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Gender, Health and the Millennium Development Goals

A briefing document and resource guide

Lesley Doyal

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Introduction

The eighth annual meeting of the Global Forum for Health Research was held in Mexico City in November 2004. The focus of this meeting was 'Health Research to Achieve the Millennium Development Goals' and an overview report is available at www.globalforumhealth.org. The gender dimensions of the discussions at Forum 8 are examined in more detail in this resource briefing.

The document begins with a brief account of the emergence of the Millennium Development Goals and their links to wider health and gender issues. This is followed by a review of some of the major criticisms of the goals from an equity perspective. Section 2 explores the links between gender and the health-related Millennium Development Goals and the implications of these for research priorities. The last section (Section 3) outlines some of the gender issues related to the 'MDG-plus' approach adopted at Forum 8. The document will draw throughout on presentations from Forum 8 and from Forums 6 and 7 where many of these questions were also debated.[1]

[1] All presentations and publications referred to in the text are listed in the References, p. 23 onwards

Section 1

Gender, health and the Millennium Development Goals

In September 2000, 189 countries ratified the United Nations Millennium Declaration. This was an ambitious document reflecting a global consensus on how poverty, deprivation and ill health should be tackled in order to achieve higher levels of human development. A set of goals, targets and indicators was defined and ratified and a timescale for their achievement was agreed. These goals were known collectively as the Millennium Development Goals or MDGs.

MDG 1 (eradicate extreme poverty and hunger), MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria and other diseases) have the most direct links with health. However global health promotion runs alongside the elimination of poverty as a theme underlying all the goals. The Millennium Declaration also proclaimed that 'the equal rights and opportunities of women and men must be assured'. Hence the entire Millennium Development Strategy is potentially of great importance for those concerned with promoting the health of poor women.

The Millennium Strategy was warmly welcomed by health professionals and advocates as the first global initiative designed to tackle poverty, disease and premature death. The focus on gender equality was especially valued as the culmination of a decade of advocacy that included the International Conference on Population and Development (Cairo 1994) and the Fourth World Conference on Women (Beijing 1995). However the strategy has also been criticised from a number of different perspectives.

Most importantly, critics have pointed out the absence of appropriate mechanisms of accountability. The development policies of recent decades have not created an equal world. More than one billion people still live in extreme poverty and the resources available for health care are diminishing in many of the world's poorest countries. MDG 8 identifies the need for a global partnership to tackle this crisis but there is no indication of how the necessary political will is to be generated or the contributions of the different players monitored.

Millennium Development Goals and Targets

Goal 1 Eradicate extreme poverty and hunger

Target 1 Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day

Target 2 Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Goal 2 Achieve universal primary education

Target 3 Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3 Promote gender equality and empower women

Target 4 Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015

Goal 4 Reduce child mortality

Target 5 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5 Improve maternal health

Target 6 Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6 Combat HIV/AIDS, malaria, and other diseases

Target 7 Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8 Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7 Ensure environmental sustainability

Target 9 Integrate the principles of sustainable development into country policies and program and reverse the loss of environmental resources

Target 10 Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11 Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers

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Goal 8 **Develop a global partnership for development**

Target 12	Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)
Target 13	Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)
Target 14	Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
Target 17	In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Accessed from http://developmentgoals.org/About_the_goals.htm 27 April 2005

Criticisms have also been made of the lack of focus on equity. Even if the targets themselves were all met this would not eliminate the gap between rich and poor in access to good health. These equity issues are especially important to those concerned primarily with gender. Though MDG 3 does focus on the empowerment of women it has been interpreted mainly through the lens of education. Other aspects of gender equality such as physical security and freedom from violence are not included in the targets.

Critics have pointed out that the female images presented in the MDGs are primarily those of girl children, pregnant women and mothers. This ignores the role of women across the life cycle as workers, community members and major contributors to development. Similarly, the links between gender and poverty are not formally integrated into the MDG framework. As a result, the common causes of major problems such as maternal and childhood mortality and HIV/AIDS are obscured and the strategies proposed for solving them are correspondingly less effective.

Section 2
Engendering health dimensions of the MDGs

If the potential of the MDGs for improving the health of poor women is to be realised, more attention will need to be paid to gender issues. This will require a closer examination of each of the health-related goals to identify relevant differences between women and men and to elaborate gender-sensitive strategies for their achievement. Given the historical disadvantages of women in most cultural, social and economic settings, priority will need to be given to identifying and meeting their particular needs. But men's health too can be damaged by their gender and this also needs to be taken into consideration.

MDG 1: Eradicate extreme poverty and hunger
Target: halve between 1990 and 2015 the proportion of people whose income is less than one dollar a day

Gender is central to meeting the poverty goal and hence to enhancing the health of the poor. This is because both the causes of poverty and its health effects will not always be the same for women as for men. In many communities women are more likely than men to be poor. This reflects the cultural devaluation of females as well as structural discrimination including lower wages, less access to formal employment, lower levels of literacy and a greater likelihood of becoming single parents.

The tasks women undertake in managing the burden of household poverty can affect their health in complex ways that are often difficult to disentangle. Ensuring the survival of their families can lead to physical and psychological exhaustion which in turn can increase vulnerability to infectious diseases and reproductive health problems. Poverty and dependence make it more difficult for women to protect themselves from HIV and may also put them at greater risk of gender violence.

This means that policies designed to meet the poverty target set out in MDG 1 will need to be both gender sensitive and pro-poor in their approach. More studies will be required to fill the current gap in gender-disaggregated data

on poverty at local and national levels. Both quantitative and qualitative research is urgently needed to clarify the links between gender, poverty and health at different stages in the lifecycle. And more work is needed to design and evaluate intervention strategies that can tackle the different dimensions of poverty in gender-sensitive ways appropriate to particular settings.

Target: halve between 1990 and 2015 the proportion of people who suffer from hunger

Around 852 million people still go to bed hungry each day and this has obvious links with gender. Women produce 60-80% of the food in most developing countries. However they frequently receive less than their fair share of what is available. In many communities the preference for male children means that girls are nutritionally disadvantaged. This may continue into adulthood which in turn may result in nutritional deficiencies especially during the reproductive years.

The final report of the UN Millennium Project Task Force on Hunger highlights the promotion of gender equality and the empowerment of women and girls as a central pillar in the fight against malnutrition. It recommends the targeting of mothers and children in nutrition programmes as well as the mainstreaming of gender equality in the pursuit of hunger elimination. This will require a research agenda that highlights the complex links between gender and the production and consumption of food in a wide range of social and cultural contexts.

MDG 4: Reduce childhood mortality

Target: reduce by two thirds between 1990 and 2015 the under-five mortality rate

Approximately 10.8 million children under the age of five die each year, 4 million in their first year of life. Around the world, the under-five mortality rate is roughly equal for girls and boys. However in some communities girls are at significantly greater risk. In South Asia in particular, young girls are less likely to survive the dangerous environment of early childhood. Some of this reflects gender differences in nutrition but wider inequalities in access to health-related resources are also implicated.

It is generally agreed that nearly two thirds of childhood deaths could be averted with interventions already proven to be effective. However many obstacles prevent these from being put into practice and in some environments these constraints will be gender related. Where the status of girls is low, they are less likely than their brothers to receive health care. Two papers presented at Forum 6 shed light on these issues.

Shally Awasthi summarised a number of research projects in rural India showing a marked gender bias in both preventive and clinical services. In one setting less than 50% of girls had been immunised for measles compared with around 60% of boys. Another study showed that girls made up only about one third of those receiving ambulatory care for acute respiratory infection or for diarrhoea.

Shafika Nasser reviewed progress on infant and child health in Egypt during the 1980's and 1990's. Significant gains were made during this period but sex-disaggregated analysis showed infant and child mortality to be higher among females. Despite widespread access to primary care facilities, 35% of boys suffering from acute diarrhoea received private health care compared with only 11% of girls with the same condition. Studies in rural areas also showed that girls were more likely than boys to be malnourished.

These studies highlight the importance of making links between gender and other dimensions of socio-economic status in meeting the goals for child health. The most effective interventions for reducing childhood mortality may be widely known but the constraints on putting them into practice are not so well understood. Unless these obstacles are properly explored for boys and girls in different social groups the evidence base available to policy makers will be partial and young lives will continue to be lost.

MDG 5: Improve maternal health

Target: reduce by three-quarters between 1990 and 2015 the maternal mortality ratio

Despite 15 years of the global Safe Motherhood Initiative, overall levels of maternal mortality have stayed largely unchanged with the number of deaths remaining at about 530,000 per year. Some countries have made huge improvements but in others the number of fatalities has increased. Maternal

mortality also remains an extremely powerful indicator of global inequities. In some parts of Sub-Saharan Africa, a woman still has a 1 in 6 chance of dying in childbirth while in most of North America and Europe the risk is as low as 1 in 8,700.

Health sector interventions do exist to successfully prevent or treat the vast majority of conditions that kill women during pregnancy and childbirth. They are well known and well accepted. Yet they are not available to those who need them most. This reflects the low status still given to women in many communities and the lack of political will to tackle maternal mortality and morbidity at both local and national levels.

In a paper presented at Forum 8, Asha George, Aditi Iyer and Gita Sen explored aspects of gender inequality that explain the persistence of maternal mortality in the southern Indian state of Karnataka. They highlighted the importance of poverty, poor diet, low levels of literacy and exhausting work in increasing women's vulnerability to health problems during pregnancy. However their main focus was on what happens when women seek help in obstetric emergencies.

During the period of the research, seven local women died from pregnancy-related causes. The researchers carried out a detailed case study of each death in order to identify the reasons for this huge toll. In all cases the lack of effective emergency care was the immediate causal factor. In some instances this was due in part at least to the inability or unwillingness of the family to get appropriate medical help. But the studies also revealed that health workers frequently failed to recognise women's needs. They were expected to tolerate extremely high levels of pain and blood loss and their interests were often seen as secondary to those of the child.

The authors conclude by calling for greater accountability of health workers. They attribute bad practice to the lack of cultural value attached to mothers and to the interaction between unequal gender relations and wider socio-economic hierarchies. Through the use of a case study approach they were able to develop a detailed understanding of how the devaluation of women presented obstacles to the reduction of maternal mortality and morbidity in a specific social context.

In the conclusions to its final report, the MDG Task Force on Child Health and Maternal Health calls for all research and programming to be sensitive to equity issues. This will require local documentation and problem-solving processes. But it will also necessitate the creation of national and international mechanisms of accountability to ensure the delivery of appropriate and affordable child and maternal health services to all those in need.

MDG 6: Combat HIV/AIDS, malaria and other diseases
Target: have halted by 2015 and begun to reverse the spread of HIV/AIDS

It is now clear that the HIV/AIDS epidemic is profoundly gendered in very complex ways. In 1997 women represented only about 40% of those infected but by 2004 this had risen to about half. In Sub-Saharan Africa where the epidemic has taken greatest hold, this figure is as high as 60%. Biological factors mean that women are more likely than men to be infected through heterosexual intercourse. But a wide range of gender inequalities has been shown to exacerbate this inherent vulnerability.

At Forum 6 Geeta Rao Gupta made an important presentation on the history of gender and research into HIV/AIDS. She outlined the contribution of gender analysis to understanding the epidemic and highlighted a list of priority issues that would need to be addressed if MDG 6 was to be tackled appropriately.

Recent evidence has shown that gender issues are central to understanding and controlling the HIV/AIDS epidemic. Gender analysis can help us understand the vulnerability of different individuals to infection across a range of settings. At the same time, it improves our understanding of the epidemiology of HIV/AIDS. It can help to explain for example, why there is such a high rate of new infection among young women aged 15-24 in so many parts of the world.

Gender analysis may also help to increase access to HIV/AIDS services. Early attempts at interventions to prevent mother-to-child transmission had very limited uptake. This could only be explained through in-depth research with women themselves. They reported that they were reluctant to be tested at a

time when they were most vulnerable and many feared their partners might blame them for bringing the infection home. Some of the men were jealous of services available only to women and the women themselves were afraid of what would happen if they were seen leaving the hospital with canned milk.

The biggest gap in the current evidence base for HIV prevention is in the field of operations research. If this is to be filled, more work will be needed to understand gender constraints on service use and to translate existing knowledge into useable guidelines for policy makers and service providers. One of the biggest challenges here will be the development of appropriate indicators to measure levels of empowerment and agency in different groups of women.

Rao Gupta concludes by highlighting the need to test different models of community mobilisation and education for changing social values. If the culture of silence around sexuality is to be opened up, a variety of interventions will need to be tested and their findings disseminated. At the same time, different approaches to advocacy will need to be evaluated so that a gender-responsive political climate for combating HIV/AIDS can be put in place.

Another major requirement for the creation of a gender-sensitive evidence base for MDG 6 is a clearer understanding of the nature of masculinity and its links to HIV/AIDS. This issue was highlighted at Forum 8 by Brigitte Bagnol who described a research project carried out in 2003 on 'intergenerational compensatory sex' in Mozambique.

Thus far, the gender focus in HIV/AIDS research has been mainly on male oppression and women's lack of power to negotiate safer sex. Much less attention has been paid to masculinity and manhood as objects of study in their own right. Hence it is often difficult to explain (and change) men's risk-taking behaviour. In an attempt to explore this further, a qualitative study was carried out using focus groups and interviews with older men and younger women in non-occasional sexual relationships involving monetary compensation.

The men reported getting involved with younger partners for several reasons including sexual satisfaction and the acquisition of power and status. Being

seen in public with a younger woman was seen to boost their reputation as a man. It was more prestigious than being with a sex worker and less expensive than going out with an older woman. It was also perceived to be safer since younger women were less likely to be infected.

Bagnol concludes by arguing that more sophisticated strategies are needed to protect men from the multiple risks that they (and others) may incur as a result of their risky sexual practices. Both men and women are shaped by social norms and cultural pressures. A clearer understanding of the links between masculinities and sexualities across a range of cultural settings is therefore essential if we are to have an effective evidence base for preventing HIV infection in women and in men.

Target: have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Malaria remains a major public health problem with more than 50% of the world's population exposed to the disease. It is estimated to cause between 300 and 500 million episodes of acute illness and between 1.2 and 2.7 million deaths each year. More than 90% of the malaria burden is in Africa.

Biological factors influence patterns of malaria with men being slightly more susceptible to infection than women. However women's biological immunity is compromised during pregnancy, making malaria an important cause of maternal mortality, spontaneous abortion and stillbirths. Gender roles and relations are also important in shaping exposure to the relevant vectors.

Differences in living and working conditions can generate different risks. Men are more likely to be infected through economic activities for example while women are more likely to be infected through domestic tasks such as collecting and using water. Diagnosis and treatment may also be affected by gender divisions. Women are more often constrained in their use of services by heavy workload, lack of transport or inability to pay the fees. However some studies have shown that they are more willing than men to spend money on preventive strategies such as the use of bed nets.

A paper presented at Forum 6 by Rachel Tolhurst described a case study of malaria management from the Volta Region of Ghana. The main aim of the

project was to analyse gender and socio-economic inequalities in the burden of malaria and in access to related services. Local health workers used a number of different methods to explore community perceptions of preventive measures, health-seeking behaviour and the impact of the disease on women and men. The data was then fed back to different groups in the community through drama. Strategies for action were discussed at community meetings and plans of action were developed by district teams.

All socio-economic groups reported difficulties in accessing treatment but not surprisingly the barriers were greatest for the poor. The poorest group was also found to suffer most from the impact of fever. Women appeared to face particular problems. In the first place they tended to lose more time at work than men through individual episodes of illness and this affected their livelihood. They also had to make more complex and difficult decisions in relation to funding both their own treatment and that of their children.

Tolhurst concludes by arguing that attention to gender should be central to poverty-focused responses to the challenges posed by malaria (and other infectious diseases) in developing countries. However this will not be easy to achieve since it will require the reshaping of some of the most intimate parts of the lives of women and men. Innovative and participatory methods will be needed to create an appropriate knowledge base for both individual and community-based intervention strategies.

Section 3
Gender and the 'MDG-plus' approach

Many of the participants at Forum 8 endorsed what has been called an 'MDG-plus' approach (see Health Research for the Millennium Development Goals). This involves a broad interpretation of specific MDG targets in order to address all the major health concerns affecting the global population including sexual and reproductive health problems, mental and neurological illness and noncommunicable diseases. It also requires a focus on equity and on the health needs of particular disadvantaged groups. A range of presentations at Forum 8 explored this extended 'MDG-plus' approach through the lens of gender.

Gender, sexual and reproductive health and the MDGs
Many commentators have highlighted the relatively narrow focus on maternal mortality in MDG 4. They have stressed the wider agenda outlined in the Platform for Action from the International Conference on Population and Development held in Cairo in 1994. In particular they have highlighted the absence of an explicit MDG target of universal access to reproductive health services. Adrienne Germain examined some of these concerns in her address to Forum 8.

If interventions to meet the MDGs are correctly designed they will meet the Cairo goals. Conversely it will be impossible to achieve the MDGs unless the strategies spelled out in Cairo are implemented. This will require a research agenda that focuses on the creation of a woman-centred, rights-based framework.

The most urgent item on this agenda is the development of improved indicators to assess progress in the area of fertility control and wider sexual health. These indicators will need to monitor women's ability to choose the number, spacing and timing of their children (if any) and their ability to give birth safely, effectively and affordably in a manner that is acceptable to them. They should include data on the proportion of all births that are unplanned and the proportion of induced abortions that are unsafe. We also need to know more about sexual initiation and partnerships and levels of knowledge relating to HIV/AIDS prevention.

If more research on these topics is to be funded, policy makers will have to be persuaded of the benefits of reproductive health not just to individuals but to society more generally. More work will therefore be needed to demonstrate how women's reproductive illness and death may negatively affect their families. We need to know more about the impact of a mother's death on child nutrition for example as well as school attendance, violence against girl children and vulnerability to HIV.

Looking at the effects of maternal morbidity and mortality more broadly, more information is needed on productivity losses due to unwanted pregnancy, unsafe abortion, obstetric complications and violence. At the same time we need to know more about the 'cost effectiveness' of different reproductive health interventions. This evidence can then be used to demonstrate the contribution that investment in reproductive health can make to reducing poverty at family and societal levels. In particular we need to assess the ways in which expanded reproductive health services could contribute to the prevention of HIV/AIDS.

Germain concludes by arguing that much remains to be done despite the considerable progress that has been made in the decade since Cairo. Contraceptive access has improved markedly and fertility rates have fallen. But maternal morbidity and mortality, HIV infection and rates of unsafe abortion remain inexcusably high. More political action will be needed to hold governments accountable for meeting the interlinked visions of the Cairo Programme of Action and the Millennium Summit Declaration.

Gender, mental health and the MDGs

A number of commentators have pointed out the exclusion of mental health from the MDGs. The most recent estimates suggest that mental illness or neuro-psychiatric disorders rank number one in the burden of disease across the range of high, middle and low income countries. There are well-researched linkages between mental health problems and most of the MDG targets especially poverty, HIV/AIDS, maternal health and child health. In a paper presented at Forum 6 Vikram Patel explored the complex relationships between gender, poverty and mental health in the context of global restructuring.

In most communities women are two to three times more likely than men to become depressed. Many studies have shown the complex determinants of

depression and anxiety in the daily lives of poor women. The struggle to enable their families to survive in the context of poverty and insecurity is a source of great stress and anxiety. Resulting mental health problems can become chronically disabling and stigmatising and rapid social and economic change often play an important part in initiating and exacerbating them.

Cultural factors are especially important in shaping women's perceptions of their own worth. In South and East Asia for example there is growing evidence of sex selection and imbalanced sex ratios. Three recent cohort studies have shown the impact of this on women's mental health. Around 20% of mothers suffer from post-natal depression. But this rate is greatly increased when the newborn is a girl. This is likely to become increasingly common as fertility rates fall and the pressures on women to produce boys increase.

Global change may also increase eating disorders in young girls. A recent cross sectional survey of adolescent Fijian girls found that the introduction of TV had made dramatic changes in their eating habits. After three years a sharp rise was noted in disordered attitudes to eating and in harmful food-related behaviours such as induced vomiting. This raises important questions about the gendered impact of western media images on eating and other health related behaviours especially in countries with very different cultures and few material resources.

Patel concludes by arguing that the impact of gender and social change needs to be integrated into mental health research. Differences between women and men need to be not just reported but explored in depth. Most importantly, mental health paradigms need to be mainstreamed into other areas of research especially those connected with reproductive health which is such a major health priority for most developing countries.

Gender, noncommunicable diseases and the MDGs

Poor countries now shoulder a double burden of disease. They have to face not only infectious diseases such as HIV/AIDS, malaria and TB but also the so called 'diseases of affluence' such as cardiovascular diseases (CVDs) and diabetes. CVDs now account for 30% of global mortality and 10% of the global burden of disease. 80% of all deaths from CVDs now take place in low- and middle-income countries.

Both mortality and morbidity from CVDs are expected to increase dramatically over the coming decades and the poor are likely to suffer most. They will be at greatest risk but will have less access to care. If this problem is to be tackled effectively, more research will be needed on the social determinants of CVDs in developing countries and the appropriateness of existing interventions for prevention, treatment and rehabilitation in these settings. A paper presented by Lesley Doyal at Forum 8 highlighted the fact that both biological sex and social gender will need to be central themes in these studies.

It is now clear that coronary heart disease (CHD) is not just a problem for white middle class men in developed countries. It is a worldwide (and growing) problem for women too. CHD rates are twice as high in men as they are in women and males also have an earlier onset of the disease. But the actual number of deaths in women and men is broadly similar because of women's longer life expectancy. Indeed in Brazil, Russia and South Africa CHD now causes more deaths in women than in men. Women in these countries also have higher rates than comparable women in the US especially in the youngest age groups.

Yet there are still huge gaps in existing knowledge about male and female factors in CHD. First the differences between the biology of CHD in women and men are not yet properly understood. The major risk factors appear to be the same in both sexes but they may sometime operate in different ways. It appears for example that the physiological effects of smoking may be worse for women than for men. There is also evidence of biological factors underlying differences in symptoms especially pain.

Few attempts have been made to explore the impact of gender on the development of CHD in either women or men. However it is clear from research in the developed countries that some of the major behavioural risk factors such as smoking, diet and lack of exercise are shaped by gender. There are also gender differences in illness behaviour with women likely to delay longer in seeking help with symptoms of CHD. After diagnosis, women appear to get less social support and to find adjustment harder. Some studies from the US and the UK have also indicated that there may be gender differences in the health care received by women and men that are not explicable in terms of differences in clinical condition.

Doyal concludes by arguing for a more rigorous evaluation of the medical knowledge base of CHD to assess its applicability to both sexes. More work is also needed on the social dimensions of CHD in women and in men. If equity is to be a goal in tackling the spread of noncommunicable diseases, these studies will need to be carried out in a variety of different settings with poor communities in developing countries receiving most attention.

Conclusion
Gender, health and the MDGs

If the potential of the MDGs for promoting global health is to be fully realised, gender issues will need to be central to all research and implementation strategies.

The gender issues underlying each of the MDGs will need to be made visible and gender-sensitive indicators developed for each target. The production of gender-disaggregated health data at local and national levels will be essential if progress towards equality is to be properly monitored. And policy frameworks for health promotion will need to be developed with women's empowerment in mind. If these are to be implemented in areas of greatest need, programmes of national capacity building will also be required to provide skills in gender analysis and gender mainstreaming.

Gender equality is a goal in its own right as the Millennium Declaration acknowledges. But it is also an essential ingredient for achieving all the other targets laid out in the strategy. The vision for global health implied in the Millennium Development Strategy can only be realised if gender is fully integrated into a research strategy designed for the pursuit of equity.

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For an overview of the Millennium Project, detailed analyses and recommendations of the different Millennium Development Project Task Forces and continuing progress reports go to www.unmillenniumproject.org/

A new website on gender equality and the Millennium Development Goals offers a wide range of resources at www.mdgender.net

Resources relating to Millennium Goal 3 on Gender and Women's Empowerment are available online from the UN Non-Governmental Liaison Service at www.un-ngls.org/MDG/Goal_3.htm

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Awasthi Shally, *Access to health services for the child from a gender perspective*

Nasser Shafika and El Rafie Mervat, *Gender and child health and nutrition*

Gupta Geeta Rao, *Gender issues in HIV/AIDS research*

Tolhurst Rachel, *Researching gender issues in malaria management: a case study from the Volta regions of Ghana*

Patel Vikram, *Gender and mental health research in developing countries*

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George Asha, Iyer Aditi and Sen Gita, *Maternity in crisis: gendered health system experiences from Koppal, Karnataka*

Bagnol Brigitte, *Sexuality and the need to integrate men's perspectives*

Germain Adrienne, *Sexual and reproductive health: foundation for achieving the MDGs*

Doyal Lesley, *Integration of gender into coronary heart disease research*

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