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ADVANCES IN GENDER MAINSTREAMING IN A PAHO TECHNICAL COOPERATION AREA: NATIONAL HEALTH ACCOUNTS

Empowering women and achieving gender equality is a social objective as well as an instrumental means for the achievement of overall social and economic development. Women contribute to health and economic development and to the reduction of poverty through both remunerated and unremunerated work at home, in the community, and in the workplace. However, the contribution of women to health and economic development is often undervalued (remunerated) or not included (unremunerated) in a country's National Health Accounts (NHA) studies and/or in a country's System of National Accounts (SNA).

The "Beijing Declaration and Platform for Action" adopted at the Fourth World Conference on Women (Beijing, 1995) aims at removing all the obstacles to women's active participation in all spheres of public and private life and to the promotion of gender equality and empowerment of women. Also, the promotion of gender equality has been included as one of the goals of the U.N. Millennium Declaration (Goal 3).

This document contains the proposed actions for promoting the development of equity-sensitive gender economic and financial indicators that may contribute to making visible women's contribution to health and development in the countries of the Americas. These actions are promoting and supporting the development of household sector accounts and studies assessing the magnitude and distribution of the burden on household members, particularly women, of underfunded public health care systems and on the consequences of the additional burden on women's unremunerated work on the ongoing demographic and epidemiologic changes. Also, included in the analysis of health sector reforms would be the "cost shifting" to households of the invisible costs of cost containment policies, and promoting the development of empirical evidence on the contribution of women to human development potential, poverty reduction, and the alleviation of health-based poverty traps. Proposed actions are geared to helping countries of the Region to implement the commitments they made in Beijing and in the Millennium Declaration. Making women's contribution to health and development visible will allow for a better assessment of the gender-related barriers to poverty reduction and economic growth and facilitate the incorporation of gender inequality concerns in national development strategies.

This document is submitted to the Subcommittee on Women, Health, and Development with a recommendation to request the Subcommittee on Planning and Programming to review the proposal and advise the Executive Committee and through it the Directing Council and the Director on the importance of supporting further analytical and empirical work for making visible the invisible contribution of women to health and economic development.

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Introduction

1. Empowering women and achieving gender equality is a social objective as well as an instrumental means for the achievement of overall social and economic development. As an instrumental means, the contribution of women to health and development and the reduction in gender inequalities are critical factors in eradicating poverty and in reducing social inequalities. Women contribute to health and economic development and to the reduction of poverty through both remunerated and unremunerated work at home, in the community, and in the workplace. However, these contributions are seriously underestimated, and thus their social recognition is limited. The contribution of women to health and economic development is often undervalued (remunerated) or not included (unremunerated) in a country's National Health Accounts (NHA) studies and/or in a country's System of National Accounts (SNA). The full visibility of the type, extent, and distribution of this unremunerated work will contribute to a better assessment of the contribution of women to health and economic development and to the reduction of poverty. Making the contribution of women to health and economic development visible is a mechanism for the empowerment of women and for reducing gender inequalities.

2. The "Beijing Declaration and Platform for Action," adopted at the Fourth World Conference on Women (Beijing, 1995) aims at accelerating the implementation of the Nairobi Forward-looking Strategies for the Advancement of Women and at removing all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural, and political decision-making. The promotion of gender equality and empowering of women have been included as one of the goals of the United Nations Millennium Declaration (Goal 3), which contains several goals that cannot be achieved without addressing gender inequalities.[1] The Millennium Development Goals are intended to further progress on some of the 12 critical areas for action identified by the Beijing Platform of Action, such as the areas of women and poverty, women and health, and women and the economy.[2] Among the strategic objectives considered in these areas of concern are: to develop gender-based methodologies and conduct research to address the feminization of poverty;

[1] The Eradication of extreme poverty (MDG 1) cannot be achieved without due attention to both women and men living in poverty. The reduction of child mortality (MDG 4) **c**annot be achieved without better access to reproductive health services for women and the end of discriminatory behaviors that contribute to high levels of female child mortality. The reduction of maternal mortality and improving maternal health requires a reduction in the gender gaps in resources and access to health care services. The burden of caring for HIV/AIDS victims and orphans also falls disproportionately on women.

[2] The other areas of action of the Beijing Platform of actions deal with issues related to education and training of women, violence against women, women and armed conflict, women in power and decision making, institutional mechanisms for the advancement of women, human rights of women, women and the media, women and the environment, and the girl child.

and to generate and disseminate gender-disaggregated data and information for planning and evaluation.

3. The recommended actions to be taken by Governments, intergovernmental organizations, academic national and international statistical organizations, research institutions, and the private sector included:

- Devise suitable statistical means to recognize and make visible the full extent of the work of women and all their contributions to the national economy, including their contribution in the unremunerated and domestic sectors, and examine the relationship of women's unremunerated work to the incidence of and their vulnerability to poverty (Strategic Objective A.4).

- Developing methods, in the appropriate forums, for assessing the value in quantitative terms of unremunerated work that is outside national accounts, such as caring for dependants and preparing food, for possible reflection in satellite or other official accounts that may be produced separately from but are consistent with core national accounts, with a view to recognizing the economic contribution of women and making visible the unequal distribution of remunerated and unremunerated work between women and men.

- Develop an international classification of activities for time-use statistics that is sensitive to the differences between women and men in remunerated and unremunerated work, and collect data disaggregated by sex at the national level, subject to national constraints.

Rationale: the Contributions of Women to Health and Development in Latin American and the Caribbean—Developing Gender-based National Health Accounts

4. Women contribute to health and economic development and to the reduction of poverty through both remunerated and unremunerated work at home, in the community, and in the workplace. Development of indicators assigning a monetary value to the contribution of women’s unremunerated work to the formation of the human capital of the next generation and to the overall family and societal well-being may provide the basis for increasing the visibility of women's contribution to health and development.

Sex, Gender, and Gender Equality and Equity

Sex

Sex refers to the biological characteristics which define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females. (WHO)

Gender

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviors, values, and relative power and influence that society ascribes to the two sexes on a differential basis. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender is relational and refers not simply to women or men but to the relationship between them[1].

Gender Equality

Gender equality entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality means that the different behaviors, aspirations, and needs of women and men are considered, valued, and favored equally. It does not mean that women and men have to become the same, but that their rights, responsibilities, and opportunities will not depend on whether they are born male or female[2].

Gender Equity

Gender equity means fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations, and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women.[3]

[1] Exploring Concepts of Gender and Health. Ottawa: Health Canada, 2003. http://www.hc-sc.gc.ca/english/women/exploringconcepts.htm

[2] ABC of Women Worker's Rights and Gender Equality, Geneva: ILO, 2000.

[3] Gender and Household Food Security. Rome: International Fund for Agricultural Development, 2001. http://www.ifad.org/gender/glossary.htm

Source: United Nations International Research and Training Institute for the Advancement of Women INSTRAW: Glossary of Gender-Related Terms and Concepts.
http://www.un-instraw.org/en/index.php?option=content&task=view&id=37&Itemid=76

5. By entering in the labor force, women participate in the production of goods and services and generate resources to finance household consumption and well-being. By participating in unremunerated work in the production of goods and services, particularly agricultural production in small-scale household enterprises, women generate resources for household members. However, in most cases, while some of the work of women in rural areas in agriculture, food production, or family enterprises is included in the labor statistics and in the country's SNA, this unremunerated work is not fully recognized; commonly it is underrecorded and undervalued.

6. The persistence of gender inequalities is having a negative impact on economic growth and development. Gender inequalities often lower the productivity of labor and create inefficiencies in labor allocation in households and the general economy. Gender relations affect all aspects of poverty, including income, opportunity, security, and empowerment. With regard to income poverty, in some countries, girls in poor families receive lower-quality nutrition, less health care, and poorer education than their brothers.[3] The result is an unequal distribution of resources, which contributes to the nonmonetary aspects of poverty—lack of security, opportunity, and empowerment—that lower the quality of life for men, women, and children. Women and girls bear the largest and most direct costs of inequality between the sexes. But the costs cut broadly across society and ultimately harm everyone.[4] The gender-based division of labor, disparities between males and females in power and resources, and gender biases in rights and entitlements act to undermine economic growth and reduce the well-being of men, women, and children. They also contribute to poverty and reduce human well-being.[5]

7. The contribution of women to health, in addition to their contribution through remunerated work by their participation as providers of health care services at hospitals, health care centers, or medical offices, also includes the unremunerated time dedicated to providing care to a sick, disabled, or elderly family member, friend, or community member. This type of work is usually invisible from the national health accounts and system of national accounts perspective. It is seen as an extension of women's domestic work, and therefore is not recorded in national health statistics, national budgets, or national accounts.

8. Over recent years a number of factors are contributing to increase the burden of women regarding unpaid health work: the aging population, the increase in the incidence of diseases that require long-term care, and the increasing reliance of the health sector on ambulatory care and out-patient services. This is happening at a time when the entry of

[3] The World Bank, World Development Report 2001/02: Attacking Poverty.
[4] World Bank, Gender Inequalities Harm Everyone, Washington DC. 2003 (?).
[5] The World Bank; "Engendering Development—Through Gender Equality in Rights, Resources, and Voice." Policy Research Report, Washington DC, 2001 (cfr).

women into the work force means a decrease in the numbers of available unpaid health workers. Inadequate sharing of family responsibilities, combined with a lack of adequate social protection systems continue to restrict employment, economic, professional, and other opportunities as well as mobility for women.

9. The unequal division of labor and responsibilities of unremunerated work within households limits the potential time of women to be used to acquire knowledge and develop the skills required for achieving full participation in policy- and decision-making spheres and their overall human development potential. A more equal sharing of those responsibilities between women and men may provide a better quality of life for women and enhance their opportunities to participate in market activities in the political arena and in policy design and decision-making public policy processes.

10. In general, the impact of public policies is assessed without consideration of the impact on unremunerated activities and its distribution within households. Making women's unremunerated work visible and an integral part of public policy analysis will provide a different perspective on the overall welfare impact of those policies. It will allow a more comprehensive assessment of the full impact of health sector reform policies, including the total burden and the distribution of unremunerated work. Stabilization and structural adjustment policies focus mainly on the impact of those policies on macroeconomic balances—fiscal, monetary, and balance of payment. They rarely look into the impact of these policies on the amount and distribution of unremunerated work being shifted to households.[6]

Women's Remunerated and Unremunerated Work in the Americas: Market and Nonmarket Activities in Health

11. In most countries of the Americas, the share of women in the labor force has been rising continuously. Income from women's participation in market economic activities, labor market, and formal and informal entrepreneurial activities is becoming a significant part of household income. Across developed and developing countries, women are a significant part of the labor force. However, while women's participation (time) to market-related, income-generating activities has been increasing, there has been little change in the overall burden and distribution of the burden of unremunerated household activities.

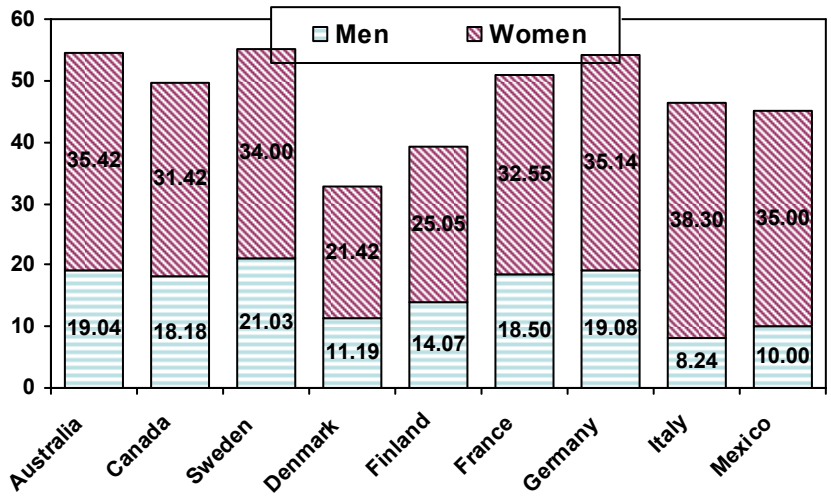
12. Across the countries, the amount of time dedicated to unremunerated activities related to household production of goods and services is greater than the time dedicated

[6] As an example, privatization of health-care systems, by reducing the access to health care services, increases the burden of health care services being provided through unremunerated work.

to market income-generating activities. In the case of most advanced countries of the Organization for Economic Cooperation and Development (OECD), an average of around 50 hours per week (ranging between a low of 32 hours in Finland to around 54 hours per week in Austria, France, and Germany) are dedicated to unremunerated household activities related to the production of goods and services to be used by household members. This time is in addition to an average of 40 hours per week dedicated to income generation, market-related activities. In developing countries, the situation seems to be similar. In the case of México, it is estimated that, on average, household members dedicated 45 hours per week to unremunerated household activities. Around 80 % of this unremunerated work is performed by women.

Graph 1

Time devoted to unpaid labor- weekly hours per person
OECD countries



Source: OCDE. Producción doméstica: fuentes de datos métodos de medición. For México: INEGI, Encuesta de aportaciones y uso del tiempo. Módulo de la Encuesta de Ingreso-Gasto

Taken from: Gómez Luna María Eugenia. *Cuenta Satélite de los Hogares. Valoración del Trabajo Doméstico no Pagado*. El Caso de México. Taller de Cuentas de Salud con Enfoque de Género. CEPAL, OMSY OPS. Santiago, Chile, 2001.

13. An estimated 80% of health care is provided in the home, principally by women. The time that women invest in caring for others reduces their potential to develop their human capital. Assuming that providing family health care does not have personal,

family, and social consequences is unfair, unrealistic, and dangerous for health policy.[7] Unpaid care constitutes an underground economy.[8]

Demographic Transitions, Unremunerated Work, and the Persistence of Gender Inequalities

14. Underfunded health care systems are able to operate because family members, particularly women, are willing to shoulder the burden of care of the sick, chronically ill or disabled. However, because of the rapid process of aging of the population, the national health care systems of the countries of the Region are about to face an unprecedented demand for long-term care services, which the majority of them are unprepared for. Currently, most of the care for the chronically ill and elderly relies to a large extent on women's unpaid labor, particularly in rural areas.

15. The burden of unpaid health work on women is also increasing as a result of health sector reform processes. Most health sector reform focuses primarily on reducing the number of hospitals, the number of beds in hospitals, and the amount of time beds are occupied, with little thought as to where people go once they leave the hospital. There has been some increase in state spending on community and home care services, but in very few cases has the increase been large enough to offset the cuts to formal health services. The shift to ambulatory care and an increasing reliance on outpatient services is predicated on the fact that there will be someone at home to care for the recovering patient. In some cases, paid home-care services are available, though not always affordable. In other cases, patients are referred to publicly-funded community or home care services, which are generally overburdened and understaffed. In a great number of cases, however, patients are simply sent home with their partners, mothers, daughters, or friends, who are given instructions on how to care for them, and left to manage on their own.

16. Since the burden of the care of children, the sick, the disabled, and the elderly falls disproportionately on women, changes in the dependency ratio are likely to affect the overall burden and the distribution of unremunerated work at home.[9] The demand for unremunerated work to take care of the elderly and sick is likely to substantially increase in the coming years. From 1970 to 2000, the ratio of population older than 60 years to

[7] PAHO. Director Dr. Mirta Roses Periago in a statement delivered from Nicaragua; Women International Day 2004 celebration. IWD Conference; Washington DC, March 8, 2004.

[8] Pat Armstrong, professor of the Department of Sociology of Canada's York University.; IWD Conference; Washington DC. March 8, 2004.

[9] An increase in the dependency ratio is likely to increase the demand for unremunerated work at home. Recent and expected demographic trends suggest that the "window of opportunity" is being offset by the aging of the population.

women between 15 to 59 years of age remained almost constant, around 4.0. In the next 25 years, from 2000 to 2025, while the population older than 60 will almost double—from 41.4 million in 2000 to 96.3 million in 2025, the number of women in the working-age population will increase less than proportionally. The number of women of working-age per population older than 60 years will decline to around 2.1. The burden of taking care of the elderly and sick will substantially increase, and because of the lack of equality and the unbalanced distribution of unremunerated work at home, most of the burden will be borne by women.

Work on Gender-based Health Accounts in the Region

17. In most countries of the Americas, the burden of health care for households is significant, yet it is rarely measured or included in a health sector analysis or in assessing the impact of public policies or health sector reform policies. Most of the burden is not fully recognized in sector specific or in national macroeconomic statistics. A 1997 research survey in Canada and the United States of America showed that 70% to 80% of nursing/personal care for the elderly was provided by family members. Studies on the significance of health care services related to unpaid work for Canada suggest that 80% of paid and unpaid caregivers are women, 75% of them between the ages of 50 to 65 years. In the case of the United States of America, it was estimated that between 55% to 70% of persons providing primary care services were women. Also, it is estimated that the average woman will spend 18 years taking care of a parent[10].

18. In Ecuador, the National Council for Women (CONAMU), created in 1997, identified the need for developing gender indicators that would facilitate the detection of gender inequalities as demonstrated by studies on the *use of time* by gender, which will shed light on the origin of gender inequalities in the distribution of unremunerated work and on women's contribution to the overall population's well-being.[11] In the case of Mexico, for the period 2001-2006, the Secretariat of Health had identified three main challenges as the focus of its work: equity, quality, and financial protection. Critical gender issues existed in all three areas. One of the areas of work of the Secretariat's Women and Health Program was aimed at generating statistics disaggregated by age and sex, developing gender indicators, and incorporating satellite accounts into national

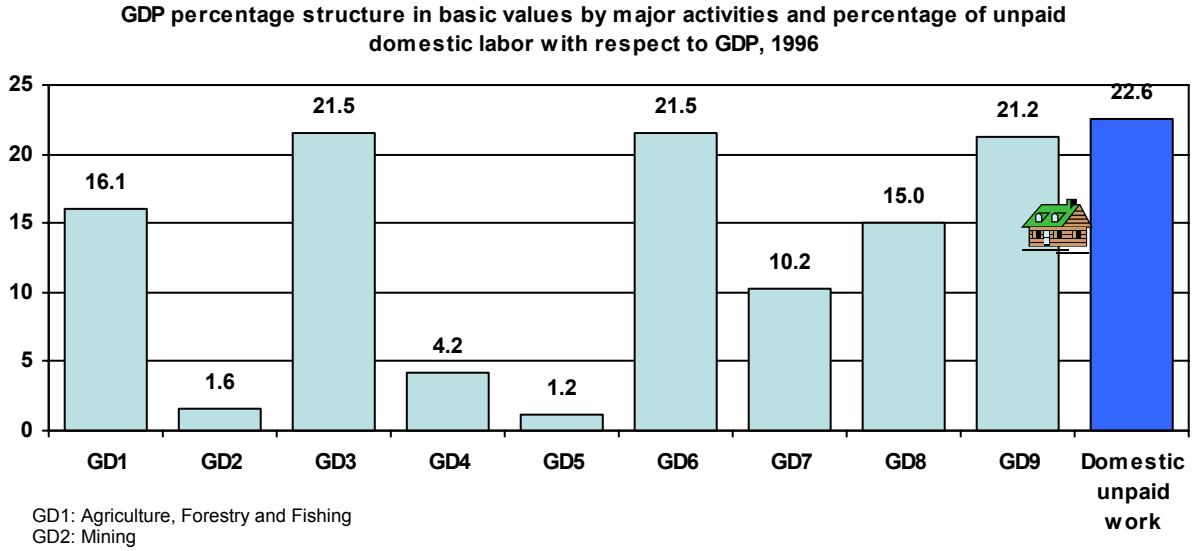
[10] Final Report 20th Session of the Subcommittee on Women, Health, and Development of the Executive Committee; Washington, D.C., 25-26 March 2003. MSD20/FR, Rev. 1 (Eng.) 3 June 2003.

[11] "Experiences with analysis and monitoring of gender equity in health and development: Experience in Ecuador;" By Lily Jara; Consejo Nacional de las Mujeres del Ecuador. 19th Session of the Subcommittee of the Executive Committee on Women, Health and Development; Washington, D.C., USA, 12–14 March 2001; Provisional Agenda Item 6 MSD19/5 (Eng.). 5 March 2001; ORIGINAL: SPANISH

accounts to reflect the value of women's unpaid work in the health sector.[12] The overarching objective of this component was to generate evidence of gender inequities in health and reveal the causes and effects of those inequities.[13] Identifying gender inequalities and their impact on poverty are key elements for designing gender-sensitive, poverty-alleviation policies.

19. Estimates developed by the National Statistical Institute of Mexico (INEGI) suggest that unremunerated work represents a substantial part of the national economy, around 23% of the gross domestic product. One-fifth of this production is related to unremunerated time dedicated to personal, community, and social services. Almost 80% of this production can be attributed to women's unremunerated work within the households (Graph 2.a and 2.b).

Graph 2.a

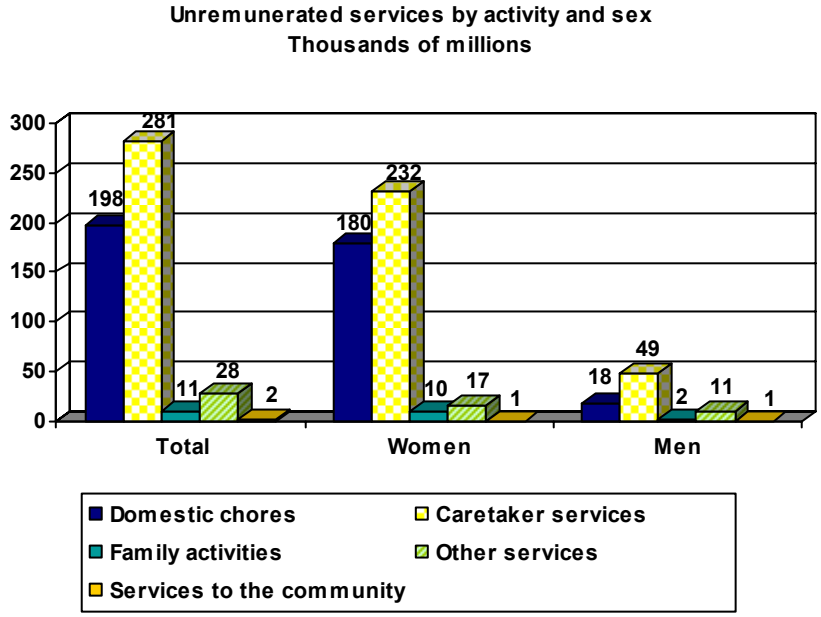


GD1: Agriculture, Forestry and Fishing
GD2: Mining
GD3: Manufacturing
GD4: Construction
GD5: Electricity, Gas and Water
GD6: Trade, Restaurants and Hotels
GD7: Transport, Storage and Communications
GD8: Financial services, Insurance, Real Estate and Rent
GD9: Social, Personal and Communitarian service

[12] The other components of the program were: the institutionalization of gender perspective throughout the health sector, women's health, female health workers, and home and community health.

[13] Final Report 20th Session of the Subcommittee on Women Health and Development of the Executive Committee; Washington D.C., 25-26 March of 2003. MSD20/FR., Rev 1 (Eng.) 3 June 2003.

Graph 2.b



Source: Gómez Luna María Eugenia. *Cuenta Satélite de los Hogares. Valoración del Trabajo Doméstico no Pagado*. El Caso de México. Taller de Cuentas de Salud con Enfoque de Género. CEPAL, OMSY OPS. Santiago de Chile, 2001

20. In the case of Chile a study based on a survey on health and quality of life provided compelling evidence on the impact and distribution of the shifting of health care from the national health system to the households. Increases in responsibility in caring for a disabled or chronically ill family member resulting from health sector reforms had a negative impact on families' quality of life, particularly of women.

PAHO's Work on Gender-based National Health Accounts: Measuring Unremunerated Work

21. At its 20th Session (25-26 March 2003), the Subcommittee on Women, Health, and Development looked at the progress being made in the incorporation of gender in PAHO technical programs, and the monitoring of national health policies from a gender perspective. At this session, PAHO's Director affirmed that achieving gender equality was a priority for the Organization in general and for herself in the current five-year period.. While it was recognized that substantial progress had been made towards that goal, both within the Secretariat and in the countries, two types of strategies were needed

to reach the goal of gender equality: (1) gender mainstreaming in all policies, plans, programs, projects, etc., and (2) empowerment of women by making women's contribution to health and development visible.

22. Since 2001, PAHO's Gender and Health Unit (GH) and the Unit of Health Policies and Systems (HP) have been promoting further analytical and empirical work for making women's contribution to health and development more visible. With the support of the Norway Agency for Research and Development (NORAD) through the National Health Accounts Project, the Organization has been promoting and supporting the development of methodologies and empirical studies for the measurement of the contribution of women to health and development within the framework of the country's systems of national accounts. Work in this area included the development of methodologies aimed to measure the significance of unremunerated work that are consistent with the System of National Accounts and National Health Accounts methodologies.

23. At its 20th Session, the Subcommittee on Women, Health, and Development agreed that more such research, incorporating a gender perspective, was essential in order to provide the evidence needed to design policies that would effectively support families who were providing health care in the home. The International Women's Day on 8 March 2004 focused on Health Care in the Home: Invisible Work. In Washington, D.C., PAHO's celebration focused on women's invisible and unpaid contribution to health and development, and on the need to shine a spotlight on unremunerated health care work at home in order to make it an integral part of health policy analysis and design.[14]

24. The proposed activities in this document seek to develop a more comprehensive knowledge of work and employment and the extent and distribution of unremunerated work, particularly work in caring for dependants, children, and the elderly, and of the unremunerated work in taking care of the sick and disabled. The dissemination of information on studies and experience in this field includes the dissemination and applications of methods for assessing the value of unremunerated work at home in quantitative terms to better reflect the contribution of women to the health and economic development within the core of the country's national health accounts and system of national accounts.

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[14] Dr. Roses Periago. International Women's Day 2004; Health Care in the Home: Invisible Work, March 8th 2004, Washington, D.C. Press Release: Women Bear Burden of Home Care; Washington DC, March 8, 2004.

Proposed Actions for Promoting Equity-sensitive Gender Economic and Financial Indicators within the Secretariat and with Member States

25. The following is a list of actions to promote the development of gender economic and financial indicators that may contribute to making visible women's contributions to health and development in the countries of the Americas. Proposed actions are geared to helping countries of the Region implement the commitments they made in Beijing. Making the contribution of women to health and development visible will allow for a better assessment of gender-related barriers to poverty reduction and economic growth and facilitate the incorporation of gender and gender-inequality concerns in public policies and national development strategies.

- To promote and support the development of household sector accounts as complementary to the development of national health accounts and the system of national accounts to generate indicators assigning monetary values to unremunerated contributions of women to health and development.

- To promote the development of studies assessing the magnitude and distribution of the burden of underfunded public health care systems on household members, particularly women.

- To include in the analysis of health sector reforms the "cost shifting" to households of the invisible costs of cost containment and structural adjustment reform policies.

- To promote studies on the consequences of the additional burden on women's unremunerated work of the ongoing demographic and epidemiologic changes (e.g. aging, chronic diseases, mental illness, HIV/AIDS, and reemerging infectious diseases).

- To promote the development of empirical evidence on the contribution of women to human development potential, poverty reduction, and the alleviation of health-based poverty traps.

Action by the Subcommittee on Women, Health, and Development

26. To review this proposal and advise the Executive Committee and through it the Directing Council, and the Director, on the importance of supporting further analytical and empirical work for making visible the invisible contribution of women to health and

economic development as well as the impact of inequalities in the distribution of work in explaining the persistence of gender inequalities as constraints for achieving women's full human development potential.

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