The new women's health agenda

Ana Langer talks to Fiona Fleck about a new women's health agenda that is needed to address the emerging epidemic of chronic diseases among women.

Courtesy of Ana Langer

Ana Langer has devoted the last 25 years as a researcher, programmer and advocate to improving women's health through the introduction of evidence-based practices. In 2010 she joined the Harvard School of Public Health as a professor of the practice of public health in the Department of Global Health and Population. From 2005 to 2010 she was the president and CEO of EngenderHealth, an international women's health nongovernmental organization. Based in Mexico, from 1994 to 2005 she served as the Population Council's Regional Director for Latin America and the Caribbean and from 2003 to 2004 as acting director of the Population Council's Global Reproductive Health Program. Before joining the Population Council she was the chair of the Department of Research in Women and Children's Health at the Mexican National Institute of Public Health, where she led several clinical trials and established and directed the first Master's Program in Reproductive Health in the region, in collaboration with WHO. Langer is board certified in paediatrics and neonatology. She earned her medical degree from the National University of Buenos Aires in her native Argentina.

Q: Is the world ready to embrace the new women's health agenda?

A: The world still focuses very much on maternal health and, more recently, family planning, which definitely reflect critical needs. The predominant view today is still of women as reproductive beings, which unfortunately leads to neglect of women's health in other stages of life. The focus on noncommunicable diseases has been growing since the 2011 United Nations General Assembly declaration, but these diseases do not receive the attention they deserve. Women's non-reproductive health is becoming important as a public health issue, mainly due to population ageing and changing lifestyles, but health systems, especially in low- and middle-income countries, are not prepared to deal with the double burden of disease among women.

Q: What double burden is that?

A: On the one hand, countries must address the unfinished business of sexual and reproductive health problems, malnutrition, HIV and other infectious diseases and gender-related issues, like gender–based violence and other forms of discrimination against women. On the other hand, countries must also tackle the emerging epidemic of chronic diseases. Governments are not focused explicitly on chronic diseases or allocating enough resources to deal with them. It seems that donors are not prepared to invest in the prevention, detection and treatment of chronic diseases affecting women unless more progress is made in the unfinished agenda of reproductive health. Very few researchers are working on the women's epidemic of chronic diseases in low- and middle-income countries or on the link between old and new diseases, which is important but badly neglected.

Q: What is that link?

A: Women face a myriad of problems in their post-reproduction years, some resulting from their reproductive health history and others that are unrelated to it. So, for instance, women may face chronic morbidities, such as obstetric fistula, pelvic pain and incontinence as a result of their pregnancies. These problems are more common in low- and middle-income countries, particularly in places where fertility is high and women do not have access to good quality health care for pregnancy and delivery. More than 80% of cervical cancer cases are due to infection with the human papillomavirus, which is acquired through sexual activity. Breast cancer incidence is growing, particularly in developing countries. This disease has a link with a woman's reproductive history, as the age at first pregnancy, number of pregnancies and breastfeeding history can increase or reduce a woman's risk of developing breast cancer. Finally, women who are obese have more complications during pregnancy and delivery. Some research suggests that the maternal mortality ratio in the United States of America (USA), which is high for a developed country, is associated with the high prevalence of obesity in the US, which also increases the risk of gestational diabetes and of chronic diabetes later in life. In developed and developing countries, the combination of obesity and high rates of Caesarean section is the perfect storm to increase maternal morbidity and mortality because surgery is riskier in women who are obese.

Q: What other non-reproductive health problems do women face?

A: Many chronic problems are not specific to women, although some do have links with health during pregnancy. As mentioned, obesity and diabetes affect both men and women, but the risks of developing Type II diabetes are higher among women with a history of gestational diabetes. Mental health problems, depression and anxiety-related disorders in particular, are more common among women, and some researchers believe that postpartum depression is just another manifestation of chronic depression. All over the world eating disorders represent a very important but almost invisible problem that affects mainly young women. Other problems were once more common among men but are rapidly growing among women. One example is lung cancer, as more women are smoking.

Q: Are there discrepancies between the health care men and women receive for these and other shared problems?

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A: Yes. Sometimes women's symptoms are neglected by physicians, nurses and other health professionals in emergency departments because health providers do not always recognize them as indicative of a serious disorder. For example, women's symptoms of cardiovascular disease are sometimes mislabelled as "anxiety attacks" or "panic attacks" that health providers wrongly link more readily to women. As a result, women may receive delayed and less effective treatment for cardiovascular disease. Something similar happens with lung cancer, which health providers associate more often with men.

Q: Why have you called for equal treatment of women in clinical trials?

A: There is evidence that discrepancies exist between men and women in terms of the attention they receive for the problems they have in common. I am more familiar with the literature here in the United States on this issue, which shows that women are not recruited in clinical trials for the testing of drugs for chronic diseases that, once approved, are used by women. Women are often not considered "stable enough" to participate in such trials because of their menstrual cycles, because they may become pregnant during the trial and because they may be breastfeeding, which could incur risks for the baby. So women are excluded from many trials and, as a result, don't get proper treatment later.

Q: What is being done about it?

A: There is now a movement to make sure that all relevant trials recruit women and men and that the results are broken down by sex. Often trial results and even information in vital statistics and health information systems are not disaggregated by sex, so it is difficult to know how men's and women's health differ. The Women and Health Initiative is campaigning for all data to be disaggregated by sex. What you don't measure, you can't address.

Q: Tell us about the Women and Health Initiative?

A: It was established three years ago at the Harvard School of Public Health (HSPH). It is a school-wide programme that addresses women's health throughout the life course, the roles and responsibilities that women play as health-care providers at all levels of the formal and informal health system, and the links between these two dimensions. We do research, offer education, and provide evidence for advocacy. A year ago, we established the Lancet Commission on Women and Health, with the medical journal *The Lancet* and the school of Nursing at the University of Pennsylvania. We invited 18 experts in the field of women and health to deliberate on this comprehensive agenda and these deliberations will contribute towards a joint report including actionable recommendations on how to improve women's health and support women as health-care providers. This discussion is particularly relevant at this critical juncture, when the global policy agenda is being actively debated. Next year, we will reach the end of the 20-year International Conference on Population and Development (ICPD) Programme of Action. The development of the post-ICPD agenda and of the post-Millennium Development Goal (MDG) agenda provide golden opportunities for women and health.

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Q: Will women's health, including women's health beyond reproduction, have a place in the future development agenda?

A: I certainly hope so. It seems that universal health coverage will be a salient feature in the post-2015 agenda and that will benefit all women throughout their life course. Maternal health will remain an unresolved issue that still needs to be addressed. I am not so sure how much prominence the agenda will give to the chronic diseases and conditions we have discussed or whether it will view women's health as a continuum during the life course, which is something we strongly support. I am also not sure to what extent the agenda will address the social determinants of health, but we are hopeful and there is still time to influence those discussions.

Q: What is your message to those shaping the global health agenda?

A: Governments and donors should continue their efforts to reduce maternal mortality, considering that MDG 5 is lagging farther behind than any other goal, and to curb HIV infection, which is now a feminized epidemic mainly affecting young women. But they should not wait until these problems are solved to embrace the emerging epidemic of chronic diseases. That, from my perspective, is short-sighted and a false dichotomy. We can address women's health comprehensively by using some existing service delivery platforms for the "old" problems to start addressing the "new" chronic diseases epidemic. For instance, HIV services, which have been established in many places to treat chronically ill men and women, could be scaled up and used to screen for other chronic diseases. Maternal health services and family planning clinics, which exist in most countries, should also be used to raise awareness, screen for and provide counselling on chronic diseases. Many organizations and individuals are trying to help in that transition but it will take time. It is a change of perspective that the world is not embracing very easily.

Q: Where has this approach worked?

A: Not many countries have tried this. So far, there are only pilot experiments that in most cases have not been scaled up, so this is very early work from which we are trying to draw some lessons.

Q: How can change come about with regard to the new women's health agenda?

A: With a combination of policy, social research and health systems efforts led by a wide range of players, including women themselves. Gender is such a pervasive social determinant of so many things, health among them. This *Bulletin of the World Health Organization* theme issue on women's health beyond reproduction is timely and welcome. Many others are also working to make these issues more apparent. We are making some progress, but the challenges are still huge. ■