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REPORT ON PAHO ADVANCES ON GENDER, HEALTH, AND DEVELOPMENT

This document summarizes the progress achieved through the technical cooperation of the Pan American Sanitary Bureau (PASB) in the Area of "Women, Health, and Development" during the period between the 20th and 21st Sessions of the Subcommittee on Women, Health, and Development (March 2003–March 2005).

The purpose of this document is twofold. First, it outlines the principal activities and achievements of the Bureau during the period in question in terms of its progress in integrating gender equality criteria into the objectives and strategies for its technical work. Second, in view of the historic opportunity afforded by PAHO's decision to formulate an organizational policy on gender equality, the document aims to elicit the views of this Subcommittee with respect to the evaluation of the achievements of the past and the prospects for the future. In particular, within this future context, the Subcommittee is asked to comment on the role that should be played by the technical, consultative, and governing bodies of the Organization in the process of ensuring that gender equality does indeed become a crosscutting dimension of PAHO technical cooperation.

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Introduction

1. This report summarizes the progress achieved through the technical cooperation provided by the Secretariat of the Pan American Health Organization (PAHO) in the Area of "Women, Health, and Development" during the period between the 20th and 21st Sessions of the Subcommittee on Women, Health, and Development (March 2003–March 2005).

2. The purpose of this document is twofold. First, it outlines the principal activities and achievements of the Secretariat in terms of its contribution to the achievement of the goal of gender equality in the Region. Second, in view of the historic significance of PAHO's intention to formulate an organizational policy on gender equality,[1] the document aims to elicit input and recommendations from this Subcommittee concerning priority areas for the process of institutional "mainstreaming"[2] of the gender equality perspective, the roles of the actors involved, and accountability mechanisms for effectively implementing the policy.

3. The document is organized in three sections. The first relates to the institutional context in which the Organization's work with regard to gender equality is taking place. The second summarizes the activities undertaken in this area by the Gender, Ethnicity, and Health Unit and by other technical units and country offices of the Secretariat. The third section highlights the challenges surrounding the commitment to implement an institutional policy on gender equality, indicating the areas in which the Subcommittee is requested to provide input.

The Context

4. The 20th Session of the Subcommittee on Women, Health, and Development—the beginning of the period covered by this report—took place a month and a half after the first woman to be elected to the directorship in the Organization's 100-year history, took office.

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[1] Gender equality in health means that women and men have the same opportunities to enjoy optimal health and to participate in decision-making that affects their own health and the health of their families and communities.

[2] "Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality. (United Nations 1997)

5. The managerial strategy formulated during the restructuring of the Pan American Sanitary Bureau (PASB) prioritized work with the population groups that suffer the greatest inequities in health. Women were identified as one such group, and the Secretariat made a commitment to support countries in the design of interventions to reduce gender gaps. In line with that commitment, the Administration of PAHO proposed the immediate formulation and implementation of a policy on gender equality that would permeate all aspects of the Organization's work.

6. The priority attached to this objective is consistent, on the one hand, with long-standing institutional mandates of PAHO/WHO and, on the other, with commitments assumed by the countries at various international conferences since 1975. The internal mandates include the recommendations made by the Subcommittee on Women, Health, and Development of the Executive Committee since its creation in 1980, as well as the WHO Gender Policy adopted in 2002. The international mandates, in addition to the agreements arising from the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) and the conferences in Cairo (1994), Belém do Pará (1994), Beijing (1995), and Quebec (2002), include, notably, the Millennium Declaration (2000), which established as one of its eight global objectives, the achievement of "gender equality and the empowerment of women."

7. In this context, the former Program on Women, Health, and Development has undergone significant change with regard to its objectives and location within the institutional structure. In February 2003, the Program—which for 10 years had been part of the Division of Health and Human Development—became the Gender and Health Unit (GH) within the Area of Governance and Policy under the Office of the Director of Program Management. Subsequently, in August 2004, the unit experienced two more significant changes: it became responsible for promoting and supporting a corporate policy of ethnic equality, and it was relocated and placed under the direct responsibility of the Assistant Director (AD).

8. The change in name from "women" to "gender" stemmed from PAHO's decision to align itself explicitly with international trends—including those within WHO—in the conception of technical cooperation in the area of woman and development. This conception has been evolving from the "women in development" (WID) approach that prevailed in the 1970s towards the "gender and development" (GAD) approach, which has been the approach espoused in international agreements for the past 11 years. The fundamental difference between the two approaches is that while the former focuses on women as the problem, the latter is concerned with the family, economic, and social context of women's lives and identifies inequality as the main issue to be addressed. In accordance with these conceptions, WID initiatives aim to correct the disadvantages suffered by women through interventions targeted exclusively to them, whereas the GAD approach seeks to change the structures and institutions that perpetuate inequalities

between women and men. The former tends to be assistance-oriented; the latter relies on the empowerment of women and on strategies for organizational change, in particular gender mainstreaming, as recommended by the Beijing conference (1995).

9. Another substantive change was the addition of the promotion of ethnic equality in health as part of the Unit's work. This addition occurred because it was recognized that there were common denominators related, on the one hand, to ethical principles of equity and human rights and, on the other, to shared strategies of technical cooperation that emphasize mainstreaming and empowerment for the achievement of equality objectives. The Director's determination to give concrete expression to these commitments was reaffirmed subsequently with the decision to relocate the Unit to a strategic position in the institutional structure so as to give it readier access to the highest decision-making levels within the Organization and, at the same time, to facilitate horizontal coordination with the various working groups, technical and administrative units, and PAHO/WHO Representative Offices. The name given to this new unit was *Gender, Ethnicity, and Health* (AD/GE).

10. The current period is one of significant functional transition for GE, with new responsibilities coexisting alongside old ones. It is important to emphasize, however, that the Unit's new responsibilities do not represent any fundamental shift in its technical cooperation goals and strategies. Since 1990, part of its mandate has been to integrate the gender equity perspective into the policies and programs of PAHO. In consonance with that goal, its strategic approach to technical cooperation has been systematically oriented towards gender mainstreaming, the components of which include, as will be discussed below, production of evidence, training, advocacy, and institutionalization. Hence, the qualitative change is related less to the *what* and *how* of the Unit's work than to *who* its partners will be as it continues to carry out its mission. This is because the work—which up to now has been seen as the responsibility of a few individuals—will now be considered work for the Organization as a whole. It is important to point out, however, that expanding the range of actors will lead to heightened expectations with regard to GE's role in supporting the process of implementing the policy. Even if implementation is programmed to take place gradually, the demands on the unit will no doubt increase significantly, necessitating the mobilization of substantial technical, financial, and political resources.

Activities and Accomplishments

Advances Spearheaded by the Gender, Ethnicity, and Health Unit [3]

Objectives and strategies

11. The goal that guides GE's actions in the area of gender is to further the achievement of equality between women and men in terms of the opportunity to enjoy optimal health, contribute to the well-being of their families and communities, and participate as decision-makers in both personal and public health development processes. To achieve this goal, GE has emphasized the elimination of systematic, unfair, and avoidable inequalities in (a) health and its determinants; (b) access to quality care, regardless of ability to pay; and (c) the distribution of responsibilities, benefits, and **power** in the development of health.

12. The strategy for achieving these objectives has been to develop tools for mainstreaming the gender approach in key areas for gender equity in health. This strategy has had four basic components, which are closely related among themselves and are founded on participatory work in the field:

- Production of evidence of the existence of gender inequities and their relationship to health and development, and communication of this evidence for purposes of training and advocacy.
- Capacity-building in governments and civil society to enable the incorporation of the gender equality approach into health analysis, planning, and advocacy.
- Creation of intersectoral networks, associations, and coalitions of stakeholders in order to build consensus and promote pro-gender-equality agendas.
- Institutionalization of accountability policies and mechanisms, with participation by affected groups, particularly women.

13. The premises underlying the activities and strategies of GE are based on recognition of the following principles: (a) health as human right; (b) gender equality as an end in itself and as a condition for the achievement of sustainable development; (c) equity as an instrument for achieving equality; (d) participation as a civil right, and empowerment as an indispensable condition for achieving equality; (e) the need to address multiple levels of exclusion and discrimination, in particular those associated with gender, ethnicity, and age; (f) the importance of working intersectorally to address

[3] Called the Gender and Health Unit prior to July 2003.

the determinants of health and provide comprehensive and integrated responses; and, finally, (g) collective effort as a means of ensuring population ownership of processes.

Principal activities and results

14. GE's achievements in promoting gender equality in health have been concentrated in the following areas of action:[4]

- Production of evidence and the democratization of information on gender, health, and development
- Mainstreaming of the gender equity perspective into development and monitoring of health sector reform policies
- Consolidation of the intersectoral model of prevention and integrated response to gender-based violence, and extension of this methodology to other areas of health.
- Development of inputs for the formulation of the PAHO policy on gender equality.

a) *Production and democratization of knowledge on gender and health*

15. Particularly noteworthy in this area of action are the achievements with regard to production of technical information and tools, training in statistical analysis with a gender perspective, incorporation of gender-sensitive indicators into PAHO's core data, and utilization of modern means of communication to make information accessible and facilitate exchange between stakeholders.

16. During the period covered by this report, GE took part in and provided support for the development of a set of conceptual and methodological tools in the area of health analysis. Their development was enriched through exchanges with experts from throughout the Region and with other agencies, including WHO, the United National Economic Commission for Latin America and the Caribbean (ECLAC), the Women's Health Bureau of Health Canada, and the Center for Health Development in Kobe, Japan. These tools include the following publications and working documents:

[4] Financial support for the activities carried out in these areas of action has been provided by the Governments of Sweden and Norway, the Ford and Rockefeller Foundations, the United Nations Population Fund (UNFPA), and the United Nations Development Fund for Women (UNIFEM).

- *Gender, Health, and Development in the Americas 2003 (Washington D.C., PAHO).* Biannual statistical bulletin. This initiative has been replicated in Belize, Peru, and El Salvador.
- *Equidad de Género y Salud en las Américas: Elementos para un diagnóstico (OPS, Washington D.C., 2004). Dossier con tres separatas: 1) Desigualdades socioeconómicas entre mujeres y hombres en América Latina. 2) Igualdad de género en salud en las Américas: Marco legal. 3) Equidad de género y salud en las Américas a comienzos del Siglo XXI,* [Gender Equity and Health in the Americas: Elements for an Assessment (Washington, D.C., PAHO, 2004). Dossier in three parts: (1) Socioeconomic inequalities between women and men in Latin America; (2) Gender equality in health in the Americas: Legal framework; (3) Gender equity and health in the Americas at the start of the 21st century.]
- *Indicadores básicos para el análisis de la equidad de género en salud. Marco conceptual y metodológico (OPS, Washington D.C., 2004)* [Basic Indicators for the Analysis of Gender Equity in Health. Conceptual and Methodological Framework (PAHO, Washington, D.C., 2004)]
- *Perfil de salud de mujeres y hombres en Chile* [Profile of women's and men's health in Chile](Santiago, Chile, PAHO, 2004).
- Training Modules for the Introduction of Gender Analysis in Health Statistics (in progress).
- Guidelines for the Preparation of Gender and Health Profiles (in progress).

17. GE has made headway in its strategy of strengthening national capacity and institutionalizing processes of producing and using relevant indicators for that purpose. This strategy entails joint learning and dialogue between users and producers of information—in government and civil society—with a view to ensuring the quality, utilization, and relevance for policy-making of such information. The actors systematically involved in these efforts include ministries of health and of women, national statistics and social security institutes, universities, women's NGOs, and international agencies. The first step in this initiative was to conduct training workshops. As an outcome of these workshops, intersectoral working groups were formed. These groups, under the coordination of ministries of health, are developing not only statistical bulletins and profiles on gender and health, but also strategies for institutionalizing the production and analysis of gender-sensitive statistics. This initiative is being carried out in all the countries of Central America, with the collaboration of the Area of Health Analysis and Information Systems (PAHO/AIS).

18. The Unit is also part of the Interprogrammatic Consultative Group on Core Data and Health Analysis, coordinated by AIS. Its membership in this group has facilitated

interaction with other units of the Organization in relation to indicators, as well as the integration of gender-sensitive indicators into the regional health core data initiative coordinated by AIS.

19. GE continues to implement its strategy of i*nformation, education, and communication* (GenSalud) in response to countries' need to have access to relevant information on gender and health and to exchange knowledge and experiences. GenSalud includes two websites, a listserv, a virtual library administered in Costa Rica, and a platform for virtual forums. This strategy has greatly expanded PAHO's range of action, facilitating the creation of virtual communities of knowledge, learning, and advocacy. It has also fostered and supported the development of similar initiatives in other countries of the Region

b) *Incorporation of the gender equity perspective into health sector reform policies*

20. PAHO was the pioneering agency in the Region to draw attention to the gender inequities inherent in health sector reform (HSR) policies and processes and in launching a process of evidence-based advocacy to address the problem. Important advances were achieved during this period in the area **of production and validation of analytical and methodological instruments.** The publications and working documents listed below, in which these advances are reflected, are the result of regional and national consultation processes carried out both in person (workshops) and virtually (electronic forums).

- Guide for Assessing Gender Equity in Health Policies (Washington, D.C., PAHO, 2004).
- Gender Equity and Health Sector Reform in Latin America. Chapter in a publication of the Committee for International Cooperation in National Research in Demography (CICRED) (in press).
- *Reforma del Sector Salud y Derechos Sexuales y Reproductivos,* Washington DC, OPS, 2004 Health Sector Reform and Sexual and Reproductive Rights (Washington, D.C., PAHO, 2004).
- *Políticas para la mujer y la equidad de género en los municipios, OPS, Perú, 2003* (Gender Equity and Municipal Policies for Women, Peru, PAHO, 2003)
- *Procesos de reforma del sector salud y programas de salud sexual y reproductiva en América Latina, Cinco estudios de caso. México, OPS/Funsalud/FNUAP/ Banco Mundial, 2004* (Health Sector Reform Processes and Sexual and Reproductive Health Programs in Latin America. Five Case Studies, Mexico, PAHO/Funsalud/UNFPA/World Bank, 2004).

- Proposal for Estimating the Value of Unremunerated Household Production of Health Services [in progress, in partnership with the Health Policies Unit (SHD/HP)].
- Costing of Sexual and Reproductive Health Services. Basis for the Development of a Methodology. Joint project with the International Planned Parenthood Federation (IPPF), Bogotá, 2004.
- Gender Equity in Access to Health Services in Four Countries (Washington, D.C., PAHO, 2004).

21. In regard to **strengthening capacity and creating networks for advocacy** to promote gender equality in reform policies, the Regional Training Program "Adapting to Change: Health and Sexual and Reproductive Rights, and Health Sector Reform," is worthy of note. This joint initiative of UNFPA, PAHO, and the World Bank—together with the secretariat of the Fundación Mexicana para la Salud (Funsalud) and the Population Council—led to the planning and facilitation of two regional courses (one in Oaxaca in 2003 and the other in Mérida in 2004), with, in both cases, the participation of intersectoral teams from government and civil society from seven countries. The strategy of this program includes national support for teamwork before, during, and after the course for (a) the preparation of situation analyses, (b) the design of intersectoral work plans, and (c) the implementation of those plans. The results thus far are very encouraging.

22. Within this context of training and advocacy on the issue of gender equity and reform, GE organized the following events at the regional level: (a) three international training workshops for focal points and national counterparts in government and civil society; (b) two interagency advocacy forums, with participation by universities and networks of the women's movement; (c) a virtual forum, with participants from 25 countries from within and outside the Region. At the subregional level, training and advocacy programs have been carried out, in coordination with the regional level, in the countries of Central America and in Bolivia, Chile, and Peru, with a strong emphasis on facilitating dialogue between government and civil society in order to build consensus.

23. In Chile, the initial testing ground for this experience, intersectoral partnerships formed since 2001 have made it possible to raise awareness among government officials, empower civil society groups, propose draft legislation to eliminate gender discrimination in private insurance systems, and create **policy monitoring mechanisms.** One of these mechanisms is the "Observatory of Gender Equity in Health Policies," established at the University of Chile (2004) with the participation of civil society. This observatory is a model for social monitoring of policies that is now being replicated in another province of Chile.

c) *Models of intersectoral intervention for an integrated approach to violence against women and other problems of gender inequity*

24. Since 1994, based on a study carried out in the field, PAHO has been developing a model for preventing and addressing gender-based violence. This model, implemented in ten countries (Belize, Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Peru), has three major components: (a) creation of community networks at the local level; (b) development of standards, protocols, and surveillance systems at the sectoral level; and (c) development of policies and legislation at the national level. The model has been replicated by other entities in seven additional countries and is being used to address problems other than violence. The strategy for mainstreaming gender equity through these models has been based on gathering of evidence, capacity-building, advocacy and formation of intersectoral partnerships, and institutionalization of changes and policies. The principal activities and products in this area during the period are described below.

25. **Production of information and tools:** During the period in question, the following publications were produced:

- *Violence against Women: The Health Sector Responds* (Washington, D.C., PAHO, 2003).
- *Situation Analysis of Medico-Legal and Health Services for Victims of Sexual Violence in Central America* (San José, Costa Rica, PAHO, 2003).
- *Model Laws and Policies on Family Violence against Women.* (Washington, D.C., PAHO, 2004).

26. In coordination with the Healthy Settings Unit of PAHO and with the United States Centers for Disease Control and Prevention (CDC), the Unit has also worked toward the improvement of epidemiological surveillance systems. In that connection, surveillance systems have been established in five countries, a data collection instrument is being tested, and a guide for epidemiological surveillance of family/domestic and sexual violence has been produced (2004).

27. In terms of tools for the national level, a proposal for model laws and policies on family violence against women has been developed and is being validated in Brazil, Costa Rica, the Dominican Republic, and Honduras. This effort has received input and support from UNIFEM, the Inter-American Commission of Women of the Organization of American States (CIM/OAS), UNFPA, the Inter-American Parliamentary Group on Population and Development, the Center for Reproductive Health Rights, Isis Internacional, and the Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM). With regard to policies for the sectoral level, GE is

collaborating with the Department of Gender, Women and Health (GWH) of WHO to adapt and validate in Nicaragua the WHO **protocol** for medico-legal care for victims of sexual violence.

28. **Training of human resources.** This training was carried out in priority sectors (health, justice, offices of women and/or gender equity, and education), with emphasis on the skills needed for prevention, care, and the development of integrated programs. Training programs were conducted in 10 countries, with more than 15,000 officials from the health and other sectors receiving training. The subject of gender-based violence was introduced into primary education curricula in Belize and Peru and into university curricula in Belize, Costa Rica, El Salvador, Nicaragua, Panama, and Peru. In 2004, in coordination with the Virtual Public Health Campus of PAHO, the Unit offered to participants in 16 countries the first regional distance learning course on integrated care for women who are victims of domestic violence and sexual abuse. In addition, a regional community was created for the exchange of knowledge through virtual forums and a listserv.

29. **Advocacy and promotion of intersectoral and interagency dialogue.** The information packets and fact sheets for advocacy, together with the printed publications distributed through Gensalud and the Unit's webpage, have helped foster dialogue among stakeholders at the regional, subregional, national, and local levels. The PAHO Regional Campaign to Address Violence against Women, launched in 2004 and scheduled to conclude on 28 May 2005, has mobilized various sectors and new actors, including several private companies. In November 2004 alone, more than 35,000 copies of the materials produced for the campaign were distributed in 17 countries. Belize, Bolivia, Brazil, Chile, Cuba, Dominican Republic, El Salvador, Mexico, Nicaragua, Panama, and Venezuela have undertaken advocacy activities using these materials. In terms of interagency partnerships, the partner agencies have been UNIFEM, CIM/OAS, UNIFEM, UNFPA, Latin American and Caribbean Women's Health Network, Isis Internacional, Ipas, and the Latin American Consortium on Gender-based Violence.

30. Coordination with other PAHO initiatives: This model for addressing gender-based violence has served as a bridge to joint initiatives with other PAHO units. One of the them, a joint undertaking with the Women and Maternal Health Unit (WM) being carried out in six countries of Central America, seeks to **involve men in reproductive and sexual health programs**. The other, a joint effort with the **3 by 5 Initiative,** aims to use the model for addressing domestic and sexual violence as a point of departure for HIV/AIDS prevention and care.

d) *Development of the gender equality policy*

31. In preparation for the formulation of the PAHO policy and action plan on gender equality, GE has developed the following inputs: analysis of regulatory frameworks, socioeconomic context, assessment of the current situation of gender equity in health, analysis of external actors (in progress), and a policy proposal, which will be presented for discussion during the 21st Session of the Subcommittee.

Advances Coordinated by Other Technical Units of PASB

Health Analysis and Information Systems Area (AIS)

32. Pursuant to the commitments assumed during the 20th Session of the Subcommittee on Women, Health, and Development with respect to incorporation of the gender approach into the core data and health analysis initiatives, AIS designated one professional to work in coordination with GE. The following are the principal joint activities carried out:

33. Participation of AIS in the GE initiative on preparation of training modules and facilitation of a course in gender statistics and indicators, sponsored by Universidad Centroamericana, the Nicaraguan Institute of Women, and the United Nations system, in Managua, Nicaragua (November 2003).

34. Support to GE for the production of a brochure on statistical indicators in gender and health and a proposal to integrate a gender perspective in health statistics.

35. Compilation and review of bibliography on gender and health and of methodologies for a gender approach to health situation analysis, in preparation for the development of a proposal on health situation analysis with a gender perspective.

36. Suggestions on incorporation of gender issues in (a) a meeting of national directors of vital and health statistics in the Americas, (b) a proposal on urban health profiles formulated by the PASB Healthy Settings Unit, and (c) the work of the Subgroup on the Millennium Development Goals (MDGs).

37. In the analysis of causes of death, AIS has continued to work—and has continued to urge countries to work—towards ranking leading causes of death by sex. In addition, the issue of domestic violence as a cause of death among pregnant women is being studied, and it is hoped there will be increased activity in this area in the future. Some countries, such as Brazil, are now including this cause in surveillance of maternal mortality.

Women and Maternal Health Unit (FCH/WM)

38. The regional strategic framework for reducing maternal mortality explicitly recognizes that the empowerment of women, families, and communities (WFC) is crucial in order to reduce maternal mortality. Within this framework, achieving the empowerment of women entails activities aimed at strengthening their capacity and skill to care for themselves, stay healthy, and make healthy decisions, such as knowing how to respond to obstetric and neonatal emergencies. This WFC approach has been integrated into all technical cooperation activities, including policy development, essential obstetric care interventions, and skilled attendance at birth. The development of this framework grew out of discussions held with 11 priority countries and the implementation of medium-term WFC intervention programs in 4 key countries. This framework has been essential for supporting and strengthening national WFC empowerment efforts, especially in countries where cultural and socioeconomic obstacles have been identified as key contributors to poor maternal and newborn health.

39. WM has promoted broad institutional efforts to incorporate the gender perspective into the development of regional policies for the reduction of maternal mortality. An important effort in this regard was the promotion and the launching, in February 2004, of the Regional Interagency Strategic Consensus for the Reduction of Maternal Mortality. This policy paper was developed by the interagency working group for the reduction of maternal mortality, in consultation with countries. The participants in this initiative, working in an integrated manner, sought to identify evidence-based interventions and systematize the lessons learned and the most appropriate strategies for reducing maternal mortality and morbidity in the region. The principles of rights, equity, and equality are at the core of the strategic proposal, which represents a joint and common vision of how to respond to maternal deaths in a cohesive and unified manner in order to optimize technical cooperation and collaboration in countries and among agencies.

40. The emphasis on the issue of violence against women in the context of the Maternal Mortality Reduction Initiative began during this period. Recognition of violence against women as a global public health problem with adverse impacts on maternal and perinatal health led WM to endeavor to measure that impact and improve understanding of the connections between the two phenomena. To that end, WM, with support from GE, is developing a multicenter research protocol for a study of the association between violence during pregnancy and maternal and perinatal health. Argentina, El Salvador, Guyana and Nicaragua are expected to take part in this study.

41. An innovative means of furthering gender equity and equality objectives has been the initiative to involve men in sexual and reproductive health programs. This effort is being carried out jointly by WM and GE in six countries of Central America.[5]

42. Surveillance of maternal mortality is seen as another crucial element for ensuring that the gender perspective is a priority within PAHO for monitoring progress towards the Millennium Development Goals and making interventions more efficient. Accordingly, WM has provided support for baseline studies of maternal mortality in Bolivia, Brazil, and Guatemala. In 2004, steps were taken to carry out such studies in the Dominican Republic and El Salvador, including mobilization of support from other agencies, such as the CDC, and strengthening the leadership of the ministries of health.

43. In this same area of work, the Latin American Center for Perinatology and Human Development has provided technical cooperation to priority countries to improve monitoring of maternal and perinatal health through the use of standardized instruments, such as the basic perinatal clinical history form and software for automated data analysis.

Health Policy Unit (SHD/HP)

44. Following the recommendations of the Subcommittee in March 2003, HP has continued to improve—and apply in the countries—methodological instruments that incorporate gender-related indicators for monitoring and evaluation of sectoral reforms in the health systems. These instruments (system profiles, sectoral analyses, and measurement of exclusion in health) perform a dual role: on the one hand, they measure processes and outcomes of changes in health systems and, on the other, they serve to guide the identification and selection of priority interventions, both for policy-making by Member States and for PAHO technical cooperation.

45. Between 2003 and 2004 sectoral analyses were carried out in Bolivia, Haiti, and Puerto Rico (http://www.lachsr.org/is/hsanalyses.cfm). The methodology used emphasizes exclusion in health and includes sex among the variables analyzed.

46. System profiles are reports on the health system of each country that provide, in a standardized format, a synthetic and analytical description of the structure and dynamics of the health system. They are prepared by countries using the methodological guidelines for preparation of health system profiles. The profiles provide a means of monitoring and evaluating health sector reform processes. They include variables and indicators related to the gender dimension and are updated periodically. At present, full-text versions of 35 country profiles are available online (http://www.lachsr.org).

[5] With financial support from the German technical cooperation agency, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

47. HP has continued to use the methodology for measuring and characterizing social exclusion in health. Through the application of this instrument, information on a variety of gender-related indicators is collected, including level of poverty by sex, level of poverty by sex of the head of household, discrimination by sex in affiliation with existing health protection systems; discrimination by sex in the coverage, cost, and copayments of available health plans; household health expenditure by sex of the head of household; and waiting periods for health care by sex. This has made it possible to gain a better understanding of the gender dynamics of access to health care and identify correlations between problems of exclusion in health and gender factors.

48. In the area of human resources for health, HP, together with GE, is developing methodological and conceptual bases for measuring and estimating the economic value of unremunerated household production of health care services, within the framework of national accounts systems. (This work is described in detail in another document being submitted to this Subcommittee). The Human Resources Development Unit (SHD/HR) has also participated in the analysis of policies relating to formal and informal human resources of the system and has introduced a section on gender equity in the Observatory of Human Resources in Health.

49. An agreement for a joint project by PAHO and the United States Agency for International Development (USAID), signed in late 2004, calls for the identification of new indicators incorporating the gender dimension for the system profiles and sectoral analysis methodologies. In addition, the HP, GE, and Adolescent Health Units have jointly prepared a research proposal on the subject "sex, age, and exclusion." There is also a proposal for work in the area of extension of the social protection in health in the countries of Latin America and the Caribbean, with emphasis on maternal and child care within the framework of the Millennium Development Goals.

Communicable Diseases Unit (DPC/CD)

50. The Prevention and Control of Priority Communicable Diseases Project—funded by CIDA Canada—includes gender as a cross-cutting component and a gender equality strategy as part of its implementation plan. The Project involves five countries (Colombia, Ecuador, Paraguay, Peru, and Venezuela) and works in the areas of tuberculosis, sexually transmitted infections (STIs), Chagas' disease, dengue and early childhood illnesses (IMCI strategy).

51. The three objectives of the project's gender equality strategy are to: (1) integrate a gender perspective into the delivery of health services to improve access to care, coverage, and quality of services; (2) ensure the collection, presentation, and distribution of data by sex, gender analysis of data, and development of appropriate indicators to measure advances in gender equality; (3) support the design of interventions to improve

gender equality in health services, specifically in relation to the communicable diseases targeted by the Project.

52. This gender mainstreaming strategy has been initiated in Paraguay, where this project is working closely with the Secretariat of Women of the Presidency of the Republic of Paraguay to ensure collaboration between the Project and the Lines of Action of the Plan de Igualdad de Oportunidades entre Mujeres y Hombres 2003-2007 of the Secretariat for Women's Issues [Plan for Equality of Opportunities for Women and Men, 2003-2007]. A series of workshops was conducted from June to August 2004 by the Department of Social Sciences of the Institute of Health Sciences Research, with participants from all areas of the Project (tuberculosis, STI/HIV/AIDS, Chagasdisease, IMCI strategy, surveillance, maternal health). The workshops addressed gender training in order to sensitize participants to the role of gender in health and human development and help them develop skills to operationalize a gender approach in health, specifically in the Communicable Diseases Project. A product of these sessions was that all of the project disease components have reviewed their data from a gender perspective and, based on the analysis, are determining how they can incorporate a gender approach into their respective programs within the scope of the Project. The next step will be the development of action plans for each disease component, which will be carried out over the next project year.

Noncommunicable Diseases Unit (DPC/NC)

53. NC is pursuing three lines of work in the areas of cardiovascular diseases, cervical cancer, and diabetes in which a fundamental focus is the empowerment of women to promote their own health.

54. The initiative "Women talk to women about health" is a response to the fact that cardiovascular diseases are the leading cause of premature death among women in the Region. The objective of this initiative is to develop a strategy for preventing cardiovascular mortality among women through self-made changes in their lifestyles. It is currently being pilot-tested in Panama and in Trinidad and Tobago. Similarly, the Cervical Cancer Prevention Initiative is a response to the fact that mortality from cervical cancer, despite its essentially preventable nature, remains prevalent in the Region, particularly in low-income sectors. The objective of the initiative is to promote Pap testing throughout the Region, with special emphasis on places with high poverty rates in El Salvador (Chalatenango), Peru (San Martín), and Suriname (The Hinterlands). These two projects are promoting, on the one hand, community action, with emphasis on the participation of women leaders, and, on the other, communication among women, particularly mass communication aimed at encouraging prevention and healthy lifestyles, rather than pharmacological treatments.

55. Project VIDA (Veracruz Initiative for Diabetes Awareness) seeks to improve diabetes control through the active involvement of patients, especially women, who are most affected by this disease. Based on research conducted in Argentina and Nicaragua, an intervention is being carried out in Mexico and is being extended to the countries of Central America.

Progress Led by PAHO/WHO Country Offices

56. Described below are the experiences of four PAHO/WHO Representative Offices in the Region that have been in the vanguard within the Organization in implementing a strategy of gender mainstreaming, both internally and in technical cooperation in their respective countries. They are, in alphabetical order, Belize, Bolivia, Chile, and Nicaragua.

Belize

57. The PAHO/WHO country office in Belize is involved in an effort to mainstream a gender perspective into its technical cooperation program. The implementation of the GE initiative "Reducing gender inequities in Health" has supported this effort.

58. In 1998 the PAHO Office promoted and supported a major country initiative approved by the Prime Minister to sensitize cabinet members on gender concepts and the implications of gender mainstreaming in the overall development of the country. As a result, various plans were defined and the National Women's Commission developed a National Gender Policy. Alongside the approved policy was the establishment of a Gender Integration Committee, which is responsible for spearheading multiple actions to promote and implement the Policy. In 2004, with the support of UNIFEM, the Women's Department led an audacious initiative of implementing a national gender budget analysis.

59. During the past and present biennial program budget (BPB), PAHO´s technical cooperation has provided support for several national efforts of major importance for mainstreaming gender equality in health. The first was support for the development and approval of the Sexual and Reproductive Health Policy. The Policy addresses various gender issues: the lifecycle approach, attention to gender-based violence, treatment of HIV/AIDS, and masculinity and sexuality, among others. Presently, PAHO is participating with the national authorities to define the action plan (in the area of sexual and reproductive health) for the implementation of the policy. The other national efforts which supported gender equality components were: the approval of the Global Fund on AIDS Project and the Country Strategic Plan; the approval of the National Plan of Action for Children and Adolescents; and the participation in the development of the MDG report with the inclusion of gender indicators.

60. Clearly, many other ongoing or spontaneous opportunities exist to channel gender mainstreaming efforts into regular programming and planning. To this end, PAHO also contributed to other country efforts such as: the Food and Nutrition Security Project in the Toledo District (an indigenous community); the national disaster reduction plans; the new mental health policy; and research conducted on environmental health issues.

61. Finally, PAHO and the other agencies of the United Nations system working in Belize have recently participated in a two-day gender training workshop for all staff of the agencies. The general objective was to institutionalize a gender perspective in the work of the agencies and to increase sensitivity among staff members. Follow-up actions will tie United Nations country plans to the commitments contained in the Millennium Development Goals.

62. The practice and culture of mainstreaming gender in the technical cooperation in the Belize country office is far from being an institutionalized experience; however, concrete successes and lessons are emerging. These include:

- The support, advocacy and commitment of the PAHO Country Representative continue to play a pivotal role.
- Sustained alliances with a multiplicity of stakeholders as varied as national ministries to women and sports groups or village leaders and the university etc., have created multiple avenues to initiate or support processes that build advocacy.
- The value of sensitization efforts internally and with major national players cannot be emphasized enough.
- The existence of a focal point and the special dynamic of being responsible for wider health promotion activities is an advantage that has been fully exploited.
- The new/strengthened alliance with the United Nations agencies is very significant for a small country.
- The use of the biennial program budget and other internal planning processes is critical to creating a culture for horizontal planning and mainstreaming cooperation.

Bolivia

63. ***Context:*** The work accomplished in the area of gender and health is the fruit of a process carried out over many years, during which Bolivia, together with nine other countries, was involved in the initiative to prevent and respond to intrafamily violence against women. When external financing for that initiative ceased, the professional who was coordinating the initiative joined the staff of the PAHO/WHO Representative Office. The focus of the Office's work in the area of gender has been on building evidence of inequalities and on the coordination of activities, information, sensitization, and training in health for managers, including personnel from, inter alia, the Ministry of Health and Sports, the Association of Women Town Councilors of Bolivia, the Vice-Ministry for Women, the Coordinator for Women, and the National Network of NGOs in Health.

64. The most significant achievements during this period were the following:

For the country

- Creation, by means of ministerial resolution, of the Gender and Violence Unit (now called a program) under the Directorate of Health Services within the Ministry of Health. At the same time, nine unit chiefs were appointed for each of the departmental health services in the country, which constitutes a historic milestone in the institutionalization of the issue.
- Preparation, publication, and dissemination of the first National Plan for Gender Equity in Health, 2004-2007. This instrument emphasizes the following lines of action: effective participation of women in health, sexual and reproductive health rights, mental health and violence, and health system reform.
- Within the framework of the aforementioned Plan, mapping of community grassroots organizations to guide activities for the empowerment of women; development of a methodology for municipal public hearings, aimed at consolidating procedures for public monitoring of health policies, with the participation of women; identification of health indicators within the framework of the Essential Public Health Functions for monitoring gender inequalities; preparation and validation of a model of health services with a gender approach to improve the quality of and access to primary health care (PHC).
- Incorporation of a component on sexual violence in the National Plan on Sexual and Reproductive Health and development and validation of standards of care for health services at the primary and secondary level, aimed at improving the technical quality of the institutional response to sexual abuse and violence. The end of this period was marked by updating, recycling, and transfer of methodologies to assist health workers in the nine departments in managing family and domestic violence.

For the Representative Office

- Enhanced knowledge of the issue and support from the PAHO/WHO Representative,[6] which increased both internal and external motivation for work in this area.
- Introduction into the Biennial Program Budget (BPB) preparation process of an exercise designed to incorporate gender considerations into the indicators and activities for all technical cooperation projects. The country BPB also included an expected outcome in the area of Gender and Health, with allocation of regular funds.
- The presence of a national professional with terms of reference that explicitly include responsibilities in the area of gender, financed with regular funds of the Representative Office

Chile

65. ***Context:*** Because Chile was the site of the oldest formal health system and social security reform process in the Region and was seen as a model for other countries, it was selected four years ago as a pilot country for the development and validation of an instrument for mainstreaming gender equity in such reforms. The existence of this initiative in Chile signified the presence of human and financial resources concentrated in this area, which gave a considerable boost to efforts to integrate the gender perspective in the technical cooperation of the Representative Office. In addition to this availability of resources, however, there were a number of other important factors that contributed to the significant progress in gender mainstreaming achieved by this initiative. Those factors included the following:

Facilitating factors:

- Political will on the part of the two PAHO/WHO Representatives,[7] who initiated, encouraged, and supported the process of institutional change and negotiations with the Ministry of Health.
- Openness to the issue on the part of the professional team of PAHO, and generation of an informed critical mass within the Representative Office, the outcome of the work of sensitization, information, and training carried out since 2001.

[6] During the period 2003-2004, the PAHO/WHO Representative in Bolivia was Dr. José Antonio Pagés.
[7] Dr. Cristina Nogueira (2000-2002) and Dr. Henry Jouval (2002-2004).

- A legislative process of health system reform that created concrete, public, and practical challenges for mainstreaming.
- Partnership between PAHO and the National Women's Service (SERNAM) in technical cooperation aimed at mainstreaming the gender equity approach in health.
- Joint effort by SERNAM and the Ministry of Finance for the implementation of methodologies to improve institutional management, with incorporation of the gender perspective as a key requirement.
- Political support at the highest echelons of the Ministry of Health for gender mainstreaming activities, and presence within the Ministry of an informed critical mass of professionals with decision-making authority, the fruit of efforts carried out in previous years and of the process of cultural change.
- Civil society backing for the effort to mainstream gender in the health sector reform process.
- Impact of the Cairo + 10, Beijing + 10, and MDG processes on public policies during 2003 and 2004.
- Active involvement of the Interagency Group on Gender.

Strategy: The strategy for this initiative included the following components:

- Production of knowledge and information as a requirement for justifying and legitimizing gender equity mainstreaming proposals
- Advocacy on the part of the project and the Representative Office, in coordination with SERNAM, professional counterparts within the Ministry of Health, legislators, professional associations, health professional associations, academic institutions, and civil society
- Media campaign work by the Representative Office, in coordination with SERNAM and civil society, including press conferences by the PAHO/WHO Representative and institutional team for the initiative; series of radio programs featuring representatives of government, academia, and civil society; and columns and interviews in the press
- Technical cooperation with governmental institutions and civil society
- Support for the work of PAHO from a political-technical group of experts from civil society and academia, endorsed by the national government.

Achievements: Listed below are the most noteworthy achievements within the Representative Office, the Government of Chile (Ministry of Health and SERNAM), academia, and civil society.

Within the PAHO/WHO Representative Office

- Technical and administrative teams sensitized to gender issues with the Representative and professional staff applying a gender perspective in their work.
- Participation by the Representative and professional staff in public activities of the GE initiative: Congresses of Women for Reform, inauguration of the Observatory of Gender Equity in Health.
- Negotiation of the 2004–2005 BPB, which includes a Ministry of Health project on application of the gender equity approach in the implementation of the Law on Health Authority at the central and regional levels of the Ministry and in work with the community. This will entail gender training by staff from PAHO Headquarters for officials at the central and regional decision-making levels.
- Provision of information to the media by the Representative Office on topics relating to gender equity.
- Launching of the publication *Perfil de salud de mujeres y hombres en Chile* [Profile of Women's and Men's Health in Chile] by the Representative and the Minister at the Ministry of Health.

Within the Ministry of Health

- High-level officials interested in mainstreaming gender in policies, as evidenced by the project "Support for Incorporation of the Gender Approach in the Implementation of the New Legal Framework for Health Activities in Chile," included in the 2004-2005 BPB.
- Work with PHC and mental health officials within the Ministry to ensure national availability of integrated care for victims of gender-based violence at the first and second levels of care, as well as training (resident and online) on gender-based violence for the team of the national PHC network over 3 years, starting in 2005.
- Receptiveness of the National Health Fund to the need for treatment protocols and resources for providing care to victims of gender-based violence at the primary and secondary levels.
- Availability of counterparts in both ministerial undersecretariats to work toward the formation of a Ministry of Health/SERNAM/civil society/PAHO working group.

Within the National Women's Service

- Financial support for the inauguration of the Observatory of Gender Equity in Health (OEGS) in Santiago, and joint effort with civil society in the Araucanía region for the establishment of a regional branch of the OEGS with the explicit addition of an ethnicity component.
- Joint sponsorship with PAHO of a seminar on sexual and reproductive rights and health policies.

Within academic institutions

- Agreement with the Center for Gender Studies of the University of Chile to serve as the virtual headquarters of and provide academic support for the OEGS.
- Work with four entities at Frontera University in Temuco and two entities at the University of Concepción to establish and house the regional branch of the OEGS.
- Preparation of a chapter on gender and health for a book on the social determinants of health for the Universidad del Desarrollo of Chile.

Within civil society

- Creation and functioning of the Civil Forum within the OEGS.
- Strengthening of the capacity of civil society for advocacy, with impact on national situations (maternity leave and rights, dialogue with Parliament).
- Systematization of the work of civil society with regard to gender-based violence, and consensus-building for the development of protocols for care in shelters for victims (2005).
- Formation of a civil society working group in Region IX in order to establish the regional branch of the OEGS.

Nicaragua

66. ***Context:*** Mainstreaming of the gender approach as an instrument for reducing gender inequalities in health in the cooperation program of the PWR began with processes of sensitization and training on gender and health for the staff of the country office under the leadership of the current PAHO/WHO Representative. This approach led to a shift in the model of cooperation, from a program approach to a corporate strategy involving all of the Office's resources and interdisciplinary technical capabilities. Another facilitating factor was the allocation of regular resources under the BPB to the areas of gender and ethnicity.

67. The process undertaken within the Ministry of Health to develop new health policies and formulate the National Health Plan 2004-2015 created an additional window of opportunity for the work of the Office in this area. One of the central concerns for the women's movement and for the donor community, including PAHO, was the incorporation of gender equity in the health policies and in the Plan as a cross-cutting element in the work of the Ministry of Health, and PAHO received a special request for support in this specific area.

68. ***Strategy:*** The process of mainstreaming gender in PAHO cooperation in Nicaragua has been the result of several years of work within the Office, coordinated by a professional with explicit responsibilities in the area of gender. Those responsibilities included: (a) raising awareness of the issue through staff training processes, and (b) establishing partnerships between the Gender and Health Unit and cooperation programs in which women's health was a priority and which, therefore, facilitated the production of evidence. Those programs were: Maternal Health, Adolescent Health, HIV-AIDS, Workers' Health, Men's Sexual and Reproductive Health, Mental Health, and the Project for the Development of Comprehensive Health Care Local Systems (PROSILAIS Project).

69. The production of evidence on the relationships between equity, gender, and health has facilitated internal advocacy. This evidence made it possible to carry out a health situation analysis, with information disaggregated by sex and analyzed from a gender perspective, at least for the problems prioritized by the Ministry of Health. This effort, which involved the entire team at the Representative Office, led to a cooperation agreement between PAHO and the Ministry of Health for the formulation of the health policies and the National Health Plan and for the creation within the Ministry of a technical group—of which PAHO was a member—whose mission was to ensure that both policy documents incorporated gender equity criteria. The health care model and the basic health care package constitute an attempt to operationalize this orientation.

70. *Partnerships with Cooperation Agencies*: It is important to note, within this strategic context, the importance of PAHO's participation on the United Nations Inter-Agency Committee on Gender and the expanded interagency group which includes the other donor agencies: the Swedish International Development Agency (SIDA), the Norwegian Agency for Development Cooperation (NORAD), the Finish International Development Agency (FINIDA), the Danish International Development Agency (DANIDA), the Spanish International Cooperation Agency (AECI), the Inter-American Development Bank (IDB), the Japanese International Cooperation Agency (JICA), Embassy of the Netherlands, the Netherlands Development Organization (SNV), and the German Agency for Technical Cooperation (GTZ). Consensus was reached with those agencies on a joint agenda in several areas, one of which was a review of the extent of gender mainstreaming in each agency and another was coordination of efforts under

various lines of action for cooperation with the country. The lines of joint action identified were: sexual and reproductive health; gender-based violence; gender indicators; legal frameworks, particularly relating to the Law on Equality of Opportunity for Women and Men, National Development Plan, National Gender Equity Plan, and Plan for Prevention and Response to Gender-based Violence, the latter two in coordination with the Nicaraguan Institute for Women.

71. The ***lessons learned*** in the political and technical spheres are the following:

- Active political and technical support by the Representative as an essential condition.
- The strategic utility of the shift from a program-based model of technical cooperation to a model with a corporate approach.
- The need for partnerships with other agencies of the United Nations system in order to reach consensus on a gender agenda that will permeate the entire system.
- The importance of motivating high-level authorities within the Ministry of Health and the team responsible for formulating health policies and the health plan, in order to facilitate incorporation of the issue into national documents.
- Production of scientific evidence as a key element for sensitization and advocacy, both in the Ministry of Health and in the Representative Office itself.
- The importance of teamwork within the Office, expressed through a common discourse and coordinated technical cooperation work.
- The facilitating effect of identifying gender equality in health as a crosscutting element in the Office's country cooperation strategy.

Topics for Discussion

72. The year 2005 will mark the anniversary of three historic events that have sealed PASB's institutional commitment to gender equality. They are: the 25th anniversary of the creation of the Subcommittee on Women, Health, and Development, which first proposed institutional goals for equality between women and men in the area of health; the 10th anniversary of the Fourth International Conference on Women, held in Beijing, in which Member States reaffirmed their commitment to women's rights and accepted the responsibility of integrating gender equality criteria in the formulation and implementation of their policies and programs; and the fifth anniversary of the Millennium Declaration, in which Member States established as one of eight priorities "gender equality and the empowerment of women." To highlight and reaffirm these commitments, PAHO will unveil its official gender equality policy in 2005.

73. In view of the political significance for PAHO of formally declaring its intention to allocate human, financial, and managerial resources in order to fulfill its commitment to actively promote gender equality, this Subcommittee is asked to provide input on a number of issues in order to assist the Secretariat in conducting an adequate assessment of institutional assets and needs vis-à-vis the challenges and opportunities. The following are some of the issues that are considered important for this assessment and whose nature and scope are submitted for consideration by the Subcommittee.

a) Internal analysis of needs for training and technical support, and of strengths and weaknesses for advancing the mainstreaming process
b) Criteria for establishing priority areas and strategic points of entry for the process
c) Analysis of external actors to identify synergies and strategic partnerships for the achievement of gender equality and the empowerment of women in the area of health.
d) Role of the Gender, Ethnicity, and Health Unit at Headquarters and in the field offices; role of the PASB national focal points
e) Opportunities arising from the incorporation of the issue of ethnicity to strengthen integrated action in order to address multiple levels of discrimination and exclusion
f) Role of the internal committees concerned: Advisory Committee on Women (CAM), Staff Association Committee on Women
g) Appointment of an advisory group on gender mainstreaming
h) Role of the focal points in ministries of health
i) Role of the Governing Bodies, particularly the Subcommittee on Women, Health, and Development of the Executive Committee
j) Incentive and accountability mechanisms, both within the Secretariat and in the countries and the Governing Bodies

Action by the Subcommittee on Women, Health, and Development

75 The Subcommittee is invited to consider the present report and comment on future lines of action for the PASB with regard to the promotion of gender equality in the health sphere.

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