

SAVING WOMEN'S LIVES: A PUBLIC HEALTH APPROACH

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It is an honor to give the Calderone Lecture for 2001. I thank you most sincerely for the Award. Of all the honors and recognition I have received, none is more precious than one bestowed by one's peers. The Award is really not so much for me but for all of you: organizations public and private, individuals in the health sector, and to my former colleagues at the United Nations Population Fund. I would also like to pay special tribute to my friend Allan Rosenfield, whom I have known for more years than I care to count. Through all these years, Allan has been a tireless crusader for women's health, especially their reproductive health.

In the past thirty years, we have all worked extremely hard and achieved, I believe, so much together. Yet, for all our progress, so much remains to be done for women's health. The frustration is that the area of maternal mortality and morbidity is a subject about which we know so much in the clinical sense, but so little in the social and cultural sense.

In all cultures and societies of the world, motherhood is revered. "Heaven lies at the feet of a mother," could be a slogan in every corner of the world. And yet, paradoxically, maternal mortality remains one of the most recalcitrant of social indicators. Consider the facts: in today's world of about 6.2 billion people, there are 1.5 billion women of reproductive age, giving birth to 133 million babies each year, or 247 births every minute, four every second. Less than half of these births will be attended by qualified health workers. Fifteen million of these births (12 percent) are to adolescent mothers whose mortality rate is higher (25 times higher for girls under 15, and two times higher for those 15 - 19 years). Every year about 515,000 women die of pregnancy related causes, 90 percent of these deaths occurring in developing countries.

Of all the social indicators, the largest gap between rich and poor nations is seen in maternal mortality levels. Over 90 percent of maternal deaths occur in Asia and sub-Saharan Africa, with sub-Saharan Africa accounting for 50 percent and India for 25 percent of such deaths worldwide.

The lifetime risk of maternal death is one in 16 in Africa (one in 12 in sub-Saharan Africa), one in 65 in Asia, one in 130 in Latin America, compared with one in 400 in Northern Europe. Even more worrisome is the fact that for every woman who dies, at least 30 suffer injuries and often permanent disability. It is estimated that one in four women in the developing world suffer from acute or chronic conditions related to pregnancy.

Maternal morbidity is highly prevalent but not accurately reported, either in developed or in developing countries. When a woman dies in childbirth, she often leaves behind small children who often do not survive without a mother's care. Surviving daughters are especially vulnerable.

One-third of all pregnancies are unwanted or unintended and even today, about 350 million women do not have the choice of safe, effective contraceptive methods. There are estimated to be 70,000 deaths each year due to unsafe abortions.

Maternal mortality and morbidity is more likely in nations and cultures which give little priority to the needs, status and situation of girls; where girls and women are routinely discriminated against; where girls are married off as soon after puberty as possible; where education levels are low; and where the only role of women is seen as wives and mothers. In many of these cultures, maternal illness, suffering, and health are viewed as natural, inevitable, and part of what it means to be a woman.

Our work in saving women's lives should start by first understanding the social and cultural environment in which the above facts occur. As health workers, as physicians, as development workers, we must never miss the opportunity to point to troubling practices. Girls routinely face discrimination in many cultures because of gender. In many cultures, a baby girl is less welcome than a boy: her birth is not celebrated with the same enthusiasm as her brother's; her need for nutrition and healthcare is likely to be neglected, resulting in poor physical development and consequences during childbirth; a girl child is less likely to go to school and will stay there for a shorter time. Indeed, girls comprise two-thirds of young people not in school; women comprise two-thirds of the world's adult illiterate population. Among other handicaps, lack of education prevents women from accessing and learning about pregnancy and health issues for themselves. Girls marry early and are expected to begin childbearing before being physically ready.

More than 80 percent of maternal deaths worldwide are due to five direct causes: hemorrhage, sepsis, unsafe abortion, obstructed labor and hypertensive disease of pregnancy. Indirect deaths are due to conditions that, in association with pregnancy, precipitate the fatal outcome, e.g. malaria, hepatitis, and increasingly, AIDS. Most life threatening complications occur around the time of birth and require recognition and prompt treatment to save the lives of women and their infants.

A Paradigm Shift

Today, there is great reason to hope that progress can be made in reducing maternal mortality as well as maternal morbidity. First, practical solutions to improve availability, access, and use of maternal health services are known and affordable. Second, pragmatic use by basic health providers are improving their skills to deal with emergency situations rather than relying on systems that may not exist. I want to especially recognize Dr. Rosenfield and the Mailman School of Public Health for pioneering work in this area. Third, the idea that all citizens possess equal rights to health, education, and other social services is becoming more widely accepted by lawmakers in many countries. And fourth, reproductive health, including safe motherhood, has been promoted as a right. This lays the foundation for an integrated, multi-sectoral approach by relating factors underlying maternal survival and health to fundamental rights enshrined in international conventions and national constitutions: rights of girls and women to education, nutrition, healthcare; the right to decide if and whom she will marry; when and how many children she will have, and freedom from discrimination. These trends are important for building societies based on the fulfillment of human rights particularly significant for the health of women.

Maternal Mortality and Morbidity Reduction Programs

In my opinion, there are four main interventions needed to reduce maternal death: reducing social and cultural obstacles; strengthening reproductive health care systems, including family planning services; emergency care for obstetric complications; skilled attendants at birth.

Reducing Social and Cultural Obstacles

As clinicians and public health practitioners, you are familiar not only with the medical and immediate causes of maternal death and problems, but also some of the underlying causes, many of which are rooted in traditional practices and attitudes towards women's health. You, no doubt, appreciate that reproductive health is fundamental to, and is at the core, of women's health concerns.

Women in developing countries do not wish to deny or give up their reproductive roles despite the risk to their lives and health. They need to be given all available support by society in order to reduce the risks associated with their role. They need to be protected from harmful traditional practices such as female genital mutilation (FGM), early marriage and premature childbearing, food and nutritional taboos, and other practices which undermine their health. Women's health is closely tied to and greatly influenced by their low social and educational status. Many do not have access to resources of their own, or any power of decision over how family resources are used. Any meaningful attempt to improve women's health must also address these issues, including improved access to basic education as a condition to making decisions that shape their lives. We need to do three things to protect girls and women: first, empower women, second (linked to the first), value the female child, and third, involve men as partners. These three areas overlap and they interact throughout the life cycle.

Strengthening Reproductive Care Delivery Systems

Promoting the integration and quality of a constellation of reproductive health services, including family planning, maternal and infant care, and STD prevention and treatment, is an essential component of health sector reform. Improving access to client-centered family planning information and services, where a range of effective contraceptive methods are offered and responsive counseling provided, reduces the number of unplanned pregnancies, which often lead to sub-optimal pregnancy care and unsafe abortion procedures. Currently, as many as 50 percent of pregnancies are unplanned, 25 percent are unwanted, and complications of unsafe abortions are responsible for a substantial proportion of maternal deaths. Meeting the existing demand for family planning services would reduce pregnancies in developing countries by 20 percent and maternal deaths and injuries by a similar degree or more. Safe, effective contraceptive services must be ensured and access to the most vulnerable segment of the population promoted. Challenges include targeting single women and adolescents, and promoting new and under-utilized methods such as female condoms, vasectomies, or emergency contraception. Reproductive tract infections and STDs, in particular, are a major cause of maternal and neonatal morbidity and mortality.

In many poor communities, the interplay between poor nutrition and debilitating diseases, malaria and tuberculosis, for example, means that many women are unhealthy at the onset of pregnancy. They are already at a disadvantage if an obstetric emergency arises. For example, about 56 percent of women in developing countries suffer from anemia, caused by parasitic infections from malaria and hookworm and/or from inadequate intake of iron and folic acid and, as a result, face an increased risk of maternal death from hemorrhage and infection.

Recently there has been an attempt to address nutritional deficiencies that affect women by distributing medication to pregnant women. In several developing country settings, trials are underway to determine the effectiveness of this intervention. I believe that it should be an integral part of the approach to educate women to defer pregnancy until anemia is treated or other health risks eliminated.

Although the previous emphasis on prenatal care and traditional birth attendant training did not succeed in reducing maternal deaths, it is important to establish a relationship between women and the health system by providing good, empathic prenatal care by fostering the dialogue with traditional birth attendants and female community leaders. All women need access to women-friendly health services which meet established criteria for quality: women-friendly services which are available, accessible, and affordable, located as close to home as possible; services which are available at convenient hours and reasonably priced for both clients and the healthcare system. Those healthcare providers with the highest possible technical standards, including infrastructure, infection control, written protocols, and necessary supplies and equipment; ensure the satisfaction of both users and providers through support and motivation of providers, client involvement in decision-making, and provider responsiveness to the cultural and social norms; and respect women's rights to information, choice, safety, privacy and dignity. In particular, obstetric emergencies need priority access to operating rooms, and safe blood transfusion must be available 24 hours a day.

In Peru, a project called “10 Steps for a Safe Delivery,” is now being implemented in maternity hospitals. The criteria for certification of a maternal health facility include: a written policy of safe delivery, trained staff, compassionate care, priority to obstetric emergencies, surgical facilities with necessary equipment for Cesarean section and neonatal resuscitation, a functioning and safe blood bank, communication and transportation equipment, care for premature babies and breastfeeding policy, a monitoring committee, and community support groups. A national facilitation team works with local institutions to implement the ten steps and accreditation is based on process indicators.

Improving the Availability and Use of Essential Obstetric Care

Building effective referral systems is critical for ensuring that women who need emergency attention are able to obtain it. While most obstetric complications can neither be predicted nor prevented, they can be successfully treated. Even where emergency obstetrical care (EOC) services are available, a substantial number of maternal deaths occur because women with obstetric complications fail to receive appropriate care soon enough to save their lives. The three-delays model is often used to help program managers and communities understand the determinants of maternal mortality and put in place adequate responses: delay in recognizing the need for care and in seeking care, delay in reaching care, and delay in obtaining appropriate care at the medical facility. Once services are in place, effective healthcare in rural areas depends on educating communities, including men as husbands and fathers, leaders and decision-makers, about birth preparedness, and on strengthening links between community practitioners and the formal health system. Unless the three-delays are addressed, no safe motherhood program can succeed.

In guidelines jointly issued in 1997 by WHO, UNICEF, and UNFPA, it is recommended that for every 500,000 people there should be four facilities offering Basic EOC and one facility offering Comprehensive EOC. Basic EOC provided in health centers and small maternity homes includes administration of antibiotics, oxytocics, anticonvulsants, manual removal of the placenta, removal of retained products, and assisted vaginal delivery with forceps or vacuum extractor. Comprehensive EOC delivered in district hospitals included all Basic EOC functions plus Cesarean section and blood transfusion.

Existing facilities (district hospitals and health centers) can often, with limited inputs, become capable of providing EOC. These interventions include: renovating an existing operating theatre or equipping a new one; repairing or purchasing surgical and sterilization equipment; converting unused facilities within hospitals or health centers into a basic or comprehensive EOC facility; training doctors and nurses in life-saving interventions; and, improving the management of health services through better use of existing resources.

A system has to be in place to ensure that staff is available to manage obstetric emergencies 24 hours a day, including a functioning operating theatre and an anesthesiologist, or a nurse with special training.

Through the “Averting Maternal Death and Disability” (AMDD) program, funded by the Bill & Melinda Gates Foundation and led by the Mailman School of Public Health, UNFPA is working in four countries, Morocco, Mozambique, Nicaragua and India/Rajasthan, to improve availability of emergency obstetric care in district hospitals and health centers, strengthen transportation systems, and improve financial access for poor families. Nationwide data collection for processing indicators in five countries in West Africa has been undertaken as well as a distance learning course, “Reducing Maternal Deaths: Setting Priorities, Tracking Progress,” that will be made available to all UN staff and counterparts in governments and NGOs. The AMDD program has fostered a very innovative partnership, with two UN agencies, UNICEF and UNFPA, and two major NGOs, Care and Save the Children, to implement large scale activities with national and provincial governments in more than 40 countries which will, I am certain, yield important results.

Ensuring Skilled Attendants at Birth

Most complications occur at childbirth, and the presence of a professional, nurse, midwife, doctor, is crucial to take urgency actions that save lives. Women attended to by professionals are more likely to avoid serious complications and receive treatment early, when the situation can still be controlled. The demand for professional health workers increases with urbanization and girls' education. Yet, in the developing world today, only 58 percent of all deliveries take place with the assistance of a skilled attendant. Health and educational systems have failed to develop a strong cadre of professional practitioners to assist women in childbirth, especially the poor and those living in rural areas. Professionally qualified birth attendants include midwives, doctors and practitioners who have received at least 18 months of midwifery training and attend on average, five-10 deliveries per month. Throughout the developing world, there is a chronic shortage of midwives, and this is most acute in rural areas. This needs to be addressed through housing, distance learning, career prospects, and a mix of public-private practice. In the meantime, pragmatism dictates that best use be made of the health workers in place now, especially in situations where referral sources are declining or inaccessible, by training workers in techniques to deal with life-threatening emergencies.

There are three issues in maternal health that I would specifically like this group to think about and about which I have been increasingly concerned in the last years: vesicovaginal fistula, violence against women, and gender and HIV/AIDS.

Vesico-Vaginal Fistula

Obstetric fistula is a serious form of maternal morbidity that results from prolonged and obstructed labor. Vesico-vaginal fistula, or VVF, is a hole or false communication between the bladder and the vagina, resulting from necrosis of the vaginal tissue caused by constant pressure of the baby's head through the birth-canal for a prolonged period of time. In some cases, the fistula develops between the rectum and the vagina, causing recto-vaginal fistula or RVF. In nearly every case, the baby dies undelivered, and the fistula occurs shortly after the delivery of the stillborn baby. The fistulae result in constant leakage of urine or feces through the vagina, frequent bladder infections and ulceration of the genital area from the constant wetness. "Foot drop" or neurological damage to the lower limbs, sustained during childbirth from the same causes, can make it difficult for some patients to walk.

The social consequences are equally severe, and often mean that affected women are ostracized from the community, divorced, abandoned and remain childless. The smell of urine or feces and the inability to stay dry are humiliating and uncomfortable. The social isolation compounds the woman's own belief that she is a disgrace and has brought shame to the family. Women with VVF often work alone, eat alone, and are not allowed to cook for anyone else. They sleep in separate huts and often end up on the streets, begging for their survival.

Obstetric fistulae are found most often among very young and very poor women. The conditions that contribute to obstructed labor, like malnutrition and stunting, a young age at first pregnancy/childbirth, and poor access to emergency obstetric care also lead to VVF.

Current data on the incidence of VVF are practically non-existent, although the problem has been reported throughout Africa and the Indian subcontinent. WHO estimates that there are two million women living with fistulas and an additional 50,000 - 100,000 new cases every year. Many women who develop fistulas live with the condition for decades. Because fistula is surrounded by shame and dishonor, many women suffering from the problem remain hidden. Current estimates of prevalence are derived from actual cases of women living with fistula who are seeking treatment in hospitals and clinics. These are likely to be gross underestimates.

Because nearly all obstetric fistulae can be prevented through access to emergency obstetric care, the incidence of fistula gives an indication of the accessibility and quality of maternity care. The lack of

financial resources stops women from seeking care for VVF, and is also likely to play a role in women's inability to access health services during childbirth. In Africa and South Asia, many VVF patients are in their teens and primipara and tend to give birth alone or with a family member. They often cannot ask for help when a complication arises.

Fistulae can be surgically repaired. Successful surgery requires a specially trained surgeon and support staff, access to an operating theatre, and attentive post-operative care. Several specialized fistulae hospitals have provided excellent training to surgeons and nurses over the last few decades and have done a great deal to alleviate the problem of fistula. Success rates for primary surgical repair range from 88-93 percent and decrease with each successive attempt. After a successful intervention, 90 percent of women are accepted back into their communities.

There is some reluctance among the medical community in affected countries to take on the repair of VVF. The surgery is technically difficult, and few doctors are adequately prepared to perform it without specialized training. Few of the women living with fistulas are able to pay the cost of surgery. Post-operative care is also difficult and requires that nurses and other paramedical staff be well prepared.

VVF have traditionally been a neglected issue in reproductive health. They are not getting the attention of programmers, researchers, and donors, often in the context of interventions to reduce the maternal death and disability. Areas with high incidence of obstetric fistula also have high rates of maternal mortality, and low access to emergency obstetric care, so synergistic efforts in addressing these issues may prove to be an extremely effective strategy.

To enable women and girls to benefit from improved availability and quality of reproductive health services, we must pay special attention to the socio-cultural barriers to good reproductive health. One of these is the practice of very early pregnancy and childbirth, among women who are often still girls themselves. This frequently leads to prolonged obstructed labor that can too often cause the women's death, and that of the child she is carrying, or leave her with vesico-vaginal or recto-vaginal fistula. Permanently incontinent of urine or feces, as well as childless, she often is abandoned by her husband and lives, poverty-stricken, in a state of almost total social exclusion. The stigmatization associated with obstetric fistula means that these young, poor, often malnourished and uneducated women suffer for many years in silence, with minimal public attention being paid to this issue.

In particular, hands-on training for doctors and nurses in surgical and post-operative nursing care is needed, and should include psychosocial support to patients. Given the highly stigmatized nature of VVF, special clinics within established health facilities provide a good opportunity to offer care for women in a safe and respectful way. Financial resources are critical if VVF clinics are to provide free treatment to those who cannot afford care.

UNFPA in collaboration with the International Federation of Gynecology and Obstetrics is organizing a meeting in July 2001 with all major actors in the field. They include the Fistula Clinic in Addis Ababa, hospitals in Nigeria, as well as a few very committed individuals, agencies and potential donors. The objective is to reach a consensus on the interventions most needed in order to help the victims and reduce the incidence of fistulae. One key intervention is the training of doctors and nurses in the most affected countries. They also need support to set up special wards in hospitals, providing a range of activities from treatment and care, to rehabilitation and social support, to prevention activities such as community education. UNFPA is the first UN agency to start an initiative on fistulae, with encouragement and support from many, including The Mailman School's AMDD program, and I am confident that this initiative will be successful in gathering support for this crucial undertaking. If anyone has seen the sad eyes of these young girls, really children, embarrassed and ashamed of themselves, they will never forget the torment and despair. It is a disability from pregnancy that is disgraceful, unacceptable, and a denial of our claim to being a caring and compassionate society. We, as health providers, must accept our fair measure of blame for not speaking out and for not doing more to prevent and treat it.

Violence Against Women

Girls and women must be freed from violence, coercion or the threat of violence, and fear of female genital mutilation (FGM) and other harmful traditional practices.

At least one in three women has been beaten, coerced into sex, or abused in some way, most often by someone she knows. Female genital mutilation continues to be inflicted on two million girls every year and many more are at risk.

Between 100 to 300 million women and girls have undergone FGM. It has both short and long-term consequences that negatively impact women and girls. But the disgraceful fact is that there is no empirical data on its effects on maternal and other reproductive health complications. I hope this neglect can be soon remedied.

Violence against women knows no age, class, or race and affects the emotional lives of women and families. It can cause immense psychological problems. Among the most common reactions to violence affecting mental health are depression, fear, anxiety, fatigue, low self-esteem and post-traumatic stress disorders. Violence can also cause extensive damage to women's reproductive health and well-being, resulting in unwanted pregnancies, miscarriages, gynecological problems, and sexually transmitted diseases, including AIDS. Gender-based violence is rampant in refugee situations in disaster areas and in civil conflict and war situations. Rape has been used as a weapon of war.

Thankfully, in the face of these problems, the international community and many countries have put in place policies and legislation to shield women from violence. Women's groups, NGOs, civil society groups, and international organizations are campaigning with governments and working with communities to change societal behavior and attitudes towards gender-based violence with some success. For example, many countries have banned FGM, including Burkina Faso, Central African Republic, Cote d'Ivoire, Djibouti, Egypt, Ghana, Guinea, Senegal, Tanzania, Togo and Uganda.

Gender and HIV/AIDS

In no area of health is the gender bias and vulnerability of women more visible than in sexually transmitted diseases, including HIV/AIDS.

The male/female ratio among HIV infected persons has begun to equalize. According to WHO, 55 percent of infected persons in Africa, and 40 percent in North Africa and the Middle East are women; these are the two regions that have the world's highest female infection ratios. In fact, in Africa, the number of infected women has already outnumbered men by 2 million. WHO estimates that worldwide, half of the newly infected adults each day are women.

For example, in Africa, most infected women are infected by their only sexual partner. The overwhelming majority of women at high risk of infections in these regions are "faithful wives." The proportion of wives to all infected women is increasing and that of sex workers is decreasing. While the pandemic may be stabilizing in Africa, it is spreading rapidly in China, India, and Eastern Europe.

These facts considered, national as well as international programs should focus more on male involvement. These programs should mobilize and involve men in safeguarding their spouses and partners from HIV/AIDS, and at the same time, ensure that they are provided with necessary support to enable them to take responsibility for their own reproductive behavior.

It should be ensured that marginalized groups of women and girls have access to reproductive services and care. Minority, disabled, and elderly women, and female slum-dwellers are often left out in both, including the prevention of HIV/AIDS.

The HIV/AIDS epidemic disproportionately burdens women and girls. They are more likely to be caretakers of people infected with AIDS than men and boys. More women are widowed than men, which forces them to face a tragic set of circumstances in terms of loss of social support from family members, ostracism from the community, and a lack of legal protection to inherit land and property. A gender perspective needs to be incorporated in policy and legal reforms to meet the special needs of women and girls in the HIV/AIDS epidemic.

Similarly, more than 13 million children are left as AIDS orphans with little or no education or means of making a living, and the figure may reach 30 million before the end of the decade. Orphaned girls are particularly vulnerable to HIV/AIDS and other STDs as a result of bartering sex for cash or food.

Partnerships are essential in the prevention of HIV/AIDS and providing care for people with AIDS. Investments are critically and urgently needed in research on further affordable methods, controlled by women, to prevent HIV and other STDs, on strategies empowering women to protect themselves from HIV/AIDS and other STDs, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research.

Initiatives in the research on safe, effective, affordable, and acceptable methods and technologies for the reproductive and sexual health of women and men are necessary. Such methods and technologies include methods to protect against HIV/AIDS and other STDs, and simple and inexpensive methods of diagnosing such diseases.

Policymakers everywhere should urge for stronger law enforcement to halt the commodification of women and girls' sexuality through trafficking. Feminization of poverty, the underlying cause, needs to be tackled in the context of the process of globalization. Many women and girls forced into prostitution are sexually exploited, and put at great risk of getting HIV/AIDS and other STDs.

Rape of young girls is increasing in AIDS affected countries because of the belief that sex with a virgin will cure the disease. Recent studies indicate that infection among girls aged 15-19 are five to six times higher than boys of the same age, which means that girls are being infected by older men. Women and girls in conflict situations are especially vulnerable to HIV/AIDS. They are constantly facing the danger of gender-based violence including sexual rape. In addition, men in the armed forces tend to be young and sexually active, known as having a two to five times higher rate of STDs in peacetime and a much higher rate during wartime than the civilian population. Programs to prevent mother-to-infant transmission of HIV/AIDS programs should be expanded, as well as access to drugs for treatment. But the principal focus must be on prevention of any new infection.

Everyone should recognize HIV/AIDS as an imperative, life-threatening issue and work to put it on the political agenda in order to mobilize the necessary resources to combat it. People living with AIDS, including women, must be integrated in the effort to combat the pandemic.

CONCLUSION

Public health interventions have proved their value as an investment that not only saves women's lives, but speeds recovery from crisis and promotes traditional development. Specific interventions for women's health have proved their value many times over.

We have moved the field of women's reproductive health a long way in a short time. Now we have to build on our success. We know what to do and how to do it, but we need to better understand the social and cultural context. We must keep our ideals to establish the perfect health system but we must be pragmatic in our strategies to more effectively use the resources that we have. We must continue to be bold in our advocacy because we, as health practitioners, now have the world community supporting us.

The United Nations' Millennium Development Goals, endorsed by 189 countries, states that reproductive health services must be made accessible to all by the year 2015, and maternal mortality ratios must be reduced by 75 percent between 1990 and 2015. We have the support of the NGOs, civil society, and the intellectual community.

The world, as a whole, has changed in ways that create new opportunities for addressing women's health issues. Among the most significant are the major shifts in attitude among the world's people and its leaders in regard to gender issues, reproductive health, including family planning and sexual health, and the embarrassment of all countries by the statistics on maternal mortality, on HIV/AIDS in young girls and women, and by the increasing number of rape and incest victims. A particularly encouraging trend has been the political commitment by developing countries to implement the goals of the International Conference on Population and Development (ICPD) 1994, and the World Conference on Women and their Five Year Reviews. There is no better time for action than now when the international community has reaffirmed its commitment to "ensure that the reduction of maternal morbidity and mortality is a health sector priority," and that the reduction of maternal mortality and morbidity "should be prominent and used as an indicator of such (health sector) reform."

The five-year review of ICPD affirmed the right to reproductive and sexual health and agreed on new benchmarks in the area. The benchmarks are very specific; they show how far the field has come in recognizing the needs and how to meet them.

By 2005, 60 percent of primary healthcare and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections including STDs, and barrier methods to prevent infection; 80 percent of facilities should offer such services by 2010; and all should do so by 2015.

At least 40 percent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and by 80 percent globally, by 2005; these figures should be 50 and 85 per cent, respectively by 2010; and 60 and 90 percent by 2015.

Any gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2001, 75 per cent by 2010, and 100 per cent by 2015. Recruitment targets or quotas should not be used in attempting to reach this goal.

To reduce vulnerability to HIV/AIDS infection, at least 90 percent of young men and women aged 15-24 should have access to preventive methods, such as female and male condoms, voluntary testing, counselling, and follow-up, by 2005, and at least 95 percent by 2010; HIV infection rates in persons 15-24 years of age should be reduced by 25 percent in the most affected countries by 2005; and globally by 25 percent by 2010. Working together, we can help all countries achieve their goals.

I sincerely thank you again for the Award of the 2001 Frank Calderone Lectureship and Prize by the Mailman School of Public Health Columbia University. I have devoted my career to improving women's health and saving women's lives and I intend to continue the fight. Saving women's lives is a moral imperative.