PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

26th PAN AMERICAN SANITARY CONFERENCE
54th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 23-27 September 2002

Provisional Agenda Item 4.11

CSP26/16 (Eng.)
19 July 2002
ORIGINAL: ENGLISH

WOMEN, HEALTH, AND DEVELOPMENT

This report provides a brief overview of what the gender inequities in health are and how they affect the differences between men and women in health status, and in the access, provision, and financing of health care. The Pan American Health Organization (PAHO) defines gender inequities as those inequalities between men and women that are unnecessary, avoidable, and therefore unjust. Within this context the document reviews the challenge that PAHO and its Member States face in assessing the impact of these inequities on health, given the overall scarcity of sex-disaggregated information within the Region. But there has been progress in bridging the gender gap in health, mostly as the result of the international conventions and mandates that have been supported and ratified by most countries of the Americas.

The report identifies actions for Members States prescribed from these international mandates and PAHO resolutions, and describes how PAHO's Women, Health and Development Program (HDW) can support them in bridging the gender equity gap. Accordingly HDW has identified five strategic areas of collaboration:

(a) Incorporate gender in health situation analysis to better target policies and programs;

(b) Formulate and monitor policies to reduce gender inequities in health;

(c) Strengthen the model for addressing gender-based violence at the policy, sector, and community levels, and use this type of model to involve men in reproductive health decision-making and to address mental health inequities;

(d) Reach out with information, education, and communication strategies and materials for advocacy and training, especially via "virtual channels;" and

(e) Collaborate with PAHO programs and Member States to incorporate a gender equity perspective in research, policies, and programs.

The 26th Pan American Sanitary Conference is invited to consider the resolution CE130.R14 recommended by the Executive Committee at its 130th Session, that includes actions for PAHO and its Member States for reducing gender inequities in health.

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Bridging the Gender Gap in Health in the Americas

This report presents the challenges of reducing gender inequities in health, how they have and can be addressed, and the role of Member States and PAHO's Women, Health and Development Program (HDW) in breaching the gap. The final sections outline HDW strategies and accomplishments in closing the gender gap in health.

1. The Meaning of Gender Equity in Health

Gender is not equivalent to sex. While sex refers to the biological differences between men and women, gender refers to the social, political, and legal constructs ascribed to those differences. Gender's focus of concern is not women or men, per se, but the unequal social relationships between men and women and their impact on society as a whole.

Equity is not synonymous with equality. Equity is an ethical concept based on notions of fairness and social justice, which considers need, rather than social advantage in decisions about resource allocation.[1] Not all inequalities are inequities. Inequities are those inequalities considered unnecessary, avoidable and unfair.[2] Thus, gender equity in health does not necessarily translate into men and women experiencing the same rates of morbidity and mortality, or that they share equally in the distribution of services. Rather, it calls for equal access to those opportunities that permit them to enjoy optimal health, to not become ill, disabled, or die prematurely from preventable causes. It means that health resources are allocated according to the different needs of men and women, given their different biological risk factors and societal roles, so as to ensure that they can attain the highest possible level of health. Furthermore, it implies that health services are received according to this differential need, irrespective of the individual's ability to pay. It also means that contributions to health care financing be made according to economic ability to contribute, and not be based on women's reproductive risk.

2. The Challenge: Assessing and Bridging Gender Gaps in Health

2.1 *Impact of Gender Inequities on Health*

Gender disparities in access to and control over resources affect the health status of men and women, as well as the financing, access to, and participation in the provision of health care. They interact with and are exacerbated by such other determinants as poverty, education, and ethnicity.

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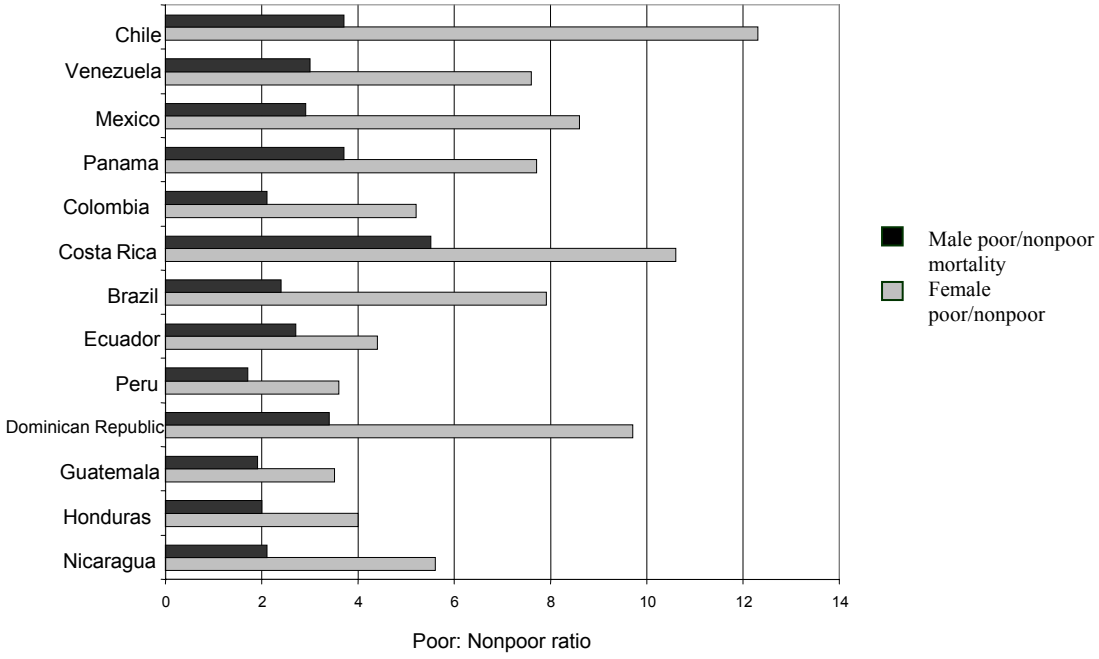
[1] Braveman, P. *Monitoring Equity in Health: A Policy-Oriented Approach in Low- and Middle-Income Countries.* Geneva, World Health Organization, WHO/CHS/HSS/98.1, 1998.

[2] WHO definition adopted by PAHO. For a detailed discussion, see: Whitehead, M., *The Concepts and Principles of Equity and Health*. Document EUR/ICP/RPD/414, WHO Regional Office for Europe, Copenhagen, 1990.

2.1.1 *Gender Inequities Affect Health Status*

Women outlive men in most countries of the world. Poverty, however, has a more detrimental effect on women's than on men's survival. As Figure 1 shows, the poor/non poor ratio of the probability of dying prematurely is much larger for women than for men. Thus, while poverty increases two to five times men's probability of dying prematurely, it increases 3 to 12 times the same probability for women.

Figure 1. Poor/Nonpoor Ratio of the Probability of dying between the Ages of 15 and 59, by Sex, in 13 Latin American and Caribbean Countries

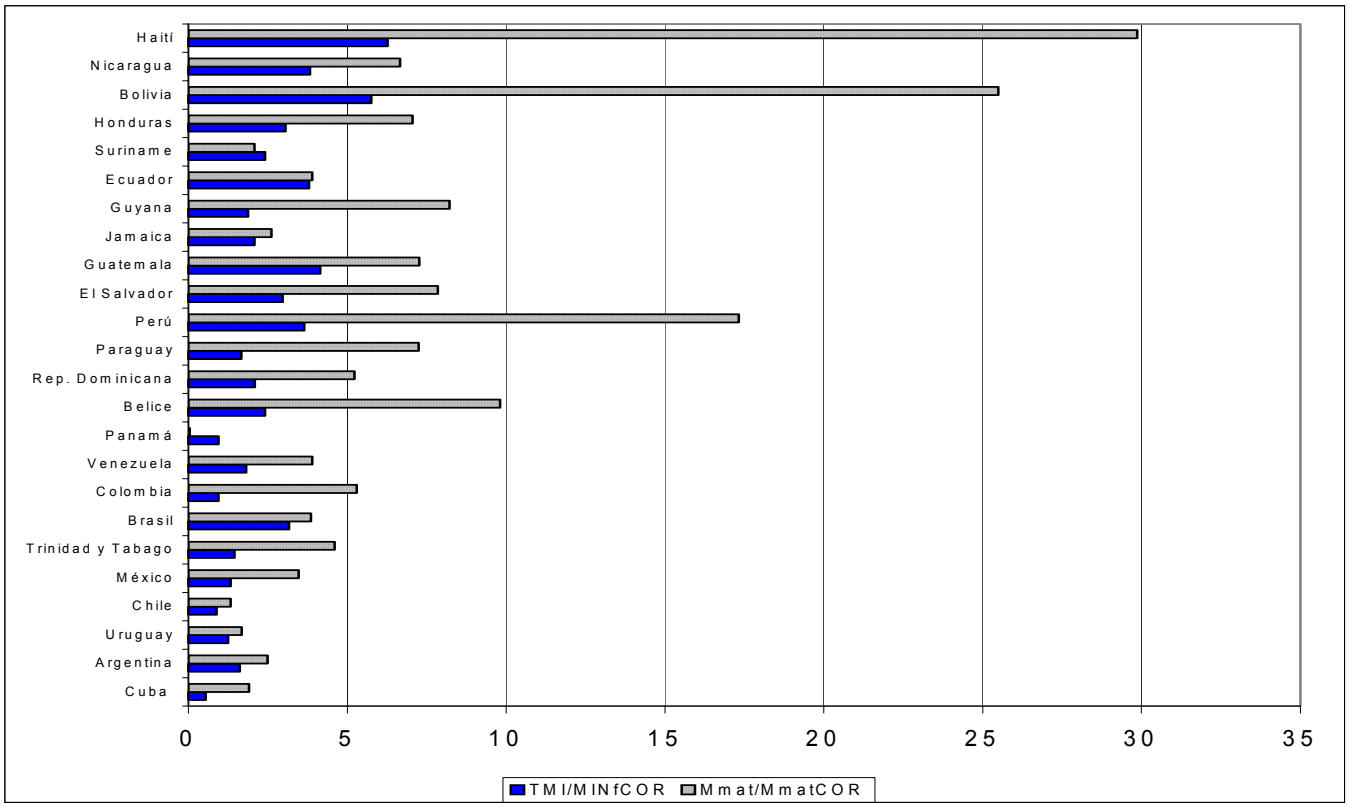


Adapted from World Health Organization, World Health Report 1999, Statistical Annex

Causes and, therefore, the prevention of illnesses and death are different for men and women. As attested by the Region's unacceptably high maternal mortality rates, complications in pregnancy and childbirth remain among the leading causes of death for women of reproductive age. For men in the same age group, mortality relates strongly to risk behavior: injuries, violence, lung cancer, substance abuse, and HIV/AIDS.

Figure 2 shows that the differences between maternal mortality rates remain larger than the differences between infant mortality rates. While, for example, Haiti's infant mortality rate is six times higher than Costa Rica's infant mortality rate, Haiti's maternal mortality rate is 30 times higher.

Figure 2. Comparative Importance of Maternal and Infant Mortality as Social Development Markers: Ratios between Maternal and Infant Mortality Rates of Selected Countries of the Americas in relation to those of Costa Rica.

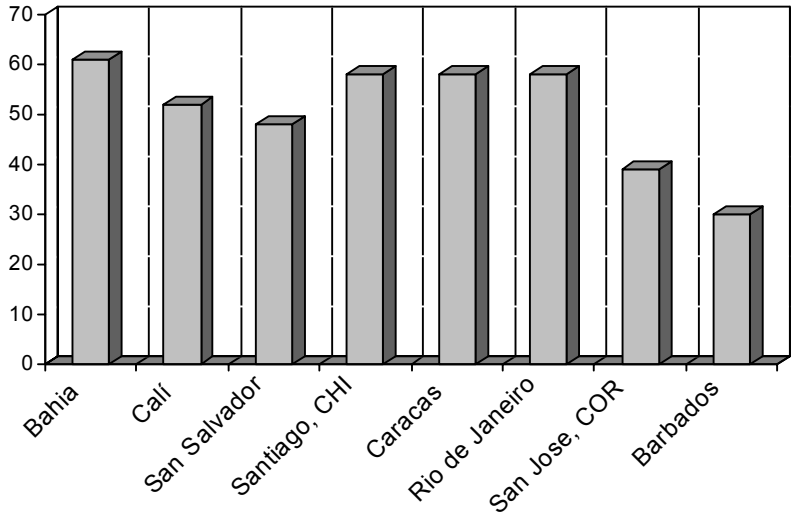


Countries in ascending order of their per capita GNP in 1998. There is no GNP data for Cuba.

Source: Based on analysis of PAHO's Basic Indicators 2000.

The most disturbing manifestation of gender inequity is gender-based violence (GBV), which affects between 30% and 60% of women throughout the Region, and is caused primarily by intimate partners (Figure 3).

Figure 3. Percentage of Women Who have Experienced Violent Acts by Their Partners in the 1990's –in Eight Sites of Latin American and Caribbean Countries

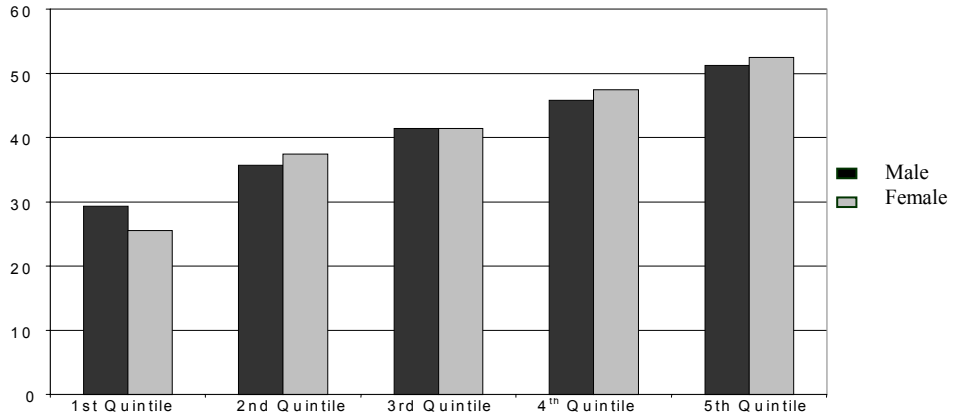


Source: Adapted from Lori Heise. Coercion and Abuse: "Implications for Health Programs." (Nov. 2001)

2.1.2 *Gender Inequities Affect Access to Health Care*

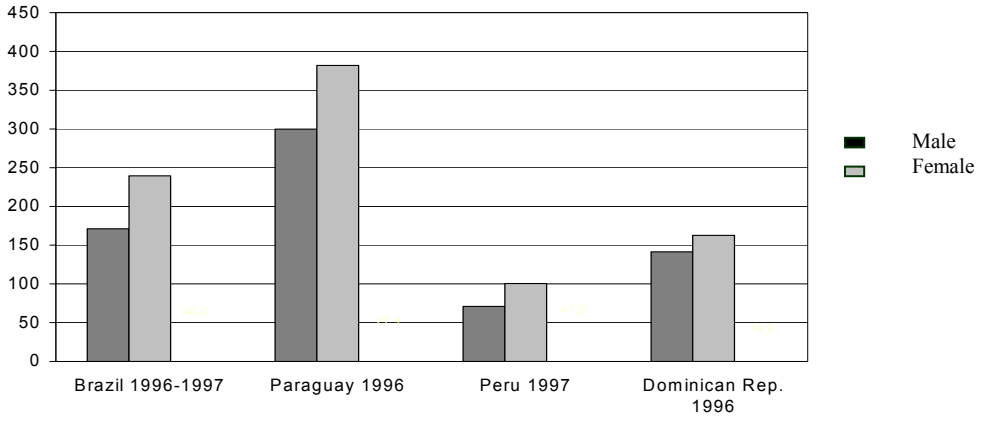
Overall, women tend to use health services more often than men, due to greater need related to their reproductive role, their more frequent illness, and their longer life expectancy. However, as Figure 4 indicates, when need is taken into account, poor women do not always use health services more often than men. Some health care financing systems discriminate against women because of their reproductive role, resulting in women paying higher insurance premiums than men. Furthermore, because of their greater need for care, women spend more out of pocket than men in order to maintain their health (Figure 5).

Figure 4. Percentage of Persons with Health Problems That Sought Health Care, by Sex and Household Level of Expenditure, in Five Latin American Countries, 1994-1996



Source: LSMS Survey: Bolivia, Colombia, Ecuador, Nicaragua, Venezuela, 1994.

Figure 5. Out-of-Pocket Health Expenditures for Men and Women in Four Latin American Countries (United States Dollars)



Source: PAHO/LSMS Surveys for Brazil, Paraguay, and Peru. DHS

2.1.3 *Gender Inequities Affect the Distribution of Power and Rewards in Health Work*

While women represent approximately 80% of the remunerated health sector labor force, they remain underrepresented in the decision-making ranks and predominate in the lowest levels of income and status. Moreover, women are the principal providers of health care and promotion in the family and the community, where more than 80% of health care takes place outside formal health services and is mainly provided by the unrecognized, unremunerated work of women.

2.2 *Lack of Sex-disaggregated Information for Planning and Evaluation*

In most countries of the Region, there is a lack of information disaggregated by sex, age, socioeconomic status, and other relevant indicators. The development of gender statistics is still in its early stages and has not been assumed by the national statistics services.[3] Despite the progress made in the past 25 years, there is still resistance in many areas to consider gender as a relevant issue, and the health sector is no exception.

In most countries, disaggregation by sex in the collection, processing, and publication of data is either not a priority or simply is not applied. Disaggregation, however, is only a first step for incorporating a gender perspective into statistical work. An effective process includes advocating with policy-makers for its inclusion, participation with stakeholders to define relevant indicators, training of users and providers of information, and an analysis focused on gender inequities, as well as technical and financial resources to support this process.

Beyond epidemiological data on health and its determinants, health information should also include the contribution of women and men to health development, including their health work outside the formal health sector, e.g., home care for the sick, the disabled, and the elderly. This information would make visible the economic contribution of women to health care, as well as the unequal distribution of remunerated and unremunerated work between women and men.[4]

3. Progress in Bridging the Gender Gap

Despite the undeniable persistence of obstacles that must be recognized and dealt with, there are also very positive elements facilitating efforts to attain gender equity in health. Decisive factors in this respect have been:

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[3] Fourth World Conference on Women Platform for Action (Annex).

[4] Fourth World Conference on Women (Beijing, 1995).

- The commitments made by Member States in United Nations conferences during the last decade: the Convention on the Elimination of All Forms of Discrimination against Women (General Assembly, New York, 1993); the International Conference on Population and Development (Cairo, 1994); and the Fourth World Conference on Women (Beijing, 1995). At the inter-American level, a main catalyst has been the Convention on the Prevention, Punishment, and Eradication of Violence against Women (Belém do Pará, 1995).

- The growing influence of the women's health movement, which has fueled the debate both nationally and internationally. This movement has been instrumental in advocating for the protection of health, including reproductive health, as a human right, and for social transformations based on solidarity and social justice.

- The relatively recent recognition of violence against women as a public health issue requiring a coordinated response. The women's movement and the international conferences were driving forces of this recognition. PAHO and its Member States have been playing a lead role in addressing the problem since the early 1990s.

- The emergence of women's ministries or bureaus in most countries of the Region, and the drafting of gender equality plans in a growing number of Member States.

- The fledgling support given by government agencies in some countries to the development of gender-sensitive statistical information systems.

- The firm backing offered to HDW by United Nations sister organizations and other international cooperation agencies that support gender equity goals.

4. How Can Countries Bridge the Gender Gap in Health?

While there is a general recognition that social, as well as biological determinants affect health, gender continues to be an afterthought for most analysts and policy-makers. Inequities in health will persist unless there is a commitment to include gender in health data collection and analysis, in the formulation and monitoring of policies, in the design of innovative and integrated programs, and in the training of health care providers.

Almost all Member States have ratified the relevant global and regional conventions. To mobilize the health sector's response to gender-based violence, Member States supported the Plan of Action of the Symposium 2001: Gender Violence, Health, and Rights in the Americas. As representatives of the Subcommittee on Women, Health, and Development of the Executive Committee, countries have drafted a number of recommendations aimed at promoting gender equity in health in Member States. Based

on these commitments, HDW sets forth the following specific recommendations for Member States to bridge the gender and health gap in the Americas:

- Improve data collection on the full contribution of women and men to the economy, including their participation in unremunerated work that is outside national accounts, such as caring for the sick, the disabled, and the elderly (Beijing);

- Design and implement, in cooperation with women and community-based organizations, gender-sensitive health programs that address the health needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands of their time, and the diversity of women's needs (Beijing);

- Train personnel and allocate resources for producing and disseminating gender and health information needed to guide health policies and monitor the fulfillment of national and international commitments on gender equity in health (19th Session of the Subcommittee on Women, Health, and Development of the Executive Committee);

- Ensure that users and producers of statistics in government and civil society participate in the definition of contents and processes for the production, dissemination, analysis, and monitoring of information on gender and health (19th Session of the Subcommittee on Women, Health, and Development of the Executive Committee);

- Develop and implement policies, programs, and training to detect, attend to, and prevent GBV within the health sector, as well as in other sectors (Beijing, Cairo, and Belém do Pará);

- Ensure that gender is an explicit component of PAHO's mental health framework (19th Session of the Subcommittee on Women, Health, and Development of the Executive Committee); that mental health services are integrated into primary health care systems to address the different needs of men and women; and that GBV is included in mental health care and policies (Beijing);

- Encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles, and to increase their participation and sharing of responsibility in the practice of family planning (Cairo);

- Promote and strengthen women's social participation in community structures for decision-making about health, without increasing their workload (18th Session of the Subcommittee on Women, Health, and Development of the Executive Committee); and

- Ensure that medical and other health care training curricula include gender-sensitive, comprehensive, and mandatory courses on women's health (Beijing).

5. How Can PAHO Support Its Member States to Meet the Challenge?

HDW was established to support Member States in achieving gender equity in their health policies and programs. PAHO and the Governing Bodies have adopted several resolutions (CSP22.R12 of the 22nd Pan American Sanitary Conference, and CD32.R9, CD33.R.6, and CD34.R5 of the 32nd, 33rd, and 34th Directing Councils, respectively) that define the mandate and operations of HDW. One central goal is to integrate gender within the programs and policies of PAHO, country representations, and Member States, in order to reduce gender inequities in health within the context of PAHO principles of equity and Pan Americanism.

The Governing Bodies also established the Subcommittee on Women, Health, and Development of the Executive Committee, which meets biannually to identify relevant gender and health issues and to make recommendations to the Executive Committee and PAHO's Director for addressing them.

The HDW mandate calls for the redistribution of responsibilities and power between men and women in order to improve the physical, psychological, and social well-being of the population. Within this framework, HDW seeks to identify and reduce inequities in health status; improve access to appropriate health care; and promote a more equitable participation in health care work. The Program adheres to the following crosscutting commitments:

- Empowerment and participation of women and communities to control their health;

- Capacity-building of stakeholders at the local, health sector, and policy-making levels to improve health advocacy, care, and promotion; and

- Intersectoral collaboration among the public sector, civil society, women's organizations, and international donors and agencies.

5.1 *Strategic Areas for Technical Collaboration*

Based on the commitments and needs of Member States, HDW defined five strategic areas as the most effective way to reduce gender inequities:

- Incorporate a gender perspective in health analysis to target policies and programs more effectively;
- Formulate and monitor policies to reduce gender inequities in health;
- Develop and implement models that address gender inequities in health in an integrated manner;
- Support outreach activities with information, education, and communication strategies and materials for advocacy and training; and
- Integrate a gender perspective in PAHO and Member State research, policies, and programs.

These strategic areas were widely discussed with the Program's network of national focal points and regional women's organizations, and provide the basis for the HDW biannual plan for 2002–2003. The following sections provide highlights on the Program's progress in these areas, as well as plans for ongoing work.

5.1.1 *Incorporating a Gender Perspective in Health Analysis to Target Policies and Programs More Effectively*

HDW and its constituents clearly identified the importance of producing information on existing gender inequities in health. While women's organizations and international agencies have lobbied successfully for international conventions and national legislation, policies, and programs to reduce these inequities, there are currently only a few countries that disaggregate their health data by sex and that use a gender perspective in their analysis. Many of the conventions—and those who uphold them—agree that such information is essential for targeting inequities, and for monitoring the effect of health sector reform and other policy changes.

HDW has identified the production of this information as a top priority. Accordingly, it advocates that Member States include gender analysis in policy-making. The program has developed gender and health indicators and analysis tools, has provided training for country counterparts, and provides technical collaboration to produce this information. Within the near future, HDW also plans to develop a biannual statistical

pamphlet and a comprehensive publication on the regional situation of gender equity and health.

Within the next three years the Program will implement its health information strategy in six countries – four Central American countries, Chile, and Peru. This strategy is aimed at strengthening the capacity of policy-makers, users, and producers of information to advocate for production, to identify relevant gender and health indicators, to produce and disseminate information, and to use it for formulating and monitoring policies.

Advocating for Improving Health and Gender Situation Analysis. Improving gender and health situation analysis was the theme of the 19th Session of the Subcommittee on Women, Health, and Development of the Executive Committee (March 2001). The Subcommittee presented a number of recommendations to the Executive Committee, *inter alia*:

- That statistics be compiled, processed, analyzed, and disaggregated by sex and age to reflect and monitor gender inequities, and that they include the unremunerated contribution of women to health care;

- That information systems be established to guide health policies and monitor the fulfillment of national and international commitments on gender equity in health;

- That users and producers of statistics in government and civil society participate in the definition of contents and processes for the production, dissemination, analysis, and monitoring of information on gender and health; and

- That priority be given to training, in order to implement quantitative and qualitative analyses and interventions with a gender perspective.

Strengthening National Capacity to Carry Out Gender and Health Analysis. In keeping with PAHO's commitment to implement the Subcommittee's recommendations, the Program collaborates with national counterparts to strengthen their gender analysis capacity. In 2001 it facilitated the participation of representatives of the ministries of health and national statistical offices of four Central American countries in a gender and statistics course presented by the National Statistical Institute of Mexico (INEGI), United Nations Development Fund for Women (UNIFEM), and PAHO. As a next step, HDW aims to strengthen the capacity of multisectoral teams of users and producers of information from different sectors of government and civil society in Chile and Peru, as well as expand the training of Central American teams.

HDW is a member of the "Task Force on Tools and Indicators for Gender Impact Analysis, Monitoring, and Evaluations," coordinated by the Economic Commission for Latin America and the Caribbean (ECLAC). The Task Force is developing indicators for monitoring United Nations compliance to the Beijing and Cairo conventions. As part of this effort, PAHO, UNIFEM, and ECLAC held a regional meeting in 2001 in Bolivia to define GBV indicators. The Program sponsored participants from seven countries who have been implementing GBV surveillance systems, and will collaborate with these participants to strengthen the GBV information and referral systems within Central American and Andean project countries.

Promoting Research for Informing Policy-makers. HDW facilitates the relationship with researchers and policy-makers to design and apply research for improving health and gender policies. Recently, the Program coordinated a research initiative, "Gender Equity in Access to Health Care," in six countries—Barbados, Brazil, Chile, Colombia, Ecuador, and Peru. While results varied between countries, household survey data confirmed that, overall, women have greater need for services, use them more, and spend more out of pocket on health. However, the data from Ecuador and Peru indicated that despite their greater need, poor women do not always use services more often than men. The data also indicated that health insurance payments based on risk, as promoted by private services, tend to marginalize those in greater need, such as women of reproductive age, the poor, the elderly, and the chronically ill.

5.1.2 *Formulate and Monitor Policies to Reduce Gender Inequities in Health*

A key goal of gender and health analysis is to improve policies that ignore, create, or exacerbate health inequities between men and women. This is particularly pertinent to health sector reform processes that many countries are implementing. There is evidence that some health care financing models promoted by these processes may further marginalize the poor, the elderly, certain ethnic groups, and especially women in all these categories. Moreover, in most countries, women's organizations and other important stakeholders are excluded from defining health sector reform policies and monitoring outcomes.

Developing a Strategy for Reducing Gender Inequities in Health Sector Reform. HDW, in collaboration with other PAHO programs and national counterparts, has developed a strategy to identify and focus attention on these inequities, while involving stakeholders, especially women's groups, in addressing them in every stage of the process. This strategy includes:

- Developing information on gender and health inequities and their relation to health policies;

- Strategically disseminating information to stakeholders in health and other sectors, and in civil society, especially women's health advocacy groups; and

- Institutionalizing the involvement of these informed stakeholders in formulating better policies and in monitoring their implementation and effect on women and men.

HDW developed this strategy in consultation with experts from regional women's groups (in particular the Women's Health Network for the Caribbean and Latin America), the World Health Organization (WHO), and universities in a number of countries, during a regional meeting of gender and HSR experts (1998). In subsequent consultations, HDW, with other PAHO programs, WHO, the Government of Chile, UNIFEM, the United Nations Development Program (UNDP), and ECLAC, organized the first international workshop on including gender indicators in national health accounts (Chile, 2001). Gender equity and HSR was the theme of the 18th Session of the Subcommittee on Women, Health, and Development of the Executive Committee (1999), which recommended that PAHO support, and its Member States include gender equity criteria and the participation of stakeholders in their ongoing health sector reform processes.

Implementing Strategies for Reducing Gender Inequities in Health Sector Reform. To implement and test its gender and health sector reform strategy, the Program is coordinating a three-year project with support from the Ford Foundation and Rockefeller Foundation. The project includes a regional component for developing conceptual and methodological tools, interagency collaboration, and a national component for integrating gender equity in health sector reform in Chile and Peru.

HDW has developed a number of conceptual papers and tools aimed at increasing knowledge and social participation to promote gender equity in health sector reform. The paper "Gender Equity and Health Sector Reform in Latin America and the Caribbean" was developed for the 8th United Nations Regional Conference on Women in Latin America and the Caribbean (ECLAC, 2000, Lima) and has been widely circulated as a leading resource on this issue. These papers and PAHO technical collaboration will contribute to the 2002 World Bank regional seminar "Adapting to Change: Health Sector Reform and Sexual and Reproductive Rights," and to other national and regional training workshops on this issue.

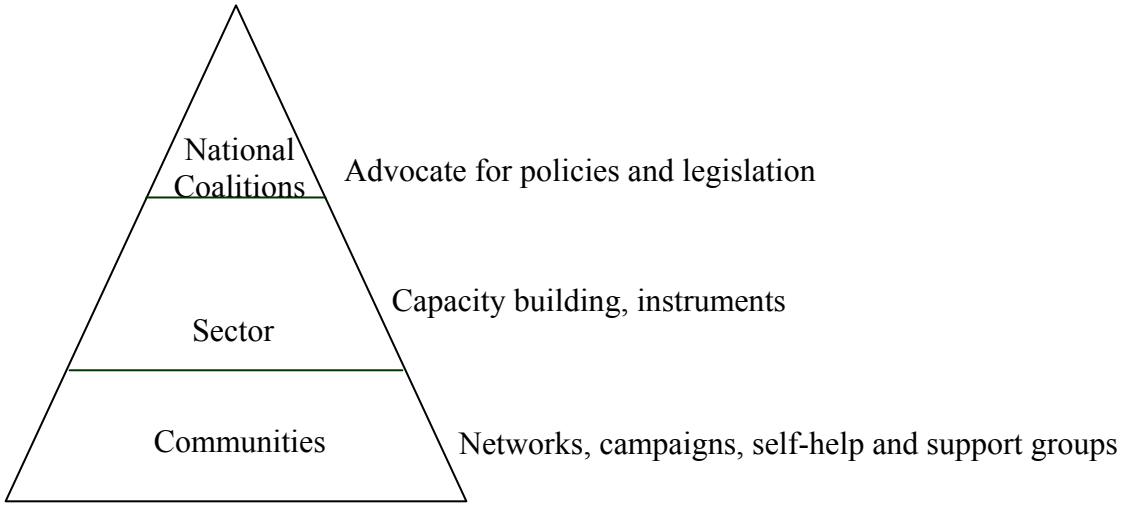
HDW developed the "Indicator Guide for Analyzing and Monitoring Gender Equity in Health," and "A Guide for Evaluating Gender Equity in Health Sector Reform," and incorporated gender indicators in PAHO/United States Agency for International Development (USAID) instruments for evaluating HSR performance monitoring. Over the next two years, these tools will be tested and subsequently disseminated throughout the Region.

The national component of the project on gender equity and health sector reform implemented in Chile (2001) and Peru (2002) will provide lessons learned for other countries. As part of the newly negotiated three-year project for Central America, supported by the Governments of Norway and Sweden, the strategy will be applied in El Salvador (2003), Guatemala, Honduras, and Nicaragua.

In Chile, the project facilitated stakeholder participation at the national and provincial levels to debate newly formulated HSR policies. A PAHO project team was instrumental in supporting the Gender Advisory Committee convened by the Minister of Health to assure that gender is considered throughout the reform process. This committee developed a strategy paper that the Minister of Health presented to the National Health Sector Reform Commission, and that under her leadership was debated with civil society participation at the central level and in two provinces. On all occasions, the project team provided training to involve organizations as stakeholders in the health sector reform debate, which included the Minister of Health, the Minister of Women's Affairs (SERNAM), and legislators.

5.1.3 *Developing and Implementing Models That Address Gender Inequities in Health in an Integrated Manner*

Since the early 1990s, HDW, in partnership with health and other sectors, has worked at the regional and national political levels, and at the community level, to advocate, strengthen capacity, and involve communities in formulating better health policies and in improving prevention of gender-based violence (GBV) and care of those affected by it. As a result, HDW and its multiple counterparts have developed an Integrated Model for Addressing Gender Inequities.



Addressing Gender-based Violence. Since 1995, HDW has implemented this model to address GBV in 10 countries (7 Central American countries and Bolivia, Ecuador, and Peru) with support from the Governments of the Netherlands, Norway, and Sweden. The model is globally recognized as a method for addressing GBV; has been adapted by the Inter-American Development Bank in six other countries; and is promoted by WHO in other Regions.

A recent evaluation highlights the successes of the model in Central America, especially at the policy and community levels, while summarizing the lessons learned for the challenges ahead. The evaluation included an extensive review of documentation, interviews, and focus groups with over 300 policy-makers, service providers, and women clients. Its results have been presented to stakeholders of projects and of other countries to improve responses to GBV. The lessons learned will provide the basis for a PAHO centennial publication on the Integrated Model for Addressing GBV. The project resulted in the following achievements.

Highlights at the Regional Level

- *The Symposium 2001: Gender Violence, Health, and Rights in the Americas* was organized with five United Nations agencies and two NGO partners. Its "Call to Action" mobilized health and other sectors to strengthen policies and capacity to detect, prevent, and attend to women and families affected by GBV.
- Cooperation between five Caribbean and three Central American countries was facilitated with the goal of exchanging experiences and adapting the integrated model in five Caribbean countries.
- Technical exchange projects among six countries were promoted, which resulted in the production of improved training materials and curricula, an increased number of support groups facilitated by community women, and standardized reporting forms.
- Gender violence prevention was included in regional and subregional policy fora: the Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), Latin American Parliament (PARLATINO), First Ladies meetings, and regional summits.

Highlights from the National Policy Level

- Multisectorial coalitions were established in 10 countries resulting in legislation passed in 10 countries, monitoring bodies in six Central American countries; and the incorporation of the GBV Model in health sector reform processes of five countries.
- Studies were published to inform and influence policy-makers, and to improve services: Results of the "The Critical Path of Women Affected by Intrafamily Violence in Latin America" study of 10 countries; in Bolivia a prevalence study on gender-based violence and the role of men; and a knowledge, attitudes, and practices study in Peru.
- Tools (norms and protocols in 10 countries, surveillance systems in five countries, and training modules in 10 countries) were developed and implemented; and more than 15,000 representatives from health and other sectors each year were trained in their use.
- GBV prevention campaigns were carried out in 10 countries to promote non-violent lifestyles.
- The study of violence was included in primary school curricula in Belize and Peru, and in college curricula of health providers in three countries.

Highlights from the Community Level

- 100 community networks were formed that support, refer, and care for women and families living in violent situations; members include the health, education, and judicial sectors, police, churches, community leaders, and women's organizations.
- Community support groups were trained and functioning in eight countries, support groups of women and men operating in five countries.

Involving Men in Reproductive Health Programs. In Central America, with support from the Government of Germany, HDW and the Program on Family Health and Population (HPF) are developing models for involving men in reproductive health. The

project was launched in 2001 in El Salvador, Guatemala, Honduras, and Nicaragua, starting with participative studies of men's knowledge, attitudes, and practices regarding their own and their families' reproductive health. Based on the results, HDW and HPF will coordinate with the ministries of health, men's groups, and other partners to develop the models in health and recreation or sports center.

5.1.4 *Reaching Out with Information, Education, and Communication Strategies and Materials for Advocacy and Training*

One of the key objectives of HDW is to provide current information, training and education materials to its network of focal points, counterparts, stakeholders, health and gender professionals, and advocates throughout the Region.

Providing Access to Information for Advocacy and Training via the PAHO Website. Through its new interactive GENSALUD website (http://www.paho.org/genderandhealth), HDW makes available its publications, a database of gender and health courses and training experts, monthly fact sheets, and advocacy packets. The GENSALUD list server (gensalud@paho.org) currently provides more than 500 subscribers with information on websites, publications, conferences, and other relevant information, as well as the monthly fact sheets.

Establishing a Virtual Information Center on Women, Gender, Health, and Development. The GENSALUD Virtual Library is in the process of being transformed into a regional virtual information center on women, gender, health, and development, as part of the Virtual Health Library of PAHO/BIREME. The current system provides access to a bibliographic database (http://www.metabase.net/miembros/vermiembros.phtm/GENSALUD-OPS).

Providing Access to Virtual Curricula in Gender and Health. During the next biennium, HDW will work with the PAHO Program on Human Resources Development and other United Nations agencies to develop a prototype virtual curriculum on health and gender for the Virtual Health Campus. This curriculum will be made available to gender and health training institutions and universities throughout the Region. Its first modules will be on GBV and reproductive health.

5.1.5 *Integrating Gender in PAHO and Member State Policies and Programs*

HDW collaborates with most PAHO divisions in meeting its mandate to incorporate gender equity in all PAHO technical collaboration, activities, and policies. It developed a "Training Manual on Gender and Health," which is widely used throughout

the Region. Within the next biennium, the Program will coordinate interprogrammatic participation in the adaptation and implementation of the recently approved (March 2002) WHO gender policy.

Within the last two years, HDW has advocated for sex-disaggregated indicators to be included in PAHO's Core Data Base, managed by the Special Program for Health Analysis (SHA), and has incorporated gender indicators within PAHO health sector reform monitoring tools (Division of Health Systems and Services Development), as well as in violence surveillance systems (Division of Noncommunicable Diseases). With the Division of Health and Environment, the Program has integrated gender in the training, activities, and policies of a Central America project, PLAGSALUD, and in the development of health standards for workers in export industries. HDW is collaborating with the Mental Health Program to strengthen community approaches to gender equity and mental health.

During the next biennium, HDW will work with the Division of Disease Prevention and Control to strengthen its outreach with women's groups, in order to empower women to promote healthy behavior to prevent HIV/AIDS and chronic diseases, such as cervical cancer.

6. Conclusion

The commemoration of PAHO's Centennial provides an excellent opportunity for HDW, PAHO, and its Member States to renew their commitment to bridge the gender equity gap in the Americas. PAHO's Women, Health, and Development Program commits to this goal by improving information in order to target and monitor policies and programs aimed at reducing these inequities; to develop and strengthen models and integrated approaches; providing information for advocacy and training; and to integrate gender in PAHO programs.

7. Action by the Pan American Sanitary Conference

The Pan American Sanitary Conference is invited to consider the annexed resolution CE130.R14 recommended by the Executive Committee.

Annex

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

130th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 24-28 June 2002

Annex

RESOLUTION

CE130.R14

WOMEN, HEALTH, AND DEVELOPMENT

THE 130th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director on women, health, and development (Document CE130/18),

RESOLVES:

To recommend to the Pan American Sanitary Conference the adoption of a resolution along the following lines:

THE 26th PAN AMERICAN SANITARY CONFERENCE,

Having considered the report of the Director on women, health, and development (Document CSP26/16);

Taking into account the inadequacies of current information and surveillance systems for documenting the health situation and trends in women's health and the existing gender inequities in health;

Being aware that policies for reducing gender inequities require information for their formulation and evaluation; and

Bearing in mind the ongoing initiatives of other agencies of the United Nations system,

***RESOLVES*:**

1. To urge Member States to:

(a) assign a high priority to establishing and financing information systems on gender differences in health and development; and to the collection, processing, and presentation of health information disaggregated by sex;

(b) promote the participation of users and producers, from both government and civil society, in gender and health issues.

2. To request the Director to:

(a) stimulate and support the production, dissemination, and analysis of data disaggregated by sex;

(b) support the periodic production of statistical bulletins and health profiles on gender, health, and development;

(c) stimulate and support technical cooperation among countries in the development, analysis, and use of information on gender and health;

(d) continue efforts to integrate gender into the work of the Organization, in particular in the strategic planning process and its follow-up.