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### WOMEN, HEALTH, AND DEVELOPMENT

This report presents the mandate, challenges, strategic areas, and accomplishments of the Program on Women, Health, and Development (HDW) of the Pan American Health Organization (PAHO). HDW's main goal is to reduce those health inequalities between men and women that are unnecessary, avoidable, and unfair. It also provides a brief overview of how gender inequities affect the health status, care, and access of women, as compared to men. The report also identifies actions for HDW, PAHO, and Member States to achieve this goal.

The central mandate of HDW is to mainstream gender within the programs and policies of PAHO, PAHO/WHO country representations, and Member States, in order to reduce gender inequities in health within the context of PAHO principles of equity and Pan Americanism.

HWD has identified five strategic areas to address these inequities most effectively:

- (1) Incorporate a gender perspective in health situation analysis to better target policies and programs;
- (2) Formulate and monitor policies to reduce gender inequities in health;
- (3) 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;
- (4) Reach out with information, education, and communication strategies and materials for advocacy and training, especially via "virtual channels"; and
- (5) Collaborate with PAHO programs and Member States to incorporate a gender equity perspective in research, policies, and programs.

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 health in the Americas.

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## **Bridging the Gender Gap in Health in the Americas**

This report presents the challenges, strategic areas, and accomplishments of the Program on Women, Health, and Development (HDW) of the Pan American Health Organization (PAHO). The first three sections of the report provide a brief conceptual overview of the nature of gender inequities in health, and describe the challenges and opportunities met by the Program in responding to the institutional mandate of reducing these inequities. The final two sections outline HDW strategies and accomplishments in closing the gender gap in health, and identify needed actions from HDW, PAHO, and Member States to achieve this goal.

### **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 meaning 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. Equity implies that need rather than social advantage is considered in decisions about resource allocation.<sup>1</sup> Not all inequalities are inequities. Inequities are those inequalities considered unnecessary, avoidable and unfair.<sup>2</sup> Thus, gender equity in health does not signify that men and women experience the same rates of mortality and morbidity, or share equally in the distribution of services. Rather, it calls for equal opportunity to enjoy health and 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. Furthermore, it implies that health services are received according to this differential need, irrespective of the ability to pay, and that payment for health services is made according to economic ability.

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<sup>1</sup> 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.

<sup>2</sup> 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. The Challenge: Assessing and Bridging Gender Gaps in Health

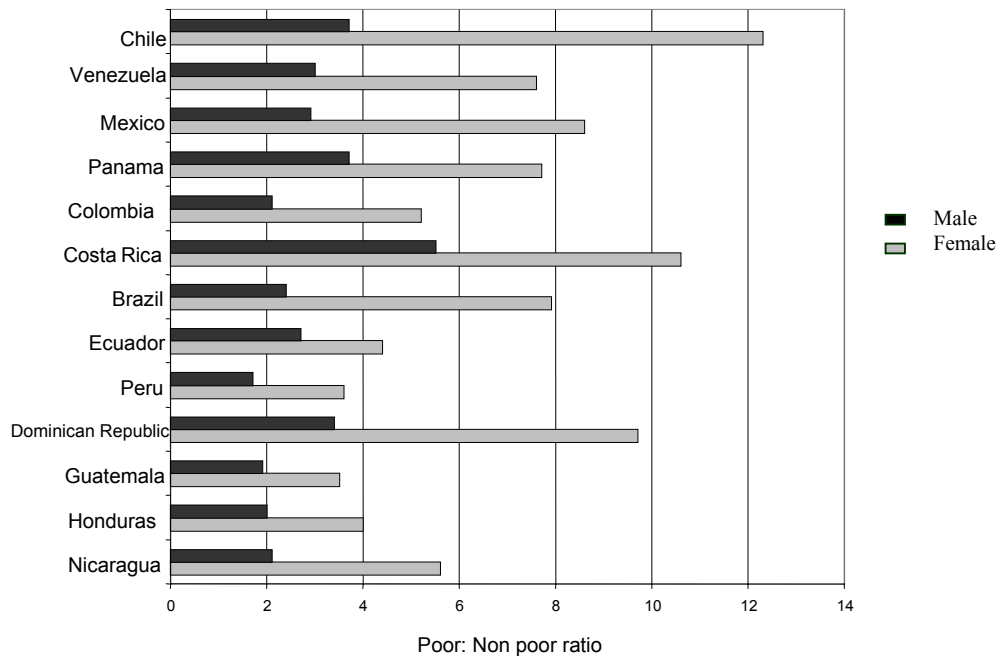
### 2.1 The Impact of Gender Inequities on Health

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.

#### 2.1.1 Gender Inequities Affect Health Status

Women outlive men in most countries of the world. Poverty, however, has a negative effect on women's propensity to outlive men (Figure 1).

**Figure 1. Poor: Non-poor Ratio for the Probability of Dying (per 1,000) among Women and Men between the Ages of 15 and 59 in 13 Latin American and Caribbean Countries**



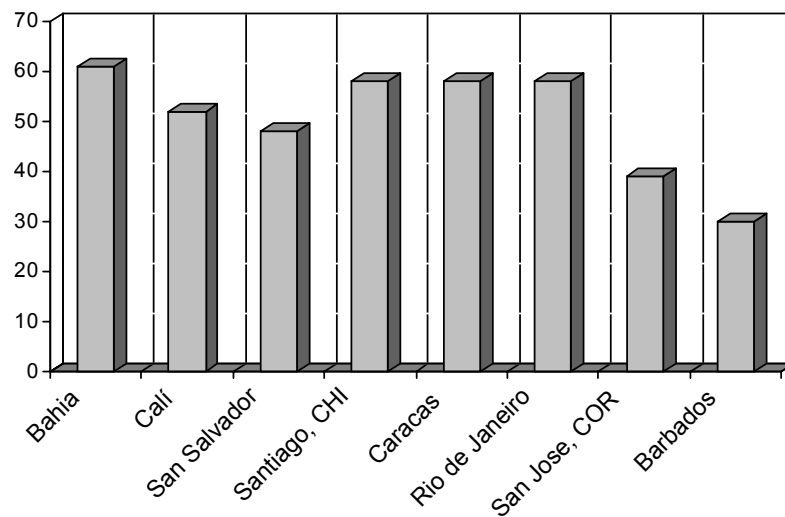
Adapted from World Health Organization, World Health Report 1999, Statistical Annex

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: accidents, violence, lung cancer, substance abuse, and HIV/AIDS.

The most disturbing manifestation of gender inequity is gender-based violence (GBV), which affects between 33% and 60% of women throughout the Region, and is caused primarily by their intimate partners (Figure 2).

**Figure 2: Percentage of women who have experienced violent acts by their partners in 1990's - eight cities of Latin American and Caribbean Countries**

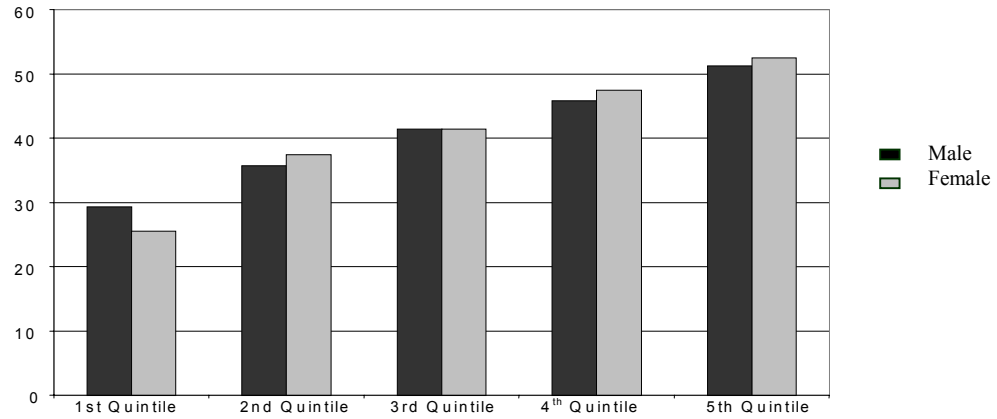


Source: Adapted from Lori Heise. Coercion and Abuse: "Implications for Health Programs." (Nov. 2001)

### 2.1.2 Gender Inequities Affect Access to Health Care

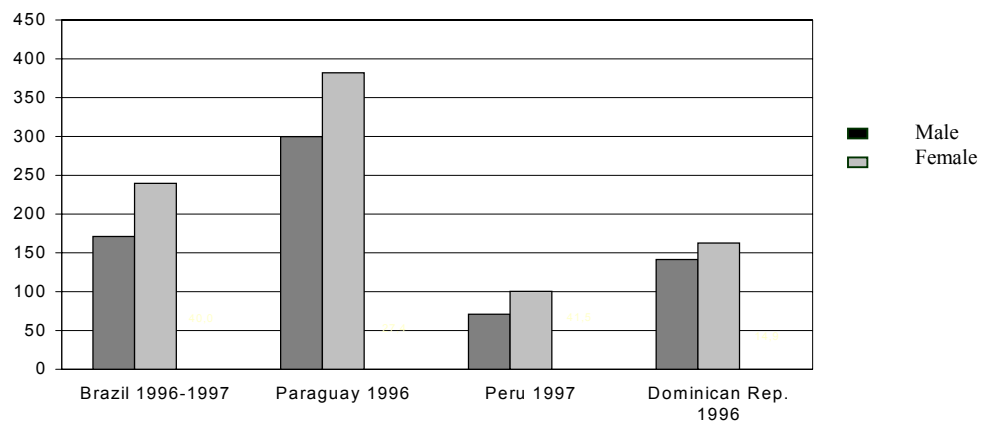
Overall, women tend to use health services more often than men, due to greater need related to their reproductive role, their more frequent illness, and their longer life expectancy. However, as Figure 3 indicates, when need is taken into account, poor women do not always use health services more often 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 than men out of pocket in order to maintain their health (Figure 4).

**Figure 3. 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 4. 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 survey for DR.

### *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 prestige. 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 generation and dissemination 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.<sup>3</sup> 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.

The mandates on disaggregation by sex in the collection, processing, and publication of data are either not a priority or simply do not exist and, even if they did, would be insufficient in themselves to stimulate the introduction of a gender perspective into statistical work. In order for this type of mandate to be effective, it must be accompanied by concrete work proposals, as well as technical and financial resources to begin their implementation.

Beyond epidemiological data on health and its determinants (including health care), improved data collection is required on the full contribution of women and men to health development, including their participation in health work that is outside national accounts, e.g., household care for the sick, the disabled, and the elderly. This must be carried out with a view to recognizing the economic contribution of women to health care, and to making visible the unequal distribution of remunerated and unremunerated work between women and men.<sup>4</sup>

## **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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<sup>3</sup> Fourth World Conference on Women Platform for Action (Annex).

<sup>4</sup> Fourth World Conference on Women (Beijing, 1995).

- The commitments made by Member States in United Nations conferences during the last decade. Among these forums, the most critical for HDW mandate have been: 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 a critical advocate for the protection of health as a human right, the recognition of women's reproductive health rights as human rights, and the need for social transformations based on principles of solidarity and social justice.
- The relatively recent recognition of violence against women as a public health issue requiring a coordinated multisectoral response. The women's movement and the international conferences mentioned above 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 policymakers. 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 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 (19<sup>th</sup> 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 (19<sup>th</sup> 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 (Beijing, Cairo, and Belém do Pará );
- Ensure that gender is an explicit component of PAHO's mental health framework (19<sup>th</sup> Session of the Subcommittee on Women, Health, and Development of the Executive Committee); that mental health services are integrated into primary health care systems; and that primary health care workers are trained to recognize and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse, or other abuse resulting from armed or non-armed conflict (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 (18<sup>th</sup> 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 22<sup>nd</sup> Pan American Sanitary Conference, and CD32.R9, CD33.R.6, and CD34.R5 of the 32<sup>nd</sup>, 33<sup>rd</sup>, and 34<sup>th</sup> 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 those inequalities in health status between men and women that are unnecessary, avoidable and unfair; 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.

### 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 (HSR) 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. The Program also plans to develop a biannual statistical pamphlet and a comprehensive publication on the regional situation of gender equity and health.

*Improving Health and Gender Situation Analysis.* Improving gender and health situation analysis was the theme of the 19<sup>th</sup> 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. Within the next biennium, 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, and as well as expand the training of Central American teams.

HDW promotes the monitoring of gender equity in health in the Region and 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 develops and applies indicators for monitoring United Nations compliance to the Beijing and Cairo conventions. PAHO, UNIFEM, and ECLAC held a regional meeting in Bolivia to define GBV indicators. The Program sponsored participants from 7 countries that have been implementing GBV surveillance systems, as part of PAHO's intra-family violence projects in 10 countries.

HDW has developed health and gender indicators and analysis tools that will be tested in Chile and Peru. In 2002-2003, HDW will make these tools available to

counterparts in all countries in the Region and will provide direct technical cooperation to carry out a gender and health situation analysis in five countries.

*Promoting Research for Informing Policymakers.* HDW facilitates the relationship with researchers and policymakers 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 HSR 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 HSR 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 18<sup>th</sup> 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 HSR processes.

*Implementing Strategies for Reducing Gender Inequities in Health Sector Reform.* To implement and test its gender and HSR 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 HSR 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 HSR. The paper “Gender Equity and Health Sector Reform in Latin America and the Caribbean” was developed for the 8<sup>th</sup> 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: HSR 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 HSR,” 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.

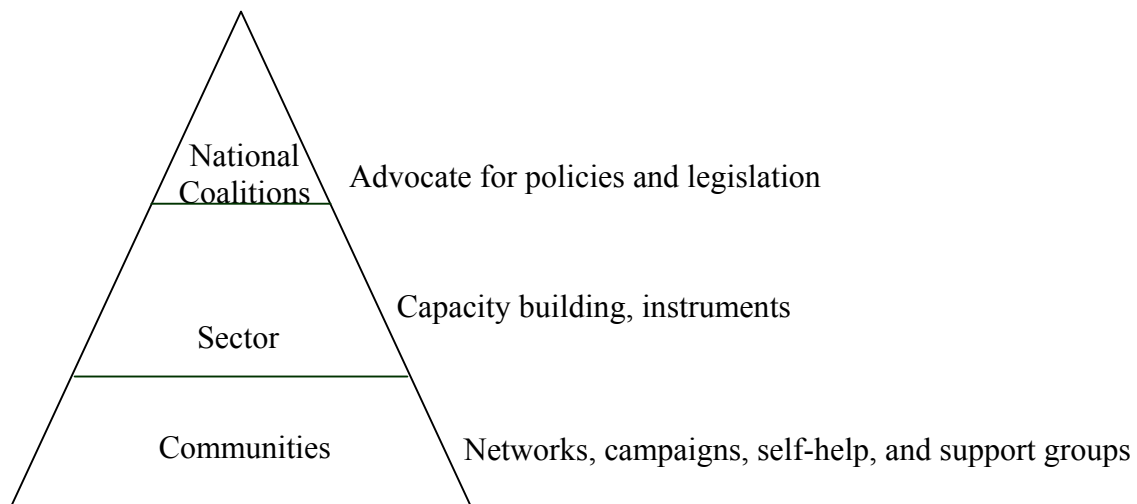
The national component of the project on gender equity and HSR implemented in Chile (2001) and Peru (2002) will provide lessons learned for other countries. As part of the newly negotiated three-year project for Central America, supported by the Governments of Norway and Sweden, the methodological tools 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 HSR 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 HSR 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 and care of GBV. As a result, HDW and its multiple counterparts have developed an Integrated Model for Addressing Gender Inequities.



This model is being implemented to address GBV and to involve men in reproductive health programs. Its use in the area of mental health is included in the 2002–2003 plan mentioned above.

*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; it has been adapted by the Inter-American Development Bank in six other countries; and is promoted by WHO in other Regions.

In the 10 project countries, the GBV model has resulted in over 100 intersectoral community networks that support, refer, and care for women and families living in violent situations, and that mount education and media campaigns on prevention. Counterparts have developed and implemented training modules, procedures, and surveillance systems for health providers in all these countries. They have strengthened national coalitions that advocate better laws and the institutionalization of project achievements. At the regional level, the Program has worked with United Nations agencies to implement international and regional conventions to mobilize the health sector to address GBV.

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 policymakers, service providers, and women clients. Its results have been presented to stakeholders of project 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.

***Achievements at the Regional Level***

- Organized *Symposium 2001: Gender Violence, Health, and Rights in the Americas* with the United Nations Population Fund (UNFPA), UNIFEM, the United Nations Children’s Fund (UNICEF), UNDP, Inter-American Commission of Women of the Organization of American States (CIM/OAS), and the Canadian International Development Agency (CIDA)/Center for Research on Women’s Health. The Symposium’s “Call to Action” aims to mobilize the health and other sectors to strengthen policies and capacity to detect and prevent violence and provide care and support to women and families living with violence.
- Facilitated exchange between Caribbean and Central American countries with the goal of implementing the integrated model in five Caribbean countries.
- Promoted technical exchange projects among six countries on topics ranging from policy promotion to training of health providers, and the establishment of networks and support groups.
- Included gender violence prevention in such regional and subregional policy forums as the Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD), Latin American Parliament (PARLATINO), First Ladies meetings, and regional summits.



### *Achievements at the National Policy Level*

- Multisectorial coalitions were established in 10 countries.
- Legislation was passed in 10 countries and monitoring bodies set up in 6 Central American countries.
- Research results of “The Critical Route that Women Affected by Intrafamily Violence in Latin America Take” in 10 countries were published, including a prevalence study on violence affecting women and on the role of men in promoting violence in Bolivia; and a knowledge, attitudes, and practice study in Peru.
- Tools (norms and protocols in 10 countries, surveillance systems in 5 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.
- GBV prevention campaigns were carried out in 10 countries.
- The Integrated GBV Model in health sector reform processes was incorporated in five countries.
- Study of violence was included in primary school curricula in Belize and Peru, and in college curricula in three countries.

### *Achievements at the Community Level*

- 100 community networks formed comprising health, education, and judicial sectors, police, churches, community leaders, and women’s organizations.
- Community support groups trained and functioning in eight countries.
- Support groups formed for men and women in five countries.

*Involving Men in Reproductive Health Programs.* In seven Central American countries, in collaboration with the Division of Health Promotion and Protection, and with support from the Government of Germany, HDW is developing models for involving men in reproductive health. The project, which was launched in four countries (El Salvador, Guatemala, Honduras, and Nicaragua,) in 2001, consists of participative

studies of men's knowledge, attitudes, and practices regarding their own and their families' reproductive health. Based on the results, HDW and the PAHO Program on Family Health and Population will coordinate with the ministries of health, men's groups, and other partners to develop male involvement models in health centers in seven countries and a recreation or sports center in the four study countries.

*Addressing Gender Equity and Mental Health.* The *World Health Report 2001 - Mental Health: New Understanding, New Hope* identifies depression as a priority health problem and indicates a higher prevalence of depressive disorders among women (reviewed studies show women/men ratios between 15:1 and 2:1), while substance abuse and anti-social personality disorders are more common among men.

Through its Integrated Model for Addressing GBV, the Program is already examining mental health problems, especially through community-based self-help groups. During a recent meeting of representatives and coordinators of support groups in Central America, participants agreed on the value of such groups, although they recognized that a lack of funding and strategies prevented them from establishing these groups in the most effective manner.

In 2001, HDW focal points participated in a planning meeting of the PAHO Mental Health Program and in activities in Central America, especially in disaster areas. They met with the Program Coordinator on Mental Health to promote the use of community approaches and the integrated model in addressing mental health and gender within their countries and in Central America. This collaboration will be consolidated in 2002 through a project designed to strengthen community approaches to gender equity and mental health.

#### 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, a training database, and virtual communication channels 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.* HDW will disseminate a number of its publications in hard copy and through its new interactive GENSALUD website [www.paho.org/genderandhealth](http://www.paho.org/genderandhealth). The website also includes an interactive database of gender and health courses and training experts, monthly fact sheets on health and gender issues, and advocacy packets that include a fact sheet, an issue paper, and a Power Point presentation. To date, HDW has developed an advocacy packet on trafficking of women, with the Inter-American Commission on Women of the Organization of American States; and advocacy packets on HIV/AIDS and

GBV are being developed. HDW's GENSALUD list server ([gensalud@paho.org](mailto:gensalud@paho.org)) currently provides more than 400 subscribers with information on websites, publications, conferences, and other relevant information, as well as 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. Currently the Information System on Women, Health, and Development (SIMUS) provides requested information and access to an annotated 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. HDW 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 sex-disaggregated indicators to be included in PAHO's Core Data Base, managed by the Health Analysis Program (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). It has integrated gender in the training, activities, and policies of the project Occupational and Environmental Aspects of Exposure to Pesticides in the Central American Isthmus [PLAGSALUD (Division of Health and Environment)]; and is collaborating with this Division on a participative project to develop health standards for workers in export industries.

During the next biennium, the priority of HDW is to collaborate with the Division of Disease Prevention and Control to strengthen its outreach with women's groups. PAHO aims to partner with these groups to empower women, especially those at risk, to protect themselves from these risks, and 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. The Program commits to collaborate with PAHO colleagues and country counterparts to improve information, in order to target and monitor policies and programs aimed at reducing these inequities; to develop and strengthen models and integrated approaches; to provide information for advocacy and training; and to integrate gender in PAHO programs.

## **7. Action by the Executive Committee**

Based on the information presented, the Executive Committee is requested to:

- Consider the strategies presented, regarding what PAHO together with the countries can do to ensure that gender equity is successfully incorporated in the policies and programs of PAHO and Member States.
- Recommend actions that PAHO and its Member States can take to ensure the broadest and fastest promotion and implementation of the recommendations for bridging the gender equity gap in health.
- Suggest to PAHO and its member countries to disaggregate health data by sex, apply a gender analysis, and widely disseminate this information to stakeholders to involve them in the formulation and monitoring of health policies.