

"Are the Poor and Rich Truly Different?"

**Panel at the Annual Conference of the Global Health Council
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My task is to provide a gender perspective on the question, "Does the DALYs approach Truly Represent Global Needs?" From a gender perspective, my answer is, "Not yet!" In thinking about gender, the global burden of ill health and health policy, it is essential to take into account gender differentials in health status and in the determinants of health, on the one hand and women's specific health needs on the other. The two are not equivalent.

In overly simplified terms: women's health needs arise largely, but not solely, from the biology of sex and reproduction.

Gender differentials reflect the sociology of relations between males and females and their significance for access to health services--for both a sense of wellness and the reality of wellness.

A gender perspective, by definition, therefore, must be concerned not only with biological and epidemiological differences between males and females, but also with the social, behavioral, and political power factors that underlie or exacerbate many of these differences.

How well has the DALYs methodology met this dual challenge? It has so far, for example, revealed some important global differences in patterns, types and significance of violence and depression among women compared to men. Further, the methodology's consideration of several aspects of reproductive health has begun to expose the enormity of the physical health burden of sex and reproduction born by women as compared to men. But it does not capture all of reproductive and sexual health, nor the interdependence between mental health problems and reproductive health problems, especially for women.

According to DALYs estimates based on 1990 data, reproductive health accounts for 22% of the global disease burden among women aged 15-44, but only 3% of the burden among men. In sub-Saharan Africa, the magnitude is far greater, especially for women: 40% of the burden among women, 9% among men is due to reproductive health. If perinatal causes are included in the reproductive health estimate, then some 10% of total DALYs lost can be ascribed to reproductive ill health, all ages and both sexes combined. What are we to make of these figures? Clearly, the definition of reproductive health dramatically affects our understanding of

the magnitude of the burden. How do we choose one definition over another? Who decides? And with what consequences for gender equity?

Some of the shortcomings of the DALYs approach from a gender perspective are a function of intrinsic limitations in the model. To name four:

1. The model is highly data dependent, but for poor countries, and for women's health needs in particular, we have few valid and reliable data.
2. Important parts of the model rely not on data, but on value weightings by selected experts who may or may not value health in the same ways that people different from them do.
3. In the model, life is valued differently at different ages, but in equity terms, and from a gender perspective, it would be more appropriate to value life equally for all individuals.
4. The methodology underestimates, undervalues, or excludes altogether co-morbidities, and multiple cumulative insults to health over time, which may be particularly important in assessing the health of girls and women.

In applying a gender perspective specifically to DALYs associated with sex and reproduction, we need to recognize and seek to overcome specific data limitations, address methodological shortcomings, and redress problems in the use of DALYs to set global and national health priorities.

First, Data Gaps. Generation of data on sex and reproduction is deeply affected by societal norms, gender inequalities, myths and taboos. Estimation of illness and causes of death are further hampered by biological factors. For example, half or more women who have certain STDs are asymptomatic; but routine, population-based STD screening is prohibitively expensive. As a result, across the global south, only a sparse handful of population-based estimates of gynecological morbidity exist. Some of the major challenges for future work include measurement of not only the physical, but also the emotional and the social costs to individuals of events such as the millions of still births that occur each year; obstetric fistula; infertility; HPV infections and cervical cancer; female genital cutting and sexual violence; the significance of socio-cultural, behavioral, political and economic factors that determine disability and death, and/or obstruct effective interventions.

The second challenge is to address methodological shortcomings in the DALYs approach. As

mentioned earlier, the definition of reproductive health that is used--the scope of illnesses, injuries and deaths included--dramatically affects the number of DALYs attributed to reproductive health and ultimately to the priority assigned to policies and interventions concerned with sex and reproduction. If these health burdens are going to be properly weighed and valued, we must figure out how to assess the interdependence among conditions at a moment in time (e.g. the cumulative insults of malnutrition and stunting in girlhood leading to obstructed labor and its sequelae in adulthood.) We need a way to value not only the ill health and disability of the woman who experiences it, but also the consequences for those for whom she cares or for the pregnancies she bears. Without these more sophisticated weightings, we undervalue the burden of ill health and, more important, the benefits that would accrue to interventions to prevent or cure that burden.

And this brings me to my final concern and the major purpose of a gender perspective--the achievement of equity in health interventions and outcomes. We are all of us challenged by demands for health sector reform. Without systemic gender analysis across the board, and without gender sensitivity in whatever methods we use (DALYs or QALYs or others) to determine health priorities, we risk exacerbating, not ameliorating, inequities, particularly inequities between women and men. Health sector reform requires hard choices regarding which services are to be included in minimum or essential care packages, what methods of cost recovery to implement from which sources, how barriers to access can be reduced and for whom, and who is represented in all levels of decision making as services are decentralized and ministries of health reorganized.

At the core of these decisions will be estimates of the burden of disease. The methods used to value the multiple elements of this burden, and ongoing work to improve methodologies, will benefit from engagement of the broadest possible range of stakeholders who bring multiple insights on the weights assigned to various health states, the social and emotional dimensions of ill health and injury, and use of the methodology to set policy priorities. Certainly no one methodology can meet all these demands. Nor will we easily fill the major data gaps that remain. But we can do more to ensure gender sensitivity in the models and in their application. We must resist the temptation to look only for simple quantitative answers to what are the most complex and contentious of human behaviors.