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The Value of Health: Creating Economic Security in the Developing World

Perspectives from Disruptive Women in Health Care
December 2009

Disruptive Women in Health Care is Going Global with a New Series and e-Book on Global Health

"As study after study has taught us, there is no tool for development more effective than the empowerment of women. No other policy is as likely to raise economic productivity or to reduce child and maternal mortality. No other policy is as sure to improve nutrition and promote health, including the prevention of HIV/AIDS. No other policy is as powerful in increasing the chances of education for the next generation. That is why discrimination against women of all ages deprives the world's children—all of them, not just the half who are girls—of the chance to reach their potential."

Kofi A. Annan
Former Secretary-General of the United Nations

While health reform in the US tops the domestic policy agenda, at least for now, the need to improve health care in the developing world must be a high priority on the global policy agenda as well. And indeed, for many Disruptive Women, it is.

This evening (December 2, 2009) Disruptive Women in Health Care will host a reception and program at the Women in the Arts Museum to launch our new series on The Value of Health: Creating Economic Security in the Developing World. I will have the privilege of speaking at the program along with World Bank economist Dr. Maureen Lewis and Creative Women founder Ellen Dorsch.

Robin Strongin
President & CEO,
Amplify Public Affairs;
Founder, Disruptive Women in Health Care

Robin Strongin is an accomplished public affairs expert with more than 25 years of experience working in Washington, DC. Her areas of specialization include health care, science, technology and innovation. Robin has worked with and for Federal and state governments, regulatory agencies, Congress, think tanks, nonprofit organizations, corporations, coalitions and trade associations. Robin is currently serving on the Public Affairs Council's Senior Executive Task Force and the AcademyHealth Health Policy Communications Interest Group Advisory Committee. She has recently been appointed to the board of the Juvenile Diabetes Research Foundation (JDRF).

It is no coincidence that we chose this Museum. It's where women, economics, the arts and health care intersect. If we are ever to improve and sustain the health of women worldwide, women must be economically empowered. For many women around the world, the arts have provided just such a path.

Nobel Peace Prize winner Muhammad Yunus' pioneering work has taught us that microcredit, "the innovative banking program that provides poor people—mainly women—with small loans they use to launch businesses and lift their families out of poverty[i]" along with social business, "a business that is cause driven rather than profit driven with the potential to act as change agent for the world"[ii] can help create a World Without Poverty.

Many Disruptive Women are economists, artists, social business CEOs, innovators and health care experts and all Disruptive Women want to see improved health care access and delivery—in the US as well as in developing countries.

Economic empowerment alone is not enough. Education is critical. And there are enormous infrastructure, workforce, and communication challenges to overcome. At the same time, progress is being made, solutions exist and goals are being met. This series will highlight both the progress and the challenges. As always, we encourage your comments, feedback and ideas.

Please visit the individual blog posts at http://www.disruptivewomen.net/category/policy/global-health/ to add your comments.

[i] Muhammad Yunus, "Creating a World Without Poverty: Social Business and the Future of Capitalism," 2007. Back Cover.
[ii] Muhammad Yunus, "Creating a World Without Poverty: Social Business and the Future of Capitalism," 2007. Page 22.

Disruptive Women in Health Care Founder Robin Strongin

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Value of Health Launch Event Attendees

Women's Empowerment: A Call to Action

A young girl in Africa awakens early to fetch water for her families' daily needs. She will need to make multiple trips, carrying the largest volume possible to shorten the task. This daily ritual can take 3 hours or more. For these young girls there will be no school, basic necessities of life are their first priority. They will marry young, have children and the cycle of limited education and opportunity will begin all over again for the next generation. Education can help break this cycle. However to change the health and economic status of women, empowerment is the key to success.

In February of 2006, the World Health Organization (WHO) released a report entitled *What is the evidence on effectiveness of empowerment to improve health?* The report stated that improved education for women, including adult literacy and empowerment, improves child health and reduces fertility. Microenterprises were identified as a faster route to improving health. However, the report warned that "it is not enough to increase women's percentage of household income; this must be accompanied by increasing women's autonomy, mobility, decision-making authority and power within the household." Many argue that one leads to the other: increasing a woman's percentage of household income leads to the increased autonomy but it is not guaranteed. Providing only micro financing without a contextual understanding of societal restrictions will not ensure women's empowerment. Effective solutions must be created and offered in an integrated and sustainable manner.

Karen Nielsen,
President,
Nielsen &
Associates, LLC

Karen H. Nielsen, MBA, MPA, consults with industry and non-government organizations (NGOs) to identify and enable public health-centered solutions. Ms. Nielsen has a passion for global health and began blogging during the spring of 2008 to document the challenges of health care delivery for women, children, the HIV-positive and intravenous drugs users in urban and rural India. She is also a contributor to the American Public Health Association, International Health Section blog where she shares the passion and creative solutions that public health professionals bring to some of the most challenging environments all over the world.

The United Nations (UN) Millennium Development Goals (MDGs) are attempting to create an integrated, sustainable approach to reducing poverty by 2015. If you look at the eight categories you see the impact they have on women and children: (1) reduce poverty and hunger, (2) universal education, (3) improve gender equality, (4 & 5) improve maternal and child health, (6) combat HIV/AIDS, (7) ensure environmental sustainability and (8) global partnerships. The MDGs are a framework, agreed to by all the world's countries and all the world's leading development institutions, with a goal to unify efforts to improve the lives of the world's poorest. You will note that the eight goals are larger themes with many subcategories. For instance, under goal number 7, environmental sustainability, Target 3 is to "halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation". A WHO report on the Self Employed Women's Association (SEWA) in India has shown that a regular supply of drinking water, adequate housing and proper sanitation not only makes a substantial difference in health status, but also in income generation. Women shoulder the largest burden of water collection, reducing the amount of time that can be used for income generation. The UN estimates that in sub-Saharan Africa alone, 40 billion hours each year are spent collecting water, equal to a year's labor for the entire workforce of France. The same report reinforces that lack of sanitation negatively impacts women beginning at a young age. In areas where no latrine is available for students, adolescent girls quit school instead of facing the humiliation of relieving themselves in front of others. The system as a whole must be considered when addressing the needs of women and girls.

Although the MDGs are in place, we have a long way to go. The 2009 WHO report, *Women and health: today's evidence tomorrow's agenda*, states that there is an "urgent need for more coherent political and institutional leadership, visibility and resources for women's health" if progress is to be accomplished in saving the lives and improving the health of women and girls. The report highlights some important facts:

- Gender-based inequalities – for example in education, income and employment – limit the ability of women and girls to protect their health.
- Complications of pregnancy and childbirth are the leading cause of death in young women aged between 15 and 19 years old in developing countries.
- Globally, the leading cause of death among women of reproductive age is HIV/AIDS.
- Suicide is among the leading causes of death for women between the ages of 20 and 59 years globally. While the causes of mental ill-health may vary from one individual to another, women's low status in society, their burden of work and the violence they experience are all contributing factors.

These are just a few data points from a robust report. The WHO made it clear that societ-ies are still failing women and too many women and girls are still unable to reach their full potential because of persistent health, social and gender inequalities. The world leaders must address these issues, and pressure must also come from all levels of society for this change to occur. And when possible, individuals must organize at a grassroots level to force change within their own communities.

SEWA based in Ahmedabad, Gujarat (India), is one example of how individuals organized into a collective to bring about change. SEWA was founded in 1971 by a small group of poor and largely illiterate women that were led by Ela Bhatt. They believed economic security was crucial to the empowerment of women, and worked to achieve social and economic wellbeing of women through full employment and self-reliance. The founding members turned SEWA into a social movement across various states of India. At present SEWA is the largest trade union of informal workers in India, with nearly 1 million women members.

SEWA members demand fairness and justice in their fight to seek a livelihood. As a collective, they fight against harassment at the hands of the police and municipal authorities. As trade and service based cooperative, members have increased their ability to bargain with middlemen and contractors. A SEWA Bank was started to provide microcredit to its members and train members in skills that enable them to start or expand their businesses. The bank also provides insurance to protect members from property and asset losses. SEWA understands that health is directly related to the ability to work, productivity levels and income generation. Health programs were organized in addition to health insurance. The SEWA pushed forward with social change in a bottom up or grass roots approach, empowering women and providing a framework for the next generation.

You may wonder what the United States is doing to support this issue. Multiple federal channels have supported women's empowerment. The U.S. Agency for International Development (USAID) is one example of an agency that has worked on education, political participation and entrepreneurship for women. Under Secretary of State Hilary Rodham Clinton, the U.S. State Department will be focused on financial inclusion: ensuring that women have access to savings accounts, health insurance, home ownership and business funding. Secretary Clinton has announced that she will launch a fund for international women's empowerment in Fall 2009. The money raised will go to combat violence against women and girls, promote girls' education, and create economic opportunities for women. A great next step would be for the U.S. to ratify the 30-year-old Convention on the Elimination of All Forms of Discrimination Against Women. The U. S. is one of only a handful of countries that have not ratified the treaty. Treaty supporters point out that America's lack of participation is used

as a reason for other countries to not enforce the agreement. The treaty is reported to be on the Secretary of State's priority list, and should be on the priority list of those outside of Capitol Hill.

Empowering women must be a united approach, a cause that requires continued attention and stewardship by all. Awareness is part of the solution. The recent book Half the Sky: Turning Oppression into Opportunity for Women Worldwide brings attention to the issue. The authors, Kristof and WuDunn, provide examples of how empowerment has transformed lives while generating a call to action. Their blog provides ways for individuals to get involved in the cause by spreading the word or by supporting organizations committed to the needs of women and children. Empowerment and health are tied together. When a woman is empowered, her health and the health of her family improve, thus benefiting communities and societies at large. As the 2009 WHO report so eloquently concluded, **"Improve women's health – improve the world."**

Solutions to Poor Health in Developing Countries

Health is a concern in all countries. But in the developing world poor women bear a disproportionate brunt of poor access and low quality health care.

But the solutions to poor health in developing countries aren't always obvious. Moreover they vary across countries. First, all developing countries aren't alike and national incomes range from less than $200 per capita to almost ten times that, which means that their capacity to manage and pay for public health differs. Despite the popular perception of high poverty in poor countries, the majority of poor families live in the large Middle Income Countries like Brazil, China, India, Indonesia and Mexico, rather than in Africa. Hence health priorities vary. The one constant is that health care is always complex.

What is critical to good health for mothers and children in poorest countries? All studies point to the overwhelming importance of mothers' education, as well as to clean water and immunizations. Even with just some education, mothers are better able to prevent illness, and know when, where and how to obtain medical care. But that is just half of the equation.

Maureen Lewis,
Advisor to the Chief Economist, The World Bank

Maureen Lewis, Ph.D., was formerly the Chief Economist Human Development and Advisor to the Vice President for Human Development at the World Bank. Much of her research, publications and policy work examine governance and efficiency in the social sectors, particularly health.

Good health care can be helpful but in the poorest countries government provided and financed health care is often plagued by quality shortfalls. The poorer the country the larger the share of out of pocket payments and the least likely there is to be health insurance. Virtually all countries have a thriving private sector and it serves all income levels.

In many developing and transition countries government financed and operated health care services face some common operating problems like high levels of absent medical staff and shortages of drugs and supplies.

But many of the issues facing developing countries' health care systems mirror some of those confronting the US in our drive for health reform. For example, who pays for health care, who is to be subsidized, how to control costs and how to balance interest group demands all remain relevant to health care reform across the globe.

What to do about lack of access, poor quality? First, money alone isn't enough and can be problematic if there is too much of it and not enough capacity to use it. Local not for profits are vitally important and often do a better and less expensive job than the public sector in delivering health care. Second, public sector institutions need strengthening and greater accountability in their health care delivery. And finally, education, formal and informal, can't be forgotten if the ultimate goal of healthy women and children is to be achieved everywhere.

World Bank Economist, Dr. Maureen Lewis, at Launch Event

It's High Time for Higher Goals

It has been long recognized that the growth of a nation's economy improves the health of its people.

The converse is also true. Improving health is an economically wise and productive investment.

In fact, that's the reason that health systems were established – by the King and the employer – documented as far back as 4,000 years ago.

There is good news to today's world: a positive cycle of gains in both *health* and *economic security* occurs as either one is improved.[1]

Have we taken the value of health for granted? I think so and find that especially the case among those of us in the health community. We talk endlessly about improving health outcomes as if those outcomes were an end in themselves. We have fallen victim to the notion that health expenditures are a cost, rather than an investment. We have forgotten our origins in economic growth and security. We have set our sights too low.

It's high time we set higher goals. Disease creates barriers and slows progress towards economic status and security. As health improves, people experience both immediate and long-term economic benefits. Individuals become more productive; they enhance not only the quality of their lives but their capacity to enrich economic well-being.[2] "Health is an economic engine."[3]

Glenna Crooks,
Founder &
President,
Strategic Health
Policy
International, Inc.

Glenna Crooks solves some of the toughest health care problems of our times by distilling chaos and complexity into recognizable and easily digestible, action-oriented insights. Her clients, businesses and governments around the world, have used her Centricity Principle™ approach to create successful organizational, national and global transformational strategies. Her work is based on a professional history in senior government positions as a Reagan appointee, lobbyist and professional society and bio-pharmaceutical company executive. She served on the Bill and Melinda Gates Foundation Pediatric Dengue Vaccine Initiative Board of Scientific Councilors and was a member of the Institute of Medicine committee to advise the Department of Defense on bioterrorism countermeasures.

This is true not only for individuals but also for families and societies.

World Health Organization (WHO) and World Bank benchmark reports outline the relationship between good health and economic development; good health is not only a means to *reduce poverty*, but also a means to *accelerate national and personal economies*.[4],[5]

- Individual health increases personal productivity and earnings. Extending healthy years of life increases the *number of working, income-earning years*. Healthier workers are more productive economically during their working years as well.
- Good health reduces the funding required to treat disease, allowing people and nations to invest in other needs.
- A healthy population encourages foreign investment, technology transfer, and facilitates access to global markets.[6]
- Healthy children are more prepared for school, miss fewer days of school, attend school for more years, and learn more while in school. In addition, longer life span is associated with more years in school and each year of schooling results in a 15% higher starting wage and a *doubling* of the rate of subsequent salary increases.[7]
- Natural resources previously inaccessible due to disease (e.g., agricultural acreage unusable because of malaria) are made available for production and farming.[8]

Health benefits everyone. Illness harms everyone – not only those who are sick, but also other, healthy household members. The healthy must work harder or longer to make up for lost of income when the major breadwinner is ill and in some societies, girls miss school to care for sick relatives.[9] As households cope with illness, they may also reduce spending – including on food – to account for declining in income.[10] These adjustments have ripple effects through the entire family, though are not generally counted in cost of disease because they are losses borne by the household overall.[11]

In recent decades, education and on-the-job training were viewed as the principle determinants of human productivity. In recent years, however, economists have recognized health as equally important and it is time that those of us in health care do likewise.

Half of overall economic growth in the US in the past 100 years is estimated to be related to improvements in health and cross-national studies have shown that the 27-year difference in the life expectancy between low- and high-income countries – 51 vs. 78 years – is associated with a difference of 1.6% in annual compounded economic growth rates.[12] The return on improvement in health is very large, overshadowing gains from most other investments.[13]

These issues are not trivial. Though wealthy and poor countries benefit, the *poor in any country benefit most* and the imperatives for health today, stated well by the Institute of Medicine, have never been greater.

It is in both our domestic and our international interests.[14] Here's hoping that as the new year approaches that we will provide the quality of care we have pledged in healing oaths and that we will set our sights even higher, returning people to productive lives in the workforce – or if they are not enriching our economy but enriching our hearts – to fruitful lives in families and communities across this nation and the world.

In other blog posts I have noted the critical role of women as "Dr" Mom, Sister, Friend, Spouse — and policy maker. In this series, the role of women in the development of the developing world has also become clear. That role is critical. It can't be ignored. Here's hoping that as the new year approaches we will pledge to help them. Their heroic efforts will be made ever more successful if we do.

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Disruptive Woman Glenna Crooks, PhD, and Launch Event Attendee Stephen Keith, MD, MPH

Global Health Starts at Home

My 30+ year health care career is catching up with me – my eyes are wide open, my heart is heavy, and my mind is racing. What is happening? In the summer 2008, I had the privilege to help convene and participate in a week long, by invite only conference on ehealth capacity and workforce, sponsored by the Rockefeller Foundation and part of their series of topically focused conferences. In June 2009, I traveled with my daughter to Ecuador as part of a humanitarian trip to provide health, education and infrastructure support to several indigenous rural villages. And at AMIA, I have the good fortune to participate in several globally focused health informatics and workforce projects.

I have learned a lot about how health workers are inequitably distributed throughout the world, with severe imbalances between developed and developing countries. It is clear to me that tens of thousands of people lack the information, knowledge, or resources to take care of themselves or their families. The growing worldwide shortage of health care workers, along with the imbalance of the availability of health workers, stands in the way of achieving such key global public health priorities as reducing child and maternal mortality, increasing vaccine coverage, treating people with chronic diseases, and combating epidemics such as TB, malaria, HIV/AIDS and H1N1.

Over the decades, there has been much discourse and many, many meetings on the topics of access to health care, the shortage of health care workers, and the lack of adequate

Meryl Bloomrosen,
Vice President, American Medical Informatics Association

Prior to her position with AMIA, Ms. Bloomrosen was a Vice President at the eHealth Initiative and the Program Manager of the Connecting Communities for Better Health Program, a HRSA-funded, multi-million dollar cooperative agreement. Earlier in her career she was a senior policy analyst at the Prospective Payment Assessment Commission. She has a certificate in health information management from the U.S. Public Health Service, an MBA in Information Systems from George Washington University, and is currently enrolled in the Graduate Certificate Program in Biomedical Informatics at the Oregon Health Sciences University in Portland. In addition she has completed the Medical Informatics MBL/NLM Course Fellowship program at the Marine Biological Laboratory, Woods Hole, MA.

information about health and health care. Philanthropies have created and launched multiple programs to help eradicate poverty and disease; to help educate generations of world citizens; to help train doctors and nurses; to increase world literacy. Papers and reports written. Speeches and testimony given. There are just too few hands-on healthcare workers to provide essential health interventions, and reports conclude that this shortage requires adopting a global approach to health worker human resources.[1-12]

The United Nations' (UN) Millennium Development Goals (MDG) to promote poverty reduction, education, maternal health, gender equality, and aim at combating child mortality, AIDS and other diseases represent one global partnership. The World Health Organization (WHO) devotes resources to the topic of the ongoing and growing shortage of health care workers as it relates to global health noting that prevention and treatment of disease and advances in health care cannot reach those in need. In the U.S., several reports discuss the current and future demand for health workers (including primary care physicians, nurses, providers, and public health workers) and conclude that we too face a critical national shortage driven by such factors as U.S. population growth, increased need for health care, the aging population, an aging and retiring workforce. The general consensus is that demands will outstrip the supply.

Historically there is consistent under-attention given to women's health and inadequate information available to and for women about women's health issues worldwide. Women are a vulnerable population, and programs that improve women's health have a direct impact on maternal and fetal morbidity and mortality. Women's health is particularly at risk due to pregnancy, childbirth, their role in conflict and in displaced populations, and lastly because of their role in society. Organizations like Global Alliance for Women's Health and Our Bodies Ourselves as well as initiatives like Wye River Call to Action for Global Women's Health and The Global Women's Health Fellowship at the Connors Center for Women's Health are among many that seek to combat the worldwide deficit in information and attention.

These days, the US government is tackling the complex topic of health care reform "to ensure Americans get the high-quality, affordable care they need and deserve."

Attainment of health and access to health care and health information, is a multi-faceted, long-standing political, economic, educational, social, cultural and GLOBAL issue.

The status quo is killing us.

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Disruptive Woman Lisa Korin and Launch Event Attendees

Prioritizing Tuberculosis (TB) Vaccine Research

Shortly, I will be heading to Cancun, Mexico, for the 40th Union World Conference on Tuberculosis and Lung Health. The meeting will bring together hundreds of dedicated researchers, project implementers, World Health Organization officials and advocates who have committed themselves to stopping tuberculosis, which is second only to HIV/AIDS as the most infectious disease killer globally. Yet decades after the first meeting of this august body, we are still using the same outdated, inefficient and marginally effective tools to fight TB. Meanwhile, the wily tuberculosis bacterium – which has been killing people for tends of thousands of years – continues to get ahead of us with its growing resistance to available treatment.

Peg Willingham,
Senior Director for External Affairs, Aeras Global TB Vaccine Foundation

Vaccines remain the most medically efficient and cost-effective ways to prevent and eliminate disease. To stop TB, we must do all we can to mobilize the scientists, researchers, public health decision-makers and funders to make new TB vaccines a reality.

The development of new TB vaccines is a vast and expensive undertaking requiring an all-hands-on-deck approach. Private foundations and a select group of European governments are supporting this work, but the US government lags woefully behind. The US established itself as a world leader in HIV/AIDS through President's Emergency Plan for AIDS Relief (PEPFAR) and contributions to the Global Fund to Fight AIDS, TB and Malaria. The U.S. also is a dominant force behind ramped up HIV and malaria vaccine research. Yet, the US has failed to take up TB vaccine research as a priority funding area. Because of PEPFAR, many are now living full lives with HIV, only to be struck down by TB. Why this lack of action on TB?

The pandemic is ever-more dangerous as it evolves globally and thousands of Americans become ill with TB each year. TB is a disease of poverty and it kills nearly as many women as all causes of maternal mortality. Active TB disease hampers a mother's ability to care for her family and robs many children of their mothers. Children, especially those living

in the crowded conditions of poverty, are also at greater risk of becoming infected with TB when a parent or family member has TB.

The good news is that there is tremendous momentum in TB vaccine research, with seven TB vaccine candidates currently undergoing clinical testing. My organization, Aeras Global TB Vaccine Foundation, and a handful of others are doing all we can with available resources to accelerate the process to get new, safe and effective vaccines to those who need them so urgently. Although Aeras is a non-profit research organization, developing new vaccines is still a complex and expensive undertaking. One large-scale clinical trial designed for potential licensure of a vaccine will cost approximately $160 million. Yet this represents a smart investment, because a TB vaccine would be save millions of dollars – and lives. As the Obama administration and Congress outlines their foreign assistance agendas, TB vaccine research should be prioritized. Investment in preventing TB today will translate into fewer resources in treatment and lost productivity – and lives – in the future.

Why VirtuArte?

Events in life often force you to step back and review where you are. In 2007 this is exactly what happened to me. I had spent the last 15 years working for three different multinational corporations, the last one for six years.

As is often the case in the corporate world, in early 2007 my job suddenly changed. So I took the opportunity to evaluate where I was in my career and to think about what I really wanted to do next.

In the early years of my career I worked at the Inter-American Development Bank, an institution that focuses on economic development in Latin America. This was my first “international” experience, where I got my passion for developing country issues and found that I love to travel. I left the Bank after 10 years and began the next phase of my career working for multinational corporations. Each position I held over these 15 years allowed me to continue to work internationally on developing world issues and travel extensively. On these travels I always took the opportunity to look for artwork and crafts that were unique to bring home either for my own enjoyment or to give as presents.

In the developing world people have always produced crafts. Over the years the skills of these individuals have developed and many have now become true artists/artisans. However, many of the creators of these beautiful products — artwork, jewelry, weavings, and textiles – are located in countries and often in remote areas where their works are seen only by locals, expats or a few tourists

Debbie Myers,
Founder,
VirtuArte

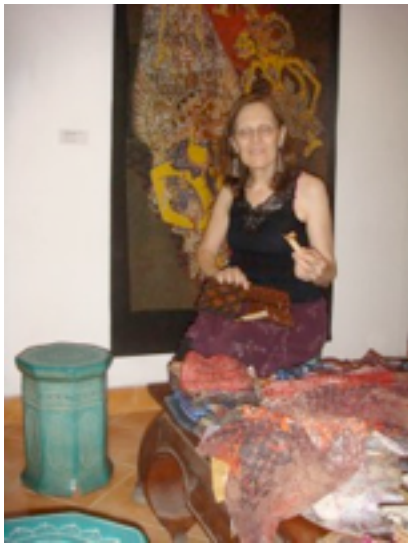
Deborah E. Myers has more than 25 years of experience in international economic development, including advocacy, public policy and developing strategic partnerships. She has worked with major corporations, governments, non-government organizations, and international organizations to find solutions to problems facing the people and governments in the developing world.

who venture to these regions. Many of these items are being made by women who live in rural areas that are trying to earn an income to support their families. Their products are often expressions of traditions and customs that are slowing dying out because there is insufficient incentive — economical or cultural — to pass on these traditions/customs on to the next generation. These products are not only interesting from an anthropological perspective, they are works of art that will stand the test of time and are worthy of a place in the marketplace of beautiful objects.

After doing some soul searching I knew I did not want another corporate job. I was ready to do something different. So I left my corporate position at the end of 2007 and decided to bring my experience and passion together in a new venture, VirtuArte. VirtuArte is founded on the premise that there is a market for unique art, folk art, “fine” crafts and curios from the developing world. The purchase of a one of these pieces has an impact on both the purchaser and the artist/artisan.

The purchaser will:

- be introduced to distinctive, handcrafted products;
- be given a glimpse into another culture;
- help create further awareness of these beautiful works of art; and
- contribute to the improvement of economic well being of the artist/artisan.



The artist/artisan will be able to:

- support their family;
- improve the quality of their lives;
- stay “home” in the local village rather than migrate to urban areas to look for employment; and
- preserve traditional customs and craftsmanship.

Many of these artist/artisans are women. The increased awareness of their work and the income generated by the sale of their products to an international clientele helps these women to move up the economic ladder and begin creating new opportunities for

themselves and their children. Studies have found that when women hold assets or gain incomes, family money is more likely to be spent on nutrition, medicine, and housing, and consequently children are healthier.

It is my belief that the increased awareness and ability to earn an income will also encourage and provide an incentive to the artist/artisans to continue their traditional weaving, carving, sculpting, painting and other craftsmanship, and pass their skills onto the next generation.

As defined by Muhammad Yunus, the founder of the Grameen Bank, VirtuArte is a “social business.” That is, it has two motivations: maximizing profits and doing good for people and the world.[1] Profits will be reinvested back into the company to expand its outreach and increase the number of artists/artisans promoted. Nonetheless, a percentage of the profits will be given back to the communities to help increase access to healthcare and education, key areas for the economic development of any country.

Over the past two years I have had the opportunity to meet and get to know people like Carol Cassidy, textile designer from Laos; Ann Elston, who works with the Koumama family in Niger; Ellen Dorsch, who works with women owned textile businesses in Ethiopia, Swaziland, and Afghanistan; and Judy Frater, director of a design school for traditional artisans in India. All of them are working to help develop local/traditional craftsmanship, create jobs and assist in bringing the products to international markets. In future posts I look forward to introducing you to these individuals and others, presenting their products, and telling their stories.

For more information about VirtuArte, the artists, products and events please visit the website at www.virtuarte.com and/or the blog at www.virtuarte.com/blogs.

[1] Muhammad Yunus, “We Can Create a Poverty-Free World,” Spiegel Online (7 June 2007)

VirtuArte Founder and Disruptive Woman Debbie Myers

Start With a Girl: A New Agenda for Global Health

The recent attention given to women's role in development is great. Even better, it happens to coincide with an increasing focus on health system strengthening. And in the case of the Obama administration's Global Health Initiative, these two are coming together to promote women-centered health care.

We're thrilled. But we also need to remember that healthy, empowered women don't just spring out of the ground ready to contribute to their nation's development. Adolescent girls are the foundation for progress on a slew of major global health goals—including maternal mortality, HIV, and infant mortality reduction—not to mention accelerated social and economic development. Yet there are around 600 million adolescent girls whose rights aren't assured. So what can we do to make sure that girls pass through the critical juncture of adolescence with their rights to health, education, and safety intact?

Most girls enter adolescence healthy. It's what happens to them in the eight or nine years following puberty that shapes their future. Unacceptably, it is factors largely beyond their control—both social and biological—that put them at risk.

Girls' health status during adolescence has lifelong consequences for them, as well as for the next generation. Unhealthy mothers pass on poor health status to their babies. This relationship spans multiple generations; research in several countries shows that grandmothers' height is significantly associated with their grandchildren's birthweight. The inter-

Miriam Temin,
Co-Author,
Start With a Girl: A New Agenda for Global Health

Miriam Temin has 12 years of experience in Africa, the United States, and Europe working on HIV/AIDS, sexual and reproductive health, and social protection with donors, UN agencies, and non-profit organizations. Previously, Temin was a senior AIDS policy advisor at UNICEF headquarters, where she brought greater attention to children affected by HIV/AIDS through research, advocacy, and technical assistance.

With contributions by Sandy Stonesifer, Program Coordinator, Center for Global Development.

generational transfer of ill health is amplified when mothers are young, since babies of young mothers are less healthy than babies born to older women.

Yet despite their vulnerability and their critical role in social and biological reproduction, adolescent girls are often overlooked. While it isn't difficult to find high level commitments to adolescent girls—their importance is recognized in a few of the Millennium Development Goals, in UN Declarations of Commitments, and in some important donors' White Papers—these grand statements are not matched by the serious funding, scale up, and research that girls need to make real progress. According to coverage surveys of youth centers and peer based programs, even youth oriented programs often fail to reach them.

One of the starkest illustrations of how inattention to adolescent girls jeopardizes their wellbeing is child marriage. In 10 countries, over half of all girls are married by the age of 18 (a full 77% in Niger) despite the fact that in almost half of those countries, the practice of child marriage is illegal (Sierra Leone, Central Africa Republic, Bangladesh and Nepal). Where are the focused efforts in communities to enforce the laws, promote alternatives to marriage, and help girls stay or re-enroll in school instead of marrying? Some current approaches are having notable success in delaying marriage, but they are too often small scale, fragmented, and unsustainable.

There's no question child marriage is bad for girls. Those available for marriage have left school prematurely and ended their chance for vocational training. Most young wives face isolated lives of restricted mobility, with little or no control over household finances. And the health risks are significant. Early childbearing, which poses threats to mothers and their babies, and heightened vulnerability to HIV infection are but a few. The nature of sex within marriage, typically frequent, unprotected, with wives unable to insist on condom use, and the typical age gap between young wives and their older husbands, conspire to place young wives at increased risk.

Tackling the social forces that underlie girls' ill health, such as child marriage and limited education, and most importantly, the gender inequality that lays the foundation for these social determinants of girls' health is the only way to achieve a real transformation in adolescent girls' health.

So where is the health sector in all of this?

While addressing the social determinants of health is imperative, adolescent girls also need health systems that work for them. Yet from the age of their last immunization, usually five, until their first pregnancy, developing country health services often fail to reach girls. The consequences? Unplanned early pregnancies; maternal mortality; HIV infections; undetected gender-based violence and mental health problems; and a looming burden of chronic disease due to poor diets, sedentary lifestyles, and tobacco and substance abuse picked up during adolescence.

There is much we can do to make health systems more responsive to adolescent girls. Girl-friendly adaptations are feasible and timely given the current surge of interest in health sector strengthening. Measures include training health workers to be more competent in adolescent health, using adolescent girl-specific indicators to measure health system performance, and ensuring that service delivery approaches and demand side financing mechanisms reach girls. Expanding high quality youth friendly health services is also key. Without a doubt, all users of health systems stand to benefit from changes made in the name of adolescent girls.

A new report by the Center for Global Development, Start with a Girl: A New Agenda for Global Health, sheds light on the realities of girls' health and wellbeing in developing countries, on the links between their health and prospects for their families, and on the specific actions that will improve health prospects for millions. It lays out an ambitious yet feasible agenda for governments, donors, the private sector, and civil society organizations—complete with indicative costs.

We know what to do: expand proven and promising approaches to protect adolescent girls' health through the health sector, communities, schools, workplaces, and the media to alter the equation for girls, women, and beyond. Start with a Girl and unleash the transformative power.

Mental Health is a Basic Human Right to Fight For

A few days ago the world celebrated Mental Health Day, and more recently it was the Human Rights Day, as such I have decided to post a reflection on the rights of all people to access mental health care as a part of the access to health care as a basic Human Right. I especially dedicate this reflection to the issues surrounding access to quality mental health care services for women.

Unfortunately, in the majority of the developing world, mental health is not an issue that is given adequate attention. However, if we take the definition of WHO, mental health plays as important part in overall health as the physical aspects do. To improve mental health, governments have to create a well-trained and well-equipped workforce to care for mental health and ensure that the funding and human and physical infrastructures are available. This will help to increase access to mental health care, but should be completed by making drugs available, like psychotropic drugs. Many of these medications are not so expensive and can be part of public essential drugs available at public health facilities. It is a matter of paying attention to the problem.

Dr. Agnes Binagwaho, Permanent Secretary, Ministry of Health of Rwanda

Dr. Binagwaho is a pediatrician specializing in emergency pediatrics, neonatology, and the treatment of HIV/AIDS in children and adults. She has served 4 years as Chair of the Rwandan Steering Committee for the United States President's Emergency Plan for AIDS Relief (PEPFAR), and was responsible for the management of the World Bank MAP Project in Rwanda, while also serving on the country's High Commission on Aid Policy.

Also, the general population should be educated via mass media campaigns so that they will have less fear and a better understanding of mental health diseases and those who suffer from them, causing mental health patients to suffer from less isolation, stigma and discrimination. This can be done by partnering the government with civil society organizations to improve the public education on this issue through TV, radio, speeches, billboards and community events.

Both of these points are vital and necessary if we wish to improve the care of people who suffer from mental illness, because they will encourage the community to send people for care when mentally ill, and when the patient arrives, the health care providers will be ready to give proper care.

This is the system that the Government of Rwanda is creating by having one psychiatric nurse in each district hospital working in an integrated manner with hospital personnel, and by training general practitioners in the diagnosis and treatment of simple mental diseases and in the identification of severe ones so that such patients can be transferred to the national referral hospital for mental health. We also have some psychotropic drugs available as essential drugs, but we still have a long way to go to ensure that every Rwandan in need of mental health receives it.

An extremely important area of mental health care for women is trauma due to conflict situations, where many women are devastated because of rape and other sexual violence, as these health issues are often neglected. Mass rape has been used as a tool for war for centuries, and can be found in modern history as well: from the rape by German and Japanese armies during World War II, to the use of systematic rape and deliberately infect women with HIV during the Rwandan 94 genocide against Tutsis; this: from the rape of women during the Kosovo conflict, to the current use of rape to intimidate and humiliate women in the eastern regions of the Democratic Republic of Congo and through the devastation of their genital organs. For these women, international organizations should play a bigger role, since most of the conflicts are predictable and usual time for rape, sexual abuse and violence and psychological traumas.

In post conflict situations such psychological destruction needs specific attention to rebuild mental health and care for psychological reconstruction as a priority. Instead, the thousands of individual women suffering from this type of trauma are totally neglected and suffer in silence. Furthermore, in some countries these women additionally face stigma because of forced sex and pregnancy out of marriage, and are sometimes even forced to leave their households and villages because of that – doubling their trauma. In this manner, the communities who should be helping these women instead end up being on the same side of the perpetrators of this violence. For the prevention of mental health illness in women post wartime sexual violence, we must do massive behavior change campaigns for tolerance in countries recovering from wars. That was we did and still do in Rwanda. If not, these women will be denied their basic human rights to gender non-discrimination, to live without violence, and to access care for mental illness and other health issues like STIs, HIV, and genital organ damage.

Employment: A Public Health Intervention

When I left my consulting business about seven years ago, friends and colleagues asked me if I thought I would miss working in Public Health. I had been working, for over 30 years, in Vermont (my home), nationally, and in East Africa, Central American, and Russia … in program development, evaluation, and administration. I had decided that I no longer enjoyed writing grants or looking for new contracts, and I very much wanted to experience working in the private sector.

I left and started Creative Women, an importer of elegant textiles from Ethiopia and a business with a social mission … to create jobs. I soon realized that I didn't leave public health, but rather was impacting on women's lives from another perspective. I saw that with some independent money, women would have more options about their lives, including (hopefully) the ability to leave a relationship where they or their children are not safe.

After 7 years working with women-owned businesses in Ethiopia, Swaziland, Afghanistan, and now Mali, I've expanded my definition of Public Health and believe that employment is as necessary for good health as vaccines and clean water. Initially, I argued that financial independence, or at least some earning power, meant a woman could say no to an abusive partner, or could pay school fees for her daughter(s). This became more real to me as I heard stories from some of the sewers and cleaners who worked at Menby's Design, the first business I worked with in Ethiopia. A woman whose husband beat her up because she objected to him having a "second wife" was able to take her

Ellen Dorsch,
Founder,
Creative Women

Building on her commitment to women's well being, her love of travel, her desire to experience the challenges of the private sector, and her love of hand-made products, Ellen Dorsch decided to leave the non-profit sector and start Creative Women. Today, Creative Women imports elegant hand-woven products from women-owned businesses in Ethiopia, Afghanistan, Swaziland, and Mali. Each product Creative Women sells, allows the company's colleagues to hire more workers and to pay them decent wages and benefits helping them, and their families, to live a healthier lifestyle, and to receive health care when needed.

children and leave her unsafe home. And because she had some income, she could return to her parents' home and not be a financial burden to them. This income meant the difference between safety and abuse to her and her children.

I also saw that a business owner, who pays her employees fairly, gives workers benefits, recognizes the demands on working women, and creates a safe working environment is a vitally important public health intervention. The owner of Coral Stephens, in Swaziland, provides transportation and time off, so that employees can get free and anonymous HIV testing. By doing this, in a country with one of the highest HIV/AIDS rates in the world, she allows her employees to get testing, counseling, and treatment without her partner and/or family knowing her status.

At Azana, a small weaving studio in Afghanistan, employees are encouraged to join a free, in house, literacy class at the of their work day. Not usually seen as a health intervention, being able to read, among other things, increases a woman's ability to find work and to provide clothing, health care, good food, and school fees for her kids.

Working with other women allows women to form the equivalent of support groups, where they a share information about their bodies, bringing up their kids, and their rights. In some of the workshops that I work with, this dynamic serves a similar purpose as parenting groups, health ed programs, and informal referral groups that are often offered at clinics in the US.

Finally, employment, and the resulting information, money, and support, can greatly impact a woman's self-esteem. At Sabahar, in Ethiopia, one of the finishers, a young woman who had very bad teeth, and rarely smiled because of this, saved some of her small salary and eventually was able to buy false teeth. I have a wonderful photo of her, smiling and talking with a group of her peers. I wonder how much these new teeth, and her new sense of self, affect her ability to move ahead at work, bring up her children, and create a better life for those around her.

Creative Women Founder Ellen Dorsch

Saving Money While Saving Lives: The Economic Argument for Childhood Vaccination

Hib, pneumococcal and rotavirus vaccines that have long been available in the US, offer significant promise to the children in developing countries. Not only could these vaccines, save millions of lives over the course of the next couple of decades, but they also have the potential to add to the wealth of nations. Yet, despite enormous promise, there are still delays 1-2 decades before children in developing countries have access.

Vaccines have long been considered one of the most affordable and cost-effective public health interventions available today. Historically, they have been pennies per dose. According to the World Bank's Disease Control Priorities Report, at $7 per DALY averted in Sub-Saharan Africa for the Expanded Program on Immunization (EPI), a package of six WHO recommended vaccines including diphtheria, tetanus, pertussis, polio, measles and represents excellent value for money. By comparison, statin with aspirin, beta blocker and ACE inhibitors for ischemic heart disease costs $2,028/DALY averted.

However, with newer vaccines costing not pennies, but dollars per dose, do we need to reestablish our paradigm for affordability?

A recent review of the economic case for expanding vaccination coverage of children done by researchers at Harvard and Johns Hopkins suggests that new vaccines are a good investment. Cost-benefit analyses of Hib vaccination, for example, indicate

Lois Privor-Dumm,
Director of Alliances and Information for the PneumoADIP, Johns Hopkins Bloomberg School of Public Health

Lois heads up several vaccine projects related to advocacy and communications as well as access and implementation. She is currently working as Director, Large Country Introduction for a project which aims to accelerate introduction of pneumococcal and rotavirus vaccines in low-income countries. Lois has been at Johns Hopkins since 2005 helping guide strategies and accelerated uptake on both the Hib Initiative and PneumoADIP and has been leading projects in developing and donor countries to support strengthening of policies and awareness for childhood pneumonia as part of a global World Pneumonia Day Coalition effort.

that the cost of vaccination is less than the savings accrued by preventing mortality, lowering future health care costs, and reducing productivity losses among parents (who no longer have to stay home with a sick child). However, even these analyses may underestimate the true economic benefits of childhood vaccination.

Cost-benefit analyses of childhood vaccination have typically focused on a narrow set of benefits such as those mentioned above. However, these calculations fail to account for a broader range of indirect effects, such as herd-immunity—which occurs when an unvaccinated individual experiences a lower risk of infection due to the vaccination of others in the community—and lower fertility rates as families decide to have fewer children due to improved survival rates, thereby generating a demographic dividend.

Perhaps most interestingly, vaccination may have long-term implications for a child's productivity potential. Measles vaccination has been shown to improve education attainment among children in Bangladesh and South Africa. Hib, pneumococcal and rotavirus are expected to show similar results Early improvements may have a positive impact on long-term economic wellbeing.

Health is not just an outcome of economic development; it may be a critical driving force. A study published in World Economics suggests that childhood vaccination may have as great a return on investment as primary education. Consequently, our economic development initiatives cannot afford to neglect health, especially health in the earliest years of life.

The GAVI Alliance and donors have been convinced by the investment case for these new vaccines and now offer vaccines for as low as 15 cents per dose to help accelerate introduction. More money is needed to support the investment in saving lives and helping in the development of nations. Stakeholders will need to reset their paradigm of affordability and recognize the investment required to make significant changes to benefit the developing world.

Private Sector Contribution to Developing Countries' Health Unheralded

Susan Crowley,
President,
Multilateral
Consulting, LLC

By any measure, giving programs directed at developing countries by research-based pharmaceutical companies are the most generous of any industry. The Geneva-based International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), whose methodology and data presented in its most recent "Partnerships Report" were validated by the London School of Economics, reported $6.7 billion in giving.

The 2009 "Index on Global Philanthropy," published by the Hudson Institute, provides a measure of global private giving and, once again, demonstrates that private flows continue to make up a larger percentage of resource flows to the developing world than official development assistance (ODA, i.e., government). Hudson reports that total corporate contributions to overseas programs amount to $6.8 billion. Of this amount, Partnership for Quality Medicine Donations, whose source is pharmaceutical firms, accounts for $6.1 billion, or 90% of total corporate contributions from all sectors to developing countries. Moreover, the $6.8 billion reported by Hudson is greater than the combined annual health budgets of USAID, WHO, the World Bank, and the Gates Foundation.

The geographical scope and therapeutic breadth of these contributions, and the programs they support, are evident immediately via the Global Health Progress searchable database. What is less obvious, but also important, is that these companies have amassed considerable experience in designing and implementing health initiatives across the developing world, and can offer invaluable insight to partnering organizations.

Although the industry's, and individual companies', commitments to improving health in developing countries are documented on a scale unmatched elsewhere in the private sector and – in fact—one which exceeds the magnitude of overseas giving programs of several OECD-member nations, staff at the UN institutions, including WHO, remain, on balance, unaware or unimpressed.

The breathtaking generosity of the pharmaceutical industry does little to alter deeply-entrenched views throughout UN organizations and among UN leaders that health and profits are incompatible. Yet, these programs give innovative medicines companies an entry ticket to UN discussions, and the opportunity to engage and make their case. Let's hope they can succeed.

Disruptive Woman Phyllis Greenberger and Launch Event Attendees

Franchising Child and Family Wellness

Context: Lack of Access to Quality Basic Healthcare: The market for drugs and basic healthcare in sub-Saharan Africa is large and fragmented, with millions lacking adequate access to basic healthcare and low quality standards prevailing in many existing private and public facilities. This leads to unacceptable statistics, including 2007 under-5 mortality rates of 12.1% in Kenya[1] and of 18.1% in Rwanda.[2] Furthermore, throughout the world 10 million children die each year, almost two out of three from a short list of easily preventable or treatable diseases and illnesses.[3]

Dr. Gunther L. Faber,
CEO,
The HealthStore Foundation®

CFW Franchisee Mrs. Credence Maina serving a Patient

Approach: Business Format Franchising: From SUBWAY, to ExxonMobil, to Marriott Hotels, the franchise business model has proven to be the most effective way to mass distribute goods and services where standards matter most. The HealthStore Foundation®–founded by an American entrepreneur and a Tanzanian pharmaceutical microbiologist—applies lessons learned from the franchise industry to increase access to high-quality essential drugs and basic healthcare through its Child and Family Wellness ("CFW") franchise network.

Empowering Female Nurses in Africa to Own Their Own Clinics: Since opening its first outlets in 2000, The HealthStore Foundation® has developed a network of franchised medical clinics and drug shops now totaling 85 locations serving approximately 45,000 patients and customers per month in Kenya and Rwanda. CFW franchisees are in

A typical setting of a CFWclinic in rural Kenya

franchisees using HealthStore's CFW branded business format franchise system. The CFW system includes diagnostic and treatment guidelines, drug formularies, and operating procedures. Each franchisee is contractually obligated to follow the CFW system; if they fail to comply, their franchisee rights are revoked. This creates a powerful incentive for franchisees to maintain basic clinical and business standards across the CFW network. In addition to the work they do inside the four walls of their stores, CFW franchisees also reach out to their communities, conducting a range of health promotion activities including HIV/AIDS prevention, health screening of school children, and distributing health and hygiene products.

business for themselves. They create wealth for themselves and their families, and they create other jobs as well, such as by hiring local women to clean their clinics. As the CFW network grows, hundreds more nurses will own their own clinics, building wealth for themselves and jobs in their communities, all the while improving conditions for economic development by reducing illness and death.

CFW Standards: CFW clinics and shops prevent, detect, and treat the short list of most common diseases that cause approximately 70% of illness and death in sub-Saharan Africa. Local nurses and health workers own CFW outlets, operating as

CFWclinics
Child and Family Wellness Clinics

Summary Statistics--Kenya	2008
Total patients and customers	554,009
In Store	370,873
Outreach	183.136
Prevalent Diseases Addressed	
Malaria Treated	42,394
Respiratory Infections Treated	65,805
Worms and Deworming	45,587
Diarrheal Disease/Vomiting	10,356
Bednets Sold	2,201

Results: In 2008, HealthStore's network of 85 CFW outlets served over 500,000 people.

Vision: In the years ahead HealthStore aims to continuously improve its CFW franchise model and to expand it throughout Africa. HealthStore plans to grow its network in Rwanda to 60 clinics over the next three years, and is currently seeking funding to expand its operations to other countries in sub-Saharan Africa. Its ultimate vision is a self-sustaining network of CFW clinics and shops throughout sub-Saharan Africa serving hundreds of millions of patients and customers each year with high quality healthcare services and medicines.

Learn More: Visit www.healthstore.org and watch "Health Care Franchise", an Emmy-Award-Winning PBS Documentary.

[1] This statistic from UNICEF: http://www.unicef.org/infobycountry/kenya_2621.html (accessed 2009-06-05).
[2] This statistic from UNICEF: http://www.unicef.org/infobycountry/rwanda_statistics.html (accessed 2009-11-11).
[3] This statistic from WHO: http://www.who.int/pmnch/topics/child/childfacts/en/ (accessed 2009-06-05).

Economic Security and Reproductive Health

Women's economic autonomy and employment opportunities are crucial to their health, particularly their reproductive health. Each year, 536,000 women die, nearly 10 million are disabled, and 250 million years of reproductive life are lost because of poor reproductive health. Enabling women's economic sovereignty has the potential to allow women to take control of their fertility – they would have the resources to access family planning services, effectively space wanted pregnancies and limit unsafe abortions – all of which are leading factors to poor maternal health.

Rachel Hampton,
Research Associate,
Global Health Council

Rachel's areas of focus include maternal, newborn and child health and reproductive health. She has authored research briefs on private sector involvement in health systems, commercial sexual exploitation, the integration of maternal, newborn and child health and family planning, in addition to a variety of other publications from the GHC.

Limited economic security, limited access to education and poor employment opportunities contribute to lack of access to health services, education and employment, and lead to high fertility rates and increased maternal mortality and morbidity. In many countries, women are not allowed to own property and are limited in their economic opportunities, restricting their economic security and limiting access to reproductive health services. Lack of finances is particularly problematic for women who are heads of households or married women who have little say in family finances.

Limited financial autonomy for women also has a profound impact on their children, resulting in generations of young people who have limited opportunities for education and employment. Young girls are particularly vulnerable, as they often miss out on educational or employment opportunities because they have to provide care for sick relatives or have children at a young age. Economic empowerment could break this circle of poverty and ensure economic security and improved health for generations to come.

In addition to affecting women, families and future generations, poor reproductive health has an impact on the broader community and nation. Rapid population growth because lack of contraception exacerbates poverty, as scarce resources

must be distributed among more people, resulting in small investments per person and exacerbated financial hardship. Poor reproductive health also stalls economies, exacerbates food shortages, and contributes to national security issues. The economic security of women has an important impact on their reproductive health. Opportunities for economic empowerment, such as VirtuArte, are absolutely essential to ensuring that women have access to reproductive health services, including family planning, birth spacing and safe abortions. Without good reproductive health, women, families, communities, and nations in developing countries will continue to face poverty, economic insecurity and poor health.

Disruptive Woman Ruth Lubic, EdD, RN, CNM, FAAN and Launch Event Attendee

The Elephant in the Room: A Nation of Band-Aids

There's an elephant in the room: band-aids.

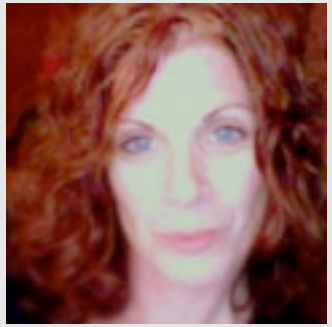
Poverty and its relationship to the provision of and access to healthcare is a global problem. This month, esteemed Disruptive Women in Healthcare bloggers and guest posters are writing on this critical issue with a unique look at the problems abroad. Yet, this has prompted me to look within, for if we can't address our own problems, how can we possibly be successful at addressing problems outside our immediate borders?

It's no secret that the divide in the U.S. comes down to socioeconomic status. And while our representatives in Washington continue to battle it out to devise a healthcare reform bill that, for all intents and purposes, may ultimately serve the power lobbies more than the public, a significant proportion of our population is being pummeled into submission with powerful drugs.

According to an article in the New York Times, children from poor families receive antipsychotic medications four times as often as those from wealthier families. What's more, it appears that these children are likely to receive a prescription for less serious conditions than would commonly prompt a prescription for a wealthier child. The divide: Medicaid versus private insurance.

The underlying message appears to be that if you need to rely on assistance to access health services, that your problems are likelier to be shoved under the rug and "numbified" rather than

Liz Scherer,
Principal,
Digital Copy, LLC



Liz Scherer is a digital copywriter, health reporter, medical writer, marketing and social media consultant, blogger and women's health advocate. With over 25 years experience in the healthcare arena, Liz has worked in the private and public sectors on behalf of web-based and traditional science publishers, public relations and advertising agencies and non-profits. Her work has appeared on- and offline in websites, multimedia, magazines, peer-reviewed journals and in conference proceedings. Liz's blog, Flashfree, is geared towards providing evidence-based, alternative and integrative strategies to manage the medical, emotional, social and physical issues of menopause and midlife. It is currently ranked among the Top 100 Women's Health Blogs and Top 100 Best Wellness Blogs for women.

addressed in a methodical manner. Although this it not necessarily a revelation, some medical experts appear to be "stunned by the disparity in prescribing patterns." The winning quote in the NYT's piece is "if it helps keep them in school, maybe it's not so bad."

Maybe it's not so bad on the surface, but the longer-term prognosis appears quite grim. In this particular situation, statistics suggest that as the Medicaid rolls expand, the scope and expense of antipsychotic prescribing could outgrow the budget.

So I'd like to pose the following question as Disruptive Women in Healthcare explores these issues: if we don't address the underlying challenges that poverty, broken homes and sub-par education pose at home, and how they breed behavioral and physical health issues, how can we develop adequate solutions for the global population? We have become a nation of band-aids that only cover the problems, not fix them. Short-sighted? Indeed.

Health and Economic Security in the US: Why Community Health Centers Matter

Health is an important part of economic security – not only in the developing world, but in the US. No one knows that better than those who, for over 40 years, have worked within Community Health Centers (CHCs) providing primary and preventive care to the medically underserved.

These private, not-for-profit corporations are so keenly aware because:

- Boards of Directors are made up of at least 51% patients,
- They are located in medically underserved neighborhoods,
- Their hours of operation reflect patient needs/preferences,
- Their sliding-fee scales accommodate the patient's ability to pay and
- They provide "enabling services" such as transportation, translation, outreach and health education designed to meet the needs of their patients.

Malvise A. Scott, Senior Vice President, National Association of Community Health Centers

Malvise A. Scott leads the Partnerships and Resource Development department at NACHC. NACHC is the largest organization representing nonprofit health centers and clinics in the United States.

Are CHCs needed in the US? Yes, and by many people. During 2008, CHCs operating over 7,500 sites, provided care for over 20 million patients, of whom:

- 38.3% were uninsured
- 70% were below poverty, and
- 59% were women and among women, 40% were in the traditional working-year ages of 20-64.

The economic recession exacerbated the already difficult circumstances of patients in these medically underserved communities and increased the demand on CHCs. From June 2008 to June 2009, total visits increased by 14% and the number of uninsured patient visits increased by 21% reflecting additional needs in already-stressed communities. By June of this year, 68% of CHCs reported that at least 10% of their patients were affected by unemployment.

CHCs, remaining true to the original mission and vision, have continued to provide much needed care – and at cost-effective and high quality outcomes – but have also generated an aggregate economic impact of an estimated, $12.6 billion, in part by creating 143,000 jobs in some of the nation's most disadvantaged neighborhoods.

What of health reform? Will CHC's be needed in a post-reform era? Certainly.

- Not all individuals will be insured, under even the most optimist scenarios.
- Of those who will be insured, "having a card" will not guarantee access to providers, certainly not one in the neighborhood with the skills to understand the needs of a diverse group of patients such as served by CHCs, and
- Patients will seek high quality comprehensive health care that is accessible, coordinated culturally and linguistically competent and community directed.

As we look to the needs of those in the developing "world," we must recognize that there are those in nearby communities with similar needs. CHCs are here to help meet those needs.

Shopping at Launch Event

To receive invitations to events, announcements of special series, and other news from the Disruptive Women in Health Care blog, please sign up on the site.

Disruptive Women in Health Care is a blog dedicated to serving as a platform for provocative ideas, thoughts, and solutions in the health sphere. We recognize that to accomplish this, we need to call on experts outside of the health industry.

The Disruptive Women have audacious hopes for our blog:

* We're driving change;
* We're creating chaos;
* We're finding cures;

…We're disrupting the health care status quo.

Disruptive Women is a project conceived of and owned by Amplify Public Affairs.

Amplify Public Affairs is the next generation in public affairs, leading the way in the integration of new media and traditional communications strategies. With unequalled expertise in aligning allies, connecting voices, and promoting action, Amplify serves as a relationship builder, creating and sustaining win-win collaborations to move issues forward and influence targeted audiences. Through the blending of innovative communication technologies, credible coalition building, grassroots and top-tiered public affairs expertise, Amplify leverages connections to achieve targeted objectives in the public, private, and political arenas.

This e-book was compiled from the December 2 through December 22, 2009, global health posts on the Disruptive Women in Health Care blog, http://www.disruptivewomen.net/category/policy/global-health/.