



CARE USA
151 Ellis Street, NE
Atlanta, GA 30303-2440
USA
tel 404.681.2552
fax 404.577.5557
www.care.org

**STATEMENT SUBMITTED FOR THE RECORD
HOUSE FOREIGN AFFAIRS COMMITTEE, SUBCOMMITTEE ON AFRICA
AND GLOBAL HEALTH**

HEARING ON CHILD SURVIVAL

MARCH 13, 2008

**HELENE GAYLE, MD, MPH
PRESIDENT AND CEO, CARE USA**

Helene Gayle, MD, MPH, President and CEO, CARE respectfully submits the following testimony for the record:

I want to thank the members of the Subcommittee for focusing today's hearing on Child Survival and for supporting the Global Child Survival Act (HR 2266). Continued U.S. leadership in addressing the vulnerability of children saves lives and leads to healthier individuals, families and communities.

CARE has over 61 years of experience working to end extreme poverty and preventable illness. Our experience has shown that health and development issues cannot be addressed independently; success can only be achieved through integrated and comprehensive approaches that address the underlying vulnerabilities facing poor people in the communities where they live. These approaches must work across sectors and engage the basic determinants of vulnerability that drive disease risk, such as gender inequality, stigma, and poverty. CARE's programming in 71 countries around the world-- regardless of sector, context or country-- works to ensure that basic needs are met; to improve quality of life; to enhance the position of marginalized individuals within their communities (especially women and children) and strengthen their ability to make decisions that affect their lives; and to build the capacity of political institutions, service delivery systems and civil society to ensure equal treatment of all people.

While the global community has made progress in improving child survival over the last four decades -- a 60 percent reduction in under 5 mortality since 1960-- a large number of countries in the developing world that account for the highest mortality and morbidity burdens have made little to no progress. For those countries that have made progress, in recent years this progress has stagnated and in some cases is being reversed. In addition,

over the past two decades, little progress has been made in reducing the rate of death and disability associated with pregnancy and childbirth in the developing world. Maternal mortality remains the greatest health disparity between developed and developing countries. We must ask ourselves why when cost effective, evidence-based interventions exist:

- Over half a million women a year die during childbirth. For every woman that dies, 30 more suffer injuries, infection or disability, and many more suffer debilitating long-term effects.
- Over 2 million children are left as orphans due to the loss of their mother during pregnancy and childbirth, increasing their risk of death and decreasing their educational and livelihood opportunities.
- Around 80 million women a year have unintended pregnancies, leading to millions of unplanned births, and tragically, thousands of unsafe abortions.
- Over 10 million children die each year of preventable or easily treatable causes such as newborn diseases and conditions, pneumonia, malnutrition, diarrhea and malaria before reaching their 5th birthday. Around 4 million of these babies die during their first month of life, about half on the day they were born.

Approximately 99 percent of these maternal and child deaths occur in the poorest, most disadvantaged countries in the developing world; the global community must take action! U.S. leadership on this issue is essential to turning the tide on maternal health and child survival and for helping the world reach Millennium Development Goals 4 and 5, reducing child mortality and improving maternal health, respectively, by 2015.

We are grateful that USAID's Child Survival Health Grants Program has enabled CARE to implement 41 projects in 21 countries. Based on our experience, we know that by more strategically investing in simple, cost effective interventions such as breast feeding, oral rehydration therapy, vaccines, clean water, and bed nets we can significantly reduce the number of children under 5 that are dying of preventable causes. Using the Community Based Integrated Management of Childhood Illnesses approach promoted by UNICEF, WHO and the World Bank, a CARE child survival program in Nepal reduced the under-5 mortality in the extremely poor far-west region by 53 percent. This community case management intervention focused primarily on teaching mothers how to identify the 'danger signs' of common and potentially deadly childhood diseases such as diarrhea, measles, pneumonia, and malaria and removing barriers to accessing needed medications by training community-based female health volunteers to deliver approved medications directly to the households in need.

In order to improve child survival over the long term, we must efficiently address the factors that affect maternal health, as these two issues are inextricably linked. Improved maternal health is essential to increasing child survival; therefore they must be understood and addressed together using comprehensive approaches. In some countries, if a mother dies, the risk of death for her children under 5 doubles or triples. A study in Nepal found that infants of mothers who died during childbirth were six times more likely to die in the first week of life, 12 times more likely between 8 and 28 days, and 52

times more likely to die between 4 and 24 weeks¹. In addition, research has shown that when women are able to space births through family planning, the health of their children improves. Improving the health and nutrition of mothers and providing quality reproductive health and family planning services are pivotal to addressing many underlying causes of child mortality.

In rural Ayacucho, 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 helped to increase the "met need" for emergency obstetric care to 84 percent and 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 through collaboration among doctors, nurses, midwives and Ministry of Health staff, drawing from the ideas and addressing the realities of rural health personnel. As a result of providing competency-based training 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. 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 (MOH) established new national clinical guidelines for obstetric emergencies, based on those developed by this project. In addition, the MOH plans to partner with CARE to scale up this project to six other vulnerable regions.

To implement programs that address maternal health and child survival in a comprehensive and sustainable way, we must promote community-driven program development, strengthen the healthcare system, and build the capacity of the workforce. Between 1998 and 2002, CARE partnered with the Municipal level Ministry of Health in Nicaragua (MINSA) to implement a USAID child survival project in the municipality of Matagalpa, one of the most economically depressed areas in north-central region. Based on the success and lessons learned during this project, between 2002 and 2007, CARE scaled up the implementation of integrated maternal and child health services in two

¹ Katz J, West KP Jr, Kahtry SK, et al. Risk factors for early infant mortality in Sarlahi district, Nepal. *Bull World Health Organization* 2003; 81: 717-25.

additional municipalities. The program also added a more targeted maternal and newborn health intervention in order to provide a more complete package of health activities for mothers and children. Through this project, CARE improved the access and quality of maternal and child health services in the public and private sectors and at the hospital in Matagalpa and strengthened household decision-making which led to improved health behaviors. At the end of the project, we saw a dramatic reduction, about 77%, in maternal mortality at the regional hospital in Matagalpa. By working with and building the capacity of our partners, CARE has helped to ensure that these results will be sustainable.

Despite successes like these, a global assessment of maternal health outcomes over the 20-plus years since the launch of the global Safe Motherhood initiative indicates that there has been little and in some countries no reduction in maternal death and disability rates in the developing world. And, while there is a growing need for services, specifically family planning and reproductive health, and growing investment in other international health accounts (specifically HIV and AIDS and malaria), U.S. investment in maternal health and child survival programs has actually decreased over the last decade. If we are going to address the issues of maternal health and child survival effectively, this funding trend must be reversed. We must substantially increase both U.S. and global investments in maternal health and child survival, while we target limited resources more strategically toward evidence-based programming that engages the underlying drivers of increased vulnerability, risk and ultimately mortality rates.

Though there is a long way to go in meeting the needs of women and children globally, we know that there are cost-effective strategies for improving outcomes and strengthening community resilience by addressing the root causes that drive vulnerability and disease burden. Again, I would like to thank the Subcommittee for your dedication to maternal health and child survival issues. CARE looks forward to working with you to improve the health and well-being of women, children, and communities around the world in the months ahead.