ECOSOC Annual Ministerial Review
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Welcome remarks

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Your Excellencies, Ladies and Gentlemen, good morning, bonjour à tous et à toutes.

I am very honoured to be here, to participate in this important discussion about the advancement of women and health in Africa.

I bring you the greetings of Dr Chan, the Director-General of the World Health Organization, who was unfortunately unable to be here because of preparations for the Executive Board meeting which starts in a couple of days.

The issues to be discussed here are close to Dr Chan's heart. As you may be aware, when she took office in 2007, she asked that her performance be judged by results in terms of improvements in

of maternal mortality not as an outcome of a biological process that went wrong, but as a key indicator of women's health and status. There is nothing inevitable about these deaths. In fact, with the appropriate care, maternal mortality is a very rare event. Maternal mortality shows most poignantly the difference between rich and poor, both between countries and within them.

This underlines a key concern that will be addressed during this conference: women's health is profoundly affected by their status in society. Where women continue to be discriminated against or subjected to violence, their health suffers. Where they are excluded by law from the ownership of land or property their social and physical vulnerability is increased. What is clear is that we will not make progress on any of the health-related MDGs, MDGs 4, 5 or 6, unless we also address the other MDGs, especially the goals on women's empowerment and on poverty alleviation. All the MDGs are linked.

What can we say about progress towards the MDGs in the region? On present trends, Africa may not reach any of the health-related MDGs. Progress is patchy, or too slow, or entirely stalled, as is the case with maternal mortality. It is easy to feel discouraged, as we move into the last 5 years towards 2015. How can progress be accelerated?

We believe that we need to dig deeper and uncover the success stories in many areas of health and learn from the tremendous innovations that we have seen in so many African countries in recent years. The successes are many. The gains in malaria control, for example, and the extraordinary achievements in Africa with respect to reducing measles mortality. These bear witness to the remarkable capacity, talent, energy and committed leadership that can be found in Africa.

There is no room in this conference for sweeping generalizations. The region as a whole may not reach the MDGs, but individual countries are showing how they can overcome problems posed by poverty, poor infrastructure and insecurity, and make a difference.

The picture is not so much one of slow, incremental change but rather of leaps and bounds, made possible by bold leadership and transformational social changes in which concerns about social equity and women's empowerment are made explicit policy objectives.

I look forward to learning more about the reforms that are making a difference to women's health in Africa in the coming two days.

Thank you for your attention.

In this presentation I will discuss the critical importance of reducing maternal mortality for improving women's health in Africa.

Slide 2: Structure of the presentation

My presentation will be in 4 parts. First I shall discuss the role of maternal health within the broader context of women's health in the world today. Second I shall give a brief overview of maternal health in Africa. Third I shall touch upon the key intervention approaches to reduce maternal mortality. Finally I shall end on key policy responses that can take us forward.

Slide 3: Understanding women's

The Women and health report outlined critical issues that help us understand women's health in the world today. One of these is the increasing life expectancy of women.

This slide shows the female life expectancy at birth in different country income groups and regions. In most parts of the world, there have been improvements over the years. Life expectancy for women is now more than 80 years in at least 35 countries.

Not all women have benefitted however. For instance, a woman born in East and Southern Africa can expect to live only for 50 years, and her future is actually looking bleaker, largely because of the AIDS epidemic.

Women generally live longer (but not necessarily healthier) lives than men - on average 6 to 8 years longer, due to biological and behavioural factors. However, in some low-income countries, women's life expectancy is equal to or shorter than men's as a result of the social disadvantages that they face.

Slide 4: Inequities in access to health care..

As mentioned earlier this morning, the other key issue highlighted in the report relates to the large inequities that are seen in women's health, both between countries and within countries. Nearly everywhere, poverty and low socioeconomic status are associated with worse health outcomes. In both high income and low income countries, levels of maternal mortality may be up to 3 times higher among disadvantaged groups than among other women. There are similar differentials in terms of use of health care services. For instance, women in the poorest households are least likely to have a skilled birth attendant with them during childbirth, as shown in this slide for a number of countries, including Chad and Gabon.

Slide 5

Slide 6:
This slide identifies the leading causes of death among women in the years between puberty and menopause. Globally, the leading cause of death in this age group is HIV/AIDS, followed by maternal conditions.

The leading risk factors for death and disability from late adolescence through adulthood are unsafe sex and lack of contraception, globally and most particularly in Africa. Women who do not know how to protect themselves from sexually transmitted infections, such as HIV, or unwanted pregnancy, or who are unable to do so, face greatly increased risks of death or illness.

Slide 7

The majority of deaths were due to direct obstetric complications, primarily hemorrhage, sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labor, which are largely preventable.

I draw your attention to the large portion of deaths due to indirect causes, that is, they due to pre-existing medical conditions such as HIV infection. There is now substantial evidence that HIV infection increases the risk of maternal mortality by a factor of 6 at least, such that in some countries with high HIV prevalence, HIV is now the leading cause of maternal mortality, accounting for about half of all deaths during pregnancy and in the few weeks post-

What can be done about this? I now turn to the last part of my presentation, which proposes some ways forward.

Policy action in the following four areas is proposed.

First, strong leadership is required at national, regional and international levels, given the current tendency for fragmented and limited responses that only address some parts of the problem.

For example, the Millennium Development Goals have been vitally important in maintaining a focus on health in an overall developmental framework, and in setting benchmarks for progress. The existence of a separate goal on maternal health calls our attention to the stunning lack of progress in this area, attracting both political and financial support for accelerating change. The addition of the target on universal access to reproductive health has helped broaden the scope of the goal. But again, all the MDGs are linked and progress depends on broad-based action that takes into account the realities on the ground.

Second, we need to build health systems that work for women. This requires attention to increasing access, to reach out to those who are currently excluded, and to expanding the range of services that are offered, to encompass a range of sexual and reproductive health services along a continuum of care.

Health systems reflect the societies that create them. We must

Third, action is required that reaches beyond the health sector. The health sector can contribute by

(Seven agreed programme components:

1. Support **needs assessments** to identify constraints to improving MNH/RH in countries and ensure that health plans are MDG-driven and performance-based
2. **Develop and cost national plans** and rapidly mobilize required resources
3. Scale up **quality health services** to ensure universal access to reproductive health (4 pillars)
4. Address the urgent need for **skilled health workers**, particularly midwives and other related cadre of personnel and for HR management including supervision.
5. Address **financial barriers to access**, especially for the poorest
6. Tackle the **root causes of maternal mort 1 1(ed)-215ei(i7TJETT1 0 0 1 33**