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"MATERNAL AND NEONATAL HEALTH - TOWARDS A HOLISTIC APPROACH" Praise is to the Almighty for His Blessings in enabling us to gather here within an environment of peace and stability. I wish you a very good morning and to all our distinguished delegates and guests "SELAMAT DATANG", a warm welcome to Kuala Lumpur. As you can see, Malaysia represents a truly harmonious and vibrant blend of people from diverse cultural, social and ethnic backgrounds, all sharing similar hopes and aspirations and working towards Malaysia becoming a value based knowledge and industrialised nation by the year 2020.

2. I am deeply honoured to be invited to officiate the 8th World International Association of Maternal and Neonatal Health (IAMANEH) Conference and I thank the organisers for choosing Malaysia as the venue for this congress. As Patron of MAMANEH - Malaysian Association of Maternal and Neonatal Health, I have followed the activities of MAMANEH and IAMANEH, and I commend you for your dedication in improving health of women and newborns in your areas of specialisation. We are meeting at a particularly significant time - this is the first world gathering of IAMANEH at the dawn of a new century and I believe that it will pave the way for a more active sharing of experiences and expertise over the years to come particularly among younger generation of professionals and facilitated by access to modern IT and communication systems.

3. Over the last decade, major global UN conferences have drawn governments to commit themselves to achieve internationally agreed goals to improve health of women and children. The urgent calls for action to reduce maternal and infant mortality has been reiterated at these conferences and in the resultant plans of action of The World Summit for Children in 1989, International Conference on Population and Development in Cairo in 1994 and the 4th World Conference for Women in 1995.

In the year 2000, we further committed ourselves to achieve the developmental goals of the UN Millennium Declaration or the MDG's, with specific targets for reducing maternal and child mortality by the year 2015.

4. If we recognise the right to development, to alleviation of poverty, and access to health as a basic human right, why then are we still faced with gross inequities in opportunities and access to social and economic progress? Why do women, infants and newborns especially in developing countries and from poorer segments of the community continue to be marginalised and deprived of the benefits of scientific progress, and technological advancements in health care, information and education? 5. It is indeed sad to note that globally, in spite of all their achievements, health systems have generally failed to narrow the health divide between the rich and the poor over the last 100 years. In fact, according to the World Health Report 2000, the gap is widening. This statement reflects the grim scenario of prevailing high and unacceptable maternal mortality in developing countries where women lose their lives unnecessarily from complications of pregnancy and childbirth and when one of the most joyful moments of a woman's life ends in a personal and societal tragedy.

6. We know that most of these deaths could be prevented if women had access to good quality prenatal care, timely referral and transportation to adequately equipped health facilities for emergency obstetric care, if they had opportunities for family planning, and better education. 99 percent of more than half million maternal deaths each year occur in developing countries, with highest rates in Sub Saharan Africa and South Asia while in developed countries, this has become a rare event. It is envisaged that unless countries and governments recommit themselves to increased resources and implement effective and efficient strategies urgently, this MDG goal of maternal mortality reduction will not be achieved.

7. In this context I urge you to take this issue seriously and to share your wealth of experiences to overcome this critical problem. Every minute 380 women become pregnant, 190 women face an unplanned or unwanted pregnancy, 110 women experience a pregnancy related complication, 40 women

have an unsafe abortion and one woman dies! We cannot allow this to continue! 8. In the Asia Pacific region we face major challenges especially for women, children and young people. Those living in extreme poverty are rising; 50 percent of the world's unsafe abortion and 55 percent of the world's maternal deaths occur in Asia and 25 percent of female children don't even survive their 15th day! 9. Asia faces yet another daunting challenge with the rapid spread of HIV/AIDS especially among young people and women of reproductive age, with transmission of infection from mothers to children. We have seen the devastating effects of HIV/AIDS breaking down already fragile health, education, welfare, and agricultural and economic development systems in affected countries of Africa. More than 60 million people have been infected with HIV/AIDS over the last two decades - premature deaths are rising, life expectancy falling, maternal and infant mortality increasing, leaving behind helpless poor families and AIDS orphans. Asia faces more serious threats if we do not implement more vigorous and targeted prevention and control. In the Asia Pacific, 7.2 million people are now living with HIV/AIDS and the potential for growth is enormous especially in China and India.

10. Young people are the forgotten 1.5 billion whose enormous needs for information, education and services are scarce, fragmented or non-existent, and yet half of all infections are among this age group of 10 to 24 years. If we are to make any gains in prevention and control of HIV/AIDS, prevention of unwanted pregnancies and unsafe abortions, we need to provide our young with correct information and knowledge on living skills, personal development, healthy lifestyles, and reproductive health including sexuality education so that they can make informed and correct decisions and choices.

11. I realise that this is a sensitive and difficult issue, as the decisions we have to make will encroach on prevailing social, cultural and religious values and practice. Nevertheless, we need to face the stark realities of changing behaviour patterns of youth today and to be able to respond to meet their urgent needs.

Between 1.4 to 5 billion adolescent girls in developing countries have abortions each year and 10 percent of all births are in teenage girls and this is becoming a seriously increasing concern.

12. I see from the programme that you will be discussing several controversial topics that impinge on human rights, ethics, and personal choices. Many questions will be asked - Do young people have a right to sexuality education and to reproductive health services; do women have a right to opt for a Caesarean delivery; do women and unmarried girls have a right to terminate their pregnancy; do HIV/AIDS infected pregnant women have a right to affordable therapy? 13. These among others are real life issues, which difficult as it may be, would need the professional wisdom and integrity of the scientific community such as this, to look for best possible options in the best interest of people and clients. These challenges will increase with rising expectations of people for health care and information, increased consciousness of their rights for choices of treatment and care and the health effects of changing lifestyles and disease patterns.

14. We must therefore be at the forefront of fast expanding medical and health advances in information and technology and yet make practical and realistic decisions as infrastructure, financial and other resources largely depend on decisions of professionals.

We in developing countries are functioning under situations of serious resource constraints. This underlies the fact that scientific evidence is needed for decisions on national allocation of resources for the most effective and efficient intervention strategies and programmes to reduce maternal and neonatal mortality and improve health of women and newborns.

15. I leave this challenge to you and I urge you to give priority to the poor, marginalised, vulnerable and those affected by disaster or calamity. The recent disastrous effects on the health and sufferings of women and children in Iraq, Afghanistan, Palestine and Liberia calls for urgent and compassionate intervention and I am pleased to note that you have dedicated a session for this much needed humanitarian health care and support.

16. Coming back to home ground, Malaysia prides itself with a comprehensive and accessible health care

system which has been continually developed, upgraded and expanded over the years since independence in 1957.

Today the primary health care system is able to reach out to almost all population groups through static health facilities, which are supplemented by mobile services for the remoter areas and disadvantaged groups. Preventive health including maternal and child health and family planning services are regarded as public goods and are provided free through a network of health facilities in the rural and urban areas while those who can afford avail themselves of these services through the private health care sector. Through the family health development programme and based on a life cycle approach, Malaysia has given emphasis to identification and implementation of strategies to reduce maternal and child mortality using a problem solving approach. This has included upgrading of training of nursing and medical personnel in midwifery and obstetric skills, equipping district hospitals with essential and emergency obstetric care facilities, and implementing a system of referral and care for pregnant women based on a risk assessment colour coding system.

From 1991, maternal mortality continued to be monitored and corrective measures taken through a confidential "no-blame" enquiry system and through specific maternal health indicators for quality-of-care assessment of services. A surveillance system for prenatal mortality also has been instituted to reduce main causes of prenatal deaths and to improve neonatal health care.

17. A strong point in Malaysia's MCH programme has been due to the fact the "M" in MCH has never been neglected; in fact it has been the major component of our strive to improve health of women and neonates as we believe that every woman has a right to quality health care to safeguard her health and life. Hence from the inception of the rural health programme in the 60's, we have worked on various approaches and to ensure the availability of skilled attendants for prenatal care, delivery and postnatal care. I understand that this is a very topical area of discussion in the search of effective Strategies for Safe Motherhood and that Skilled Attendance at Delivery has been highlighted as one of the most important strategies. I understand there are others in the professional field that believe that emphasis should be placed on providing emergency obstetric care. After two and the half decades of working on the field, I have seen that single intervention strategies are not sufficient. We need to put in place a set of interventions that would provide the means for women to get to primary health care facilities or hospitals including transportation and referral. Malaysia has gone through this process and has devised a Systems Approach to provide for continuity of prenatal care and active management of delivery especially for those with pregnancy complications. I am sure you will discuss these strategies further in this conference and exchange experiences with countries that have successfully reduced their maternal and neonatal mortality.

18. The road towards Malaysia's success has not been easy. Perhaps the most complex and challenging has been in evolving strategies and approaches that are sensitive to community needs and perceptions; be they social, cultural, traditional or religious. Realising that health programmes work best within an integrated developmental approach, our socio economic development plans are based on multisectorial and intersectorial collaboration of health with rural development, poverty alleviation, education and other relevant sectors within a framework of inter agency partnerships, and linkages between the public, private and non- Governmental sectors. We have built upon our strengths; tried to reduce the equity gaps; and bring closer to communities and families an affordable, comprehensive and acceptable package of comprehensive health care.

19. The results of Malaysia's consistent and sustainable policies, strategies and programmes have yielded results. Our maternal mortality ratio has fallen from 570 in 1957 to 38 per 100,000 live births in the year 2000. Infant mortality rate has fallen from 75 to 8 per 1,000 live births during the same period and more than skilled professional birth attendants such as nurses and doctors attend 95 percent of deliveries. We have much more to do to further reduce our maternal and neonatal mortality especially in the face of the HIV/AIDS epidemic and we need to reenergise our efforts to sustain our programmes and progress. In this regard, I do hope we will learn from each other what has worked and what has not so that we do not waste valuable time and resources.

20. In conclusion, I wish all of you a very successful and fruitful conference and pray that the experience and knowledge gained will improve the quality of life and health of women, children and families and reduce unnecessary death and suffering. I hope you have a good stay in Malaysia and have some time to experience our unique fusion of culture and cuisine. I express my appreciation to all speakers, chairpersons, resource persons and board members of IAMANEH for your contribution and support. Congratulations to the MAMANEH National Organising Committee for their tireless efforts in making this conference a reality.

21. With the grace and blessings of the Almighty, I have great pleasure in officiating the 8th World International Maternal and Neonatal Health Conference.