

**The Barnard Summit: Women and Health  
Panel Three: Women and World Health: A Matter of Survival  
Barnard College, New York, NY  
Saturday, April 5, 2003**

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**FEMALE VOICE 1:** Good afternoon and welcome back. First a special note of thanks to the Gates Foundation for sponsoring this, our third panel "Women and World Health: A Matter of Survival". We are very, very pleased to have with us Soledad O'Brien, co-anchor of NBC News' Weekend Today with us today to moderate this panel as we expand our discussion into the international realm. [Off mic]

**SOLEDAD O'BRIEN:** Great. Well let's begin. Good afternoon everyone and thanks for joining us this afternoon I really appreciate it. As you've just heard in that short clip they've pretty much set up the litany I think of topics that are open for us to discuss today. Our panel, as we mentioned is called "Women and World Health: A Matter of Survival".

Today we're going to take a look at what has changed for women's health care around the globe and also examine how these changes or in some cases a lack of changes are affecting development in third world nations, global stability, and also issues here in the U.S.

So without further ado I want to begin by introducing our panel, we've got a lively discussion ahead this afternoon and we're going to try to leave a little time for questions at the end so if a question pops into your mind, write it down and we'll try to get to you. Okay, we begin with Dr. Apock Moleese (misspelled?) she is a nurse and a medical sociologist. She currently [unintelligible] as the Margaret Bond Simon Dean of

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Nursing at the University of Pennsylvania, her research there focuses on the multiple roles of women throughout their lives and immigration transitions, marginalization (misspelled?) and their health. Also this afternoon we have with us Miss Carolyn Hennin (misspelled?). She is currently the Director for the Division for the Advancement of Women in the United Nations. She's an associate professor in social and economic geography at the University of London Sweden. She has also worked and lived in Africa and has some shorter assignments in Asia, Latin America, Eastern Europe, and in the Middle East. Also with us this afternoon Dr. Helene Gale, she is the Director of HIV, TB and Reproductive Health for the Bill and Melinda Gates Foundation. She has spent almost two decades in public health focused on issues relating to women and children both internationally and here in the U.S. Dr. Gale is also a Barnard graduate. Also with us this afternoon Dr. Mary - I'm sorry I'm skipping over these professors, please forgive me. Professor Zack (misspelled?) is the Director of the Earth Institute at Columbia University and in January of last year he was appointed by UN Secretary General Copi (misspelled?) Annin (misspelled?) as his Special Advisor on the Millennium Goals. We're going to talk a little bit more about that this afternoon, in addition Professor Zack (misspelled?) serves as an economic advisor to several governments in Latin America, Eastern Europe, the former Soviet Union, and in Asia. Also with

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us today Dr. Naseef (misspelled?) Sahdit (misspelled?), she is a physician from Pakistan who has worked in women's health, especially in reproductive health for the last 40 years. She served as Secretary General for the ICCD in 1995 and is currently the Special Envoy of the UN Secretary General for HIV/AIDS in Asia. With us today as well Professor Ping Chin Chong (misspelled?) she is an expert on gender and medicine in China. She has a PhD in history, a masters in public health, she is an activist in children's health and aging in Taiwan, she speaks on women's health at the UN and other international conferences. Also with us today we have Dr. Mary Pravisassit (misspelled?) she is New York City Deputy Health Commissioner overseas and directs the district public health program and the Bureaus of Chronic Disease and Tobacco Control, School Health Day Care, Minority Health and Family Health. She is responsible for decreasing disparities in health outcomes, promoting healthy behaviors and addressing the critical needs of at risk communities and populations. So I welcome all of you. Thank you very much for joining us.

We've had an opportunity to hear from two panels earlier today and I think the role of our panel today is to put it into perspective but we want to begin with the big picture and the global picture and I'm going to ask each panelist to present, I don't want to say briefly but concisely what he or she thinks is the most critical issue in women's health today

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and why. Let's begin with Dr. Moleese (misspelled?).

**DR. APOCK MOLEESE:** -right now. Actually in a way this is what it is - we - conceptually we have looked at women's health in terms of a biomedical model which reduced women into the different parts and components and also reduced women to [unintelligible] and we moved from that and we looked at women's health in terms of reproductive health and reduced them to the uterus and ovaries and hormonal replacement therapy and all these issues that we continue to think about and worry about and then we moved from that to another model that has focused on the morality related to women. So therefore we deprive a large group of marginalized women from health. So I really think that one of the most major issues that women are facing in women's health is facing in this world is our continuing to look at and reducing women to either part diseases or uterus or those things that do not look at the women's [unintelligible] which is war and poverty and what's happening to their lives [unintelligible].

**MISS CAROLYN HENNIN:** I think to me a very important challenge is to be able to help move women's health out of the [unintelligible] and to show the linkages between women's health and other areas of development. To look at women's daily lives and see what's happened in their lives which impact negatively on their health and I think the two topics that have been raised already, poverty and also conflict are very

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important but there are also other much more if you like issues of women's daily lives which impact negatively on their health and I think we need to be able to look at the social economic context, the environmental context and understand why women don't get access to the healthcare that they need and I think that this morning we heard a lot of talk about differences between women and men but I think when you're looking at health in the context of developing countries I think also in other countries particularly in developing countries you need to understand it's not just difference we're talking about it's also inequality and discrimination in many, many ways which impact on women's health, their well being and also on their access to health.

**FEMALE VOICE 2:** I guess I would ditto a couple of things that the first speakers said that I think that the overall major issue is the inability to look at women's lives in totality and looking at how particularly in developing countries what we as a world community are doing by robbing women of the ability to fully participate in economic development and to fully participate in the world and the world community. I think by not doing that we really rob ourselves of you know at least a half of the world potential and [unintelligible] what that means in terms of economic development, social development and all the rest of it.

I think HIV/AIDS is a paradigm for that in many ways. I

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think it does look at a lot of the issues that women face, the issues of gender and equality and poverty and how that plays out with the disease that's ravaging our world. Women now make up 50% of all new HIV infections and that's up from 41% just 5 years ago so clearly what's happening for women in HIV is a paradigm for many of the other issues that women face that are - stem from gender and equality and poverty.

**PROFESSOR ZACK:** I think all of us see the same thing, which is the world, is divided between rich and poor to such a shocking extent it's almost impossible to believe that we're on the same planet. We're living lives where life expectancy is 78, 79, 80 years in some countries and yet all of us have the chance and the responsibility indeed to visit countries where children are dying in huge numbers, boys and girls, men and women are dying of preventable or treatable pandemic diseases so the life expectancy is 35, 40 years. This means the absence of life chances for hundreds of millions of people on the planet.

And I think the real issue for us especially for this dreadful time that we're in right now is whether or not our country is going to have the capacity to care and do something about it anymore or whether we see war and conflict as problem solvers because right now we're putting in perhaps 100 times more of our resources and certainly our blood and effort into this war in Iraq than we're putting into solving any of these

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problems of disease and death. I think I'll stop there.

**DR. NASEEF SAHDIT:** Thank you very much and I agree with all of the previous [unintelligible] disagree with any one of them. I want to start by saying how pleased I am to be here in this panel and to have the opportunity to speak to young people because in my long professional career I've seen so many changes and a lot of changes for the better in fact you know the first international women's health conference was only held in 1975 in Mexico.

Not too long ago and I remember at that conference how difficult it was to bring women's health issues onto the agenda, it was somehow like you know why are you worried about women's health? It's the same as anyone else's health kind of thing and from that day to today look at all the things that have happened. Family planning is in all countries of the world, the developing world.

When I started in the UN in '71 it was only in 5 countries that it was allowed, it was banned in most of the other countries, so huge change. Issues like female genital mutilation were not allowed to be stopped, I worked in the UN population [unintelligible] and we wanted to have some meetings to discuss this issue and we were always being told that this is a cultural thing and you cannot and I used to say but it's got nothing to do about culture, it has to do with control and it took so many years until 1994 at the International

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Conference on Population and Development to bring this onto the international agenda and since then a huge change has happened.

Issues like violence against women only became an international issue in 1995, especially sexual violence and this is something that is experienced by all women in the world, every one, I mean women in all countries in the world not just the developing world. Half of all the women in the world have been violated by someone, mostly by someone they know very well. Look at that huge statistic.

Issues like rape, incest, were considered like family matters, dishonor to the family if the poor girl brought it up. These are now being discussed on [unintelligible] and all of those issues, which affect the health [unintelligible].

Violence against women which you see women going in and seeing physicians about it all the time and they never did anything about it. Now it's in the medical curriculum it's on the agenda of physicians.

So I want to just establish what a lot - what a huge gain we've taken here. In this country, family planning, the right to abortion, the right to choice was in this century, in the '70's and what I want to say to the young people here is and yet in the developing world things remain so much the same thing because of the fact that we have not addressed other issues which affect the health of women, the right of women to have economy over their own decisions, the [unintelligible] in

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the families the preference for sons in our society, the fact that girls are not educated because their economic security would come from their house and not from them [unintelligible], and they are not kept healthy because they are going to someone else's family and they will be an asset to that family so why should this family where they're born look after them?

So in fact girls' rights in a sense are preempted even before they're born and you know you have sex selection, which shows the discrimination of girls even before they're born. So that embodiment has not changed as much as it should have and my point is that why has it not?

In this 30 years that so much has been discussed. Everything is out on the table there's access to resources, why have women's rights to health not changed? And you look at the United Nations and it's a very good indication of how the [unintelligible] mindset is in all societies.

Every time reproductive health and [unintelligible] is on the agenda in an international conference there is huge conflict. If the result is that the nations and including the United Nations is running scared about reproductive care and rights.

**SOLEDAD O'BRIEN:** I want to call on more so let me just stop you there and I want to hear from Professor Chong (misspelled?) to answer the original question that we posed.

**PROFESSOR PING CHIN CHONG:** Okay. Coming from Asia and

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actually flying in for this occasion and listening to the first two panels this morning I feel like inviting all of you to think with me about the importance of recognizing differences in women's health issues.

Differences in perspectives, in statuses, in conditions before we could talk about common ground so that eventually we could all survive together. Thank you.

**DR. MARY PRAVISASSIT:** I work for the New York City Department of Health and Mental Hygiene so I guess I'm here to remind all of us that this city is part of the blow and in our city I think the principle thing driving health differences in the city including health [unintelligible] is poverty. In the city as a whole things are getting better in terms of the health of all New Yorkers including women but these improvements aren't occurring equally in all of our population.

So the infant mortality remains twice as high among African-Americans as it does among whites. An area like central Harlem continues to have double-digit infant mortality rates while the city as a whole has reached the national target. Even worse for maternal mortality although the city is twice as high as the nation there are four or five fold gaps in terms of racial disparities in maternal mortality and these are issues that are special issues for women.

But we also see disparities in the big killers and the chronic disease, cancer and cardiovascular disease and

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underlying these disparities is the issue of unequal access to resources for people of color generally and for women in particular and we need to pass all those differences and life chances.

**SOLEDAD O'BRIEN:** Well let's talk a little bit about what is working out because you don't have to be a rocket scientist or say a medical sociologist to see clearly from all of our panelists that there's this big link between poverty, a lack of power and access that will determine the outcomes in women's health.

Dr. Moleese (misspelled?) you are excuse me a medical sociologist, give me an example, a country as an example of what you have seen that's worked.

**DR. APOCK MOLEESE:** That didn't work [cross talk] well I want to start with [cross talk] there are some things that work. I can't think of too many things but [unintelligible].

You know women have been increasingly been coming into the workforce, so that's working that there is more - there is less gender equity into bring women into the workforce but let's look at where women are in the workforce. They are in low income and low status and low image kinds of positions. So that's one aspect of it.

Women are also in all kinds of care giving and informal work of which they are not compensated and which they are not valued, which has absolutely no status including now

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increasingly for us also here, right here in the United States.

It's because all the care giving functions that women are supposed to be providing because the healthcare system is cutting and is sending the patients out early or expecting the family to do it. So who is in the family that's doing it? It's women who are adding to their already busy lives with a new load of responsibilities.

The way we have looked - because of all of that, the way we have defined women's work, we have defined it from a capitalistic, male oriented approach that it's male oriented work that's considered valued work in society and anything else that the women do outside of that is not considered work and has absolutely no benefits and nothing is built around the women and women's responsibilities in terms of and I always say you know when we ask in our research do you work or not work and I say show me a woman who does work.

So one of the questions is if we merely define work in terms of really what women do then instead of looking only at it from a capitalistic, employment, non-employment perspective we might look at it in terms of the energies that women spend, the amount of time they spend doing it, the status they have, the value, how marginalized they are, how valued the work is and when you take all of these into consideration and you try to develop an approach to women's health it's going to be completely different than when you take it from

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employment/unemployment.

So what has worked internationally is that these - some of these things have been taken into consideration and now our aid that's going to some of the developing countries is to support of women. Development in developing countries has been only focused on the development of men in developing countries and only when we start to be thinking about what women do then we began focusing and providing an approach to women for their development within the work that they do which is farming or the care giving of the world. So that's one thing that worked.

**SOLEDA O'BRIEN:** We heard from Dr. Sahdit (misspelled?) a lot about women's rights being preempted and because of tradition truly and I think there are many people on the panel who could sort of speak to this. So I want to first start with Professor Zack (misspelled?). How do you go about changing the environment, especially from what you have seen in your work with HIV/AIDS?

**PROFESSOR ZACK:** I think first of all you have to start back with poverty because it is the lack of resources that is the most important driver of whether people live or die and millions of people are dying today - not today but thousands are dying today, maybe twenty five or thirty thousand people will die today from being too poor to stay alive around the world.

Certainly on the order of eight to ten million deaths

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per year could easily be avoided if it weren't for that extreme poverty or if the [unintelligible] functions were actually trying to do something to help work on the [unintelligible] poverty.

Now getting out of poverty is a complicated story. It involves not just health, it involves not only empowering women although it does involve that for sure. It involves education, it involves building roads, allowing the rural villages to sell goods to cities, and it involves linking economies with the rest of the world. There's a whole task that is a pretty fundamental goal for our planet actually if we're going to have [unintelligible].

You mentioned the Millennium Goals and I'll take a moment to say a word about them. The world rather nicely committed at the start of this new millennium in a special meeting at the United Nations to achieve poverty alleviation including dramatic improvements of health, reductions of half a million mothers dying in childbirth now by at least three quarters by the year 2015, to reducing infant mortality and child mortality rates by two thirds by the year 2015, by cutting hunger and poverty and many other goals. Wonderful goals. Who here knows anything about these goals that the United States government signed up to?

I know that the President never heard of them. In 1990 - I'm sorry the year 2000 the United States twice again signed

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once in Monterrey Mexico at the summit of March 2002 and then Johannesburg in August/September 2002 that the U.S. and others would encourage all rich countries that have not done so, so far and that's us by the way to take concrete steps to raise their development issues for the core to the international goal of 0.7 of 1% of GNP.

Let me tell you what that means very briefly, concretely, it means that the United States signed up to take these steps to be spending \$70 billion dollars a year to help the poorest of the poor stay alive. We do 1/7 of that and our national leaders told us all the time well to do more we can't afford that and now we're going to drop \$75 billion dollars and I mean drop literally because a lot of it's coming out of the bottom of a bomber in Iraq. We're going to spend \$75 billion dollars according to the President's recent estimate for the first 6 months of this after being told for years no we can't save lives, we don't have the money for that, we don't have the money for poverty alleviation and that's why I say we really face a fundamental choice now and the most fundamental choice is whether we care and whether we can act as a country to do something about it.

Now Americans do care but our political process is not delivering that care in any concrete results. Actually health people whose lives literally depend on this, that's what those Millennium Development Goals are all about and we're

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signatories and we're signatories three times now in the last three years but the President of the United States I'm afraid hasn't spoken even one time in 10,000 speeches that he's given on Iraq - one time about how to save millions of lives abroad through the Millennium Development Goals.

**SOLEDAD O'BRIEN:** Clearly poverty [unintelligible]

**FEMALE VOICE 2:** And just to add, I think we've all in different ways that poverty is so much of an underlying factor in this and I think that some of the things that Professor Zack (misspelled?) talked about clearly are important as we think about how do we really have - make a major impact long term on this.

But I think going back to what you said about what you said about things that work, I think one of the things about trying to make a difference in the lives of women if we know that poverty is a driver is can we also look at some possible things that can make a difference while we are also looking at the big picture and so for instance we know that many women are at risk for HIV and other sexually transmitted diseases because the only way that they can put food on the table or one of the options that's open to them is the commercial sex industry and so you know there have been some very good programs that have looked at can you give young women a trade so that they can take themselves out of the situations that put themselves at risk which ultimately are economic situations, can you give

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them - can you start them in micro credit lending programs where they can take out money to build small businesses, can you teach them a trade so they can use - so they can get themselves out of poverty and then take themselves out of risk?

And so I think more and more there are concrete examples as we all work on how can we make our goal a more just goal that we can do to look at some of these things more properly.

Now I also think you know as the other panelists said one of the things is all you know the U.S. panel they talked about the fact that we don't know enough about women's health, we don't have the right kind of research that is at least 100 fold in the developing world, although we know broadly what some of the risks are we haven't looked at the kind of research that we can use to ground some of our actions.

As an example, a disease like shiftasimiosis (misspelled?) that is a disease that you would not think would have a gender inequity to it with shiftasimiosis (misspelled?) you get from standing in dirty water where and you get parasites that give you a serious infection that it affects your bladder and other things, well women in many countries because they are the ones who have to stand in stagnant water and wash clothes and use water for cooking are at greater risk than are the men and you never would've thought that that would be you know it's not a reproductive health issue but there are

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other things like that.

Environmental smoke because women stand inside and cook in closed compartments where they're using wood to cook their food and to clean water. So there are a lot of these issues that we need to do a better job of looking at what are all the reasons - what are as somebody said what are the day to day things that are a part of women's lives that may put them at risk for diseases and then think about what are some of the practical ways that we can make a difference with those issues.

**FEMALE VOICE 3:** I want to defer a little bit back to the poverty issue. On the poverty issue I mean undoubtedly has a role to play in health in general but you know you look at some of the data from the developing countries and you see that in which families women have the same problems in health.

So it's not necessarily that poverty is the only issue-

**SOLEDAD O'BRIEN:** Is that tradition then? [Cross talk]

**FEMALE VOICE 3:** -and that's why I agree with everyone that talked about the need to look at health of women as part of the totality of everything else that they need and it includes their environment and everything else-

**SOLEDAD O'BRIEN:** Well then let me stop you there because then how do you tackle [cross talk]

**FEMALE VOICE 3:** -way to tackle it is to have more women in decision making positions then you have a critical mass of people in decision making positions then it does make a

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change. You look in India for example or now at Bangladesh where they've got 33% of local body elections are women in the local body legislation.

Now that group has started to make a difference because when they start to look at [unintelligible] allocation their first priority is the family and the local community, not war and whatever else [unintelligible]. So I think that you have to think about how do we make changes in the longer term and in the immediate, immediately they need access to education and access to services and making sure that women have access.

So my last point that I want to make in the millennium development goals and poverty and I know that [unintelligible] you are directing is that in the allocation of resources that countries make they must find a way to make and to ensure that enough resources and by enough in my opinion is not 50% of the resources but 60% or 70% of the resources at least in the health and education sector must be allocated for girls and women. That's the only way that you will change you know the discrimination that's being [unintelligible] and women and children are the ones who need the health services the most.

**SOLEDAD O'BRIEN:** Let's hear from Dr. Moleese (misspelled?) and then we'll-

**DR. APOCK MOLEESE:** You can't do that unless you put women in decision making positions and then [cross talk] and we can see this happening on the global level actually the

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difference between the Nairobi Conference for Women's Health which did not come up from the grassroots and did not come up from the developing countries' perspective was a completely different conference than the one in Beijing and Cairo conferences where it was [cross talk] the developing world's women who we thought were voiceless and therefore we in the West are supposed to speak for them because they don't know how to [unintelligible] issues and their problems and they revolted and said in Nairobi you can't define our issues for us. You cannot define vaginal mutilation as the issue for us. There are many other issues for us which then as they grouped and they mobilized and they organized and presented those issues in the Cairo conference and in the Beijing conference and then this was the beginning of the [unintelligible] experiences of women coming up as really important as a context for women's health without which we cannot understand the issues and without which we cannot plan the intervention.

**SOLEDAD O'BRIEN:** I think that [unintelligible] directly to what you started out saying as about the day-to-day issues that affect women and why they're so critical in the big picture outcome of women's health and I know you had something that you wanted to add.

**MISS CAROLYN HENNIN:** Yes just on the poverty issue. I don't think that there's anybody who would disagree that poverty is a major factor contributing to women's health and

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there's lots of studies done, lots of research, conferences, papers available my concern is that there's a lot of attention to women and poverty as a separate issue but the main discussion on poverty are carried out in a gender insensitive manner, it's not informed by gender [unintelligible] analysis and so we're not looking at what's the difference of the course of the poverty for women and men, what's the difference for the impact of poverty, what does poverty mean for a woman and what does it mean for a man in say rural Tanzania or in New York and that we're not looking either at how do men and women cope? What's the difference? What kind of survival strategies, coping mechanisms can they put in place? And the differences are very often again can I come back to the fact that we're talking about inequality and discrimination.

The differences in women's ability to cope with poverty are very much related to the fact that they are in subordinate positions, they don't have access to resources, they're not the ones who make the decisions, not in the families, not in the communities and certainly not at national levels. So I think that's very important to keep in mind in talking about poverty yes it is important but we should stop talking about the poor and poor people and we should talk about poor women and poor men and force ourselves to [unintelligible] not just desegregate [unintelligible] but also look to see if we're asking the right questions, collecting the right kinds of data

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on poverty and I think the answer today is still no we're not doing it.

To come back to a point I do like to come down to the village level and I'd like to say a few words about - I worked on women's reproductive health in Tanzania and many of the women I met and I'll just give you an example she's probably got a lot of children, she's responsible for food production, she grows all the food crops and she also helps on the cash crops so she's overburdened, she doesn't make any decisions, very few decisions in the household if any, she has no control over any money that she might make, she maybe has income generating projects but she doesn't control that money, if she needs help or her children need healthcare she has to go long distances, she has to walk carrying her children, if she goes to the health clinic she has to decide can I actually go today or should I be working on my fields because it's an opportunity cost in going to the health clinic. When she gets to the health clinic she's probably not treated very well and this is not something that's talked about very much but there are lots of human rights [unintelligible] women within the healthcare system and this is something that she's treated in a very demeaning manner, she's not given information for example her child could die and she's not told why the child died, the child could die and she's given the body to take home and so I'm just trying to paint for you a picture of a woman - a rural

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woman in Tanzania could face.

If she wants contraceptives she can't get them unless she has a signed paper from her husband saying she's allowed to have these contraceptives, if she desperately wants the contraceptives and decides to go ahead without her husband's permission she faces the risk of violence, a beating if she's found out and so that's the situation that women are facing.

I think we're really dealing on the grassroots village level, we're dealing with relations between women and men and unless we also tackle the issue of men's attitudes and men's behavior and start to work with men I don't think we're going to solve these problems and you asked you know what works.

I think for me a very hopeful sign is that we are starting to look at men, what causes male violence against women? Not to condone us but to understand and also put together the right kinds of preventive strategies and that for me is a little window of hope and if we could start working more with men and trying to make partnerships between men and women we might be able to move ourselves in the right direction

And just to add there for the first time next year we have in the United Nations an inter-governmental body where the governments from all over the world come together to discuss policy, next year for the first time the UN is going to discuss the role of men and boys in promoting gender equality and I think it's going to be a very interesting and very difficult

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discussion.

**SOLEDAD O'BRIEN:** Dr. Prasassisit (misspelled?) I'm curious to know as you listened to this and we're getting a very global perspective, bring it home for me, you're in New York, you work in the public schools, is what you see in terms of the microcosm of the schools in New York reflected here?

**DR. MARY PRAVISASSIT:** Well this is a really interesting discussion and I if I can just diverge from your question a little bit I would really hate the audience to think that [unintelligible] until we were to topple the issue of poverty in gender and equality.

I think everybody agrees that poverty is fundamental and that the great social inequalities of our times and in inequality, gender inequality, of race - you know racial and ethnic discrimination are important determinants of health but we've made a lot of progress without - in the context of those unfair and unjust relationships.

So we've increased for example access to family planning to young people and this is really important and we should be paying attention to it and ensure that it continues because we want teen pregnancy rates to continue to fall in New York City as they have for the past decade, in the last decade pregnancy rates by pregnant teens have gone down by 25% even as we've seen continued inequality in income in this city we've seen those mediated by ensuring that we provide better access

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to services by young people.

So I think just to echo what [unintelligible] said that we have to pay attention to the big picture and there's no doubt that that's the most fundamental part of health the social context, but we also have to look at the smaller picture what services are available to people? What can they get? Where can they go when they're sick? What can a teenager get who wants to have family planning? And there we can sometimes make a difference even if we haven't addressed the fundamental issues that shape their life chances.

**FEMALE VOICE 2:** -Mary speaking and I just want to point out that although she's representing New York City and the Health Department just came back from a decade of spending time in Zimbabwe and I think one of the things that I think is always important to point out is that when we talk about global health and issues in other countries it's often times easy to forget that there are mutual lessons to be learned and I think there's a lot that people who work in developing countries can come back and teach us of ways of addressing the problems and vice versa and I think there's some real mutual learning and you're one who's gone back and forth between the domestic and the international arena and there are so many parallels.

I think you know for myself having also been back and forth between domestic and international I have learned so much that it's helped me in my work here in this country by getting<sup>5</sup>

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a broader understanding so I just say that to [unintelligible] audience of people who you know may or may not work directly in international but we have so much to learn from.

**SOLEDAD O'BRIEN:** You know specifically what? You say you've learned a lot out there.

**FEMALE VOICE 2:** Well I guess one that there are some real commonalities in a lot of these issues that we're talking about, two, I just think because the issues sometimes are so much more severe we are willing to take risks and do things in a much bolder way in international settings that we can then come back and renew some of those. For instance I think the whole involvement of communities is something that we've been doing in the international setting for a long time. It has really helped a lot of our responses to health problems here in this country and we learn a lot from the ways in which we can involve communities and in this case how do we involve women in really helping to make decisions about the way programs are developed, how they meet their needs, whether or not they are acceptable and some of those other things. So those are the kinds of things I think you can learn from the different settings.

**FEMALE VOICE 3:** -to the whole world and had a lesson to tell in health especially the lessons in reproductive health a lot of common issues in the developing countries and in many of the developed countries including the United States and in

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talking to you I think that this is being demonstrated by projects for example the Adolescent Health Project in [unintelligible] I think that is being run by the Turner Foundation, they brought people from many developing countries in despite unbelievable - the common factors preventing access to things like health education, sex education, access to services for young people that existed between the developing countries' societies and the U.S. and people from the UK in fact as well.

The kinds of approaches that then were developed using some of the experiences and Helene is saying of the community work and using community leaders, religious leaders et cetera that we have been using in our programs in the developing world also in this country and in the U.S. I can [unintelligible] in the UK [unintelligible] cooperation in health, especially for adolescents' reproductive health from Bangladesh to a community in the UK in Manchester which is largely [unintelligible] and this was quite remarkable. The amount of attention and the [unintelligible] that immigrant community showed to what was happening back home which was [unintelligible] what was happening within that immigrant community and it was really an eye opener so in fact many issues are the same in the sense that well there may be different [unintelligible] but [unintelligible].

I think HIV/AIDS is definitely an area where in fact we

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have a lot of common ground and [unintelligible] of AIDS to women which is now being recognized for the first time in the global AIDS system the new infections for women have outstripped those for men. Young girls getting HIV/AIDS from older men, the comparable 15 to 24 age group of girls is four or five times as highly infected as boys the same age group meaning that these young girls are getting HIV/AIDS from older men.

The fact that most women in Asian societies have only have one partner and yet they are found to be infected from their spouses. Many young girls have [unintelligible] a large number in [unintelligible] you know in [unintelligible] have arranged marriages and many of them get married to HIV infected young men. Some [unintelligible] in India are thinking about having and introducing AIDS testing before issuing a marriage license.

Issues of these kinds and the UN AIDS program is now looking at how to address the special vulnerability of women to HIV/AIDS common [unintelligible] for sure but [unintelligible] has been there and has not been [unintelligible] as much as it should be the increase in rape and incest because of this belief that you get cured if you have sex with a virgin is a phenomenon in southern Africa and it's been [unintelligible] spreading to Asia because I've been hearing some rumblings that you'll have heard that this is a way to get cured and God

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forbid that this gets out somewhere and someone starts to believe it, it would be really terrible.

**SOLEDAD O'BRIEN:** We - I think we've - I'm sorry you want to say something?

**FEMALE VOICE 3:** It's actually a humbling experience to go to developing countries and to see how they are providing care with the limited resources that they have and how effective in some ways they are more than us when we're spending so much money on healthcare and so two other examples of what we've learned from our colleagues internationally is the work in primary healthcare and in Northern Thailand superb primary healthcare is provided with very limited resources that is reaching out to the people and that's something we're learning and we're including in our curricula in our medicine and nursing. Family healthcare is another area that we have learned from our colleagues internationally.

**SOLEDAD O'BRIEN:** I know Professor Chong (misspelled?) wanted to jump in.

**PROFESSOR PING CHIN CHONG:** Right. You were asking about what has worked. I was thinking you know wouldn't it be ironic if I said SARS? [Cross talk] you know among other things here's this reminder for all of us that in front of the serious acute infectious disease this might be the greatest equalizer of all because it's - in Southeast Asia you see that it's now past in breaking down barriers of class, gender, community, of

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citizens of social economic and so you have Hong Kong, Singapore with you know high income, devout [unintelligible] experienced health professional you know working with different kinds of policies and you also have Kin Tung (misspelled?) China and Hanoi with a different kinds of social economic circumstances and the same thing still from November to the end of March and we have some clues and people work very hard and it doesn't look like we will have complete competence in controlling this thing.

It also reminds us this [unintelligible] we have in and about the success and ability of modern medicine may again face a very serious challenge. It is indeed a great humbling experience for all health workers in East Asia, Southeast Asia and now in other places and [unintelligible], Ireland because we realize you need meticulously sort of well tailored understanding of local circumstances and you need both [unintelligible] expertise of centralized control in global health organizations like WHO and CDC but we also face sometimes the possibility of global concerns [unintelligible] made get into the way of local solutions because we still don't know whether we're talking or facing just one illness, one syndrome or clusters of pearl illnesses and therefore you know variations of different problems and that are also changing so what if this isn't an acute serious disease or diseases are here to remind that we really need to work together and to know

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more about one another before we could consider women's health and international health together.

**SOLEDAD O'BRIEN:** We [unintelligible] the fundamental issues of poverty and conditions but I do think we do need to talk about policy and the role not only of policy not only of local policy and you mentioned the community rules and laws but also U.S. policy on developing countries and their success or lack of success in tackling some of their biggest health issues for women [unintelligible].

**PROFESSOR ZACK:** Back to what Mary said and a couple of other things that were said that while poverty is very important access is an immediate issue and I want to absolutely hope that everybody is clear that poverty means lack of action. If people are so poor than they can't get those services and it isn't the case actually that as much as we can learn from poor countries about good ways to do things that the services in poor countries are better or acceptable or even remotely humane.

When I was in [unintelligible] recently I was in a medical ward and [unintelligible] because there were no medicines there it was a ward with occupancy of 160 in which that day there were 450 dying people, dying of AIDS. They had access to a hospital but they had access to no drugs. They were dying. Across the hall a few [unintelligible] who could afford it were paying for their own drugs this wasn't a question of

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infrastructure technology or knowledge this was a question of poverty that kills and talk about what it means to women when we went to the village outside of [unintelligible] where the grandmother was watching her 14 orphaned grandchildren because her children had died of AIDS because they couldn't get drug treatment or access. The grandmother was watching hungry children at risk of death at any day because their bodies were immuno (misspelled?) compromised for lack of food, because it was malaria season where the grandmother had carried one of the children the previous week 10km on her back during a malaria episode only to find there was no quinine in the local health clinic and local within quotation marks, 10km away and thank goodness the child survived the next day because after she walked back and walked again the next day there was quinine that happened to be there.

I don't think its right to make the - to give an image [unintelligible] situations and we're all in the same boat that I agree with but we're not all in the same situation. Hundreds of millions of people - that they are those people and trying to make ends meet and trying to stay alive with AIDS by making ends meet without drugs it doesn't work, trying to make ends meet without the anti-malarial good luck it doesn't work.

**SOLEDAD O'BRIEN:** I want to get to some questions but before we wrap up our panel I want to hear from Professor Chong (misspelled?) one more time.

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**PROFESSOR PING CHIN CHONG:** Right. I think you know on the bottom line I completely agree with what he, Professor Zack (misspelled?) has just said but allow me to do a little balancing act here, impoverishment inside of [unintelligible] economic statuses but also deprivation of information.

When I flew into New York a day ago I felt that the residents of this town is deprived of some key information about SARS. New York is this wonderful place and I used to live here when September 11th happened my husband was teaching at Columbia and I was at Princeton so we have always been with this community and realized that the local reports only started to talk about this thing publicly or directly forcefully a few weeks ago in March not in November when we were anxiously monitoring it everyday. I feel deeply for the residents here. New York can be the center of the world but could also be a completely sealed off village. I hope you would pardon me for saying that.

I feel that the residents here are directly connected physically to everything that's happening elsewhere and therefore we need to understand [unintelligible] about the way news is treated and handled here, the way that this war is something unhealthy, against health and I'm sure that all of you agree that when we talk about health we consider it as a sign of life not death and therefore you know how could we consider international health, women's health or anybody's

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health when we also have to consider war?

Then you know you will be traveling everywhere and meeting with every single young or old man or woman and they - you could either face serious disagreement that we've asked for mental health or more serious threat. That kind of thing I don't know whether you would agree [unintelligible] deprivation and impoverishment.

**SOLEDAD O'BRIEN:** Thank you. I want to first thank all the members of the panel and I want to open this up to questions now. If you have a question we have microphones set up, a couple of things we have a lot of people lining up for questions, we have a number of panelists and so here are the ground rules. I beg of you keep it brief, if you don't I will stop you and your question will end where I stop you. That's to be able to get to all the questions and please direct the question to a [unintelligible] panelist you have in mind. Why don't we start right over here?

**SUSAN:** Hi my name is Susan [cross talk] okay this question is for Dr. Gale, you had said that a lot of programs in developing communities and health have actually made a difference in helping women, do you think the reason that it hasn't worked in America is because there's an overwhelming attitude of privileged white women thinking that we really don't have it that bad and they're not faced with seeing these women from poverty all the time and that is why these programs

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don't work in America?

**DR. HELENE GALE:** I didn't say the programs don't work [cross talk] but I think there's mutual learning that can take place and I think that there are things that we have learned from activities in poor countries that have been incorporated and vice versa and so you know I wouldn't say that those have not worked here but I would say that we have not done as many of those sort of those activities, so I you.

**SUSAN:** Did you think that's the opinion of the women in the United States thinking that women's situation is not as bad as we're making it out to be and they're not aware of all these poverty problems?

**DR. HELENE GALE:** Well one you know and I think that [unintelligible] said it very eloquently our situations are not the same and I think that we do have to recognize that while we do have a real obligation this country to look at the relative differences and a country as rich as ours there are glaring disparities that shouldn't exist. We're too wealthy a nation to have some of the kinds of disparities, those are still far different than what women in poor countries face and I think we need to be real about that and then look at not only what is our responsibility for addressing some of those issues here that just should not exist but what can we do as better global citizens to address those issues for women in poor countries and for poor countries in general and so I think we've got to

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figure out how do we do a better job here but also extend that and recognize the situation is very dire for the lives of women around the world in ways that are unimaginable for many people sitting here in this country.

**SONJA LANDRA:** Hi my name is Sonja Landra (misspelled?) I'm a [unintelligible] and about to be a certified nurse from Yale in five weeks and thank you very much and it's such an honor to be here and I really want to thank Barnard for developing thriving, enthusiastic breath of fresh air panel of issues that are so important to the heart of -

**SOLEDAD O'BRIEN:** Could I stop you there for one second I so appreciate the preamble and I just want to get to your question because we have a lot of other people so thank you from all of us up here.

**SONJA LANDRA:** Got it. So as a new [unintelligible] I want advice on how do I best mobilize to contact some of these health disparities to fight [unintelligible] I don't see any [unintelligible] on the panel and I think that that is such an important [cross talk].

**SOLEDAD O'BRIEN:** Let's give the new graduate some advice.

**FEMALE VOICE 3:** This expertise to become an expert here get an internship with WHO or ITN in Geneva, make yourself known to the international community, network with other nurse midwives who are part of the international council of nurse

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midwives and make yourself available to go to other countries to be working with [unintelligible] not to be helping there because I really do want to emphasize we learn from our colleagues internationally that we bring to this country. We still have 45 million Americans with no health insurance, we have a developing world right in our backyard and we have disparities like [unintelligible] which is actually inexcusable it's almost excusable in other countries but this is inexcusable here. So there are opportunities for you to practice your midwifery here and that's [unintelligible] internationally and but midwifery but nurse midwives are [unintelligible] in the healthcare system but [unintelligible] you have a wonderful role to play.

**SOLEDAD O'BRIEN:** All right let's take a question right over here.

**MICHELLE ROSE:** Hi my name is Michelle Rose and I am a graduating senior at Barnard and I am also part of the [unintelligible] program at Barnard and the issue that I wanted to raise to the panel and that's the issue of abortion and it hasn't really been given a lot of attention for today and I was just curious as to what you would say that we can do in light of the recent threat of Roe versus Wade being overturned making the partial abortion legislation to go through and as a young woman and as a woman in general this is a very, very scary threat that is becoming an increasing reality.

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**SOLEDAD O'BRIEN:** Dr. Sahdit (misspelled?) why don't you handle that and why don't you also include in there contraception as well as you really haven't had an opportunity to discuss.

**DR. NASEEF SAHDIT:** Thank you very much. I think that - first I just wanted to tell you that the [unintelligible] of your country is 118th allowable [unintelligible] the health of the mother, the health of the fetus [unintelligible] and international feelings on abortion is that abortion should not be [unintelligible] family planning but where abortions take place we must have good counseling and in every case they must have access to safe and effective methods of family planning but where it is in [unintelligible] they should have access to safe and effective services.

Now the way the U.S. [unintelligible] is very important role is that you know that this Administration is obviously against abortion but what is happening there is that their opposition to abortion is being perfected in policies which are denying access to U.S. aid and other resources of funding even for organizations who [unintelligible] abortion in their countries where it is legal for monies that are given through those organizations from other countries or from other sources and these are the same organizations that provide access to contraceptive services as well.

So what is happening is that in our developing

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countries organizations that are denied funding or that have to give up you know the [unintelligible] for abortion either reduce the services or they have to forego the services for contraception and there's another aspect of this debate which is also coming out and it's in the context of HIV/AIDS and you know it very well and it's whether young people should have access to sexuality and reproductive education and whether they should have access to condoms and the [unintelligible] go out and be sexually active I think will be a hundred years old and but on the other hand we know that the sexual activity is occurring at younger ages all over the world and that young people, boys and girls are sexually active.

In a sense it's like your own moral values you are setting or you are jeopardizing the health and the life of your children and of yourself and again here the gender bias is very visible because the girl can get pregnant it does not matter she should be punished for being sexually active and that's why they're [unintelligible] but I mean this is in fact the basis for this discussion and that is very dangerous because [unintelligible] one billion of the world's population are young people today from 15 to 24 and they are the future of our society and if they don't have access to proper information and education and in the New York area as well there was said that there is information deprivation and access to condoms because many will delay sexual activity but not everyone and those that

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do not delay in our society and I'm not talking about developing countries some of them go to sex workers, they get infected and then come back and they give [unintelligible] to young girls who get infected with HIV through their mothers. That's [unintelligible] to themselves but that's an affect to the rest of the population. So this whole issue of contraception, reproductive health, reproductive rights, linked with abortion and abortion rights is a very strong and sensitive [unintelligible] but instead of being a pragmatic health issue when in fact we need to address health issues and look at the health of [unintelligible] health practioners and leave the [unintelligible] issues in fact to individuals and this issue should be left to the individual. We don't have to really [unintelligible] on everyone.

I think that's the point I want to make that everybody's relative and everybody's [unintelligible] culture and [unintelligible] and I have certain values for myself but I cannot impose them on you who might have a different set of values but I think we can all have the same values as far as health outcomes.

**SOLEDAD O'BRIEN:** That will be our final word.

**DR. NASEEF SAHDIT:** -in society because that is where the control is imposed in our society.

**SOLEDAD O'BRIEN:** And that will be the final word. I thank you so much to our panel and to our audience and thank

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you for the terrific questions we appreciate it. Have a great  
afternoon.

[ END]

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