Gender and Health:
A Global Perspective

Anne Monroe, MD
University of Miami/Jackson Memorial Hospital
Miami, Florida
March, 2007

Prepared as part of an education project of the
Global Health Education Consortium
and collaborating partners
Objectives

- Illustrate how gender affects health status
- Describe barriers to women’s health
- Describe the impact of limited sexual and reproductive health services on global health and development
- Understand the role of gender in the global HIV/AIDS epidemic
- Review global development goals related to gender

Gender is a social construct which is an important determinant of health globally. Violation of women’s rights, including violence against women, lack of reproductive and sexual health options for women, and lack of education of women create significant barriers to health. Gender norms have been devastating to women in the HIV/AIDS epidemic, and women are disproportionately affected by the disease, both in rates of infection and social impact. International development and health organizations are addressing gender inequalities and working to improve women’s health status.
Determinants of Health

• A *determinant* is a primary risk factor causally associated with a health problem

• Examples:
  – Genetic predispositions
  – Environmental exposures
  – Behavior patterns (dietary habits, smoking, physical activity)
  – Social circumstances (class, gender)
  – Educational attainment
  – Cultural norms
  – Access to healthcare
Notes on Determinants of Health

Determinant: A determinant is a primary risk factor associated with the level of a health problem.

There are five major determinants of health, i.e., factors which promote or impair individual and community health. Genetic or biologic factors, such as age, sex, race, and genetic susceptibility to disease are innate and, at present, unchangeable. Environmental exposures, such as physical (sunlight), chemical (pollutants) and biologic (exposure to viruses/bacteria) also influence health. Behavior patterns, such as diet, physical activity, and sexual behavior, play a major role in the development of both infectious and chronic diseases. Access to medical care influences both development and outcome of disease, and individuals or communities with limited or difficult access to healthcare fare worse than those with easy access to healthcare. Finally, social circumstances are a major determinant of health. Socioeconomic status and class have a profound impact on health, as people living in poverty do not have the resources necessary to maintain their health.


Social Determinants of Health. [www.who.int/features/factfiles/sdh/01_en.html](http://www.who.int/features/factfiles/sdh/01_en.html)
• In the social sciences, gender emphasizes the social, cultural, or psychological dimensions of being a man or a woman, in contrast to biological sex

• Gender refers to culturally based expectations of the roles, traits, and behaviors of men and women

While poverty is the single most important determinant of health, gender is also of crucial importance. Gender “refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women.” Characteristics that are considered masculine or feminine may help or hinder health. For example, if risk-taking is considered a masculine characteristic, men may be more likely to have accidents or be victims of trauma. If gender norms in a society dictate that women be demure and sexually inexperienced, women may be less likely to seek information about sex or governments may not prioritize sexual education for women.

What do we mean by "sex" and "gender"? http://www.who.int/gender/whatisgender/en/index.html

‘Gender mainstreaming’

• Gender must be considered in all health and development goals

• Development programs must strive for gender equality, i.e., equal life opportunities for men and women

• Development agencies must assess the implications for women and men of any planned action, and ensure that both women's and men's concerns and experiences are considered

• ‘Gender mainstreaming’ refers to efforts to ensure that health care providers know how gender affects health and that they act to address gender issues
Notes on Gender Mainstreaming

The World Health Organization (WHO) has promoted gender mainstreaming as a way to incorporate gender into all aspects of health delivery. Gender mainstreaming promotes knowledge of the ways in which gender affects health, and makes awareness of and responsibility for gender the task of all health professionals. This is crucial in the public health sector to ensure that programs are sensitive to the specific social issues that influence women’s health care needs.


While working towards development goals, gender issues must be addressed early. The following article considers the Millennium Development Goals with emphasis on gender:

‘En-gendering’ the Millennium Development Goals (MDGs) on Health [www.who.int/gender/mainstreaming/MDG.pdf](http://www.who.int/gender/mainstreaming/MDG.pdf)

Barriers to Women’s Health

1) Violence against women

2) Sexual and reproductive health concerns
   - Inadequate services
   - FGM (female genital mutilation)
   - Women and HIV/AIDS

3) Gender inequity
1) Violence Against Women

- A public health and human rights problem throughout the world
WHO multinational study (2005) found that the lifetime prevalence of physical or sexual violence, or both, ranged from 15-71% of women from various urban and rural areas.
Notes on the WHO study.

Violence against women is a public health and human rights problem throughout the world. A 2005 WHO study collected violence data through interviews with over 28,000 women from urban and rural settings in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania.

The study revealed the lifetime prevalence of physical or sexual violence, or both, ranging from 15-71% of women (higher in rural areas). Up to 28% of women interviewed had been beaten during pregnancy. The most commonly perpetrator was a husband/male partner, and the violence was in many cases not formally investigated or punished, stemming from cultural norms that violence should be treated as a private or family matter.

Violence not only affects women by the direct injury, but also indirectly, with women who had ever experienced physical or sexual partner violence, significantly more likely to report poor or very poor health compared with women who had never experienced violence. Partner violence is also linked with mental health problems, emotional distress, and suicidal behavior. The health sector must respond to partner violence with measures to identify abuse early, provide necessary treatment, refer for appropriate care as well as advocacy to change the cultural norms that allow violence against women. A point of entry into the healthcare system for many women is reproductive health services; this provides an opportunity to address issues related to domestic violence. Interestingly, women with unintended pregnancies were more likely to have experienced physical violence than women whose pregnancies were planned.


• Additional WHO study findings:

  – Husband or male partner was the most frequent perpetrator
  – Violence against women is often not formally investigated or punished
  – Partner violence contributes to poor physical and emotional health in women
Barriers to Women’s Health

1) Violence against women

2) Sexual and reproductive health concerns
   - Inadequate services
   - FGM (female genital mutilation)
   - Women and HIV/AIDS

3) Gender inequity
2) Sexual and Reproductive Health Concerns

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

In order to achieve international development goals, reproductive and sexual health services must be available worldwide. Adequate reproductive health services allow women to space pregnancies, with significant social, economic, and health benefits. Reproductive health, as defined at the International Conference on Population and Development in 1994, is “complete mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.”

Components of Sexual and Reproductive Health Care:

- Antenatal, perinatal, postpartum, and newborn care
- High-quality services for family planning, including infertility services
- Elimination of unsafe abortions
- Prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer, and other gynecological morbidities
- Promotion of healthy sexuality
Realities: Reproductive health care

- Poor access to services exists
- UN Population Fund estimates that 120 million women desire contraceptives but lack access to them
- 80 million unintended pregnancies annually, with 45 million ending in abortion
- 19 million abortions are unsafe, with 68,000 deaths annually

Increased access to information and technologies to improve reproductive and sexual health is desperately needed. Unfortunately, politicians do not always take good public health practice into consideration, and conservative governments may reduce reproductive health services, to the detriment of women. The UN Population Fund estimates that 120 million women who wish to access contraception cannot. Lack of reproductive choices increases the number of unintended pregnancies and illegal and/or unsafe abortions. Estimates place the number of unintended pregnancies at 80 million annually, with 45 million ending in abortion, 19 million of those unsafe abortions, with 68,000 deaths annually. Rates of sexually transmitted infections are high, estimated at 340 million new infections annually. Globally, maternal morbidity and mortality remain high, with eight million of the approximately 210 million women who become pregnant in the world suffering life-threatening complications of pregnancy and 529,000 dying in childbirth. Currently, only about 60% of births globally are assisted by a professional attendant, with the percentage dropping as low as 33% in the least developed countries.


Estimated annual unsafe abortions per 1000 women aged 15-44

• There are many negative consequences of poor access to sexual health services:
  – High rates of sexually transmitted infections
  – Unintended pregnancies/inadequate birth spacing
  – Increased maternal morbidity and mortality

• WHO identified unsafe sex as the second greatest risk factor (after underweight) for disease and death in the developing world
World

Disease burden (DALYs) in 2000 attributable to selected leading risk factors

- Underweight
- Unsafe sex
- Blood pressure
- Tobacco
- Alcohol
- Unsafe water, sanitation, and hygiene
- Cholesterol
- Indoor smoke from solid fuels
- Iron deficiency
- High Body Mass Index
- Zinc deficiency
- Fruit and vegetable intake
- Vitamin A deficiency
- Physical inactivity
- Occupational risk factors for injury
- Lead exposure
- Illicit drugs

Number of Disability-Adjusted Life Years (000s)

Source: WHR 2002
FGM (Female Genital Mutilation)

• FGM = removal of part or all of the external genitalia for non-medical reasons
• Over 130 million women worldwide have been subjected to FGM
• FGM has both immediate and delayed adverse effects, including increased peripartum complications

Reproductive and sexual health may be adversely affected by female genital mutilation (FGM), removal of part or all of the external genitalia for non-medical reasons. The practice is common in some regions of Africa and in the Middle East, and it is estimated that 130 million women worldwide have been subjected to FGM, with two million girls at risk. There are significant medical risks associated with the procedure, including severe pain and bleeding, infection risk, scarring, and the possibility that the vagina be will need opened at the time of childbirth.

Increased levels of education decrease the frequency of the practice in certain countries, however social convention, including perceptions that FGM maintains virginity or increases a young woman’s value as a wife, persist. The health dangers of FGM with relation to childbirth have been examined. A study of over 28,000 women recently published in Lancet examined the relationship between female genital mutation and peripartum complications. There was an increased relative risk of caesarian section, postpartum hemorrhage, extended hospital stay, requirement of infant resuscitation, low birthweight, and stillbirth among women who had been subjected to the most drastic forms of FGM.

• FGM is widespread: performed in 28 African countries and in some areas in Asia and the Middle East

• It is a cultural practice, not the mandate of a particular religion

• FGM is typically performed by traditional practitioners, often without anesthesia or clean instruments

• Wealthier members of society sometimes opt to have FGM performed in a hospital setting
Although widely considered a human rights violation and forbidden by law in many countries, FGM continues.

There are many reasons for the continued practice of FGM:
- FGM is thought to decrease sexual drive, desire and/or enjoyment in females in order to ensure chastity until marriage and fidelity in marriage.
- Identification with cultural heritage; initiation of girls into womanhood.
- External genitalia considered dirty and unsightly.
- Purported to enhance fertility and promote child survival.
- Some Muslim communities practice FGM in the belief that it is demanded by the Islamic faith, but FGM predates Islam.

WHO Fact Sheet: Female Genital Mutilation
http://www.who.int/mediacentre/factsheets/fs241/en/

UNICEF Female Genital Mutilation/Cutting http://www.unicef.org/protection/index_genitalmutilation.html
http://en.wikipedia.org/wiki/Female_genital_cutting
(This reference includes a description of legal measures in various countries)
• **Short-term** complications of FGM may include hemorrhage, infection, shock (all of which can cause death), pain, urinary retention, potential for spread of HIV and hepatitis through contaminated tools.

• There are many potential **long-term** consequences of FGM:
  – cyst/abscess formation
  – keloid scars
  – urinary incontinence
  – painful sexual intercourse/sexual dysfunction
  – difficulties with childbirth: caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant

• FGM may also have lasting effects on the psychological health of women.
Gender and HIV/AIDS

• HIV/AIDS disproportionately affects women in the developing world

• In Sub-Saharan Africa
  – Women comprise 59% of adults living with HIV
  – Women ages 15-24 account for 75% of all young people infected

Fifty percent of HIV infections globally are in women, with the majority of infections occurring as the result of heterosexual sex. In Sub-Saharan Africa, the region hardest hit by the AIDS epidemic overall, there are twelve to thirteen women infected for every ten infected men. In addition, young women account for 75% of all HIV infected young people (ages 15-24) in that region. Biologically, it is easier for a male to transmit HIV to a female, as there is more mucosal area in the vagina which increases ease of transmission.

AIDS epidemic update. UNAIDS.
Social and cultural norms are devastating to women’s ability to protect themselves from HIV:

- Forced sex
- Men with multiple sex partners
- Older men in relationships with younger women
- Belief that women should be ignorant about sex
- Most HIV prevention methods are male-dependent (condoms, withdrawal, abstinence)
- Poor women may be obliged to sell sex to support themselves and their children and often cannot negotiate safer sexual encounters
- Women and girls are more frequently victims of trafficking and sexual slavery
Notes on Social and cultural norms

Gender norms rather than biology fuel the AIDS epidemic. These norms include the acceptance of men having multiple sex partners and older men having relationships with younger women, particularly virgins. Social acceptance of intimate partner violence and rape also contributes to HIV infection. In male-dominated societies, men control women’s access to healthcare, making it difficult for women to obtain prevention and treatment services. Furthermore, our current methods of HIV prevention, condoms and abstinence, are male-dependent, making it nearly impossible for women to protect themselves against infection. If within a given culture it is felt that a women’s place is in the home, and that only men should be active outside of the home, women will have limited access to productive resources, with resulting poverty if a woman is not married. Poverty increases the danger of HIV infection, especially if women must sell sex in order to provide for themselves or their children. Finally, the social stigma and fear of abandonment with and HIV diagnosis are great, which may prevent women from seeking voluntary testing and counseling and HIV treatment.

• HIV/AIDS has wide-ranging effects on women:
  – Women fear abandonment if HIV-infected status is known
  – Men control women’s access to health care
  – Women are caretakers for the ill and HIV orphans

• HIV prevention efforts are crucial to curb the epidemic
• Women-controlled methods of HIV and/or fertility prevention are currently under development and in field trials:
  – Female condoms (available)
  – Cervical barriers (available)
  – Microbicides (in development)

• Improving access to services to prevent mother-to-child transmission of HIV is also a priority
• Female condom:
  – Provides protection against both HIV and unwanted pregnancy
  – Obstacles to use have included negative perceptions of barrier methods, cost, provider bias, and lack of support for large-scale programs

Global Campaign for Microbicides: Female Condom
http://www.global-campaign.org/female-condom.htm
• Cervical Barriers:
  – The target cells for HIV, including CD4 cells, are found more frequently on the cervix than throughout the rest of the vagina
  – A physical barrier covering the cervix may decrease risk of HIV transmission; more research is required
  – Options include diaphragm, cervical cap

Global Campaign for Microbicides: Cervical Barriers
http://www.global-campaign.org/barriers.htm
• Microbicides:

  – Physical or chemical barriers to HIV infection which can be used by a woman without the knowledge or consent of her partner

To combat HIV infection in women, microbicides, which are physical or chemical barriers to HIV infection which can be used by a woman without the knowledge or consent of her partner, have been developed and are currently in clinical trials. However, it is unclear if the women who need microbicides the most (poor women in the developing world) will have ready access to them, and continued advocacy is required.

About Microbicides. [http://www.global-campaign.org/about_microbicides.htm](http://www.global-campaign.org/about_microbicides.htm)
• Preventing Mother to Child Transmission of HIV:

  – Over one-half million children under age 15 acquired HIV in 2006, most through mother-to-child transmission of HIV
  – Without Prevention of Mother to Child Transmission (PMTCT) services, about one-third of infants born to HIV positive mothers will acquire HIV
  – This rate can be decreased dramatically (transmission rate less than 2%) with comprehensive PMTCT services
  – PMTCT is available to only 5% of women in need in Africa
Notes to: Preventing Mother to Child Transmission of HIV

About 530,000 children under fifteen years were infected with HIV in 2006, most through mother to child transmission (MTCT) of HIV. The medical community has known how to prevent MTCT of HIV since the trials of AZT in pregnancy in 1994 (ACTG 076), however, in 2003 only 5% of HIV-infected women in Africa were offered services to prevent MTCT. As antiretroviral therapy becomes more widely available in resource-poor settings and more women achieve virologic control and immune reconstitution, there will be less transmission from mother to child at birth and through breastmilk. However, women must have access to antiretroviral drugs and must have access to clean water and affordable formula if they choose to not to breastfeed.


Components of comprehensive PMTCT programs:

- Voluntary counseling and testing for HIV during pregnancy
- Comprehensive antenatal care
- Providing short-course antiretroviral therapy to mother and newborn
- Counseling on infant feeding
- Intrapartum and postnatal care
Barriers to implementation of PMTCT vary but may include:

- Poverty (even if services are free, travel expenses may be prohibitive)
- Poor infrastructure (poor roads, difficultly obtaining clean water, etc)
- Difficulty training already overextended reproductive health personnel to provide PMTCT
- Poor knowledge of HIV transmission, including mothers unaware that HIV may be transmitted through breastmilk
- Need rapid HIV testing for immediate provision of services – lost to follow up rate is high
- Need education and involvement of the women’s partners
- Babies who are delivered at home do not receive full services
Notes to: Barriers to implementation of PMTCT

Women cannot space pregnancies; detriment to their social/economic situations

Increases number of illegal/unsafe abortions performed

PMTCT (no formula available), limited access to healthcare system


Bajunirwe F and Muzorra M. Barriers to the implementation of programs for the prevention of mother-to-child transmission of HIV: A cross sectional survey in rural and urban Uganda. AIDS Research and Therapy. 2005, 2:10.
• Of 20 infants born to HIV infected mothers without any PMTCT services, up to 7 will acquire HIV infection; 4 during pregnancy or delivery and 1-3 with breast feeding
Components of PMTCT: Providing antiretroviral therapy to mother and newborn

- Women who meet WHO clinical guidelines for ARV therapy should be treated regardless of pregnancy status
- Pregnant women who do not meet clinical criteria for ARV therapy or who do not have therapy available should be offered a regimen for PMTCT


• Regimens:
  
  – Optimal PMTCT regimen is Zidovudine (AZT, Retrovir) from 28 weeks of pregnancy + single-dose nevirapine (Viramune) during labor AND single-dose nevirapine and one week AZT for infant
  
  – Even if this optimal course is not available, treatment at the time of labor and delivery may still have an effect on decreasing transmission
Alternate regimens have been studied:
- AZT (zidovudine) alone
- AZT together with 3TC (lamivudine)
- Nevirapine alone (single dose for mother and infant)
- AZT plus single-dose maternal and infant nevirapine
- AZT and 3TC plus single-dose maternal and infant nevirapine

Choice of therapy made based on effectiveness of therapy, safety (including concerns about resistance), and capacity of health system to deliver therapy.
• **Components of PMTCT:** Counseling regarding alternatives to breast milk (replacement feeding) to prevent HIV transmission

• **Methods of Replacement Feeding**
  – Commercial infant formula prepared with sterilized water
  – Home-modified animal milk (boiled, with sugar and micronutrients added)
  – Wet-nursing by HIV-negative woman
  – Express and heat-treat breast milk
  – Breast-milk banks


• Methods of replacement feedings must be:

  – **Acceptable** (no cultural or social barriers, no fear of stigma or discrimination)
  – **Feasible** (adequate time, knowledge, skills for sufficient feedings)
  – **Affordable** (the family – with community support if available – can absorb the cost of all food/equipment)
  – **Sustainable** (replacement feeding is available as long as infant needs it)
  – **Safe** (hygienic preparation and storage)

• Otherwise, UNICEF and WHO recommend exclusive breastfeeding during the first months of life
• Lack of breastfeeding confers increased risk of malnutrition, diarrheal illnesses and respiratory infections for the newborn

• In addition, women who do not breastfeed are more likely to become pregnant again too soon
Major barriers to women’s health

1) Violence against women

2) Sexual and reproductive health concerns
   - Inadequate services
   - FGM
   - Women and HIV/AIDS

3) Gender inequity
International Responses to Gender Inequity

• Objectives from the UN’s First World Conference on Women in 1975
  – Full gender equality and the elimination of gender discrimination
  – The integration and full participation of women in development
  – An increased contribution by women towards strengthening world peace

• An international bill of rights for women, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), was adopted by UN General Assembly in 1979, the United States government has still not ratified CEDAW
International Responses to Gender Inequity

• Fourth World Conference, Beijing, 1995, resulting in the Beijing Declaration

  – Overarching goal: Advance the goals of equality, development and peace for all women everywhere in the interest of all humanity
International Responses to Gender Inequity

- Beijing Conference Platform for Action identified 12 critical areas:
  - Disproportionate effect of poverty on women
  - Unequal access to education and training
  - Unequal access to health care and related services
  - Violence against women
  - Effects of armed or other kinds of conflict on women
  - Inequality in economic structures and policies, in all forms of productive activities and in access to resources
  - Inequality in the sharing of power and decision-making at all levels
  - Insufficient mechanisms at all levels to promote the advancement of women
  - Lack of respect for and inadequate promotion and protection of the human rights of women
  - Stereotyping of women and inequality in women's access to and participation in all communication systems, especially in the media
  - Gender inequalities in the management of natural resources and in the safeguarding of the environment
  - Persistent discrimination against and violation of the rights of the girl child
• Subsequent Beijing + 5 (years) and Beijing + 10 (years) conferences have reaffirmed global commitment to the platform of action

• They have also targeted specific issues, e.g. creation of non-discriminatory, gender sensitive legal environments, ending the trafficking of women and girls, and reversing the AIDS epidemic
WHO Millennium Development Goals

- Announced in 2002 with the overarching aim of freedom from want for every man, woman, and child
- Targets to achieve by 2015
  - Halving extreme poverty
  - Halting spread of HIV/AIDS
  - Universal primary education

The aim of the UN Millennium Development Goals is freedom from want for every man, woman, and child. Three of the eight goals are specific to women: Goal 3, to promote gender equality and empower women, and Goals 4 and 5, to reduce child mortality and improve maternal health. Other goals can also be evaluated with gender concerns incorporated. For example, Goal 2, universal primary education is extremely important to achieve gender equality. Goal 6, to combat HIV/AIDS, malaria and other diseases is of crucial importance to women’s health. Goal 7, to ensure environmental sustainability, is also important for women. Many households use solid fuels, such as wood smoke, rather than sustainable methods. Women are more likely to be at home, inhaling the smoke, which can have serious health effects.

The World Health Organization (WHO) has promoted gender mainstreaming as a way to incorporate gender into all aspects of health delivery. Gender mainstreaming promotes knowledge of the ways in which gender affects health, and makes awareness of and responsibility for gender the task of all health professionals. This is crucial in the public health sector to ensure that all programs are sensitive to the specific social issues that influence women’s health care needs.


There are eight goals, three of which are specific to women:

- Goal #3: Promote gender equality and empower women
- Goal #4: Reduce child mortality
- Goal #5: Improve maternal health
Working towards the MDGs

Goal #3: Promote gender equality and empower women

• Progress towards gender equality can be evaluated by monitoring women’s participation in the labor and political arenas
• 2006 MDG Report: Women are increasingly involved in the labor market
• Continued barriers:
  – Difficulty obtaining jobs in the formal market
  – Closely spaced births
  – Lack of child care options


More countries have laws banning domestic violence, says UN women’s rights official. UN News Service, November 2006.
• Women’s participation in politics is increasing, with women holding a larger percentage of parliamentary seats worldwide (12% in 1990, 17% in 2006)

• 95 countries have now implemented either mandatory or voluntary measures to increase women’s political participation

• Progress towards gender equity: targeting domestic violence

• Legal protections: 89 countries with provisions against domestic violence, 60 with specific laws (up from 45 in 2003)

• Continued attention to education of society and police force, and funding for enforcement, is required
Goal #4: Reduce child mortality

• The under-five mortality rate in developing areas has decreased from 106/1000 live births in 1990 to 87/1000 live births in 2004

• Structural interventions to provide: clean water, immunization with clean needles, adequate food, mosquito control
  – These measures benefit the entire community and raise life expectancy
Goal #5: Improve maternal health

- The number of births assisted by skilled birth attendants has significantly increased in several regions: Eastern and South-Eastern Asia and Northern Africa

- Sub-Saharan Africa and Southern Asia have persistently high maternal mortality rates

- Gaps remain between services available to urban and rural women and rich and poor women in the developing world

In order to attain the goal of improved health for women around the world, existing mechanisms of health care delivery must be strengthened and expanded. Public health professionals can promote women’s health by implementing specific health initiatives for women, however, they must also address social forces that promote gender inequality to have a sustained impact. A primary concern for the public health sector is ending partner violence, which causes serious health effects as well as contributing to the subordination of women. The importance of gender as a determinant of health must always be considered as the public health sector works to achieve the Millennium Development Goals.
Conclusion

• To achieve improved health for women around the world, we must strengthen and expand existing mechanisms of health care delivery and work towards gender equity


Conclusion

• Practical aspects include:
  
  – Create sustainable programs and build health care capabilities; increase the number of health care workers
  
  – Focus on basic maternal and child health and essential public health services; disease-specific programs may channel money to achieve certain goals to the detriment of other health markers
  
  – Always consider and address women’s concerns in health and development projects
Credits

Anne Monroe, M.D.
UM/Jackson Memorial Hospital
1611 NW 12th Ave, Rm Central 610
Miami, FL 33136
annekmonroe@yahoo.com

• Material for this presentation was originally submitted as coursework for the School of Public Health UM/Miller School of Medicine
  • Special thanks to Drs. Stephen Symes and Thomas Hall
The Global Health Education Consortium gratefully acknowledges the support provided for developing these teaching modules from:

Margaret Kendrick Blodgett Foundation
The Josiah Macy, Jr. Foundation
Arnold P. Gold Foundation

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 United States License.