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Commission on the Status of Women
Fifty-third session
2-13 March 2009
Agenda item 5
Follow-up to Economic and Social Council resolutions and decisions

Gender perspectives on global public health: implementing the internationally agreed development goals, including the Millennium Development Goals

Moderator's summary

1. On 12 March 2009, the Commission on the Status of Women convenee C0131fT.n5272 Tw 0 -1.198

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3. While important progress towards the achievement of health-related Millennium Development Goals and reduction in overall health inequities was being made, significant gaps and inequities persisted. In efforts to strengthen health systems, renewed emphasis was placed on the role of primary health care in addressing health challenges and as the main strategy for attaining health for all. Reforms in primary health care aimed at better and more equitable health outcomes, greater efficiency and better service delivery, lower health-care costs and higher user satisfaction.

4. Participants stressed the importance of universal health coverage through primary health care in order to improve health for women and men. Lack of coverage disproportionately affected the poor, especially poor women, and women belonging to vulnerable groups such as minority or rural women. Experience indicated that women's out-of-pocket health expenditures were in general higher than men's; their contribution to and benefits received from social security schemes were lower; and comprehensive packages of services and entitlements did not always cover women's specific health needs. Universal coverage as well as a gender-specific approach were critical in overcoming health inequities for women.

5. Service delivery reform in primary health care could have a positive impact on women's right to health. Reforms should include a culturally and gender-sensitive approach that responded to the different health-seeking behaviours of women and men. Women's input in decisions affecting their health was crucial and had to be enhanced.

6. The need to focus on capacity- and skills-building of health workers, through enhanced gender-sensitivity training, was recognized. It was noted that the majority of health workers were women and that much of the unpaid care work in households and communities was also performed by women. Service delivery should aim to enhance access to primary health care for women, as well as to reduce their unpaid care-giving responsibilities. There was also a need to focus, in a gender-sensitive manner, on effective community participation, raise awareness about people's right to health and encourage participation of vulnerable groups in health provision. A rights-based approach that emphasized providers' obligations and care seekers' rights should be applied, and training of health providers should focus on eliminating any stigmatizing attitudes or discrimination towards any person seeking care.

7. Participants stressed the role of public health literacy for health promotion and prevention of ill health and noted that health education should be part of basic primary health-care packages. The importance of gender-sensitivity in health education for enhancing women's health was stressed, as was the urgency of targeting health messages to the needs and priorities of women and girls in a gender-responsive manner. Consideration should be given to the choice of medium for delivering health messages and ways to take into account the barriers that women faced in accessing means of mass communication, including newspapers and the radio, as well as positive experiences with the use of interpersonal communication. The frequency and timing of such communication opportunities was critical to ensuring that women could take full advantage of these opportunities.

8. Participants called for gender-responsive health systems that provided sexual and reproductive health services for all women and girls. Less progress had been made towards achieving Millennium Development Goal 5, on improving maternal

health, than any other Goal. At the global level, maternal mortality decreased by less than 1 per cent per year between 1990 and 2005, far below the 5.5 per cent annual improvement needed to reach the target. Maternal mortality represented one of the largest inequities in health, reflecting a lack of access to sexual and reproductive health care as well as the failure of the health system to adequately address the particular needs of women and girls. The consequences of failing to improve access to and quality of sexual and reproductive health care included maternal morbidity and mortality, infertility and unintended pregnancies, fistula, sexually transmitted infections and cervical and breast cancers. A number of effective strategies were available to enhance women's sexual and reproductive health and accelerate progress towards achieving Millennium Development Goal 5, including: increased access to skilled birth attendants, access to family planning and to emergency obstetric care. Since young women were especially vulnerable to poor sexual and reproductive health, early child-bearing, sexual coercion and violence, the inequities they faced in accessing quality services required particular attention.

9. The link between violence against women and women's poor physical, mental and reproductive health was stressed. Participants noted that violence against women required a multisectoral response that included the public health perspective. The health sector should provide medical care, counselling, referrals, emergency contraception and prophylactic HIV treatment. The broader response should include legal measures, changing of attitudes and the provision of services for victims.

10. Participants emphasized the need for a gender-specific approach to the prevention of and response to the HIV/AIDS pandemic. The public health system should effectively address women's increased vulnerability to HIV/AIDS and provide a gender-sensitive response. Women and girls had unequal access to health resources for the prevention, treatment and care of HIV/AIDS. They also faced particular cultural barriers in accessing services, including stigma and other negative repercussions when their HIV status was revealed. Integration of services for HIV prevention or treatment with reproductive and sexual health care was recog()recos poor phy4(c9en36lodbaeu)-6(-6(r)2(od0.0176tw/1 Tc fnt)-7(69 TwTc fntT0.1981Tw 1th)6( )T

end was also highlighted. Participants drew attention to the linkages between the Millennium Development Goals, noting that efforts to eradicate poverty required by Goal 1 also contributed towards the achievements of Goals 4 and 5, as well as Goal 3 on gender equality and the empowerment of women.

14. The need for increased health financing was noted, as was the need for increased gender-responsiveness of financing to ensure proportionate allocation of resources to women-specific health needs. Analysis of the differential disease burdens of women should result in commensurate resource allocation and expenditure. There was also a need to consider the scope of health insurance and social protection schemes as these did not typically cover the informal sector, where women predominate. Gender-responsive budgeting was suggested as an effective strategy for setting priorities in health resource allocation. Such gender-responsive budgeting was especially critical during times of financial and economic crisis.

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