What Is Her Fate?

Strong Women
Shaping the Global Agenda

7 Questions
Ashley Judd interviews
Nicholas Kristof

Women on the Frontlines

July 2010

the magazine of psi

impact
HIV is now spreading faster in marriages than in any other group of people. In fact, nearly half of all new HIV infections are happening in marriages.

Why? It’s simple. Because many married men, and women too, have long-term girlfriends and boyfriends who they trust so much that they stop using condoms.

What they don’t know is that many of these girlfriends and boyfriends also have other serious partners with whom they don’t use condoms. This creates a huge network of trusting relationships, so when one person gets infected with HIV, everyone can get infected.

And with HIV being most contagious within the first three weeks of infection, it spreads through these networks like wildfire.

So please think again before you relax the rules with a ‘spare wheel’.

Don’t let HIV destroy your marriage.
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PSI is a leading global health organization with programs targeting malaria, child survival, HIV and reproductive health. Working in partnership within the public and private sectors, and harnessing the power of markets, PSI provides life-saving products, clinical services and behavior change communications that empower the world’s most vulnerable populations to lead healthier lives. www.psi.org
Out of 100 adolescent girls under the age of 19 in El Salvador are mothers. 
Source: Save the Children

13% of adolescent girls in Bolivia are pregnant or have already had children. 
Source: Save the Children

43% of women are living with HIV in the Caribbean. 
Source: WHO

“Happiness is Planned”
PSI/Benin launches “Happiness is Planned” campaign to build men’s interest in family planning and support for their partners. A 2007 PSI study revealed that women who discuss family planning with their partners are more likely to use a modern contraceptive method.

1,700 per 100,000 Maternal deaths per live births in Sudan – 10x that of Europe. 
Source: Save the Children

Reduced maternal mortality

Women Deliver 2010
Thousands from around the world gathered June 6-9 in Washington, D.C., to advocate for improving maternal health. 
www.womendeliver.org

New United Nations Foundation campaign encourages supporters to give a “High Five” to girls in developing countries by donating $5 or more to provide girls with basic needs. www.girlup.org

43% of women are living with HIV in the Caribbean. 
Source: WHO
Findings published in *The Lancet* in April reported a significant drop worldwide in maternal mortality from 526,300 in 1980 to 342,900 in 2008.

Source: The Lancet

**33-51**
Percent increase in the contraceptive rate in Ethiopia from 2006 to 2008.
Source: United Nations Development Program

**$10**
Less than this amount is spent on maternal and newborn health per birth in India.
Source: World Vision

**AIDS in Lesotho has a Woman’s Face**
HIV prevalence is at 8% among women 15-19 and gets worse as they age. At 20-24, the rate rises to 25% and again to nearly 40% among 25-29 year olds. PSI/Lesotho is working with the World Bank on a performance-based financing study using sexually transmitted infections (STIs) as proxy indicators of HIV risk to test whether short-term financial incentives have an impact on sexual behavior, the incidence of HIV and some curable STIs.

Source: UNAIDS, Lesotho Analysis of Prevention Response and Modes of Transmission Study, 2009

**Unique Identifier Codes**
In Central Asia, China, Laos, Thailand and Vietnam, PSI is using Unique Identifier Codes to monitor work with injecting drug users and sex workers who also inject drugs. The codes protect the clients’ anonymity while enabling PSI to track each contact a client has with PSI’s services, including information on coverage, frequency of contact and uptake of HIV-related services.

Source: Family Health International

**1:1**
Global ratio of male HIV infections to female infections by the end of this century.
Source: Family Health International

Latin America and the Caribbean, Northern Africa and Southeast Asia reduced their maternal mortality ratios by about 1/3 between 1990 and 2005.

Source: Millennium Development Goals

www.psi.org | impact 3
What Is Her Fate?

Suddenly, women and girls are everywhere.

Once a subject of mainly academic interest, the role of girls and women in development has attracted interest far beyond specialist circles. Best-selling books and high-profile international conferences are now devoted to figuring out the best way to put The Second Sex, as Simone de Beauvoir once called females, at the center of efforts to improve health and welfare.

This growing public attention to girls and women in the development field has highlighted how intrinsic this gender-focused approach is to PSI’s work. At times, whether in the field or at headquarters in Washington, the main challenge is to refine PSI’s long-standing mission, a task that starts with awareness of exactly how central women and girls are to PSI’s work.

“We are doing a lot of work for women without recognizing what we are doing,” said Krishna Jafa, director of HIV, tuberculosis and reproductive health at PSI. “Often, until we think about the ‘girl effect’ we do not consciously realize that we are doing it. But we are absolutely doing it, and I think we are doing it well.”

In every country where it is active, PSI looks at what diseases represent the largest public health threats and works to fight the “burden of disease.” Take a look at the life cycle of a female, Jafa points out, and you can appreciate how PSI’s myriad projects become, by their very nature, wrapped around the needs of women and girls.

Before a woman even gives birth to a baby girl, she is likely to have
Hairdressers wear "care" female condom aprons. These girls work as peer educators for PSI.

Before a woman even gives birth to a baby girl, she is likely to have made use of PSI products and services. Different forms of family planning allow her to plan a family rather than enter into motherhood unprepared, and when she does become pregnant, micronutrient supplements are a vital part of prenatal care. Clean delivery kits assist in the actual birth.

Diarrheal diseases and malaria take a terrible toll on baby girls, one reason that water purification products and mosquito nets are mainstays of the PSI product line. As she grows into adolescence, PSI communications can play a role in delaying sexual debut, while the ever-present PSI-marketed condom can make pregnancy a choice she makes at the right time, when the cycle begins anew.

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“PSI has not blown with the wind and tried to repackage our work to focus on women and girls,” said Karl Hofmann, PSI’s president. “We don’t market ourselves as a women’s rights organization, but since we started putting control of fertility in women’s hands we have worked this angle every day of our existence.”

Usage of intrauterine devices under one PSI project exploded from around 200 per year to 20,000 annually after only two years thanks to a deft mixture of targeted subsidies and evidence-based project design.
Put another way, PSI’s larger task has become designing and refining health interventions that better meet women’s needs, with an eye toward one day eliminating disparities in health between men and women.

“We’ve moved way beyond the issue of neglecting women toward the tougher question of how you favor women in the right way,” said Steven Chapman, PSI’s senior vice president and chief technical officer.

Advocacy vis-à-vis public officials of all stripes represents an additional frontier for PSI, which has traditionally leaned heavily on its role as a technical, apolitical organization but now finds itself a reservoir of expertise for governments.

“We have grown to a size where we can and should have an impact on the debate over what works in development,” Hofmann said. “We have our own approach focused on markets and the private sector, and we need to not only have the courage of our convictions but we need to have an effective voice in the debate over what works.”

With little fanfare, PSI representatives on the ground have found that voice.

John Hetherington, PSI’s country representative in Myanmar, often appears for meetings with the government as the only international NGO at the table. He said that reflects a low-key approach that emphasizes the nuts and bolts of health policy.

“Even in Myanmar, which is a highly complex operating environment and politically sensitive, I find earnest open dialogue at a technical level builds trust and helps move forward on the agenda of better policies for the people and a better operating environment for PSI,” Hetherington said.

For example, usage of intrauterine devices under one PSI project exploded from around 200 per year to 20,000 annually after only two years thanks to a deft mixture of targeted subsidies and evidence-based project design.

The program, very popular with poor women, also represented a technical solution to unwanted pregnancies, and by extension heads off unsafe abortions in a country where abortion conflicts sharply with widely held Buddhist beliefs. It also opened minds within the government, where many officials thought such a program was not possible.

“Sometimes the best way to ‘do’ advocacy,” Hetherington said, is to ‘do.’”

Carter Dougherty is a freelance writer in Washington, DC.
Healthcare leaders from developing and developed countries alike are preoccupied with finding ways to improve access to medical care while simultaneously reducing costs and improving quality.

The goal, essentially, is to “get more for less” by boosting the productivity of healthcare systems to deliver quality products and services to a greater number of clients. But getting more for less cannot be achieved with the status quo; it requires innovation in the way healthcare is delivered, both on a macro level by advancing healthcare systems and on a micro level through the improvement of specific interventions and clinical care.

Tanzania, which hosted the World Economic Forum (WEF) on Africa in early May, is at the forefront of efforts among developing nations to implement innovative changes to healthcare. Speaking on a WEF panel, titled “Innovations In Health: Shaping a New Landscape,” the Tanzanian Minister of Health and Social Welfare Professor David Mwakyusa noted the challenges facing countries on the continent, which carries 25 percent of the global burden of disease but is home to only three percent of global healthcare workers.

“We have challenges to deliver healthcare to our people,” said Prof. Mwakyusa. “Currently, those who need healthcare the most can’t access...
“The Secrets of Successful Innovation*”

Through its research on unlocking productivity through healthcare delivery innovations, McKinsey & Company observed six things that innovators do to be successful:

1. GET CLOSE TO THE PATIENT AND FOLLOW THEIR ESTABLISHED BEHAVIOR PATTERNS. This enables delivery innovation that lowers distribution costs while improving adherence to clinical protocols.

2. REINVENT THE DELIVERY MODEL BY USING PROVEN TECHNOLOGIES DISRUPTIVELY. Technology can extend access, increase standardization and drive labor productivity.

3. CONFRONT PROFESSIONAL ASSUMPTIONS AND ‘RIGHT-SKILL’ THE WORKFORCE. Successful innovations tightly link skills to the task at hand, challenging existing practices and confronting professional assumptions about who is allowed to do what.

4. STANDARDIZE OPERATING PROCEDURES WHEREVER POSSIBLE. The operating procedures of many effective innovations are highly standardized, allowing the elimination of waste, the improvement of labor and asset utilization, and the raising of clinical quality.

5. BORROW SOMEONE ELSE’S ASSETS. Smart innovators enhance their business models by utilizing existing networks of people or fixed infrastructure, enabling them to reduce capital investment and operating costs—and then passing those savings on to consumers.

6. OPEN NEW REVENUE STREAMS ACROSS SECTORS. Some healthcare delivery models collaborate with other sectors such as retail. This enables them to share costs, capture additional revenues and, where a social component is strong, to cross-subsidize.

ASHLEY JUDD, PSI board member, talks with NICHOLAS KRISTOF, a two-time Pulitzer Prize winner, author and New York Times columnist.

Nick Kristof tries to do the heavy lifting and a tricky balancing act that is the daily grind of local village women in the Democratic Republic of Congo.

1 MS. JUDD: You’ve drawn global attention to the unique needs and challenges of women in the developing world. Is the battle to bring attention to this issue being won or lost? And how do you feel about your contribution, both through your columns and the extraordinary book, Half the Sky, you and your wife Sheryl have written?

MR. KRISTOF: Oh, the battle is definitely being won. There’s no question that “international women’s issues” are going from a fringe concern and a “soft” issue to a serious topic in the spotlight. Partly that’s because women’s rights are increasingly recognized not only as a justice issue but also as a way to fight poverty and reduce civil conflict. When you have American generals in Afghanistan trying to get more girls in school, because they recognize that that’s an effective strategy to undercut the Taliban, you know things have changed. And the Council on Foreign Relations used to be the place to discuss missile shields and Middle East politics, while now it is also discussing maternal mortality and human trafficking.

At The New York Times, I was delighted to see an article about maternal deaths as the lead story on the front page in May. We in the news media traditionally haven’t been great at covering these issues, and the lead story traditionally was reserved for some ponderous pronouncement by a president or prime minister. So to see dead mothers being treated with equal seriousness was a welcome surprise and reflects the way these issues are rising on the agenda.

The tide was already coming in, but I hope that Half the Sky helped it gain a bit of momentum. One of the greatest challenges is how to reach beyond the choir, and I think the book clubs that have chosen Half the Sky and the universities that chose it for a college-wide read have helped expose the ideas in it to people who were outside that choir. One of the most exciting things for Sheryl and me has also been the number of readers who have started giving to clubs or aid organizations to try to make a difference.

2 MS. JUDD: Maternal mortality has been thought to be an unmovable problem yet a recent study by The Lancet shows that several countries have made progress in its reduction. What, in your view, are the contributing factors?

MR. KRISTOF: The study by The Lancet underscored just how much we don’t know. It’s quite remarkable that we don’t have a grasp on how many women die from pregnancy complications each year. Is it 350,000 or 550,000? The data just aren’t good enough to be sure, partly because no one counts dead mothers in many poor countries. I must say that I often see statistics in United Nations studies and elsewhere that claim a degree of precision that I find absurd. For example, there’s an often-cited statistic that
one-quarter of young women aged 15-19 in the developing world are married (outside China). But in truth, in many poor countries, kids have very little idea how old they are and don’t have birth certificates. So any age-related statistic is a wild guess.

In terms of reducing maternal mortality, my sense is that the big effort to train traditional birth attendants was pretty much a failure. It probably reduced neonatal mortality, but didn’t obviously save mothers’ lives. But rural health systems have been improved, infrastructure has improved, vehicles and cell phones have become more common, and all these make it easier to rush a woman to a hospital when she’s in obstructed labor. More broadly, I think some countries are now taking maternal health more seriously, and that perspective is trickling down to the villages.

3 MS. JUDD: Much of the funding for development targets specific health or social areas without addressing overlapping issues or systemic failures, but there’s a trend now to address issues more holistically. Have you seen integrated development projects that work?

MR. KRISTOF: The old stove-piping clearly didn’t work very well. It was maddening that all the HIV funding meant that a woman could be treated for HIV but wasn’t helped when she suffered from pregnancy complications. On the other hand, the drawback of the integrated approach is that it’s expensive and it’s hard to know what is cost-effective when you try a bunch of interventions simultaneously. I’m a huge believer in rigorous testing in randomized experiments, with careful measurement before and after. Monitoring and evaluation has traditionally been a weak area for nongovernmental organizations (NGOs), and humanitarians should be every bit as careful as for-profit businesses in ensuring that they get the most bang possible for the buck.

4 MS. JUDD: What are the benefits of working through the private sector in developing countries to improve women’s health and overall well-being?

MR. KRISTOF: Look, the private sector is incredibly good at distribution. If we could get condoms and bed nets into every village that serves beer, we’d save vast numbers of lives. The NGO world used to have a bit of disdain for business, but it’s shedding that and I think it is an important step forward. The private sector and NGO sectors can accomplish a huge amount if they work together.

5 MS. JUDD: What role do NGOs like PSI play in helping to empower women?

MR. KRISTOF: I’m a huge fan of PSI, partly because you can’t begin to chip away at poverty unless you deal with rapid population growth. And you can’t empower women when they are obliged to churn out babies non-stop because they don’t have access to birth control. I also think PSI is very good at listening to local people and giving them ownership, which is crucial for any aid program.

There are no silver bullets in development, and that includes family planning and health work. But we’re getting better at figuring out what works and how to make it happen. And reproductive health is clearly part of the package of solutions.
Questions

with Nicholas Kristof

**6 MS. JUDD:** You’ve been outspoken about the need to reduce unsafe abortions, one of the leading preventable killers of women globally, and you have come out as a proponent of expanded availability of medications such as misoprostol for early abortion. Why?

**MR. KRISTOF:** I think medications are going to transform abortions. Surgical abortion involves a measure of risk and is relatively easy for authorities to crack down on. If a woman shows up at a hospital after a botched surgical abortion, she can face legal consequences. But medications such as misoprostol are now available to induce a miscarriage early in pregnancy, and there’s nothing to differentiate it from a regular miscarriage. The medications have other standard uses, for ulcers and for postpartum bleeding, so they can’t be banned. They’re also very cheap. My hunch is that surgical abortions in the first trimester will become much rarer and that abortion will become much harder for governments to control.

**7 MS. JUDD:** We often struggle to include men in family planning interventions, yet research shows that men significantly influence women’s reproductive health decisions. What are the more successful strategies you have seen to engage men in supporting a woman’s right to make her own decisions?

**MR. KRISTOF:** We often try things like billboards and slogans to change attitudes, and it’s not obvious to me that they work very well. The three things that seem most effective to change men’s attitudes toward women (and women’s attitudes toward themselves) are education, television and income generation.

Getting more boys in school helps women as well. Television tends to expose conservative rural families to middle class urban norms, where wives can come and go and aren’t beaten. Income generation, micro-savings and micro-lending give women more economic weight and more voice in the household.

**WOMEN DELIVER 2010 DID MORE.**

Richard Horton, the editor of the *The Lancet*, called the 2010 Women Deliver conference “the most significant event for the future of women and children in 20 years.” What, might we ask, would lead Horton, a man not known for extravagant praise, to make such a claim for a conference? Even if it were one that brought together 3,200 experts and advocates including UN agency heads and the Secretary-General, ministers of health, parliamentarians, health workers, young professionals, and women’s and human rights advocates to talk about maternal mortality and raise public awareness about the need for more funding and better strategies to end maternal death and injury? Has not the world heard over and over again that more money is needed for every development and humanitarian cause in the world to the point of donor fatigue?

Women Deliver, however, did more. It presented women as powerful forces for social change, not victims of high-risk pregnancy. At the foundational level, the case was made that investing in women pays off for all of us, not just for the woman, her newborn and more extended family, but for all of us. A productive empowered woman is a critical participant in wealth creation, democratic governance, scientific advancement, ending violence and environmental sustainability.

A productive empowered woman will also lead a full personal life. Women Deliver recognized that women deliver for themselves as well as others. It appealed not just to the head and pocketbook of donors, but to the heart of each woman. Sexuality and reproduction are social, cultural and spiritual matters. And so along with crunching numbers and strategies for meeting Millennium Development Goal 5, and breaking down barriers between issues and interests, Women Deliver made space for women like Africa’s Yvonne Chaka-Chaka to sing and former Chilean President Michelle Bachelet, UNDP Administrator Helen Clark, PSI Board Member Ashley Judd, and White House Senior Advisor Valerie Jarrett to talk about what it means to be a woman who has power and soul.

It is this combination of heart and head, economics and culture, compassion and respect that made Women Deliver 2010 more than a conference but the expression of a mature movement that seeks the best for all women at all stages of their lives.

Frances Kissling was a member of the Women Deliver Conference team and is a visiting scholar at the Center for Bioethics at the University of Pennsylvania, USA.
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CEO of The Elders

Laura Liswood  
Secretary General of the Council of Women World Leaders

Her Royal Highness Mette-Marit  
of Norway, UNAIDS Goodwill Ambassador

Jeannette Kagame  
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President Ellen Johnson Sirleaf

PRESIDENT ELLEN JOHNSON SIRLEAF was elected President of Liberia in 2005 and took office in January 2006. A peace movement called the Women of Liberia Mass Action for Peace led to her election, making Liberia the first African nation with a female president. President Sirleaf discusses her efforts to create a brighter future for girls with Axel Addy, PSI’s Country Representative in Liberia.

MR. ADDY: Based on your work in Liberia, is the global battle to empower women politically achieving any success?

➤ PRESIDENT SIRLEAF: The global battle to empower women politically is taking tiny steps in Liberia, but we are making progress. In my inaugural address, I pledged that my administration would endeavor to give Liberian women prominence in all affairs of our country, and we are endeavoring to keep that promise. For example, women head some of our key ministries: Foreign Affairs, Justice, Agriculture, Commerce and Industry, Gender and Development, and Youth and Sports. On the Bench of the Supreme Court of Liberia, two of the four associate justices are women. Our government’s efforts to promote gender equity and enhance the role and participation of women made impressive gains in 2009. Our Gender Ministry launched a National Gender Policy to guide all sectors in planning and implementing gender equality programs by providing mechanisms for accountability within government itself and with other stakeholders to chart the progress made in eliminating all forms of gender-based discrimination.

MR. ADDY: You said around the time of your election as president that you wanted to bring motherly sensitivity and emotion to the presidency. What did you mean by that?

➤ PRESIDENT SIRLEAF: Motherly sensitivity simply means handling the nation with care. I did not refer to motherly sensitivity as a sign of weakness but rather as a sign of strength. Women are persuasive and convincing. Women are caring human beings. Because they are experienced in running a family, mothers are better managers. A mother is someone who puts her children’s interest ahead of her own.

MR. ADDY: A centerpiece of Liberia’s pro-women policies has been a National Reproductive Health Policy. What will this strategy entail?

➤ PRESIDENT SIRLEAF: The priorities of our National Reproductive Health Policy are fourfold: (1) to provide essential sexual reproductive health services to victims of sexual and gender-based violence, for pre- and post-natal maternal health, for sexual and reproductive-tract diseases, and for family planning and

-President Sirleaf joins PSI and Liberia Marketing Association at the Rally Time Market for the launch of WaterGuard.
adolescent health; (2) to increase access and utilization of sexual and reproductive health services; (3) to improve quality of sexual and reproductive health services; and (4) to ensure sustainable financing and effective management of reproductive health services.

**MR. ADDY:** The male dominance of the political system is surely as strong in Africa as anywhere else in the world. What advice can you pass on to future female heads of state in Africa?

**PRESIDENT SIRLEAF:** Leadership has many serious challenges. Women who want to lead and be hailed must also be prepared to be criticized and ostracized at some point in their career. If you want to lead you have to accept that there will be conscious attempts to push you into oblivion. You have to be prepared to be very lonely sometimes. Women are breaking barriers daily, and in another decade there will be hundreds of women in real positions of leadership all over Africa and all over the world. Africa needs strong women who will develop into strong women leaders and will stand up and show courage and commitment.

**MR. ADDY:** Your government has placed a strong priority on better education for girls and is especially trying to slow the steep drop-off in enrollment as they progress from primary to secondary and tertiary education. What strategies do you advocate to achieve this goal?

**PRESIDENT SIRLEAF:** [My government’s] policy of Free and Compulsory Primary Education has doubled enrollment in the past two years, resulting in 46.9 percent of girls enrolled in school. At the Junior High level, the percentage of girls to boys is 40.0 percent. And at the Senior High level, the percentage of girls is 40.8 percent. The goal of this administration is a 50-50 ratio. The Liberian Education Trust, with US $2.5 million in private funding, has provided scholarships to 3,500 girls. To implement our goal of quality education for all, the Ministry of Education is developing a 10-year National Education Sector Plan (2010-2020), complemented by an Education Strategy study which provides the roadmap for basic secondary, tertiary, and technical and vocational education. Because we place emphasis on developing local institutions as the best means to educate our population, we therefore provide subsidies of US $435,120 to more than 20 private institutions.

On another front, the Nike Foundation/World Bank Economic Empowerment of Adolescent Girls Project recruits out-of-school girls between the ages of 16-24 to benefit from business development and job skills training. To empower our market women, the Liberia Agency for Community Empowerment conducted a literacy program which benefited 3,500 women.

Axel M. Addy is the country representative for PSI/Liberia, overseeing the strategic direction and growth of the platform. Mr. Addy has secured over $5 million of diverse funding from UNICEF, UNFPA and USAID. Mr. Addy was born in Liberia and left with his family in 1990. He returned in 2006 to launch PSI/Liberia.

One in three Liberian girls is pregnant by age 19, due to a high incidence of cross generational sex and lack of adequate information given appropriately to youth. As a result, PSI/Liberia initiated SmartChoice, a program for youth, encouraging smart choices on reproductive health issues. The first component of the SmartChoice program is a half hour radio show hosted and developed by youth called, “Let’s Talk About Sex.” The show airs nationwide on the UN Peacekeeping Mission’s radio station and at smaller community radio stations. The show is also a community outreach tool using out-of-studio live shows, listening events and blogs.

Go to www.psi.org/liberia to learn more about PSI’s programs in Liberia.
MS. SCHOCKEN: You have done significant work promoting greater emphasis on women and girls in development. Is the battle for their health and education in Rwanda, and in Africa, being won or lost? 

➤ MADAME KAGAME: I believe things are getting better. Although we still have a long way to go. We also have to keep fighting for girls and women, without forgetting that in many of our countries, especially in Rwanda where we had to start from zero, boys also need to be supported, and men need to be mobilized to be part of the struggle for healthier, better educated families. At the Imbuto Foundation, we have 1,000 disadvantaged boys and girls on scholarship, and with the understanding that girls face specific barriers to performance, each year we reward the best performing girls in every district to motivate them towards academic excellence. This is our way of contributing to government efforts.

In an environment where there is so much need, every effort counts. It is particularly important that Rwandans be involved in solutions to our healthcare challenges as a nation. With committed governments, involved communities, and effective coordination of global and regional partnerships, I have no doubt that Rwanda and Africa will win the battle for healthy, educated and skilled citizens.

MS. SCHOCKEN: Rwanda has an unusually high proportion of women in the general population because so many men died during the genocide. How does that affect the country? Can it help to explain the exceptionally prominent role of women in leadership positions?

➤ MADAME KAGAME: Rwandan women make up 52 percent of the population. In the immediate aftermath of the genocide, indeed many men had died or were in prison for genocide crimes; this left women in charge of homes and communities. However, it is incorrect to attribute this factor to the prominent role of women today. Historically, Rwandan women were treated with respect and considered a quiet force. The prominent role of women in Rwanda today is due to conscious decisions made by the post-genocide leadership, which understood the importance of women and supported women’s active participation in all aspects of the nation’s development.

President Kagame sums it up with this quote: “How can a society hope to transform if it shoots itself in the foot by squandering more than half of its capital investment?”

MS. SCHOCKEN: Your country has received significant development assistance from international donors since the genocide in 1994. What has been learned through this process, and how would you advise other countries as they work with international donors?
A group of young women perform at a PSI program visit in Butare, Rwanda.

➤ MADAME KAGAME: The support we have received from donors has been crucial to our recovery since 1994. However we have always viewed aid as a means to an end – as something that ultimately enables us to stand on our own feet. Every country has to define its own path and set its own priorities before even seeking external assistance. For Rwanda, this means focusing on our people as the most valuable resource. This is why the government is investing heavily in health and education – wiring the country for super-fast internet, developing infrastructure and energy production.

We have learned that we need to aspire to independence from aid and that reform starts from within. Rwanda has embraced homegrown solutions and continues to seek international and private sector support to achieve our vision.

MS. SCHOCKEN: In some ways, by emphasizing issues affecting children and women, you are following in the footsteps of first ladies around the world. As the first established Rwandan First Lady after the genocide, how did you decide what role you would play?

➤ MADAME KAGAME: Following the genocide, we consulted a wide variety of stakeholders to determine the role of the First Lady and how best our office and programs would support and add value to the work that the government was already doing. This assessment process is dynamic, and we regularly review our priorities. We have since evolved from Protection and Care for Families against HIV/AIDS (PACFA) to the Imbuto Foundation, reflecting the changing needs of our country and our clients.

MS. SCHOCKEN: Rwanda has made great strides in bringing women into official leadership positions. To what extent has this changed attitudes among ordinary Rwandans, especially men?

➤ MADAME KAGAME: It is true that attitudes have gradually changed, and we are all the better for it. This shift has come about mainly because Rwandan women have contributed positively to the healing of society and to nation-building. Women alongside their male colleagues have demonstrated leadership and strength through active participation in key national programs, including Unity and Reconciliation; fostering of orphans of the genocide; the Gacaca courts (Rwanda’s traditional court system that has been modernized and used to simultaneously administer justice and promote reconciliation); as well as the repatriation and reintegration of former government soldiers. Also, there are an increasing number of women holding elected positions in parliament and local government. Their positive contributions to different aspects of society have won them the confidence of Rwandan men and society at large, who now view women as true partners in nation building.

As director of International Organizations, Celina Schocken oversees the management and implementation of PSI’s grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Prior to joining PSI, Ms. Schocken worked as an early alert and response systems manager for the Global Fund. In 2004, she was chief advisor to the Rwandan Minister of State for HIV/AIDS and Other Epidemics, where she was responsible for drafting national HIV/AIDS policies and coordinating the implementation of multimillion dollar HIV/AIDS programs.

Go to www.psi.org/rwanda to learn more about PSI’s programs in Rwanda.
Dr. Margaret Chan

**DR. MARGARET CHAN** is the Director-General of the World Health Organization (WHO), appointed by the World Health Assembly in November 2006. Before her appointment, Dr. Chan was WHO assistant director-general for Communicable Diseases and representative of the director-general for Pandemic Influenza. She also served as director of Health in Hong Kong for nine years where she successfully defeated the spate of severe acute respiratory syndrome in 2003. Dr. Chan shares her thoughts with Dr. Jane Miller, PSI Malaria and Child Survival Technical Adviser in Tanzania.

**DR. MILLER:** The WHO is the coordinating authority for health within the United Nations system and is responsible for providing leadership on all global health matters. As director-general, do you believe the battle to improve the health of women and girls is being won or lost?

**DR. CHAN:** On balance, we are moving towards the winning side, after a long time of slow, sometimes stalled progress. Commitment to the health of women and girls, at national and international levels, seems to be growing month by month.

For women, removing some of the arduous burdens of daily life helps free them to realize their full human potential.

We are seeing an unprecedented level of agreement among the many agencies and partners, and at levels from heads of state to grassroots initiatives, about what needs to be done. To guide the coordinated work of relevant international agencies, a joint action plan has now been agreed at the highest level.

We are seeing a two-pronged approach. First are the long-term needs, like raising the status of women, doing more to support their basic rights, and strengthening health systems in ways that respond to the distinct needs of women and girls. Of course, we all know that maternal mortality will not go down in sustainable ways until more women have access to skilled attendants at birth, facility-based care, and emergency obstetric care. This is the consensus based on abundant evidence, and this is a reality we have to face. Fortunately, recognition of the need to strengthen health systems across the board and to find the funds is, likewise, at an unprecedented level.

In a second approach, we are seeing agreement on the many concrete actions that can be taken right now. Many life-saving actions involve simple, yet ingenious solutions that can be introduced, and have an immediate impact, without having to wait for better health services, or a higher social status for women, or reduced poverty and illiteracy rates. Examples include local construction of maternal ambulances from modified bicycles, which I saw in Africa, or kangaroo care for newborns, or ensuring that the staff, medicines, and supplies needed to keep women from bleeding to death are available in district health centers. As is so often the case in public health, when the commitment is strong, solutions can nearly always be found.

For example, we know that some essential medicines, like oxytocin, lose potency in hot tropical climates and have to be kept cool, which creates added logistical problems. Commercial shops in remote rural areas have found ways to keep colas and beer cold despite erratic power supplies. If you can do this for beer, you can do this to protect life-saving medicines.

**DR. MILLER:** Earlier this year, on International Women’s Day, you acknowledged that women and girls still do not face equal rights and opportunities around the world. How integral is health in advancing the rights and opportunities of women around the world?

**DR. CHAN:** Of course, good health in itself helps girls and women realize their potential and take advantage of opportunities, including exercising their right to health. I am a great believer in the power of grassroots initiatives, especially when they are led by women. It is similar to the so-called “rising tide of expectations” that historians believe has fuelled some of society’s revolutionary changes for the better. It is when girls and women realize their right to better health care and begin to demand it so that the pressure on governments starts to build. Politicians will deliver on health when they know it gets them votes. This is a different kind of pressure than what comes from signing or endorsing a declaration on human or women’s rights.

There is another dimension to this issue. Many studies of community participation in health projects show that, when people are debilitated by multiple infections, poorly nourished, or infested with worms, they simply will not engage in community improvements. You have to reach a certain level of health before you can expect communities to take on responsibility for improving their own health. For women, removing some of the arduous burdens of daily life helps free them to realize their full human potential. In many developing countries, women and girls spend as much as four hours every day fetching water. Reaching the Millennium Development Goal for water supply and sanitation could help reduce this burden, and free women and girls for a more rewarding use of their time. Helping women to plan their families is another powerful source of support.

**DR. MILLER:** Progress in reaching the Millennium Development Goal (MDG) 5 targets on maternal health has been the most disappointing of all the MDGs. What is it going to take to ensure that we achieve MDG5 by 2015?

**DR. CHAN:** Education of girls, empowerment of women and greater engagement at all levels. Maternal deaths are a marker of decades of failure to invest adequately in basic health infrastructures, delivery systems, information systems and staff. This creates the dilemma. Building health systems takes time and money, and we are short on both. We are in a situation of having to compensate, very quickly, for decades of neglect.
But it can be done. Again, we need to focus on the many things that can be done right now. For example, an estimated 137 million women of reproductive age have an unmet need for family planning. Recent studies suggest that if this unmet need were filled, maternal mortality would decrease, worldwide, by 30 percent and newborn mortality by 16 percent. Other things that work include health insurance schemes, so that poor women are not punished by the costs of care, and cash transfers or other incentives that encourage women to deliver in health facilities. Transportation that gets women quickly to emergency care makes a life-and-death difference. Mobile phones are a widespread asset that ought to be exploited more. I have been in villages with no electricity or running water, and no shoes for the children, but people do have mobile phones. Some clinics use phone networks, linking rural midwives, around the clock, to specialists who can advise on difficult cases. This strategy helps compensate for the shortage of doctors in rural areas. When backed up by good referral and emergency transport, it saves lives. In one project using mobile phones in rural India, nurses and midwives, tapping expert advice, have managed more than 3,000 deliveries over the past nine years. Only one maternal death occurred.

As another example, some countries are getting good results with legislation that requires notification of every maternal death, or ensures the quality, availability and fair price of essential medicines, like oxytocin for postpartum hemorrhage; or that allows nurses and lower-level staff to perform life-saving procedures within their area of competence. These kinds of solutions don’t break the bank.

**DR. MILLER:** You were quoted as saying that you want your leadership at WHO to be judged by “the impact of our work on the health of two populations: women and the people of Africa.” What achievements in these areas are you most proud of and where do the greatest challenges lie ahead?

**DR. CHAN:** For Africa, the progress we are finally beginning to see with malaria thrills me, though I know this progress is fragile. Tens of millions of bed nets, treated with long-lasting insecticides, have recently been distributed in sub-Saharan Africa. In some areas, deaths from malaria have dropped by more than half. I have personally seen the empty hospital wards and talked with mothers who have lost previous babies to malaria and no longer live in fear of this disease. As an unexpected bonus, better diagnosis and treatment of malaria has been accompanied by better detection and treatment of childhood pneumonia, with the result that these deaths are also dropping. As I said, the gains are fragile. Nets eventually wear out. Will the funds be there to replace them? Will the parasite develop resistance to the last remaining class of effective drugs?

I am also pleased that health problems in sub-Saharan Africa are no longer being generalized as a consistently despairing story. Some African countries are making tremendous progress. Country leadership makes all the difference in the world, and I have met many committed, brilliant health leaders in Africa. Even extremely poor countries, like Ethiopia, Rwanda and Tanzania, with good leadership and a health plan biased towards the poor are getting stunning results, also for women, measured most directly as drops in maternal mortality.

For women and girls, if the push we are now seeing to meet MDG 5 gets results, that too will be a thrilling achievement.

As Malaria and Child Survival technical adviser in Tanzania, Dr. Jane Miller has developed and launched campaigns and home treatment kits for mosquito nets, mobilized communities to receive and use nets, and established relationships among public and private sector malaria partners. She has carried out technical assistance in 16 other countries for PSI. Dr. Miller recently received one of the most distinguished U.K honors for her work, the Order of the British Empire.

MS. FITZGERALD: Based on Your Royal Highness’ work to generate attention and support for young people living with or affected by HIV/AIDS, is the battle being won or lost?

➤ HRH METTE-MARIT: From one perspective there is all reason to be optimistic: There are increasingly more effective HIV prevention programs, good results from treatment and greater awareness among young people about HIV transmission.

Nevertheless, the harsh fact is that almost half of all new HIV infections are among young people under 25, and young women comprise a majority of infected youth. Also, there is a kind of HIV/AIDS fatigue and we must constantly struggle to keep the issue high up on the global agenda.

It gives me hope to follow some of the remarkable emerging young leaders in the AIDS response. Around the world, at the grassroots level, there is amazing work being done by youth leaders to work on HIV in their communities. In spite of the accomplishments, on a global level, the number of new infections grows faster than the increase in access to treatment.

MS. FITZGERALD: How did Your Royal Highness’ studies at the School of Oriental and African Studies in London and involvement with the Norwegian Agency for Development influence Your Royal Highness’ current work and beliefs?

➤ HRH METTE-MARIT: Knowledge is a key fundament for HIV/AIDS related work. For me, it has been important to have knowledge and studies as background for my engagement.

In 2005 I travelled to Malawi with the Norwegian Minister of Development and visited HIV-related projects supported by the Norwegian government. In Malawi, I met mothers with dying children. As a young mother myself, that was a ground-breaking experience. That is when my engagement for HIV and AIDS really started.

MS. FITZGERALD: As a UNAIDS goodwill ambassador, Your Royal Highness visited Nicaragua in 2007 to learn more about women and HIV. Your Royal Highness also experienced the poverty that is pervasive in Central America. How does the problem of poverty intersect with the issue of women with HIV/AIDS?

➤ HRH METTE-MARIT: In Nicaragua, I experienced the connection between male-dominant power structures and HIV related to women. If a woman’s right to control her own body is not respected, she becomes so much more vulnerable to HIV. This is a serious problem that must be addressed on all levels in society – nationally and globally. For women in some parts of the world, being married is a great risk – because it is quite common that their husbands have unprotected sex with others.

Lack of education is another important factor that makes girls and women in poor countries vulnerable to infection. Regrettably, we see that boys in poor families are prioritized before girls to access education. It is therefore important that HIV prevention programs and information about HIV transmission takes place in arenas independent from school.

There is also a physical side to poverty and HIV. If you are already HIV-positive, malnutrition can worsen the virus’ effect on the body.

MS. FITZGERALD: Your Royal Highness’ likeness once appeared on a poster designed to raise awareness about the stigmatization of people living with AIDS. Is progress being made in reducing stigma?

➤ HRH METTE-MARIT: That is definitely my impression. Some brave people have chosen to be open about their status and give a face to
the epidemic. That contributes to the “normalization” of HIV and in the long run to reducing stigma. But it is a very personal question whether to be open or not. And I fully understand those who choose not to. A friend of mine, Todd Murray, has created a beautiful campaign to reduce stigma: “Does HIV look like me?” That is the core of the issue: HIV can hit anybody, anywhere. It hits rich and poor, young and old, across cultures, nationalities, status and sexual orientation. I think one of the reasons why there is stigma connected to HIV is the fact that it concerns the most intimate part of our lives.

Unfortunately, many HIV-positive people still experience stigma and discrimination at work, in social life and in public health services. We still have a long way to go. But sufficient information and openness are important factors.

MS. FITZGERALD: Last year, Your Royal Highness hosted a group of youth in Norway to talk about stigma. Overall, what role do young people play in this regard?

HRH METTE-MARIT: Youth are instrumental for many reasons. They are the hardest hit globally, and therefore, know what makes them vulnerable and what needs to be done. Youth also have the stamina, the guts and the will to fight. They are more easily than adults – open about sensitive issues. And they get things done. This is my experience with the young leaders I have known over these years.

There is also another aspect: the HIV virus has now been known for 25 years. Those who have been on the barricades since the start have done a fantastic job – but they need others, a new generation, to take over. Young people today are also connected globally in a way that makes them form networks across the world – unlike a generation ago. My main focus in HIV/AIDS engagement today is to promote and strengthen youth leadership. I am convinced this is the only way we can truly succeed: by supporting young people with the tools they need to be in power to make the change they are more than capable of making. Young leaders need more opportunities to exercise leadership, more funding, more public attention and more influence. It is a responsibility for all in power to see this happen, to give them a space and voice.

MS. FITZGERALD: How has the global dialogue around HIV/AIDS and women changed since 2006 when Your Royal Highness participated in the International AIDS Conference held in Toronto? And how has this shaped Your Royal Highness’ approach to being a UNAIDS goodwill ambassador?

HRH METTE-MARIT: Since I became special representative of UNAIDS in 2006, there has been an increased focus on the feminization of HIV/AIDS; the face of AIDS is in fact a young African woman south of the Sahara. I am deeply concerned with women and AIDS because it is such a complex issue. We deal with power structures and deep rooted cultures that are hard to change. But I have noticed increased awareness of women’s issues. Last year, we marked the 15-year anniversary of the Population and Development Conference in Cairo, where the groundbreaking message was “the right of women to choose” and to make decisions about their own body and childbearing. In 2010, it is 15 years since the Women’s Conference in Beijing – where an action plan was signed on a broad spectrum of women’s issues. Recent reviews of these plans of action show that we still have a long way to go.

It is a worrying fact that in some countries with fundamentalist regimes, we have seen a set-back for women. It is more important than ever to support young women into positions of power – at all levels – to secure women’s rights and issues that are not automatically included in a world of male leaders. In this work we also need to join forces with an increasing number of men, not least young men, who see that both men and women benefit from a society that is more equitable to both sexes.

Chastain Fitzgerald is vice president of New Business Development and Advocacy at PSI. She is also responsible for the rollout of PSI’s new web-based accounting system to country platforms. Ms. Fitzgerald joined PSI in 2001 as a country representative in Togo, and then in Uganda, she oversaw the expansion of social marketing programs and new products and services development. Prior to PSI, Ms. Fitzgerald was a U.S. Foreign Service officer in Israel.
Professor Awa Marie Coll-Seck

PROFESSOR AWA MARIE COLL-SECK is Executive Director of the Roll Back Malaria Partnership (RBM), a global partnership founded in 1998 by several United Nations agencies, with the goal of halving the world’s malaria burden by 2010. Prior to this appointment, Prof. Coll-Seck was minister of health of the Republic of Senegal, where she initiated far-reaching reform of the health sector. She also served at the United Nations Joint Programme for HIV/AIDS (UNAIDS). Prof. Coll-Seck recently sat down with PSI Senior Vice President and Chief Liaison Officer Sally Cowal, a friend and former colleague at UNAIDS, to discuss achievements and challenges in the battle against malaria.

MS. COWAL: Based on your work promoting effective solutions in the fight against malaria, would you say that fight is being won or lost?

➤ PROF. COLL-SECK: I think we have momentum now, and we need to build on that. We have a lot of positive things like progress in countries. We have clear strategies, and we have more financial resources. This is why I say that this needs to continue; we cannot stop now.

MS. COWAL: Women’s groups in some countries have taken a leading role in distributing insecticide treated nets, working with school groups and selling nets to their peers through social marketing and other mechanisms. In other countries the favored strategy has been mass distribution of free nets to get them out to everyone. Which of these methods do you think is better?

➤ PROF. COLL-SECK: If we want to control malaria and have action very quickly and catch up, the free distribution has shown that it is a good way to do work. To keep up we need to have some other types of strategies like social marketing, using women, using schools – all of this needs to be done.

MS. COWAL: What do you hope to achieve in 2010?

➤ PROF. COLL-SECK: My focus will be to look at big countries. If we have two big countries in 2011 that are able to show that they are successful in fighting malaria, I think that we will really overcome all the challenges we have today.

Sally Cowal is senior vice president and chief liaison officer, overseeing PSI’s New Business Development, Advocacy, and Corporate Marketing and Communications. Sally came to PSI from a distinguished career in the Foreign Service. She served in India, Columbia, Israel, New York, Mexico, Washington and Trinidad & Tobago, where she was ambassador under Presidents Bush Sr. and Clinton. She became a founder of the United Nations Joint Programme on HIV/AIDS (UNAIDS), serving as its deputy director for four years before coming to PSI.
Mabel van Oranje

MABEL VAN ORANJE is CEO of The Elders, an independent group of eminent global leaders, brought together by Nelson Mandela, who offer their collective influence and experience to support peace building, help address major causes of human suffering and promote the shared interests of humanity. Ms. van Oranje is also a founder and co-chair of the European Council on Foreign Relations and is a World Economic Forum Young Global Leader (YGL). During the Forum in Tanzania in May, Ms. van Oranje talked with PSI Vice President of Corporate Marketing and Communications Kate Roberts, a fellow YGL, about girls and women and the global agenda.

MS. ROBERTS: Based on your work with The Elders on issues related to equality for women and girls, is the fight being won or lost?

MS. VAN ORANJE: I prefer not to talk in terms of a fight. The question of equality for girls and women, is an issue that is not only about improving education, health and the overall well-being and rights of girls and women, it is ultimately about all of us making the best use of 50 percent of our society. Therefore it is not a fight, it is actually an issue that we should all be collaborating on because it is in the best interest of all of us, women and girls, men and boys to make sure that women can develop and live up to their full potential.

MS. ROBERTS: You recently tweeted your admiration of “No Woman, No Cry,” a documentary about maternal mortality. How does maternal mortality fit into the overall campaign for greater equality?

MS. VAN ORANJE: Women play such a crucial role within a household, in the education of their children and, in many places, within local economies that I find it actually quite amazing that they’re still being treated as if they were second class citizens when it comes to education and healthcare. It is absolutely – excuse my language here – it is absolutely stupid in my view when preference is given to men over women when it comes to access to healthcare. Every minute of the day, a woman dies from complications related to pregnancy or childbirth. Also, women are one of the most vulnerable groups in the fight against HIV/AIDS and are often infected not because of their own behavior, but because of the behavior of their husbands. The fact that we don’t focus on their health and put them on treatment, instead letting these women die, that is a tremendous loss for all of us.

MS. ROBERTS: The Elders recently started a new initiative around tradition and religion. How is this contributing to the girl effect?

MS. VAN ORANJE: Religion and tradition play such a decisive role in our world and have been a great force for good. However, unfortunately, there are too many cases where religion and tradition are misused in order to justify the unequal and sometimes even dangerous treatment of girls and women. For example, people say it’s because of tradition that we have to circumcise girls even though we know that it is an enormous health risk. In those cases, tradition can actually be harmful rather than a positive thing. In terms of religion, it is not one particular religion but many religions that treat women unequally. Former U.S. President Jimmy Carter, for example, pointed out that in his own church in America women cannot hold certain positions. It is very much a taboo issue, and The Elders hope that by speaking out about it, that by calling out to religious and traditional leaders, they can help take this taboo away and create positive change. I must say the responses have been amazing. Women from all over the world have been writing to us and saying, “Look, what you said is what I am feeling, but I can’t say it. But now I can refer to the words that you have said, and we hope The Elders will keep up the good work.”

MS. ROBERTS: As a Young Global Leader at the World Economic Forum you’ve been a real champion for The Girl Effect and even visited some of PSI’s reproductive health activities in Tanzania. What does the girl effect really mean to you?

Kate Roberts is the vice president of Corporate Marketing and Communications at PSI. She oversees internal and external communications strategies, corporate partnerships and branding. Ms. Roberts founded YouthAIDS and Five & Alive, two marketing campaigns that aim to raise funds and awareness about PSI’s HIV/AIDS and child survival programs.

>>> MS. VAN ORANJE: For me the girl effect means empowerment and smart development. By giving a girl an education, by giving her a healthy life and making sure that her rights are respected, she could grow up to become an influential doctor, a great community leader, a teacher; she could do so much for society and that’s why I think you are just not empowering the girl, you are also doing smart development. Investing in a girl will ultimately pay off for everybody who lives around that girl. Not just next to her but in the wide, wide society.

Watch the interview with Kate Roberts and Mabel van Oranje at www.psi.org.
Jennifer Buffett & Maria Eitel

As presidents of two exceptional, multimillion dollar foundations, JENNIFER BUFFETT and MARIA EITEL are women with a shared passion to affect change among girls in the developing world. Ms. Buffett is President and Co-Chair of the NoVo Foundation, a philanthropic organization focused primarily on the empowerment of women and girls. She shares leadership of the foundation with her husband Peter Buffett. Maria Eitel is the founding President of the Nike Foundation, where she works to drive resources to girls through a variety of initiatives and put them on the global agenda.

In 2008, NoVo joined forces with the Nike Foundation, committing $90 million to The Girl Effect. This global campaign promotes the powerful social and economic change brought about when girls have the opportunity to participate. Here, Ms. Eitel and Ms. Buffett share their thoughts on investing in girls with PSI Vice President of Corporate Marketing and Communications Kate Roberts.

**MS. ROBERTS:** The Nike and NoVo Foundations focus on empowering women and girls around the world. Would you say this battle overall is being won or lost?

➤ **MS. EITEL:** Slowly, but surely I believe the battle is being won. Our goal is to eradicate global poverty by investing in girls. The challenge is massive. Despite their proven potential to change the world, the 600 million adolescent girls living in today’s developing countries are still more likely to be uneducated, child brides and exposed to HIV/AIDS.

But I believe we’ve made some tremendous milestones in changing this picture. The first step has been to get the world to realize the power of the girl effect. When you improve a girl’s life, everyone benefits: her brothers, sisters, parents, future children and grandchildren.

➤ **MS. BUFFETT:** To reframe slightly, we don’t think of this as a “battle” (Who is against whom?). However, the challenge is getting the message out in ways that truly address and change the inequity and imbalance that exists.

The reason that empowering girls and women is so absolutely critical is that when they are empowered, everyone – boys and men included – benefits. This is a WIN-WIN. Girls and women are the mothers of every child born. So if they are not educated, safe, skilled, healthy, able to nurture their children, disease-free, violence-free or able to lead...they cannot offer much to their children. They can’t ensure that they are nurtured, healthy, educated or able to contribute in positive ways.

So, perhaps to reframe the question: “Are we making real progress?” There has been a tremendous amount of awareness-raising about the importance of empowering girls and women. However, are we moving systems towards meaningful action in terms of modifying attitudes and patterns of behavior AND moving large dollars and resources for more equitable distribution? I think we are just scratching the surface.

**MS. ROBERTS:** Jennifer, your foundation supports unique projects targeted at women and girls, including microfinance programs in Bangladesh, anti-sex work initiatives in India, and campaigns to end gender-based violence in the Democratic Republic of Congo. What has shaped NoVo’s focus and mission?

➤ **MS. BUFFETT:** We spent the first years forming the NoVo Foundation very intentionally, seeking greater understanding about what is playing out in the world right now and a vision for how the world could change. Time and time again in our travels we saw the world out of balance between the “masculine” and “feminine” impulses. The vision for the change we seek is to move from systems of domination and exploitation towards partnership and collaboration with girls and women as agents of change in healthy partnership with boys and men. So we fund initiatives like the ones you describe to try and get at the most egregious displays and results of systems of exploitation in hopes of raising awareness and affecting deep systemic change.

The reason that empowering girls and women is so absolutely critical is that when they are empowered, everyone – boys and men included – benefits.

— Jennifer Buffett

Jennifer poses with children on a visit to the Biruh Tesfa program in Bahir Dar urban slum.
MS. ROBERTS: This year at the World Economic Forum in Tanzania, the Nike Foundation and PSI partnered on exciting activities around The Girl Effect. What are you hoping will come out of these activities?

➤ MS. EITEL: The Nike Foundation was extremely excited to be working in partnership with PSI in Tanzania. We supported a Girl Effect learning journey on the ground hosted by PSI for the World Economic Forum’s Young Global Leaders. It was an opportunity to bring continued awareness to the powerful potential of girls. In addition, it was a chance to build new girl champions for the issue among these key global leaders who have the power to impact change for girls in their respected industries.

MS. ROBERTS: The NoVo Foundation partnered with the Nike Foundation on The Girl Effect in 2008. Tell us about this partnership. What do you hope for the campaign moving forward?

➤ MS. EITEL: This is a momentous time for girls, and I think we’re starting to really move the needle. It is something that wouldn’t have been possible without Jennifer and Peter Buffett’s continued endorsement of our work through their active partnership and significant commitment of $90 million. Together we have touched the lives of more than 2 million girls, and through The Girl Effect, their families, communities and nations.

➤ MS. BUFFETT: The Girl Effect has been able to get the attention of many large and important global players so that they begin to understand “why girls?” And it has evolved in its commitment to work out the “how” to invest in adolescent girls. So if you are a government or a large health-systems organization, The Girl Effect partnership is committed to working to assist in weaving girls efficiently and strategically into large strategies for big benefits and big results.

MS. ROBERTS: It is easy to focus on economic empowerment issues – especially education – and lose sight of the fact that only a healthy girl can become a productive member of society. How do we combine economic initiatives with health projects to get the maximum bang for the buck?

➤ MS. BUFFETT: You’ve said it! We need holistic solutions that aren’t “one-offs!” We need to combine low-cost safe spaces where girls can come together and receive valuable information, education, skills training and financial assistance combined with healthcare and information. No one prospers in his or her life from just ONE intervention. The Nike/NoVo portfolio of grants is full of combinations of interventions mixing health and economic investments in girls in places that are low cost and highly effective.

➤ MS. EITEL: There is a significant relationship between adolescent health and a broad range of social outcomes. “Start with a Girl: A New Agenda for Global Health” offers substantive recommendations to the global health community that will have a transformative impact on the healthcare landscape. Place adolescent girls at the center of international and national action and investment on maternal health. Support research on the risk factors and translate evidence into programming to reduce mortality; earmark funding for girls. Focus HIV prevention on adolescent girls. Support efforts to transform harmful social norms; educate girls about avoiding HIV/AIDS, and work with boys and men to change their behaviors. Make secondary school completion a priority for adolescent girls. Secondary school is a key determinant of good health. Governments, the private sector and donors must extend facilities, offer scholarships or cash transfers to disadvantaged girls and create open-learning programs.

MS. ROBERTS: What are both of you looking forward to in 2010?

➤ MS. EITEL: The Foundation has spent the past six years finding, funding, designing and refining the best models of investments in girls. In 2010, it will be about reaching scale. One way we’re doing this is through innovative partnerships. This is an issue owned by all of us and we won’t make progress unless we work together. The Foundation has established key partnerships that bring investing in girls to the center and focus on bringing programs to scale to impact real systemic change. These include the World Bank’s $20 million Adolescent Girls Initiative and the U.K. Agency for International Development’s $20 million Girl Hub initiative.

➤ MS. BUFFETT: It takes time to be very sure and clear about your particular role and assess the unique opportunities right for you as a funder. It also takes time to be strategic in one’s choices and able to know that you can commit to these areas for the long term. We are finally there and have a sense of clarity that we hoped for. We value humility and this will be a continuous and organic process of learning every day that we have the opportunity to work through the NoVo Foundation. I am looking forward to the deepening and broadening of this work and seeing millions more girls and women worldwide safe, prospering and empowered.

Kate Roberts is the vice president of Corporate Marketing and Communications, where she oversees internal and external communications strategies, corporate partnerships and branding. Ms. Roberts founded YouthAIDS and Five & Alive, two marketing campaigns that aim to raise funds and awareness about PSI’s HIV/AIDS and child survival programs.

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Kate Roberts is the vice president of Corporate Marketing and Communications, where she oversees internal and external communications strategies, corporate partnerships and branding. Ms. Roberts founded YouthAIDS and Five & Alive, two marketing campaigns that aim to raise funds and awareness about PSI’s HIV/AIDS and child survival programs.
Tina Brown

TINA BROWN is the Editor-in-Chief of The Daily Beast and the author of the 2007 New York Times best seller The Diana Chronicles. Brown is the former editor of Tatler, Vanity Fair, The New Yorker, and Talk magazines and host of CNBC’s “Topic A with Tina Brown.” She shares her thoughts on what prompted her to be an outspoken advocate for women with actress and PSI Ambassador Debra Messing.

MS. MESSING: Based on your work promoting greater emphasis on the achievements of women, is the battle being won or lost?

➤ MS. BROWN: You know, when we were organizing “Women in the World” – The Daily Beast’s summit on challenges facing women and girls in the developing world – it was very easy to get depressed. The stories were awful – a Senegalese mother, Marietou Diarra, who lost two daughters to botched female circumcisions; young women tricked into sex slavery; and on and on. But the common thread, actually, in all the stories we told at the summit, wasn’t despair, but hope. These women don’t wait to be rescued; they’re forming their own community organizations to advocate for themselves. A great example is Leymah Gbowee, The Daily Beast’s Africa columnist, who helped force the Liberian dictator Charles Taylor from power by launching a peaceful women’s movement that eventually launched a sex strike!

What’s so important is that we in the West remember these women and support them. I think that battle is being won. There is so much recognition right now that empowering women and girls is the best way to economically liberalize and culturally modernize a society. Many people call it “the girl effect.”

MS. MESSING: What in your own personal experience has made you particularly passionate about empowering women and gender equality?

➤ MS. BROWN: Until a few years ago, the idea of being a feminist activist was pretty foreign to me. But little by little, I kept hearing these incredibly moving stories of women
encountering discrimination and despair around the world, and overcoming it. One way I was introduced to these issues was through the great nonprofit Vital Voices, which works with women in conflict zones to help them get involved with government and launch businesses. Through Vital Voices, I met Chouchou Namegabe, a Congolese radio journalist who takes audio testimonies from rape survivors, and airs them on the radio in order to fight stigma. How amazing is that? I knew that was work I wanted to support and tell the world about. And I couldn’t believe the American media wasn’t doing more to tell these stories.

MS. MESSING: You’ve not only been complimentary of women who have reached professional pinnacles, you have also criticized powerful women for not asserting themselves more. Why the need to police the landscape of successful women?
➤ MS. BROWN: You’re probably thinking of my Daily Beast column from last year, in which I wrote to Hillary Clinton, “Take off your burqa!” Obviously, that was a metaphor for something else – a way to ask the question of whether the Obama administration was going to empower this incredibly smart and accomplished secretary of state – or whether, instead, he continued to feel threatened by her. That was my way of holding the administration accountable for continuing to promote women’s leadership, even though Barack Obama defeated Hillary Clinton in the presidential primary.

MS. MESSING: What was your most memorable experience from the “Women in the World” summit?
➤ MS. BROWN: Well, the most amazing thing was seeing all these inspiring women activists from around the world up on stage with the likes of Hillary Clinton, Meryl Streep, Queen Rania, Valerie Jarret, Christiane Amanpour and so on – and the celebrity women just felt blessed to be in the company of these real-life heroines! I can’t stop talking about women like Sunitha Krishnan, who rescues women and children in Hyderabad from sex slavery, or Edna Adan Ismail, a midwife who is training a new generation of nurses and midwives to ensure that incredibly poor, rural women in her native Somaliland have access to competent, modern maternal health care. The thing I kept hearing from summit attendees was that after meeting these leaders and hearing their stories, they would never again forget to support these causes and spread the word about them. That’s just incredibly powerful.

MS. MESSING: Do you see a difference in the empowerment of women in Europe versus the U.S.?
➤ MS. BROWN: Sure, there are differences. Germany and the U.K., for example, have had women heads of state, and we still have not achieved that in the U.S. And European women have greater access to affordable healthcare and child care, which can make their lives a lot easier day to day. But both continents have a lot of work to do. Think about the financial crisis – one thing that was talked about in both Europe and America was the lack of women at the top of the big banks. In Iceland, the one bank led by a woman was the one that didn’t collapse.

Debra Messing joined PSI as an ambassador in 2009. She visited Zimbabwe to learn about PSI’s HIV prevention programs in the country. Ms. Messing has also testified on Capitol Hill to advocate for continued funding for HIV/AIDS prevention programs. Ms. Messing is best known for her role on NBC’s Emmy Award-winning comedy series “Will & Grace.”
Laura Liswood

MS. LAURA LISWOOD is the Secretary General of the Council of Women World Leaders, a group composed of women presidents and prime ministers. The Council is a Policy Program at the Aspen Institute. Ms. Liswood has spent 20 years contributing to global democracy efforts by increasing the number, effectiveness and visibility of women who lead at the highest levels in their countries. She recently spoke with PSI Director of International Organizations Celina Schocken about women and leadership.

MS. SCHOCKEN: What is the common denominator among women who advance in the top posts of government?
➤ MS. LISWOOD: By and large one common denominator is that women have a passion and a desire to change things. I think any successful person – male or female – develops an extraordinary manner of communicating with people. Women particularly have a way of speaking that appeals to people on an emotional level. They can relate their own life story and bring that forward. All great leaders are great storytellers and that’s certainly something I have seen in women.

All great leaders are great storytellers and that’s certainly something I have seen in women.

To listen to the full audio interview with Ms. Liswood and Ms. Schocken, go to www.psi.org.

MS. SCHOCKEN: Can health policy play a role in breaking through the structural barriers that often prevent women from achieving their fullest potential? Is healthcare a barrier for women to succeed in business and government?
➤ MS. LISWOOD: Policy has an importance in cultural change. PSI is a perfect example of understanding why you have to get to the grassroots to change a culture and, yes, it does play a major part in women’s health. How can women who have no control over their reproductive cycle possibly think about getting into positions of power? This is step one. Step two is closing the gaps on education. The gaps are closing between men and women in terms of access to healthcare, and similarly they are closing in education. But the gaps in economic participation and political participation are not closing, so we still have a long way to go to translate some of the things that women are having challenges with now.

MS. SCHOCKEN: Is there one particular woman you would consider a mentor or hero?
➤ MS. LISWOOD: Well, many, many, many. I am always amazed at any woman who decides to take on a leadership role. It’s so incredibly important for women to go from being in the crowd to in front of the crowd. So my heroes are all the women who take on leadership roles.

As director of International Organizations, Celina Schocken oversees the management and implementation of PSI’s grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Before PSI, Ms. Schocken worked as an early alert and response systems manager for the Global Fund. In 2004, she was chief advisor to the Rwandan Minister of State for HIV/AIDS and Other Epidemics, where she was responsible for drafting national HIV/AIDS policies and coordinating the implementation of multimillion dollar HIV/AIDS programs.
Susan Smith Ellis

SUSAN SMITH ELLIS is CEO of (RED), an initiative launched in 2006 to raise money for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The (PRODUCT) RED brand is licensed to partner companies that create and sell products under the (PRODUCT) RED brand and then contribute a percentage of revenue from each sale to the Global Fund to help finance AIDS programs in Africa. Susan Smith Ellis shares her thoughts on (RED)’s mission to help eliminate HIV/AIDS in Africa with PSI’s Director of New Business Development Shannon England.

MS. SMITH ELLIS: There has been incredible progress over the past few years in engaging the private sector in these initiatives. In the first four years of the Global Fund, business had given only $5 million to support its global health initiatives, compared to $5 billion from governments. In the past four years since (RED) was created, we’ve been able to channel $150 million from business to the Global Fund to support AIDS programs in Africa. Still, while we’ve seen great progress, there is so much more to be done. In Africa, there are 3,800 people still dying a day from a preventable, treatable disease and millions more who need access to antiretroviral (ARV) medicine. It will take continued and increased involvement and commitment from both the private and public sector to address this need.

MS. SMITH ELLIS: Perhaps the most important things that business can bring to bear on these issues is marketing talent and best practices used day in and day out to help companies run efficiently and effectively. First, the private sector has the best marketing talent. It is their job to build attention for their brand or their product. Beyond marketing, global health initiatives can learn a lot from how business is run. For example, the Global Fund has entered into a unique pro bono partnership with Standard Bank, Africa’s largest banking group, through which Standard Bank offers financial and management expertise to Global Fund grant recipients in selected countries in Africa. The partnership not only helps ensure that Global Fund resources are distributed in-country in a timely manner and that reporting requirements are met, but it also helps train in-country recipients on skills that can be applied on a broader level.

MS. ENGLAND: Based on your work in using the private sector to raise money for health initiatives, is the battle being won or lost?

➤ MS. SMITH ELLIS: There has been increasing involvement from the private sector in these initiatives. It is so much more to be done. In Africa, there are 3,800 people still dying a day from a preventable, treatable disease and millions more who need access to antiretroviral (ARV) medicine. It will take continued and increased involvement and commitment from both the private and public sector to address this need.

➤ MS. SMITH ELLIS: While our mission is to help eliminate AIDS in Africa, we recognize that this cannot be achieved without a special focus on women within the programs the (RED) money supports. Nearly 60 percent of the people infected with HIV in sub-Saharan Africa are women, and more than 90 percent of the children living with HIV are infected through mother-to-child transmission during pregnancy, around the time of birth or through breastfeeding. It is absolutely critical to our mission to engage women in this fight and encourage them to know their status and, if positive, to stay healthy and, if negative, to maintain that status. The Global Fund finances more than half of all treatment to prevent transmission of HIV from mothers to their children. With sustained investment, the world can reach the goal of eliminating mother-to-child transmission of HIV by 2015.

MS. ENGLAND: What is the role of the business sector in global health initiatives, and how can the business sector contribute to the Global Fund?

➤ MS. SMITH ELLIS: Perhaps the most important things that business can bring to bear on these issues is marketing talent and best practices used day in and day out to help companies run efficiently and effectively. First, the private sector has the best marketing talent. It is their job to build attention for their brand or their product. Beyond marketing, global health initiatives can learn a lot from how business is run. For example, the Global Fund has entered into a unique pro bono partnership with Standard Bank, Africa’s largest banking group, through which Standard Bank offers financial and management expertise to Global Fund grant recipients in selected countries in Africa. The partnership not only helps ensure that Global Fund resources are distributed in-country in a timely manner and that reporting requirements are met, but it also helps train in-country recipients on skills that can be applied on a broader level.

MS. ENGLAND: There is an emerging consensus among global health policy makers that a focus on women’s health is a must for durable development. Could you foresee targeting this issue specifically?

➤ MS. SMITH ELLIS: While our mission is to help eliminate AIDS in Africa, we recognize that this cannot be achieved without a special focus on women within the programs the (RED) money supports. Nearly 60 percent of the people infected with HIV in sub-Saharan Africa are women, and more than 90 percent of the children living with HIV are infected through mother-to-child transmission during pregnancy, around the time of birth or through breastfeeding. It is absolutely critical to our mission to engage women in this fight and encourage them to know their status and, if positive, to stay healthy and, if negative, to maintain that status. The Global Fund finances more than half of all treatment to prevent transmission of HIV from mothers to their children. With sustained investment, the world can reach the goal of eliminating mother-to-child transmission of HIV by 2015.

As director of New Business Development, Shannon England is the senior technical resource for PSI programs working on proposals, and she develops strategy for the department. Ms. England has served in several roles within PSI, including senior program manager for Asia and voluntary counseling and testing program development manager in Lusaka.

“The Lazarus Effect” premiered May 24, 2010, on HBO and is currently available at www.youtube.com/joinred. Dr. Mannasseh Phiri, executive director of Society for Family Health, PSI’s affiliate in Zambia, appears in the documentary, which tells the story of four HIV-positive Zambians and how treatment transformed their lives. To learn more, visit www.joinred.com.
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The Obama administration’s Global Health Initiative, a six-year, $63 billion effort to improve and expand access to health services globally, has a strong focus on improving maternal, newborn and child health. Leaders in Congress are fighting to pass legislation to improve access to life-saving care for women and infants around the world. Maternal and child health will be a key priority for action at the 2010 G8 Summit this June. And the Millennium Development Goals (MDGs) that focus on women and children will be prioritized at the United Nations’ MDG review summit this fall.

In Africa, President Kroma of Sierra Leone and President Kikwete of Tanzania are prioritizing maternal and child health. I have met with both leaders and am inspired by their focus on saving the lives of women and girls. All of this indicates that political will is increasing. Now, we need adequate resources and a concrete plan of action, developed in partnership with countries and communities, to improve the health of girls and women and create lasting change.

DR. HELENE GAYLE is President and CEO of CARE USA. She also chairs the Obama administration’s Presidential Advisory Council on HIV/AIDS. Dr. Gayle has worked at the Centers for Disease Control and Prevention and the Bill & Melinda Gates Foundation. In an interview with PSI’s Global Director of HIV, TB and Reproductive Health Dr. Krishna Jafa, Dr. Gayle shares her thoughts on creating lasting improvements in the health of girls and women worldwide.

DR. JAFA: Based on your work in international development, are world leaders finally recognizing the crucial role that better health for women and girls plays in this battle?

DR. GAYLE: I’m pleased that leaders around the world are not only recognizing the critical impact that the health of women and girls has on poverty reduction and development, but also stepping up and facing these challenges head-on.

DR. JAFA: What is your own personal history that helped convince you that women and girls need to be the focus of successful development strategies?

DR. GAYLE: I have seen what life is like for girls and women around the world who have no rights and seemingly few opportunities to change their circumstances. Yet it is these very people who are working so hard to reshape their lives. Investing in girls and women – empowering them with access to education, quality health services and the ability to become economically self-sufficient – is key to building a better, more equitable and stable world.

DR. JAFA: No health problem has a greater prominence in this world than HIV/AIDS. What women-specific strategies are needed to fight the epidemic?

DR. GAYLE: CARE has worked on HIV and AIDS prevention for more than 20 years. In that time, we have learned that public health or medical interventions alone are not enough to address HIV; we must also look at the social factors contributing to transmission and prevention. A recent maternal health study in the medical journal The Lancet found that 64,100 maternal deaths were attributable to HIV in 2008. It is critical to provide a network of services that help women in all aspects of their lives.

CARE also works to break down barriers to accessing and using services, such as stigma, discrimination, social norms that prevent women from leaving home, issues with service quality and basic transportation challenges. CARE addresses the legal issues that put women at risk of HIV infection. We also address violence against girls and women. Finally, while women-specific strategies are critical, we can’t overlook including boys and men. Counseling, testing and health programs must support both genders in order to be effective.

DR. JAFA: CARE has launched the “Voices Against Violence” campaign to call attention to gender-based violence. What has been the response to the campaign been so far?

DR. GAYLE: The Voices Against Violence campaign is a multi-year campaign that is showing great success in raising awareness of, and action against, gender-based violence. To date, 14,000 people have signed an online petition that calls for an end to violence against girls and women. This will be delivered to elected officials with the message that more can and must be done to address gender-based violence. CARE supporters have sent more than 10,000 messages to members of Congress this year, asking them to co-sponsor the International Violence Against Women Act (IVAWA). If passed, IVAWA will increase resources for legal, health and social survivor support.

DR. JAFA: CARE and PSI are partnering on a Global Fund grant to distribute mosquito nets to pregnant women and children and train NGO partners in Cote d’Ivoire. What are the key components to ensuring this program is effective and sustainable?

DR. GAYLE: CARE has been very pleased to work in partnership with PSI since 2004 in Cote d’Ivoire. Our recent partnership for a nationwide malaria project has been a tremendous success. Together, we are distributing nine million bed nets treated with insecticide, to prevent the spread of malaria in the region. At CARE, we know we can’t solve a problem as big as global poverty on our own. When we combine our strengths with those of our partners like PSI, we can make tremendous progress.

Dr. Krishna Jafa is PSI’s global HIV, TB and Reproductive Health director. She manages technical teams with social marketing, epidemiological, clinical and training expertise to support PSI country programs and partners in implementing evidence-based and cost-effective interventions. Krishna is a physician and epidemiologist. She has worked for PSI in Zimbabwe, Afghanistan and India.

Dr. Helene Gayle with a group of children in India in 2008.
On April 10, *The Lancet* published some of the best news international health had heard in years. Maternal mortality has long been thought not to be decreasing. Yet, using new measurement methods, researchers at the University of Washington found that death rates had in fact dropped significantly. Since 1990, the annual rate of decline of the global maternal mortality rate was 1.3 percent. In 1980, more than 500,000 women died from maternity-related causes; in 2008, fewer than 350,000 did.

For PSI, the significance of this finding was clear. Many more years of effort will be required to bring maternal mortality rates in low-income countries down to high-income country levels. Our single most important challenge as an organization is how to sustain programs over the decades that it takes to solve the world’s most important health challenges, particularly those that affect women.

More than 10 years ago, PSI published its first position statement on sustainability – distancing itself from the almost exclusive focus on financial sustainability used by other social marketing organizations. Instead, we emphasized producing health and quality-of-life benefits at scale and with equity, increasing cost-effectiveness, minimizing financial subsidies, reducing the financial vulnerability of our social marketing partners in the developing world, and building unique competencies needed to address the public health challenges of today and tomorrow.

We recently updated that position statement using new examples, yet reaffirming its central point. For PSI, sustainability is achieving positive public health impact and continuing that impact over time.

At PSI, we believe the best way to do this is to use social marketing approaches that make it easier for populations to access products, services and information that address the priority contributors to a country’s burden of disease and unintended pregnancy. We believe that high proportions of the vulnerable and low-income populations over time will adopt healthy behaviors; the burden of disease will decrease and change; and that donor subsidies can be reduced, eliminated or shifted to other priorities over time. We believe that new financing arrangements, particularly health insurance, will emerge to complement public health impact and continuing sustainability is achieving positive impact tomorrow.

Steven Chapman leads PSI’s efforts to improve the effectiveness, cost-effectiveness and equity of its interventions. He manages PSI’s Technical Services team which consists of about 50 experts in five departments: Malaria and Child Survival; HIV, Tuberculosis and Reproductive Health; Research & Metrics; Social Marketing; and Capacity Building.


2. To read PSI’s new position statement, go to [www.psi.org](http://www.psi.org)
and perhaps replace the need for donor support as we know it today.

We know that this will take years. PSI has been working in family planning for 40 years during which contraceptive prevalence rates in the developing world have increased at just 1.5 percent per year. Since 1988, we have been working with many partners to increase condom use, the age of sexual debut and the number of people having just one sexual partner at a time. An analysis of a nearly 10-year trend in those behaviors among women ages 15-24 in 18 African countries found that condom use increased by 1.4 percent per year and secondary abstinence increased significantly.4

We apply three general strategies to achieve sustainability. The first is to achieve positive health impact. We do that by first setting priorities based on the burden of disease in a country and unmet need for family planning. We launch multiple interventions and use measurement tools to determine whether the interventions are effective in changing behavior. We monitor whether, among the vulnerable, the low-income groups are adopting behaviors at the same rate as those with more means and, if not, we work to make it easier for the low-income to adopt the behavior. This way, globally, PSI averts between one and two percent of the world’s disability-adjusted life years (DALYs).

Achieving scale and equity in the practice of a behavior in a given population is expensive. To reduce costs, PSI divides up markets in order to route the middle-income toward paying for products and services and the low-income toward programs that supply products and services at no cost. PSI actively works at the very least to get out of the way of the commercial sector and indirectly (and in a few cases, directly) to help it grow.

PSI’s second strategy is to minimize financial vulnerability rather than to maximize financial self-sufficiency. We see no evidence that organizations seeking to maximize financial self-sufficiency can achieve meaningful health impact among low-income clients. PSI does not expect the need for subsidies for public health and family planning programs to go away. We see donors, governments and foundations giving unprecedented amounts of funding to improve the health of low-income populations and have no reason to believe that this support will not continue for the foreseeable future.

With this in mind, PSI’s third strategy is to strengthen our various country platforms as locally-grounded institutions so that they continue to attract funding. In some circumstances, this may mean locally incorporated and governed nonprofit organizations that participate in the PSI international network and that have significant decision-making authority. In every case, we set objectives and minimum standards for platforms in order to maintain accountability and quality. These include requirements to base decisions on evidence, monitor and improve intervention, team and organizational performance, and maintain required governance and employment procedures.

PSI transfers competencies from other organizations through partnerships. We are using partnerships to develop competency in performance-based financing, including being paid for outputs rather than inputs, health insurance and voucher programs. We believe that these payment mechanisms could over time provide significant leverage to international donor funding.

PSI believes that by pursuing the three sustainability strategies—maximizing health impact, minimizing financial vulnerability and strengthening institutional capacity—susceptibility to the primary contributors to the burden of disease can be significantly and equitably reduced through social marketing and behavior change.

Improving women’s health takes time. PSI works every day to create a lasting solution for women in the developing world.
every year more than 1,000,000 children are left motherless and vulnerable because of maternal death
Meet five women

they live different lives in different parts of the world. but they share a common bond of personal struggle, strength and passion to improve the health of women.

1. Yingzi
   China

2. Marípaz
   El Salvador

3. Aggie
   Zambia

4. Khom
   Laos

5. Tears
   Zimbabwe
Yingzi left home at 13 with a hope of making money for her farming family in rural Jinping County, Yunnan Province, China. Her friends told her she should go to a big city to find work. So when she had the opportunity to leave Jinping, Yingzi made her move. She went to Mengzi City.

When she first arrived, Yingzi took various jobs in restaurants, clothing shops and as a nanny. But with her salary of 400 or 500 yuan a month, she couldn’t afford to eat well and still support her family. When she was 16, she decided to get a job at a karaoke bar, or KTV as they’re commonly known. Karaoke bars in China are at the heart of the country’s sex industry. Customers are usually groups of men who want to sing and drink in the company of young women.

“Looking back, I think the friends that told me to come to Mengzi were sex workers, but when I first arrived I didn’t know what they were doing,” said Yingzi. “In the beginning, I didn’t do sex work. But later, for economic reasons and because my family was poor, I started to.”

It wasn’t long before Yingzi realized the risks associated with living life as a sex worker. She saw many girls, as young as 15 years old, with reproductive health problems during that time. Some would have severe abdominal pain. Like Yingzi, they had no family members around who could take them to the hospital for treatment.

“Knowing these women’s health conditions made me realize how hard life can be.”
Women on the Frontlines

In 2009, Yingzi got acquainted with PSI through the Mengzi Sisterhood Health Home (SHH), a drop-in center for female sex workers that was launched in August 2005 as a focal site for PSI’s outreach program.

In December 2009, Yingzi became a part-time staff member for PSI/China. Yingzi does outreach work in brothels and KTVs. She also works at SHH as a peer educator.

The program, funded by the U.S. Agency for International Development, reaches female sex workers, a particularly vulnerable population in Mengzi, through quality outreach and interpersonal communication methods. HIV prevention activities are peer-based using carefully tailored behavior change messages which are evidence-based and determined through exhaustive research.

SHH provides free check-ups for sexually transmitted infections by a local doctor, who can also make referrals for other testing and/or treatment at the local maternal and child health hospital.

After being a sex worker for several years, Yingzi has come a long way. As a PSI/China peer educator she has not only learned how to protect her own health, but is actively engaged in helping her peers do the same for themselves.

“I’ve learned a lot from working at PSI. Now I know about women’s health, reproductive health and how to protect myself. Take condoms as an example. I used to not know how condoms could protect me. But I’ve learned a lot here, especially as a girl from a rural village. I think PSI is a good place.”

PSI Author: Mandy McAnally, Coordinator, Corporate Marketing & Communications, Washington, DC

PSI’s Sisterhood Health Home (SHH) provided sexually transmitted infection (STI) screening and treatment to more than 100 female sex workers in Mengzi. About 170 sex workers visited SHH to participate in edutainment activities and gather with their peers. During the same period, PSI’s peer educators reached 380 street-based sex workers through outreach activities. In addition, PSI’s female sex worker program trained 10 women on STI management. All participants were trained on the correct forms of diagnosis and treatment of STIs.

Reaching More

From October 1, 2009, to March 31, 2010, PSI’s Sisterhood Health Home (SHH) provided sexually transmitted infection (STI) screening and treatment to more than 100 female sex workers in Mengzi. About 170 sex workers visited SHH to participate in edutainment activities and gather with their peers. During the same period, PSI’s peer educators reached 380 street-based sex workers through outreach activities. In addition, PSI’s female sex worker program trained 10 women on STI management. All participants were trained on the correct forms of diagnosis and treatment of STIs.
Marípaz
The Strength of a Mother

My sons keep me grounded,” María Paz Callejas says with a smile. “Whenever I feel like giving up, they snap me right out of it.” Marípaz, as she is affectionately known, has felt like giving up a few times in her life. In 1996, she was diagnosed with HIV several months after her husband died of AIDS-related causes.

Without proper counseling or anyone to turn to, Marípaz returned home with her test in hand. “I locked myself in my bedroom, because I didn’t want my children to see me crying.”

Marípaz was born the youngest of 12 in the outskirts of San Agustín Usulután, a town in a southeastern region of El Salvador. According to statistics from the United Nations Joint Programme on HIV/AIDS, adult HIV prevalence is still relatively low (less than 1 percent) in this small but densely populated country of about 6.2 million inhabitants. Nevertheless, approximately 35,000 people are estimated to live with HIV and many, like Marípaz, may not have received adequate counseling before and after taking an HIV test.

It wasn’t until a friend referred her to a local nongovernmental organization, Fundasida, where Marípaz took another HIV test and finally received professional counseling. “I had so many questions,” she says, “and I finally had someone to answer them.”

After several months of continued counseling, Marípaz joined a support group for people with HIV. She started two other groups for youth (both positive and negative), and for family and friends of people with HIV. She then went on to volunteer at the foundation’s confidential hotline and prepared meals for people who came to receive treatment, care and other services.

In 2002, Marípaz received a phone call about a job opening at PASMO, PSI’s Central American affiliate. “When I interviewed her,” says Susan Padilla, PASMO’s HIV manager, “she didn’t have a lot of experience in education. But I saw a lot of potential in her, and I told her that she was completely capable of carrying out the work.” A few days later, she was hired to do interpersonal activities with groups particularly vulnerable to HIV.

At the end of the day, Marípaz says her family and children are what motivate her to keep going each day. Her three sons, none of whom tested positive for HIV, are healthy and in school.

Her eldest, José Luis, is studying psychology at the university-level and says he would like to work at PASMO helping others. He has also given Marípaz the chance to be a grandmother, and she proudly shows the pictures of her granddaughter on her mobile phone. “I always wanted a little girl, and now I finally have that chance.”

PASMO’S IMPACT IN EL SALVADOR

In 2009, PASMO averted 1% of the national burden of disease due to HIV through product and service distribution alone. PASMO sold and distributed 2.1 million male condoms; distributed 12,000 female condoms; conducted 10,874 activities with most at-risk populations and youth; and reached 200,393 people. PASMO also helped facilitate the provision of voluntary counseling and testing services to 1,914 most at-risk populations. In El Salvador, the Ministry of Health conducts the HIV testing and PASMO provides the pre- and post-test counseling.
Every day, Agnes Phiri Kornika wakes up at 5:00 in the morning to pray for the rural women of Zambia. She prays for women who have 16 children, for women struggling with unwanted pregnancies, for women who have no access to family planning. Then, she puts on her dancing shoes and does something about it.

Agnes, Aggie for short, has six children of her own between the ages of 39 and 11 and has been a midwife for 34 years; she knows a thing or two about reproductive health. Her passion for serving the underserved has brought her to the far reaches of rural Zambia.

“My family lives in Lusaka, but at the moment I am in an eastern province of Zambia, where I am helping, or rather saving, the rural women with a long-term family planning method,” she says.

Aggie provides family planning counseling and insertion of long-acting reversible contraception, namely intrauterine devices (IUDs) and implants. She considers her work for PSI’s local affiliate, Society for Family Health (SFH), her God-given profession not only because she is committed to helping women take control of their reproductive health, but also because she is a gifted communicator. She speaks multiple languages and has a way about her that puts people of all backgrounds at ease.

“I don’t really have a problem in communicating with anybody, be it young, old or middle aged. They find me accommodating, and I also find them accommodating. Because of this relationship, something just comes in me,” she says.

Aggie takes an active interest in the women she serves. She talks extensively about one woman she met. This woman had been pregnant 16 times. “A rural woman gets married at 14.
This rural woman, at 42, had been pregnant half of her life. Because her children were dying of malnutrition she kept on producing every year,” Aggie says.

“I was really affected; I’ve never seen a sixteenth child from the same woman and man in my life.”

Aggie counseled the woman on her family planning options, and she chose an IUD, which Aggie inserted. Both the woman and her husband came back to thank Aggie and have served as role models for other couples in the community by dispelling myths around IUDs.

While access to family planning can be a matter of life or death, Aggie educates women and men in a positive and engaging manner, through dancing, singing and by talking about the real reason people need family planning: sex.

“I’ve come to discover that in a woman’s life and a man’s life the best thing is sex...so as a part of my sensitizezation, I always say that what you have to enjoy is your sex,” says Aggie. “I tell them to enjoy sex with the partner God has given you rather than you trying to find satisfaction from someone else. And this has also helped them to maintain their relationships. Even the men have come to appreciate it; they come personally to say thank you.”

Aggie discusses how using long-acting reversible methods of contraception will help relieve a woman’s anxiety about becoming pregnant, thereby freeing her from worry during sex.

“With this long-term family planning method, which is never forgotten, you can go anywhere anytime. You won’t forget to take your pill; you won’t forget the date of your next injection because you already have the device in you. That brings a lot of comfort to a lot of women.”

Aggie’s smiling face and upbeat personality undoubtedly bring a lot of comfort to a lot of women as well. In these rural areas, SFH, working in partnership with the Ministry of Health, is one of the only organizations that has been able to successfully increase informed demand for and use of IUDs.

“I would say our program is doing the best and it is the best, especially for rural women. It has never been done there.”

For Aggie, there is no uncertainty about how these rural women view SFH’s program.

“When you see them dance, you know they really appreciate the service.”

PSI Author: Laura Glish, Intern, Reproductive Health, Washington, DC
Vongphachanh “Khom” Temmelath lives in Sythane Tai Village, in Vientiane, the capital of Lao PDR. Born a boy, Khom knew from an early age that she was different.

Growing up, Khom had a group of friends who were also born and raised as boys, but who identified as girls. As they grew older and began to express their identity, their families reacted with anger, often hitting and abusing them. Early on, Khom’s family was deeply embarrassed and worried that their small community would judge them. They urged her to wear men’s clothes and to act more masculine. But she insisted this was how she felt in her heart. At the age of ten, Khom lost her father.

With time, Khom’s family accepted her identity as a male-to-female transgender, or katoey. In high school Khom began wearing make-up but still dressed as a man and kept her hair short. By university, she had grown her hair long and wore women’s clothing. She became an active part of social events on campus, volunteering and organizing events. But the school authorities challenged her repeatedly. Eventually, the constant pressure from the school and the discrimination from fellow students caused her to drop out of school.

Khom says that it is nearly impossible to find a job in Laos as a transgender: “Companies look at your picture, your long hair, and then they see that you are born male, and they toss your CV out.” Unemployed, she felt alone and adrift.

Khom’s health was also at risk. HIV prevalence among the general population of Laos is relatively low (0.1 percent), but a recent survey established the HIV prevalence among men who have sex with men, including transgender, to be 5.6 percent. Among that group, there is a self-reported prevalence rate of sexually transmitted infections at around 42 percent. In response, PSI/Laos opened three New Friends Drop-in-Centers in 2008 in the country’s largest urban areas, providing a range of HIV and sexually transmitted infection (STI) prevention education and services for an estimated 6,000 transgender and their partners.

After being isolated for so much of her life, Khom found a sense of community through PSI. She helped with a research survey and became more and more involved in the New Friends Drop-in-Center activities. Eventually, she began working as a peer educator. Now, she mentors youth who visit the Drop-in-Center. She urges her peers to focus on their studies and to finish their degrees. She also gives them the emotional support they need in order to face the discrimination they feel at home and at school.

“Not even in my dreams did I imagine I would be able to do this kind of work,” Khom says. Before working at New Friends, she had heard of HIV and STIs but did not know how important it was to keep herself healthy and to prevent these diseases. Fearing discrimination, she rarely saw a doctor and had never been tested for HIV or STIs. Now, she says of her work at New Friends: “I can protect myself and protect others.”

PSI Author: Sihamano Bannavong, National Coordinator, Laos

[1] Lao Ministry of Health & Burnet Institute
When she was younger, Tarisai “Tears” Wenzira dreamed of being a nurse like her mother. Tears’ parents died when she was 15, and she went to live with her grandmother, a farmer, along with three siblings and her late aunt’s three young children.

Times were difficult financially. She felt the dream of becoming a nurse slip away when she was forced to drop out of secondary school to help her grandmother support their large family.

With little education and a lack of job opportunities, Tears drifted into marriage and motherhood at 17. After three years of struggling to cope with both, she divorced her husband and returned to her grandmother’s home in rural Wezda, this time with her two young daughters.

She had come full circle. Again she found herself in search for a job to help support her family. She found one as a hairdresser, which she didn’t realize then would change her life.

It was at the salon that she was first approached and trained by PSI to promote and sell female condoms to her clients. “I remember learning about PSI when a field officer visited our salon and introduced the care female condom and its role in HIV prevention. She demonstrated how it is used and coached us on how to teach our clients on correct use of the condom as well as negotiating for its use with their partners. She sold some condoms to us for resale to our clients, and when I became interested and agreed to continue,” says Tears.

Twenty-one percent of Zimbabwean women, compared with 14 percent of men, are HIV-positive. Yet, cultural and gender dynamics often prevent women from purchasing and initiating condom use.

PSI found that hair salons can break through these cultural barriers. According to research, a majority of women in Zimbabwe visit a hair salon at least once a week and spend about 45 minutes at an hour at each visit. Clients often become friendly with their hairdresser and discuss social issues.

Tears became one of the more than 2,000 hairdressers in Zimbabwe who work closely with PSI, as part of a program, co-funded by the U.S. Agency for International Development and the U.K. Department for International Development, to prevent HIV transmission by promoting the use of female condoms to their clients. During discussions with their clients, hairdressers show women how to use the product and let them touch and feel it. Research also showed that lack of knowledge about how to insert the female condom correctly and fear of the sheer size were also barriers to use.

Today, Tears, a radiant 28-year-old with beautiful hair and a welcoming smile, has remarried and has a third daughter. She has moved to Chitungwiza, a small town 30 kilometers from Zimbabwe’s capital, Harare, where she continues her work as a hairdresser, advocate and educator.

Tears sells 100 female condoms per month and makes a profit of US $4.00 – enough to buy basic groceries like bread and milk for her family. In 2009 alone, PSI sold more than 2 million female condoms, and more than 50 percent of them were distributed through the network of 1,700 hair salons across the country.

Tears is proud of her confidence to talk about the female condom even to clients who are more educated than herself. “My work with PSI has been an eye opener. Despite my incomplete secondary education, I can confidently speak about the care female condom to women and men, some of who are professionals.”

She also feels her work with PSI has benefitted her family; she introduced her sister, who is HIV-positive, to the female condom. This sister is happy and now enjoys a normal sexual life.

Tears’ strength to overcome her life’s hardships has made her a powerful advocate for PSI’s HIV prevention and family planning efforts.

**HAIRDRESSER HEALTH IMPACT**

In 2008, PSI/Zimbabwe conducted a survey of women to evaluate the hairdresser program. The survey showed that 80% of women reported ever having heard about the care female condom. Of these women:

- 38% had heard about care through hair salons.
- 79% said they felt comfortable talking about the product with their hairdressers.
- 76% said they could insert the product correctly after watching a condom demonstration.
- 18.8% of those exposed to hair salon program activities reported ever using female condoms, compared to 1.9% among those with no exposure.

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PSI Author: Kumbiri Chatora, Deputy Country Representative, Zimbabwe

To view more photos of Tears with PSI Ambassador Debra Messing during Debra’s visit to Zimbabwe in December 2009, go to www.psi.org/multimedia. Tears will attend the International AIDS Conference in Vienna in July. Meet her and learn about her work as a hairdresser and PSI peer educator.
Members of Congress introduced two new pieces of legislation with the potential to improve the health of women and girls in the developing world.

**Global Sexual and Reproductive Health Act**
Representative Yvette Clarke (D-NY) was joined by 17 other original cosponsors when she introduced the “Global Sexual and Reproductive Health Act” (HR 5121) on April 22, 2010. The bill aims to build on the successes of the U.S. government’s international family planning and reproductive health program by comprehensively addressing a larger spectrum of sexual and reproductive health issues. By broadening the scope of U.S. foreign assistance for sexual and reproductive health programs, the bill would ensure that women and girls have access to important, and often life-saving, health services.

Activities supported under the bill would include voluntary family planning; education and outreach; reduction in the incidence of unsafe abortion; prevention of sexually transmitted infections, including HIV; abandonment of harmful traditional practices; engagement of men and boys; integration of family planning services with other services; contraceptive development; and training for healthcare professionals.

**Improvements in Global MOMS Act**
A more specialized bill to address maternal mortality, the “Improvements in Global Maternal and newborn health Outcomes while Maximizing Successes Act” or the “Improvements in Global MOMS Act,” was introduced by Representative Lois Capps (D-CA) on May 11, 2010, following Mother’s Day in the U.S.

The bill would facilitate funding for tools and services to prevent the deaths of hundreds of thousands of women each year from causes related to pregnancy and childbirth. The bill would authorize family planning, antenatal care, skilled delivery care, emergency obstetric care, postpartum care, post-abortion care and comprehensive sexuality education.

Both of these bills reflect representatives’ awareness that the advancement of sexual, reproductive and maternal health is necessary to meeting most of the eight United Nations Millennium Development Goals (MDGs), including MDGs related to eradicating poverty, achieving universal education, promoting gender equality, improving maternal and child health, combating HIV/AIDS and ensuring environmental stability.

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**Europe**

**Mother’s Night Campaign to Improve Maternal Health**
Germany, Hungary, Malta and the Netherlands have launched “Save Women’s Lives,” a European Union-funded campaign. The campaign will contribute to poverty reduction by promoting the United Nations Millennium Development Goal (MDG) 5 on maternal health and augment support for the International Conference on Population and Development (ICPD) as reconfirmed by the European Union (EU) at the September 2005 United Nations Summit.

A core element of the campaign was Mother’s Night, a special event before Mother’s Day. The event held in the Netherlands on May 8, 2010, was organized by a group of Dutch nongovernmental organizations. The event featured debate, music and pregnant women who had their bellies painted to promote MDG 5. Sixteen female members of the Dutch parliament kicked off the campaign. They were served breakfast in bed by 16 pregnant women in front of the parliament buildings in The Hague, attracting much publicity.

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**PSI Authors:** Jennie Quick, Manager, Policy and Advocacy, Washington, DC; Iris Tzur, Manager, Communications, Amsterdam, the Netherlands
PSI Measures Health Impact in 2009

PSI’s interventions averted 16.5 million DALYs in 2009. A DALY, or Disability Adjusted Life Year, is the international standard measurement, which measures both the years of life spent with a disability and the years lost due to an early death. The graphs below look at the number of DALYs that PSI averted in each health area from 2007–2009.

HIV Cases Averted
- 10-year average annual growth rate = 15.2%
- 3-year (2007-2009) annual growth rate = 9.0%

Malaria Cases Averted
- 10-year average annual growth rate = 66.4%
- 3-year (2007-2009) annual growth rate = 21.9%

Diarrhea Cases Averted
- 10-year average annual growth rate = 72.2%
- 3-year (2007-2009) annual growth rate = 30.4%

Unintended Pregnancies Averted
- 10-year average annual growth rate = 13.8%
- 3-year (2007-2009) annual growth rate = 10.3%

To read more of PSI’s research and metrics, go to: www.psi.org/resources/research-metrics.
Let Women Deliver for Us All

In April, *The Lancet* published some encouraging statistics on maternal health: maternal deaths dropped from about 526,000 in 1980 to around 343,000 maternal deaths worldwide in 2008.

This is a decline worth celebrating, but not a reason to pull back; if anything, this study should drive us to do more.

This issue of *Impact* is full of stories of powerful women – some with titles, some of very humble roots – who inspire us all to do more. We know the Millennium Development Goals (MDGs) will not be achieved without investing more in women. Despite *The Lancet*’s positive news, we are woefully behind on MDG 5, which calls for a 75 percent reduction in the maternal mortality ratio by 2015. Reducing the maternal mortality rate continues to be a challenge for most national health systems.

In PSI’s experience, the best recipe for progress against this challenge lies in a total market approach, working with both public and private sectors, to ensure that a consistent supply of high-quality reproductive health products and services matches up with an informed demand from women.

A woman I met recently in Zambia comes to mind. Martha Moyo was a retired midwife who had left government service, when the Society for Family Health, PSI’s affiliate in Zambia, recruited her. Martha now works in a busy urban health center, overseeing PSI’s highly successful work to provide women with postpartum long-acting reversible contraceptives like the intrauterine device (IUD). When I saw Martha, she was midway through a day that would yield dozens of satisfied women clients who were receiving a quality service they had not been able to find previously in this public facility. Elsewhere in the PSI network, women might be accessing quality supplies and services directly from the private sector, such as with ProFam in Uganda. The ProFam network of reproductive health providers works with PACE, PSI’s affiliate in Uganda.

In Zambia, Uganda, and many other PSI platforms around the world, PSI began in 2008 to scale up delivery of long-term family planning methods like IUDs and implants. Often using private franchise networks, such as ProFam, PSI franchising programs are helping to meet existing and latent demand for quality services and products from the millions of women who seek modern contraception. Since 2008, more than one million IUDs have been distributed to women under this scaled-up program.

Providers like Martha in Zambia, and the ProFam network in Uganda, remind us that it’s possible to change the reality and raise the trajectory of women, their families and their communities.

The MDGs give us a deadline; naturally, there is also a price tag. Aren’t fewer maternal deaths worth it? Of course they are. ■
Girls! The gifts, the nights out and the cash can never be worth your lives and future. Older men are taking advantage of you and putting you at risk of HIV infection, in exchange for material things. This practice is called cross generational sex. Respect yourselves and Say NO to Sugar Daddies.

You might want the phone, meals out and fancy clothes...

...but do you need HIV?

Office of the First Lady.