



## **A Vision for Change: Taking a Stand for Women's Health and Rights**

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For 15 years, I have had the extraordinary honor to bestow the Mailman School's Frank A. Calderone Prize on some of the most distinguished leaders in global health: C. Everett Koop, the late Jonathan Mann, Bill Foege, D.A. Henderson, Nafis Sadik, Peter Piot, and Mary Robinson. They are giants in the field of global health, and I feel fortunate to count them as good colleagues and friends. Each recipient was selected by a national committee of leading public health figures. So, it was a rather humbling experience when I was asked not to participate as a member of the selection committee this year. When I learned that I'd been selected by the committee to be recipient of the 2007 Calderone award, I was deeply honored. I have been truly touched over the last year by the tremendous support of my colleagues and by the tributes I have received for my work. All of this means more than I can easily express.

The title of this talk, "A Vision for Change: Taking a Stand for Women's Health and Rights," implies that there are choices to be made in how we approach these issues. At the Mailman School of Public Health, I hope we have instilled in our students the curiosity to ask questions, the capacity to see from different angles, and the courage to go against mainstream thinking when duty and conviction requires it.

I'd like to take a few minutes to reflect on these questions: what broader lessons can be drawn from our experience in women's health, and what do these lessons tell us about how to position our work for the future? I think the answer has two components signaled by the title of this talk: a "seeing" component and a "doing" component. The "seeing" part concerns how we frame problems and possibilities and, therefore, how we build visions of a better world. The "doing" part concerns not only the translation of knowledge into action but also the conscious approach to how we work.

Let me take some of the women's health issues closest to my heart—indeed, the issues to which I have devoted much of my own career in medicine and public health—to demonstrate what I mean.

For decades, women's health in resource-poor countries had virtually no place on the public health agenda. The focus was on conquering diseases, especially those affecting young children and infants. Certainly the vanquishing of disease is a worthy goal in itself, but when this goal was converted into a disease-based, child-centered, fundamentally narrow approach to public health, the consequences for women were profound. In 1985, when my colleague, Deborah Maine, and I wrote what became a well-received article in *The Lancet* raising the question, "Where is the M in MCH" (or where is the "maternal" in "maternal and child health"), we wanted to spotlight the shocking number of women dying each year from complications during pregnancy and childbirth, mostly in

resource-poor countries. These deaths—more than half a million each year, or one every minute of every day—were essentially invisible, going unnoticed and unaddressed. At the time, programs focused on training traditional birth attendants, which was sometimes helpful for the baby but almost completely ineffective for women with life-threatening obstetrical complications. Yet deaths from these complications were almost all avoidable through access to emergency obstetric care, services that were universally available in industrialized countries. Tragically, nothing was being done to bring such services within the reach of poor and rural women in Africa and Asia, where 95 percent of maternal deaths occur.

Fifteen years later, in 2000, I was asked to give a talk at the International AIDS Conference in Durban, South Africa with the title, “Where is the M in pMTCT” (or where is the “maternal” in the “prevention of maternal-to-child transmission”). At that time, the world finally had some tools, namely single-dose nevirapine and short-course AZT, for preventing HIV transmission from mother to child, and funds were just becoming available to expand treatment to resource-poor countries. pMTCT programs were being hailed as crucial in curbing the epidemic. Yet, with just a slight shift of vision, it became apparent that, once again, women were being left out. We were using the mother to deliver life-saving drugs to the child while completely ignoring the mother’s own care and treatment. In short, we were leaving her to die and, ultimately, leaving the very children we had saved to become orphans, with all of the risks and tragedy that that entails. “Where is the M in pMTCT” was a call to treat the mother and family, too.

In retrospect, the “where is the M” question seems almost obvious. Yet to ask the question meant stepping back from the traditional ways that health services were conceptualized and delivered and asking a very simple question: How do these services look through the eyes of women? Even more radically, how do these services look if we begin with the fundamental premises that, first, women are intrinsically valuable members of society—equal to men and equal to children—and, second, women are silenced and neglected not only by the traditions of their own societies, but also by the traditions of our culture that shaped us as health professionals.

It was not just the mainstream child health field that had ignored the health and rights of women. In my earliest experiences working in public health in Nigeria and Thailand, I saw how seriously women’s lives were affected by their inability to control the number and spacing of pregnancies. At that time, Nigeria had essentially no population or reproductive health programs at all. However, in other parts of the world, as large-scale contraceptive delivery programs were established, they were often driven by concerns over the impact of rapid population growth on the economies of resource-poor countries and on the interests of rich countries. The emphasis was on meeting demographic targets rather than allowing women the freedom to make decisions about childbearing and to shape the course of their lives.

When we dared to “see” more deeply into women’s lives, or to extend our perspective beyond conventionally defined parameters of public health problems, it became clear that we would have to adopt a broader and more ambitious social agenda concerned with the overall status and rights of women. As affirmed by the Universal Declaration of Human Rights developed by the United Nations more than 50 years ago, there is an essential link between public health and social justice. Indeed, imbalances of power between men and women, deeply entrenched within the social, economic, and cultural structures of most societies, lie at the heart of the many threats to women’s health and well being.

Perhaps nowhere are the social dimensions of health more evident than in the problem of violence against women and girls. It is a tragedy of epidemic proportions that, even now, is shrouded in silence. Worldwide, one in three women at some point in her lifetime will be the victim of abuse—physical, sexual, or psychological. In many countries, teenage girls are often subject to forced sexual intercourse or other forms of sexual violence by both young and older men, and in conflict settings, sexual violation and torture of women and girls are routine and often systematic. Violence is also common in the intimate spaces of home and family. Across countries, the lifetime prevalence of violence by an intimate partner ranges from 15 percent to an astounding 71 percent. Here in the United States, more than 20 percent of women are physically abused by their current or former partners. This is not just a problem for women “somewhere else”—it is universal.

Violence against women and girls has profound consequences. It results in loss of personal freedom. It is a major contributor to illness and death among women, and the psychological impact of violence can be as serious as the physical effects. It is also very closely linked to the global AIDS epidemic. Women who have experienced violence may be up to three times more likely to acquire HIV. Yet acts of violence often go unpunished, and violence against women becomes normalized. Until women are treated as equal citizens, and all sectors of society come together to address discrimination, coercion, and violence, we will never truly be able to safeguard women’s health.

As Stephen Lewis, former United Nations Special Envoy for HIV/AIDS in Africa, once said, “I challenge you to enter the fray against gender inequality. There is no more honorable and productive calling. There is nothing of greater import in this world. All roads lead from women to social change...”

We can reframe a problem and establish a vision, but how do we begin to take action? Here at the Mailman School, we have several major on-the-ground programs that speak directly to the issues I have raised. The Averting Maternal Death and Disability Program (AMDD) is the only global program to focus on increasing women’s access to life-saving emergency obstetric services. Since its inception, AMDD has supported 83 projects in 51 countries, covering hundreds of millions of people. It is fair to state that no new technologies or further research are required to make an impact on maternal health. Rather, we need to expand access to maternity care services as a basic human right.

Our MTCT-Plus Initiative, now a part of Mailman’s International Center for AIDS Care and Treatment Programs (ICAP), has shifted attention to families, with women as the cornerstone. MTCT-Plus was the first program to provide comprehensive HIV care and treatment services to women and families in resource-poor countries. To date, ICAP-supported programs, focused primarily on sub-Saharan Africa, have provided HIV care and treatment to over 250,000 HIV-infected people, including anti-retroviral treatment to 120,000 people.

More recently, the Mailman School developed a major new initiative, the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, to increase the provision and quality of sexual and reproductive health care in crisis settings. The program will promote emergency obstetric care, family planning, prevention of STIs/HIV, and response to

gender-based violence among populations affected by armed conflict in Africa, Asia, and Latin America.

Closer to home, we are proud of the Mailman School's long-standing commitment to addressing the health needs of the Washington Heights and Harlem communities. In collaboration with community partners, we provide a wide range of health programs—primary care, reproductive health, mental health, and health education services—to women, men, and adolescents in our community.

These programs, along with many others at the School, reflect a distinct approach to public health. They are guided by five fundamental principles:

- First, our programs embrace women as intrinsically valuable members of society.
- Second, our programs are built on real partnerships—respectful, collaborative, and mutually beneficial.
- Third, our programs strive to reach the disadvantaged. Equity matters.
- Fourth, a commitment to scientific excellence permeates everything that we do.
- Fifth, our programs work to strengthen health systems. Rather than seeing health interventions as technical fixes, we recognize that equitable access and respectful, compassionate treatment depend on the entire system through which these interventions are delivered.

This leads me to perhaps the biggest challenge in public health today. What do funders, and many practitioners, find glamorous and exciting? Ultimately, where do we put our money? The fact is we love “magic bullets” and we want fast-acting, high-impact programs. These are not bad things. The discovery of oral rehydration solution has saved the lives of millions of children. The eradication of smallpox was a remarkable achievement, one of the great success stories in public health. We hope to see many more important innovations in the future. An effective microbicide that can be used by women to protect against sexually transmitted diseases, including HIV, would be an incredible breakthrough, and a vaccine against HIV would utterly reshape the global health landscape. But the challenge in public health right now—and certainly in women's health—is to develop functional delivery systems to ensure that people who need life-saving care get it. While most of the prestige and attention goes to developing new technologies, the reality is that we already have what we need to save the lives of most women.

Let me give you one example to illustrate this point. A recent study on research priorities in child health estimated that just three percent of research dollars is invested in improving delivery, access, and utilization of existing and effective interventions. We need a profound shift in values and priorities, and that shift needs to be reflected across the entire field from funding, to research, to action.

Finally, as we shift our perspective and course of action, we also need to pay attention to how we facilitate and support the next generation of public health and medical professionals. In the field of obstetrics, many of my fellow obstetricians have taken a stand by continuing to provide safe abortions, even in the face of considerable opposition. Some have paid with their lives by acting on their belief that women are entitled to make choices and decisions about their reproductive lives. Today, however, too few obstetricians are engaged in ensuring women's access to abortion. One-

third of women in the United States live in counties where there are no abortion providers. In the midwest and south, this figure is nearly one-half. Many factors feed into this, but the reality is that medical residency programs are failing to train doctors to provide the full range of reproductive health services. One survey found that only 20 percent of OB/GYN residency programs require first- and second-trimester abortion training. Like it or not, obstetricians are linked to one of the most politically and socially contentious issues of the day, and we must grapple with the question of how well this community is serving women.

The recent Supreme Court decision to uphold a law banning an effective second-trimester abortion procedure is alarming. As Justice Blackmun once said, “a chill wind blows.”

On the global level, there are also other immensely important issues for the obstetrics profession. In many resource-poor countries, there are just not enough doctors and even fewer obstetricians. Obstetricians are rarely willing to work in rural areas, where the need is highest. This isn't surprising given the very poor working and living conditions that often exist there. However, the medical community must not stand in the way when countries find innovative solutions to this problem. For example, we and our colleagues have shown that non-specialists, even non-physicians, can be trained to safely and effectively perform many of the procedures traditionally restricted to obstetricians. We demonstrated this in Thailand in the 1960s by showing that auxiliary midwives, using a simple checklist that I developed, could prescribe contraceptives as effectively as doctors. This meant that Thai women in rural areas finally had access to family planning, and the country's national family planning program took off. Today, in the area of maternal mortality, non-obstetricians, even non-physicians, are being trained in a small number of African countries (Mozambique, Tanzania, and Malawi) to provide life-saving emergency obstetric care, including surgery. As public health professionals, it is our obligation as to put women's access to life-saving care first, to challenge the narrow interests of professional lobbies that too often stand in the way, and to convince government leaders that access to maternity care is a basic human right for women everywhere.

What are the take away messages I'd like to leave with you?

- Don't just accept conventional wisdom. Ask questions, look at problems from different angles, and don't be afraid to challenge mainstream thinking.
- In the search for program and policy solutions, learn to “see” through the eyes of others—through the eyes of women and especially through the eyes of those who are most marginalized.
- Ensure that programs are based on principles of fundamental human rights, equitable access, and respectful, compassionate care and treatment.
- Finally, have the courage to stand up and do what is right, even if it puts your courage to the test.

Thank you.

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