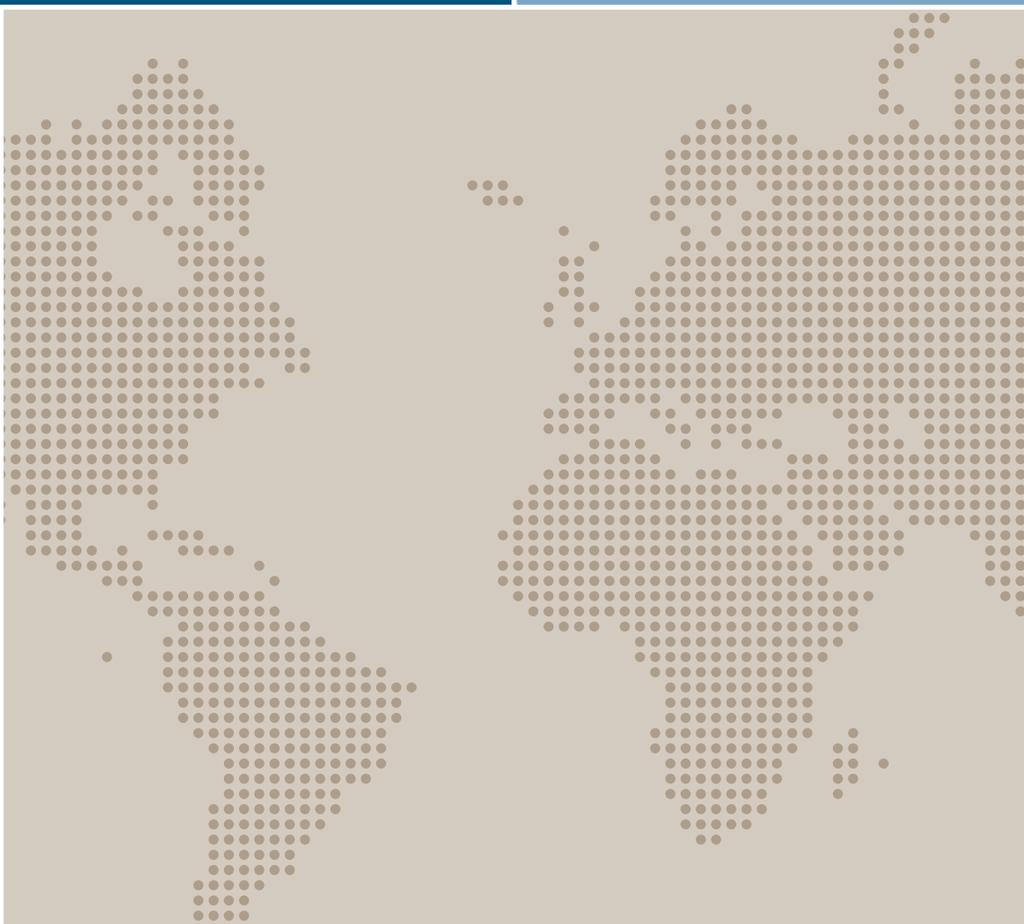


# Making Gender a Global Health Priority

A Report of the CSIS Global Health Policy Center

AUTHOR  
Janet Fleischman

November 2009



# Making Gender a Global Health Priority

A Report of the CSIS Global Health Policy Center

AUTHOR

Janet Fleischman

November 2009

## About CSIS

In an era of ever-changing global opportunities and challenges, the Center for Strategic and International Studies (CSIS) provides strategic insights and practical policy solutions to decisionmakers. CSIS conducts research and analysis and develops policy initiatives that look into the future and anticipate change.

Founded by David M. Abshire and Admiral Arleigh Burke at the height of the Cold War, CSIS was dedicated to the simple but urgent goal of finding ways for America to survive as a nation and prosper as a people. Since 1962, CSIS has grown to become one of the world's preeminent public policy institutions.

Today, CSIS is a bipartisan, nonprofit organization headquartered in Washington, DC. More than 220 full-time staff and a large network of affiliated scholars focus their expertise on defense and security; on the world's regions and the unique challenges inherent to them; and on the issues that know no boundary in an increasingly connected world.

Former U.S. senator Sam Nunn became chairman of the CSIS Board of Trustees in 1999, and John J. Hamre has led CSIS as its president and chief executive officer since 2000.

CSIS does not take specific policy positions; accordingly, all views expressed herein should be understood to be solely those of the author(s).

© 2009 by the Center for Strategic and International Studies. All rights reserved.

Center for Strategic and International Studies  
1800 K Street, NW, Washington, DC 20006  
Tel: (202) 775-3119  
Fax: (202) 775-3199  
Web: [www.csis.org](http://www.csis.org)



## MAKING GENDER A GLOBAL HEALTH PRIORITY

*Janet Fleischman*<sup>1</sup>

The world faces enormous challenges in the global health arena, many of which have a disproportionate impact on women and girls. Many key global health priorities revolve in fundamental ways around the gender-related barriers that women and girls face in accessing health-related information, services, and resources, all of which increase their vulnerability to ill health. For success and sustainability, the United States should anchor its global health strategy in a firm commitment to address the gender disparities that affect global health outcomes.

The United States has a compelling, strategic interest in making gender equity in access a key global health objective.<sup>2</sup> Indeed, investing in women's health is a critical component of a "smart power" global health strategy. With both President Barack Obama and Secretary of State Hillary Clinton committing publicly to making women's health issues a priority area in the new Global Health Initiative as well as in foreign policy, this is truly a historic moment. The administration should seize this opportunity to elevate and institutionalize gender equity as a global health priority for the United States by requiring that a "gender lens" be applied to the design and implementation of all U.S. global health programs. (*See the text box "What Is a Gender Lens?"*) Such an approach will have far-reaching implications, including empowering U.S. government in-country teams, program priorities, monitoring and evaluation systems, financial allocations, and diplomatic engagement. The current global financial crisis only heightens the urgency for

---

<sup>1</sup> The CSIS Global Health Policy Center commissioned this paper from Janet Fleischman, senior associate at the Global Health Policy Center. It is based on research and interviews conducted with numerous individuals involved in U.S. global health policy as well as in gender issues.

<sup>2</sup> The definition of gender has sometimes been a barrier to action, with some assuming that gender refers only to women and girls, while others use a broader definition to include male norms and sexual minorities. Although this paper focuses on women and girls, the author recognizes that gender encompasses "widely held beliefs, expectations, customs and practices within a society that define 'masculine' and 'feminine' attributes, behaviors and roles and responsibilities," and, as such, gender is a key factor in determining one's vulnerability to many global health concerns. See UNAIDS, "Gender," <http://www.unaids.org/en/PolicyAndPractice/Gender/default.asp>.

such a strategy, as women and girls—often the poorest and most vulnerable members of societies—are likely to be hit hardest by the effects of the economic turbulence.

This report proposes that a gender-focused approach to global health build on four cornerstones: (1) maternal child health and family planning, (2) infectious diseases that disproportionately affect women, (3) gender-based violence, and (4) food security. These areas are clearly linked and underscore the importance of an integrated, comprehensive global health policy. To operationalize this approach, the report focuses on three key recommendations for the Obama administration:

- require a gender lens in program design and implementation,
- support capacity strengthening and resource mobilization, and
- coordinate among U.S. government agencies and promote U.S. global leadership.

### What Is a Gender Lens?

A *gender lens* means paying special attention to the gender-related vulnerabilities and disparities that affect global health outcomes. The goal of using a gender lens is to recognize and address the gender dynamics that contribute to risk, exposure, and vulnerability. Using a gender lens allows program staff to identify gender barriers that exacerbate women's and girls' vulnerabilities to ill health and to implement specific gender strategies designed to reduce barriers that women and girls face in accessing health-related information, services, and resources. A gender lens involves critically examining a range of issues, from the engagement of men and boys to the reasons why women are unable to access family planning services. Examination of these issues requires collection of better data on women's agency, involving questions such as family size, fertility intentions, power structures, access, and household decision-making. To appropriately address gender disparities, health programs must incorporate specific strategies during the design, implementation, and evaluation of interventions.

The report attempts to capture what is at stake in making gender a global health priority and to present a viable approach for implementation. It also raises some key questions that will need to be answered, notably

- how to define goals;
- how to prioritize investments;
- how to pick the places to implement the strategy; and
- how to measure progress.

The answers to these four questions will inform the structure and scale of a gender-focused strategy. In some cases, the strategy will have to address political, cultural, or religious barriers presented by partner governments or religious institutions, which may not necessarily embrace these goals on gender equity.<sup>3</sup> This highlights the importance of working with national governments and civil society organizations to ensure country ownership of programs.

## New Directions from the Obama Administration

*“We cannot simply confront individual preventable illnesses in isolation. The world is interconnected, and that demands an integrated approach to global health.”<sup>4</sup>*

— President Barack Obama

The issues faced by women and girls around the world have gained new prominence in the Obama administration, including the creation of the post of ambassador-at-large for Global Women’s Issues and a new White House Council on Women and Girls. Secretary of State Clinton herself has long been an advocate for women and children and has used her platform as secretary of state to make the case that women’s health and empowerment are critical national security issues.<sup>5</sup> The administration’s new Global Health Initiative has identified the need to address women’s health needs as one of its pillars. The issues of women and girls worldwide are also being taken up by a new Senate Foreign Relations Subcommittee on International Operations and Organizations, Human Rights, Democracy, and Global Women’s Issues, chaired by Senator Barbara Boxer, and many women’s advocacy groups, nongovernmental organizations, and U.S. policy think tanks are actively engaged in this agenda. Taken together, the growing momentum on the issues of women and girls within the U.S. context makes this an unprecedented moment to develop a new approach to global health that recognizes the centrality of women and girls and breaks down the barriers they face in accessing health-related services.

The Obama administration has undertaken a number of steps related to global health that could have a significant impact on how a gender lens is incorporated into global health programs. In

---

<sup>3</sup> An example of the cultural and religious barriers relating to health services for women involves Ethiopia, where there is a serious lack of rural health infrastructure and little priority attached to family planning by either the Ethiopian government or the U.S. government. This is despite the fact that Ethiopia’s population doubled between 1983 and 2009, rising from 42 million to 83–85 million; that a significant proportion of the population is malnourished; and that survey data show high demand for family planning services among women. The recent deployment of 30,000 health extension workers—virtually all women—to 15,000 communities raises hope that maternal and newborn health may improve, but there is still deep cultural and religious resistance to family planning.

<sup>4</sup> The White House, “Statement by the President on Global Health Initiative,” May 5, 2009, [http://www.whitehouse.gov/the\\_press\\_office/Statement-by-the-President-on-Global-Health-Initiative/](http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/).

<sup>5</sup> Mark Landler, “Hillary Clinton Talks about the Obama Administration’s Plans to Push Women’s Rights Issues on the International Stage,” *New York Times Magazine*, August 23, 2009, pp. 42–43.

May 2009, the administration announced its new Global Health Initiative, a \$63 billion program over six years. A pillar of this initiative is women-centered care, including maternal and child health and family planning. In July, the administration announced a new global food security initiative focusing on agricultural development, committing \$20 billion over three years. Although the details of this initiative are still emerging, Secretary Clinton stated in September that women would be "at the heart of the U.S. government's food security initiative."<sup>6</sup> In August 2009, Secretary Clinton highlighted the tragedy of sexual violence, announcing \$17 million to prevent and respond to gender and sexual violence in the Democratic Republic of Congo (DRC).<sup>7</sup>

To meet these challenges, the United States will have to demonstrate high-level leadership to ensure that U.S. global health programs devote specific attention to gender in program design and implementation both by integrating gender into global health programs and by identifying specific gender-related program areas. This will require a range of initiatives, such as involvement of the Office of Global Women's Issues in program development and granting it oversight authority; a requirement for gender analyses of global health programs with clear goals and indicators; and an initiative to identify three to four countries where a gender-focused global health strategy can be operationalized to create one or more models for success. An essential element of this approach will be to involve those with gender expertise as well as women in the affected communities in the design, implementation, measurement, and evaluation processes.

## Past U.S. Policy on Gender Equity and Global Health

The United States has long been a leader in the global health arena, both financially and technically. Yet gender equity has not been an explicit priority concern in U.S. global health programs. For example, U.S. funding for maternal health, child survival, and reproductive health was essentially flatlined between 1998 and 2007, and the Women in Development (WID) Office at the United States Agency for International Development (USAID) saw its funding reduced from \$11 million in FY05 to \$7.7 million in FY09, although USAID also employs gender advisers in regions and missions. While maternal and child health (MCH) funding appropriated by Congress has begun to increase, it has not kept pace with increases in overall U.S. global health funding.<sup>8</sup> At

---

<sup>6</sup> Kaiser Daily Global Health Policy Report, "Secretary of State Clinton Announces Food Security Initiative," September 28, 2009, <http://globalhealth.kff.org/Daily-Reports/2009/September/28/GH-092809-US-Food-Initiative-CGI.aspx>.

<sup>7</sup> This funding, which was part of the Supplemental Appropriations bill passed by Congress, focused on training for health care workers in complex fistula repair, medical care, counseling, economic assistance, and legal support, as well as recruiting and training police officers, particularly women, to investigate sexual violence.

<sup>8</sup> Kaiser Family Foundation, "Fact Sheet: The U.S. and Global Maternal & Child Health," August 2009, <http://www.kff.org/globalhealth/upload/7963.pdf>.

this writing, President Obama has requested increases for MCH, but the final FY 2010 budget figures have not been determined.<sup>9</sup>

In the last two years, Congress has asserted leadership on the issue of integrating women and girls into health and development programs in the annual appropriations process. For example, Section 7062 of the FY 2010 appropriations bill, called “Women in Development,” requires programs to integrate gender equity issues into their programming, where appropriate, in the planning, assessment, implementation, and monitoring and evaluation of such programs.<sup>10</sup> It also directs USAID to report on the steps taken to integrate gender considerations into economic development and to describe current and future programming to promote women’s economic opportunities.<sup>11</sup>

U.S. policy documents explicitly acknowledge the importance of gender to U.S. global health programs, although the policy aspirations have not been sufficiently linked to program design, implementation, and outcomes. USAID, for example, has incorporated gender issues into its Automated Directive System (ADS), the agency’s official guidance on policies and operating procedures. The ADS requires that gender issues be articulated in the activity approval documents to ensure that critical issues and obstacles are outlined and incorporated into USAID Requests for Applications (RFAs), Requests for Proposals (RFPs), and Annual Program Statements (APs), as well as into project activities and outcomes. This gender analysis is supposed to describe how gender roles, norms, and resources within a community affect men’s and women’s health and social outcomes. With the new administration, combined with advocacy from women’s organizations, a revision of the ADS utilizing stronger requirements on gender integration has been proposed and may be approved shortly.

---

<sup>9</sup> This budget request represents an increase from the \$495 million that was enacted in FY09, and up from the \$369.5 million requested in FY09 by President George W. Bush. In July 2009, both houses of Congress took action that could increase spending even further, with the House appropriations bill calling for \$538 million and the Senate bill calling for \$555 million. See Global Health Council, “U.S. Investments in Global Health: An Analysis of the President’s Fiscal Year 2010 Budget Request,” June 2009. For family planning, the president has requested \$475 million, an increase of \$20 million, for FY 2010, and an increase from President Bush’s last budget request of \$302 million. The full House bill would increase funding to \$588 plus \$60 million for the United Nations Population Fund (UNFPA), and the Senate approved \$578 million for family planning, plus \$50 million for UNFPA.

<sup>10</sup> Library of Congress, Thomas, “S.1434, Department of State, Foreign Operations, and Related Programs Appropriations Act, 2010,” <http://thomas.loc.gov/cgi-bin/query/F?c111:1:./temp/~c111IjgP1X:e201982>.

<sup>11</sup> Library of Congress, Thomas, “House Report 111-187 – State, Foreign Operations, and Related Programs Appropriations Act, 2010,” [http://rs9.loc.gov/cgi-bin/cpquery/?&sid=cp111DGdGa&refer=&r\\_n=hr187.111&db\\_id=111&item=&sel=TOC\\_172780&](http://rs9.loc.gov/cgi-bin/cpquery/?&sid=cp111DGdGa&refer=&r_n=hr187.111&db_id=111&item=&sel=TOC_172780&).

In 1997, USAID created an Interagency Gender Working Group (IGWG) tasked with providing guidance to promote gender equity within family planning, health, and nutrition programs.<sup>12</sup> The IGWG is a collaborative, interagency network involving USAID, NGOs, advocacy groups, and researchers interested in integrating gender into the population and reproductive health work of the USAID's bureau for global health.

These past steps at USAID have had relatively modest impact; the gender analysis required in the ADS process has not been consistently reflected in the agency's RFPs/RFAs, and no mechanism is in place for monitoring or reporting on agency compliance with these requirements. Although the IGWG and other parts of USAID have developed guidelines for USAID projects and staff in the Global Health Bureau on how to use the ADS and to give the gender requirements greater traction, the issue has yet to be prioritized by the agency. This will require USAID to raise awareness about the gender requirements among its staff in Washington and in the country offices, to provide them the tools to operationalize the guidelines, and to commit the financial and human resources required to train the staff— including procurement officers— who are responsible for the writing of RFPs and RFAs and for the evaluation of incoming proposals. Most importantly, USAID's global health programs will have to develop and implement gender strategies, with the clear goals and indicators to track progress. USAID should make gender equity one of its strategic objectives, which would require all parts of the agency to report on their work in that area.

Applying a gender lens would require U.S. programs to critically examine a range of issues, from the engagement of men and boys, to the reasons why women are unable to access family planning services. Results of the examinations would then lead to questions of knowledge, access, and decision-making power (e.g., whether such power resides with men, mothers-in-law, or others). Adequate examination of these issues would also require collection of better data on women's agency involving issues such as family size, fertility intentions, power structures, access, and household decision-making. Issues such as gender-based violence (GBV), which can have an enormous impact on health programs, have not been integrated into other health programs because gender is seen as an independent stream, rather than as an integral part of global health strategies. Even basic health interventions—such as childhood immunizations, nutritional supplements, and insecticide-treated bed nets (ITNs) for malaria prevention—often fail to recognize the gender dynamics that contribute to risk, exposure, and vulnerability.

The President's Malaria Initiative (PMI), a \$1.2 billion, five-year program that began in 2006, was designed to reduce malaria-related deaths by 50 percent in 15 countries in sub-Saharan Africa with a high burden of malaria.<sup>13</sup> Though its guidance is gender neutral, PMI has focused

---

<sup>12</sup> USAID, "Gender Issues," [http://www.usaid.gov/our\\_work/global\\_health/pop/techareas/gender/](http://www.usaid.gov/our_work/global_health/pop/techareas/gender/).

<sup>13</sup> USAID, "The President's Malaria Initiative: Working with Communities to Save Lives in Africa," Third Annual Report, March 2009, p. 2.

considerable activity on maternal child health issues, given the vulnerability of pregnant women and children to malaria. Its targets include ensuring that 85 percent of pregnant women and children under five will have slept under an ITN the previous night or in a house that has been sprayed with indoor residual spraying (IRS) in the last six months. While PMI recognizes that gender-related barriers may impede women's access to malaria services, there are no gender experts within PMI and no specific guidance to help the initiative address these issues.

The largest U.S. program ever dedicated to one disease is the President's Emergency Plan for AIDS Relief, known as PEPFAR. PEPFAR has made some progress in integrating gender into its programs, assisted by the gender language in the authorizing legislation.<sup>14</sup> Although PEPFAR did not consider gender to be a priority issue during its initial start-up, it soon became apparent that reaching its goals on prevention, care, and treatment and ensuring the quality of programs and services would require addressing the gender dimension of the HIV pandemic. Accordingly, the Office of the Global AIDS Coordinator (OGAC) increasingly articulated a commitment to gender issues and adopted five gender strategies as essential to AIDS outcomes:

- increasing gender equity,
- addressing male norms,
- reducing violence and sexual coercion,
- increasing women's legal protection, and
- increasing women's access to income and productive resources.<sup>15</sup>

Although PEPFAR still has far to go in ensuring adequate gender-related programming, its model of developing gender strategies can be built upon by other U.S. global health areas.

---

<sup>14</sup> The legislation creating PEPFAR, the U.S. Leadership against HIV/AIDS, TB and Malaria Act, required PEPFAR to report on its specific strategies for women, including the empowerment of women in interpersonal situations, young people, and children (OVCs and victims of the sex trade, rape, sexual abuse, and exploitation), and increasing women's access to employment, income, and productive resources. The legislation creating PEPFAR II expanded on these requirements, including greater emphasis on women and girls, particularly related to PMTCT and families, and it adds language about gender and gender-related vulnerabilities to HIV. See Henry J. Kaiser Family Foundation, "Reauthorization of PEPFAR, the United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act: A Side-by-Side Comparison to Current Law," <http://www.kff.org/hivaids/upload/7799.pdf>.

<sup>15</sup> The United States President's Emergency Plan for AIDS Relief, "Responding to Critical Issues: Gender and AIDS," <http://www.pepfar.gov/pepfar/press/81164.htm>.

## Maternal and Child Health/Family Planning

*“By saving these women, we save not only a mother—but perhaps, the whole family. The mother is the central figure in maintaining the health of her family. The newborn’s life is far more secure if his mother is also alive, as are the lives of her other young children. We must ensure ‘the continuum of care’ links care from the mother to that of her newborn and young children under five.”*

— Dr. Francisco Songane<sup>16</sup>

Of the estimated 536,000 women who die each year from pregnancy-related causes, 99 percent live in the developing world.<sup>17</sup> Sub-Saharan Africa and South Asia account for the majority of those deaths, and underscore the links between maternal mortality and poverty, poor access to health care, and gender inequities. The numbers—and contrasts—are stark: women in sub-Saharan Africa face a 1 in 6 risk of dying during pregnancy or childbirth; women in South Asia face a 1 in 43 risk; and women in Sweden face a 1 in 30,000 risk.<sup>18</sup> The fact that rates of maternal mortality have remained essentially unchanged for 20 years shows how little progress has been made in this area and how important it is for a gender approach to be integrated into both community-level care and strengthened health systems.

Rates of maternal mortality are not likely to be reduced unless women have access to adequate emergency obstetric care<sup>19</sup> and to a continuum of care from the home to the hospital. In the area of maternal mortality, the gender-related obstacles to health care have been described as the “three delays”: delay in decisions to seek treatment (depending on the decision-makers in the family); delay in reaching health facilities (including travel time and cost of transportation); and delay in receiving treatment (including shortages of equipment and trained personnel).<sup>20</sup> All of these delays have strong gender-related components that can circumscribe a woman’s or girl’s

---

<sup>16</sup> Dr. Francisco Songane, director of the Partnership for Maternal, Newborn and Child Health, at the Lancet Maternal Series Launch, September 27, 2006, [http://www.who.int/pmnch/media/pmnch.in.the.press/Songane\\_speech\\_lancetmaternal.pdf](http://www.who.int/pmnch/media/pmnch.in.the.press/Songane_speech_lancetmaternal.pdf).

<sup>17</sup> See World Health Organization (WHO), “Maternal Mortality,” [http://www.who.int/making\\_pregnancy\\_safer/topics/maternal\\_mortality/en/index.html](http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html). According to WHO, more than half of maternal deaths occur in sub-Saharan Africa and one-third in South Asia. In developing regions the maternal mortality rate (MMR) is 450 maternal deaths per 100,000 live births, compared to 9 in developed regions. A total of 14 countries—Afghanistan, and the rest in sub-Saharan Africa—have MMRs of at least 1,000.

<sup>18</sup> London School of Hygiene and Tropical Medicine, “Call for Global Action over Continued Huge Burden of Maternal Deaths in Poor Countries,” September 2006, <http://www.lshtm.ac.uk/news/2006/maternaldeaths.html>.

<sup>19</sup> Margaret Chan, “Progress in Achieving the Millennium Development Goals: Have We Reached an Impasse?” speech in Copenhagen, Denmark, April 10, 2007, [http://www.who.int/dg/speeches/2007/100407\\_mdg/en/index.html](http://www.who.int/dg/speeches/2007/100407_mdg/en/index.html).

<sup>20</sup> Sreen Thaddeus and Deborah Maine, “Too Far to Walk: Maternal Mortality in Context,” *Social Science and Medicine* 38 (8): 1091-1110.

ability to travel to receive health care and can determine whether the family will pay for her treatment. Given that 80 percent of births take place at home in South Asia and Africa, these are essential issues facing women and girls.

Child survival is closely linked to maternal health, as the health of the mother has a profound effect on infant and child survival, as well as on the child's future well-being, especially for girls. Appropriate care for the mother before, during, and after delivery could prevent most maternal and newborn deaths. According to UNICEF, about three-quarters of neonatal deaths occur in the first week of life, and most of these could be prevented if the mother received appropriate care during pregnancy and childbirth.<sup>21</sup> The solutions include access to skilled birth attendants as well as to information about birth spacing, breastfeeding, and family planning. Maternal illness and death have an enormous impact on the household, in terms of both loss of income and other economic contributions and the broader social stresses.<sup>22</sup> Growing numbers of children are also excluded from care because their mothers are dying of AIDS.

Ensuring access to voluntary family planning information and services is a critical way to address maternal and infant mortality and to improve family health. Family planning programs help equip women and men around the world to make informed decisions about the number and spacing of their children—decisions that have a direct impact on key global health outcomes. Most experts agree that providing women with adequate access to family planning could help significantly to cut maternal mortality.<sup>23</sup>

The “unmet need” for family planning refers to women or couples who would prefer to avoid or postpone a pregnancy but are not using any effective contraceptive method. It is estimated that more than 200 million women would like to limit and/or space their children but do not use contraceptives. Many gender-related factors contribute to unmet need, including women's access to services, level of education, access to and control over economic resources, geographic location (rural versus urban), and degree of women's autonomy, with poor women in developing countries being least likely to have access to family planning services.<sup>24</sup>

---

<sup>21</sup> UNICEF, “State of the World's Children, 2009,” p. 2-3, <http://www.unicef.org/sowc09/docs/SOWC09-FullReport-EN.pdf>.

<sup>22</sup> Kirin Gil, Rohini Pande, and Anju Malhotra, “Women Deliver for Development,” *The Lancet*, October 12, 2007, <http://www.icrw.org/docs/Women-deliver-Lancet-published.pdf>.

<sup>23</sup> See Lancet series on Maternal Health, September 2006, [http://www.womendeliver.org/pdf/Maternal\\_Lancet\\_series.pdf](http://www.womendeliver.org/pdf/Maternal_Lancet_series.pdf).

<sup>24</sup> World Bank, “Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe and Central Asia,” December 2007, <http://siteresources.worldbank.org/healthnutritionandpopulation/Resources/2816271095698140167/FertilityRegulationsFinal.pdf>, p. 2.

The risks of unplanned pregnancies, especially for teen first pregnancies, are another critical area of concern that points to gender disparities. Pregnancy is the leading cause of death in teenage girls in developing countries. Girls ages 15–19 are twice as likely to die from pregnancy-related complications as are women in their 20s, and the infants of these young women face a 50 percent higher risk of dying before the age of 5. Young women and girls less than 15 years old are five times as likely to die as women in their 20s from pregnancy-related complications.<sup>25</sup>

## Infectious Diseases that Disproportionally Affect Women

*“For many infectious diseases, women are at higher risk and have a more severe course of illness than men for many reasons, including biologic differences, social inequities, and restrictive cultural norms.”<sup>26</sup> — Dr. Julie Gerberding, former director of the Centers for Disease Control and Prevention (CDC)*

While many countries have established early-warning systems for reporting disease outbreaks, few have incorporated gender-based metrics into their systems. This means that sex-disaggregated and gender-sensitive data (such as pregnancy status) are rarely collected or analyzed for many diseases. For most diseases, the difference in infection rates between men and women is linked to exposure rather than to biological differences. Sexually transmitted infections (STIs), however, are an exception to this, because biological differences may lead to different risk ratios. In general, women are at greater risk of contracting HIV from an infected man than the reverse.<sup>27</sup>

Gender roles and behaviors have a significant impact on HIV transmission, and thereby shape the differential vulnerabilities to infection between men and women, boys and girls, and their respective abilities to mitigate the impact once infected. Gender norms about femininity and masculinity often increase HIV risk by leaving women and girls unable to negotiate sex or condom use and by encouraging men and boys to seek multiple partners and take other risks.<sup>28</sup> Curbing the global epidemic thus requires addressing the gender-related factors at the different levels of risk that have given rise to a disproportionately large impact on women and girls. The proportion of women and girls among newly infected people continues to rise in every region of the world—reaching almost 60 percent of those living with HIV/AIDS in sub-Saharan Africa,

---

<sup>25</sup> World Vision, “Birth Spacing/Pregnancy Spacing: World Vision’s Newest Strategy to Improve and Sustain the Well-Being of Children,” USAID presentation, June 2008.

<sup>26</sup> Julie Gerberding, “Women and infectious Diseases,” *Emerging Infectious Diseases*, Vol. 10, number 11, November 2004, <http://www.cdc.gov/ncidod/eid/vol10no11/pdfs/04-0800.pdf>.

<sup>27</sup> WHO, “Addressing Sex and Gender in Epidemic-prone Infectious Diseases,” <http://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf>, 2007, p. 12.

<sup>28</sup> See UNAIDS, “Gender,” <http://www.unaids.org/en/PolicyAndPractice/Gender/default.asp>.

including three-quarters of 15–24-year-olds in some countries.<sup>29</sup> Recent progress in expanding access to AIDS treatment has not halted the epidemic’s disproportionate impact on women and girls; that would require far higher attention to gender-related factors beyond treatment. Women’s and girls’ lack of access to economic resources, education, and skills magnifies their vulnerability to HIV/AIDS. Linking family planning and HIV/AIDS programs is also critical: sexual transmission is the primary route of HIV infection, and family planning services often serve as a gateway for women and girls to access HIV information and services, including effective means of preventing HIV infections.

Physiologically, females and males are equally vulnerable to malaria, but pregnant women and children under age five are particularly vulnerable. Accordingly, the main interventions usually focus on women, such as ensuring that they benefit from insecticide treated bed nets (ITNs), indoor residual spraying (IRS), preventive treatment for pregnant women (IPTp), and appropriate treatment if they have malaria. To reach women, IPTp is often administered in antenatal clinics, and illustrates the importance of integrating malaria prevention and treatment into reproductive health services.

In some countries, gender roles increase women’s and girls’ risks of contracting malaria and complicate efforts at testing and treatment. Gender norms influence malaria prevention due to differing risk exposure for men and women— related to factors such as the division of labor, which may affect their risk of being bitten and infected, and sleeping arrangements, which may mean that women and children are not protected by bed nets. Gender barriers also affect women’s ability to access care and treatment for malaria and to access and purchase prevention items such as bed nets.<sup>30</sup> Accordingly, malaria programs are increasingly recognizing the importance of including a gender analysis to improve their coverage and effectiveness.

## Gender-based Violence

*“[W]e say to the world that those who attack civilian populations using systematic rape are guilty of crimes against humanity. These acts don’t just harm a single individual, or a single family, or a single village, or a single group. They shred the fabric that weaves us together as human beings. Such atrocities have no place in any society.”<sup>31</sup> — Hillary Rodham Clinton, U.S. Secretary of State*

---

<sup>29</sup> UNAIDS, “AIDS Epidemic Update 2008,” [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008\\_Global\\_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp).

<sup>30</sup> WHO, “Gender, Health, and Malaria,” June 2007, [http://www.who.int/gender/documents/gender\\_health\\_malaria.pdf](http://www.who.int/gender/documents/gender_health_malaria.pdf).

<sup>31</sup> Department of State, “Hillary Rodham Clinton, Secretary of State, Roundtable with NGOs and Activists on Sexual and Gender-based Violence Issues,” Goma, DRC, August 11, 2009, <http://www.state.gov/secretary/rm/2009a/08/127171.htm>.

Gender-based violence (GBV)—including physical violence and sexual violence and the accompanying emotional abuse—is an epidemic of global proportions, although it has only recently been recognized as a major global health issue, with significant costs to individuals, health systems, and societies. Evidence from around the world indicates that a substantial proportion of girls and women are subjected to domestic violence, sexual abuse (including child sexual abuse), and forced or coerced sex, both outside of and within marriage.<sup>32</sup>

A World Health Organization (WHO) report found a strong association between violence and other physical and mental symptoms of ill health among women, beyond the physical injuries immediately caused by the violence. The results suggest that “the physical effects of violence may last long after the actual violence has ended, or that cumulative abuse affects health most strongly.”<sup>33</sup> In the majority of countries studied by WHO, pregnant women who had suffered abuse were also more likely to report miscarriages and induced abortions.<sup>34</sup>

The consequences of gender-based violence can be extreme, from death due to homicide, suicide, or AIDS-related causes, to traumatic injuries such as gynecological fistula, to chronic pain, and often have severe consequences for maternal and child health. Women’s and girls’ sexual and reproductive health is often seriously affected, either as a result of forced sex or of childhood sexual abuse.<sup>35</sup> Globally, GBV is a major cause of disability and death among women. Health services have an important role to play in identifying, treating, or referring women and girls who have been subjected to GBV. In particular, family planning and reproductive health services, which provide the primary entry point for women and girls into the health sector, should be prioritized for GBV-related interventions.<sup>36</sup>

Sexual violence is often a feature in conflicts around the world. It has been especially evident in the former Yugoslavia, in the genocide in Rwanda, in the current humanitarian crises in eastern DRC, and in Darfur. In these conflict and post-conflict situations, sexual violence and rape have been both a weapon of war and a consequence of the breakdown of societal structures and the rule of law. In some cases, women and girls are raped by soldiers or combatants who may be at

---

<sup>32</sup> Sarah Bott, Andrew Morrison, and Mary Ellsberg, “Preventing and Responding to Gender-based Violence in Middle- and Low-Income Countries: A Global Review and Analysis,” World Bank Policy Research Working Paper no. 3618, June 2005, pp. 10–11.

<sup>33</sup> WHO, “Summary Report: WHO Multi-Country Study on Women’s Health and Domestic Violence against Women,” Geneva, 2005, [http://www.who.int/gender/violence/who\\_multicountry\\_study/summary\\_report/summary\\_report\\_English2.pdf](http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf), p. 15.

<sup>34</sup> *Ibid.*, p. 17.

<sup>35</sup> USAID, “Gender-Based Violence,” [http://www.usaid.gov/our\\_work/global\\_health/pop/techareas/gender/gbv\\_info.html](http://www.usaid.gov/our_work/global_health/pop/techareas/gender/gbv_info.html).

<sup>36</sup> USAID, “Issue Brief: Confronting the Impact of Gender-Based Violence on Women’s Health,” November 2008, [http://www.usaid.gov/our\\_work/global\\_health/pop/news/issue\\_briefs/gender\\_violence.pdf](http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/gender_violence.pdf).

high risk of HIV, or they may be compelled to engage in transactional sex as a survival strategy.<sup>37</sup> During the 1994 Rwandan genocide, an estimated 250,000 women were subjected to sexual violence as a tool of genocide, and many of these women became infected with HIV.<sup>38</sup>

## Food Security

*“Breaking the cycle of hunger and poverty at its roots begins with women. Hunger breeds insecurity and often exacerbates circumstances that lead to conflict and crisis, and creates situations where women and girls are often victims of abuse, rape, and violence. In situations of desperate poverty, access to food is power.” — Josette Sheeran, Executive Director, United Nations World Food Program<sup>39</sup>*

The current global food crisis is having a particularly severe impact on poor women and children.<sup>40</sup> According to the World Food Program (WFP), the current rise in food prices has compelled women in developing countries to increase their workload while reducing their food intake. In many of these countries, women tend to eat last to ensure that their children and other family members have already eaten. In response, WFP is putting an emphasis on getting women and girls nutritious food during critical periods, notably during childhood and pregnancy. Iron deficiency, anemia, and maternal short stature contribute to risk of death during delivery and account for some 20 percent of maternal mortality.<sup>41</sup> Gender inequality is a significant factor in perpetuating hunger and poverty around the world.

Women play a critical role in farming and food security in developing countries. This includes the work of women and girls in gathering firewood for fuel and getting water, activities that can expose them to dangerous situations, including gender-based violence. While they are key actors in feeding their families and communities, they are often denied access to land, water, credit, technology, and decision-making, and are often themselves impoverished and malnourished. In fact, women in developing countries produce 60–80 percent of the food, but own only some 1 percent of the land. These women are also far more likely than men to use the money they earn

---

<sup>37</sup> Global Coalition on Women and AIDS, World Health Organization, “Violence Against Women and HIV/AIDS: Critical Intersections—Sexual Violence in Conflict Settings and the Risk of HIV,” Information Bulletin Series, Number 2, November 2004.

<sup>38</sup> Human Rights Watch, “Struggling to Survive: Barriers to Justice for Rape Victims in Rwanda,” [http://hrw.org/reports/2004/rwanda0904/5.htm#\\_Toc82319926](http://hrw.org/reports/2004/rwanda0904/5.htm#_Toc82319926).

<sup>39</sup> UN World Food Program (WFP), gender policy, January 2009, <http://one.wfp.org/eb/docs/2009/wfp194044~1.pdf>.

<sup>40</sup> CSIS Task Force on the Global Food Crisis, *A Call for a Strategic Approach to the Global Food Crisis*, July 2008, p. 3, [http://csis.org/files/media/csis/pubs/080728\\_food\\_security.pdf](http://csis.org/files/media/csis/pubs/080728_food_security.pdf).

<sup>41</sup> World Food Programme, “News: Women Shoulder Heaviest Burden in Global Food Crisis,” March 2009, <http://www.wfp.org/stories/women-shoulder-heaviest-burden-global-food-crisis>.

from the sale of crops to benefit their children and ensure their nourishment, yet they are often denied entry into farmer's associations and services.<sup>42</sup>

There is also a clear correlation between food security and HIV. A study in Botswana and Swaziland found that, compared to women receiving adequate nutrition, women who lack sufficient food are 70 percent less likely to perceive personal control in sexual relationships, 50 percent more likely to engage in intergenerational sex, 80 percent more likely to engage in survival sex, and 70 percent more likely to have unprotected sex.<sup>43</sup> In addition, people on anti-retroviral treatment for AIDS (ARVs) need sufficient food and nutrition to ensure the efficacy of the treatment.

## Recommendations

Success in promoting and institutionalizing gender as a global health priority will require both high-level public commitment from the Obama administration, including from the president and the secretary of state, and empowerment of U.S. government in-country teams to encourage innovative gender-focused programming. This means transforming the U.S. approach to global health programming to avoid the “silos” in favor of a more integrated, comprehensive approach, based on the four cornerstones of maternal child health and family planning, infectious diseases that disproportionately affect women, gender-based violence, and food security. The ultimate goal is to change the way U.S. global health programs operate in three principal areas:

- systematically applying a gender lens in program design and implementation;
- supporting capacity strengthening and resource mobilization; and
- coordinating within the U.S. government programs and promoting U.S. global leadership.

These steps will advance the effectiveness and sustainability of U.S. global health programs and help them achieve their targets.

### **Recommendation 1: Require a Gender Lens in Design and Implementation of U.S. government-supported programs**

- Require all U.S. global health programs to ensure that gender considerations designed to reduce barriers to access and vulnerability to ill health are incorporated into the design, implementation, and assessment of projects, and report to Congress on progress.

---

<sup>42</sup> International Alliance Against Hunger, “Allied Against Hunger,” March 2009, [http://www.iaahp.net/fileadmin/templates/iaah/docs/Message\\_EN.doc](http://www.iaahp.net/fileadmin/templates/iaah/docs/Message_EN.doc).

<sup>43</sup> Sheri D. Weiser et al., “Food Insufficiency Is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland,” *PLoS Medicine* 4, no. 10 (2007): e260 doi:10.1371/journal.pmed.0040260.

- Routinely collect, analyze, and report health and disease data by sex and age, and examine data to determine the level of gender disparities in specific settings and health programs. Conduct analysis on specific gender-related issues to identify barriers to information and access for women and girls, including factors contributing to unmet needs for family planning. Where necessary, commission new epidemiological surveys to identify gender-related barriers.
- Identify three–four countries in different regions to demonstrate how gender-focused global health programs can be operationalized. Leverage additional resources to support these efforts, collect appropriate data and evidence, and compile lessons learned to build on the successes. Empower U.S. government country teams to elevate their gender-focused programming.
- Dedicate adequate resources and staff with gender expertise, and solicit input from community-based women’s groups, to ensure that the design and implementation of gender-focused programs address access and vulnerability.
- Disseminate existing guidelines and tools to assist implementing partners in developing gender strategies and targets.
- Promote integrated, comprehensive care to enable a woman taking her child for immunizations, visiting an antenatal clinic, or using other primary care services to also access services or referrals to services such as family planning, reproductive health, and prevention and treatment of infectious diseases including HIV/AIDS and malaria.

## **Recommendation 2: Support Capacity Strengthening and Resource Mobilization**

- Provide training to all health providers to identify the specific health needs of women and girls, including adolescent girls. Enhance providers’ capacities to implement gender-responsive programs.
- Promote linkages and programmatic integration between U.S. global health and development programs, especially relating to education for girls, economic empowerment for women, reducing gender-based violence, food security, and legal reform.
- Mobilize resources— including funding and technical assistance—to support enhanced and integrated programming in maternal child health and family planning, infectious diseases, gender-based violence, and food security, and ensure that adequate budgets are attached to these programs. Explore alternative, innovative funding mechanisms to focus on women’s health issues.
- Remove financial barriers to care that prevent poor women and girls from accessing services, including user fees for prenatal and obstetrical services.

### **Recommendation 3: Coordinate among U.S. Government Agencies and Promote U.S. Global Leadership**

- Continue the high-level U.S. leadership on gender as a strategic priority in global health, including speaking out against gender-based violence and addressing gender vulnerabilities as social determinants of health.
- Ensure that the office of the ambassador at large for Global Women's Issues is directly involved in program development related to global health, and that it has appropriate oversight authority to ensure that gender issues figure prominently in global health programs.
- Establish an interagency task force on gender concerns in U.S. global health policy and in the Global Health Initiative to facilitate coordination among agencies and monitor implementation. Establish high-level gender focal points at each agency with the authority to ensure implementation of guidelines and to report to the interagency task force.
- Announce a Presidential Policy Directive (PPD) making gender equity a priority in U.S. global health and development programs, and ensuring that a gender lens is used in the design and implementation of all programs, including, but not limited to, maternal and child health, HIV/AIDS, malaria, family planning and reproductive health, food and nutrition, clean water, and health system strengthening.
- Commission a study by the National Intelligence Council (NIC) to examine the strategic implications of gender in global health and development and to analyze the potential impact on U.S. national interests of increasing the gender focus in these areas.