Globalization, Gender & Health Research-to-Policy Interface

Discussion paper prepared for
Globalization and Health:
The Gender Challenge

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Globalization, Gender and Health Research-to-Policy Interface Project Partners

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TABLE OF CONTENTS

PREFACE 1

CHAPTER 1: GLOBALIZATION AND HEALTH: A FRAMEWORK 2

- Globalization is Not New But It is Different 2
- But How Does This Affect Men and Women Differently? 3
- Globalization May Be Good for Our Health 3
- Then Again, Globalization May Be Bad for Our Health 4
- A Framework for Understanding Globalization's Impacts on Health 4

CHAPTER 2: ENGENDERING ECONOMIC GLOBALIZATION 7

- Introduction 7
- Globalization & Neoliberal Economic Theory and Practice 8
- Gendered Critiques 9
- Closing Remarks 13

CHAPTER 3: THE GENDER DIMENSIONS OF GLOBAL PUBLIC-PRIVATE PARTNERSHIPS 15

- Introduction 15
- Global Public-Private Partnerships and Global Public Goods 15
- Global Public-Private Partnerships and Health 16
- Global Public-Private Partnerships, Health & Private Sector Involvement 18
- Global Health Governance & GPPPs: A gendered analysis 19
- Future Research 20

CHAPTER 4: KEY ISSUES AT THE INTERFACE 24

- Brief Introduction to the Globalization, Gender & Health Issue Papers 24
- Food Security & Nutritional Well-Being 25
- HIV/AIDS 27
- Tobacco 31
- Occupational Health 35
- Mental Health 37
- Infectious Disease 41
- Violence 43

GLOSSARY OF TERMS 47

APPENDIX 1: *Defining Globalization* 53

APPENDIX 2: *Women and Men's Participation and Voice* 55

APPENDIX 3: *Globalization, Gender & Health Project Partners* 57

REFERENCES 59

FEEDBACK FORM 71

LIST OF FIGURES

Figure 1: Globalization and health: selected pathways and elements 6
Figure 2: Trends frequently associated with the current wave of globalization in the literature 7
Figure 3: Bias in macroeconomic policies associated with the current wave of globalization 10
Figure 4: Gendered labour trends associated with the current wave of globalization 11
Figure 5a: Summary of the challenges and opportunities: A gendered analysis 19

PREFACE

This working paper provides stakeholders with a springboard for discussing key issues at the interface of globalization, gender and health. The discussion is not exhaustive; rather its function is to challenge peoples' thoughts and ideas on the gendered health issues that are associated with the current wave of globalization. Although our analysis is largely structured around a general discussion of the differences between developed and developing countries, there is clearly a need for more specific analysis within and between countries. In addition, our analysis is focused on gender and thus the issue papers do not consistently address other important forms of social stratification, including class, race, ability and sexual orientation. Another important limitation of the working paper is the absence of a consistent historical analysis of globalization.[1] Indeed, there is a need for this form of analysis, particularly with respect to the impact of globalization on the health of Indigenous Peoples. Historically, their experiences of oppression extend well beyond the present wave of globalization, and yet continue to have profound, long-standing effects on their health (Reading, personal communication, January 20, 2003). Finally, the health issues discussed in this paper are based on an extensive literature review and discussions with experts in the field. As might be expected, the definition of globalization invoked and the 'priority' health issues at the intersect of globalization, gender and health vary depending on one's geographic location and socio-political perspective. Thus, the papers can only be characterized as a starting point for more rigorous analysis. Ultimately, it is hoped that the discussions generated from this paper will serve as the basis for future action, including the conducting of research, training, and policy development.

Structure of the Working Paper

The working paper is divided into four chapters: (1) a framework for globalization and health; (2) engendering economic globalization; (3) the gender dimensions of global public-private partnerships for health; and, (4) key issues at the interface of globalization, gender and health. In addition, the document includes a glossary of terms, appendices, list of referenced materials, and a feedback form that we encourage you to complete after reading through the document, or parts thereof. Briefly, chapter one introduces Labonte and Torgerson's (2002) framework as a heuristic tool that can be used to develop a more critical understanding of the dynamic relationship between globalization and health. Chapter two focuses more narrowly on the theory and practice of economic globalization, and summarizes some of the gender critiques of these ideas and approaches. Chapter three builds on the first two chapters, exploring issues of governance and health through the lens of global public-private partnerships, and provides an illustrative case study on the International Trachoma Initiative. The final chapter includes a series of brief papers on a number of issues at the interface of globalization, gender and health which illuminate, and in some instances expand on the points presented in the earlier chapters. These papers are deliberately brief and offer a synthesis of related literature on food security and nutritional well-being; HIV/AIDS; tobacco; mental health; infectious disease; and, violence.

[1] See Branko Milanovic (2003) and Katz (2001) for a discussion of the relationship between colonialism and globalization.

CHAPTER 1: GLOBALIZATION AND HEALTH: A FRAMEWORK*

Globalization describes a process by which nations, businesses and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel. It is not a new phenomenon. Jared Diamond, in his book, *Guns Germs and Steel* (2000), recounts how the history of humankind has been one of pushing against borders, exploring, expanding, conquering and assimilating.

Globalization is Not New But it is Different

Contemporary globalization, abetted by innovations in communications technologies, is characterized by increasing liberalization in the cross-border flow of finance capital and trade in goods and services. It differs from previous eras in several ways:

1. *The scale and speed of such movement, particularly of finance capital.* Over US $1.5 trillion (some estimate $2 trillion) in currency transactions occurs daily, more than double the total foreign exchange reserves of all governments. Such transactions reduce the ability of governments to intervene in foreign exchange markets to stabilize their currencies, manage their economies and maintain fiscal autonomy (UNDP, 1999a). The domestic burden these currency crises precipitate (increased unemployment, decreased public services, rise in poverty) have been borne disproportionately by women (Gyebi et al., 2002), with evidence of increased violence against women and children in the wake of such sudden downturns (Shin & Chang, 1999; UNFPA, 1998).
2. *The establishment of binding rules, primarily through the World Trade Organization.* Trade agreements are increasingly establishing enforceable supra-national obligations on nation-states. Countries have also entered into scores of other multilateral conventions and agreements on human rights and environmental protection, but few of these carry any penalties. This asymmetry between enforceable economic (market-based) rules and unenforceable social and environmental reciprocal obligations is the biggest governance challenge of the new millennium (Kickbusch, 2000; Labonte, 1998; UNDP, 1999a).
3. *The size of trans-national companies involved, several of which are economically larger than many nations or whole regions.* Much of the global trade in goods is intra-firm, meaning that a company's subsidiary in one country sells parts or products to a subsidiary in another country (Reinicke, 1998). This allows companies to locate labour intensive parts of the production chain in low-wage countries (often in exclusive export production zones) and to declare most of their profits in low-tax countries (leading to global tax competition and lower corporate tax revenues in all countries).
4. *The apparent commitment of most countries to continue the project of global economic integration through increased market liberalization.* This commitment is built upon two decades' of dominance of neo-liberal economic assumptions, reflected in the macroeconomic policies of many governments, the World Bank and International Monetary Fund, and most trade agreements. It is somewhat tempered by the reluctance of many of

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the world's wealthiest nations to abide by these assumptions if they are not to their benefit, witnessed by the continued presence of and even increase in trade-distorting domestic agricultural subsidies in the European Union, Japan and the United States.

5. *The "inherently global" nature of many social, economic, environmental and health issues* (Labonte & Spiegel, 2002). Environmental impacts of human activities are planetary in scale and scope; disease pandemics and economic stagnation partly underpin state collapse and regional conflict (Price-Smith, 2002); almost 1/6th of humanity is "on the move" to escape environmental or economic degradation and conflict, straining against the borders of other nations. The risk of a return to unilateralism by the more powerful nations is always present; the evidence of the need for multilateral (global) solutions is irrefutable.

But How Does This Affect Men and Women Differently?

Much of the focus of globalization phenomena has been on the effects of various macroeconomic policies (i.e. liberalization, privatization, state minimalism) on economic growth and poverty reduction. Less attention, until recently, has been given to the effects of contemporary globalization on health, and less, still, on how its health impacts (both positive and negative) differentially affect men and women. Many studies of gendered differences in health and development in poorer nations focus on the household or local community level. Here the evidence is convincing: All things being equal, households where women control more of the domestic income or food resources tend to be healthier (Rico, 1998). Women historically have more responsibility for children and sustenance of household members, and give this responsibility more priority than men in domestic expenditures.

But if we interrogate further upstream and higher up the ladders of political economy, we might ask, why do women generally have less control over material resources, or what determines their increased control over domestic resources? More broadly, what influences the social, environmental, economic and political contexts that distribute the necessary resources for health differentially for men or for women? What role does contemporary globalization play in this shaping? The key question here is whether globalization is leading to a form of economic development that allows women to close the gap with men in measures such as health, education and legal rights.

Globalization May Be Good for Our Health

From a health vantage, there are several compelling pro-globalization arguments. The diffusion of new knowledge and technology through trade and investment, for example, can aid in disease surveillance, treatment and prevention. There is also broad consensus on the positive effects of globalization on gender rights and empowerment, though with the *caveat* that these rights are not simply an invention of the West but existed (often more strongly in pre-Western colonization times) in many presumably less emancipated countries today (Sen, 1999). In economic terms, the pro-globalization argument posits that increased trade and foreign investment through liberalization can improve economic growth. Such growth can be used to sustain investment in necessary public goods, such as health care, education, women's empowerment programmes and so on (Dollar, 2001; Dollar & Kray, 2000). Such growth, particularly in poorer countries, also reduces poverty, which leads, in turn, to better health. Improved population health, particularly amongst the world's poorest countries, is increasingly associated with improved economic growth (Savedoff & Schultz, 2000; World Health Organization, 2001) and so the circle closes virtuously upon itself.

Then Again, Globalization May Be Bad for Our Health

The pro-globalization argument, while compelling, has its skeptics who quickly point out that globalization's virtuous circle can have a vicious undertow. This includes the more rapid spread of infectious diseases, some of which are becoming resistant to treatment; and the increased adoption of unhealthy 'Western' lifestyles by larger numbers of people (Lee, 2001). The more significant challenge is that liberalization does not always or inevitably lead to increased trade, foreign investment or economic growth and that, when it does, it does not inevitably reduce poverty (Cornia, 2001; NDP et al., 2000; Weisbrot et al., 2001). Much depends upon pre-existing social, economic and environmental conditions within countries; and upon specific national programmes and policies that enhance the capacities of citizens, such as health, education and social welfare programmes (UNDP 1999a, UNDP et al., 2000).

China, Korea, Thailand, Malaysia, Indonesia and Vietnam did increase dramatically their role as global traders, but this was primarily in terms of their exports. They retained tariff and non-tariff barriers that shielded important sectors of their economy from competitive imports, public ownership of large segments of banking and placed restrictions on foreign capital flows – which is precisely how wealthier European and North American economies developed historically (Rodriguez & Rodrik, 2000; Rodrik, 1999). World Trade Organization rules now largely prohibit poorer countries from doing the same, with only modest provisions for "special and differential treatment" (trade agreement exemptions). Weaker economies with fewer domestic protections, largely removed through earlier World Bank and International Monetary Fund "structural adjustment" loan policies, have fared poorly under liberalization, notably those in Africa and Latin America. The net effect for them has been suppressed domestic economic activity, depressed wages and tax revenues, and worsened balance of payments (Sustainable Developments, 2001). Mexico, Uruguay, Zimbabwe, Kenya, India and the Philippines all witnessed serious declines in income, and corresponding increases in poverty and poor health, amongst its rural farming population following liberalization (Hilary, 2001).

A Framework for Understanding Globalization's Impacts on Health

Globalization may improve peoples' health in some circumstances but damage it in others, especially when liberalization has been rapid and without government support to liberalization-affected sectors and populations (Ben-David et al., 1999; Cornia, 2001; UNDP, 1999a). Liberalized trade in agricultural products may provide short-term economic benefit to less developed countries. This can improve peoples' health, dependent on how equitably those benefits are allocated amongst all citizens. But food exports from poorer countries can also increase fossil-fuel based transportation, creating short and longer-term health- and environment-damaging effects, decrease food security (FAO, 1996; Karl, 1997) and increase women's labour time in household food production (Tibaijuka, 1994); while commodity-led export produces lower long-term economic growth than manufactured ("value-added") export (Kim et al., 2000). Protectionist policies, including subsidies, may preserve rural life and livelihoods, arguments frequently advanced by the European Union and Japan (Labonte, 2000). This benefits the health and quality of life of rural people. But such policies can also support ecologically unsustainable forms of production and increase oligopolistic[*] corporate control over global food production.

[*] An oligopoly is monopoly power in the hands of 2 or more companies (Online Oxford English Dictionary).

Trade openness has increased women's share of paid employment, which is an important element of gender empowerment (Ozler in UNDP, 1999a). Yet much of women's employment remains low-paid, unhealthy and insecure in "free-trade" export zones that often prohibit any form of labour organization and employ only single women. Often, the income they earn still goes to male household members. Women are favoured in such employment because they can be paid less. Most developing countries lack pay equity laws; the gender income gap in many countries is widening (Gyebi et al., 2002). Public caring supports for young children have been declining in many trade-opened countries, portending future health inequalities. There is also evidence of a global "hierarchy of care." Women from developing nations employed as domestic workers in wealthy countries send much valued currency back home to their families, some of which is used to employ poorer rural women in their home countries to look after the children they have left behind. These rural women, in turn, leave their eldest daughter (often still quite young and ill-educated) to care for the family they left behind in the village (Hochschild, 2000).

What is the gain? What is the loss? Or, perhaps more poignantly expressed, who gains and who loses? And how is this gain and loss differentially apportioned to women and to men?

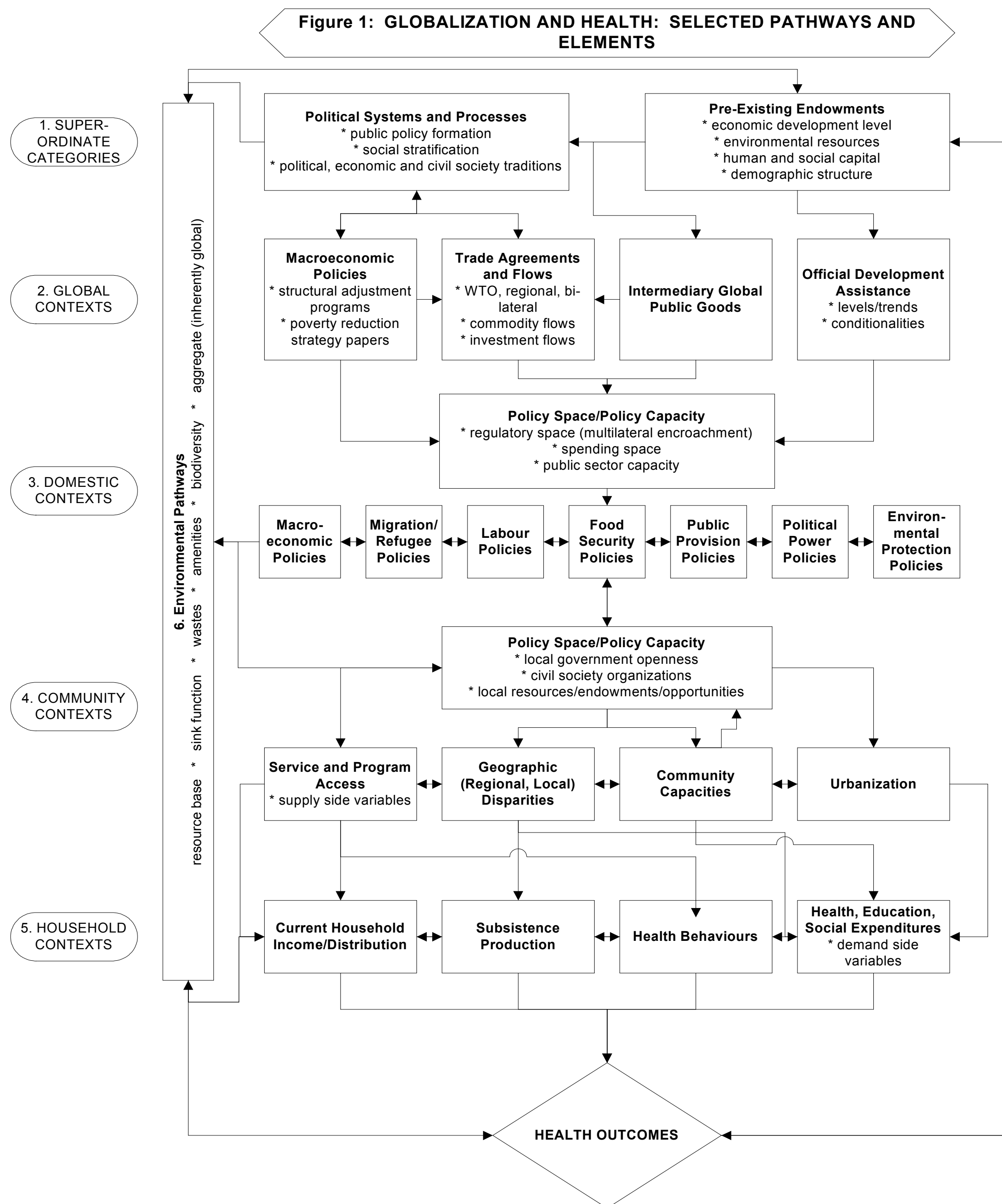
Tracing the impacts of globalization on health to answer such questions can be a daunting and complex task. Figure 1, based upon a more extensive study (Labonte & Torgerson, 2002), provides a framework for understanding how contemporary globalization can affect health. The key points conveyed by this Figure are, in descending order of scale:

1. How contemporary globalization affects health depends on the historical context of particular countries, specifically their political, social and economic traditions (e.g. democratic, oligarchic, patriarchal, theocratic, dictatorial); and their stock of pre-existing endowments (e.g. level of economic development, environmental resources, human capital development).
2. Globally, the major vehicles through which contemporary globalization operates are imposed macroeconomic policies (notably the Structural Adjustment Programmes of the World Bank and International Monetary Fund, which are the precursors today's "free trade" agenda); enforceable trade agreements (notably the World Trade Organization) and associated trans-border flows in goods, capital and services; official development assistance as a form of wealth transfer for public infrastructure development in poorer nations; and "intermediary global public goods," the numerous yet largely unenforceable multilateral agreements we have on human rights, environmental protection, women's rights, children's rights and so on.
3. These vehicles, in turn, have both positive and negative health effects on domestic policy space, by increasing or decreasing public sector capacity or resources and regulatory authority. Key domestic policies which condition health outcomes include universal access to education and health care, legislated human and labour rights, restrictions on health-damaging products such as tobacco or exposure to hazardous waste and environmental protection. At issue are the impacts of liberalizaton on public revenue and redistribution programmes, and the role of trade agreements in circumscribing domestic regulatory capacities in areas of social and health development.
4. National policies and resource transfers affect the abilities of regional or local governments to regulate their immediate environments, provide equitable access to

health-promoting services, enhance generic community capacities (community empowerment) or cope with increased and usually increasingly rapid urbanization.

5. At the household level, all of the above determines in large measure family income and distribution, health behaviours and household expenditures (both in time and in money) for health, education and social programmes.
6. Each level affects, and is affected by, environmental pathways, chief amongst these being resource depletion (water, land, forests), biodiversity loss and pollution.

Figure 1: Globalization and health: Selected pathways and elements



CHAPTER 2: ENGENDERING ECONOMIC GLOBALIZATION*

Introduction

For the purpose of this paper, globalization (see Appendix 1) describes how nations, businesses and people are becoming more connected and interdependent across the globe "through trade, finance, production and a dense web of international treaties and institutions" (Cameron & Stein, 2000: p. S16). Kelly Lee notes that these processes are changing the nature of human interaction by "reducing barriers of time, space and ideas which have separated people and nations in a number of spheres of action, including health and the environment, social and cultural, knowledge and technology, and political and institutional" (Lee cited in Lister, 2000; see also Lee, 2000b; UNDP, 1999a). Both Lee and Scholte (2000) distinguish between the terms such as 'global' and 'internationalization', which describe geographic extensions of economic, social and cultural activities, from the term 'globalization' which describes the functional integration of these activities. Moreover, globalization's functional integration, manifests in five ways: (1) an increase in provision of services at the expense of heavy industry and manufacturing, and (2) the rise of the information economy. Lee argues that both of these are economic and technological changes that, in turn, enable: (3) greater economic integration in the production of goods and services across national boundaries; (4) regional and global economies of scale in production and consumption; and, (5) more mobility of capital, goods, services and sections of the labour market (Lee, 2002). Lastly, it is important to note that while globalization is not a new phenomenon, most agree that the pace of change is an important distinguishing feature of the current wave (see Fidler, 2001; Kennedy, 1996; Labonte, 2002; Scholte, 2002; UNDP, 1999a; World Bank, 2001c). Figure 2 provides a partial list of hotly debated trends (many of which are explicitly discussed in the brief issue papers included in a later section of this report) that are often associated with the current wave of globalization.

Figure 2: Trends frequently associated with the current wave of globalization in the literature

Trend	Examples
Technological	Faster and more affordable transport (air, rail and road); Advances in information communication technologies (internet, global satellite communications; telemedicine, etc.); Growth in electronic commerce and communication; Expanding media
Economic	Increase in volume and speed of flows (capital, currency, goods); Global production and trade (food, cars, illicit drugs); Market volatility and financial crisis; Global spread of capitalism; Increasing privatization; Increasing foreign direct investment; Declining levels of official development assistance; Increase in female participation in the labour force, Power/role of multinational corporations & bodies.
Socio-cultural	Cultural flows and the exchange of ideas; Concern over westernization and challenge to Indigenous cultures/knowledge; Strengthened civil society (transnational social movements); Demography (aging populations in high income countries, orphans/child-headed households in some low income countries); Changing gender roles, relations and family dynamics
Movement of People	Migration within and between countries; Displacement; Travel and tourism; Trafficking; Migrant labour and 'brain drain'; Diasporic communities; Unprecedented urbanization; Emergence of mega-cities
Political	Increase in multilateral agreements; Increasing attention to human rights; Increased speed of political change; Increasing scope and power of multilateral organizations; Growth in non-governmental organizations; Changing roles of government and concerns about public provision of social safety nets
Environmental	Accelerated resource depletion; Environmental degradation; Climate change (greenhouse effect, El Nino); Growing global environmental awareness and interest in protecting global public goods; Increase in international environmental treaties

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To date, much of the debate surrounding globalization has been polarized—representing diverse theoretical, disciplinary and ideological perspectives (Lee et al., 2002: 16; see also Dollar, 2001k; Hoffman, 2002; Milanovic, 2003). Indeed, whether (and the degree to which) globalization is defined in positive or in negative terms is seemingly contingent on a number of factors including the values, theoretical lens and depth of analysis applied; the subsequent measurements and outcomes that are invoked; and, the level of attention given to distinguishing between those who benefit and those who do not. Naturally, given the scope of this discourse and in light of this paper's focus on gender, it is not possible to provide a comprehensive review of the globalization literature. Instead, this paper is specifically focussed on key aspects of economic globalization. Accordingly, the paper provides a brief description of the neoliberal theories and policies related to the current wave of globalization followed by a summary of gendered critiques of these theories and policies. For convenience, the latter is divided into two admittedly broad categories. The first section challenges the theory and assumptions implicit in the pro-globalization literature and in many of the macroeconomic reforms associated with the current wave of globalization. The second section examines the measurements used to determine the nature of the relationship between globalization, growth and development.

Globalization & Neoliberal Economic Theory and Practice

At one end of the continuum of debate on economic globalization are those praising political and economic policies associated with the current wave of globalization, most notably macroeconomic policies that encourage or facilitate liberalization, deregulation and privatization. Generally speaking, these arguments reflect neoliberal or neoclassical economic theory (Lee, in press), which emerged in the 18th century and continues to play an important, albeit often implicit, role in mainstream economic discourse and practice. The core assumptions associated with neoliberal arguments include an acceptance of western individualism; emphasis on efficiency; a 'laissez-faire' approach to markets; and, an acceptance of 'rational choice theory'. In keeping with these beliefs, neoliberal proponents assert that markets are 'self-correcting' in the face of 'market imperfections' including, for example, gender discrimination in the workplace (see World Bank 2001a).

Neoliberal conceptualizations of globalization and the movement towards a single global economic system view this process as inevitable, and believe the impact on growth and development are overwhelmingly positive (Anker 2002; Beneria et al., n.d.; Lee in press; Scholte, 2002). To support their position, advocates often point to the successes of Asian countries, namely China, India, and Viet Nam. In addition, neoliberal scholars offer evidence of: (1) substantial economic growth and increased economic freedoms that have emerged in response to effective macroeconomic policies; (2) significant advances in human development in the face of improved governance, technological innovation and the reduced costs of these technologies; and, (3) increasing international and institutional democratization (Ames et al., n.d.; Froning cited in Campbell et al., 2002; Dollar & Gatti, 1999; Pinnix & Griffin, 2002; International Monetary Fund, 2000; The Economist, 2000; World Bank, 2001c; Yusuf, 2001). Furthermore, when these scholars discuss the relationship between globalization, gender and health they often describe a significant increase in women's participation in the paid labour force, shrinking gender gaps in wages, an overall decline in absolute poverty, significantly improved female education levels worldwide, and dramatic increases in women's life expectancy in many developing countries (World Bank, 2001c).

The literature also offers a different view of the impacts of globalization. Indeed, many scholars have called into question the macroeconomic policies associated with the current wave of globalization (e.g., tax reform, liberalization of inflows of foreign direct investment, trade

liberalization, reduced public expenditures, deregulation and privatization), stating that they are inherently problematic because they are rooted in neoliberal economic theory. These alternate visions of globalization (whether reformist, rejectionist, or transformatory in nature) reflect a broad range of perspectives yet with common themes. The first theme is a belief that the benefits of globalization are not evenly distributed within and between countries; while the second is a skepticism (though of varied intensity) concerning the ability of neoliberal economic reforms (and organizations believed to be premised on neoliberal theory) to address these disparities. To this end, it is suggested that these macroeconomic reforms maintain dominant power relations and existing levels of inequity and inequality; while others assert that they either exacerbate and/or create new types. In support of their claims, they note the impact of financial volatility and crisis on different segments of society, and make reference to the differential impact of structural adjustment programmes on vulnerable members of society (see Aslanbeigui & Summerfield, 2000; Elson & Cagatay, 1999; Floro & Dymski, 2000; Seguino, 2000; Silvey, 2003; Singh & Zammit, 2000; UNDP, 1999a; UNIFEM-ESEA, 1998; Upadhyay, 2000; WHO, 2002c).

Gendered Critiques

Gendered critiques of economic globalization and related macroeconomic reforms share many of these concerns; however, they introduce another layer to the analysis by explicitly examining the relationship between globalization, gender and other types of social stratification. These critics challenge the assumption that the contents of macroeconomic policies are 'gender-blind' or 'gender-neutral'. Instead they argue that these policies are inherently social and thus have gendered impacts (see Elson, 1995; Elson & Cagatay, 2000; Upadhyay, 2000). For convenience, we have divided our discussion of this literature into two broad categories. First, a review of challenges to the theoretical assumptions implicit in macroeconomic reforms associated with the current wave of globalization and espoused in the literature supporting these reforms. Secondly, scholarship that questions the measurements and outcomes associated with globalization, growth and development.

(1) Theoretical Critiques

Challenging and transforming neoliberal thinking implicit in mainstream economic theory and practice is at the core of many gendered critiques of both economic globalization, and the institutions, governments and individuals who facilitate related macroeconomic reforms. Specifically, gendered critiques argue that economic globalization is not void of social content, that is, the macroeconomic policies related to economic globalization are not 'gender blind' nor do they exist in a vacuum. Rather, these reforms are based on a 'certain set of distributive relations and institutional structures' (Elson & Cagatay, 2000: 1347; see also Elson & Cagatay 1999; Katz, 2001; Sadasivam, 1997; World Bank, 2001c), which reflect and in some instances may reproduce dominant power relations in a given society (Elson & Cagatay, 2000: p. 637). Accordingly, macroeconomic policies contain biases (and interact with other policies and institutions that contain bias, such as legal processes and the courts, Ministries of Finance, and multinational corporations and bodies) that may have a more profoundly negative impact on women and girls relative to men. Elson and Cagatay (2000) divide these biases into three types, including: 'marketization bias'; 'male breadwinner bias'; and, 'deflationary bias' (see Figure 3).

Figure 3: Bias in macroeconomic policies associated with the current wave of globalization

Marketization Bias	• Occurs when governments are pressured or required to exercise fiscal restraint, and minimize deficits, levels of taxation and public expenditures. In this instance, public benefits and social services are replaced by market-based, individual entitlements available to those who can afford them. • Marketization fuels the growth and power of financial institutions.
Male Breadwinner Bias	• A form of systemic, economy-wide entitlement failure[2] inherent in macroeconomic policies that rely solely or principally on full-time employment to achieve social goals. • Assumes that women and children have, and should have, their livelihoods provided by incomes earned by husbands and fathers who have little or no domestic responsibilities. • This bias makes it more difficult for women to access social benefits, and makes women dependent on men – particularly when they are intensely involved in child care, and care of the elderly and sick members of their family.
Deflationary Bias	• Occurs when governments adopt macroeconomic policies (e.g., high interest rates, tight monetary policies and fiscal restraint) that are required to secure and/or attract short-term capital. These policies may prevent governments from effectively dealing with the social consequences of recession. • Have a disproportionate negative effect on women as they: lose jobs in the formal sector; and, consequently flood the informal sector which in turn causes wages to drop. In addition women are disproportionately negatively impacted because they seemingly have less access to social safety nets than men; and, assume greater responsibility for cushioning their families from the negative effects of recession

Adapted from: Elson & Cagatay (2000).

An additional observation frequently cited in gendered scholarship of economic globalization pertains to the general 'invisibility' and 'under-valuing' of women in macroeconomic reforms. This invisibility and under-valuing is pervasive and encompasses: (1) the absence of women in the decision-making processes and machinery at the macro, meso and micro levels (see Appendix 2); (2) the lack of attention given to existing gender discrimination; (3) the lack of attention to women's and men's differential access to and control over productive assets; (4) a failure to appreciate the full range of women's paid (market) and unpaid (non-market) activities (see Figure 4), and their impact on growth and development; and, (5) lack of consideration given to the double-work burden and what some have called women's time-poverty that many women endure (Anker, 2002; Beneria, 1995b/2002; Beneria et al., 2000; Braunstein, 2000; Commonwealth Secretariat, 1999; Sen, 2000; WEDO, 2002; WHO, 1995/1998; Women's Edge, 2002; UNDP, 1999a/2002; UNIFEM-ESEA, 1998; World Bank, 2001c).

In this context, feminist scholars and activists offer an alternative approach. These scholars suggest governments and multinational organizations adopt strategies that can better identify and address these systemic types of bias. In so doing, gender scholars assert that the benefits of globalization will be maximized and more evenly distributed, and the goals of human development achieved more swiftly. Elson and Cagatay (2000) state that to date mainstream economics' handling of these biases reflects an 'add-on approach' whereby social policies are an "afterthought to macroeconomic policies" (p.1347). Accordingly, they suggest a variety of strategies including calls for more gender mainstreaming in finance; gender assessments of trade and investment agreements; the development of more sensitive gendered poverty diagnostics; use of gender-aware policy appraisals, gender-

[2] Entitlement failures are systemic and said to occur when 'capabilities are denied or stunted because of market or other settings where bargaining strengths are unequal' (Africa Action, 2002).

disaggregated beneficiary assessments and other means of engendering budgets (see Bamberger et al., 2000; Durbin, 1999; Elson & Cagatay, 1999; Fine, 2002; Gibb, 2001; ICRW, 2002; Sen, 1999; Subramarian, 1999; UNIFEM-ESEA, 1998). Elson and Cagatay (2000) extend the discussion by calling for a 'transformatory approach' to macroeconomics whereby the 'soundness' of these reforms is judged according to their ability to fulfill a social justice agenda rather than being judged solely by existing 'market-based criteria' as is often the case. The authors cite the 'Canadian Alternative Federal Budget' as an example of such an approach (Ibid: 1359; see also the Canadian Centre for Policy Alternatives, 2003).

Figure 4: Gendered labour trends associated with the current wave of globalization

Labour Trends
Agricultural Sector: Evidence suggests that in some countries there has been a shift from sustenance farming, which predominantly employs women—to cash cropping, which predominantly employs men. Challenges associated with work in this sector given this shift include long working hours; significant loss of income and/or potential earnings for women who are not legally permitted to own land and/or are unable to access credit and other productive resources; and increased competition among women in similar micro-enterprises who must sell goods in a flooded local/domestic market. Accordingly, 'many women are unable to reap the benefits of export based diversification' (Women's Edge, 2002).
Public Sector: The public sector has been a traditional source of formal employment for many women. In addition to job losses, the 'hollowing out of the state' represents a significant increase in the unpaid reproductive work that women and girls must endure given that they are often primarily responsible for providing care to children, as well as to elder and sick members of their family. In addition, there is some evidence to suggest that women in developed countries are negatively impacted by downsizing of the public sector because it drives them into the informal sector where wages are smaller and there are fewer benefits, such as health coverage and pension benefits (Doyal 2002; UNDP, 1999a; Women's Edge 2002).
Manufacturing Sector: The elimination of tariffs and quotas under GATT sparked the globalization of manufacturing and production. Developments in the manufacturing centre, namely the mechanization and technological sophistication of modes of production, have produced better employment opportunities and higher wages for some. However, women's access to these positions is often hindered by gendered occupational segregation and gender discrimination. Furthermore, poor women, who are more likely to be under-educated and/or have limited access to job training, are even less likely to be employed in these higher-skilled positions than other women (Women's Edge 2002).
Informal Sector: There has been a significant increase in women's participation in the informal sector, including export processing zones, contract work, part-time or seasonal employment; unprotected and unregistered day labour positions; home workers doing piecemeal jobs; and, sex work. Women in these low-skilled jobs typically earn little pay; endure poor/unregulated working conditions (e.g., in some places unionization is illegal in this sector); work long hours; have little job security (fluctuations correspond with market demands); and often have little or no benefits. In addition, large numbers of the population working in this sector translates into lower contributions to the tax base which is required for a publicly funded social safety net (See Beneria, 2002; Women's Edge 2002)
Reproductive Sector: Women are disproportionately responsible for the provision of care for children and the elderly. For some women, this gendered division of labour in the home translates into working longer hours, less work experience (particularly in the formal sector), and higher fixed costs of labour market participation relative to men. Also, during economic crisis and in response to declining household incomes women's and girls reproductive work increases. Although governments can support the reproductive sector and effectively reduce women's time burdens through the provision of publicly funded social services (e.g., paid maternity leave, subsidized day care, health care coverage), privatization, reduced government spending, and a shrinking tax base may weaken a government's ability to provide adequate social safety nets (Beneria et al., 2000; UNDP, 1999a; Women's Edge 2002)

(2) Refuting the Evidence: Questioning Measurements and Outcomes

Our review of the globalization literature thus far has led us to three important and related insights. First, very early in the review it became obvious that there are significant gaps in the data available (see Berry, 2002). Specifically, there is relatively little gender/sex disaggregated data readily available—particularly when looking for research at the interface of globalization, gender and health

(Subramanian, 1999; Upadhyay, 2000; World Bank, 2001c). In addition, gendered analysis' of the impact of globalization (regardless of how one defines it) is sparse, and where it does exist tends to focus on the impact of trade, for example, rather than on the gendered dimensions of contemporary macroeconomic policies (though gendered critiques of the structural adjustment and stabilization policies of the 1980s and 1990s are a noteworthy exception). Indeed, to date we have found relatively little research on the gendered impact of increasing Foreign Direct Investment (FDI); recent declines Official Development Assistance (ODA) from OECD, Development Assistance Committee member countries; or, Poverty Reduction Strategy Papers, for example.

A second insight pertains to how contested and at times fragmented research on the relationship between globalization, growth and development can be. Although there seems to be a general consensus in the literature reviewed that globalization has led to significant growth, and growth is good for development; there appears to be less agreement on what growth should mean or how it should be defined, how it ought to be achieved, and thus how it ought to be measured. Joekes (1998?) and Seguino (2000) provide two examples of how some gendered critiques challenge the evidence of a positive and robust relationship between trade liberalization, equalizing growth, and gender equality (see also UNDP, 1999a). Applying a gendered analysis, and having premised their work on different conceptualizations of what growth entails, their findings contrast with conclusions reached in other studies. A third insight pertains to operational definitions. Specifically, conducting a gendered analysis of the globalization literature reveals how important one's operational definitions and chosen measurements or outcomes are in influencing a study's findings (see Berry, 2002; Durbin, 1999; Ravillon, 2003; World Bank, 2001c). Moreover, where no explicit definition is given and/or where no standardized measurements are used it is exceedingly difficult to generalize study findings, conduct/consider cross-country comparisons, or identify/consider regional trends.

Two examples demonstrate the need for standardized definitions and shared methodologies. The first example is adapted from Ravillon's (2003) recent work exploring the debate on the progress made towards alleviating poverty and inequality in the current wave of globalization. The neoliberal position suggests that globalization has had a positive impact on poverty and inequality. As such, neoliberal scholars are likely to present evidence (previously noted) that during the current wave of globalization, inequality and poverty have significantly declined. In contrast, those opposed to neoliberal formulations posit the opposite—that globalization has had little or no effect on poverty and inequality. In part, the discrepancy between these two conclusions lay in the use of a gendered lens and the operational definitions and measurements of poverty and inequality that are used. For example, those who believe that poverty and inequality are decreasing are speaking in terms of *absolute poverty* (poverty line with fixed purchasing power), and *relative inequality* (concerned with the perceived differences in levels of living in relation to other individuals or groups in society). Notably, the use of relative measures of poverty suggests a different pattern. Specifically, they indicate that economic growth as experienced during the most recent wave of globalization has had little or no impact on poverty.

A second example demonstrates the added-value of applying a gendered lens. It speaks to the significance of standardized and explicit operational definitions in determining how success is defined, and thus what outcomes will be measured. Specifically, many measures of poverty are implicitly based on the unitary household model[3] which assumes that there is (1) income and risk pooling in the home; (2) a cross-wage effect whereby the impact of income compensated changes in a husband's wage on his wife's labour supply are equal to the impact of income-compensated

[3] See World Bank, 2001c: 307-312 for an annotated table of empirical tests of this model.

changes in the wife's wages on her husband's labour supply; and, (3) intra-household allocations are 'pareto-efficient'[4] (Lundber cited in World Bank, 2001c: 157-8). Research that is implicitly based on this model (e.g., many household consumption studies) has been criticized by some because there is evidence to suggest that these assumptions do not reflect actual household dynamics. Specifically, the unitary household model has been widely criticized for its failure to consider gendered power relations within the home, asymmetries in resource allocation, disparities in investments in human capital, and disparities in access to and control over productive assets in the home that may favour males (World Bank, 2001c; see also Biswal-Dhawan, 1999; Phipps & Burton, 1996). It is argued further that adherence to this model renders a large amount of women's and children's unpaid reproductive work invisible, and obscures the actual impact of various macroeconomic conditions associated with the current wave of globalization.

Closing Remarks

This paper has provided a brief review of the literature on economic globalization surveyed by the author to date. Accordingly, it alludes to the competing definitions of globalization discussed in the literature and the contested trends associated with the current wave. In addition, it provides a brief overview of mainstream economic theory and corresponding conceptualizations of globalization discussed in the literature, as well as some of the more common gendered critiques. In so doing, it demonstrates the importance and significance of providing explicit operational definitions when conducting research on globalization. Furthermore, the paper emphasizes the need for (and importance of) regional and/or international standardized measurements that are both sex and gendered disaggregated to: (1) facilitate more critical and grounded research on the differential impact of globalization on men and women, both within and between countries; and, (2) ultimately enhance the effectiveness and sensitivity of policy and programme development.

[4] That is, no reallocation of household resources can be made without making at least one member worse off.

CHAPTER 3:
The Gender Dimensions of Global Public-Private Partnerships for Health**

Introduction

This brief paper provides an overview of the international challenges inherent in managing global public goods. In particular, it explores the emerging role of Global Public Private Partnerships (GPPPs) in the delivery of health care, and considers the gendered impact of this form of governance on health.

Global Public Goods (GPGs) are at the core of the debate on globalization. Managing the impact of globalization depends largely on the adequate provision and protection of GPGs at the national and international level. Many of the larger protests against globalization (e.g. Seattle, Quebec City) have focused on the way in which the forces of globalization have mitigated the equitable provision of GPGs such as clean air and water, as well as social goods such as peace and security. They are also critical of the way in which global public 'bads' (GPBs) such as the trade in illicit drugs and the spread of infectious disease have seemingly escalated in this era of globalization (Lee & Dodgson, 2000; UNDP, 1999a; UNFPA, 1998).

Both public and private goods are defined as "economic inputs to human well-being" (Kaul & Faust, 2001). This broad category includes components of our ecosystem, social and economic goods and basic necessities such as food, clothing and shelter. Private goods (e.g. bread, shoes) are distinct in that they can be withheld from other individuals, and tend to have clear property rights. In contrast, public goods are "non-rival and non-excludable in consumption" (Kaul et al., 2003). They include components of our ecosystem such as air, water and forests, as well as social and economic goods such as peace, health care and education (Kaul & Faust, 2001). In a broader context, *global* public goods are public goods with benefits or costs that spill-over borders, including regional, class and generational divides (Kaul, 2000).

In the last decade there has been a growing movement in the international community to develop frameworks to govern the provision of GPGs (Sachs, 2001). In particular, there has been a strong movement to reform the process of public policy development to include other players, with a particular emphasis on those from the private sector (Kaul & Ryu, 2001). The inclusion of the private sector is viewed as essential for credibility given the dominant impact of transnational flows of finance and goods characteristic of this wave of globalization (Kaul & Ryu, 2001). Accordingly, a leading approach to policy in the international arena has been the development of global public private partnerships (GPPPs) to govern the provision of GPGs.

Global Public-Private Partnerships and Global Public Goods

Global Public Private Partnerships have been termed "social experiments" in public policy as they mark an innovative, if not entirely new, approach to the management and provision of public goods (Widdus, 2003). In the health sector, they are defined as "collaborative relationships that transcend national boundaries and bring together at least three parties to achieve a shared health creating goal" (Buse & Walt, 2000a; Buse & Walt cited in Reich, 2002). In the past decade, GPPPs have emerged as a strategy to overcome past market and public failures in national and international public health

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(Buse & Walt, 2000a: 549). Moreover, GPPPs encompass a variety of partnerships[5], including those with legal status, those with de facto joint governance between the partners, and those with informal, close collaborations (Buse & Walt, 2000a).

Notably, GPPPs are appealing to multi-lateral organizations such as the United Nations, World Bank, World Health Organization, International Chamber of Commerce, pharmaceutical companies and health oriented non-governmental organizations for several reasons. First, it is assumed that GPPPs have the capacity to control the transfer of public goods or bads across national borders, or to guide the process of privatization (e.g. the growing global concern with the privatization of water). Second, stakeholders are increasingly acknowledging that the breadth and complexity of the world's health problems are too large for only one sector to manage. Third, public organizations, like the WHO which has seen minimal increases in its total budget over the last twenty years, are keen to pursue "open and constructive relations with the private sector and industry" (WHO 1998 cited in Reich, 2002). Finally, the new environment has also created the potential for an expanded role for NGOs and civil society organizations, particularly with respect to the reform of health systems.[6]

Global Public-Private Partnerships and Health

The ideological debate surrounding GPPPs and their role in the provision of health hinges on issues of access. Underlying many of the world's current health concerns is evidence of the rising inequities in financial and health resources between developed and developing countries (UNDP, 1999a; Upadhyay, 2000). Inequities in resources are associated with the overwhelming burden of disease in developing countries relative to developed countries. However, although the developing world carries a disproportionate burden of communicable diseases, the unprecedented international migration of people has meant that these diseases are no longer isolated to these regions, for example, the global spread of HIV/AIDS, antibiotic resistant Tuberculosis, and more recently the spread of Severe Acute Respiratory Syndrome or SARS (Arhin-Tenkorang & Conceicao cited in Kaul, 2003). From a political perspective, inequities in resources between rich and poor nations are also associated with global health risks such as war and terrorism (Kaul, 2000).

Proponents of GPPPs suggest that their presence will reduce health inequities between developed and developing countries by (1) addressing the divide between the multi-faceted, global nature of health challenges, and the current configuration of domestic policy and regulatory frameworks; (2) the public/private configuration of the organization will decrease the bureaucratic management of international relations common to the existing system, and allow for an increasingly systematic combination of national and international players; (3) GPPPs offer the potential for multiple actors to democratize the process of developing an international policy agenda, whereas previously it had been primarily an intergovernmental process, and (4) GPPPs provide effective incentives to motivate both public and private actors to develop efficient, effective means to provide public goods, and in particular to provide health services (Kaul, 2000; Reich, 2002).

On the other hand, those who are skeptical of GPPPs make the following arguments:

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[5] These include (1) product based partnerships, (2) product development partnerships, and (3) systems/issues based partnerships. See Thomas & Curtis 2001 and Buse & Walt, 2000 for a more comprehensive discussion.

[6] Note Medecins Sans Frontiers' Access to Essential Medicines Campaign. They have been successful in restarting production on several drugs to treat sleeping sickness, as well as decreasing the price of AIDS drugs in Africa. In addition, as a result of this campaign legislation has been passed or affirmed in Kenya and South Africa to make essential drugs more accessible to their poorest populations (MSF Activity Report 2000/2001).

(1) GPPPs contribute to the public/private divide in the provision and consumption of health services, which may exacerbate existing inequities both within and between countries (Kaul et al., 2003). The claim that GPPPs "democratize" the international health policy agenda through the involvement of multiple partners assumes a level political, financial and social playing field between developed and developing countries. This view overlooks a number of important differences at the national level (e.g. variations in political cycles, political stability, financial stability and infrastructure) that could have a substantial impact on the ability of GPPPs to achieve both short and long-term goals (Phillips, personal communication, June 2003).

(2) At the national level, countries that have historically had negative experiences of colonialization may feel protective of their national identity and view GPPPs as a 'new form of elitism' dominated by the governments and businesses of developed countries (Lee, personal communication, June 2003; Phillips, personal communication, June 2003).

(3) At the national level, economic reforms and an emerging neo-liberal ideology (e.g. Structural Adjustment Programs [SAP] and the Poverty Reduction Strategy Papers [PRSP]) had already initiated the privatization of public health care services in many developing countries, for example, China and Sub-Saharan Africa (Sen & Koivusalo, 1998). In developing countries where the privatization of public health services resulted in a reduction in access to health care services among countries' poorest members, the confidence of both the public and governments in the purported benefits of the privatization of health services on an international scale through GPPPs has been undermined (Phillips, personal communication, June 2003).

(4) The relationship between GPPP partners is often controversial and contentious, requiring compromise on all sides (Lee, personal communication, June 2003). This is particularly true in the developing world where many governments are struggling to retain public trust and credibility in their ability to provide social welfare services following the introduction of SAPs and PRSPs. GPPPs create competition between the public and private sector for health professionals within countries, thereby further undermining the ability of the public sector to provide adequate services. With respect to retaining their legitimacy, developing countries are also hesitant to hand over the control of delivery of social services to Civil Society Organizations (CSOs), while simultaneously aware that they need their assistance (Phillips, personal communication, June 2003). For their part, many CSOs are frustrated with what they perceive as limited access to participate in GPPPs.

(5) The arguments for and against GPPPs rarely take into consideration their role (or absence thereof) in the provision and management of 'global public bads'. The management of GPBs highlights the tension between the national and international provision of public goods. Unlike global public goods, where the key issue is to ensure access for all, global public bads require management to limit consumption, or prevent it entirely. With respect to health care, the majority of public bads (e.g. polluted water, polluted air, the spread of infectious disease) have been left to the nation state to manage through the public health sector.

The majority of GPPPs have well-defined, narrow agendas that focus on the production of public "goods" (e.g. the donation and distribution of essential medicine, vaccine programs, research and development) at the national and international level. Critics of the privatization of public health services contend that the depletion in resources in the public health sector at the national level is contributing to current global public health challenges (e.g. HIV/AIDS) (Deber, 2000; Sen & Koivusalo, 1998). However, little is being done at the international level through GPPPs to address

inadequacies in national health public health systems. As the recent attempt to control the global outbreak of Severe Acute Respiratory Syndrome (SARS) illustrates, the international management of global public bads such as infectious disease, is in its infancy, and has yet to benefit from the resources invested in GPPPs.

Global Public-Private Partnerships, Health & Private Sector Involvement

Organized capital (e.g. The World Bank) has emerged as a new power in the management of GPGs, and according to some experts offers the potential to address the pressing concern of rising inequities in health (McKinsey & Gates, 2002). For their part, private foundations in the US have responded to the current political environment by increasing their role in creating and financially supporting GPPPs (for example, The Bill & Melinda Gates Foundation, the Edna McConnell Clark Foundation, and the Rockefeller Foundation).

The private sector (e.g., foundations, pharmaceutical companies) is motivated to participate in GPPPs by a growing demand for corporate responsibility and accountability, and the hope to improve corporate image and enhance corporate citizenship. They are also interested in increasing the influence of corporations, multi-nationals and transnationals in the global policy arena. In addition, there are often direct financial benefits for the private sector (e.g. tax deductions, market development and market penetration) associated with work in the health sector. Finally, companies, particularly drug companies, are motivated to promote their brands through donation programs (Buse & Walt 2000a; Thomas & Curtis, 2000).

There are a number of opportunities associated with the blending of public and private cultures (see figure 5a). Furthermore, it creates an opportunity for public sector organizations to learn new skills, particularly in management. The focus on a narrower health agenda may improve the monitoring and surveillance of health problems, which has been a particular concern in developing countries. Finally, it offers the potential for developing countries to strengthen capacity by supporting sustainable infrastructures capable of delivering vaccines, administering treatments and monitoring disease (Ahrin-Tenkorang & Conceicao cited in Kaul, 2002).

On the other hand, a number of concerns have been raised in relation to private sector involvement in GPPPs for health. First, there are fundamental differences in norms, values and motivation between the public and private sector (Buse & Walt in Reich, 2002). Second, there are concerns that the profit motive may obscure public health objectives; for instance seeking to develop new products subsidized by public funds, or donating drugs to claim tax deductions. Third, the private sector may be more inclined to narrow the health agenda to funded projects, at the expense of strengthening health delivery systems. A related concern is that GPPPs may limit partnerships to "win-win" situations, whereby countries that are considered high risks are abandoned in favour of more amenable political and social climates (Buse & Walt in Reich, 2002).

With respect to the gendered impact of private sector involvement in GPPPs, there is concern that women's health will not be a priority in the blending of public and private cultures as there are few, if any processes to ensure women's health remains on the agenda. Perhaps more troubling is the lack of high level, female decision makers in the private sector to ensure a place for women's health within GPPPs (see Appendix 2). The narrower health agenda of GPPPs has specific implications for women. Gender inequities are rooted in social forces (e.g. poverty), which are not typically addressed through the focused agendas of GPPPs. A related concern is that the limited agenda overlooks women's social responsibilities (e.g. water collection, caregiving) and the role they play in women's experiences of health. To protect women's health, there is a need for a global agenda that prioritizes

gendered aspects of health, which is developed and facilitated by an international body governing GPPPs.

Figure 5a: Summary of Private Sector and GPPPs: A Gendered Analysis

PRIVATE SECTOR INVOLVMENT*		
Challenges	*Opportunities*	*Gender Considerations*
Differences in norms, values and motivation.	*Opportunity for Organizations to learn new skills,* particularly in management.	*Concern that women's health will not be a priority* in the blending of public-private cultures.
Profit motive may obscure public health objectives.	*Improve monitoring and surveillance* of health problems. *Strengthen capacity in developing countries* by supporting sustainable infrastructure.	
Private sector has increasing influence over the agendas of international organizations.	*UN assistance no longer as dependent* on political and economic objectives.	*There is a need for a global agenda in women's health which all (private and public) sign.*
Fragmentation of existing international cooperation in health. *Potential for corruption at international level.*	*Coalition building at national level.* *Drug donation programs:* Commonly associated with fragmentation of international cooperation and corruption. However, they are useful in bringing much needed drugs, vaccines and other health products to populations who cannot afford to pay for them.	*Delivery and distribution of drugs should occur within the context of existing national priorities.* However, existing national priorities may not prioritize women's health without the resources encouraging this. *Potential for public private investment in maternal/ reproductive health*, particularly in development of contraceptives.
Narrow the health agenda to funded projects.	*Ability to deploy rapid response health task forces.*	*Gender health inequities rooted in social forces* (e.g. poverty). These are typically not addressed in narrow agendas of GPPPs (see case study below).
Partnerships may shift locus of expert, health advisory committees outside the UN.	*Potential for broader input and greater innovation.*	*Concern that women's health will not be a priority*, technical health committees will not have adequate female representation.
Access and Availability of Medical Knowledge.	*Less bureaucratic.* Potential to take a leadership role in making health related knowledge and technology more accessible.	*The availability of gender specific medical knowledge* and women's access to medical information is not ensured in the new, rapid transmission of knowledge.

** Sources: IPPI Sept. 2001. Ed. Karin Holm; Arhin-Tenkorang & Conceicao in Kaul 2002: 499; Buse & Walt in Reich 2002: 187; Reich 2002; IPPI Mtg of Managers Oct. 2001.*

Global Health Governance & Global Public-Private Partnerships: A Gendered Analysis

Global public-private partnerships are in a position to develop a template for global health governance that will transform the global health system for future generations (see Figure 5b). In particular, if leadership for GPPPs is established through the development of an international governing body, there is the potential to influence health system reform on a global scale. However, there are as yet no standards for the governance, evaluation, accountability or transparency of GPPP processes (Reich, 2002). With respect to accountability, it remains unclear where it will lie given that it is to shareholders in the private sector, and to political structures in the public sector. Further, the criteria for membership in governing bodies has yet to be determined, and is currently dominated by northern scientists and the commercial sector (Buse & Walt in Reich, 2002). Finally, despite concerns that the private sector will dominate the development of a framework for global health governance, it remains unclear who will emerge as the leader in the development of a legislative framework for GPPPs.

Given the historical lack of opportunity for women to participate at senior levels in private, for-profit organizations, there are concerns that women will not be in a position to influence the development of a governance framework during this "transformative" phase (see Appendix 2). Finally, if women are invited to participate, there are concerns about the geographical and racial diversity of the select group. In general, women from developing countries, with fewer resources and connections are less likely to be in a position to influence the evolution of an international framework for health.

Figure 5b: Summary of Governance: A Gendered Analysis

GOVERNANCE*		
Challenges	*Opportunities*	*Gender Considerations*
No standards for governance, evaluation, accountability, transparency.	*Potential to develop a template* that will transform the global health system for generations to come.	*Women's ability to influence the framework* during this 'transformative' phase.
Accountability: is very different in public versus private sector. *Transparency*: Membership in governing bodies is unclear. Few partnerships include LIC representation.		*Women are underrepresented in decision making*, particularly at the senior level in private, for-profit organizations (see Appendix 2). *Which women may be invited to participate and at what venues?* *Women from developing countries,* with fewer resources and connections less likely to influence the agenda.
Concerns that the private sector will dominate the leadership of GPPPs.	*Potential to transform health systems reform* through new, innovative approach to global leadership in health.	*Women are not currently in the positions of power* necessary to influence the leadership of GPPPs.

**Sources: IPPI Sept. 2001. Ed. Karin Holm; Arhin-Tenkorang & Conceicao in Kaul 2002; Buse & Walt in Reich, 2002: 187; Reich 2002; IPPI Mtg of Managers Oct. 2001.*

Future Research

Our review of the literature to date has revealed a number of areas that warrant further research. First, we did not find any gender analyses of the role of GPPPs in the delivery of health services. Second, based on our findings that women are poorly represented at high levels in World Financial Institutions, the World Trade Organization and Regional Development Banks, it is clear that more research is needed on the social position of women vis-à-vis the governance structure of GPPPs. Further, from a policy stance, more high level discussions are needed with respect to the power and influence of women in decision making in GPPPs. Third, more research is needed to develop an evaluative framework to determine the gendered impact of these 'social experiments' (Widdus, 2003). Finally, the role of global public bads as they relate to the national/international tensions implicit in the formation of GPPPs warrants further research, in addition to further analysis from a gendered perspective.

Global Public-Private Partnerships Case Study: The International Trachoma Initiative[^^^]

Based on work by Dr. Paul Courtright and Dr. Ken Basset (2002)

Background

In 1997 the WHO developed an initiative to combat blindness known as the Vision 2020 Initiative. Its stated goal is to "coordinate activities and mobilize resources to assist national governments with trachoma control programmes as part of primary health care" (Vision 2020 cited in Reich, 2002: 43). WHO took a multi-faceted approach referred to as 'SAFE' which includes: **S**urgery to correct advanced stage trachoma; **A**ntibiotics to treat active infection; **F**ace washing to reduce disease transmission; and, **E**nvironmental improvement to increase access to clean water, better sanitation and health education (Reich, 2002).

In the following year, the Edna McConnell Clark Foundation[7] and Pfizer Inc[8] announced the formation of the International Trachoma Initiative (ITI), a non-profit organization with the goal to implement a multifaceted strategy to combat trachoma (Reich, 2002). In 1999, the ITI programme identified Ghana, Mali, Morocco, Tanzania and Vietnam as the first countries for its trachoma control programme. By 2001, Ethiopia, Nepal, Niger and Sudan were included in the programme.

Early indications of the impact of ITI are promising: In December 2000, ITI announced that pilot projects in Morocco and Tanzania had cut the prevalence of trachoma by over 50% among two million people in just over one year (Reich, 2002). The initiative has received an additional $6 million in funding over three years from the Clark Foundation; from Pfizer it has received 10 million doses of Zithromax and $6 million in funding over three years for operational expenses. Bill and Melinda Gates Foundation have also contributed $20 million over five years, and the United Kingdom's Department of International Development has agreed to provide approximately $2 million over the next year (ITI cited in Reich, 2002).

Women and Trachoma

Trachoma is the 2nd or 3rd leading cause of blindness worldwide. Globally, there are 150 million people affected in 48 countries, 6 million of whom are blind (Kilimanjaro Centre for Community Opthamology, et al., n.d.). This disease is both treatable and preventable. It is an easily spread infection of the eye characterized by repeated infections that scar the upper eyelid, eventually turning it inward. The eyelashes then scratch the cornea, leading to blindness. It is most common in rural communities where access to clean water and healthcare is limited, and overcrowded living quarters are common (Kilimanjaro Centre for Community Opthamology, et al., n.d.).

Trachoma is primarily a disease of women. The rate of trachoma and the risk of blindness from this disease is 3 to 4 times higher in women than in men (GAWH, n.d.). Biological differences explain very little of the increased prevalence among women. Rather, women of all ages experience greater exposure to causative factors, including:

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^^ Special Thanks to Dr. Paul Courtright, Dr. Ken Basset and the Kilimanjaro Centre for Community Opthamology, and the British Columbia Centre for Epidemiologic & International Opthamology for granting permission to include their work as a case study.

[7] The Edna Clark Foundation is a large, private New York based philanthropic foundation.

[8] Pfizer Inc. is a global pharmaceutical company that generated over $13.5 billion in revenue in 1998.

- *Caring for children*: Studies indicate children are the major reservoir for the chlamydial infection associated with inflammatory trachoma (Thylefors et al. cited in GAWH, n.d.).
- *Water*: Inaccessibility of water, disparities in household distribution of water, and an unwillingness to use limited water for hygiene purposes are associated with higher rates of trachoma. However, studies of the relationship between trachoma and distance to water have been inconclusive. (Taylor et al. cited in GAWH, n.d.).
- *Women's socioeconomic status*: Studies have found an inverse relationship between socio-economic status and the risk of trachoma (Millar & Lane cited in GAWH, n.d.).
- *In developing countries, women tend to utilize eye care services much less than men*: (Lewallen & Courtright, 2002). A literature review and meta-analysis of the data revealed that eye surgical rates are 1.2-1.7 times higher for men than for women, despite the fact that women accounted for 63% of all cases with potential for surgery in the study populations (Ibid). It is thought that there is a cultural component to the differences in rates (e.g. women are less likely to seek health care for their eyes). Thus, if surgery is not targeted to women, then women will remain under-serviced compared to men.

In many countries, antibiotic distribution and monitoring has been happening at the expense of other more long-term effective aspects of the SAFE strategy, such as face washing and environmental changes (Kilimanjaro Centre for Community Opthamology, et al., n.d.). Given the factors that place women at higher risk of contracting trachoma, this focus may disadvantage women. Accordingly, The Kilimanjaro Centre asserts that gender should be considered in all four components of the SAFE strategy.

In some countries (notably Tanzania) antibiotic distribution programmes are vertically organized, which can be a significant burden on the time of health care staff. More research is necessary to determine whether this time burden differentially affects male and female healthcare providers (Kilimanjaro Centre for Community Opthamology, et al., n.d.).

Also of concern is the cost of distributing the antibiotics. In Tanzania, the district health authorities were recently asked to adopt the cost of distribution. The gap between the donation and distribution of antibiotics in many health systems has been identified as a common problem in health GPPPs (IPPI, 2001). An oft-cited criticism is that the distribution of donated drugs in developing countries takes important resources away from other sectors in the health system, notably the public health system (IPPI, 2001). The relative effect of this shift in resources on female and male health professionals as well as the general public have yet to be researched (Kilimanjaro Centre for Community Opthamology, et al., n.d.).

Finally, reductions in the prevalence of trachoma have been reported from developing countries (Gambia and Malawi) that have yet to benefit from GPPP involvement in antibiotic distribution for trachoma. These reductions paralleled targeted improvements in sanitation, water supply, education and access to healthcare. Based on the factors known to place women at higher risk of trachoma, improvements in these areas could have a gendered impact on the incidence of disease.

GLOBALIZATION
GENDER & HEALTH

KEY ISSUES AT THE INTERFACE

Food Security and Nutritional Well-Being

HIV/AIDS

Tobacco

Occupational Health and Safety

Mental Health

Infectious Disease

Violence

CHAPTER 4: KEY ISSUES AT THE INTERFACE

Brief Introduction to the Globalization, Gender & Health Issue Papers

Much of the analysis documenting the linkages between globalization and health fails to recognize the gendered impacts. Clearly, men and women experience different patterns of illness and different lifespans (Wizemann & Pardue, 2001) which vary considerably between countries at different development levels. This gap persists despite an extensive body of literature documenting the relation between sex and gender divisions and women's health (Doyal, 1995; WHO, 1995/1998/2001c). Biologically, the capacity for reproduction puts women in a vulnerable position with respect to controlling fertility, and ensuring safe pregnancy and childbirth (Doyal, 2002). Social factors also play a significant role in the differences. Indeed, the literature suggests that in no society are women treated as equals to men (UNDP, 1997/1999a; United Nations 2000a/b)—a fact that has substantial consequences for women's health (Doyal, 2001).

The following section presents a number of health related issues that highlight a differential health impact on women and men as a result of globalization. These include overviews of food security, HIV/AIDS, tobacco, occupational health, mental health, infectious disease and violence. With some of the issues there is a considerable amount of data that demonstrates a robust relationship. In other cases, the impacts are less well documented and rely on speculative literature and some case study analysis. Nevertheless, all of the examples underscore the significance of globalization as a powerful catalyst for changes in health status, some of which are positive, more of which are negative, for many women, world wide.

A. Food Statistics and Features at a Glance^

Prevalence of Child Malnutrition using World Development Indicators*								
Region / Country	Child Wasting	Child Stunting	**Region / Country**	Child Wasting	Child Stunting	**Region/ Country**	Child Wasting	Child Stunting
North America			**Eastern Europe**			**Sub-Saharan Africa**		
Canada	–	–	Ukraine	3	16	Kenya	22	33
United States	1	2	Uzbekistan	19	31	Ethiopia	47	52
Central America			**Middle East**			**West Africa**		
Costa Rica	5	6	Lebanon	3	12	Gambia	17	30
Guatemala	24	46	Kuwait	2	3	Sierra Leone	27	n/a
South America			**Northern Asia**			**South Africa**		
Chile	1	2	China	10	14	Zimbabwe	13	27
Bolivia	8	27	Mongolia	13	25	Zambia	24	42
Western Europe			**South-East Asia**			**North Africa**		
France	–	–	Philippines	32	32	Togo	25	22
			India	53	52	Senegal	18	23

* *Numbers refer to the % under age 5* — *Source: World Bank, 2003.*

^ *Given the absence of gender-disaggregated data, child malnutrition is used as a proxy for female malnutrition.*

B. Background

Women are differentially affected by global food security as a result of: (1) the gendered division of labour; (2) disparities in household distribution of food that disadvantage women; (3) a global increase in the number of women who are heads of household; (4) the strong link between maternal and child nutrition; (5) biological differences in dietary needs, primarily due to women's reproductive role; and, (6) a dearth of scientific research on the impact of agricultural chemicals and the use of genetically modified foods on women.

C. Key Issues at the Interface

Issue 1: Multilateral Agreements, Corporations & Domestic Policy

- *The appropriation of food production by transnational agribusiness corporations* is displacing small farmers. In the developing world women constitute the majority of sustenance and marginal farmers. As women are displaced from the land and their ability to produce food for domestic consumption decreases, many are seeking work outside the agricultural sector in order to earn the income necessary to purchase food (Kulkarni, 2002; Storey, 2002). For many women this adds considerable daily travel time to their pre-existing household responsibilities, resulting in exhaustion and protein energy malnutrition
- *The reduction in safe water as a result of monocropping* is forcing women to expend more energy to sustain the household. In some rural areas women now spend up to 4-5 hours/day fetching water (Khosla & Pearl, 2003). An increase in energy output without adequate nutrient intake will result in protein-deficiencies amongst women (Kulkarni, 2002). Also of concern is the fact that irrigation and access to water for agricultural production is typically a male responsibility, whereas women are responsible for domestic water collection (Kulkarni, 2002; Francisco, 2000). The gendered division of responsibility between water for agricultural production and that for domestic consumption is contributing to concerns with access and availability to safe water.

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Issue 2: Increases in Imported Foods

- *National food shortages are occurring as developing countries struggle to earn sufficient foreign exchange to import required foods.* Despite efforts to increase export production, it is projected that by 2020 many developing countries will not have sufficient foreign domestic exchange to import required food (FAO, 2002a). Food shortages are experienced differently by men and women at the household level due to widespread disparities in the intra-household allocation of food that disadvantage women (Haddad, 1999; Messer, 1997)
- *In developing countries where the need for imported food is increasing, and the capacity to provide appropriate surveillance of food safety standards is declining, there is a possibility that large portions of the population will be exposed to untested genetically modified foods (GMF).* This is significant because there is relatively little known about the potential transfer of genes from GMF to humans (WTO/WHO, 2002). Furthermore, given the historical lack of participation of women in clinical and scientific trials, there may not be sufficient evidence to support a female specific health exemption too the WTO Agreement on Technical Barriers to Trade (Gammage et al., 2002). Specifically, there is limited knowledge about the implications of exposure to GMF for reproduction/pregnancy and lactation. Finally, the increasing reliance on foreign food undermines women's capacity to provide safe, nutritious food for their families.

Issue 3: Introduction of Genetically Modified Foods

- *The content and evolution of women's technical, agricultural knowledge is often seemingly at odds with the patenting requirements of TRIPS.* An additional barrier for women in the developing world is their limited access to financial and legal resources to pursue patents (Gammage et al., 2002). This issue, and the pursuit of sui generis systems for protecting traditional knowledge, has yet to be adequately addressed by the WTO Council on TRIPs.
- *Genetically modified organisms (GMOs) present concerns with "out-crossing"* (the development of more aggressive weeds with increased resistance to diseases or environmental stresses). As farmers on marginal land, women will be the first to experience the impact on their ability to produce food (Francisco 2000)

Issue 4: The Movement of People and Ideas

- *Violence and migration.* At all levels, violence also reduces women's ability to grow and produce their own food. Indeed, at the national level, women and children constitute the majority of refugees, and as such are often exposed to situations where food is in short supply, and where protein-energy malnutrition and vitamin deficiencies are a serious concern. At the household level, domestic violence affects the allocation of food; studies have demonstrated a significant negative association between wife beating and the caloric consumption of the children in the household (Haddad, 1999). The displacement of women and children also reduces women's long-term ability to grow and produce their own food.
- *The global obesity epidemic is affecting men and women differently.* Although men are more likely to be overweight, the prevalence of obesity is higher for women, particularly in countries undergoing rapid transition, such as Algeria, Argentina, Chile, China, Egypt, Indonesia, the Islamic Republic of Iran, Kiribati, Morocco, Uzbekistan and many Caribbean countries (WHO, 2000e).

HIV/AIDS Issue Paper*

A. HIV/AIDS Statistics and Features at a Glance *(Source: UNAIDS, 2002d)*

	Epidemic Started	Adults & Children Living with HIV/AIDS	Adults & Children Newly Infected	Adult Prevalence Rate %	% Positive Adults (Women)	Main Mode(s) of Transmission for those living with HIV/AIDS**
Sub-Sarahan Africa	Late 70s Early 80s	28.5 million	3.5 million	9	58	Hetero
North Africe & Middle East	Late 80s	500,000	80,000	0.3	54	Hetero, IDU
South/ South East Asia	Late 80s	5.6 million	700,000	0.6	37	Hetero, IDU
East Asia / Pacific	Late 80s	1 million	270,000	0.1	24	IDU, Hetero, MSM
Latin America	Late 70s Early 80s	1.5 million	140,000	0.5	31	MSM, IDU, Hetero
Caribbean	Late 70s Early 80s	420,000	60,000	2.3	50	Hetero, MSM
Easter Europe & Central Asia	Early 90s	1 million	250,000	0.5	26	IDU
Western Europe	Late 70s Early 80s	550,000	30,000	0.3	26	MSM, IDU
North America	Late 70s Early 80s	950,000	45,000	0.6	20	MSM, IDU, Hetero
Australia & New Zealand	Late 70s Early 80s	15,000	500	0.1	7	MSM
TOTAL		**40 million**	**5 million**	**1.2**	**50%**	

** The proportion of adults (15-49) living with HIV/AIDS in 2001, using 2001 population numbers*
*** Hetero: Heterosexual transmission -- IDU: transmission via injection drug use -- MSM: sexual transmission among men having sex*

- In 2000, HIV/AIDS was the 3rd leading cause of disability adjusted life years for both sexes of all ages, accounting for 6.1 percent of the global total (WHO, 2001b: p. 27).
- In 2000, HIV/AIDS was the 1st leading cause of disability adjusted life years in females of all ages, accounting for 6.5 percent of the global total (WHO, 2001b: 27).
- In 2002, 42 million adults and 5 million children were living with HIV/AIDS – More than 95% of them in developing countries and 70% living in Sub-Sahara Africa (World Bank, 2003: 11). In addition, since the beginning of the epidemic 14 million children have been orphaned by AIDS (Hagen, 2002: 39)
- Approximately half of the new cases of HIV/AIDS in developing countries are women (UNAIDS, 2002e). Within countries, the HIV/AIDS epidemic may exacerbate income disparities between men and women, in part because of the rise in women's caregiving responsibilities for those infected and the substantial increase in the number of HIV positive women.

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B. Key Issues at the Interface

Issue 1: Multilateral Agreements and Domestic Policy

- *Under TRIPS, access to antiretrovirals is limited*, including those used to prevent mother-to-infant transmission (UNDP, 2002; WHO, 2001a; Women's Global Network for Reproductive Rights, 2002). In addition, powerful stakeholders involved in negotiations between multi-national pharmaceutical companies and governments are predominantly male reflecting dominant gendered power relations in society (UNDP, 1999a; United Nations 2000b).
- *Public health surveillance systems may be compromised by reductions in public sector funding* (Lee, 2000) and thus the collection of sex-disaggregated data and our ability to monitor the trajectory of the disease and target intervention strategies accordingly may be compromised.
- *Reduced government expenditures, the hollowing out of the welfare state and the increase in privatization* may have a disproportionate effect on women who are among the poorest and most marginalized segments of many societies (Doyal, 2002). The rapid decline and loss of social and health related services once supported by the state translate into a significant increase in women's and girl's reproductive work within the home, particularly in areas where the HIV/AIDS epidemic is at its worst (see HelpAge International; Ainsworth & Dayton, 2003; Barrientos et al., 2003).

Issue 2: Labour Trends and Income Insecurity

- *The decline of the welfare state significantly increases women's and girls unpaid work* as caregivers for those with HIV/AIDS (Doyal, 2002).
- *In the face of unemployment, and income disparities between men and women and the richest and poorest segments of society, women and girls may be more likely to engage in sex work* as a means of supplementing family incomes; placing them at increased risk of HIV infection (Paci, 2002).
- *The growing number of women entering the workforce* may challenge and strain gendered familial and community relationships (for example, where women's working and or work-related travel violate gender norms), potentially increasing these women's risk of discrimination, gender-based violence, and HIV/AIDS.

Issue 3: Population Mobility

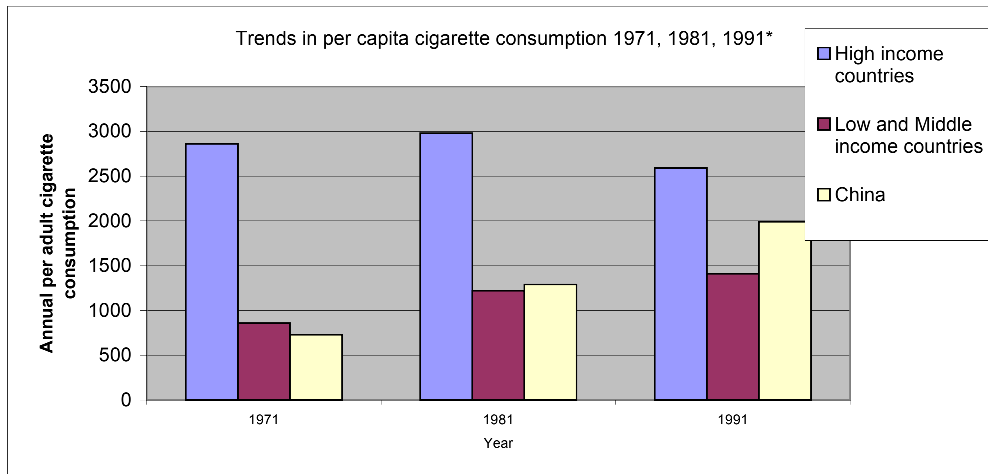
- *Displaced and refugee women may be at increased risk of HIV/AIDS due to sexual violence and a greater likelihood of engaging in sex work*. Similarly, during times of war and civil unrest women and girls are at increased risk of rape, which also increases their risk of infection (UNAIDS 2002a/2002b).
- *The increase in human trafficking is also linked to the spread of HIV/AIDS,* with an estimated 1—2 million people trafficked annually. Women and children represent the majority of trafficked persons (Paci, 2002; UNAIDS, 2002a; UNDP, 1999a).
- *The rapid increase in population density*, such as occurs in refugee camps and other forms of unplanned urbanization including people moving from rural areas to urban centers in search of employment, are often associated with poor living conditions (e.g., inadequate shelter, poor sanitation, etc.). These conditions compromise an individual's immune system leaving people vulnerable to infectious disease, including HIV/AIDS (Stillwagon, 2000). Additionally, these living conditions may increase the likelihood of engaging in high-risk activities such as injection drug use and sex work, or being a victim of sexual violence (Paci, 2002; UNDP, n.d.; UNAIDS 2002a).

- *Men whose work requires them to travel* (truck drivers and peace keepers) and those whose work keeps them away from their families for prolonged periods may be more likely to have unprotected contact with sex workers, which places them at increased risk of HIV infection. The wives and other partners of these men are subsequently placed at risk (UNAIDS, 2002a; Upadhyay, 2000; Women's EDGE, 2002).

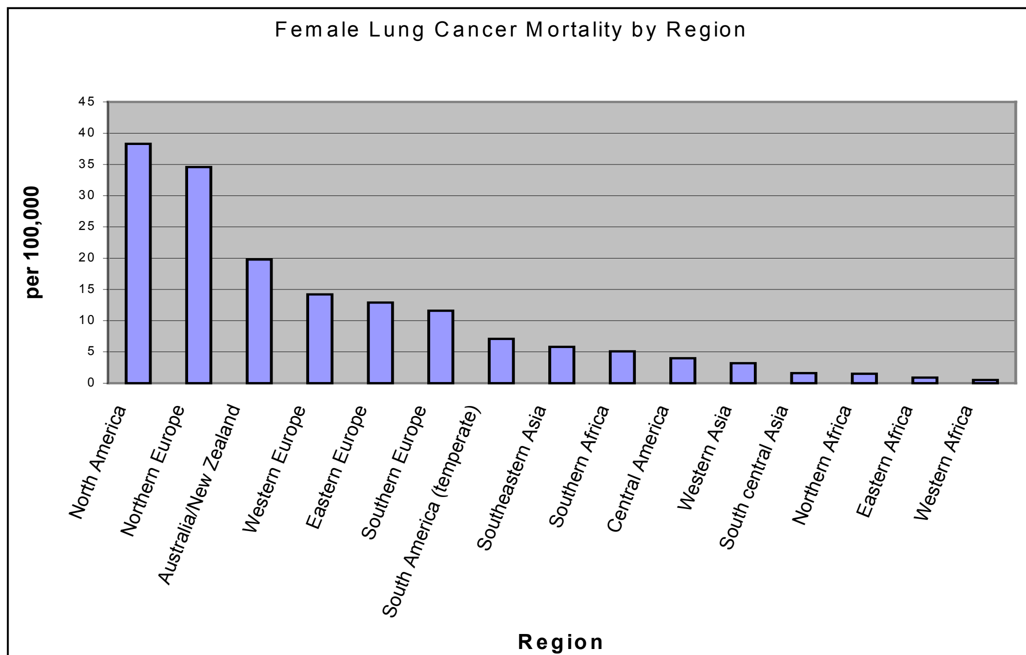
Issue 4: Information Communication Technologies and Civil Society

- *Information communication technologies (ICT) combined with increased population mobility have facilitated the participation and organization of civil society at local, national, regional and international levels on a variety of social issues including HIV/AIDS*. The resulting networks (e.g., The Global Network of Positive Persons GNP+) have been important advocates, giving a voice to people who are otherwise marginalized by societal stigma including gay men, transvestites, male and female sex workers, and intravenous drug users (Hartwig, electronic communication, 2003; UNIFEM, 2000c).

A. Tobacco Statistics and Features at a Glance



Source: Tobacco or Health: A global status report. Geneva WHO, 1997.
**Data not disaggregated by gender.*



Adapted From: Pisani P et.al. Int. J. Cancer: 83, 18-29

- *Projections suggest a four-fold increase in tobacco caused deaths in the developing world between 1990 and* 2020 (WHO 1999b). Currently, four million people die yearly from tobacco related diseases (WHO, 1999b). If current trends continue, WHO (1999b) estimates that by 2030 the number of deaths will rise to ten million.

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B. Background

Globally, 47% of smokers are male and 12% female (WHO, 1999b). While the epidemic of tobacco use among men is in slow decline, the epidemic among women is not predicted to peak until well into the 21st century. Of particular concern is the increase in tobacco use among women in the developing world, and among young girls in parts of the developed world. Currently, 8% of women in the developing world and 15% of women developed world smoke (WHO, 2001). However, it is predicted that without dramatic changes in prevention practices, the prevalence will increase to 20% amongst women in both developed and developing countries (WHO, 2001).

In the US, lung cancer has surpassed breast cancer to become the leading cause of cancer mortality among women. Worldwide, lung cancer currently accounts for over 10 percent of cancer deaths in women (WHO, 2001). Studies suggest that women may be more susceptible to lung cancer than men (Payne, 2001). Women's risk of lung cancer is higher than men's at every level of smoking and for both low and high tar cigarettes. Further, aggressive small cell cancers are more common amongst women. Also of concern is the fact that more women than men with lung cancer are non-smokers. Finally, there has been a recent, rapid increase in the incidence and mortality of lung cancer among young women in the developed world, compared with a levelling off or decrease amongst men.

C. Key Issues at the Interface

Issue 1: Multilateral Agreements and Domestic Policy

- *Reductions in tariff and non-tariff barriers on tobacco and tobacco products have decreased the price of tobacco* (Collishaw et al., 2001; Taylor et al., 2000b). Women in developing countries are a particularly vulnerable demographic to falling cigarette prices given evidence showing a marked association between lower tobacco prices and an increased consumption of cigarettes in low income countries and among the poor (Taylor et al., 2000; WHO, 2001a).
- *Restrictions on governments to regulate tobacco advertising are of particular concern for women in the developing world,* where tobacco companies are undertaking aggressive advertising campaigns that target women as an untapped market (Hammond, 1998; Jenkins et al., 1997; WHO, 2001).
- *The development of the WHO Framework Convention on Tobacco Control (FCTC) is an innovative move towards global health governance.* The goal, which is to develop an international legally binding treaty, is a new development in instituting global governance in health. Lobbying is underway for the inclusion of gender specific content.

Issue 2: Labour Trends

- *The rise in women's employment in the formal and informal sectors particularly in the developing world, may lead to an increase in tobacco consumption.* Women and girls' purchasing power has increased in many parts of the world. Although women and girls continue to earn less than their male counterparts, personal income provides a new opportunity to purchase cigarettes.

Issue 3: Population Mobility

- *The westernization of cultures across the globe is decreasing the social and cultural taboos against smoking for women in many* parts *of the developing world.* In addition, the image of the "westernized" emancipated woman is being used to market cigarettes to women in the developing world (Hammond et al., 1998; WHO, 2001).
- *Despite lower prices for cigarettes and a substantial increase in the global trade of tobacco, smuggling of tobacco products is lucrative, and is on the rise* (Chaloupka & Nair, 2000). The increased movement of people within and across borders, the presence of information communication technologies to facilitate the fast exchange of information within smuggling networks, the increased potential for profit with the rise in cigarette consumption, and the decrease in governments' ability to provide adequate surveillance or enforcement, all contribute to the rise in smuggling. The result is an increase in the availability of cheap cigarettes, which studies show enhances the consumption of tobacco products amongst the poor, of which women constitutes the majority.

Issue 4: Information Communication Technologies and Civil Society

- *Information communication technologies (ICT) have also enabled the formation of a Global Tobacco Surveillance System* that will provide information on prevalence, trends in tobacco use, related morbidity and mortality, and policy and programme interventions. Given the dearth of gender specific data in this area, the new surveillance system will provide important information for gender specific policy and programming (WHO 2001).
- *In the developed world, there has been a recent shift towards the formation of women's anti-tobacco coalitions (e.g. INWAT).* Women in the developed world have also organized two International Conferences on Women, Tobacco and Health (Northern Ireland 1992; Kobe, Japan 1999 cited in WHO 2001).

Occupational Health and Safety Issue Paper*

A. Occupational Health and Safety Statistics at a Glance

- In 1997, the overall economic losses resulting from work-related diseases and injuries were approximately 4% of the world's gross national product (WHO, 1999d; ILO, 2001: 7).
- In 1999, women reportedly made up between 33% and 42% of the estimated global working population (Brundtland, 1999; WHO, 1999d). Moreover, women represent between 60 and 90% of the 27 million workers in the more than 2,000 Export Processing Zones worldwide, where occupational health and environmental legislation may be poor and where hazardous or strenuous production processes are typically concentrated (Cornia 2001: 837; Harcourt, 2000; ILO website 2003).
- A growing number of women from Eastern European countries and China are reportedly working in the sex industry including the sex trade (Paci, 2002). Two-thirds of the estimated 500,000 women trafficked for prostitution come from Eastern European countries (McDonald, Moore & Timoskhina, 2000).
- Women's participation in the labour force has increased in almost all regions. However, more women than men continue to be employed in unpaid family work, with the largest share being in Africa and Asia (World Bank, 2003: 45).

B. Background

Women's experiences in the workplace under the current wave of globalization are distinct from those of men due to: (1) the unprecedented increase in women's participation in the work force; (2) the increasing number of women employed in the growing informal sector – particularly in lower-skilled jobs; and, (3) the increasing double-workload women face in relation to a shrinking public sector. It should be noted that there is a paucity of gender disaggregated data on occupational health and safety. As such, the facts presented below are limited to available data.

C. Key Issues at the Interface

Issue 1: Multilateral Agreements, Corporations & Domestic Policy

- *Trade liberalization and export-oriented growth have increased women's access to jobs and significantly lessened the gender gap in economic activity.* In addition, they have contributed to women's economic independence and in some instances have reduced gender wage differentials (Dollar & Gatti, 1999). However, these benefits have not consistently translated into a net improvement in health or well-being (Beneria et al., n.d.; Loewenson, 2001a/b; Women's EDGE, 2002).
- *Worldwide, women's double workload (paid employment and work in the home) is believed to be increasing in relation to reduced government expenditures and a shrinking public sector.* Consequently, women's risk of work-related illness and injury may also increase (ILO, 1999: Women's EDGE, 2002; UN, 2000b)

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Issue 2: Labour Trends

- *Women and children, perceived as a 'flexible and docile' work force, are over-represented in lower skilled positions within the often volatile informal sector.* This sector is particularly vulnerable to market shifts and is characterized by low wages, few benefits and poor work conditions (Brundtland, 1999; ILO, 1999; Women's EDGE, 2002: 45). This 'feminisation of labour' contributes to a systematic de-skilling of women, which in turn contributes to the 'feminisation of poverty' (Loewenson, 2001a; Women's EDGE, 2002).

- *Women's increasing participation in Export Processing Zones (EPZ) is associated with high levels of machine-related accidents, poor and unsanitary working conditions (e.g., unacceptable exposure to dusts, noise, toxic chemicals and poor ventilation), and discrimination and violence in the workplace.* EPZs are considered high stress jobs and are linked to cardiovascular disease, a variety of psychological disorders, as well as to miscarriage, problems with pregnancies and poor foetal health (ILO, 1999; GOHNET, 2000; Women's EDGE, 2002). Some EPZ companies have reportedly offered incentives to women who undergo sterilization, to avoid losing time for maternity leave (Loewenson, 2001a).

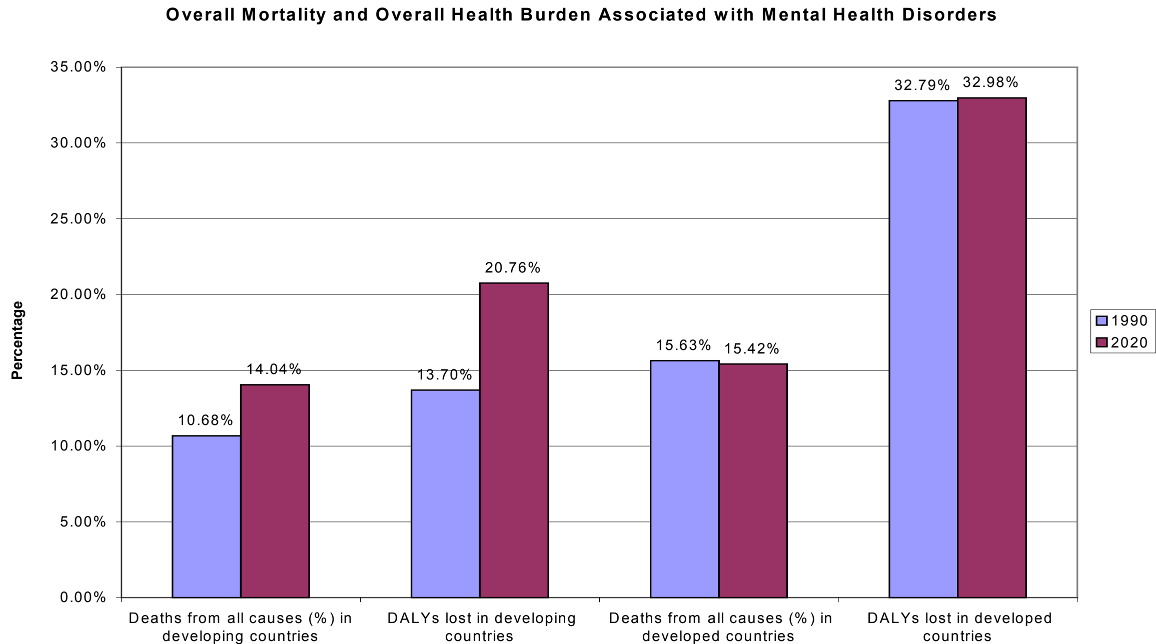
Issue 3: Population Mobility

- *Migration between regions, countries, and between rural and urban areas has increased dramatically during this wave of globalization.* Although women migrate as much as men research suggests that patterns of migration and their relationship to health are gendered (UN, 2000b). For example, many international women migrants employed in the informal sector or in illegal behaviour are at increased risk of violence and discrimination (UN, 2000b; ILO, n.d.).

Issue 4: Information Communication Technologies and Civil Society

- *Advances in information communication technologies (ICT) have benefited workers from around the world to organize and lobby governments, the private sector, and other multinational bodies for better working conditions.* This is especially significant given that worldwide, women are less likely than men to be members of trade unions (Valls-Llobet et al., 1996?). International alliances such as HomeNet, StreetNet and Women in Informal Employment: Globalizing & Organizing (WIEGO), have helped to mobilize women working in the informal sector to lobby industry and international bodies like the ILO for improved working conditions and standards, and have resulted in a number of self-help networks that assist female workers in accessing financial, health, childcare and training services (Carr et al., 2000; Moghadam, 1999; Valls-Llobet et al., 1996?).

A. Mental Health Statistics at a Glance



Source: Phillips, M. (2001). The health burden of mental and neurological conditions and of behavioural problems in developing countries. (Global burden of diseases database).
**Data not disaggregated by gender.*

Mental illness is a result of a number of social, genetic, traumatic and infectious factors and their interactions. This paper focuses on the social factors affecting mental health, particularly those associated with globalization.

- Five of the ten leading causes of disability worldwide are mental health problems (WHO/ILO, 2000). Mental health disorders accounted for 10.7% of deaths from all causes in 1990 in developing countries, and will account for 14% by 2020 (Phillips, 2001). In developed countries in 1990, mental health disorders accounted for 15.6%, a number that is estimated to remain constant to 2020 (Phillips, 2001).
- 90-95% of the cases of depression and approximately 70% of the cases of schizophrenia are untreated in the developing world (WHO/WB, 1996).
- Unipolar or major depression occurs approximately twice as often in women as in men and is predicted to be the number one cause of global disease burden for women by 2020 (Murray & Lopez, 1996; WHO, 2001c).
- Of mental health disorders, depression contributes significantly to the global burden of disease. Therefore, decreasing the overrepresentation of women who are depressed would contribute significantly to a decrease in the global burden of disability caused by psychiatric disorders (WHO, 2002a).

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B. Key Issues at the Interface

Issue 1: Multilateral Agreements, Domestic Policy and Inequity

- *In countries undergoing rapid economic restructuring (e.g. Brazil, Chile, Zimbabwe and India) studies have shown a significant relationship between high rates of depression and anxiety, female gender, low education, and poverty* (Kirmani & Manyakho, 1996; Patel et al., 1999; WHO, 2001c). In Mexico, a country that experienced a significant economic transition, suicide rates have increased 62% in the general population in the last fifteen years (WHO, 2001b).
- *Based on the Gender Empowerment Index and Gender Development Index, no society treats its women as well as its men* (UNDP, 1997). The gender based division between unpaid and paid labour renders women economically and socially more insecure and vulnerable to both chronic and transient poverty that can result from familial, personal and economic crises, including those induced by Structural Adjustment Programmes and Poverty Reduction Strategy Papers (WHO, 2000a).
- *A substantial body of research has linked rising income inequality to increasing rates of common mental disorders*, including depression, anxiety and somatic symptoms (Patel et al., 1999; WHO, 2001c). Socioeconomic change (in any direction) is also often suggested as a contributing factor to rising suicide rates (WHO, 2001b).
- *In the face of reduced public expenditures, women are left to assume a larger proportion of the care of members of their family and community who have HIV/AIDS*. The psychological effects on the members of broken families and on women who remain the primary caregivers of those suffering from HIV/AIDS are as yet unknown, but are believed to be substantial (WHO, 2001b). In addition, the effects of intense stigma and discrimination against people with HIV/AIDS are known to play a major role in the psychological distress associated with the disease (WHO, 2001b).
- *Reduced public expenditures in health care may exacerbate the gap in the clinical care and treatment of depressed and schizophrenic individuals, including access to essential medication, psychotherapy and psychosocial rehabilitation.* Given that women's rates of depression are approximately twice those of men, this has the potential to have a particularly devastating effect on women (WHO, 2001b).

Issue 2: Labour Trends and Mental Health

- *In lower skilled positions, women tend to have less autonomy over their work schedule and pace of work which contributes to depression and anxiety* (WHO/ILO, 2000). This is particularly significant given that studies suggest women are disproportionately represented in lower-skilled positions within the informal sector (Brundtland, 1999; ILO, 1999; Women's EDGE, 2002).
- *Unemployment is a common problem in countries undergoing major economic restructuring (e.g. Hungary, Thailand, China).* Those who become unemployed have over twice the risk of a diagnosis of clinical depression (WHO/ILO, 2000). Women in lower skilled occupations are most vulnerable to job loss. In China, where unemployment is a new problem, widespread joblessness and inability to cope with the pace of social change are viewed as major factors behind the high incidence of suicide attempts among women (Bezlova, 2003).
- *For many women, worldwide, employment tends to be in addition to pre-existing household and caregiving responsibilities* (ILO, 1999; UN 2000b) The literature shows that juggling multiple roles increases women's risk of mental and behavioural disorders, including depression and anxiety (WHO, 2001b).

- *Migrant women are known to be at increased risk of exposure to violence and discrimination*, two factors strongly connected to women's mental well being (UNFPA, n.d.; WHO, 2000a).

Issue 3: Population Mobility

- *Women and children constitute 80% of the 50 million people affected by violent conflicts, civil wars, disasters and displacement* (WHO, 2002a). Women's risk of developing post-traumatic stress disorder (PTSD) following exposure to trauma is approximately two-fold higher than men's (Breslau et al., 1998).
- *Studies suggest that immigrants and refugees fleeing violence, typically women, children and seniors, are at particular risk of mental health disorders* (Health Canada, 2001; Flaskerud & Kim, 1999).
- *The mental health effects of sexual trafficking on the girls and women involved in the sex trade* are likely to include those identified through research on violence against women, and to parallel those experienced by victims of torture (WHO, 2001c).
- *The increase in migrant labour, particularly the movement of men to urban areas has resulted in a substantial increase in farming responsibilities for rural women who remain in the country. In China, this has been linked to a subsequent rise in suicide rates among rural women.* From 1995-1999, rural females (aged 15-34 years) in China had the highest proportion of all suicides when compared with both rural and urban men, and urban women (Yip et al., 2000; Phillips, personal communication, April 15, 2003).

Issue 4: Information and Communication Technologies and Civil Society

- *The spread of western values is challenging traditional inequities between genders.* It is argued by some that the subsequent shift in gender relations is contributing to a rise in domestic violence, although this remains a researchable question as there is no data to support this claim. Gender based violence is a significant predictor of suicidal tendencies in women; more than 20% of women who experienced violence attempted suicide (WHO, 2001c).

Infectious Disease Issue Paper*

A. Infectious Disease at a Glance

- *Children under 5 years, pregnant women, and young mothers are the most vulnerable to infectious disease* (WHO, n.d.1). Indeed, the burden of communicable disease, maternal, perinatal and nutritional conditions, measured as disease rate, is 13 times higher in low and middle income countries than in high income countries (Global Forum for Health Research, 2002). Furthermore, 33% of all causes of death among women are due to infectious diseases (WHO, n.d.1).
- *In 1998, Tuberculosis accounted for 1.5 million deaths globally* (WHO, 2000f; UN, 2000b). The disease is the main cause of death from a single infectious agent among adults in developing countries and has reemerged in high income countries largely as a result of cases among immigrants (World Bank, 2003: 111). In addition, TB is a leading cause of death in women—with women accounting for 40% of all deaths from tuberculosis (UN, 2000b). Women between the ages of 15 and 40 are almost twice as likely to progress from infection to disease than men of the same age, while men are more likely to progress from infection to disease after age 40 (Hartigan, 1999; UN, 2000b).
- *There are an estimated 300 to 500 million clinical cases of malaria and more than 1 million deaths each year* (World Bank, 2001b). It is estimated that the disease kills more than 1 million people per year – most children and pregnant women in sub-Saharan Africa (World Bank, 2001b; WHO, n.d.1). Malaria is an important cause of maternal mortality, spontaneous abortion and stillbirths, and contributes to the development of chronic anaemia (Amazigo, nd; Global Forum for Health Research, 2002; UN, 2000b: 74; WHO, n.d.1/1998/2000f; World Watch Institute, 2003).

B. Background

The relationship between globalization, communicable disease and gender is complex and vastly understudied. Accordingly, the following discussion is intentionally broad and based on the following assumptions:

- The current wave of globalization is associated with unprecedented population mobility within and across borders, increasing and often unplanned urbanization, and a trend towards reduced government expenditures on health, education and other social programs in many countries;
- The negative outcomes associated with these trends have long been implicated in the spread of infectious diseases such as Cholera (see Lee & Dodgson, 2000); and disproportionately affect the world's poor (Hartigan, 1999; Farmer, 1996; WHO, 2000f) – of which approximately 70% are women (UNDP 1995 cited in Doyal, 2002; Farmer, 1996; WHO, n.d.1);
- The relationships between sex, gender and infectious disease can manifest in terms of different susceptibilities/immunities, exposures to disease vectors and protective factors, in the associated symptomatology or disease experience, and in related access to health services (Global Forum for Health Research, 2002; UN, 2000b).

C. Key Issues at the Interface

Issue 1: Multilateral Agreements, Domestic Policy and Labour

- *Heavy debt burdens, subsequent reductions in government expenditures in health and social services, and the introduction of user fees may compromise public health surveillance, prevention, and intervention strategies* (WHO, n.d.1). Weakened health systems and user fees are of particular concern given that

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women often postpone treatment and are less likely then men to access health services for a number of infectious diseases, including Malaria; while men are less likely than women to adhere to treatment protocols (Nanda, 2002; Sachs, 2001; Tanner & Vlassoff, 1998; UN 2000b; World Bank, 2001b). Finally, women may be more readily exposed to infectious disease as they assume caring responsibilities for sick members of their family and community in the face of these changes.

- *In some instances, increases in international trade have created conditions conducive to the spread of infectious disease;* for example, the international trade in tires has reportedly introduced dengue vectors in several countries in Europe, the Americas, and Africa (WHO–TDR website, 2002). The gendered dimensions of such phenomenon are largely understudied.
- *In many developing countries, paid and unpaid informal work with refuse may place the women and children who typically do this work at increased risk of exposure to disease vectors and subsequent infection.* Families who live on or near refuse sites are especially vulnerable. (See ILO http://www.ilo.org/public/english/dialogue/actrav/enviro/backgrnd/wesdcs2.htm; UNFPA, n.d.).

Issue 2: Population Mobility

- *The movement of people within and across borders accounts for changing geographical patterns of infectious disease and poses a significant challenge for public health measures designed to monitor and contain such outbreaks.* In addition, transnational migration potentially reintroduces 'eradicated' diseases in developing countries, such as smallpox (UNDP, 1999a; WHO, 2000f; World Tourism Organization, 2002). Although women migrate as much as men do, there appears to be a paucity of critical research on the gender dimensions of the various types of migration and how these may be differently associated with communicable diseases, whether airborne or waterborne (UN, 2000b).
- *It is estimated that approximately half of the world's refugees are infected with Tuberculosis* (WHO, n.d.2). At the start of the year 2002, in most regions, women and girls of all ages constituted between 45-55% of the global refugee population (UNHCR, 2002/2002a). In addition, the poor living conditions often associated with refugee camps are related to a number of other infectious diseases including HIV, sexually transmitted infections, and diarrhoel conditions.
- *Population density, or unplanned urbanization and subsequent inadequate infrastructure* (poor housing and sanitation, limited access to clean water, overcrowding, etc.) are fertile conditions for the spread of infectious diseases and poor people are more likely to be the first exposed to these disease vectors (WHO, 2000f; ILO, 2003a/2003b). Indeed, 'from 1990 – 2001, telecommunications and electricity captured most of the investment in infrastructure projects with private participation in developing countries, while water and sanitation accounted for 5 percent' (World Bank, 2003: 261).

Issue 3: Related Environmental Concerns

- *Changes to the environment including climate change, deforestation, air pollution and water pollution are all associated with infectious disease.* The WHO (2000f) suggests that these environmental changes, most notably deforestation, have brought humanity into closer contact with animals and insects that harbour disease. In addition, climate change and unusual weather patterns can affect animal habitats and cause a clustering of new diseases that affect humans. Such was the case with the 1993 U.S. Hantavirus Pulmonary Syndrome outbreak, and recent outbreaks of Dengue and the more serious Dengue Haemorrhagic Fever in the Americas and in parts of Asia and Africa as the mosquito carrying this disease extends its reach (WHO, 2000f; WHO-TDR website 2002).

Violence Issue Paper*

A. Violence at a Glance

- The total number of conflict-related deaths has reportedly increased over the last four centuries (WHO, 2002c). Worldwide, the highest rates of war-related deaths were found in the WHO African Region (32.0 per 100 000), followed by low-income and middle-income countries in the WHO Eastern Mediterranean Region (8.2 per 100 000) and WHO European Region (7.6 per 100 000), respectively. Interestingly, the number of civilian casualties has also increased (WHO, 2002c).
- At approximately $800 billion annually, global military expenditure and arms trade account for the largest spending in the world (cited in UN Chronicle, 2003: 9)
- During the 1990s, the number of refugees and internally displaced persons grew by 50% (UNDP, 2002: 11). In the beginning of 2002, women and girls of all ages constituted between 45-55 percent of the refugee population (UNHCR, 2002).
- In 48 population-based surveys from around the world, between 10% and 69% of women surveyed reported being physically assaulted by an intimate male partner at some point in their lives (WHO, 2002c: 89). Although physical violence against partners cuts across all socio-economic groups, studies suggest women living in poverty face a disproportionate risk of this violence (WHO, 2002c). Additionally, surveys suggest that approximately 1 in 5 women worldwide will suffer rape or attempted rape in their lifetime (WHO, 1998).
- An estimated 700 000 to 1.5 million women and children are trafficked across international borders annually (IOM, 2001). In fact, some studies suggest that an estimated 4 million women and girls are bought and sold worldwide, either into forced prostitution, slavery or forced marriage. This practice has become one of the fastest growing international criminal enterprises, earning traffickers an estimated US$7 billion per year (Hughes, 2000).
- UNICEF (2001) suggests that globalization has made it easier for traffickers to transport women and children across borders, and has increased the number of destinations where paedophiles can seek sex with children. One study conducted in the US revealed that 1 in 5 children who go online regularly are approached by strangers for sex. Similarly, in 1998, US$1 billion was spent online on 'adult content', comprising 69% of the total internet content sales (Moore cited in Hughes, 2000; see also Hughes, 2002 for discussion of ICTs and sex industry).

B. Background

Violence against women is associated with a variety of negative health outcomes ranging from acute injuries, functional impairments and permanent disabilities, a variety of gynaecological disorders, post-traumatic stress disorder, depression, anxiety, alcohol and substance abuse, sexually transmitted diseases, as well as homicide, suicide, maternal mortality and infant mortality (Heise et. al., 1994/1999; WHO, 2002c; UNFPA, 2001). Poverty and inequality mediate the complex relationship between violence and globalization, and are in turn associated with both the perpetration of violence and the risk of being a victim. In this way, poverty acts as a 'marker' for a variety of social conditions that in combination increase women's risk of experiencing violence (WHO, 2002). This relationship is significant because the benefits of globalization have not been evenly distributed within and among countries and as such globalization has in some instances contributed to widening inequality and inequity (UNDP, 1999a; WHO, 2002c).

* *Suzanne Sicchia, Heather Maclean, Ron Labonte, Keva Glynn*

C. Key Issues at the Interface

Issue 1: The Pace of Change and Gender Based Violence

- *Economic instability* in countries where there has been rapid social change (increased unemployment, currency devaluation, reduced public expenditures, rise in poverty) in response to global pressures disproportionately affects women (Gyebi et al., 2002; Upadhyay, 2000; WHO, 2002c). Research suggests that in the face of these changes violence against women and children increases (Shin & Chang, 1999; UNFPA, 1998). One example of this complex relationship is the mass rapes of Chinese women in Indonesia, which took place during street riots protesting the country's economic crisis (Shrader, 2000: 7). In addition, the income insecurity and unplanned urbanization that accompanies these changes may force women and girls into prostitution thus increasing their risk of violence (WHO, 1995/2002c).

Issue 2: Labour Trends

- *The growing number of women working in the informal sector exposes them to a variety of conditions that are deleterious to their health, including gender discrimination, workplace harassment and violence* (Poster, 2002; Women's EDGE, 2002; United Nations Commission for Social Development, 1998). The violence and subsequent negative health outcomes associated with women working in the informal sector may be especially true of the growing number of women and girls who are trafficked (Paci, 2002; WHO, 2002c).
- *In the face of income insecurity and poverty, the most vulnerable segments of the population, primarily women and children, are exposed to prostitution and violence.* Studies report that women and girls working in the sex industry are especially vulnerable to violence (Paci, 2002; WHO, 2002c).
- *In regions of chronic male unemployment, whether due to public or private sector job losses, field reports point to increased male alcoholism, domestic violence and other forms of violence* (see Commonwealth Secretariat, 1999: 27; WHO 2002c).
- *In some instances, the introduction of cash cropping has forced some women to travel greater distances to collect food and water for their families.* This may increase their risk of violence given that past studies have described sexual assaults of women and girls who must walk far distances alone for similar activities (WHO, 1995).

Issue 3: Population Mobility, Civil Unrest and Conflict

- *The World Report on Violence (2002c) reports that the 20th century was one of the most violent periods in human history.* Conflict and civil unrest as well as a rise in fundamentalism have a significant negative impact on the health and well being of women and girls (Harcourt, 2000; Katz, 2001; UNAIDS, 2002a/b; WHO, 2002c).
- *Women are at increased risk of violence during times of civil unrest and in post conflict situations.* In addition to having unequal access to asylum procedures and humanitarian assistance, during these times, women and girls are at increased risk of being physically assaulted, raped and forced to barter or sell sex for survival (UNAIDS, 2002a; UNHCR, 2002; WHO, 2002c). This is especially true of refugee women and young girls who are vulnerable because of their age (Shrader, 2000; UNHCR, 2002; WHO, 2002c).

- *The traffic in women and girls for sexual exploitation represents a significant global trend associated with the current wave of globalization.* Advances in ICTs and cheaper transportation (predominant features of the current wave of globalization) have inadvertently bolstered a number of illicit activities that disproportionately affect women from developing and transition countries including organized prostitution networks and illicit immigration rackets (Hughes, 2000; OECD, 2002; UNDP, 1999a; WHO, 2001c).

Issue 4: Information Communication Technologies and Civil Society

- *Advances in information communication technologies* (ICT) have helped to mobilize men and women in the fight against gender based violence and in raising public awareness and knowledge about the causes and consequences of conflict. These national and international networks have facilitated research on gender based violence and other violations of human rights (WHO, 2002c: 14 & 228).
- *Advances in ICTs have also assisted international non-governmental organization*, such as Amnesty International, Medecins Sans Frontieres, Human Rights Watch and the International Red Cross to monitor the causes and consequences of conflict.
- *Conversely, these technological advancements as well as cheaper transportation, the removal of market constraints, and increased incentives for profit* (all characteristics of the current wave of globalization) create conditions that are conducive to freer trade in and access to alcohol, drugs and firearms, and support the trafficking of women and girls (WHO, 2002c: 14).

Issue 5: Gender Roles and Relationships

- *Changing family dynamics and gender roles* (women working, women postponing marriage or children, men being away from home for long periods due to work) may strain intra-household relations and contribute to the abuse of women and children (Shrader, 2000: 7; WHO, 2002c: 100), particularly where these changes are contrary to traditional gender and social norms. For example, familial and community violence may be more likely when women begin working outside the home contrary to religious norms (see Vonderlack & Schreiner, 2001; Schuler, Hashemi & Badal, 1998).
- *In cases where traditional practices are called into question by changing gender roles and relations there is a risk of resistance or backlash.* For example, efforts to end harmful traditional practices may be seen as promoting 'western and/or feminist' ideals that are contrary to cultural norms (Mukhopadhyay, 1995). The tension that results from this perceived threat may lead to violence against women espousing these views or advocating for change.

Glossary of Terms

Antimicrobial agent: Any substance of natural, synthetic or semi-synthetic origin which at low concentrations kills or inhibits the growth of micro-organisms but causes little or no host damage.

Communicable/infectious disease: An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment (Last in WHO, 2001d).

Decent work: Productive work in which rights of workers are protected; which generates adequate income; and, with adequate social protection. The primary goal of the ILO is to promote opportunity for women and men to obtain decent and productive work [in both the formal and informal sector], in conditions of freedom, equity, security and human dignity (ILO presentation available online at www.ilo.org).

Economics: The study of the production, distribution and consumption of wealth in human. (The Penguin Dictionary of Economics, 1998).

Economies of scale: Factors which cause the average cost of producing a commodity to fall as output of the commodity rises. For instance, if a firm or industry which would less than double its costs, if it doubled its output, enjoys economies of scale. There are two types of such economies. The first called internal—accrue to the individual firm regardless of the size of its industry. The second type –external economies—arise because the development of an industry can lead to the development of ancillary services of benefit to all firms. (Penguin Dictionary of Economics, 1998).

Emerging infections: A collective name for infectious diseases that have been identified and taxonomically classified recently. In the final quarter of the twentieth century, more than 30 such conditions, many of them capable of causing dangerous epidemics were recognized. They include human immuno-deficiency virus (HIV) infection, ebola virus disease, Hantavirus pulmonary syndrome and other viral haemorrhagic fevers, campylobacter infection, transmissible spongiform encephalopathies, Legionnaires ' disease, and lyme disease. Some appear to be 'new' diseases of humans, others may have existed for many centuries and have been recognized only recently because ecological or other environmental changes have increased the risk of human infection. (Last cited in WHO, 2001d).

Engendering: "Engendering means much more than identifying the impact of policy or programme changes on women. Engendering also involves the recognition that the gender division of labour and its associated norms, values and ideologies about masculinity and femininity are defined by a complex of power relations which tend to accord to women lesser political voice, social/cultural value, and access to and control over economic resources. These power relations of gender…vary with historical and regional context, in addition to being cross cut by other social relations of class, caste, ethnicity, or race within a given society." (Commonwealth Secretariat, 1999: 19).

Epidemiology: Epidemiology is the study of the distribution and determinants of health-states or

Equity in health: Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. (Reference: Equity in health and health care. WHO, Geneva, 1996).

Export Processing Zones (EPZ): An EPZ is an industrial area, usually with defined boundaries, that specializes in manufacturing for export and offers a liberal regulatory environment. A number of different terms are used to describe EPZs including industrial free zones, special economic zones and tax free zones. Although EPZ's differ from country to country some common characteristics include: (1) unlimited, duty free imports of materials for production; (2) less governmental 'red tape' and more flexible labour laws; (3) long-term tax holidays and concessions; (4) often above average communications services and infrastructure, including subsidized utilities and rentals; and, (5) no limitations on foreign ownership or repatriation of profits (Robertson, 2001: 1-2).

Foodborne illness: Foodborne illnesses are defined as diseases, usually either infectious or toxic in nature, caused by agents that enter the body through the ingestion of food. Foodborne diseases are a widespread and a growing public health problem, in both developed and developing countries. The global incidence of foodborne disease is difficult to estimate, but it has been reported that in 2000 alone 2.1 million people died from diarrhoeal diseases. A great proportion of these cases can be attributed to contamination of food and drinking water. Additionally, diarrhoea is a major cause of malnutrition in infants and young children. (WHO, 2002)

Gender: Refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences (WHO, 1998: 56).

Gender based violence: Violence against women is any act of gender based violence that results in, or is likely to result in, physical, sexual, psychological harm or suffering to women, including threats of such acts, coercion of arbitrary deprivation of liberty whether occurring in public or private life (United Nations, General Assembly, 1993).

Gender budgets: A variety of processes and tools that attempt to assess the impact of government budgets, mainly at the national level, on different groups of men and women, through recognizing the ways in which gender relations underpin society and the economy. Gender or women's budget initiatives are not separate budgets for women. They include analysis of gender-targeted allocations, such as special programmes targeting women; they disaggregate by gender the impact of mainstream spending across all sectors and services; and they review equal opportunity policies and allocations within government services (Ames et al., n.d.).

Gender Roles: The particular economic and social roles which a society considers appropriate for women and men. Gender roles and responsibilities vary between cultures and can change over time. In almost all societies women's roles tend to be undervalued (WHO, 1998: 56).

Gender/Sex disaggregated data: Statistical information that differentiates between men and women; for example, 'number of women in the labour force' instead of 'number of people in the labour force'. This allows one to see where there are gender gaps (Ames et al., n.d.).

Global Public Goods: Goods whose characteristics of publicness (non-rivalry in consumption and non-excludability of benefits) extend to more than one set of countries or more than one geographic region and don't discriminate against any population groups or generations (present and future) (UNDP , 1999).

Global Public Private Partnerships in health: collaborative relationships that transcend national boundaries and bring together at least three parties to achieve a shared health creating goal (Buse & Walt, 2000a).

Gross Domestic Product (GDP): The value of aggregate production in a country during a year (Parkin & Bade, 1997). GDP is GNP excluding net income from abroad and gives some indication of the strength of industry within a country (The Macmillan Encyclopedia, 2001).

Gross National Product (GNP): A measure of the total annual output of a country, including net income from abroad; it provides a measure of the economic strength of that country. (The Macmillan Encyclopedia, 2001).

Health is defined by the WHO (1948) as: 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity'. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (Reference: Ottawa Charter for Health Promotion. WHO: Geneva, 1986).

Heavily Indebted Poor Countries initiative (HIPC): The principal objective of the Debt Initiative for the HIPCs is to bring the country's debt burden to sustainable levels, subject to satisfactory policy performance, so as to ensure that adjustment and reform efforts are not put at risk by continued high debt and debt service burdens.

Currently there are 42 countries ranked as HIPCs by the World Bank, 34 of which are in Africa. Relief under the enhanced HIPC framework has been agreed for 26 countries (World Bank Website, May 2003).

Human capital: Is the skill and knowledge of people, which arise from their education and on-the-job training. (Parkin & Bade, 1997: 44).

Incidence: The rate at which new cases of infection arise in a population (http://www.albany.net/~tjc/gloss96.html#P).

Inequality: The degree to which the distribution of economic welfare generated in any economy differs from that of equal shares among its inhabitants. In practice, the measure most commonly adopted is that of the distribution of income, other measures include expenditure and wealth. (Adapted from: The Penguin Dictionary of Economics, 1998). The World Bank website (May 2003) conceptualizes inequality as the dispersion of a distribution, whether that be income, consumption or some other welfare indicator or attribute of a population.

Inflation: Persistent increases in the general level of prices. It can be seen as a devaluing of the worth of money. Inflation is a recurring but only intermittent historical phenomenon. A crucial feature of inflation is that price rises are sustained. (Adapted from: The Penguin Dictionary of Economics, 1998).

Informal sector: Production and distribution of goods and services that take place outside the reach of the regulatory framework, often in household-based and small-scale enterprises. These enterprises generally lack legal recognition and may not be subject to labour and other standards prescribed by the legal code. Employees in the informal sector commonly lack nonwage benefits, such as disability, severance, maternity leave, or pensions, which are often required by law for formal sector employees. (World Bank, 2002p: 318).

Invisible underemployment: Is primarily an analytical concept reflecting a misallocation of labour resources or a fundamental imbalance as between labour and other factors of production. Characteristic symptoms might be low income, underutilization of skill, low productivity" (ILO cited in Bolle, in Loutfi 2002: 220).

Keynesian economics: Associated with John. Maynard Keynes. In general, Keynesian economics tends to support the following propositions: (a) Aggregate demand plays a decisive role in determining the level of real output. (b) There is no automatic tendency for the level of savings and investment to be equal, as the level of investment is not primarily determined by the rate of interest. (c) As a result, economics can settle at positions with high unemployment and exhibit no natural tendency for unemployment to fall. (d) Governments, primarily through fiscal policy, can influence aggregate demand to cut unemployment. (The Penguin Dictionary of Economics, 1998).

Macroeconomics: The study of whole economic systems aggregating over the functioning of individual economic units. It is primarily concerned with variables which follow systematic predictable paths of behaviour and can be analyzed independently of the decisions of the many agents who determine their level. More specifically, it is a study of national economies and the determination of national income. It focuses on sectors of the economy, such as, the industrial sector, the financial sector, the public sector, etc. (Adapted from: The Penguin Dictionary of Economics, 1998).

Mental health: Mental and behavioural disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behaviour associated with personal distress, and/or impaired functioning. Mental and behavioural disorders are not just variations within the range of 'normal', but are clearly abnormal or pathological phenomena (WHO, 2001b: 21).

Microeconomics: The study of economics at the level of the individual consumers, groups of consumers or firms. A broad distinguishing feature of microeconomics is to focus on the choices facing, and the reasoning of, rational individual's economic decision-making. (Adapted from: The Penguin Dictionary of Economics, 1998).

Neo-classical economic theory: Based on Adam Smith's early works. Assumes a 'laissez-faire' approach to economics, which argues that the only way to encourage growth is to allow free trade and free markets. Accordingly, the main role of government is to ensure the free workings of markets using 'supply side policies' and to ensure a balanced budget. Any other government

intervention is seen as potentially destabilizing and inflationary.

Occupational health: Occupational health should aim at: the *promotion* and maintenance of the highest degree of physical, mental and social well-being of all workers in all occupations; the *prevention* amongst workers of departures from health caused by their working conditions; the *protection* of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities. (Revised WHO/ILO definition, 1995)

Pareto-efficient: An allocation is Pareto efficient if there is no other allocation in which some other individual is better off and no individual is worse off.

Partnership: a collaborative relationship between entities to work towards shared objectives through a mutually agreed division of labour" (Buse & Walt, 2000a).

Part-time work: According to Convention No. 175 part-time worker means an employed person whose normal hours of work are less than those of comparable full-time workers (Bolle cited in Loutfi, 2002: 217. ILO Women Gender & Work).

Population of concern to UNHCR: Refugees, returned refugees or returnees, and asylum-seekers; and, certain groups of internally displaced people, certain groups of war victims, etc. (UN, 2000b: 162).

Poverty: The World Bank's 2000 World Development Report defines poverty as an unacceptable deprivation in human well-being that can compromise both physiological and social deprivation. Poverty can be defined by some absolute measure (earnings below some specified minimum level) or in relative terms (the number of the poorest 10 per cent of households, for example). The most commonly used way to measure poverty is based on incomes or consumption levels (at the household level). When estimating poverty world-wide, the same reference poverty line has to be used, and expressed in a common unit across countries. Therefore, for the purpose of global aggregation and comparison, the World Bank uses reference lines set at $1 and $2 per day in 1993 Purchasing Power Parity (PPP) terms.

Prevalence: The proportion of the host population infected (or with some marker of past or present infection) at a particular time. (http://www.albany.net/~tjc/gloss96.html#P)

Protectionism: Government restrictions on international trade in order to protect domestic industries from foreign competition Tariffs (a tax that is imposed by the importing country when an imported good crosses its international boundary) and Non-tariff barriers (any action other than a tariff that restricts international trade) are the two main protectionist methods used by governments (Parkin & Bade, 1997: 912).

Public goods: A good or service that can be consumed simultaneously by everyone and from which no one can be excluded (Parkin & Bade, 1997: 416).

Rational theory/expectations: The assumption that the behaviour of economic agents is based on an understanding of the economy, and a forecast of future events that are not systematically falsified by actual economic events. Nobody can predict the future with perfect foresight because unforeseen, random happenings are bout to occur. However, someone with rational expectations will construct their expectations so that on average they are correct; that is, they will be wrong only because of random, non-systematic errors. (The Penguin Dictionary of Economics, 1998).

Re-emerging infections: Certain "old" diseases, such as tuberculosis and syphilis that have experienced a resurgence because of changed host-agent-environment conditions. (Last cited in WHO, 2001d).

Social capital: Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit. (Reference: Health Promotion Glossary, WHO: Geneva, 1998).

Social cohesion: "Is the connectedness among individuals and social groups that facilitates collaboration and equitable resource distribution at the household, community, and state level. Social cohesion is essential for societal stability…" (Narayan et al., 1999: 175)

Trafficking in women: All acts involved in the recruitment and transportation of a woman within and across national borders for work or services by means of violence, or threat of violence, abuse of authority or dominant position, debt bondage, deception or other forms of coercion (McDonald et al., 2000).

Violence against women: The United Nations defines violence against women (VAW) as "any act of gender-based violence (GBV) that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations General Assembly, 1993). The World Health Organization has since expanded this definition by developing an ecological model of VAW that recognizes the context of GBV and provides examples of the types of violence women may experience across the lifespan (WHO, 1998).

Work: The participation of individuals in productive activities for which they either receive remuneration (in cash or in kind) for their participation or are unpaid because they are contributors to a family business enterprise. It also includes subsistence production of goods for their own households and non-economic activities. (UN, 2000b: 109).

Appendix 1: Defining Globalization

Typography of Definitions of Globalization'	
Category	**Description**
Globalization as internationalization	Globalization is viewed 'as simply another adjective to describe cross-border relations between countries', describing the growth in international exchange and interdependence.
Globalization as liberalization	In this broad set of definitions, 'globalization refers to a process of removing government-imposed restrictions on movements between countries in order to create an "open", "borderless" world economy' (Scholte 2000: 16)..
Globalization as universalization	In this use, 'global' is used in the sense of being 'worldwide' and 'globalization' is 'the process of spreading various objects and experiences to people at all corners of the earth'. A classic example of this would be the spread of computing, television etc.
Globalization as westernization or modernization	Here 'globalization' is understood as a dynamic, 'whereby the social structures of modernity (capitalism, rationalism, industrialism, bureaucratism, etc.) are spread the world over, normally destroying pre-existent cultures and local self-determination in the process.
Globalization as deterritorialization (or as the spread of supraterritoriality)	Here 'globalization' entails a 'reconfiguration of geography, so that social space is no longer wholly mapped in terms of territorial places, territorial distances and territorial borders.

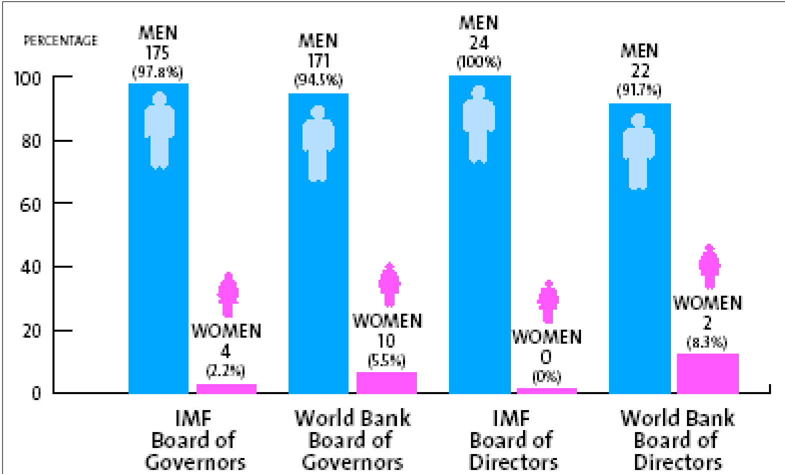
Source: Jan Aart Scholte (2000: 15-17).

Appendix 1: Defining Globalization *(continued)*

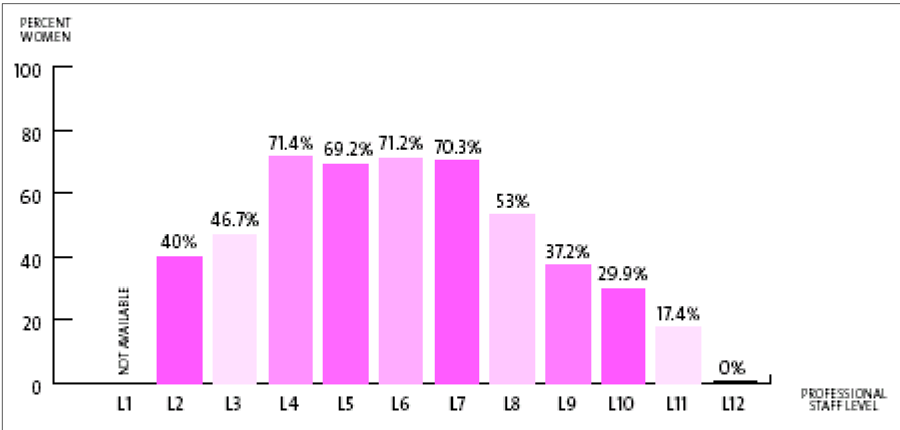
Definitions of Globalization in the Literature	
Source	**Definition**
Cogburn, D.L, 1998	"At its most organic and fundamental level, globalization is about the monumental structural changes occurring in the processes of production and distribution in the global economy. …Through the application of information and communications technologies, enterprises have the ability to diminish the impact of space, time and distance…At a more conjunctural and secondary level, Globalization is affecting all of the social, political and economic structures and processes that emerge from this global restructuring."
Cornia, G.A., 2001	"…the process whereby national and international policy-makers promote domestic deregulation and external liberalization…the shift towards such a policy paradigm began in the 1980s with the adoption of domestic deregulation, trade liberalization, and privatization, the last often taking the form of cross-border acquisitions by multinational firms."
Fidler, D.P., 2001	"…the process of increasing interconnectedness between societies such that events in one part of the world increasingly have effects on peoples and societies far away."
Giddens, A., 1990	"The intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa."
Held, D., et al., 1999	"A process (or set of processes) which embodies a transformation in the spatial organization of social relations and transactions - assessed in terms of their extensity, intensity, velocity and impact - generating transcontinental or inter-regional flows and networks of activity."
Kenedy, P., 1996	"The inter-connectedness of capital, production , ideas and cultures at an increasing pace"
Labonte, R., 2003	"Globalization describes a process by which nations, businesses and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel. It is not a new phenomenon."
Milanovic, B, 2003	"…globalization has two faces: the benign one, based on voluntary exchanges and free circulation of people, capital, goods and ideas; and the other, based on coercion and brute force."
Scholte, J.A., 2002	"Globalization is a transformation of social space that occurs with the spread of transplanetary (and in contemporary times often also supraterritorial) connections between people. … globalization and neoliberalism are not the same thing: the latter is a policy approach towards the former. Neoliberalism prescribes that globalization is an economic process that should be managed with marketization through privatization, liberalization, and deregulation.
World Bank, 2002	"…the growing integration of economies and societies around the world… [resulting from] reduced costs of transport, lower trade barriers, faster communication of ideas, rising capital flows, and intensifying pressure for migration."

Appendix 2: Women and Men's Participation and Voice*

Graph 1: Gender Breakdown of Boards of Governors and Boards of Directors at World Financial Institutions.



Graph 2: Women in professional staff levels of the World Trade Organization*

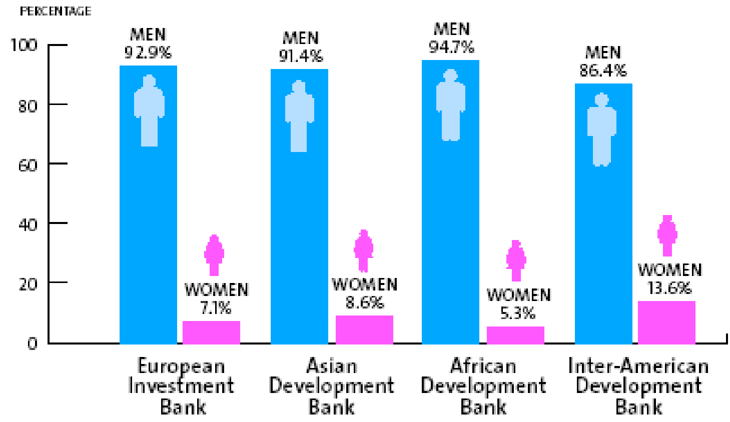


** Where L1 indicates low status and L12 indicates high status*

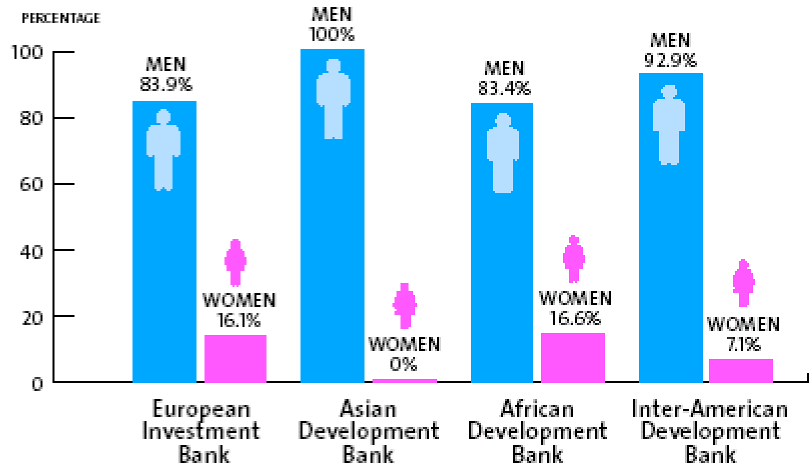
* Source: Women's Environment & Development Organization (n.d.) The numbers speak for themselves. Fact Sheet 1. WEDO: New York.

Appendix 2: Women and Men's Participation and Voice* *(continued)*

Graph 3a: Gender Breakdown of Boards of Governors at Regional Development Banks



Graph 3b: Gender Breakdown of Boards of Directors at Regional Development Banks



* Source: Women's Environment & Development Organization (n.d.). The numbers speak for themselves. Fact Sheet 1. WEDO: New York.

APPENDIX 3:
Globalization, Gender & Health Project Partners

Canadian Institutes of Health Research, Institute of Gender and Health

http://www.cihr-irsc.gc.ca/institutes/igh/index_e.shtml

The Institute of Gender and Health (IGH) is a champion (in collaboration with the CIHR Institute of Population and Public Health) of an initiative entitled Reducing Health Disparities and Promoting Equity for Vulnerable Populations. The mandate of the Institute of Gender and Health is to support research that addresses how sex (biological-genetic dimensions), and gender (social-cultural dimensions of gender identity) interact with other socio-cultural, bio-physical, and political-economic factors to influence health and create conditions that differ with respect to risk factors or effective interventions for males and females throughout the lifespan.

Canadian Institutes of Health Research, Institute of Population and Public Health

http://www.cihr-irsc.gc.ca/institutes/ipph/index_e.shtml

The mission of the Institute of Population and Public Health (IPPH) is to support research into the complex interactions (biological, social, cultural, environmental) which determine the health of individuals, communities, and global populations, and to apply that knowledge to improve the health of both populations and individuals, through strategic partnerships with population and public health stakeholders and innovative research funding programs.

National Institutes of Health, The Fogarty International Center

http://www.nih.gov/fic/

The Fogarty International Centre (FIC) promotes and supports scientific research and training internationally to reduce disparities in global health. The FIC has been a critical component of the National Institute of Health (NIH) international research effort to advance health through international scientific cooperation. Fogarty has responded to today's critical global health challenges by working to make the results of scientific discovery available to all peoples in all parts of the world. To this end, FIC has assumed a leadership role in formulating and implementing biomedical research and policy.

National Institute of Health, Office of Research on Women's Health (ORWH)

http://www4.od.nih.gov/orwh/

The ORWH is a catalyst and focal point at the NIH for efforts to improve the health of women. It collaborates with the NIH's constituent institutes and centers to stimulate investigations of women's health issues by sponsoring research initiatives and by providing funding for research projects.

Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health

http://www.cihr-irsc.gc.ca/institutes/iaph/index_e.shtml

The Institute of Aboriginal Peoples' Health (IAPH) is one of the thirteen founding institutes of the CIHR. The mandate of the Institute is to support research addressing the special health needs of Canada's Aboriginal people to improve the health of aboriginal peoples in Canada. Accordingly, the IAPH strives for research excellence and encourage health researchers from a diverse range of disciplines to work together and solve complex problems while building research capacity to improve the health of aboriginal peoples.

The Centre for Research in Women's Health

http://www.crwh.org

Established in 1995, the Centre for Research in Women's Health (CRWH) is a joint partnership between Sunnybrook and Women's College Health Sciences Centre and the University of Toronto. Its mission is to conduct and foster research relevant to women's lives, and to promote its application in diverse communities. Acknowledged as a national leader in women's health research, CRWH is also designated as the Pan American Health Organization/World Health Organization Collaborating Centre in Women's Health.

Harvard University Center for Public Leadership, Kennedy School of Government

http://www.ksg.harvard.edu/leadership/

Launched in 2000, the Center for Public Leadership (CPL) has responded rapidly to the burgeoning interest in leadership. It is equally committed to bridging the gap between leadership theory and practice. The CPL provides a forum for students, scholars, and practitioners committed to the idea that effective public leadership is essential to the common good. It creates opportunities for reflection and discovery and promotes the dynamic exchange of ideas among those from different disciplines, sectors, cultures, and nations.

Yale University, School of Public Health, Global Health Division

http://www.info.med.yale.edu/eph/

The School of Public Health at Yale University provides leadership to protect and improve the health of the public. The School's Global Health Division applies the theoretical frameworks and methods of political science, political-economy, anthropology, and epidemiology to study health policies and institutions at the global, international, national, and local levels.

The World Health Organization

http://www.who.int/about/en/

The World Health Organization (WHO), the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO is governed by 192 Member States through the World Health Assembly. The Health Assembly is composed of representatives from WHO's Member States.

Canadian Coalition for Global Health Research

http://www.idrc.ca/media/ghr_e.html

Four Canadian government Organizations have joined forces to formalize a shared commitment to address the problems of global health through research. The Canadian International Development Agency (CIDA), the Canadian Institutes of Health Research (CIHR), the International Development Research Centre (IDRC) and Health Canada (Canada's federal health ministry) have formed the Global Health Research Initiative

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FEEDBACK FORM

We welcome your comments. We will use your input to improve future versions of this paper. Please take a moment to complete and return this form by mail, fax, or email to:

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1. **Did you find the content of this resource:**

Accurate? ☐ Yes ☐ No ☐ No Opinion

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Balanced in its portrayal of the issues: ☐ Yes ☐ No ☐ No Opinion

2. **How would you rate the overall usefulness of this resource (1=very poor, 5=very good) in terms of its:**

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3. **In your view, which of the following gender and health issues are particularly important as they relate to globalization?**

☐ Food Security ☐ HIV/AIDS ☐ Tobacco ☐ Poverty

☐ Mental Health ☐ Infectious Disease ☐ Violence ☐ Occupational Health

☐ Other (please list): ______________________________

4. **Are there are other important resources, references, or agencies that are missing from this report? *(please list)***

5. **Additional comments:**

6. **Please contact us if you or your agency would like to contribute a regional case study on the impact of globalization on gender and health, to be included in future versions of this report.**

THANK YOU!

CIHR IRSC

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