

**Testimony of Helene Gayle, MD, MPH
President and CEO, CARE USA**

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Subcommittee on State, Foreign Operations and Related Programs**

“Maternal and Child Health, Family Planning, Reproductive Health”

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Chairman Leahy, Senator Gregg, Subcommittee Members. I am honored to be here, discussing issues that are vital to the future of millions of people. For the past 61 years, CARE has worked across a spectrum of poverty-fighting arenas ó from child survival to clean water, and from basic education to HIV/AIDS. We believe that poor health and extreme poverty are intertwined, and that one cannot be overcome if the other is neglected. That is why we work on a broad range of health issues, including maternal and child health, infectious diseases, ranging from HIV/AIDS to avian influenza, and reproductive health. My testimony today reflects CARE’s experience in thousands of poor communities throughout the world over the course of half a century.

We are here today to consider some basic, yet heart-wrenching, questions. Why does one woman die every minute of every day from complications related to pregnancy and childbirth? (99 percent of these deaths occur in developing countries, and the reasons are basic: women hemorrhage to death, they lack access to antibiotics to prevent infection or they don’t have the option of a cesarean section.) Why do 10.5 million children die

each year before their fifth birthday (greater than the number of adults who die from AIDS, malaria and tuberculosis combined), when most of these deaths are preventable? Why, at a time when contraception is cheap and effective, do 120 million couples have an unmet need for family planning? Why, when some 70 percent of young women in Africa become sexually-active as adolescents and more than 20 percent have their first child by 18, do we hesitate to confront that reality?

Despite the magnitude of unmet need that remains, the U.S. government can be proud of the difference it has made in the global health arena.¹ For example, American leadership in family planning has contributed to some impressive gains. In 1960, only 10 percent of married women in developing countries used modern contraception. By 2000, this figure had risen to 60 percent and the average number of births per woman had fallen from six to three. More broadly, in the past 50 years, life expectancy in the developing world has risen from 40 to 65 years, and a child's chance of living to the age of five has doubled.

We have learned that large-scale improvements in public health are achievable. We have seen the real difference made in lives saved and economies strengthened. Sri Lanka's long-term commitment to a range of safe motherhood services has, over four decades, decreased maternal mortality from 486 to 24 deaths per 100,000 live births. In Egypt, a national campaign that promoted the use of oral rehydration therapy helped reduce infant diarrheal deaths by 82 percent between 1982 and 1987. China's national

¹ A recent analysis of six projects funded by USAID's Child Survival and Health Grants Program indicates that mortality of children under five has been reduced by approximately 8 percent in project areas due to interventions supported by the program.

tuberculosis program helped reduce TB prevalence by 40 percent between 1990 and 2000, and translated directly into social and economic benefits: for each dollar invested in the program, \$60 was generated in savings on treatment costs and increased earning power of healthy people.²

Even though important progress has been made, the need remains enormous and urgent. The knowledge and experience we have already gained position us to invest resources more wisely and the partnerships formed reflect greater capacity to turn resources into effective action. Yet, even as efforts to fight HIV and AIDS are receiving greater attention and resources (as they should), we are becoming too complacent about basic public health issues like maternal and child health, family planning, and adolescent reproductive health. And we are not paying sufficient attention to building the strong, accountable health systems (both infrastructure and workforce) required to support any health interventions, be it neonatal care, family planning or AIDS treatment. Ultimately, CARE's experience in poor communities strongly supports both the need for increased investment of resources, and better use of those resources.

Our *first*, and most important, insight has been that "technical solutions" alone don't bring lasting results. For health impacts to be sustainable, they must address underlying causes of poor health, be tailored to each cultural context and be broadly owned by local communities. For example, emergency obstetric care is vital to reducing maternal mortality, but lasting improvements in maternal health are not achieved simply by making such care available.

² Center for Global Development, *Millions Saved: Proven Successes in Global Health*, 2007 edition.

In rural Ayacucho, in Peru, CARE found that only one-third of women who needed obstetric services actually accessed them; and of every 100,000 live births, 240 women died (by contrast, in the United States, this ratio is 17 of every 100,000 live births). CARE did not approach this challenge as an exclusively medical problem. Rather, we tried to understand the health system in Ayacucho as a unique social institution embedded in a specific community. We found that women did not seek care because health center staff often did not speak Quechua (the local language) and women did not feel welcome there. Health center staff felt inferior to regional hospital staff and often felt ridiculed by them when they referred an emergency case; they also did not have means to transport emergency cases. Hospital staff were frustrated that emergency referrals were often misdiagnosed or came too late to save women's lives.

By working to understand the needs of rural women and health workers at various levels, and removing blocks in the emergency referral system, CARE has helped to reduce maternal mortality in Ayacucho by half. Now, all health centers in our project area and the regional hospital have Quechua-speaking staff, a friendly environment, and culturally-appropriate options for childbirth (such as vertical birthing chairs, preferred in Ayacucho). Emergency obstetric protocols were developed by collaboration among doctors, nurses, midwives and Ministry of Health staff, drawing from ideas and realities of rural health personnel. As a result of competency-based training provided to rural health personnel and cost-effective resources like two-way radios and ambulances, women's conditions can now be diagnosed more accurately and they can be transported

to hospitals quickly. Currently, 75 percent of women who need obstetric services can access them. A key aspect of CARE's approach was building broad political will to address the exceedingly high maternal mortality rate. As a result of Ayacucho's success, in January 2007, the Peruvian Minister of Health established new national clinical guidelines for obstetric emergencies, based on those developed by this project.

Second, CARE has learned that individual and collective empowerment has much to do with access to health care services, accountability of health systems and the ultimate health status of the most vulnerable. Less power means less voice and less access, and that inequity results in poorer health. In most developing countries, women and youth are the least powerful, and their needs are often neglected. The roots of the health problems they face are often hidden, but we must strive to uncover, understand and address them.

In Bangladesh, where CARE had been implementing a safe motherhood initiative, we concluded that domestic violence was one of the greatest risks that women faced during pregnancy. Even the best prenatal, obstetric and post-partum care could not fully help these women, unless the phenomenon of rampant violence against women was also addressed. CARE's modified approach, of incorporating efforts to prevent and respond to violence against women into safe motherhood work, holds much more promise not only of helping women have healthier pregnancies but also of securing safer societies. In isolated southern Maniema province, in the Democratic Republic of Congo, local health systems were devastated by war and women had encountered brutal violence and rape in

war-time. Many women had married young and had multiple pregnancies, and CARE's promotion of family planning and birth spacing was welcomed as a respite ó a chance to control at least one aspect of their bodies and lives. A young woman named Anifa told us: "Normally, I'd be pregnant again, and able only to concentrate on my new baby, and not my other children. Now that I can control my pregnancies, I can be sure that my kids go to school. I will see a better life through my children."

Third, we have learned that dividing public health into various categories may be convenient for allocating donor funding, but these inherently related issues have to be understood and addressed within a broader and more integrated context. For example, we talk about maternal mortality and child survival as separate issues, but we know that they cannot be separated. In some countries, if a mother dies, the risk of death for her children under 5 doubles or triples. When women cannot space the births of their children, both they and their children are less likely to be healthy. Sometimes ó as with HIV/AIDS and reproductive health ó we not only pursue them as separate issues, but also build parallel systems to deliver services. This is ultimately a less efficient investment of resources as well as a barrier to effectiveness ó for example, HIV information and testing could reach many more women, in ways that are potentially less stigmatizing, if they were made available through family planning or prenatal care services. Even within CARE, which is considerably less complex than the U.S. government, maintaining a system-wide view and integrating across various sectors and technical specialties is a challenge. We are constantly trying to do better.

Finally, we at CARE have been dismayed to witness the increasing politicization of U.S. foreign assistance related to programs that deal in any way with sex or reproduction.³ For example, the abstinence-until-marriage earmark in the Global AIDS Act of 2003 requires that one-third of all HIV prevention funding be spent on abstinence programs. Administrative guidance issued by the Office of the Global AIDS Coordinator translates this earmark into a requirement that fully two-thirds of funding for preventing sexual transmission of HIV be spent on abstinence and fidelity programs. It also permits condoms to be provided only to sexually-active youth, with little recognition of the fact that those who are not sexually-active today may be so tomorrow (no matter how much we urge them to be abstinent) due to economic pressures driving transactional sex or vulnerability to sexual violence. Although the earmark governs only the U.S. government's HIV/AIDS responses, the message that A and B are the priorities have strongly influenced U.S. reproductive health programs – especially those working with adolescents. The spillover effect is that reproductive health programs targeting youth are increasingly constrained in terms of the information and services they can provide – as a result, U.S. funded programs are less effective at protecting young people from pregnancy, or HIV and other STDs.

From CARE's perspective, family planning and women's reproductive health have become too politicized and are losing ground on the U.S. global health agenda. The Mexico City Policy, in particular, is symbolic of this politicization and has caused much

³ In addition to the abstinence-until-marriage earmark and the Mexico City Policy, increased politicization is also evident in the requirement of the Global AIDS Act of 2003 that organizations must adopt a policy opposing prostitution and sex trafficking in order to be eligible for HIV/AIDS funding authorized under the Act.

difficulty for implementers of reproductive health programs. Much of the work of international NGOs like CARE is done in partnership with local organizations. In the reproductive health field, many of the best local organizations provide comprehensive family planning services, sometimes including counseling on safe abortion. The Mexico City Policy prohibits organizations like CARE from working with such organizations, and in some cases, prevents us from working with the only organizations that are capable of providing the most basic family planning services. Thus, it diminishes not just the availability of these services but also their quality.

These are just some of CARE's experiences that are pertinent to the matters at hand today. Given what we have learned, I want to urge you to consider the following:

First, invest more – and more strategically – in reducing maternal mortality and child survival. On this, the twentieth anniversary of the global safe motherhood movement, the slow progress on reducing maternal mortality undermines America's deeply-held commitment to strengthening health and well-being throughout the world. We must gather the will and do much better. Over the past five years, U.S. commitments to maternal and child health funding have not kept pace either with unmet needs or with increasing growth in other international health accounts. I urge you to provide strong funding levels for international maternal and child health programs in 2008. In particular, CARE strongly supports the requested U.S. "fair share" levels outlined by Nils Daulaire on behalf of the Global Health Council for maternal and child health, and I urge their adoption by this committee in the coming appropriations process.

The vast majority of maternal deaths are due to hemorrhage, infection and obstructed labor and can be easily prevented or treated. For each of the half a million women who die of complications during pregnancy and childbirth, 30 others are injured, many of them in seriously disabling and socially devastating ways. Women with obstetric fistulas, for example, are often abandoned by their families and condemned to isolation. The lifetime risk of dying in pregnancy or childbirth is 1 in 16 for women in developing countries, as compared to 1 in 2800 in developed countries. In Afghanistan, where 95 percent of women deliver their babies at home, without a skilled attendant on hand, the lifetime risk of dying in pregnancy or childbirth is one in six.

We must invest more strategically, not only to strengthen and expand all levels of health care (particularly speed of emergency referrals and quality of emergency obstetric care) but also to remove barriers to women's access to health systems and services. We must strive to ensure that all pregnant women have a skilled attendant at delivery; this need not be a doctor, but must be someone who can diagnose complications, administer drugs to manage them, and (where possible) refer women to emergency obstetric care. Drugs like *misoprostol*, which are cheap and easy to administer, can help strengthen contractions and control post-partum haemorrhage, and could ultimately increase the effectiveness of skilled attendants and reduce maternal mortality.

Maternal health and child survival go together – this is why funding to reduce maternal mortality is such a smart investment. Four million babies die each year in the

first month of their life; that is roughly the equivalent of all babies born in the United States in one year. Simple interventions like promoting breastfeeding, oral rehydration therapy, vaccinations, clean water, and insecticide-treated bed nets could make a huge impact on child survival, even where health systems are weak. USAID's Child Survival and Health Grants Program has done excellent work in this area and deserves your increased support.⁴ In partnership with this program, CARE has worked in the extremely poor far-west region in Nepal to reduce under-five mortality by 53 percent. A key approach in Nepal was community case management, whereby volunteers are trained to provide an antibiotic to treat pneumonia. This intervention effectively prevents pneumonia deaths in communities where many families do not have the money or means of transportation to see a doctor in time. In settings as diverse as Nepal, Mozambique and Sierra Leone, CARE has achieved significant reductions in under-five mortality for a cost per life saved of between \$740 and \$980.

Second, recommit to the importance of family planning. Access to family planning services represents one of the most cost-effective investments the U.S. can make in the future of women, children, communities and nations. Family planning returns enormous value in improved health outcomes, economic development and national security. Yet, the administration's budget request proposes a 23 percent cut in family planning funding for 2008. I urge you to not only restore the cut, but also provide significantly increased funding levels for international family planning, as the request outlined by the Global Health Council indicates.

⁴ The analysis referenced in Footnote 1 indicates that these projects saved more than 16,000 lives of children under five.

The ability to decide when, with whom and how often to have children is key not only to the individual futures of women and girls, but also to the development of countries struggling to overcome poverty. Although methods for avoiding unwanted pregnancies are cheap and effective, every year, 80 million women have unintended pregnancies. The unmet need for contraception is closely related to maternal mortality: if every woman who needed contraception had access to it, an estimated 20-35 percent of maternal deaths could be averted. However, with other health priorities taking precedence, family planning seems to be declining in importance. Between 1995 and 2003, donor support for family planning (commodities and service delivery) fell from \$560 million to \$460 million.

The rationale provided by the administration for the 23 percent cut in family planning funds for 2008 is that these efforts have been so successful that they don't require as much U.S. investment going forward. Unfortunately, that is hardly the case. Large pockets of substantial unmet need still remain, and gains are reversed all too quickly when they are not reinforced. Kenya, for example, had a fertility rate of about eight births per woman in the 1960s. After decades of investment in family planning services, the fertility rate had fallen to 4.8 births per woman in 1998. In the past few years, however, attention has shifted away from family planning. As a result, availability of contraceptives at health facilities declined, as did outreach services. Sadly, between 1998 and 2003, the proportion of births reported by mothers as unwanted rose from 11 percent to 21 percent.

On a related note, I also want to register our concern about recent reports that the World Bank's draft health, nutrition and population strategy omits any commitments to family planning. This strategy is under review as we speak today and, if approved, could deal a serious blow to reproductive health programs all over the world. CARE urges the United States, as the largest shareholder of the World Bank, to underscore the importance of family planning and reproductive health in achieving progress on multiple fronts, including economic development, basic education and public health.

Third, commit to evidence-based reproductive health programming for youth that is grounded in sound public health practice. The impending "youth bulge," anticipated by demographers, demands that we act effectively, realistically and rapidly. Sadly, the new strategic framework for U.S. foreign assistance fails to highlight the specific needs of youth, and places their critical needs underneath a broader umbrella. Although the intent to "mainstream" youth reproductive health is laudable, our observation is that fewer and fewer U.S. funding opportunities are addressing youth issues and we believe this important issue may be falling through the cracks.

Young people, especially girls and young women, are vulnerable on many fronts, but especially when it comes to pregnancy, STDs and HIV/AIDS. They are less likely than older people to protect themselves, either because they are not aware of it or cannot access it the protective measures that can keep them safe or because they have less

control over the terms of sexual relations. We must ensure that the needs and rights of the most vulnerable young people are protected: for example, adolescents at risk of inter-generational or transactional sex; girls at risk of child marriage; young people who are victims of gender-based violence; and youth in conflict or post-conflict settings. Many young people fall into the category of orphans and vulnerable children (OVCs), orphaned or made vulnerable due to HIV/AIDS, other diseases and conflict, and are left without parental guidance and are particularly vulnerable to sexual exploitation. These young people are at risk of unplanned pregnancies, HIV/AIDS and other STDs, and therefore, are badly in need of comprehensive reproductive health services.

Fourth, eliminate legal barriers that impede evidence-based programming in reproductive health and HIV/AIDS, especially related to vulnerable women and adolescents. I urge Congress to repeal the abstinence-until-marriage earmark and request the Office of the Global AIDS Coordinator to revise its ABC guidance in a way that promotes (rather than discourages) comprehensive sex education. I also urge Congress to repeal the Mexico City Policy ó there is no evidence that having this policy in place has reduced the number of abortions performed. In fact, by cutting off funds to foreign family planning organizations that reject its conditions, the Mexico City Policy has most likely increased the number of unplanned pregnancies and led to increased numbers of abortions sought.

In some of the countries in which CARE works, we see the implementation of the ABC approach translating into the operational message that abstinence and fidelity are

the most desirable and moral options, and positioning condoms as something used only by people engaging in risky sex or as a last resort. When Uganda first developed the ABC approach, it was compelling because it demystified HIV/AIDS and communicated that individuals had the power to protect themselves by choosing among A, B or C options. Delaying sexual debut and partner reduction is absolutely vital to preventing HIV and other sexually transmitted infections, but that does not mean that A, B and C should be broken up into parts and promoted to different segments of the population. In settings where risk of HIV infection is high, it is a disservice to not provide comprehensive information and prevention methods to young people who are not yet sexually active. The young girl who we counsel today about abstinence may be married tomorrow (or coerced into transactional sex), and we have an obligation to prepare her for the future.

Finally, invest more broadly and strategically in global health and development. The U.S. leadership on HIV/AIDS has been admirable, but it must be accompanied by broader investments that promote community-led development, strengthen health care systems and build workforce capacity. We cannot save babies from contracting HIV only to see them dying of diarrhea or languishing without access to basic health and social services. Our investments in drugs, tests and other health interventions will be constrained if there are not enough health workers to administer them. If all boats don't rise at similar levels, the bold investment in HIV/AIDS may fail to deliver on its promise and other areas in which gains have been made over several decades may be undermined. We cannot let that happen.

I want to thank you for inviting me here today and I look forward to answering your questions. CARE has been a partner in the fight against global poverty with the U.S. government and the American people for more than half a century and we are grateful for what your support allows us to do in thousands of poor communities around the world. We look forward to a future of productive partnership and exchange.