closing in primary school *enrollment*, one out of five girls in the developing world does not complete sixth grade.[9]
- Only 43 percent of secondary-school-age girls are in class in developing countries.[10]
- Factors that lower girls' school attendance include: fees for tuition, transport, books or uniforms; cultural biases or traditions that educate boys only or keep girls to work at home; lack of female teachers; lack of sanitary napkins; lack of separate toilet facilities; sexual harassment or abuse by teachers or other students; and child marriage.
- Where girls are expected to work at home and to join their husbands' families at marriage, parents may see sending them to school as all loss and no gain.
- Girls who suffer setbacks or long absences in primary school may not get the help they need to catch up.
- Teachers may require less from girls than they do from boys: one in three girls who complete primary school in Africa and South Asia cannot read, write or do simple math.[11]

High-level political leadership can raise public understanding and create conditions for girls' education in the developing world.

- Education costs are immediate to parents, but benefits are distant, so governments must make universal education mandatory – at least for primary grades, and eventually for secondary grades as well.
- Eliminating or cutting school fees typically causes enrollments to skyrocket.
- Stipends for tuition, books, uniforms etc. dramatically lower dropout rates.
- Schools can be made more girl-friendly with private latrines, female teachers, sanitary supplies, and an end to harassment and discrimination against girls.
- Rural and community school construction should increase and include community support, flexible schedules and child-care programs.
- Comprehensive sexual and reproductive health education should be mandatory in schools, especially for adolescents.

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[1] This section from Herz, Barbara, and Sperling, Gene B., *What Works in Girls' Education: Evidence and Policies from the Developing World,* Council on Foreign Relations, New York, 2004, p. 2-3
[2] UNFPA, UN Population Fund, *State of World Population 2005: The Promise of Equality,* UNFPA, New York, 2005, p. 47
[3] This section from Herz, p. 6
[4] This section from UNICEF, *The State of the World's Children 2007,* UNICEF, New York, 2007, p.4-6
[5] UNICEF, p. 27
[6] UNFPA, p. 45
[7] UNFPA, p. 46
[8] Herz, p. 2
[9] UNICEF, p. 4
[10] UNICEF, p. 4
[11] Herz, p. 2

Women Deliver – Against HIV/AIDS

AIDS has a woman's face

- HIV is spreading fastest among women. Of the estimated 39.5 million people living with HIV, 48 percent are women – nearly 19 million people – and half of all new infections occur among women.[1]
- Young women age 14 to 24 in parts of Africa and the Caribbean are up to six times more likely to be HIV-positive than young men their age.[2]
- In sub-Saharan Africa, 57 percent of all people living with HIV are women.[3]
- Women are more vulnerable than men to HIV infection – for biological, economic and cultural reasons (such as discrimination, gender inequality and violence).[4]
- A 2005 UNFPA report found that only about 8 percent of pregnant women and 16 percent of sex workers worldwide were being reached with prevention efforts.[5]
- In 2005, only 15 percent of those in need of anti-retroviral drugs were receiving it. Six in ten of those receiving treatment were women.[6]

Cultural factors drive the pandemic

- The stigma surrounding AIDS is a major obstacle to curbing it, especially for women, who avoid testing and treatment for fear of abandonment, violence or ostracism.
- In many of the worst-hit countries, frank discussion of gender equality, HIV prevention, contraception, or any other sex-related issue is taboo, yet ignorance of positive HIV status is death – for both infected people and their partners.
- Only *5 percent* of all HIV-positive people in the world are aware of their status.[7]
- While one person dies every 11 seconds from AIDS, one person is infected with HIV every six seconds – so the total number of infections is growing.[8]
- HIV-positive women are often denied health care, information and services to prevent pregnancy and HIV transmission because health workers assume or believe that they do not have sex and will not (or should not) have children. This is a violation of their human rights.
- In many countries, having sex with many women is a measure of male virility and prestige. Where extra-marital affairs are common, marriage can actually raise a woman's risk of contracting HIV.

Interventions targeted at women could slow the spread of HIV

- Every year of education for a girl lowers her risk for HIV infection.[9]
- A survey of 24 sub-Saharan African countries found that two-thirds of young women lacked understanding of HIV transmission. Men's knowledge was greater.[10]
- Most people become sexually active during adolescence, yet most young people have no access to prevention programs.[11]

- more -

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- Family planning and maternal care clinics are often a woman's only contact with a developing country's health system, but "stovepiping" approaches by donors, which restricts funds to HIV/AIDS uses, has led to parallel care systems in some areas. This is inefficient, reinforces stigma and creates a cadre of health care workers uninvolved in meeting basic needs.[12]
- Programs to prevent mother-to-child transmission of HIV must as a matter of human rights treat both mother *and* child.

Saving women also saves the next generation

- Treatment for HIV-positive mothers as well as their children is the most cost-effective approach, as motherless children are far less likely to survive to adulthood.
- In 2005, more than two million children 14 or younger were living with HIV.[13]
- By 2006, at least 13 million children – 12 million of them in sub-Saharan Africa – had lost one or both parents to AIDS. Such AIDS orphans are likely to number 15.7 million worldwide by 2010.[14]

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[1] Population Resource Center, "World AIDS Day: December 1, 2006," http://www.prcdc.org/World_AIDS_Day.pdf (accessed 10/3/07), p. 1
[2] UNICEF, *The State of the World's Children 2007,* UNICEF, New York, 2007, p.5
[3] UNFPA, *State of World Population 2005: The Promise of Equality,* UNFPA, New York, 2005, p. 37
[4] World Health Organization, "Women and HIV/AIDS," 2007, http://www.who.int/gender/hiv_aids/en/ (accessed 10/3/07)
[5] UNFPA, p. 37
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[11] UNFPA, p. 52
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Population Action International's 2007 Global Report Card on Reproductive Risk

Population Action International (PAI), a Washington-based nonprofit organization, has rated the countries of the world on **nine indicators of reproductive risk** that women face during their lifetimes. The Netherlands is the world's safest country for women in this broad evaluation, while Niger ranks last.

The report card, *A Measure of Survival: Calculating Women's Sexual and Reproductive Risk,* documents continuing stark disparities in reproductive risk between rich countries and poor ones. "Pregnancy and childbirth are deadly to more than half a million women worldwide every year," the report begins, "a fact that is unacceptable, but not unavoidable."

The report, the fourth in PAI's series, rates each country on indicators from the 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) of 2000, as amended in 2006. The report classifies 130 countries of at least one million in population into five roughly equal groups: lowest risk (28 countries), low risk (26), medium risk (26), high risk (24) and highest risk (26).

The framework looks at the "life cycle" of reproductive health and considers a woman's risk at each point of the reproductive cycle: (1) sex, (2) pregnancy, (3) birth, and (4) survival. It judges risk for the first three events according to whether they are **safe** and whether or not they are **voluntary**.

"This system paints a picture of a woman's risk in each country by looking holistically at all the factors that affect her reproductive years," said PAI President and CEO Amy Coen. She noted that poor-quality service often poses as much risk as sheer lack of service: sporadic supply and limited choice of contraceptive methods lowers overall contraceptive use, which raises women's lifetime risk, for example.

The nine indicators of a country's reproductive risk for women are:

1. Percent of HIV prevalence among adults 15 years or older;
2. Adolescent fertility rate (births per 1,000 women age 15-19);
3. Percent of girls married before age 18;
4. Percent of women receiving antenatal care in at least four visits;
5. Percent of family planning demand met;
6. Percent of births attended by skilled health personnel;
7. National policies on abortion;
8. Maternal mortality ratio (deaths per 100,000 live births); and
9. Infant mortality rate (deaths per 1,000 live births).

- more -

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Major Findings of "A Measure of Survival: Calculating a Woman's Reproductive Risk"

- The countries with the highest overall reproductive health risk for women, in order, are **Niger, Chad, Mali, Yemen and Ethiopia.**
  - All 26 countries at highest overall risk are in sub-Saharan Africa, except for **Haiti, Yemen and Laos**, the poorest countries in their respective regions.
- The lowest-risk countries, in order, are the **Netherlands, Switzerland, Singapore, Germany** and **Belgium.**
- Maternal mortality has been all but eliminated in most industrialized countries, where investment in women has given them means and status to obtain access to health care.
- Pregnancy remains the leading killer of women of reproductive age in most developing countries.
- Unprotected sex is the primary cause of women's reproductive risk: for transmission of HIV and other infections, for complications from pregnancy and childbirth, and from unsafe abortions of unintended pregnancies.
- Condom use remains uncommon among married couples and regular partners, in part because of an inadequate global supply of all modern contraceptive methods.
- Antenatal care coverage can be used as a general indicator of women's exposure to the health care system. Rural and poor women routinely fare worse than urban and wealthier women.

Some interesting comparisons

- The United States has the highest adolescent fertility rate of all developed countries (43.7 births per 1,000 women age 13-19). The **UK** and **New Zealand** rate is 27.1.
- Caribbean countries straddle all five categories, from **Haiti** in the Highest Risk category to **Cuba** in the Lowest Risk category.
  - **Cuba** has the same level of adolescent fertility as the United States.
  - **Haiti**, unlike other Caribbean countries, has low levels of antenatal care and skilled attendance at delivery.
- Except for **Sri Lanka** (which has practically universal antenatal care coverage and skilled attendance at delivery), South Asian countries have very low rates of skilled attendance at delivery. Some are at par with levels in **Niger, Chad and Ethiopia**.

The report called for better distribution of reproductive health care services and greater attention to local needs. "Women must have comprehensive services, especially care in pregnancy and childbirth and for sexually transmitted infections," said Coen. "These services are critical to preventing deaths and improving the health of women and their families."

To view and download a full copy of the Reproductive Risk Report Card, visit the Population Action International Web site: www.populationaction.org