Patti to

follow up.

PATTI SOLIS DOYLE

Jen Klein –

Are you working on this stuff now? Will you call me?

Patti

THE WHITE HOUSE

Hillary –

This is a project which goes to grips with learning disabled and the sounds of words to provoke creative imagination!

It provides another outlet for those children who find education a frustrating experience.

Would it be appropriate for me to follow up with Carol Rasco, if you would be interested in RFB+D?

Ellie Krupnick

Recording for the Blind & Dyslexic of Metropolitan Washington

March 17, 1997

Mrs. Hillary Rodham Clinton
The White House
Office of the First Lady
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mrs. Clinton,

We at Recording for the Blind & Dyslexic agree with you and President Clinton that every child should be reading well by the third grade, however we know that there will always be many children who will only be able to achieve this by listening to their books. RFB&D is eager to be included in your innovative project to upgrade the reading programs in D.C. public schools. By including RFB&D in your program, you will help young people who are blind or physically or learning disabled gain access to the printed word.

Our agency is one of 22 throughout the country and is in upper N.W. near the MD line. We are chartered by our National Board in Princeton, NJ to work with children in the District, suburban Maryland, and northern Virginia. At our master tape library in Princeton we have 80,000 books already transcribed and ready to mail out to students.

Often, learning disabled children who were considered backward or slow have shown remarkable progress as they listen to the tapes while studying their textbooks. Not only do their reading skills and comprehension improve, but their grasp of mathematics, social studies and other subjects also shows rapid progress. Equally important, their self-esteem rises along with their grades.

In D.C. our core ambition is to be useful to children , with learning disabilities in every public school. Our outreach committee is now working with 25 schools and social work agencies in the city. We hope your inclusion of RFB&D in your much-needed push to improve public education will benefit more of the children we need to reach.

5225 Wisconsin Avenue, NW
Suite 312
Washington, DC 20015
202-244-8990
FAX 202-244-1346
rfbddc@mail.erols.com

We hope you will agree that RFB&D's work to improve the academic skills of learning disabled children falls within your guidelines of addressing the needs of those with severe economic and social problems, and helping them to emerge from low-income, dysfunctional situations. This is precisely what happens in a remarkable number of cases when children with learning disabilities use our tapes and see their grades and achievements soar.

Thank you for considering this request, and for letting us know how we may help your effort by calling or writing to Kay Marshall, Project Outreach Director, at our above address.

Yours most sincerely,

Amelie Burgunder

Amelie Burgunder
Board Chairman RFB&D

Recording for the Blind and Dyslexic of Metropolitan Washington

Annual Report

Year Ending June 30, 1996

Reaching Out To Our Community

"After a few days of listening to their social studies texts, three of my fifth grade students began to participate in class discussions of reading assignments for the first time. It was clear that the experience of being able to understand the textbook has created a new enthusiasm and self-confidence for these children."

— District of Columbia Elementary School Teacher

This teacher's experience symbolizes the tremendous success of Project Outreach in telling local public school students about RFB&D. As word has spread about our taped textbooks, the phones have been ringing constantly with calls from inquiring parents and teachers. In fact, more than 500 students in the area used RFB&D for the first time last year.

What does RFB&D do for students? In the words of a borrower who used to rely on her parents to read her books to her, "For the first time in my life, I could read on my own. My comprehension of material increased dramatically and I could read with greater speed. Today I no longer avoid reading."

Thanks to our donors and volunteers, students with visual, perceptual or other physical disabilities learned by listening to their schoolbooks in subjects ranging from kindergarten stories to third-grade spelling to master's level computer science. Last year in the District of Columbia, students in 18 public schools in all four quadrants of the city were using our service — a long way from the situation just two years ago, when essentially no D.C. public school students with learning disabilities were taking advantage of our recorded textbooks.

An interesting side-effect of Project Outreach is that information about RFB&D is also spreading to schools in Maryland and Northern Virginia. As a result, we are receiving a stream of inquiries from those areas, and our staff and volunteers now regularly present RFB&D's services to parent, teacher and social agency meetings in these communities as well.

We are indeed pleased with the substantial volume of new students who are using our services and we look forward to serving even more students in the years to come. Finally, it is becoming better known that learning and visual disabilities do not mean that a child cannot learn. Our students have the intelligence and capability to succeed, but they require a different way of taking in information. As a visitor recently remarked, "What the eyes can't see, the ears can hear."

Hyde Elementary students learn by listening to their textbooks.

RFB&D NEWS

Recording for the Blind and Dyslexic of Metropolitan Washington
Taped textbooks for students with learning or visual disabilities

Volume 1, No. 2 Fall 1996

Reading Disabilities are a Fact of Life!

Visual and learning disabilities, so prevalent in society today, often prevent students from achieving and succeeding in school. Many students with learning disabilities find they are unable to keep up with their reading assignments. Often falling behind, they eventually lose interest in their school work and confidence in their academic abilities.

Listening to taped textbooks will not solve all reading problems. However, taped textbooks will provide some students with a tool that will make reading easier and perhaps more enjoyable. It may also help them keep up with their class work and gain self confidence.

Is it easy to take advantage of RFB&D's taped textbooks service? You bet! Here are the steps you need to follow to get your students registered:

How Do I Register?

❑Call RFB&D and request an application form. We will send it to you asap!

❑Complete the application and have the certification signed by a professional --a teacher, a school counselor, your family doctor, or a psychologist.

❑Send in the application along with your registration fee and book list.

❑You can request book order forms to help you keep track of the information you need when you order books.

❑Special tape players are needed to play RFB&D tapes. Call Kay or Joyce for more information on how to purchase this equipment.

Then What Happens?

❑ It takes about two weeks to process your application.

❑ Books already taped will be shipped to you from our national office in Princeton, NJ.

❑ We'll be in touch about what books we do not have. We may be able to record books not in the library, decisions are made on a case by case basis.

Good Things to Know:

❑ RFB&D has a sliding scale application fee and payment plan for tape players.

❑ When you order taped books, we need the title, author, edition or copyright date, and publisher.

NEWS FLASH

Institutional Membership now available

To make our service accessible to more students, RFB&D is now offering Institutional Memberships. For schools in the District of Columbia which qualify, fees may be waived for the first year. We hope this will encourage schools to participate in a program that can benefit those students unable to afford an individual membership. Following is a list of schools currently registered under our Institutional Membership Program and using RFB&D taped textbooks:

Adams Elem. School
Burreville Elem. School
Tyler Vision Program
Tubman Elem. School
H.D. Cooke Elem. School
Janney Elem. School
Hyde Elem. School

Contact Joyce Zink or Kay Marshall at the number below for more information.

To order Books or request an application :
Call us at: 202-244-8990
Fax us at: 202-244-1346
email us at: rfbddc@mail.erols.com

Seeing, hearing and feeling words.....

At a school in London, England, teachers are adopting a traditional method of teaching reading. According to a recent article in *The London Times*, the method is based on a multi-sensory system devised to help dyslexic children learn to read. Students using this approach are reading six months to a year above grade level.

Dr. B. Hornsby, a speech therapist and psychologist, devised a system based on phonics which is designed to follow closely the patterns of speech development.

For example, children learn the sound of each letter before linking the letters to build up words. And, since this is a multi sensory approach involving the aural, visual and tactile senses, students hear, see and feel the words.

After hearing the teacher pronounce the letters C A T and then the word CAT, the students then write the letters, read what they have written and then close their eyes and trace the word in the air to memorize it. As the students write the word, they also learn to spell the word. Since reading, writing and spelling are inter-related, this multi-sensory approach will hopefully allow the student to master written English also.

The Hornsby School has proven that this approach works. The school has also shown that students who are dyslexic can be successfully taught along side their peers in the regular classroom using this method, thus avoiding the need for separation.

Did You Know????
Students taking the SATS can request that they be allowed to listen to, rather than read, the questions. Call the SAT Special Services at: (609)771-7137

RFB&D has thousands of taped schoolbooks for students of all ages!
Houghton Mifflin Series:
Dinosauring
Just Listen
Lyle Lyle Crocodile
Fast as the Wind
Beyond the Reef
Silly Things Happen

General Reading:
The Indian in the Cupboard
The Great Gatsby
Frankenstein
Lord of the Flies
The Cay
My Brother Sam is Dead

GED & SAT Study Guides

This newsletter is made possible by the generosity of these foundations who support RFB&D's Project Outreach:
Lois & Richard England Foundation
Fannie Mae Foundation
John Edward Fowler Foundation
Marpat Foundation
Gilbert & Jaylee Mead Foundation
Eugene & Agnes E. Meyer Foundation
Mobil Foundation
Public Welfare Foundation
Alexander & Margaret Stewart Trust

SCHOLARSHIPS AVAILABLE

The Marion Huber "Learning Through Listening" Award for High School Seniors with Learning Disabilities.
Mary P. Oenslager Scholastic Achievement Award for College Seniors who are legally blind.
Call 1-800-221-4792 or 202-244-8990. Deadline to submit application is 02/01/97

Recording for the Blind & Dyslexic
of Metropolitan Washington
5225 Wisconsin Avenue, NW, Suite 312
Washington, DC 20015

Look inside for information to help students who are struggling with reading.

MESSAGE CONFIRMATION

JUL-30-97 11:40

FAX NUMBER :

NAME :

FAX NUMBER : 94010596

PAGE : 05

ELAPSED TIME : 02'04"

MODE : G3 STD

RESULTS : O.K

Recording for the Blind and Dyslexic of Metropolitan Washington serves people who cannot read standard print because of visual, perceptual or other physical disabilities.

RFB&D/Washington's 334 volunteers are part of a dedicated corps donating time at 22 chapters across the country. Together RFB&D's volunteers have built the largest library of taped educational books in the world, housed in our national office in Princeton, New Jersey. Nearly 1,400 people from grade schoolers to graduate students in the Washington area borrowed taped books last year.

RFB&D/Washington serves students in Northern Virginia, Suburban Maryland, and the District of Columbia. Through our Project Outreach and borrower services programs, we help students, parents and teachers gain access to and use our recorded books.

202-244-8990
Fax: 244-1346
RFBDDC@mail.erols.com

A letter from the chairman and the executive director. . . .

Dear Friends,

We're Number One!!!

This year, the Washington chapter of RFB&D out-produced all of the other studios in the U.S. To say that we are proud of our volunteers who made this possible is an understatement.

In 1995/96, production increased 12.6% over the record we set last year and was more than double our output only four years ago. To make this possible, our wonderful volunteers donated 22,858 hours of their time, representing a value of nearly $600,000.

What pleases us most, however, is the continual stream of complimentary phone calls and letters we receive from students who use our recorded books and from their parents, telling us about the change that RFB&D has made in their grades and in their lives.

Financial Results

The expanded production required RFB&D to increase total expenditures this year by 20%. Fortunately, our income also increased, thanks to the generous support we received from foundations, corporations and individuals. These increases in funding reflect a major effort on the part of our volunteers, Board members and staff, as well as a wonderful response from our donors.

Our projected budget for 1996/97 includes an increase in total spending of 10%. We will continue our all-out fundraising efforts and we hope to count on your encouragement and assistance.

A Look Ahead

To keep pace with the huge increase in demand for RFB&D's services, we are now installing two new recording booths, bringing the total to nine. In addition, we plan to begin production of textbooks in a format known as E-text. E-text allows students to access books using a computer and adaptive equipment such as large print, a braille screen or a voice synthesizer. Before this program begins we must recruit and train volunteers to produce these computerized books and purchase the necessary equipment.

On behalf of our borrowers, we send great thanks to each and every one of RFB&D's volunteers and donors for making this critical service available.

Sincerely,

Amelie Burgunder
Chairman

Michele Herrington
Executive Director

Foundation and Corporate Support

Support from foundations, corporations and organizations in the Washington community is a major reason why RFB&D has been able to serve more students and to record more books year after year. With their help, we built a comprehensive program to help students gain access to our service and to record the books they need for class. We are most grateful to these donors for helping RFB&D to move forward. We are also grateful to the many RFB&D volunteers who encouraged their employers to donate, suggested places to submit requests and helped to solicit the grants themselves.

Gifts of $15,000 or more

Fannie Mae Foundation
Public Welfare Foundation
Lockheed Martin Corporation
Eugene & Agnes E. Meyer Foundation

Gifts of $10,000 to $14,999

The Aid Association for the Blind of the District of Columbia
Eugene B. Casey Foundation
The James M. Johnston Trust for Charitable and Educational Purposes
The Marpart Foundation
Mobil Foundation
The Ruth and Vernon Taylor Foundation

Gifts of $5,000 to $9,999

Appleby Foundation
The Clark Charitable Foundation
The Richard Eaton Foundation
John Edward Fowler Foundation
Kemper Open
Occidental Petroleum Foundation
Alexander & Margaret Stewart Trust

Gifts of $2,500 to $4,999

Clark-Winchcole Foundation
Dimick Foundation
The Max & Victoria Dreyfus Foundation
Lois & Richard England Foundation
Walter Henry Freygang Foundation
Gilbert and Jaylee Mead Family Foundation
National Home Library Foundation

Gifts to $2,499

American Medical Association
Atlantic Research Corporation
Bethesda Lions Club
Bethesda United Methodist Church Men's Club
Boeing Employees Good Neighbor Fund
The Charles Delmar Foundation
Ferris, Baker Watts Foundation
The Walter Henry Freygang Foundation
GEICO Philanthropic Foundation
Giant Food Foundation
Paul & Annetta Himmelfarb Foundation
IBM Corporation
Junior League of Washington
The S. Irwin Kamin Foundation
Legal & General America
Lucas-Spindletop Foundation
Mars Foundation
Masonic Lodge: William R. Singleton-Hope-Lebanon #7
Mid-Atlantic Medical Services (MAMSI)
Nordstrom
The Palisades Community Church
Queenstown Harbor Golf Links: Kathryn Fox Samway - Outback Steakhouse Memorial Golf Classic
Luther I. Replogle Foundation
Rotary Foundation of Washington, D.C.
Voorthuis Opticians
WSA St. Alban's
The World Bank

Matching Gifts

We thank the following corporations which matched donations made by their employees to RFB&D.

Citicorp Foundation
Connie Lee
William H. Donner Foundation
Fannie Mae Foundation

MESSAGE CONFIRMATION

JUL-30-97 11:51

FAX NUMBER :

NAME :

FAX NUMBER : 94010596

PAGE : 03

ELAPSED TIME : 01'18"

MODE : G3 STD

RESULTS : O.K

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Recording for the Blind and Dyslexic of Metropolitan Washington

Annual Report

Year Ending June 30, 1996

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Hyde Elementary students learn by listening to their textbooks.

BRIGHT BEGINNINGS, INC.
901 Rhode Island Avenue, NW
Washington, DC 20001

April 28, 1997

Stephanie —
Did recommend that HRC do this not the DOJ US. It's a good program.
To: Patti Solis
Ann Stock
5/7/97

VIA FAX (202) 456-2461 AND BY HAND
The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

Bright Beginnings, a model public-private partnership day care center for homeless preschool children in the District of Columbia, will open its new facility during May at 825 North Capitol Street, N.E. The new center will increase the number of preschoolers served, from the current enrollment of twenty-six to fifty-two children, ages 2 1/2 to 5. We are writing to invite you to dedicate the new center and to serve as our keynote speaker at an opening celebration event. We would be thrilled to have your and/or the First Lady's personal involvement.

Established in 1989 by the Junior League of Washington with a two-year, $200,000 grant from the Department of Health and Human Services, Bright Beginnings, a nonprofit 501(c)(3), received one of sixteen nationwide Homeless Demonstration grants awarded by Head Start in 1993. This past year Bright Beginnings, Inc. became a permanent Head Start grantee. Our move to new space and doubling of program capacity is made possible through receipt of HUD's Community Partnership funding. In addition, the program enjoys an increasing level of private financial support from corporations, foundations and individuals.

Bright Beginnings' children and their families, along with its Board of Directors and the Freddie Mac Foundation, corporate sponsor of the dedication event, would be delighted if you could attend the opening dedication. Since our priority is to secure your participation and accommodate your and the First Lady's schedule, we have selected a range of dates including Tuesday or Wednesday, June 10 and 11, also Monday-Wednesday, June 16, 17 and 18. Please advise us if an earlier or later date would better fit your schedule.

We plan a morning event, approximately 10-11 a.m., on the grounds of the center, 825 North Capitol Street, N.E. We envision a brief speaking program, followed by presentations from the children, a tree planting ceremony and a reception inside the facility. Local and interested national press will be invited. Other invited podium guests include: HHS Secretary Donna Shalala, HUD Secretary Andrew Cuomo, Congresswoman Eleanor Holmes Norton, Senator Chris Dodd, Representative Tom Davis and Steny Hoyer, Mayor Marion Barry, Head

Start Director Helen Taylor, the Chairman of the Freddie Mac Foundation and others active in the community.

The Bright Beginnings Board of Directors, dedicated staff and volunteers share your commitment to improve the lives of Washington, D.C.'s vulnerable children and their families. Our program not only provides socialization and a learning environment for these children, but acts as the only safe haven for many of them. Given the current constraints of the welfare program, the center allows their parents to pursue job training skills, complete their education, secure adequate housing and eventually enter the workforce, knowing that their children are properly cared for in a nurturing and stimulating environment.

Launched by volunteer spirit and vision, Bright Beginnings fills an acute need and remains the only preschool program in the District of Columbia where homeless children and their parents return each evening to shelters and transitional housing. We know you will be impressed by the center and its children, and they would be thrilled by your visit.

Your consideration of our request is very much appreciated. I can be reached at (202) 457-6520, and would be happy to provide additional information on the center or the event. Effective May 18, our new mailing address is 825 North Capitol Street, N.E., Washington, D.C. 20002. Please contact us at your earliest convenience so that we may plan accordingly. Thank you.

Sincerely,

Martha Kendrick Kettmer

Martha Kendrick Kettmer
President
Bright Beginnings, Inc.
Board of Directors

cc: Ann Stock
Carole Thompson Cole

250362

TO: Melanne
FROM: Jen J.C.
DATE: 5/29/97
RE: Samuel Halperin Letter

I followed up with Gene on this letter, who had already received a copy directly from the President. Gene and I will be holding a meeting next week to get a report on the School to Work program. He is also following up "behind the scenes" to get a sense of J.D. Hoye and the dynamics in the office.

I will keep you informed as I know more.

AMER CAN YOUTH POLICY FORUM

Samuel Halperin
Glenda Partee
Co-Directors

Talk to / Gene

Appreciate support of Paul Cole suggested initial thinking recommendation to Pres. Personnel

11 April 1997

Mrs. Hillary Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Hillary:

I write to share my views about the current status and future of the School-to-Career movement. These observations are based on years of visiting programs and practitioners coast-to-coast.

Despite the media-celebrated cooperation between Robert Reich and Dick Riley, all is far from well within the working levels of the Executive Branch. The National School to Work Office is starved for DoL and DoE resources to properly execute its functions. The exceptionally able director, J.D. Hoye, is second-guessed and hobbled from above in the exercise of her responsibilities. The feeling of the STW Office staff -- and much of the field -- is that the Clinton Administration's visionary initiative may well fall prey to being "just another program," resented by many vocational educators and many in the Department of Labor's employment and training arena as a "competitor" for scarce resources. Since the legislation is to sunset in a few years, there is a real danger that, in most school districts, the promise of School-to-Career will evaporate without a trace.

That is why the Administration's selection of a new Assistant Secretary of Labor for Employment and Training is so critical to the future of the School-to-Career movement. Unless the new appointee is thoroughly committed to the success of this Administration initiative, even the scant progress to date may be lost.

I hope that **Paul Cole**, Secretary-Treasurer of the New York State AFL-CIO and a Vice President of the American Federation of Teachers, is considered for the DoL assistant secretaryship. I have worked with Paul on the Jobs for the Future "Youth Apprenticeship Initiative" and have come to see him as a thoroughly dedicated educator, committed to school-to-career as a powerful lever to advance comprehensive, high standards school reform. As an able teacher, Paul would work to ease some of the antagonisms in the Department of Labor toward the Department of Education's educators and educational programs. Well-acquainted

INSTITUTE FOR EDUCATIONAL LEADERSHIP
1001 Connecticut Avenue, N.W., Suite 719, Washington, D.C. 20036-5541
Tel: (202) 775-9731 Fax: (202) 775-9733

with European workforce preparation systems and the work of the National Center for Education and the Economy, Paul would insist upon rigorous quality not only in school-to-career grants but in all the manifold tasks of the Employment and Training Administration. I believe, in sum, that he would be a great asset to Secretary Herman and to the Clinton Administration.

If your schedule ever permits, I urge you to have a conversation with Miss J.D. Hoye (401-6209, who does not know that I am writing). You will learn a great deal from one of the stars of the Administration and get an unequaled view of what is happening -- or not happening -- to school reform in the spirit of the School-to-Work Opportunities Act.

Sincerely,

Sam

Samuel Halperin

Jennifer L. Klein
05/28/97 05:37:41 PM

Record Type: Record

To: Melissa Green/OPD/EOP

cc:
Subject: School to Work

Rather than try to talk to Gene, let's try this by e-mail. The First Lady was made aware of some problems at the School to Work office. Supposedly, the director, J.D. Hoye, is being thwarted in her efforts to do her job properly. Is this true? The person who told her all this thinks that Paul Cole, Secretary-Treasurer of the New York State AFL-CIO and Vice President of the American Federation of Teachers should be appointed as the new Assistant Secretary of Labor for Employment and Training. What does Gene think?

I do need to get back to the First Lady when she returns at the end of this week. Thanks for your help.

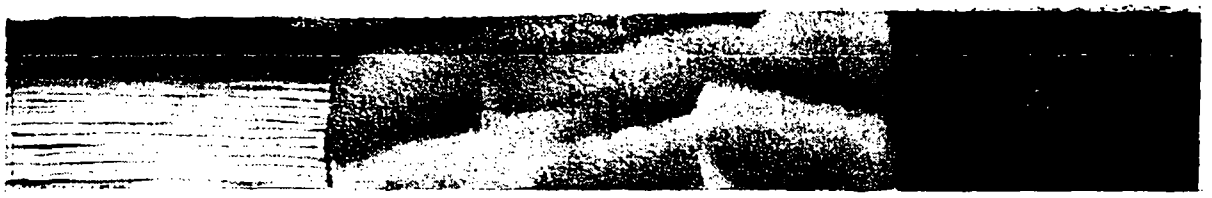
COMMENTARY

School-to-Work, Employers, And Personal Values

By Samuel Halperin

If its critics are to be believed, the fledgling American school-to-work movement is a nefarious plot by Big Government, abetted by willful or unwitting industrialists, to control the academic content of learning and dictate the occupational futures of American youths. What's more, opponents from both extremes of the political spectrum contend, our schoolchildren are in danger of becoming pawns in a computer-driven national labor-market information system that will funnel them into whatever jobs the economy needs filled.

This Orwellian prospect flies in the face of compelling success stories from many school-to-work programs here, as well as from long-standing efforts in other democracies. On both sides of the Atlantic, there is a healthy blending of school-based learning and hands-on exposure to the world of work. School-to-work champions can muster persuasive evidence that experience in actual workplaces, and not just classroom instruction, helps young people acquire essential job skills along with the habits of thought and behavior that underlie them.



Rob Colvin

Observations From Overseas Study Missions

Instead of regarding school-to-work efforts as key elements of genuine school reform, critics from the political right see a government-directed scheme to control the minds, the values, and ultimately the occupations and earnings of American workers—all of which will allegedly subordinate family values to the imperatives of the economy. For its part, too, the anti-capitalist political left envisages generations of human automatons and worker bees, brainwashed to serve the needs of corporate capitalism in cahoots with government bureaucracies. No longer capable of independent thought and self-realization, our young people are to become little more than cogs in the nation's industrial and economic machinery.

The gap between these baleful predictions and ground-level reality came into sharp focus during recent study missions to Europe and Israel. There, as we are beginning to see in the United States, enlightened businesses and supportive government policies are enabling young people to experience the best of both worlds: high-quality academic learning and practical experience in the workplace that reinforces classroom study.

Several relevant examples demonstrate persuasively that critics from both sides of the political spectrum are plain wrong.

At ABB (Asea Brown Boveri) in Baden, Switzerland, high-school-age apprentices in the giant Swiss-Swedish engineering firm study in a state-approved and partially state-financed high school located on the factory's premises. When American visitors asked what qualities are essential for success in the workplace and in nonworking life, ABB student responses included: *personal competence, self-discipline, independence, creativity (imagination and problem-solving), team effort (social competence, solidarity, communication skills), flexibility, focus on satisfying the needs of customers and colleagues, honesty, and loyalty.*

In Zurich, we met with trainers and graduates of the youth-apprenticeship program of the Union Bank of Switzerland. Like its industrial neighbor ABB, this leading Swiss bank has been "training" student workers for over 125 years. What kinds of skills and values does UBS look for in admission to, and completion of, its four-year program? The composite response from both trainer-coaches and graduates: *self-initiative, effective team player, ability to concentrate, decision-making ability, communication skills, flexibility, professional appearance, good grades in secondary school, staying power, enjoying people.* At a cost to the Union Bank of Switzerland of as much as $23,000 per apprentice per year, over and above what the state pays for secondary education, the apprenticeship program enjoys high prestige with students, parents, and the public at large. (Here, as elsewhere in Europe, requests for enrollment are often triple or more the number of available slots, especially in the more competitive professions.) Moreover, the trend is to ever higher job qualifications, more postsecondary academic specialization, and systematic follow-up through advanced learning opportunities. Indeed, there is now talk in the financial-services industry of creating a "University for Applied Science."

At the Julius Blum firm, a precision manufacturer of cabinet hardware in Bregenz, Austria, the company's training philosophy is exemplified by two mottoes: "Never underestimate the capabilities of our youth. Rather, find out what they are, and utilize them in helping to create a successful adult" and "A positive role model is the best way to form a young mind."

Blum's 22 full-time and 11 part-time trainers serve the needs of 130 apprentices who, while completing their fourth year of combined schooling and on-the-job

Continued on Page 38

Samuel Halperin is a co-director of the American Youth Policy Forum in Washington and a former president of the Institute for Educational Leadership. He was the deputy assistant secretary for legislation in the U.S. Department of Health, Education, and Welfare during the Johnson Administration.

School-To-Work And Values

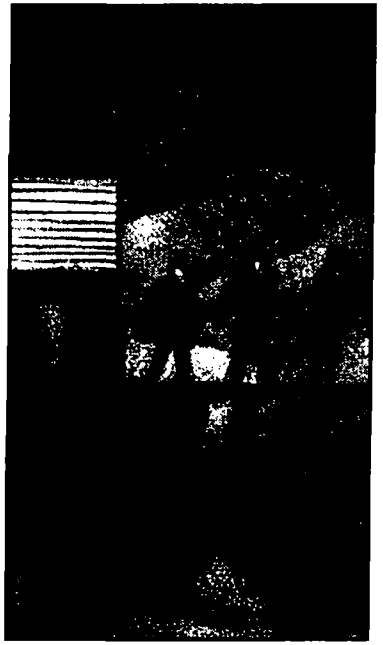
Continued from Page 52

learning at age 19 or 20, earn up to $1,700 a month. Students are offered free Saturday-morning tutoring, a physical-fitness program, and first-aid instruction, as well as bonuses for "personality development" (for example, $10 monthly for not smoking, $15 for "proper conduct" in auto traffic). Unlike other youth-apprenticeship programs, Blum's downplays a written contract defining roles for students, parents, and employer. The entire relationship, believes the firm, is built instead on mutual trust. Without trust, no contract is enforceable.

In the city of Bregenz's employer-backed public high school, where many of the apprentices study, and in Blum's own training center, students work on state-of-the-art equipment because, as the firm's educational director says, "We want our students to have the very best technology; if the equipment in the plant is better than in the schools, they will look down on schools." Far from being deprived of independence and personal autonomy, students take from the company's value system the message that "the computer shouldn't be smarter than the computer operator; faster, not smarter." Like other firms we visited, Blum's leaders practice what they preach: "Smart workers are our best asset."

Overall, the Austrian manufacturer has graduated more than 500 students, with only one dropout. The firm has recently opened a high school apprenticeship program with neighboring companies based on the tech-prep curriculum at its U.S. plant in Stanley, N.C. It will be interesting to see whether the same high standards and performance can be successfully transplanted in the New World.

At three middle-sized Austrian firms—world-famous crystal manufacturer Swarovski in Wattens, Zumtobel Lighting in Dornbirn,



Rob Colvin

ski-lift and car-park manufacturer Doppelmayer in Wolfurt—and their cooperating high schools, we met industrialists who, while under financial pressure to reduce costs, proudly told us that their investment in apprenticeship and their adherence to national standards substantially exceeded the minimum requirements arrived at in negotiations with the central government and local authorities—and that the added cost was well worth it.

For these firms, and others we visited in Europe and Israel, success in quality export markets is essential to survival. They know training is expensive, but believe it is the only way they can compete and win in world markets.

In the classrooms of schools associated with these and other employers, we never once observed the bars, metal detectors, or graffiti so common in American high schools. On the contrary, schools were characterized by quiet corridors and students absorbed in their work. Moreover, it was clear that what Europeans call "environmental responsibility" is widespread in the schools. Students are responsible for the cleanliness of their schools, for recycling, and for energy conservation.

> In the classrooms of schools associated with these employers, we never once observed the bars, metal detectors, or graffiti so common in American high schools.

When asked whether they would prefer either more time in classrooms and less in the plants, or more in the plants and less in schools, Austrian and German students, to our surprise, complained mildly about the heavy demands placed on them, but argued strongly that the present mix of experiences was the right one.

In Israel, as in much of Western Europe, high-tech industrial exports are literally the lifeblood of the society. There, the Manufacturers Association of Israel, in cooperation with the Ministry of Education, has embarked on an ambitious program to expose all Israeli students to "Think Industry," an interdisciplinary educational project teaching "entrepreneurship and industrial thinking." Seven Think Industry curricula have been developed for grades 1-12 in both Hebrew and Arabic. School classes are also brought to five employer-supported regional centers, where students mingle with industry mentors and perform hands-on experiments with state-of-the-art teaching equipment.

And just what is the "industrial thinking" that Israeli manufacturers seek to inculcate in the young? In the words of the curriculum, it includes: "education for values—work, responsibility, precision, openness to criticism, professionalism, and a constant quest for quality."

"These values are to be achieved," the curriculum goes on to say, "by teaching teamwork and interpersonal communication ... thinking skills—creative thinking, inventive thinking, logical thinking, critical thinking, and problem-solving abilities ... learning skills—the ability to acquire basic knowledge, to build on existing knowledge, and to access new sources of information ... connecting the student to real-life situations ... intertwining thinking, values, and knowledge ... teaching entrepreneurship—taking the initiative to develop new products and marketing strategies, to identify problems and find original solutions for them."

What is interesting and compelling about the educational and training values embodied in both European and Israeli high-tech firms is how similar they are to each other, and to the kind of combined academic rigor, practical work experience, and continuous-learning values promoted by the best U.S. school-to-work programs.

In all these countries and industries, we found no instance of employer or governmental interest in narrow training for mind-numbing, repetitious, automaton-like employment. On the contrary, what most impresses the American observer is the extent to which leading European and Israeli employers and curriculum specialists seek to develop individuals who are much more than skilled workers—who are creative thinkers and problem-solvers, able to cope in a stressful, fast-changing world.

While Americans seem to feel that values are the exclusive province of family, church, and schools, Europeans practice the belief that work and the workplace can also contribute powerfully to the development of autonomous and effective human beings. All of this is done in a spirit of partnership with the schools, which teach not only theoretical science and mathematics, but also a substantial load of social sciences, humanities, and, in the case of central Europe, virtually mandatory courses in religion, with a heavy emphasis on getting along with others in an increasingly diverse society.

To be sure, this level of employer involvement and leadership developed over many years. Yet the fact that it happened is encouraging for all who believe that schools and employers can work together to produce high schools that work, future employees with impressive skills, and, most important, the kind of young people whose personal values the critics on the political left and right ought to find appealing. ■

To Pauline, Chris J –
This is a good idea.
Let's look for an
opportunity to do
it

Date: January 15, 1996

To: The First Lady

From: Chick Koop

Re: Posthumous recognition of Papanicalaou.

George Nicholas Papanicalaou, inventor of the Pap Smear, was my teacher at Cornell University Medical College. It is my opinion that, compared to his contribution, his recognition as a person has been insignificant. Any interest in honoring him, perhaps at a Cornell Commencement or as a piece of a White House affair?

→ Melissa Skolfield is aware of this
→ HRC + POTUS not scheduled for Cornell
→ need to check w/ Cabinet Affairs re commencements

Check Skolfield's commencement schedules

Send cc to Jon Klein
& Chris Jennings

per HRC

June 20, 1996

JOUI

Shreveport Journal

The Shreveport Journal is now an independent editorial page published Monday through Saturday under an agreement between the Journal and The Times. Its views are independent of those on The Times editorial page.

Journal editorials represent the opinion of the publisher and editors of the Journal. Signed opinions are the views of the writer.

Letters to the editor are welcomed at P. O. Box 31110, in Shreveport, La. 71130, or by e-mail at JournalP@aol.com. The Journal's telephone number is 459-3365.

The Shreveport Journal, founded in 1895, is locally owned. It was published as an afternoon newspaper until March 30, 1991.

Publisher Charles T. Beaird

Editor Jim Montgomery

Editorial Writers Tim Greening, Rodney Grunes

This is a wonderful editorial.

EDITORIALS

NO REFORM?

State woes show health care needs change

Gov. Mike Foster turned a few heads when he named Bobby Jindal, a 24-year-old, to head the state's Department of Health and Hospitals. As it turns out, a young man was a smart move to make because the job is going to require a lot of youthful resilience.

Having just been rescued by Washington, D.C. on our last crisis — when the state was told it could no longer use the creative accounting methods that disguised federal Medicaid funds as state money to get even more matching funds — the state health system already has another problem on its hands. While it will immediately have to be dealt with by Louisiana's leaders, we think it is indicative of the need for a restructuring of the way the entire nation pays its medical bills.

Medicaid covers a lot of poor people, but not all who need assistance, so the state of Louisiana used some leftover federal money and created a fund called Medically Needy, to assist people whose earnings are just above eligibility for Medicaid but not quite enough to afford insurance. According to the Associated Press, it covers about 3,000 people in various ways, whether its subsidizing prescriptions for families or paying nursing home expenses.

Since this is not a program required by the federal government, the Legislature and the Department of Health and Hospitals agreed to end the program and use its $72 million operational funding to balance the state's budget. Problem is, the medical needs of its recipients didn't disappear along with the program. They were notified by mail last week that they're on their own, come the beginning of next month. The phones at DHH began ringing off the hook.

"We were surprised at the intensity of their problems," Jindal said at a press conference yesterday. "We knew people would be cut off from services, but we didn't realize how many. We thought there would be other programs to cover these people."

Jindal said the needs of around 25 percent of the recipients can be taken care of by other forms of state and private assistance, but that still leaves a lot of people stranded. It will probably drive most of them to the state's charity hospitals and increase their workload — just what they need after having their budgets cut $30 million in the last legislative session.

We are confident that Jindal and his DHH staff will do their best to resolve the problem — and brace themselves for the next one, if recent history is any indication. They've inherited a job that shouldn't be this hard, but our system of providing and paying for health care in this country leaves too many people unable to afford medical care. This is perhaps the inevitable result — the government can no longer afford it, either.

President Clinton tried to change this, but was overwhelmed by the few for whom the status quo works too well. It is time to revisit his plan.

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
RE: Miscellaneous Projects
DATE: 7/22/96

I thought you might be interested in hearing about several projects that are underway.

1. **Adoption/Child Welfare.** Carol Rasco is holding a series of informal sessions with experts and advocates in the field of child welfare which she has asked me to sit in on. She sees this as the beginning of a long-term effort to learn about and address the serious problems in our child welfare system. At the first session last week, Jane Spinak (Legal Aid Society, Juvenile Rights Division) said that the most important thing we can do to improve the child welfare system is to involve all sectors of society, including business, lawyers and judges, the faith community, etc. (which of course sounded very familiar). I know that you had expressed interest in convening a meeting on adoption with representatives of these sectors. I plan to call Jane to talk about what issues could be best addressed, possible people to invite, etc.

   HHS is coming up with a list of executive actions on adoption that could be announced quickly. I will meet with them early next week to discuss their suggestions.

   I know that Melanne told you about our discovery of HHS's National Strategic Plan on Adoption. Truly unbelievable and infuriating! We are now part of the development process and will have an opportunity to make changes to the plan before it goes any further.

2. **Grandparent's Project.** We are working on a project to help grandparents care for grandchildren whose parents have died (often of AIDS). In many cases, grandmothers attempt to get custody of these children, but there are a number of legal and financial barriers to placing children with them permanently and to getting health care, housing and other services that they desperately need. We are pursuing changes that require legislation as well as changes that can be done by executive action. The hope is to come up with a series of proposals to be released when the AIDS quilt comes to Washington in October. Schedule permitting, you might want to announce the proposals.

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: 3/29/96
RE: "Health Care Roulette" Column

You had asked me to respond to this column. I'm not sure that a response from you is necessary. The author argues that insurance should be available and affordable when people need it. If you do want to write a letter, we could say that we agree completely with that point. We could also urge that the first steps can and should be taken right now by passing the Kassebaum-Kennedy health insurance reform bill. The bill would stop insurance companies from denying coverage to people with pre-existing conditions and ensure that people don't lose their insurance if they lose a job or change jobs.

Health care roulette

Meredith Oakley

Upon reading Monday's column, in which I reproduced a letter from a reader in Nashville who had been denied health insurance by Blue Cross and Blue Shield after a heart transplant, a reader from Conway responded with his own tale of rejection.

"In September 1994," he wrote, "I suffered a minor stroke and was admitted to the hospital for two days. My recovery was complete within a matter of hours. Since then I have taken blood pressure medicine and a blood thinner. I walk two and a half miles every day and I am in relatively good health for a person 68 years of age."

Citing medical underwriting guidelines, Conway Reader's inquiry about obtaining a Medi-Pak policy was rebuffed by Blue Cross a month ago.

"Being somewhat concerned, I visited my doctor. He assured me I was in relatively good health, my blood pressure and body functions were normal, and I had no reason for concern. He stated that Blue Cross wanted to make money and not be out anything on a patient. Since then, I have ordered the same coverage through AARP."

What's the moral? That one should obtain every type of health care coverage that could possibly be needed *before it's needed?* Ridiculous. If one could afford that much insurance, one wouldn't need that much insurance.

I'm rather superstitious. I have this irrational notion that I won't need insurance as long as I have it and that if I were to cancel it tomorrow, I'd need it the day after.

I can afford insurance, and my health is good enough that I can have it, but I have another notion, not as irrational as the first, that if I were to become seriously or catastrophically ill, I'd lose my insurance regardless of my ability to pay the premiums (for as long as the savings account holds out).

The fact is that people are denied coverage every day, and every day people see their insurance coverage priced beyond affordability or canceled altogether.

A case in point is the experience that an unidentified Arkansan shared with lawmakers last month.

"Three years ago, my father, who had responsibly paid health insurance premiums for many years, had his health insurance canceled by Arkansas Farm Bureau and their insurance company, Blue Cross and Blue Shield," he/she wrote.

"He was having health problems at the time of the cancellation, and after an outcry by Rep. Lloyd George and a few others, he was offered a new policy at about 10 times the premium he was paying. He could not afford it and passed away shortly thereafter—uninsured.

"As you can imagine, I am appalled and incensed when I the millions of advertising dollars being spent by the insurance companies touting their 'caring attitude.' (N)ow I see the insurance companies taking aim at my mother on Medicare."

That last is a reference to recent announcements by several insurance companies about premium increases in Medicare supplemental policies.

The premier issue of *Blue and You*, the new "customer-focused" magazine of Arkansas Blue Cross and Blue Shield, addressed the subject of what it called "the rate race."

"If (rate increases) are so unpopular," the article stated, "why do health insurers raise rates and risk the wrath of policyholders? It's a simple choice: Raise rates or lose money."

Of course, popularity, or lack thereof, has nothing to do with rate increases. If it did, there would be none. Insurance companies are businesses like any other. They don't exist to lose money, they exist to make it. So, what if rate increases incur the wrath of policyholders? What are they supposed to do, cancel their policies and take their chances?

Perhaps. Or they could shop around like the reader from Conway did. Blue isn't the only color in the spectrum.

I daresay most critics did not fault the Clinton administration's desire to overhaul the American health care system, only the manner in which the administration set about doing it.

I've got a view that some acquaintances in the insurance industry see as simplistic, even simple-minded. It is that insurance ought to be available when needed.

I have no quarrel with investing in the future, putting money aside, in the form of premiums paid, in anticipation of that day of need. But when that day comes, I want the promised coverage to be there, not jerked away at the first glimmer of dawn and canceled somewhere around noon.

Unfortunately, health care isn't addressed in the Constitution. We may have an unalienable right to life, but the quality of that life is left pretty much up to us as individuals in a free-enterprise system.

Until that is changed—by Supreme Court edict, congressional mandate or the groundswell of public opinion—we're also pretty much at the mercy of the system.

Thankfully, it's still a competitive system.

Associate Editor Meredith Oakley's column appears every Monday, Wednesday, Friday Sunday.

Kathy Buto - Dean Ornish Proposal 3/10

Demonstration under Medicare to try out new things -- waive payment rules

→ Interested in proposal

Cost-effective alternative to services Med. already pays for (diet/exercise to avoid surgery)

→ Payment mechanism would get worked out by HCFA.

300 Med. benef.

Peer review panel to review - ranks it based on merit.

How Med. research can enhance better outcomes -- not just payment improvement

Looking at seriously

Summer - decisions get made

But -- facing recession

Mtg again w/ HCFA -- new data

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: August 4, 1995
RE: Maternal Health Study: Female Genital Mutilation

You had asked about the numbers in the chart on female genital mutilation (FGM). The estimate that 100 million women are affected by FGM represents approximately 34 percent of the female population of sub-Saharan Africa, since the total population is 586 million and roughly half (239 million) are women. Some of the countries with the highest *percentage* of women subjected to FGM have very small populations, whereas some of the more populated countries do not practice it so extensively. Therefore, the percentage chart may make it appear as though a greater number of women would be affected.

In addition, the 100 million figure is only an estimate, as no one knows exactly how many women are affected. Since social taboos and limited medical reporting make it extremely hard to document the extent of the practice, the estimate may understate its true extent. The estimate is based on research by Fran Hoskens (who has been studying FMG since the early seventies and developed the first estimates of its prevalence) and Nahid Toubia (a Sudanese physician who until recently worked for the Population Council).

I will put all of this in your Beijing briefing materials.

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: August 1, 1995
RE: Maternal Health Study

The women's reproductive health study reported in the *New York Times* was prepared by Population Action International, a research organization. The study ranks 118 countries on a "Reproductive Risk Index" based on their average scores on ten indicators: (1) teen births; (2) contraception; (3) abortion policy; (4) anemia during pregnancy; (5) prenatal care; (6) attendance of trained personnel at birth; (7) HIV/AIDS rates among women; (8) infertility (which often indicates STDs); (9) average number of births per woman; and (10) mortality rates in childbirth or due to unsafe abortion.

The United States ranks 18th overall, but still falls within the "very low risk" category. Italy, Denmark, Norway, Sweden, and Belgium rank highest. The main distinctions between the United States and these top countries are:

- The United States has a much higher rate of teen pregnancy (6 per 100 births as compared to 1 or 2 per 100 births);
- The United States has a lower rate of contraception use (71% as compared to 76% - 79%);
- Fewer women in the United States receive prenatal care than in Italy, Denmark, or Sweden (95% as compared to 100%); and
- The United States has a higher fertility rate (average of 2.1 births per woman as compared to 1.2 - 2.0).

The researchers believe that Italy rates well because of its high scores on all of the indicators, rather than due to a single factor. Italy has fewer births (an average of 1.2 births per woman as compared to 2.1 in the U.S.), a low mortality rate (4/100,000 as compared to 7/100,000 in the U.S.), and a very low rate of anemia (10% as compared to 17% in the U.S.). In addition, 100% of women receive prenatal care and are attended at delivery by trained personnel (as compared to 95% and 99% respectively in the U.S.). Also, despite the fact that many women in Italy rely on traditional methods of contraception, such as withdrawal and rhythm, reproductive health remains strong because a high percentage of women do practice family planning and because women have access to safe abortions.

Italy ranks well on the chart comparing the risk of death from complications of pregnancy, childbirth, or unsafe abortion because this risk is determined by looking at the chance of dying during a given pregnancy (mortality rate) and the number of times a woman is exposed to that risk (fertility rate). As noted above, Italy rates well in both of these categories.

To Jen —
Can you find out more about this study? I'm particularly interested in Italy — why Italy? So good! JH —

In a Ranking of Maternal Health, U.S. Trails Most Developed Nations

By PHILIP J. HILTS

WASHINGTON, July 25 — The United States ranks 18th in an index measuring maternal health, lower than most other developed nations in the world, a new study says.

The study reviewed the data in 10 categories of maternal health and gave each of the 118 countries surveyed a score based on its performance in those areas. Areas rated included the number of women who die during childbirth, teen-age pregnancy, contraceptive use, prenatal care and availability of safe abortions.

The study, released on Monday, shows that the chance of dying from pregnancy or childbirth varies dramatically in different parts of the world, from 1 in 7 in Mali to about 1 in 17,000 in Italy. The rate in the United States is 1 in 5,669. The study was done by the research group Population Action International in Washington.

The countries with the best overall rankings were, in order, Italy, Denmark, Norway, Sweden and Belgium. Ranked the worst were Mali, Congo, Somalia, Angola and Zaire.

Although an important factor affecting the ranking is a country's relative wealth, said Dr. Shanti R. Conly, director of policy research for the group, some quite poor countries have worked on women's health issues and ranked well, while other nations of great wealth scored relatively poorly.

Last year, at the International Conference on Population and Development in Cairo, 180 nations reached an agreement urging all countries to make reproductive health services and contraceptives available to all by the year 2015.

The United States did not rank higher largely because of teen-age pregnancies — its rate is about six times that of European nations — and a relatively low rate of contraceptive use.

Reproductive Risks: Range Worldwide

Estimated risk of death from complications of pregnancy, childbirth or abortion in a woman's lifetime in selected countries.

Italy	1 in 17,361
Norway	1 in 15,432
Australia	1 in 8,772
United States	**1 in 5,669**
Poland	1 in 3,608
Cuba	1 in 1,286
China	1 in 439
Zimbabwe	1 in 217
Mexico	1 in 131
India	1 in 59
Kenya	1 in 31
Mali	1 in 7

Source: Population Action International

Although it still fell in the study's "very low risk" group of countries, the United States ranked behind such emerging countries as Taiwan and Singapore. And Dr. Conly contended that it "is likely to drop even farther if this Congress continues as it has started." A proposal to end public contraceptive services in the United States has been approved in committee, and another to cut aid to developing nations in Africa by one-third may be an indication of what is to come, she said.

Some relatively poor countries have made long-term commitments to health care and family planning, Dr. Conly said, and have succeeding in several important measures. "Their programs may not be the Cadillac models," she said, "but they give all people access to health care of some kind."

Costa Rica, Cuba and Sri Lanka have maternal death rates lower than 100 per 100,000 births, whereas about half the world's nations have rates of 200 to 1,750 per 100,000. The study also cited Tunisia and Vietnam as having made unexpected progress.

The report contained at least two surprises for researchers. One was that Italy ranked best in reproductive health in the world.

"We didn't expect this," Dr. Conly said, "because while use of family planning in Italy is high, over half of Italian couples use traditional methods like withdrawal and rhythm, which experts generally consider less effective. However, Italian women appear able to use these methods effectively, largely because safe abortion is available on request."

Another surprise, Dr. Conly said, was that countries like Indonesia and Bangladesh, which have become exemplary nations in offering family planning broadly, nevertheless fall in the "high risk" category because their death rates from pregnancy and childbirth remain high.

The study looked at three areas for each country: family planning, which the researchers said reduced the risks associated with frequent childbearing and reliance on unsafe abortion; pregnancy and childbirth, including such related health concerns as AIDS and anemia, and post-pregnancy issues like infertility.

The nations of the former Soviet Union were not included in the survey because some data for those nations were not available in comparable form.

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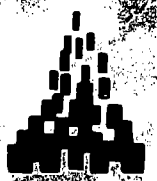
Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health



Population Action International

1995 REPORT ON PROGRESS TOWARDS WORLD POPULATION STABILIZATION

Population Action International

Formerly
Population
Crisis Committee

PRESS RELEASE

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HOLD FOR RELEASE UNTIL:
24 JULY 1995—6:00 PM EDT/22:00 GMT

WOMEN'S SEXUAL AND MATERNAL HEALTH MARKED BY EXTREME INEQUALITY AMONG NATIONS

Washington—The health risks faced by women in sexual activity and childbearing vary enormously from country to country, according to a new study of more than 100 countries from Population Action International (PAI).

A woman in **Italy**, the best ranked country in the study, faces only a 1 in 17,000 risk of dying from causes related to pregnancy and childbirth over the course of her lifetime. For a woman in **Zaire**, the worst ranked country, the risk is more than 1,000 times greater, at 1 in 16. In fully 55 of the countries surveyed, a woman faces more than a 1 in 100 lifetime risk of dying from maternal causes.

While access to medical care in pregnancy and childbirth is close to universal in the industrialized countries, worldwide only slightly more than half of all births are attended by any kind of trained personnel. In **Nepal, Afghanistan** and **Somalia**, less than 10 percent of women receive prenatal care or have a trained attendant at delivery.

The study, ***Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health***, uses ten indicators to rank 118 countries—home to 94 percent of the world's people—on a 100-point *Reproductive Risk Index*. The study also includes data on 14 of the former Soviet Republics.

"For a woman in her childbearing years, good reproductive health is crucial to her health overall and to her ability to play an active role in society," says Shanti R. Conly, editor of the study and PAI's director of policy research. "The vast disparities evident in this study reflect the failure of many countries to invest in women's health, and the consequences for women are devastating."

—more—

In the countries with the lowest reproductive risk—**Italy**, **Denmark**, **Norway** and **Sweden**—the factors contributing to good reproductive health include low teen birthrates and small family size overall; nearly universal access to maternal health services; high levels of contraceptive use; low levels of infection with HIV, the virus that causes AIDS, and access to safe abortion upon request. Out of 23 countries with *Very Low* reproductive risk in the study, the **United States** ranks eighteenth, while three non-European countries—**Singapore**, **Canada** and **Australia**—rank in the top ten.

In the three worst ranked countries—**Zaire**, **Angola** and **Somalia**—more than one-fifth of 15- to 19-year-olds give birth each year and women have, on average, close to seven children; most women lack access to basic health care in pregnancy and childbirth; fewer than 10 percent of women use any method of family planning; and abortion is illegal or permitted only to save a woman's life. Of 21 countries in the *Very High* reproductive risk category, only two—**Haiti** and **Afghanistan**—are not in Africa.

The PAI study points to the lack of family planning and basic maternity care, among other reproductive health services, as being largely to blame for women's poor sexual and maternal health in many developing countries—especially in sub-Saharan Africa.

"Country rankings on our *Reproductive Risk Index* tend to reflect income levels," says Conly. "However, some poorer countries—like **Cuba**, **Costa Rica** and **Tunisia**—have made long-term investments in expanding access to family planning and health care, and women are reaping the benefits."

A few countries where strong family planning programs have contributed to relatively high levels of contraceptive use rank worse in the PAI study than would be expected, namely **Bangladesh** and **Indonesia**. Pregnancy rates among teenage women in Bangladesh are among the highest in Asia, while the percentage of women who receive any formal maternal health care is among the very lowest. Even in Indonesia, where more than half of all reproductive age women use contraception, only 40 percent of births are attended by trained health personnel. Abortion is legal only to save the life of the woman and an Indonesian woman's lifetime risk of dying due to maternal causes—including unsafe abortion—is 1 in 72. The risk is 1 in 30 in Bangladesh.

But it is in sub-Saharan Africa that women bear the greatest burden of poor sexual and maternal health, according to PAI. Fully 32 of the 46 countries falling into the *Very High* and *High* risk categories in the study's *Reproductive Risk Index* are in Africa. Factors threatening women's health in Africa include: high pregnancy rates among teens; low levels of contraceptive use; levels of HIV infection in the *medium* and *high* range; high

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levels of infection with sexually transmitted diseases (STDs), reflected in rates of infertility that exceed 10 percent in all but a few countries; and a lack of health care during pregnancy and childbirth. The study cites female genital mutilation as another factor contributing to the abysmal reproductive health status of African women.

In all but three sub-Saharan African countries—**South Africa**, **Zimbabwe** and **Kenya**—fewer than a quarter of women use any method of contraception. Restrictive abortion policies severely limit women's access to safe abortion services throughout most of Africa. Women bear, on average, more than five children—a factor that, combined with high maternal death rates, results in a lifetime risk of dying in pregnancy and childbirth that is greater than 1 in 100 in every sub-Saharan African country surveyed except **Zimbabwe** and **South Africa**.

Among the 21 Latin American and Caribbean countries included in the study, rates of contraceptive use exceed 50 percent in all but a handful of countries. Maternal mortality remains high in a number of countries, however, and women face a more than 1 in 100 lifetime risk of dying from maternal causes in ten of the 21 countries, reflecting a lack of access to maternal health care services. **Cuba**, **Costa Rica** and **Uruguay**, rank best and fall in the category of *Low* reproductive risk on the study's *Index*. **Haiti, Guatemala** and **Honduras** rank worst within the region.

"Reproductive health concerns were at the heart of last year's International Conference on Population and Development in Cairo, and are again on the agenda for the upcoming Beijing Conference on Women," says Conly. "Our study shows the crushing burden of poor sexual and maternal health experienced by women in many countries, and we hope it will strengthen international resolve to aggressively address these issues in Beijing."

Beyond the availability of health services, a range of social and cultural factors also influence women's health, according to PAI. The low status of women in many societies helps perpetuate patterns of early and frequent childbearing and is often an obstacle to their use of existing health services. Cultural traditions—such as female genital mutilation, child marriage, and taboos against certain foods during pregnancy—also harm women. In Bangladesh, for example, custom dictates that a woman give birth alone or with only female relatives in attendance.

Thus, while access to reproductive health services is critical to improving women's health, efforts to empower women—including educating girls and providing economic opportunities to women—and to educate men about women's health needs are also important.

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PAI recommends a comprehensive approach to improving women's reproductive health that would include the provision of prenatal and delivery care, including emergency obstetrical care; access to STD services; and, at a minimum, access to treatment for the complications of unsafe abortion. The study also underscores the importance of family planning education and services to reproductive health, pointing to its potential for helping prevent *both* high risk pregnancies—especially among teenage girls—*and* the spread of AIDS and other STDs.

"A comprehensive approach to reproductive health is urgently needed," says Conly. "Access to modern methods of contraception can dramatically reduce the number of unwanted and high-risk births. To reduce maternal death rates, however, women must also have access to emergency medical care during childbirth and alternatives to unsafe abortion."

The ten indicators used in the study reflect both *access* to services that affect women's sexual and maternal health and actual health *outcomes*. Under access, the study includes four indicators:

- Percentage of women using any method of contraception;
- Percentage of pregnant women receiving prenatal care;
- Percentage of births attended by trained personnel; *and*
- Legal status of abortion.

Another six indicators reflect the health consequences of access—or a lack of access—to reproductive health services:

- Percentage of pregnant women with anemia;
- Annual births per 100 women aged 15-19 years;
- Level of HIV/AIDS infection among women [PAI places countries in one of three categories: *low*, *medium* or *high*];
- Percentage of women experiencing infertility [high infertility usually indicates high prevalence of STD];
- Average births per woman (total fertility); *and*
- Number of maternal deaths per 100,000 live births, including deaths due to unsafe abortion.

Each of the 10 indicators used in the study is scored on a 100 point scale and the scores are averaged to yield a total score on the *Reproductive Risk Index*. Countries identified as *Very Low Risk* have a total score of less than 15 points; countries with 15 to 29 points fall in the *Low Risk* category; countries with *Moderate Risk* scored 30 to 44 points; *High Risk* countries scored 45 to 59 points; and countries in the *Very High Risk* category have total scores of 60 points or more. The lowest score, 6.6 points, is that of Italy, while the highest, 76.5 points, is that of Zaire. The 118 countries included in the study all have populations of 2 million or more people.

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The PAI study includes a summary of findings for each of the ten indicators used for the *Reproductive Risk Index*, noting the great disparities among countries. With regard to **early childbearing**, for example, **Japan's** annual birthrate among 15- to 19-year olds is less than 1 in 100, while in **Angola** and **Guinea** the rate is 24 in 100. The **United States** also fares poorly on this indicator, with 6 in 100 of this age group giving birth each year—the same number as in **India** and **Pakistan**.

HIV/AIDS among women poses a new threat to reproductive health, especially in sub-Saharan Africa. PAI's classification of countries as having either *low, medium* or *high* levels of HIV infection is based on small-scale studies, usually of pregnant women in urban areas. All of Europe and North America and most Latin American and Asian countries have low prevalence of HIV infection among women. However, 19 countries fall into the *medium* classification, including 13 countries in Africa, 3 in Southeast Asia—**Thailand**, **Cambodia** and **Myanmar**—and 3 in the Americas—**Panama**, the **Dominican Republic** and **Honduras**. Another 14 African countries, plus **Haiti**, have *high* HIV prevalence among women in the general population.

The risk of death in childbearing is dependent on both the chance of dying during a given pregnancy, and the number of times a woman is exposed to that risk. Thus the PAI study, while including *data* on both maternal mortality and family size, assigns *scores* based upon a woman's *lifetime risk* of dying due to maternal causes, including unsafe abortion. Family size is highest in **Yemen**, where women bear, on average, 7.6 children. Women have the fewest children in **Hong Kong, Italy** and **Spain**, where the average is just 1.2 children. Maternal mortality is highest in **Mali** and **Somalia**, where more than 1,000 women die for every 100,000 live births; it is lowest in **Belgium**, **Denmark**, **Norway** and **Israel**. However, a woman's *lifetime risk* is lowest in **Italy**, **Belgium** and **Hong Kong**, while still highest in **Mali** and **Somalia**. Lifetime risk is about 1 in 6,000 for women in the **United States**, which ranks fifteenth on this measure of women's health.

The lack of comparable data for the former Soviet Republics (NIS) prevents their inclusion in the *Reproductive Risk Index*, but the PAI study includes new data on these countries. Use of modern contraception does not exceed 25 percent among women of childbearing age in any NIS country, due to the limited availability of contraceptive supplies. As a result, abortion rates are high throughout most of the NIS, with the annual number of abortions per 100 women reaching 8.3 in **Ukraine**, 8.5 in **Kazakhstan**, 10.4 in **Belarus**, and 12.0 in **Russia**. By comparison, the annual abortion rate is 2.6 per 100 women in the **United States**, and 2.0 per 100 in **Sweden**.

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Both family size and maternal mortality are higher in the Central Asian Republics than in the European NIS. A woman's lifetime risk of dying from maternal causes is highest in **Turkmenistan**—where 1 in 150 women die in pregnancy and childbirth—and similar to the risk faced by women in **Algeria, Colombia** and **Brazil**. Among the NIS, lifetime risk is lowest in **Azerbaijan**. In **Russia**, a woman's lifetime risk of dying from maternal causes is about 1 in 1,000, as it is in **Thailand** and **Uruguay**.

Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health is the sixth in PAI's annual *Report Card* series. The 1994 *Report Card*, ***Financing the Future: Meeting the Demand for Family Planning***, found that spending on family planning in developing countries averaged just 80 cents per capita per year. The 1994 study recommended a spending level of about $3.30 per capita for a basic package of reproductive health services, including family planning, AIDS prevention and safe maternity care. Only a handful of the 79 countries included in the 1994 study spent more than $2.00 per capita. They included **Costa Rica, Jamaica, Hong Kong, Taiwan** and **Tunisia**.

An increase in annual expenditures from the current $5 billion to a minimum of $17 billion by the year 2000 is needed to meet the growing demand for services, while improving their range and quality. Nations participating in the Cairo conference on population and development last year endorsed both this spending goal and the elements of a reproductive health care strategy. At the time, a number of countries—including the United States, Britain, Germany and Japan—indicated their willingness to increase assistance to developing countries for this purpose. Since then, however, no new donor pledges have been made and overall development aid continues to fall.

"This study's cold statistics promise more death and disease for millions of women and families, unless we implement the Cairo plan of action to make basic reproductive health care available to *every* woman in the next 20 years," says Hugo Hoogenboom, PAI's new president. "The nations of the world agreed to this last September. The retreat from this goal by the donor community—as reflected in recent actions of the U.S. Congress—is profoundly disappointing. Indeed, it is inexcusable."

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Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health
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Population Action International, a Washington, DC-based, non-profit, non-governmental organization, was founded in 1965. Population Action International is committed to universal access to voluntary family planning and reproductive health services, reproductive choices for women and men, and early stabilization of world population.

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The Reproductive Risk Index *(continued)*

Country	Annual Births per 100 Women Aged 15-19	Women Using Contraception (%)	Abortion Policies*	Pregnant Women with Anemia (%)	Women Receiving Prenatal Care (%)	Births Attended by Trained Personnel (%)	Level of HIV/AIDS in Women	Infertility in Women (%)		Maternal Deaths per 100,000 Births	Reproductive Risk Index	
Uruguay	6	*72*	C	*37*	80	96	Low	3	2.4	36	**23.7**	**LOW RISK**
Vietnam	2	53	A	*63*	73	90	Low	2	3.7	120	**25.7**	
Argentina	6	*66*	C	*37*	90	92	Low	3	2.9	140	**26.9**	
Malaysia	3	48	C	34	75	92	Low	4	3.6	59	**27.8**	
Chile	6	*43*	E	21	91	98	Low	3	2.5	67	**27.9**	
Tunisia	2	50	A	38	58	68	Low	7	3.3	127	**29.8**	
Sri Lanka	3	62	E	62	86	94	Low	4	2.5	80	**31.0**	**MODERATE RISK**
Jordan	5	40	C	50	76	87	Low	3	5.6	40	**31.0**	
Turkey	4	63	A	74	43	76	Low	2	3.5	146	**31.5**	
Jamaica	9	67	C	62	95	90	Low	7	2.9	115	**31.6**	
Colombia	7	66	E	24	80	71	Low	2	2.7	200	**32.2**	
Brazil	8	66	D	34	74	73	Low	2	3.0	200	**33.1**	
Thailand	5	66	C	52	77	66	Medium	2	2.2	37	**33.2**	
Saudi Arabia	12	*14*	C	31	86	90	Low	3	5.5	41	**33.4**	
Venezuela	10	49	E	29	74	97	Low	2	3.6	200	**34.2**	
Panama	9	58	C	*42*	72	84	Medium	3	2.9	60	**35.3**	
South Africa	7	50	C	37	84	86	Medium	5	3.8	84	**35.7**	
Lebanon	3	55	E	*50*	85	45	Low	3	2.9	128	**36.2**	
Philippines	3	40	E	48	77	55	Low	2	4.1	74	**36.2**	
Peru	6	59	C	53	64	60	Low	3	3.5	300	**36.9**	
Mexico	8	53	D	41	60	69	Low	3	3.2	200	**37.5**	
Ecuador	8	53	C	46	52	84	Low	5	3.8	300	**37.6**	
Oman	12	9	E	*50*	79	75	Low	3	6.9	7	**37.8**	
Iraq	5	14	C	*50*	65	74	Low	3	5.7	117	**38.3**	
India	6	41	B	88	49	70	Low	3	3.4	420	**39.5**	
Algeria	3	47	C	42	58	15	Low	3	4.2	129	**39.6**	
Nicaragua	15	49	E	*42*	92	73	Low	3	4.6	300	**40.0**	
Paraguay	9	48	E	63	84	66	Low	3	4.4	300	**41.2**	
El Salvador	13	53	C	*42*	34	66	Low	2	3.9	300	**41.4**	
Libya	11	*14*	E	*53*	76	76	Low	3	6.4	80	**42.1**	
Egypt	7	47	C	47	53	34	Low	4	3.9	266	**42.2**	
Bolivia	8	30	C	25	45	55	Low	3	4.8	600	**42.4**	
Dominican Republic	9	56	E	*52*	97	72	Medium	5	3.3	300	**42.8**	
Iran	9	*38*	E	*50*	47	70	Low	3	6.0	120	**42.9**	
Morocco	4	42	C	46	34	31	Low	3	4.0	327	**43.4**	
Indonesia	6	55	E	74	76	40	Low	7	2.9	400	**45.6**	**HIGH RISK**
Syria	11	20	E	52	60	61	Low	3	6.2	143	**45.7**	
Zimbabwe	10	43	C	*47*	92	69	High	*10*	5.0	77	**46.3**	
Myanmar	3	*46*	E	58	75	57	Medium	5	3.8	460	**46.9**	
Sudan	9	9	D	36	70	69	Low	9	6.1	550	**47.2**	
Honduras	13	47	E	*42*	45	81	Medium	3	5.2	221	**47.7**	

Reproductive Risk:

A Worldwide Assessment of Women's Sexual and Maternal Health

The Reproductive Risk Index

Country	Annual Births per 100 Women Aged 15-19	Women Using Contraception (%)	Abortion Policies*	Pregnant Women with Anemia (%)	Women Receiving Prenatal Care (%)	Births Attended by Trained Personnel (%)	Level of HIV/AIDS in Women	Infertility in Women (%)	Average Births per Woman (TFR)	Maternal Deaths per 100,000 Births	Reproductive Risk Index	
Italy	1	78	A	10	100	100	Low	6	1.2	4	**6.6**	VERY LOW RISK
Denmark	1	78	A	8	100	99	Low	6	1.8	3	**6.7**	
Norway	2	76	A	*17*	95	100	Low	5	1.8	3	**8.1**	
Sweden	1	78	A	*17*	100	100	Low	5	2.0	5	**8.4**	
Belgium	1	79	A	*17*	90	100	Low	7	1.6	3	**8.7**	
Netherlands	1	76	A	18	95	100	Low	*5*	1.6	10	**10.0**	
France	1	81	A	18	99	94	Low	6	1.7	9	**10.1**	
Australia	2	76	B	*20*	100	99	Low	*5*	1.9	5	**10.3**	
Singapore	1	74	A	18	95	100	Low	*5*	1.8	10	**10.4**	
Canada	3	73	A	20	100	100	Low	7	1.8	5	**10.6**	
Finland	1	80	B	*17*	100	100	Low	5	1.8	11	**10.6**	
Austria	2	71	A	*17*	96	96	Low	*5*	1.5	8	**10.7**	
United Kingdom	3	81	B	19	98	98	Low	6	1.8	8	**11.8**	
Czech Republic	5	69	A	23	100	100	Low	4	1.7	10	**11.8**	
Japan	0	64	B	*20*	99	100	Low	6	1.5	11	**12.4**	
Taiwan	2	75	B	*37*	99	100	Low	*5*	1.7	9	**12.9**	
Hong Kong	1	86	C	*37*	99	99	Low	*5*	1.2	4	**13.0**	
United States	6	71	A	17	95	99	Low	6	2.1	7	**13.0**	
Spain	1	59	C	9	96	96	Low	4	1.2	5	**13.7**	
Germany	1	75	C	12	99	100	Low	*5*	1.3	11	**14.1**	
Switzerland	1	71	C	*17*	—	99	Low	*5*	1.5	4	**14.3**	
Slovakia	4	67	A	*40*	100	100	Low	*5*	1.9	10	**14.4**	
Bulgaria	6	76	A	*40*	100	100	Low	6	1.5	12	**14.5**	
Hungary	4	73	B	*40*	100	99	Low	5	1.7	13	**15.1**	LOW RISK
Poland	3	75	C	16	99	99	Low	3	2.1	11	**15.1**	
Portugal	3	66	C	*17*	96	98	Low	5	1.5	10	**16.5**	
China	2	83	A	*37*	98	94	Low	*5*	2.0	95	**16.8**	
North Korea	1	*67*	A	*37*	100	100	Low	2	2.4	130	**17.0**	
Israel	2	*65*	C	25	90	99	Low	6	2.9	3	**17.1**	
New Zealand	4	70	C	22	95	100	Low	*5*	2.1	13	**18.2**	
Yugoslavia	4	55	A	*40*	100	86	Low	5	2.0	18	**18.2**	
Cuba	9	70	A	34	99	100	Low	*6*	1.8	36	**18.5**	
South Korea	1	79	C	*37*	89	89	Low	2	1.6	32	**19.1**	
Romania	4	57	A	*40*	100	99	Low	6	1.4	149	**20.8**	
Costa Rica	9	75	C	28	91	97	Low	2	3.2	18	**21.3**	
Albania	1	10	A	40	100	99	Low	5	3.0	30	**22.2**	
Mongolia	4	*38*	A	26	100	99	Low	*5*	4.5	140	**22.9**	

C O N T I N U E D

The Reproductive Risk Index *(continued)*

Country	Annual Births per 100 Women Aged 15-19	Women Using Contra-ception (%)	Abortion Policies*	Pregnant Women with Anemia (%)	Women Receiving Prenatal Care (%)	Births Attended by Trained Personnel (%)	Level of HIV/AIDS in Women	Infertility in Women (%)		Maternal Deaths per 100,000 Births	Reproductive Risk Index	
Papua New Guinea	2	*5*	C	75	68	43	Low	*5*	5.4	700	**48.0**	HIGH RISK
Guatemala	12	23	E	*42*	34	51	Low	3	5.4	300	**49.7**	
Benin	15	9	E	55	64	45	Low	3	7.1	161	**50.5**	
Bangladesh	13	40	B	51	12	7	Low	4	4.4	650	**50.6**	
Pakistan	6	12	C	57	27	35	Low	4	6.1	600	**51.4**	
Cambodia	13	*44*	E	*63*	100	47	Medium	5	5.3	800	**51.8**	
Madagascar	16	17	E	*47*	78	58	Low	*10*	6.1	570	**52.1**	
Ghana	13	13	C	64	82	59	Medium	3	6.0	1000	**52.1**	
Laos	5	*18*	E	62	—	20	Low	5	6.3	300	**52.4**	
Zambia	14	15	B	*47*	92	51	High	14	6.5	151	**52.6**	
Cameroon	14	16	C	*54*	79	64	Medium	12	5.8	430	**53.9**	
Yemen	10	10	E	*50*	26	16	Low	2	7.6	330	**55.7**	
Rwanda	6	21	C	*47*	80	22	High	*10*	6.2	300	**56.0**	
Togo	13	12	E	47	81	42	Medium	*10*	6.6	420	**57.2**	
Malawi	17	13	C	49	78	50	High	*10*	6.7	167	**57.9**	
Burundi	6	9	C	68	80	19	High	3	6.7	800	**58.3**	
Senegal	16	7	E	55	21	40	Low	4	6.0	933	**59.3**	
Kenya	14	33	E	57	77	45	High	7	5.4	500	**59.4**	
Nepal	10	23	C	*75*	9	6	Low	6	5.5	850	**59.9**	
Guinea	24	*5*	C	*56*	36	25	Low	6	6.0	800	**60.7**	VERY HIGH RISK
Mauritania	13	3	E	*56*	26	20	Low	6	6.5	800	**61.3**	
Liberia	23	6	C	78	50	58	Medium	4	6.8	600	**61.4**	
Nigeria	15	6	E	43	57	37	Medium	8	6.5	800	**61.5**	
Haiti	5	10	E	64	52	40	High	7	5.8	600	**62.3**	
Tanzania	13	10	E	80	90	53	High	10	6.3	342	**62.5**	
Uganda	22	5	C	*47*	86	38	High	*10*	7.4	550	**63.4**	
Burkina Faso	17	8	C	*56*	49	41	High	6	6.9	810	**63.8**	
Sierra Leone	21	*12*	C	45	30	25	Medium	*10*	6.5	450	**64.4**	
Mozambique	13	*12*	E	58	50	25	Medium	14	6.5	300	**64.6**	
Afghanistan	15	*2*	E	*75*	8	8	Low	*5*	6.9	640	**66.3**	
Central African Rep.	16	*16*	E	67	69	66	High	17	5.7	600	**66.9**	
Ethiopia	17	4	C	*47*	20	10	Medium	*10*	6.9	900	**67.7**	
Chad	19	*20*	E	*54*	30	15	Medium	11	5.9	710	**68.9**	
Côte d'Ivoire	23	3	E	*56*	66	40	High	10	7.4	680	**70.0**	
Niger	22	4	E	47	30	15	Medium	9	7.4	700	**70.3**	
Mali	20	5	E	65	31	27	Medium	8	7.1	1750	**71.1**	
Congo	15	*15*	C	*54*	35	—	High	21	5.5	900	**72.1**	
Somalia	21	*5*	E	73	2	2	Low	*10*	7.0	1100	**72.8**	
Angola	24	*2*	E	*54*	25	15	Medium	12	6.6	650	**73.5**	
Zaire	23	8	E	76	90	—	High	21	6.7	800	**76.5**	

■ This 1995 report on *World Progress Towards Population Stabilization* includes countries with a population of two million or more. The following countries were dropped because data were only available for eight or fewer indicators: Bosnia and Herzegovina, Croatia, Eritrea, Greece, Ireland and Macedonia.

■ Numbers in italics indicate estimates.

*Key to Abortion Policies:
A = available on request
B = permitted on broad social and health grounds
C = permitted on limited health grounds
D = permitted only for special cases (rape, incest, to save a woman's life)
E = illegal or permitted only to save a woman's life

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Population Action International

Chance of a Woman Dying from Complications of Pregnancy, Childbirth or Unsafe Abortion During Her Lifetime

Italy	1	in	17,361
Norway	1	in	15,432
Australia	1	in	8,772
United States	1	in	5,669
Poland	1	in	3,608
Azerbaijan	1	in	3,429
Costa Rica	1	in	1,447
Cuba	1	in	1,286
Russia	1	in	1,021
Uzbekistan	1	in	484
China	1	in	439
Zimbabwe	1	in	217
Tunisia	1	in	199
Turkmenistan	1	in	152
Mexico	1	in	131
Indonesia	1	in	72
India	1	in	59
Bangladesh	1	in	30
Zaire	1	in	16
Mali	1	in	7