Gender Mainstreaming in Health: Advances and Challenges in the Region of the Americas
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Acknowledgments

This document was prepared by Eugenia Tarzibachi, Doctor of Social Sciences and Licensed Psychologist specialized in gender studies and health. Technical coordination of the document was overseen by Lilia Jara and Catharina Cuellar under the general direction of Anna Coates. Their valuable contributions toward consolidating the document are greatly appreciated, as is the generous collaboration of the experts on gender and health who were interviewed. Also, this document was made possible by the kind financial contribution of the Government of Canada through its Department of Global Affairs.
List of Abbreviations

ECLAC  Economic Commission for Latin America and the Caribbean
ECOSOC  United Nations Economic and Social Council
GAD  gender and development
GBV  gender-based violence
GE  gender equality
GEH  gender equality in health
GEP  Gender Equality Policy (PAHO)
GM  gender mainstreaming
GMH  gender mainstreaming in health
HIV  human immunodeficiency virus
IPV  intimate partner violence
LGBT  lesbian, gay, bisexual, and transgender
MDGs  Millennium Development Goals
MM  maternal mortality
PAHO  Pan American Health Organization
SDGs  Sustainable Development Goals
SRH  sexual and reproductive health
STIs  sexually transmitted infections
WHO  World Health Organization
This document is a progress report on gender mainstreaming (GM) in the health sector in the Region of the Americas. It is based on a review of results documented by PAHO and in scientific publications and consultations with experts in the field of gender and health. Based on this evidence, it draws conclusions on the state of progress and identifies challenges that stand in the way of more rapid progress toward gender equality in health throughout the Region.

Chapter 1 summarizes the global and regional mandates that enshrine the commitments made by Member States to advance gender equality in health. Chapter 2 is a review of Member States’ progress in integrating gender perspectives into their health policies and programs, with emphasis on the results of institutional gender mainstreaming in health. Chapter 3 presents conclusions, discusses the persisting challenges, and identifies opportunities for accelerating progress toward the attainment of gender equality in health in the Region of the Americas.

One of the main findings of this report was that results-based programs are needed in order to implement the GM strategy to promote gender equality in conjunction with the strategy for the empowerment of women. This should be done within a framework that incorporates basic institutional processes for gender mainstreaming (“institutional GM”). Achieving this goal requires proactive, attentive, and expert effort; human and financial resources; and sustained political will over time. The present document makes use of the basic components of institutional GM identified by the United Nations Economic and Social Council (ECOSOC, 1997):

1. Adoption of GM policies
2. Allocation of budgetary funds for GM
3. Capacity-building in GM
4. Data disaggregated at least by sex and age
5. Integration of gender analysis throughout the programming process
6. Monitoring and evaluation
7. Accountability

One more institutional requirement not mentioned above is the need for “do no harm” principles, with strategies in place to mitigate any damages that might occur in light of policies or programs aimed at transforming gender-based inequalities. Gender relationships reflect relationships of
power and conflict arises when the order that regulates them is changed. No documentation was found regarding this requirement.

A review of the remaining basic requirements for institutional GM defined by the United Nations showed that the most progress has been made in establishing national gender equality plans, particularly in health. Increasingly, these plans have adopted an intercultural approach and an intersectional perspective toward overcoming gender inequality. However, gender-related policies still predominantly address sexual and reproductive health. This is also one of the most prevalent topics addressed by the health sector, mainly within the framework of operational or targeted GM. To date, the health sector has mostly concentrated its policies in three gender-related topics: sexual and reproductive health, violence against women, and HIV/AIDS. However, other important issues on the gender and health agenda that need to be more fully developed are gradually gaining traction. These include men’s health and masculinities, health of LGBT people, gender-related substance use disorders, and gender and mental health, among others.

Despite progress in the adoption of explicit policies on gender equality, the evidence shows that policy alone does not guarantee consistent and effective implementation around the world. The latter goal requires political will and sustained commitment at the highest decision-making levels of the state. Changes in government administration tend to affect the continuity of policies; this still represents an ongoing challenge in Latin America and the Caribbean. The driving force behind the development of policies tends to be the will of individuals who have fought for the few advances that have been made in GM in health (GMH), while implementation is typically up to institutional mechanisms for the advancement of women (as defined by UN Women) scattered across different sectors of government with differing responsibilities (and budget allocations) for meeting the objectives. This systematic review and analysis also found other shortcomings; it is imperative to transform the current policies of individual governments into broader public policies on gender in health, and to follow through on the substantive development of the rest of the institutional requirements for GM. So far, both human and financial resources for GM in health have been
limited. It has been noted that funds for the promotion of gender equality in health tend to rely on grants or non-regular budget sources and that they are insufficient to sustain the progress achieved so far. Furthermore, no policies or programs emphasizing gender-neutral approaches nor allocations for this purpose in public budgets were found. For policies on gender equality to be effective, they require adequate public, financial, and human resources. The failure to recognize the important contribution of the “care economy” in the debate on health reform has also been found to be a critical shortcoming. And finally, with regard to human capital in health, specific studies have cited the feminization of health human resources and the existence of deep gender gaps in the health work performed in countries of the Region.

The dearth of GM capacity in the health sector was evidenced by increased requests from countries of the Region for technical support in the area of gender and health, as well as in emerging priorities such as those outlined by the Pan American Health Organization (LGTB and masculinities, specific mechanisms for integration of the gender perspective in data analysis, monitoring and evaluation, and strategies for policy impact).

Regarding gender analysis in health, the literature reviewed did not show any reference in Latin America and the Caribbean to institutionalized gender analysis in health using any of the globally recognized models. However, Canada has institutionalized a noteworthy model known as GBA+.

Disaggregation of data by sex and other variables of the social determinants is an aspect that needs to be prioritized and emphasized consistently, as sex disaggregation alone is insufficient to analyze gender-based inequalities in health. It is crucial to improve information systems in the countries of the Region, ensure their comparability, and expand the disaggregation of data to other variables besides sex and age. There was a notable absence of documentation on the monitoring and evaluation of policies on GMH. Monitoring and evaluation (M&E), coupled with systematized action using a results-based approach, emerged as clear priorities. The importance of using more than just quantitative indicators for gender analysis and M&E was also emphasized, because gender
relations and their impact on health and well-being are best captured through qualitative information.

As a fundamental requirement for institutional GM, clear and factual accountability mechanisms need to be institutionalized, together with a strong integration of civil society organizations committed to gender equality. The systematic review revealed the need to strengthen the participation of civil society organizations (women’s social movements and, more broadly, the various groups that advocate for equity in health) in the development of policies on gender equality; this includes collaboration in the financing of policies and requires social participation in every step of the program cycle, from policy design to monitoring.

Other key findings of this document are the need to distinguish between sex and gender, and to clearly define the gender perspective adopted; a more sophisticated and nuanced approach to understand gender-based inequalities in health, which will require either drafting new plans or amending existing ones so that they focus on achieving equality while maintaining and respecting diversity; and engaging men in the reconfiguration of hegemonic masculinity through policies aimed at transforming gender-based inequalities in health.

Finally, the report identifies the following structural aspects as requiring a strategic response to meet the goals and targets for gender equality in health set out in the 2030 Agenda for Sustainable Development: (1) challenges posed by neoconservative politics that obstruct measures aimed at greater autonomy for women; (2) demographic trends toward an aging population and an increase in the fertility of adolescent girls; (3) differential effects of climate change on men and women, especially in the Caribbean; and (4) purely structural challenges that need to be addressed so that the Strategy for Universal Access to Health and Universal Health Coverage (universal health) does not produce gender inequities.
A. Objective of the Document

In September 2015, the United Nations General Assembly approved the 2030 Agenda for Sustainable Development with its 17 goals. The Sustainable Development Goals (SDGs) provide a new roadmap toward social, economic, and environmental sustainability aimed at building more inclusive and just societies. These goals, and the targets associated with each of them (which are considered to be integral and indivisible), constitute a tool for planning and monitoring at national and local levels, for the development of public policies, the allocation of budgetary funds, and monitoring and evaluation (ECLAC, 2017a).

The 2030 Agenda gives priority to building sustainable and universal health and to mounting a strong response against gender inequities in health, in particular, through Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce inequality within and among countries); and Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), which call on countries to work toward achieving the Agenda’s synergistic goals.

The linkage between the SDGs and the PAHO Strategy for Universal Access to Health and Universal Health Coverage (PAHO, Resolution CD53.R14, 2014) provides an opportunity to step up progress toward achieving gender equity in health (GEH) in the Member States, within the framework of the PAHO Gender Equality Policy. The aim of this policy is to concretize the right to health. Nearly two decades ago, the United Nations Economic and Social Council recognized the strategy of gender mainstreaming internationally as a means of achieving gender equality in policies and programs (ECOSOC, 1997).
Despite the progress made in GMH in the Region of the Americas, profound gender-based inequalities continue to exist and stand in the way of achieving the full status and development of the biological, psychological, and social well-being of women and men, especially those who are most vulnerable. As part of the commitment to the SDGs by 2030, and in the framework of the Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (PAHO, CD54/INF/2, 2015), it is imperative to develop both a strategic vision and a strategic approach to achieving gender equality in health.

PAHO has been a pioneer in addressing gender equality in its multifaceted aspects that relate to health and it intends to continue supporting the development agendas of the Member States with critical resources that will make it possible to accelerate progress toward guaranteeing the right to health of all people. To fulfill this mission, the Office for Equity, Gender, and Cultural Diversity (EGC) has adopted two main goals: (1) to consolidate a strategic vision regarding GEH in the Region that catalyzes effective responses for accelerating progress toward fulfillment of the 2030 Agenda for Sustainable Development, based on an intersectional perspective and unqualified respect for human rights; and (2) to document the status of GMH in the Americas. The results documented by PAHO, the reports contained in scientific publications on the subject, and the findings of experts in the field of gender and health were reviewed. Based on this evidence, the present document outlines the current state of progress and identifies the challenges that still need to be addressed in order to speed up progress toward achieving institutional gender mainstreaming in the Region.

B. Methodology for Preparing the Document

This document was prepared using a combination of qualitative analysis
and data collection tools. The first step was a systematic review of available evidence on the integration of a gender perspective into health policies and programs aimed at the general population in the 47 countries of the Region of the Americas. The review of the literature was guided by a protocol (Annex 1) defining the search strategy, the search terms used, and the criteria for inclusion and exclusion. The second part of the project was a series of semi-structured interviews with key informants, all of them experts on gender and health. Qualitative content analysis was applied to the findings from the interviews.

C. Structure of the Document

Chapter 1 outlines the global and regional mandates that establish the commitments assumed by the Member States in the area of gender equality in health. Chapter 2 summarizes the state of progress in mainstreaming the gender perspective in the health policies and programs of the Member States, with emphasis on institutional gender mainstreaming in the health sector. Finally, Chapter 3 presents conclusions, identifies the remaining challenges, and proposes opportunities for accelerating progress toward gender equality in health in the Region of the Americas.
1.1. Gender Mainstreaming: Definitions Related to the Strategy for Achieving Gender Equality

Gender equality (GE) has been enshrined as an objective in a number of international mandates that apply to the area of health. These mandates then inform the national commitments made by Member States. The following section studies the history of these commitments and the general founding agreements they lay upon.

The strength of the term gender mainstreaming derives from the implied contrast with its opposite, gender sidestreaming, or specialization in gender issues. Within the framework of the discussions in which this strategy gained international presence in the 1990s, the term mainstreaming emphasized the importance of incorporating gender into core institutional activities rather than leaving it marginalized as the purview of specialist women’s institutions (Charlesworth, 2005:1).

Mainstreaming was introduced into the development agenda in the 1980s, as part of a transition from the perspective of women in development (WID) to that of gender and development (GAD) (Ibid.:2). While the former approach (WID) regarded women as a particular group to be integrated into the existing development structures without questioning the gender biases of said structures, GAD moves beyond that perspective and focuses on the impact of unequal relations between men and women in development policies.

Within the broader context of GAD, the GM strategy called for key changes in the approach to achieving gender equality. One of these was to shift from looking at the quantitative aspects of women’s participation to transforming power relationships, access to resources, and decision-making between men and women.

A key element in the mainstreaming strategy is that there should be a shift from quantitative aspects of participation of women to more transformational aspects—bringing the perceptions of women as well as men to bear on the development process itself, rather than simply trying to integrate women into existing development agendas formulated by others. This required a further shift from focusing on women themselves—their contributions and the
CHAPTER 1. Gender mainstreaming in health: definitions and global and regional normative frameworks

impact of specific interventions on them—to a focus on development interventions, which uncovers the gender biases inherent in them (Hannan, 2000:7).

It was believed that inequalities between men and women would be prevented by changing the development practices. The GAD approach would change not only the material conditions of life for women but also their position in society (their status, prestige, authority, and power) relative to men. In this context, “gender mainstreaming was presented as a mechanism to broaden the concept of development to respond to women’s lives. It soon took on a broader significance beyond the development sphere” (Charlesworth, 2005:3).

The idea of gender mainstreaming was first posited in the Nairobi Forward-looking Strategies for the Advancement of Women adopted by the Third World Conference on Women (Nairobi, 1985), which cites as one of its strategies “the effective participation of women in development should be integrated both in those plans and in the formulation and implementation of mainstream programmes and projects and should not be confined solely to statements of intent within plans or to small-scale, transitory projects relating to women.”

Ten years later, the GM concept had acquired greater public visibility with an impressive presence in the Beijing Declaration and Platform for Action, adopted at the UN’s Fourth World Conference on Women held in 1995. In this document, the integration of a gender perspective into all policies and programs was identified as the mechanism for redressing the unequal position of women (relative to men) in 12 critical areas. One of these areas was health; others included education, armed conflict, the economy, decision-making, human rights, and women as victims of violence.

The concept is reiterated in paragraphs 79, 105, 123, 141, 164, 189, and 229 of the Beijing Declaration and Platform for Action, which also states that “Governments and other social agents should promote an active and visible policy of mainstreaming a gender perspective in all policies and programs, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively.” Beyond merely semantic distinctions, the operational application of the term implied the integration of a gender perspective as a visible and active policy of governments, with emphasis on gender analysis (in the binary male/female sense) of the impacts of all policies and programs in order to guarantee equitable results between the sexes.

More specifically, mainstreaming the gender perspective was defined as the strategy for achieving gender equality by the 1997 United Nations Economic and Social Council Agreed Conclusions (ECOSOC, 1997). These conclusions define

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1 Forward-looking Strategies of implementation for the advancement of women for the period up to the year 2000, and concrete measures to overcome obstacles to the achievement of the goals and objectives of the United Nations Decade for Women: Equality, Development and Peace.
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GM as the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality. (Generic Mandates; ECOSOC 1997)

Here the definition gains strength by becoming more specific. It refers to a strategy (mainstreaming) that is established within a process of assessing its own implications for women and men in all areas, at all levels, in any planned action (including legislation) and in all its phases: design, implementation, monitoring, and evaluation. In addition, Section B of the Agreed Conclusions identifies a series of principles for mainstreaming the gender perspective within the United Nations system, the key points of which are summarized as follows:

1. Gender neutrality should not be assumed. Issues across all areas of activity should be defined in such a manner that gender differences can be diagnosed.
2. Responsibility for translating GM into practice is system-wide and rests at the highest levels. Accountability for outcomes needs to be constantly monitored.
3. GM requires every effort be made to broaden the participation of women at all levels of decision-making.
4. GM must be institutionalized through concrete steps, mechanisms, and processes in all parts of the United Nations system.
5. GM does not replace the need for targeted, women-specific policies and programs or positive legislation, nor does it substitute for gender units or focal points.
6. Clear political will and the allocation of adequate and, if need be, additional human and financial resources for GM from all available funding sources are important for the successful translation of the concept into practice.

Among the specific recommendations from the ECOSOC meeting, it was mentioned that the strategy is designed to be adopted from the apex of the government pyramid down to its smallest capillary units. All areas responsible for programming and financial resource management should be enlisted to give visibility to GM, while those higher up in the institutional hierarchy should be responsible for monitoring it annually.

The main institutional requirements for GM in the policies and programs of each subsidiary government body can be can be summarized as follows:

- **GM policy:** The first step is to make an explicit decision to mainstream gender in the workplace by formulating a GM
policy and specific mainstreaming strategies for each sector, ensuring that all GM actions are tied to institution-wide directives and not optional guidelines.

- **Budgeting:** Assign budget categories specifically to GM.

- **Capacity-building in GM:** Integrate the gender perspective into all training programs; provide ongoing education on the subject for the entire team (including those in the upper hierarchical echelons); provide special training for gender experts to enhance their strengths.

- **Data:** Disaggregate data by sex and age, as well as other variables as the context requires; conduct specific gender-related surveys.

- **Gender analysis:** Integrate gender analysis throughout the entire programming process.

- **Operational documents:** Produce gender-sensitive guidelines and checklists for programming.

- **Monitoring and evaluation:** Establish mechanisms and instruments for monitoring and evaluation, as well as methodologies for assessing the gender impact of actions.

- **Accountability:** Establish pertinent mechanisms.

These institutional requirements underpin and guide the literature review on GM in health in the Region of the Americas presented in the following chapter. The document will often refer to these components as the “basic institutional GM processes” involved in proper development of the strategy.

The ECOSOC Agreed Conclusions also call for hiring gender specialists to advise on adapting the planning and programming processes. It regards the role of gender units/focal points as “critical in translating the mainstreaming mandate into practical reality” and entrusts them with the following responsibilities: (1) development of gender-sensitive policies and program strategies for a sector or area; (2) provision of advice and support to sectoral staff in applying gender considerations in their work; (3) development of tools and methodologies for mainstreaming; (4) collection and dissemination of information and best practices; and (5) monitoring and evaluation of progress in mainstreaming both in policy and programs.

According to Rivandran and Kelkar-Khambete (2008), the GM strategy has two interdependent dimensions: one operational and the other institutional. Operational (or targeted) GM refers to integration of the gender perspective into the content of policies, programs, and projects with a view to producing a positive impact on women by reducing
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Gender mainstreaming in health involves changing organizational structures, behavior patterns, and attitudes to ensure that they do no harm to the general state of health of women and men. This requires the participation of men and women in the definition and implementation of public health priorities. It is a long-term process that takes time, resources, and commitment (WHO, 2011b).

Implementing the GM strategy is a complex undertaking. Besides requiring the appropriate sectoral setting, it involves an exhaustive and systematic process that far surpasses simply declaring integration of the gender perspective into a policy or program. Gender mainstreaming is not just one more add-on to an existing program or project, nor is it about adopting “politically correct” semantics without a clear influence in institutional and programmatic designs and actions. It is the constant consideration of gender inequities within the institutional culture and in all phases of the program cycle (planning, design, implementation, monitoring, and evaluation) as opposed to intermittent interventions based on individual or political whim. At the programmatic level, it means not only thinking in terms of specific groups of women and men, but also ensuring that every action under every program reflects their circumstances in its legal norms, roles, and relationships, and that it ensures their access to resources, power in decision-making, and an understanding of how they will benefit from the program’s actions, since its inception.

In short, application of the GM strategy to promote gender equality, together with the strategy for the empowerment of women, requires results-based programs operating within the framework of the “basic institutional GM processes” defined above. The entire process calls for proactive, thoughtful, and competent effort, together with economic and human resources and sustained political commitment over time.

Recapturing and reemphasizing these definitions, already established within the United Nations system, was the task undertaken in the gender equality policies of WHO (2002) and PAHO (2005), which were derived from these guidelines. Both these policies will be discussed in detail below. In the Beijing Declaration and Platform for Action, the United Nations Member States agreed that: “Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis
is made of the effects on women and men, respectively.” The essence of this statement is repeated in almost all the critical areas. The principles contained in the 1997 ECOSOC Agreed Conclusions also emphasize that GM is a strategy for the achievement of gender equality and that a complementary strategy calls for the adoption of positive measures such as actions aimed specifically at the priorities and needs of women in the form of legislation, development policies, research, and projects or programs in the field.

The definitions in the 1997 ECOSOC resolution involve certain premises that may need to be updated in light of recent advances in academic forums on gender studies and new rights gained in some of the countries, such as the right to choose one’s gender identity. Progress was observed in the conceptualization of gender perspectives and of gender itself (now conjugated in the plural by some feminist movements), which is beginning to go beyond the male-female binary. Further progress could be made by considering concepts such as “biological women” and “biological men” posited by Paul Preciado (2014), and adopting an intersectional perspective that creates space for diverse social identities and the associated sex-based social vulnerabilities. Also, the results of certain gender-specific interventions cannot be overlooked (for example, the limited impact on gender equality when women are empowered but no effort is made to reconfigure hegemonic masculinity).

This systematic review and effort in reemphasizing established definitions makes it possible to understand what needs to be evaluated, what has been achieved to date in the implementation of GM, and how we can be more proactive in promoting effective (not merely declarative) gender equality within the overall framework of human rights.

1.2. GM in Health: Analysis of Other International and Regional Mandates

In 1946, the United Nations made a commitment to gender equality in the area of health under an ECOSOC resolution that created the United Nations Commission on the Status of Women (CSW). The Commission drafted a Declaration on the Elimination of Discrimination against Women, which was adopted by the United Nations General Assembly in November 1967. This was the precursor to the legally binding Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), subsequently ratified by the Member States of the United Nations in 1979.

International attention to gender-based inequality and its negative effects on development and social justice intensified in the 1990s with a series of events coordinated by the United Nations, including: the International Conference on Population and Development (Cairo, 1994), the World Summit for Social
Gender mainstreaming was introduced in some UN documents, such as the United Nations Development (Copenhagen, 1995), and the Fourth World Conference on Women (Beijing, 1995). As noted above, the Beijing Declaration and Platform for Action used the term gender mainstreaming (or gender integration) and, following two ECOSOC recommendations on the subject (in 1996 and 1997), GM was endorsed and institutionalized by all United Nations agencies and programs. As noted earlier, the use of GM to achieve gender equality (and support the strategy of empowering women) was only broadly outlined as a strategy in the ECOSOC recommendation, with the intention that it be implemented according to the needs of each sector, starting with the agencies in the United Nations system. Within the health sector, policies on gender equality were developed first for WHO and later for PAHO, in 2002 and 2005, respectively.

1.2.1. WHO and PAHO Mandates on Gender Equality in Health

We will first address the WHO Gender Policy (WHO, 2002), which mirrors the objectives of the policy prescribed for the United Nations system. Specifically, its language states that “it will be the Organization’s policy to ensure that all research, policies, programs, projects, and initiatives with WHO involvement address gender issues,” with a view to “increasing the coverage, effectiveness, efficiency, and, ultimately, the impact of health interventions for both women and men, while at the same time contributing to achievement of the broader UN goal of social justice.”

Under the WHO Strategy for integrating gender analysis and actions into the work of WHO (WHA60.25, 2007), a series of resources have been developed for integrating the gender perspective into policies and programs. One of these is a clear categorization of approaches for incorporating the gender perspective (or not) into the health program cycle (WHO, 2011b). While this resource has not been widely used, it deserves to be mentioned here (Table 1) because it can serve as an outline for addressing some of the challenges that stand in the way of achieving GEH in the Region, especially for policies at level 5 aimed at transforming gender-based inequalities.
### Table 1. WHO Gender Responsive Assessment Scale (GRAS)

<table>
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<th>LEVELS</th>
<th>CRITERIA</th>
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| **Level 1: Gender-based inequality**        | a. Gender-based inequalities are perpetuated by reinforcing inequitable standards, roles, and relationships.  
| Policies that strengthen gender-based discrimination against women or men | b. More importance is given to men over women (or vice versa).  
|                                             | c. Situations often occur in which men or women enjoy more rights or opportunities than their counterparts.                                                                                       |
| **Level 2: Insensitivity to the gender dimension, or gender blindness** | a. Gender-related standards, roles, and relationships are ignored; opportunities and allocation of resources are unequal for women and men.  
| These health policies assume that the effects of sex and gender are irrelevant, or else they are gender-neutral. They do not intentionally discriminate, but they can reinforce discrimination. | b. The principle of “justice” is often ignored and there is a tendency to treat all alike.  
|                                             | c. Gender-based discrimination is often reinforced, albeit unintentionally.                                                                                                                              |
| **Level 3: Sensitivity to gender issues**   | a. Gender-related standards, roles, and relationships are recognized.  
| Sex and gender are regarded as important variables in a given context. However, these policies do not address the fundamental causes of gender-based inequalities or discrimination, nor are actions identified to modify them. | b. However, inequalities generated by existing standards, roles, or relationships are not addressed.                                                                                                   |
|                                             | c. There is awareness of gender issues, but corrective action is seldom proposed.                                                                                                                         |
| **Level 4: Specificity regarding gender roles** | a. Specific groups of women or men are intentionally targeted and benefited as part of achieving policy or program goals or meeting certain needs.  
| These policies recognize different standards and roles for women and men and specify means for accessing resources and ensuring control thereof. | b. Support is provided for fulfilling the responsibilities attributed to women and men based on gender roles.                                                                                      |
| **Level 5: Gender-based transformation**    | a. Promoting gender equality is usually the main objective, or at least one of the main objectives.  
| The structural causes of gender-based inequality and sources of discrimination are intentionally addressed with a view to improving the health of men and women. | b. The causes of gender-based inequalities are analyzed in the context of other discriminatory factors (age, ethnicity, sexual diversity, etc.).  
|                                             | c. Strategic measures are taken to promote progressive change and transform unequal and detrimental gender-related standards, roles, and relationships.                                                                 |
|                                             | d. Health-related aspects are addressed from a gender and health perspective that goes beyond sexual and reproductive health.                                                                                |

Source: https://apps.who.int/iris/bitstream/handle/10665/44516/9789241501064_eng.pdf
In September 2005, PAHO (Regional Office of the World Health Organization for the Americas) adopted the PAHO Gender Equality Policy (GEP) [CD46.R16 and the GEP itself, CD46/12] in harmony with the WHO Gender Policy. Its goal is “to contribute to the achievement of gender equality in health status and health development through research, policies, and programs which give due attention to gender differences in health and its determinants, and actively promote equality between women and men” (PAHO, 2005:1). Inherent in this policy is a crucial distinction between the concepts of gender equality and gender equity in health, as affirmed by PAHO:

**Gender equity** means fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men. The concept recognizes that women and men have different needs, access to, and control over resources, and that these differences should be addressed in a manner that rectifies the imbalance between the sexes. Gender inequity in health refers to those inequalities between women and men in health status, health care, and health work participation, which are unjust, unnecessary, and avoidable. Gender equity strategies are used to eventually attain equality. Equity is the means, equality is the result (CIDA, 1999; cited in PAHO, 2005:4).

PAHO recognizes that “there are systematic disparities between women’s and men’s health that do not derive from biological sex traits but from the different positions that women and men occupy in society. This unequal positioning is reflected in dissimilar and often inequitable patterns of health risks and access to and control over health resources and services” (PAHO, 2005:8). Since 2005, PAHO has emphatically underscored the importance of recognizing the negative impact of the unjust social order reflected in the family distribution of tasks and health care and in the financing of health systems.

The resolution by which the PAHO Gender Equality Policy was adopted (Resolution CD46.R16) calls on the Member States to generate and analyze data disaggregated by sex and other relevant variables [operative paragraph 2[b]] and also urges them to implement the Gender Equality Policy [OP 2[a]]; to incorporate the gender equality perspective throughout the program cycle, as well as in research and training [OP 2[d]]; to actively involve men and boys in GEH [OP 2[f]]; to strive for parity between the sexes in matters of recruitment and career development, including employment in decision-making positions [OP 2[c]]; and finally, to “include, as appropriate, in the National Health Accounts indicators for the unremunerated time devoted by men and women to health care in the home, as a function of the total expenditure of the health care system” [OP 2[c]].

The PAHO Office for Equity, Gender, and Cultural Diversity (EGC) coordinates the current formulation and execution of the gender mainstreaming initiative.
It developed an implementation plan, approved by the PAHO Member States in 2009 (Resolution CD49.R12), and published a progress report for the period 2009-2014 in 2015. This report, which summarizes the results of a questionnaire self-administered by the countries, provides a core platform for defining the status of gender mainstreaming in health in the countries of the Region (see Chapter 2). It also serves to identify obstacles for meeting the goals of the 2030 Agenda, which were the basis for defining the 2015-2019 strategic lines of action for achieving GEH (CD54/INF/2 [2015]), including the following:

a) Conduct research and apply innovative methodologies to address gender inequities within the framework of the Strategy for Universal Access to Health and Universal Health Coverage, which is explicit in its people-centered, equitable approach for providing integrated services to meet the needs of different genders.

b) Generate sector-specific evidence and gender analysis for political advocacy in vertical, horizontal, and intersectoral policy and program development, implementation, and evaluation.

c) Expand the conceptual framework and modalities to promote and address gender identities, including LGBT and masculinities (among others), and their linkages with ethnicity and other social determinants of health.

The PAHO Gender Equality Policy and its corresponding action plan further adopted an intersectional approach to gender-based inequalities in health when they were mentioned in a resolution referring to barriers to accessing health services that fully respect human dignity and recognize the right to health of LGBT persons (Resolution CD52.R6, adopted in 2013)2 and various ethnic groups within a multicultural and multilingual Region (Document CSP29/7 [2017]).

The PAHO mandate, referring to the integration of gender into the policies and programs of Member States and into its own institutional structure using a rights-based, intersectional, and intercultural approach, was incorporated into the Strategic Plan of the Pan American Health Organization 2014-2019 (Official Document 345 [2013]), in which GEH is mentioned as one of the four cross-cutting themes (along with equity, human rights, and ethnicity). The Plan states that “gender equality in health is a progressive goal to ensure that women and men, in

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2 Resolution CD52.R6 (2013), which called attention to disparities in the access to and utilization of health services by lesbian, gay, bisexual, and trans persons, marked a milestone in the movement toward universal health by recognizing historically marginalized populations, including LGBT persons. The resolution urged the Member States to: (a) work to promote the delivery of health services to all people with full respect for human dignity and health rights [...] taking into account the diversity of gender expression and gender identity; (b) design policies, plans, and legislation that are sensitive to the stigma and discrimination experienced by LGBT persons, as well as to increase access to and the quality of health services; and, (c) collect data about access to health care and health facilities for LGBT populations. Document CSP29/INF/7 (2017) described the main obstacles encountered by LGBT persons in accessing health services and offers preliminary recommendations for strengthening the system so that it will be more inclusive. This document is also important for evaluating the status of GEH in the Region, as well as for understanding future challenges and developing relevant strategies (Chapter 3).
a context of sexual and ethnic diversity, have equal opportunities to access the resources necessary to protect and promote their health” (paragraph 194).

Finally, in alignment with the current Strategic Plan, which clearly emphasizes equity in health for sustainable development based on a results-based approach, certain commitments assumed at the regional level are likely to impact the strategic lines for GEH as they relate to the 2030 Agenda. The Strategy for Universal Access to Health and Universal Health Coverage [Document CD53/5, Rev.2 [2014]] is of the utmost importance in this regard. It promotes not only universal coverage (“the capacity of the health system to serve the needs of the population”) but also universal access (“the capacity to use comprehensive, appropriate, timely, quality health services when they are needed” and “the absence of geographical, economic, sociocultural, organizational, or gender barriers”). The resolution adopting this strategy [Resolution CD53.R14 [2014]] calls upon the Member States to “advance toward providing universal access to comprehensive, quality, progressively expanded health services” and “identify the unmet and differentiated needs of the population as well as specific needs of groups in conditions of vulnerability” (operative paragraph 2[d]). Furthermore, they are asked to “implement plans, programs, and projects to facilitate the empowerment of people and communities, through training, active participation, and access to information for community members, in order for them to know their rights and responsibilities, and for them to take an active role in policy-making, in actions to identify and address health inequities and the social determinants of health, and in health promotion and protection” [OP 2[j]]. Achieving universal health coverage is an essential strategic commitment in the current Strategic Plan, along with a multisectoral strategy for working on the determinants of health and an approach centered on well-being and healthy life throughout the life course.

Two other normative frameworks that synergize with PAHO’s Plan of Action for Implementing the Gender Equality Policy are the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) [Document CSP29/6, Rev. 3] and the resolution that adopted it (CSP29/6, Rev. 3, Add. I [2017]), as well as the regional plan developed on the basis of the WHO Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030. This strategy addresses the priority issues associated with reproductive and maternal health, adolescent pregnancy, and other actions for the empowerment of women throughout the life course.

SHAA2030, the PAHO Strategic Plan, the Universal Health Strategy, and the PAHO Gender Equality Plan, along with the resolutions that synergistically enrich their scope, constitute a strong approach based on the production of information and the achievement of results.
1.2.2. 40 Years of the Regional Gender Agenda: Other Regional Normative Frameworks for GE and the Empowerment of Women in Health

Latin America and the Caribbean lead the world in their commitment to eradicating gender-based inequalities and discrimination against women in the move toward guaranteeing human rights (ECLAC, 2017b). Over the past 40 years, the Economic Commission for Latin America and the Caribbean (ECLAC) has organized a total of 13 Regional Conferences on Women in Latin America, and this is the only region of the world that has a permanent body of the kind. The agreements signed at these conferences are cumulative, that is each new negotiation process and document recognizes the valuable contribution to policies and programs made by its predecessors, resulting in a collection of adopted texts embodying a wealth of policy and technical content. These documents together make up the Regional Gender Agenda that draws strength from and feeds back into the platforms and programmes of action of United Nations conferences and the binding commitments undertaken by the Governments through the signing and ratification of the Convention on the Elimination of all Forms of Discrimination Against Women and its Optional Protocol, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará) [ECLAC, 2017c:5-6].

Echoing and strengthening the ECOSOC (1997) Agreed Conclusions, several of the agreements established under the Regional Gender Agenda tie in with the GM strategy, as do some of its thematic aspects related to GE and the empowerment of women in the context of health. The purpose of the present assessment is not only to trace how the GM strategy has been endorsed and reinterpreted in regional commitments, but also to show the synergistic effect between this normative framework and the agenda for development, with emphasis on the elements of the 2030 Agenda that particularly relate to gender empowerment for the health sector in the Region of the Americas.

The consensuses reached in Mar del Plata (1994), Santiago (1997), Lima (2000), Mexico (2004), Quito (2007), Brasília (2010), and Santo Domingo (2013) confirmed the need to generate political will and the necessary commitment to advance toward gender equality. Within this framework, special importance was given to institutionalizing the gender perspective within governments along with specific financing, production of data and information disaggregated at least by sex and age, generation of technical capacity, monitoring and

evaluation based on relevant indicators, and a legal and normative foundation that supports gender equality and the rights of women. Other governmental and nongovernmental actors were approached and encouraged to adopt the gender mainstreaming perspective and policies on equality. The Montevideo Strategy for Implementation of the Regional Gender Agenda within the Sustainable Development Framework by 2030 (ECLAC, 2017e) examined these aspects in depth and identified 10 pillars for implementing the Regional Gender Agenda. Together, the 10 pillars provide the conditions and means for the effective application of public policies that will eliminate gender-based inequality (Ibid.:20). The core thrust of the Montevideo Strategy, and also a key concern in the present assessment, is “closing the gap between de jure and de facto equality by strengthening public policies to ensure the autonomy and full exercise of the human rights of all women and girls” (Ibid.:14). Furthermore, it repositions the role of states in the implementation of equality policies, assigning central governments a position of leadership in consolidating national strategies for sustainable development over the medium and long term. In this leadership role, they are called upon to enlist the active participation of civil society in all its diversity and marshal the private sector in the fight to ensure respect for the human rights and autonomy of women. The Montevideo Strategy also identifies the structural challenges that the Region faces—a vicious cycle of challenges that stand in the way of progress toward gender equality, including: (a) socioeconomic inequality and persistence of poverty; (b) discriminatory, violent, and patriarchal cultural patterns and the predominance of a culture of privilege; (c) the sexual division of labor and the unfair social organization of care; and (d) the concentration of power and hierarchical relations in the public sphere.

1.2.3. Toward the 2030 Agenda for Gender Equity in Health: Global Normative Frameworks

At the beginning of the new millennium, world leaders gathered at the United Nations to establish a set of goals for human development. The Millennium Development Goals (MDGs), adopted in 2000, placed health, gender equality, and other determinants of health at the center of the development agenda. A total of eight goals, each with vertical targets, were intended to be met by 2015. When that year arrived, after evaluating the progress made toward attainment of the MDGs, the United Nations Member States agreed on a new, broader set of goals and targets to be fulfilled by 2030: the Sustainable Development Goals (SDGs). The 2030 Agenda for Sustainable Development, approved by the Member States at the 70th Session of the United Nations General Assembly in September 2015, is a multilateral political commitment
CHAPTER 1. Gender mainstreaming in health: definitions and global and regional normative frameworks

based on 17 Sustainable Development Goals and 169 associated targets. Unlike the MDGs, the SDGs are integrated and indivisible. This new agenda recognizes the central importance of ensuring healthy lives and promoting well-being for all at all ages (SDG 3), as well as the importance of gender equality and the empowerment of all women and girls (SDG 5) in order to reduce inequalities within and between countries (SDG 10) and revitalize the Global Partnership for Sustainable Development (SDG 17).

As mentioned earlier, the 2030 Agenda for Sustainable Development is synergized with the Regional Gender Agenda. The gender and health issues in the 2030 Agenda for Sustainable Development can be seen reflected in the 10 pillars and the 74 related measures in the Montevideo Strategy and in the mandates of PAHO/WHO.

One of the main reasons behind this alignment is an attempt to avoid duplicating or fragmenting efforts (ECLAC, 2017b:17) so that energies can be focused on addressing the core commitments assumed by the Region. In the case of some of the SDGs and their targets, the Regional Gender Agenda is more comprehensive. For instance, while Goal 5 calls for recognizing and valuing care, the Regional Gender Agenda advances commitments to eliminate the sexual division of labor and promote care as a right. In addition to ensuring the full and effective participation of women and equality of opportunity, it proposes to build parity democracies in the Region. It not only recognizes reproductive rights but also establishes measures at the regional level to promote, protect and guarantee the full exercise of sexual rights for all persons without discrimination (Ibid., 2017b:17).
The previous chapter made it clear that GM is a strategy for integrating the gender perspective both at the organizational or institutional and the programmatic level. Implementation of the GM strategy, as defined by ECOSOC (1997), requires both adaptations at the institutional level and results-based program management. However, an early study on this strategy published by the Swedish International Development Agency (SIDA) [Shalkwyk et al., 1996:3] identified not two but three interrelated elements that are important for successful implementation of GM: (1) the institutional arrangements within the structures, policies, procedures, and culture of an organization; (2) the substantive activity that the organization undertakes in the form of programs; and (3) the impact of this work on greater gender equality and the empowerment of women in the broader community. However, at times, organizations have tended to blur these three areas and have often lost sight of the fact that change in partner countries is the ultimate objective. [...] It is important to keep these three areas separate, since different strategies and indicators of change are applied to each (Ibid., 1996:4).

With regard to the third element, the review did not find clear evidence that implementation of the GM strategy had had an impact on the health sector in the Americas, possibly due to the lack of documented baselines at the national and regional level that specific policies or programs are supposed to influence. Monitoring and evaluation through process and impact indicators is only possible when baselines are established and documented. The initiatives so far have been limited to statistical analyses, legislation, and policies on situations that the health sector and others need to address and assess from a gender perspective through operational (targeted) GM programs. For example, the recent UNFPA study on fertility in childhood and adolescence confirms that the problem does not seem to have changed significantly in recent decades despite efforts in countries of the Southern Cone (Binstock, 2016).4 While the persistent high prevalence in

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4 The high adolescent fertility and maternity rates in Argentina, Brazil, Chile, Paraguay, and Uruguay are a systemic challenge. It is difficult to evaluate the precise impact of health and education programs aimed at changing this reality because adolescents continue to perpetuate the structural patterns that crystallize gender gaps (i.e., less access to education and paid work for women, with resulting economic impoverishment coupled with symbolic impoverishment in which they are kept from choosing life projects beyond maternity and caregiving).
Latin America continues to perpetuate structural conditions for gender-based inequality. A recent technical consultation report entitled Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean [PAHO/WHO, UNFPA, UNICEF, 2018] sums up the challenge: “Adolescent pregnancy profoundly affects girls’ life trajectories. It hampers their psychosocial development, contributes to poor health outcomes for the girls and their offspring, negatively affects their educational and employment opportunities, and contributes to the perpetuation of intergenerational cycles of poor health and poverty.”

The following section offers a review of existing evidence of institutional GM outcomes in the health sector in countries of the Region of the Americas, together with assessments by experts who were interviewed on the subject.

Based on this review of the literature and expert assessments, the findings are followed by a brief assessment of the most commonly addressed thematic areas in the strategy of incorporating the gender perspective in specific programs, referred to in Chapter 1 as operational, or targeted, gender mainstreaming.

Finally, some general observations are offered on the effectiveness of the GM strategy within the framework of the current international academic debate.

2.1. Institutional Gender Mainstreaming in the Health Sector of the Americas

2.1.1. Normative Framework and National Policies for Institutional GM

A study conducted by the Gender Equality Observatory for Latin America and the Caribbean [ECLAC, 2017d] contains a review and assessment of the design processes used in recent gender equality plans in the countries of the Region. Although this analysis is limited to initiatives aimed at achieving equality for women, it is important to revisit the list of the 22 countries in Latin America and the Caribbean that have “gender equality plans” and the entities responsible for their execution [Ibid.:13-14]. Furthermore, the investigation is limited to Latin America and the Caribbean, leaving out Canada and the United States. Both countries have national plans that address gender equality and the empowerment of women and girls.

In this regard, two observations are relevant. First, the ECOSOC (1997) requires that gender mainstreaming be linked to the definition and implementation of a GM policy whose normative framework is a key element in implementing the Montevideo Strategy (2016). This institutional requirement...

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has been expanded because the Strategy states that the normative framework comprises the statutory, legal, and political basis for women’s rights and gender equality. It includes all the laws, policies, equality plans, planning tools, programs, standards, regulations, and intervention protocols, as well as binding and nonbinding international instruments that define the scope of public policy (ECLAC, 2017e:21).

In this context, the report points out that some countries, such as Argentina and Cuba, do not have equality plans in place at the national level, but they do have sectoral plans—for example, in the areas of education or health—and the state implements public policies and actions aimed at gender equality (Ibid.:19). Although only a few new national gender equality plans have emerged recently, covering the 2018-2030 period in Chile, Costa Rica, and Uruguay, progress has been made under all the plans in the sense of generating a “normative framework” for GM within the broader intentions of the 2030 Agenda. Costa Rica’s National Policy for Effective Equality between Women and Men 2018-2030 (2018) is consolidated at the national level with engagement of the nongovernmental sector (i.e., concrete responsibilities are defined not only for NGOs and academia but also for the private sector). This plan consistently matches up the country’s legal norms to concrete objectives. Based on the structural challenges of gender-based inequality outlined in the Montevideo Strategy and on an assessment of the resulting differences in the enjoyment of rights and the impact that these differences have on the lives of men and women, the plan establishes four core pillars, each with specific targets for 2030: the cultivation of equal rights and the distribution of time, resources, and power. The notion of “increased” permeates all the objectives, as in “increased participation” and “more women.” In the health sector specifically, the development of new policy guidelines seemed to be hampered by a lack of information needed to establish baselines for monitoring and evaluating advances with greater precision. The new national plans for gender equality show progress in incorporating an intercultural approach and an intersectoral perspective in the assessment of discrimination—for example, as complementary guidance for ameliorating gender-based inequality.

Second, the health dimensions included in the policies on gender equality in 17 countries of the Region revolve around three main approaches: (1) women’s health; (2) sexual and reproductive health; and (3) gender and health, or gender and development. Of these three approaches, the predominant one is sexual and reproductive health (PAHO/UNICEF/SE-COMISCA, 2017), which is the same conclusion the ECLAC report on gender equality plans (2017c) reached, an issue we will return to. Still, progress has been made in including
gender as a determinant of health and bringing a gender perspective to the analysis of the dimensions of problems, making it possible to frame the debate on the health of individuals as a policy and human rights issue. In fact, the new gender equality plans (2018-2030) for some of the countries in the Region have expanded the list of priority issues on their gender and health agendas—for example, emphasizing that unpaid caregiving and domestic work deserves a place on the Region’s health agenda.

A good example of expansion of the gender and health agenda beyond issues directly related to sexual and reproductive health is seen in the policy guidelines of Uruguay’s 2030 National Strategy for Gender Equality (Uruguay, 2018). Its IX Strategic Aspiration (Ibid.:88) seeks to strengthen the Integrated National Health System by providing universal and comprehensive services based on a gender approach. While this initiative involves many aspects of sexual and reproductive health, progress is also envisioned toward other issues on the gender and health agenda, such as ensuring access to mental health from a gender perspective (IX.1.d); ensuring access to appropriate medication consistent with the needs of each individual, and, in the case of women, discouraging the prescription and consumption of psychoactive drugs (IX.1.h); guaranteeing comprehensive care for trans persons through access to hormonal and sex reassignment treatments for those who decide to request them (IX.1.f); encouraging health teams to denaturalize gender stereotypes while promoting healthy lifestyles in terms of eating habits, physical activity, and the use of free time (IX.1.c); incorporating health education programs at all levels, including specific topics on gender and human rights, and mainstreaming the gender perspective in all technical and/or professional health training courses (IX.2.a); promoting education and ongoing training for professionals and health workers in gender, sexual diversity, and the ethno-racial dimension for more compassionate and skilled care (IX.2.b); intensifying training for the primary care health team in the detection, first response, and referral of cases involving gender-based violence (IX.2.c); and strengthening mechanisms to foster citizen participation, ensure the participation of users within the health system, and elicit suggestions and complaints so that problems and shortcomings can be dealt with (IX.2.d). The Strategy also addresses gender and sexual and reproductive health from nontraditional perspectives, emphasizing an intersectional approach for improving access to health. In particular, it calls for ensuring universal access to comprehensive and respectful sexual and reproductive health care for women and men, with or without disability, with special emphasis on people living in conditions of vulnerability because of their sexual orientation or gender identity, social class, geographic location, ethno-racial ancestry, or
employment as sex workers (IX.3.b); it stresses the importance of transcending the binary sex-based model of gender and ensuring that respect for sexual and reproductive autonomy are incorporated into care models, as well as appropriate care, in accordance with the various sexual orientations and gender identities (IX.3.c); it establishes guarantees so that all people may enjoy the right to sexual freedom and autonomy in their reproductive life throughout the national territory (IX.3.d); and it encourages education and health systems to recognize the pleasurable dimension of sexual life without focusing entirely on the risks of sexual activity, promoting mutual and self-care (IX.3.e).

The conclusion extracted from expert consultations and the literature review is that the adoption of an explicit policy on gender equality, although necessary, was not shown to be sufficient for consistent and effective implementation in countries throughout the world (Moser & Moser, 2010). Among other things, it is essential to have political will and sustained commitment at the highest decision-making levels of the state (Hankivsky, 2008). Changes in government administration tend to affect the continuity of policies (CEDAW, 2015), and this remains a challenge for the countries of Latin America and the Caribbean (ECLAC, 2017c).

It was also found that the policies were mostly pushed forward by a few individuals who are largely responsible for the small amount of progress that has been made in GM in health (Gideon, 2012). A significant limitation that hampers implementation of these plans is that they remain under institutional mechanisms for the advancement of women, where distribution of responsibilities (and budget allocations) across sectors is frequently unclear, making it difficult to reach objectives. Many plans refer to the importance of guaranteeing financial and other types of viability, but no specific budgets were allocated for the work of gender mainstreaming.

This analysis also found intersectoral coordination in the institutional culture of Latin America and the Caribbean to be weak (ECLAC, 2017c:64). This underscores the need for institutional GM, an aspect that was explicitly established in implementation pillar 2 of the Montevideo Strategy (2017e): Institutional architecture. We know that GM requires various types of institutions to design and implement coordination mechanisms in order to come together in a single integrated and cohesive approach to meet the challenge (Expósito Molina, 2012:205). This coordination is crucial, among other reasons, for mounting a comprehensive response to the multifaceted (not compartmentalized) lives of individuals, as well as for prioritizing the lines of intervention within the framework of the process budget, which is usually not directly correlated with the plans (ECLAC, 2017c).
Although large gaps have been found with regard to de facto progress with GM in the health sector, a few good practices were observed in current gender equality plans in Canada (Hankivsky, 2008) and Chile (Pollack, 2002; Gideon, 2012).

In Chile, which is part of a subregion (Latin America) that has been slow to make progress with GM in general, the positive developments include creation of the Ministry for Women’s Affairs and Gender Equity in 2016 and transformation of the National Women’s Service (Servicio Nacional de la Mujer—Sernam) into the National Women’s and Gender Equity Service (Servicio Nacional de la Mujer y la Equidad de Género—SernamEG). In addition, an Interministerial Committee for Equal Rights and Gender Equity was created, chaired by the Minister of Women’s Affairs and Gender Equity and attended by the ministers of Interior and Public Security; National Defense; Treasury; Economy, Development, and Tourism; Social Development; Education; Justice; Labor and Social Security; Health; Agriculture; and Housing and Urban Development and Natural Resources; as well as the General Secretariat of the Presidency and the National Council of Culture and the Arts.

Chile’s Fourth Plan for Equality between Men and Women 2018-2030 includes a set of clear targets with their respective indicators and time frames, as well as the designation of regulatory institutions and executing sectors and institutions (Chile, 2018:84-86). In addition, it establishes a matrix of targets to which the ministries are committed under other plans, policies, and strategies for guaranteeing civil and political rights, sexual and reproductive rights, the right to comprehensive health care, the right to a life free of violence and discrimination, social and cultural rights, and collective and environmental rights.

The implementation of institutional GM requires gender-sensitive democratic governance/governability (Bareiro & Towers, 2010) supported by results-based management (OLACEFS, 2015). These two factors facilitate the third dimension (sensitivity to gender issues) of GM mentioned at the beginning of this chapter in order for GM to have an impact on effective progress toward gender equality and the empowerment of women in the broader community.

The following section addresses experiences with documented evidence on systematic results in basic institutional GM processes in the health sector.

2.1.1.1. GM Policies and Plans Specific to the Health Sector

It will be necessary to see how countries manage to transfer these renewed objectives for GE and the empowerment of women and girls from general national GE plans to GM plans in the health sector. No documentation of
this process was found; however, the
first attempt to consolidate results for
different components of the GM strategy
in the health sector of the Region
has been produced by PAHO (CD54/
INF/2, 2015). The findings are based
on the results of a self-administered
questionnaire filled out in 2014 by 32 of
the 48 countries and territories in the
Region. The assessment determined a
fulfillment rate of 80% for implementing
gender-oriented plans and policies
that will provide the framework for
integration of the gender perspective
into health policies. This makes it the
most highly met requirement for GM in
the Region. However, in many countries
that have laws and projects specifically
designed to reduce gender inequity in the
health context, implementation remains
inadequate or nonexistent (Webster,
2006; Stewart et al., 2009; Ferreira,
2006). Moreover, the existing plans or
policies focused strongly on three major
GM issues: sexual and reproductive
health, violence against women, and HIV/
AIDS. Finally, the report mentioned an
absence or inconsistency of institutional
structures that promote and support
integration of the gender perspective
into the full cycle of health programs.
Changes in the political context were
cited as a key factor in the absence or
inconsistency of these structures. Some
of the experts interviewed emphasized
the urgent need for shifting the
perspective from government-specific
policy to public health policy. This
would require mechanisms to prevent
new government administrations
from reshaping existing policies
and interrupting the consolidation
of progress made under previous
administrations. Concrete measures
must be identified and implemented to
limit the uncertainty of policy and ensure
a stable administrative environment.
Two key strategies were mentioned in
this regard: strengthening the countries’
legal frameworks; and establishing
gender-labeled budget lines to ensure
the sustainability of measures aimed at
redressing gender-based inequalities,
for example, having specialists available
to advise on policy design (a point we will
return to shortly).

In the Canadian experience, one
of the factors that facilitated the
implementation of GM was the
existence of a positive and enabling
policy framework. Such a framework
should include a legal platform that
advocates gender equality coupled with
a clear commitment on the part of the
government to facilitate systematic
intersectoral initiatives (Status of
Women Canada, 2001:2). Another
complementary element indicated
for expanding the framework of an
institutional GE plan or policy is having
clearly specified roles and mechanisms
for collaboration within each sector
and between governmental sectors at
the national, provincial, and territorial
levels. Finally, GM should produce
certain changes in the organizational
culture such as having policies in place
to ensure personnel parity, especially
in decision-making positions; handling
cases of gender-based violence within health institutions; and use of nonsexist language and images in the organizational culture and the production of communication materials on programs and policies. In terms of implementing these measures, which are recognized as institutional requirements for GM, only 11 of the 32 countries that provided information for the Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015) have a policy on personnel parity. Some of the experts interviewed emphasized the importance of continuing to strengthen parity policies to empower women to assume leadership and decision-making positions. As for the prevention and treatment of gender-based violence, the conclusion regarding this institutional requirement for GM is that there was insufficient evidence of progress in terms of institutional protocols at the level of Ministries of Health.

The specific findings regarding the remaining institutional requirements for GM in the health sector are summarized below.

2.1.2. Human and Financial Resources

The evaluation of fulfillment of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action conducted by PAHO (CD54/INF/2) found that both human and financial resources for GM in health were limited. It was noted that budgets for the promotion of gender equality in health tended to rely on grants or non-regular funding sources and were insufficient to sustain progress. There is usually no specific budget allocation for GM in health, and this means that financial resources for GM are not only scarce but secondary and unreliable for guaranteeing the continuity of actions. An exploratory analysis of integration of the gender approach into the health policies of 16 countries of the Region (PAHO/UNICEF/SE-COMISCA, 2017) confirmed the self-assessments by officials responsible for GM in health in the countries. While budgetary resources for GM are called for in health sector policies, there are no legal measures to compel the executive branch to allocate the funds in the sector’s budgets. The fact that international cooperation is one of the main sources of funding for these measures shows that implementation of the GM strategy is not a high priority for governments.

For gender equality policies to be effective, public financial and human resources must be assured and budget formulation should be consistent with the plans for gender equality. According to a recent ECLAC report, with some exceptions, the profile of gender policies as a component of national budgets is faint or nonexistent. This is chiefly a consequence of the existence of strong cultural and ideological resistance to the idea of incorporating gender equality into government affairs in the countries of
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The structures of both gender equality budgets and public budgets are generally well-established and are repeated from year to year in nearly all of the countries of the region (ECLAC, 2017d: 61).

Within the Region, there are cases of budgets specifically allocated for gender mainstreaming at the national level. However, no scientific publications in academic journals were found that documented the processes of preparing and monitoring “gender-sensitive” budgets in the health sector, nor the results achieved in terms of transforming health-related gender-based inequalities.

As already mentioned in connection with the PAHO Gender Equality Policy (2005), some of the key SDGs, and the Regional Gender Agenda, the Region continues to face several crucial challenges, including the need to:

- Allocate resources for health care in accordance with the particular needs of women and men, regardless of their financial capacity;
- Establish out of pocket payment for health care according to the user’s financial capacity, not according to need, and distributing the financial cost of reproduction collectively;
- Recognize the contributions, paid or unpaid, that women and men make to the production of health care;
- Balance the distribution of work and power over decision-making equitably, not only between women and men but also between the state, the community, the family, and the market (Gómez, 2002:460).

Gómez (Ibid.) shows clearly that women perform reproductive and caregiving tasks that sustain the distribution of profits in the economic and health systems either without payment or at lower levels of remuneration and prestige within the formal health sector. This places them in a systematically disadvantageous position within the health system and represents a veiled form of discrimination. In this regard, and considering the “economic adjustment policies” that predominate in the Region, the author notes that seemingly neutral policies such as “cost containment,” “bureaucracy reduction,” and “decentralization” often conceal profound gender biases because they involve shifting the costs of an economy based on remuneration to one that relies on the unpaid work of women. The premise that underlies some of these adjustment or reform measures is that government can reduce expenditures by cutting services—for example, by reducing hospital stays, institutional care of the elderly, and care of the mentally ill—because families can provide these services. Such measures

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6 For example: in Canada, since 1993 (Budiendler et al., 2002); in Mexico, since 2006 (Arriola, 2006); and in 16 other Latin American countries (Coello, 2009). As of 2009, UN Women had identified 52 experiences with the formulation of 21 gender-sensitive budgets at national and local levels in 17 countries of Latin America (Coello, 2009).
are based on assumptions of infinite elasticity, free access to the time and services of women, and the expectation that they are always available, willing, and morally obliged to provide home care for dependents, patients, the elderly, and persons with disabilities. These policies rarely consider that the expectations of availability, obligation, and free services constrain women’s options for gainful employment and impose a burden on their physical and emotional vitality (Ibid.:460).

Various studies have pointed to the failure to recognize the important contribution of caregiving to the economy—for example, in the case of Chile (Gideon, 2012). Furthermore, in line with Target 5.4 of the SDGs and the PAHO Gender Equality Policy, evidence shows that assigning a value to unpaid work in the System of National Accounts is crucial. Failure to include it affects the allocation of resources and benefits derived from that invisible work performed primarily by women, as well as their health. “If this aspect of the economy is not recognized or its impact is not analyzed, inequalities will persist or worsen” (ECLAC, 2017f:192). This view was consistent with the opinions of the experts interviewed, who also mentioned the need to give more visibility to the unpaid caregiving that women do, both in their homes and in the community, and to assign a value to it in national accounts.

With regard to human capital in the health sector, specific analyses were found on the feminization of human resources and on the deep gender gaps among health workers in countries of the Region—for example, Argentina (Pautassi, 2001; Aspiazu, 2016; PNUD, 2018), Brazil (Schraiber et al., 2014), and Mexico (Castro, 2014; Nigeda et al., 2007).

2.1.3. Capacity-building for GM in Health

WHO and PAHO have developed training models for building GM capacity in the health sector (WHO, 2011b; PAHO, 2010). According to the PAHO Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015), some progress has been made in capacity-building for GM in health, but implementation of these advances requires greater systematization. The need for GM capacity in the health sector was evidenced by increased requests from countries for technical support on gender and health, as well as in emerging areas that PAHO has prioritized, such as LGTB issues, masculinities, specific mechanisms for integrating the gender perspective into data analysis and M&E, and strategies for achieving political impact.

In the Region, a documentation gap was found on the institutionalization of GM capacity-building processes in health, as well as on the evaluation of the results (Lugo, 2010; Newman et al., 2016; Johnson et al., 2014; Arango et al., 2014). While some country-level documents contain evaluations of past trainings and standardized training
methodologies aimed at providing theoretical and practical tools for the design, implementation, and evaluation of public policies on gender equality and equity, there were almost no specific references to trainings in the health sector. One exception was a report involving the Government of Chile (Muñoz & Varela, 2017).

According to the UN Women Training Center, five types of gender training can be identified, depending on their depth and the goals to be achieved (Leghari & Wretblad, 2016:12-15):

1. Awareness raising, to introduce participants to key issues concerning the topic of gender (in)equality.

2. Knowledge enhancement, to provide participants with more in-depth information on these issues as well as the broader power structures underlying inequalities.

3. Skills training, to strengthen participants’ specific competencies by providing them with instruments and strategies with which to apply their knowledge in practice.

4. Change in attitudes, behaviors, and practices, to foster lasting positive changes in the way participants think and act in terms of their conduct and long-term habits.

5. Mobilization for social transformation, to stimulate participants’ capacity to collaboratively put their knowledge, motivation, and skills into practice in order to begin to transform their work, communities, and daily lives into more gender-equitable spaces.

Regarding the content of training on integration of the gender perspective in health, Hankivsky (2008) indicates that, based on the Canadian experience, attitudes toward gender equality is one of the core areas where work is needed. According to this author, there is a basic lack of understanding of the fundamental concepts used in gender mainstreaming, especially within the policy sector. One of the Canadian experts interviewed noted that this task is more difficult but that we can, in fact, develop the skills and teach people the mechanics of incorporating the gender perspective. Similarly, in the work cited earlier by the Chilean government (Muñoz & Varela, 2017), an evaluation of the training programs found multiple shortcomings, including a predominance of virtual short-term basic and intermediate courses.

Another important matter is the recipients of training courses themselves. On this subject, the majority of articles in the study agreed on offering GM training both for officials responsible for policy design and for personnel in the health system. Most of the experts interviewed cited the need to incorporate the gender perspective in the undergraduate and graduate curricula of schools training health professionals. Awareness raising and
isolated trainings are not enough; it is essential to provide the new generations of health professionals, especially those working in primary health care, with a critical overview of gender-based inequalities. The GM strategies being developed, in addition to creating new skills, should be effective in transforming the political and cultural practices that currently perpetuate gender-based inequalities. PAHO/WHO has developed capacity-building materials in a face-to-face continuing education format as well as a virtual course that may need to be evaluated and updated, if appropriate, in light of the findings reported in this document.

2.1.4. Gender Analysis

Canada is a leader in the Region in the institutionalization of gender-based analysis (gender analysis) in the design and development of legislation, public policies, and programs. Since 1995, the Canadian Government has been making progress on its commitments to the Beijing Declaration and Platform for Action. Status of Women Canada (now Women and Gender Equality Canada [WAGE]) is responsible for managing the implementation of gender analysis. The latest version of their tool, Gender-based Analysis Plus (GBA+), explicitly incorporates the intersectional approach, as seen in its dynamic, nonbinary definition of sex-gender identity: “diverse groups of women, men, and gender-diverse people.”7 Strengthening the implementation of gender-based analysis using the GBA+ tool was given priority in the 2013-2014 report produced by Status of Women Canada.8

No publications were found in the countries of Latin America and the Caribbean that document the institutionalization of gender-based analysis in health using any of the globally recognized models for this type of assessment (WHO, 2003; PAHO, 2010). However, a few isolated examples of gender analysis were identified—for example, with regard to HIV/AIDS in Belize (PAHO, 2010). The few documented reports of results in connection with this requirement for GM in health were from programs facilitated by international agencies. With these models, it is important to point out that they continue to view gender in terms of the sex-based binary definition, which means, among other things, that the models need to be updated to reflect the broader and more complex view of gender in health. PAHO (2005) has also produced a series of basic indicators for the assessment of gender equity in health; they will be incorporated in a document, still in press, that will offer a conceptual framework and indicators for monitoring gender equality in health in the Americas.

2.1.5. Information Systems

The PAHO Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015) identified disaggregation of data by sex and other social determinants as a challenge that will require ongoing effort. Disaggregation of data by sex alone is not enough to analyze gender-based inequalities in health (Bekker, 2003). Even though this component has high priority in the PAHO Gender Equality Policy (2005), an analysis of integration of the gender perspective in health policies in 16 countries of the Region (PAHO, UNICEF, SE-COMISCA, 2017) found that 44% of the policies did not call for data disaggregated by sex. Of those health policies that did disaggregate data by sex, only 4% included a gender analysis based on the data obtained. Finally, it was also noted that the few policies that specify using data disaggregated by sex for the analysis of certain health-related problems focus mainly on diseases associated with the sexual-reproductive system and the stage of life corresponding to the fertile period.

According to some of the experts interviewed, it is crucial to improve information systems in the countries of the Region in order to ensure comparability of data, while also expanding the disaggregation of data to include more variables than sex and age. The experts did note that several countries have made significant progress in disaggregating data for the purpose of gender analysis and for monitoring and evaluating fulfillment of policies and programs on gender and health, including Canada, Chile, Colombia, Ecuador, Mexico, and Uruguay. The National Demographic and Health Surveys (NDHS) can be a powerful tool for generating comparable information regarding various issues on the gender and health agenda at the regional level, including the empowerment of women, as seen in the work of the Ministries of Health in Chile (2017) and Colombia (2016a). In Chile, for example, the average age of menarche has been included as a data point, although it is yet to be included on the global population health agenda (Sommer et al., 2015); the objective is to not only monitor its progressive intergenerational pattern but also to know the appropriate age to begin scheduling comprehensive sex education programs, including sexual and reproductive health.

Still, disaggregation of data by sex and age is not enough. More information is needed to capture the diverse vulnerabilities that are complexly engrained in people’s lives. Continued focus on the binary concept of sex fosters a reading of gender as a derivative of sex that fails to capture its continuum (Clow, 2009:11) and conceals, rather than illuminates, the diversity of men and women that truly reflects the intersectional perspective.

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9 See: https://dhsprogram.com/.
Thus, for example, the identities of transgender people remain invisible, along with the reported obstacles they face in access to health services. The importance of breaching this gap is evident in the PAHO report that consolidates the responses to questionnaires completed by the Ministries of Health in the countries of the Region: Report of the Director on Addressing the Causes of Disparities in Health Services Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons (CD56/INF/11, 2018). Its conclusions on progress and remaining challenges state that “more than half the Ministries of Health responding to the survey reported that their countries gather disaggregated LGBT health data, but NGOs cited a lack of data on LGBT health” (Ibid.:4). While it is possible to compile data on LGBT health by including questions on sexual orientation and gender identity in health data collection instruments, health information systems, hospital records, and national censuses, this is far from common practice in the Americas. Even when questions of this kind are formulated, they may not be included in all the instruments, or they may be drafted in a way that limits the inclusion of all LGBT identities.

Finally, time use emerged as a key dimension of gender-based inequality. Time use surveys conducted in some of the countries are contributing to progress in recognizing one of the structural ways in which gender-based inequalities are perpetuated in terms of access to health and the health sector.

To summarize, the evidence shows that it is crucial to strengthen health information systems by including gender-sensitive indicators in the area of health and their social, economic, and environmental determinants.

2.1.6. Monitoring and Evaluation

The PAHO Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015) found that monitoring integration of the gender perspective in health continues to be a challenge: only 20% of the Member States indicated that they have an active policy on the subject. Similarly, an assessment of integration of the gender perspective into health policies based on self-reporting by leaders responsible for GM in health in the countries of the Region (PAHO, UNICEF, SE-COMISCA, 2017) found that the requirement to design monitoring and evaluation mechanisms is only mentioned in four of the 16 health policy documents reviewed. Regarding evaluation, only one policy contains guidelines for a future evaluation process. Monitoring mechanisms are recognized to be valuable for improving measurement of health issues (they are cited in the second recommendation of the WHO Commission on Social Determinants of Health), which is a topic of concern addressed by 69% of the health policies.
According to the aforementioned report, Bolivia is a good example of a country that has defined processes for monitoring and evaluation of its policy; for each program, indicators are incorporated into the results matrix, defined in terms of the policy’s objectives, along with baselines and target outcomes. The section devoted to M&E distinguishes between monitoring and evaluation, making it clear that, although related, they are independent processes. It is the only policy that incorporates a timetable for execution of the plan. In addition, it includes a model explaining how data should be collected for the indicators, with criteria for defining which are intermediate or final outcomes and impact indicators, along with sources for verification and an indication of institutions responsible for the data. It is crucial to institutionalize mechanisms for regular and systematic monitoring and evaluation of fulfillment of policies and programs on GM in health. Otherwise, it is impossible to have a concrete and operational assessment of the impact of institutional GM on improving the lives of people.

In this sense, some authors point out the need to tie the strategies for integrating gender into health to concrete outcomes (Hankivsky, 2008). It was also recommended to identify evaluation criteria, including appropriate indicators for M&E. According to Moser and Moser (2005), one of the challenges is that evaluations have tended to focus on quantitative outcome indicators such as the number or proportion of women benefited, number of activities, etc., rather than measuring the impact or results. Gender indicators need uniform criteria, established by consensus, that will help address challenges such as the measurement of changes in power and status.

A majority of the experts interviewed agreed that it is a priority to monitor, evaluate, and systematize interventions using a results-based approach. They also emphasized the importance of using more than just quantitative indicators for M&E, since the impact of redistributed power on the configuration of gender relations is best characterized by qualitative indicators. One of the experts expressed concern with focusing exclusively on the SDG targets, which are tied to quantitative indicators, to measure progress in terms of impact. It is crucial to incorporate qualitative indicators in order to evaluate gender-based changes in the distribution of power and resources, which is at the heart of the social change being sought. The lack of progress in monitoring and evaluation may account in part for the scarcity of systematic evidence on the results of experiences in gender mainstreaming in health.

2.1.7. Accountability

The Montevideo Strategy (2016) states that "accountability implies the use of mechanisms to disseminate relevant,
sufficient, timely, and reliable information, and the provision of forums for dialogue with civil society, which performs a citizen oversight function” (2017e:34). According to the PAHO Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015), although the participation of civil society in the formulation of health plans and programs is mentioned in a number of the policies, there is a lack of continuity in terms of institutional relations and the consolidation of agendas shared with the state at its different levels of jurisdiction.

The institutionalization of real and transparent GE accountability mechanisms, solidly integrated with civil society organizations, is a fundamental requirement for institutional GM. The participation of civil society organizations (women’s social movements and, more broadly, the various groups that advocate for equity in health) in the formulation of policies aimed at gender equality needs to be strengthened and revitalized through the establishment or strengthening of mechanisms to ensure input from them. This effort should include funding and mechanisms for facilitating their participation in the full programming cycle, including policy design and the monitoring of fulfillment. According to the evaluation of the Canadian experience, it was crucial to facilitate mechanisms to remedy the defunding of these organizations (Hankivsky, 2008). The documented evidence and the consulted experts agreed that it was important for civil society, women’s movements, and organizations working for equity in health to be more actively engaged in policy design and accountability, based on clearly defined standards. The experts also said that it is essential to aim toward building local/territorial capacity to ensure that the measures taken are more sustainable and to strengthen mechanisms for the enforcement of rights—in other words, strategies for incorporating gender in health policies from the bottom up rather than from the top down.

2.1.8. “Do No Harm” Policies

The United Nations requirements for institutional (and operational) GM fail to mention one of the minimum standards for mainstreaming gender equality established by the Gender Practitioners Collaborative (Avakyan et al., 2017): the inclusion of “do no harm” principles in policy. This requirement emphasizes the importance of having strategies in place to mitigate any damage that might be caused by policies or programs aimed at transforming gender-based inequalities, since gender relations express power relationships that can lead to conflict when the order that regulates them is affected. The loss of privileges stemming from a redistribution of resources and power can lead to situations of conflict that affect those who are most vulnerable. No references were found that document the implementation of this requirement in the countries of the Region.
2.1.9. Regional Experiences with GM in Health

The countries of the Region that stood out in the documentation of results of experiences with institutional GM in health were Canada, Chile, Colombia, Peru, and Venezuela. However, few of the reports referred to concrete results (Hankivsky, 2008; Gideon, 2012) beyond a declaration of principles or a description of actions. Those reports that addressed results agreed that GM initiatives have been limited and that definitions relating to GM in health are unclear. It was also noted that, in addition to clarifying the technical concepts related to GM, it is necessary to understand the social and political interests that are holding back progress (Gideon, 2012).

The reports from countries that have made the most progress in this regard, such as Canada, agree that it is necessary to use a more sophisticated and nuanced approach to understanding inequality in health, which would mean designing new plans for achieving equality while maintaining and respecting diversity (Hankivsky, 2008; Stewart et al., 2009; Johnson et al., 2014).

It is crucial to engage public officials and staff at all levels and in all areas, as well as to develop institutional machinery with clearly defined roles (Webster, 2006; del Río-Zolezzi, 2008; Status of Women Canada, 2001). Otherwise, as pointed out earlier, actions will depend on the will of a few individuals (Hankivsky, 2008; Gideon, 2012), which is one of the challenges that stands in the way of institutionalizing implementation of the strategy. This isn’t to say that successful GM initiatives do not need key individuals driving policies to produce tangible results on the road to gender equality. Successful initiatives seem to come about as a result of combined pressure from within, exerted by feminist bureaucrats, or “femcrats,” and externally from women’s movements (Budlender, 2000). When bureaucrats fail to convey gender sensitivity, “gender experts” are needed to build capacity, conduct gender analysis, and help to depoliticize the concept in order to progress toward the ultimate objective, which is to translate gender initiatives into sustained and consistent action (Alvarez, 1999).

At the level of the state, it is indispensable to apply an intersectoral approach that is coordinated with civil society organizations working on behalf of women and other vulnerable groups (Debusscher, 2012; Ulloa Pizarro, 2017) and backed by feminist research. According to Hankivsky (2008), the three synergistic pillars for GM are institutional machinery, the women’s movement, and feminist research. The reports revealed a disconnect between research and public policy that needs to be rectified in order to ensure that policies are reframed from the intersectional perspective of vulnerabilities. Another recommendation by the experts interviewed was to engage academia
more actively in public management in order to ensure that health policies incorporate scientific, evidence-based research from the gender perspective. Active participation by civil society was noted as important, as were mechanisms to ensure progress in the intersectoral development of the gender and health agenda. Specifically, the experts mentioned improving coordination between the health sector and the justice system to repair damages generated within the health system.

One of the priorities outlined by this document is incorporating men in the reconfiguration of hegemonic masculinities in policies aimed at transforming gender-based inequalities in the health sector (Hartmann et al., 2016; Barker, 2008; Aguayo & Nascimiento, 2016).

High priority should be given to the distinction between sex and gender and to the development of clear definitions of the gender perspective that will be adopted (Cardaci, 2006; Salas-Valenzuela et al., 2006). In the health sector, the definition of gender has been very limited, with more emphasis on issues related to “equity” than to “equality” (Gideon, 2012).

Most of the debates on health reform have failed to recognize the contribution of the “care economy” (Gideon, 2012). Certain topics have tended to dominate the gender and health agenda in the Region, such as sexual and reproductive health, while other important subjects have been ignored. In modeling the gender agenda, progress in guaranteeing sexual and reproductive rights in Latin America has been constrained by the power exercised by the Catholic Church (Gideon, 2012).

Some of the experts noted the creation of regional structures for the implementation of GM. For example, the Technical Commission on Gender and Health of the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA) has been implementing the Strategic Plan for Mainstreaming the Gender Perspective in that subregion since 2013. The experts also cited the creation of mechanisms for the integration of regional policies, such as the Commission on Gender and Health of the Central American Integration System (SICA), which could be used as a strategy for sharing good practices and policy articulations in the service of common objectives. The results of implementing these regional structures remain to be seen.

To conclude this summary of regional experiences with GM in health, the experts interviewed highlighted some of the structural challenges that need to be addressed in the Region to accelerate the effective implementation of GM in health:

- Neoconservative politics that especially undermine efforts to reinforce the autonomy of women. In the Region, a conservative political trend is undermining the agenda of women’s
rights, sexual diversity, and gender equality and has taken on new forms in groups or states who categorize these issues as “gender ideologies.” The Region of the Americas is experiencing setbacks and concrete threats to the gender equality agenda, particularly in the area of sexual and reproductive rights. The emergence of these groups and their influence on public policies needs to be studied so that a strategy can be designed to address the problem and protect the rights that have already been gained.

- Demographic trends (population aging) and increased adolescent fertility, which require a response from the health sector from the gender perspective. An aging population implies an even greater burden of unpaid caregiving by women. It also increases demand for care of noncommunicable and degenerative chronic diseases, as well as the need to promote active and healthy aging. Both the Inter-American Convention on Protecting the Human Rights of Older Persons and the Montevideo Consensus on Population and Development (2013) have recommended priority measures to ensure quality aging from the gender perspective. The following priority measures are extracted from the latter agreement:
  - Formulate policies with a gender perspective to ensure a good quality of life in old age, not only for urban dwellers, but also for those who live in rural and forest areas (C.18);
  - Give the highest priority to older persons in plans for disaster prevention, mitigation and relief [...] (C.24);
  - Bring health policies into line with the challenges of the varied and changing epidemiological profile arising from aging and the epidemiological transition [...] (C.26);
  - Foster the development of and access to palliative care, to ensure a dignified, painless death (C.29);
  - Promote the development of allowances and services relating to social security, health and education in the social protection systems targeting older persons to improve their quality of life, economic security and social justice (C.30);
  - Include care in social protection systems, through allowances, social and health care services, and economic benefits that maximize autonomy (C.31).
  - These same demographic trends are projected to reduce adolescent fertility in general, but adolescent fertility stratified by social class and age, as well as pregnancy in childhood (due to rape in all cases), will increase.

- Effects of climate change, with devastating impacts, especially in the Caribbean, and different consequences for men and women. Natural disasters have an intensified impact on the social vulnerability of women and girls—for example, through exposure to abuse and sexual violence. Also,
some of the experts pointed out that after a disaster, efforts in the countries to monitor and call attention to the gender situation become diluted.

- Purely structural challenges that need to be addressed to prevent efforts to implement the Universal Health Strategy from perpetuating gender inequalities. The design of health systems needs to be reformulated to generate structural changes that will result in increased national public investment in health and education, as mentioned earlier, with specific lines of action aimed at promoting gender equality.

2.2. Operational or Targeted GM: Classical and Emerging Issues; Identification of Good Practices

The PAHO Evaluation of the Plan of Action for Implementing the Gender Equality Policy and Proposed Strategic Lines of Action (CD54/INF/2, 2015) showed that operational (targeted) GM initiatives have focused on three main issues: sexual and reproductive health, violence against women, and HIV/AIDS. The review of published results on these initiatives identified six main topics that were explored: universal access to SRH services, maternal mortality, pregnancy in childhood and adolescence, transmission of HIV/AIDS and other STIs, obstetric violence, and intimate couple violence. The findings have been summarized in Annex 2, Operational GM in Classical Topics of the Gender and Health Agenda. On these agenda topics, the experts interviewed cited the need to strengthen the triad of sex education, access to contraceptives, and voluntary interruption of pregnancy; continue working on the eradication of obstetric violence; and produce strong intersectoral responses to reduce pregnancy in childhood and adolescence, as well as intimate couple violence.

Despite most progress in GMH being made in SRH, intimate partner violence, HIV/AIDS, there has also been incipient but meaningful progress in other areas of the gender and health agenda, including the health of men and masculinities, health of LGBT persons, gender and drug use, and gender and mental health, among others. To recognize this progress, Annex 3 summarizes the findings from some of the reports. The findings were organized along four axes based on a synergistic reading of SDGs 3 and 5, the issues prioritized by the Gender Equality Policy (PAHO, 2005), and the Strategic Lines of Action 2015-2019, paragraph 17(c) (CD54/INF/2, 2015): health of men and masculinities, health care for the LGBT population, health and unpaid caregiving, and gender and mental health.

Over the 2008-2012 period, PAHO systematized good practices for GMH

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12 "Expand the conceptual framework and modalities to promote and address gender identities, including LGBT and masculinities (among others), and their linkages with ethnicity and other social determinants of health" (PAHO, CD54/INF/2, 2015:6).
in the Region. Annex 4 of this document reports on some of the experiences in GMH, providing a summary of actions and achievements.

2.3. Evaluations of GM in the Current International Academic Debate

There is an increasingly vocal debate on the effectiveness of GM based on the results of its implementation in several countries. In the academic debate, one can find references to the “vaporous” nature of the strategy (Hankivsky, 2005; Daly, 2005; Aasen, 2006; Ravindran & Kelkar-Khambete, 2007; Walby, 2005; Zalewski, 2010), which is also mentioned from within the United Nations system (UN Women, 2012). Some of the reports, including documents of United Nations agencies, still emphasize that incorporating the gender perspective in health policies is an important strategy for reforming political processes in the health sector and producing results in achieving gender equality (Payne, 2011).

The following are some of the criticisms of GM as a strategy for achieving gender equality:

- The strategy’s lack of clear and realistic objectives has made it difficult to evaluate whether or not its implementation has been successful (Payne, 2011; Standing, 2004; Theobald et al., 2005). This problem can be rectified with the application of robust monitoring and evaluation tools, yet to be implemented (Moser, 2006).

- The “technocratic” approach of bureaucracies in neoliberal states, also reflected in the policies of international organizations, has co-opted the original goal of radical transformation through GM and has failed to alter the relations of power (Baden & Goetz, 1998; Jahan, 1995). Underlining this point, one report noted the lack of a clearly defined methodology for using the GM strategy to bring about social change (Guijt & Shah, 1998). Another author referred to this approach as a repackaging of feminism that effectively neutralizes its transformative power by creating an acceptable and depoliticized version of the subordination of women (McRobbie, 2008). Charlesworth (2005:2) concludes that “the strategy of gender mainstreaming has deployed the idea of gender in a very limited way and has allowed the mainstream to tame and deradicalize claims to equality. The use of gender mainstreaming has made issues of inequality between men and women harder to identify and deal with.”

- Ravindran and Kelkar-Kambete (2008) attribute the lack of progress in applying this strategy in health to the following causes: (1) depoliticization and delinking of GM from the agendas for social transformation and social justice; (2) adoption of top-down approaches to its implementation; (3) growing hostility within the global policy environment toward issues of justice and equity; and (4) increasing
privatization and retraction of the role of the state in health.

- According to Zalewski (2010) and Tolhurst et al. (2012), the GM strategy assumes that gender identities are based on sex and are clearly identifiable, thus perpetuating the binary model of gender prior to the advent of poststructuralism. This characterization of gender has several drawbacks: It excludes such cases as intersex bodies (Fausto-Sterling, 2000); it fails to recognize the institutionalized heteronorm implied in that distinction; and it masks the diversity of gender identities. Furthermore, its characterization of gender relies on static roles and doesn’t recognize the dynamic positionalities assumed in different contexts as they intersect with diverse social distributions of power. For example, postcolonial feminism distinguished hierarchical differences between women in terms of ethnicity, nationality, social class, sexuality, and other criteria. It would be incomplete to reduce these many nuances to the binarism of gender (Mohanty, 1988).

According to Hankivsky (2005, cited by Tolhurst et al., 2012:1827-8), this resonates with the view that the gender analysis tools used as the basis for GM have tended to treat women and men as unitary one-dimensional categories of analysis, or given weak directives to consider how experiences of women and men will differ according to geography, poverty etc., which are insufficient to enable a robust analysis of these intersections.

Bacchi and Eveline (2009) suggest using gender as a verb rather than a noun and propose three theoretical interventions for shifting focus away from fixed categories and, instead, thinking of people in terms of the social relationships between them: (1) understand gender “as a social principle rather than as a synonym for women, or as a shorthand for ‘men and women’; (2) [make] the idea of gender relations a central notion in the deliberations, […] directing attention to the practices of gendering; (3) highlight our focus on ‘doing’, […] referring to gender as a verb rather than a noun” (Ibid.:297-8). These theoretical interventions offer the opportunity to examine the impact of assuming a gender in the maintenance of hierarchical social relationships beyond relationships between men and women. The objective is to avoid treating gender as either a characteristic of people or, at the other extreme, a cultural mantle that may be discarded, but rather as a “constellation of ideas and social practices that are historically situated and that mutually construct multiple systems of oppression” (Hill Collins, 1999:263, cited by Bacchi & Eveline, 2009:316). Tolhurst et al. (2012) claim that contemporary feminist theory needs to be understood in order for social and political action to produce progress toward gender equality in health: if gender is performative, as proposed by Judith Butler, “it is constantly ‘re-made’ or
‘rewritten’ through daily actions and interactions,” whereas “institutions and organizations work to ‘fix’ and solidify these performances through policies, laws and institutional cultures” (Ibid.:1829). Finally, the reports reviewed emphatically recommended reclaiming the relational characteristic of the gender category and intragender differences and giving visibility to masculinities in GM policies (Barker et al., 2010).

The one-size-fits-all approach to GM training has not been helpful. Every national, local, and sectoral context has its own special characteristics. These differences are a call to set prescriptions aside and find imaginative ways to develop instruments tailored to specific realities (Barrig, 2015:12).

Factors that may cause GM policies to “evaporate” include a lack of resources and the presence of equality-averse institutional cultures. When the gender machinery is vulnerable, as it is in Latin America and the Caribbean (Rodríguez Gustá, 2008), the likelihood of evaporation is much greater (Moser & Moser, 2005).

GM resources such as guidelines, tools, and checklists may be available, but they are not sufficient to be translated into practices that will transform gender-based inequalities (Hankivsky, 2005).

GM as a concept needs to be more thoroughly elaborated or restated in order to have a better understanding of its articulation with social change and with the issues involved in gender inequality that it seeks to redress (Daly, 2005). Other authors say that GM is out of step with reality; that the strategy is very limited because it prioritizes gender as the core axis of discrimination; and that it is not being seen from the intersectoral perspective in its true sense (Hankivsky, 2005). What is needed, according to Olenka Hankivsky, is an alternative to gender mainstreaming that will consistently and systematically reflect a deeper understanding of intersectionality—the simultaneous combination of oppressions that generate a form of discrimination that is completely different from isolated discrimination. Both Hankivsky (Ibid.) and Squires (2007) propose the mainstreaming of diversity rather than gender because it would transcend fixed one-dimensional categories and emphasize the complex nature of people’s identity. Squires (2005) suggests that deliberative mechanisms such as the citizen forums may help boost the transformative power of the mainstreaming model. Hankivsky and Squires join other authors who espouse intersectionality in their rejection of “identity politics for its additive, politically fragmentary and essentializing tendencies” (Phoenix & Pattynama, 2006:187). An attempt to operationalize this perspective, not
only in policies but also in research, practice, and education, can be found in Intersectionality 101 (Hankivsky, 2014). Still, those who have proposed mainstreaming diversity rather than gender, such as Bacchi and Eveline (2009), point out that such reforms can produce unwanted results. Attention needs to shift from processes and practices that give content and form to the initiatives, to policies that simply call for “doing” and which produce actual social change. In order to alter current responses so that they meet the needs and desires of diverse groups (in this case, women), attention should be directed toward democratic and inclusive ways of “doing” that especially favor women who have been marginalized in policy discussions. The concepts “coalition of commitments” and “deep listening” have been introduced to stimulate discussion of the issues under debate. Finally, other authors pointed out that the diversity mainstreaming (DM) proposal could dilute attention to gender as a social determinant of health if it means allocating resources to address inequities in general, if there is no focus, if there is no assessment of the deep causes of inequality, or if there are competing priorities for different forms of inequality (Woodward, 2005, cited by Walby, 2005:330).

As a response to some of these criticisms, Tolhurst et al. (2012) offer a systematic approach to reframing the GM strategy in global health. They identify core issues and propose an agenda for research and action to improve the reach and impact of GM. Its main points are summarized below.

1. **Addressing the disconnect between GM praxis and contemporary feminist theory.** An up-to-date definition of gender in keeping with contemporary feminist theory is necessary for use in assessing health and health systems. In a quantitative approach, this means allowing more than two categories of gender in surveys and routine data collection and empowering respondents to identify themselves beyond the male/female binary.

2. **Developing appropriate gender analysis methodologies.** While disaggregating information by sex and social class is important, this way of organizing data risks strengthening female-male binarism. It was suggested to triangulate such data with qualitative analyses in order to explore the categories more deeply. This will help understand the different experience and positionalities of women and men, using participatory approaches that are sensitive to the distribution of power in the processes and in their analysis.

3. **Developing a coherent theory of change in TG.** The GM strategy has been described as “a concept in search of a methodology” (Guijt & Shah, 1998:6, cited by Tolhurst et al., 2012:1828)
because it has paid relatively little attention to methodologies for promoting change that is consistent with feminist postulates. Instead, it was left to states to bring about the required social transformation (Daly, 2005; Standing, 2004)—which they have not done. In some cases, this was a conscious effort to neutralize the feminist demands originally included on the GM agenda. Thus, it is critical to create strategic frameworks for integrating gender into bureaucratic environments, and there need to be bottom-up planning processes with specific objectives and target groups that reflect the interests and priorities of diverse groups of women and men.

4. Seeking resolution to the dilemmas and uncertainties surrounding the role of men and boys in GM. The dilemma is whether men and boys should be included instrumentally in order to achieve health for women (e.g., in the work to reduce women’s vulnerability to HIV) or whether their needs and interests should be considered in light of the construct of gender itself. A nuanced understanding suggests that approaches to reconfiguring hegemonic masculinities should be based on the interests of both women and men. The reviews of the engagement of men and boys in health programs showed that transformative interventions in gender relations are more effective in changing the behavior and attitudes of men, while it is also necessary to ensure that women are given voice in this process to prevent unexpected consequences such as men using initiatives to consolidate their power (WHO, 2007; Barker et al., 2010, cited by Tolhurst et al., 2012:1830). Furthermore, recent work on masculinities has highlighted the need to go beyond the individual level and address the structural concentration of power, as well as avoid a false equivalence of the vulnerabilities of men and women, especially when addressing gender-based violence (Esplen & Greig, 2007, cited by Tolhurst et al., 2012:1830).

5. Developing policies of intersectionality. Tolhurst et al. (Ibid.) point out that, while notions of identity can naturalize social, political, and economic forms of exclusion, subordinate or marginalized social groups can temporarily set aside local differences in order to forge a sense of collective identity as the basis for a political movement. The authors also discussed an alternative to GM proposed by Hankivsky (2005) and pointed out that these differences in the positions adopted highlight the need for further consensus-building processes, which need to include voices from multiple positionalities that share values of social justice and gender equity (Ibid.:1831).

This systematic review of GM in the academic debate found no mention that a GM strategy can cease to be effective
as a result of ongoing failure to meet all the institutional requirements for GM set forth in the ECOSOC resolution, or to achieve the synergy generated by positive action programs that seek to empower women and girls. It would seem that institutional GM has often been implemented on paper only, without comprehensive reorganization of the institutional structure and culture (plans, specific budget allocations, etc.) and, collaterally, without any measurable or documented impact on incorporation of the gender perspective in the program cycle based on an intersectional and life course approach. Some of the experts interviewed said it is crucial to give substance to the rhetoric of integrating the gender approach in health. To this end, emphasis was placed on including concepts such as the life course approach, interculturalism, and intersectionality in operational and effective forms. The reports reviewed also underscore the importance of improving the accessibility of services in rural areas while implementing the adjustments needed so that health services can meet the gender-specific needs of the rural population in general, indigenous people, and migrants.

Finally, this systematic review of current knowledge on institutional and operational GMH requires ongoing updating within the context of the latest mandates and commitments of the states of the Region of the Americas.
At present, gender mainstreaming is the internationally agreed-upon strategy for achieving gender equality. However, there are substantial gaps in the evaluation of the results of gender mainstreaming in health (GMH).

The Office for Equity, Gender, and Diversity has made it a priority to renew the strategies for achieving gender equality in health based on the findings and lessons learned about GMH and in alignment with the commitments made by the states of the Region of the Americas. This document has reviewed the targets established in the SDGs, the ECLAC Regional Gender Agenda, and the PAHO Gender Equality Policy, and reported on a review of scientific publications, coupled with interviews with experts, to paint a picture of the implementation status of GMH in the Americas. The findings revealed increased rhetoric on incorporation of the gender perspective in health, but a weak definition of the gender approach adopted, uneven institutional performance in meeting the requirements for GM, and a notable unawareness of the actual effect of GM on achieving greater gender equality in health. While programs and projects have been implemented, they were found to have serious limitations in using a results-based approach and to be highly focused on women and sexual and reproductive health. The impact of national health policies on GE, both for women and men in general and at the level of health institutions, is unclear.

Thus, despite some success in the implementation of the GMH strategy in the Region, in many countries the results have been meager or less than optimal in terms of achieving true gender equality in health. Since this outcome requires a sustained intersectoral effort, and does not depend on the health sector alone, it is urgent to reinvigorate GM in health. To that end, the following recommendations have been identified, ranging from the more general to those that are specific for the health sector.

### 3.1. Meet the minimum institutional and programmatic requirements for development of GM

While the formulation of national plans is the most highly met requirement in the Region, these plans need to be revised with the aim of broadening the gender and health agenda to include issues that go beyond but do not neglect sexual and reproductive health. This must be supported by a results-based plan to bridge the gap between aspirations/declarations and actual results toward attaining gender equality.
The institutional mechanisms for the advancement of women, who centralize responsibility for executing gender policy, need a strategic plan that meets institutional requirements for GM, as well as a reliable budget to ensure effective performance. Morrison (2004) has suggested that creating a central GM unit at level one—i.e., the level that affects the structures, policies, procedures, and cultures of an organization—is crucial for the implementation of GM. In addition, to ensure the institutionalization of gender plans, strategies need to be developed that will shield them from changes in government, while facilitating standard mechanisms for intersectoral coordination. Those countries that have made the most progress in implementing policies for GE, such as Canada, have strong entities that coordinate these policies across all sectors of the national government.

It is critical, both at the country level and for the Region as a whole, to review existing legal frameworks, consider gaps in laws and standards that are indispensable for expanding rights, and have an impact plan for the development of such frameworks. Examples of issues to be addressed include expansion of maternity and paternity leave; recognition of unpaid domestic work and caregiving; legalization of voluntary interruption of pregnancy; implementation of gender-sensitive curricula in educational institutions at all levels (including undergraduate); financing of strategic academic research on topics related to gender mainstreaming; establishment of policies in parity; and promotion of women’s leadership in decision-making positions.

Most of these challenges are already addressed in the text of existing GM policies and plans for the health sector. However, the policies and plans should be revised with a view to bridging the gaps between the declarations made and the concrete progress achieved toward gender equity in health.

The findings regarding fulfillment of requirements for GM in health are summarized in the following paragraphs.

To sustain any policy or program, it is essential to institutionalize specific budgetary allocations for GM activities. The lack of self-managed government resources undermines the ongoing implementation of the GM strategy and is one of the factors contributing to its “evaporation.” This shortcoming also affects the availability of human capital to achieve GEH.

There are major gaps in the systematization and continuity required to build capacity in gender and health through approaches that are consistent with the GM plan. Comprehensive training programs are needed to educate on value components relative to the transformation of gender inequity (values, beliefs, and attitudes toward a gender habitus), and to provide the
capacities needed to implement the strategy and transform unequal gender relations (for example, training in how to perform gender analysis). One positive development is increased demand from countries for technical support on gender and health in general and on the emerging issues that PAHO has prioritized. These include LGBT issues, masculinities, specific mechanisms for integrating the gender perspective in data analysis, M&E, and strategies for policy impact. Capacity-building should be integrated into the training curricula for health providers as well as public policy managers.

Another notable gap was observed in gender analysis in health in the Region of the Americas. Canada was the only country reported to have a solid national model (GBA+) for conducting this type of analysis with a strong intersectional approach. Strengthening capacity in the gender analysis in health was seen to be a priority.

Improving information systems at the country level and throughout the Region is a high priority in the PAHO Gender Equality Policy and one of the areas in which shortcomings were reported in the previous chapter. It would be useful for National Demographic and Health Surveys (NDHS) and other household surveys to include questions on gender that are comparable across the Region, as well as data disaggregated not only by sex and age but also by other key variables associated with social determinants of health. Consideration should also be given to exploring elements that have been overlooked in the design of gender and health policies (for example, age of menarche) and ways of improving information systems.

One of the consequences of lack of information is a barrier to establishing M&E plans for following up and evaluating outcomes of policies that seek to redress gender-based inequalities in health. It is crucial to have baseline data and to define indicators that are sufficiently sensitive to measure transformations toward gender equality. The findings also revealed the need to define Region-wide gender-sensitive process, outcome, and impact indicators in the health area for application at the national level. They should be both quantitative and qualitative, to measure transformations in inter- and intra-gender power relations.

Accountability is another gap revealed in the reports on GM policies. It is important to enlist the contribution of civil society organizations (women’s social movements and, more broadly, various groups that advocate for equity in health) in the form of funding and participation in the full programming cycle, including design, surveillance, and sustainability, to help ensure the continuity of policies. The reports also mentioned limited incentives for achieving good results in GM, since there are no rewards for progress and few penalties for failed initiatives (UN Women, 2011).
3.2. Agree on an operational definition for the GM strategy in health

It is impossible to implement a strategy effectively without a clearly defined plan that spells out the essential approaches and the development of its components, actions, and expected results. It is essential to clearly differentiate the three macro components that determine the GM strategy, namely: institutional GM, operational GM, and impact on GE and the empowerment of girls and women in the broader community. This means not only clarifying the requirements for making the strategy operational in the literal sense, even if it is already included in national institutional policies or specific programs, but also spelling out the expected impact of GEH on the population so that it will be possible to document, monitor, and evaluate processes and outcomes. Agreeing on Region-wide definitions would also make it easier to draw comparisons between countries and facilitate collaboration.

In order to make an impact on unequal gender relations, it is important to thoroughly examine and update the operational definition of the gender perspective. This definition should reflect the progress in feminist theory in recent decades; transcend the assumption that gender is derived from sex and is binary, static, and monolithic within every group; and incorporate an understanding of how to bring about changes in social attitudes toward gender equality.

For true equality, public policies need to address the gender perspective from three critical angles (intersectorality, the life course, and interculturalism), while protecting human rights and optimizing resources and outcomes.

As a complement to the GM strategy, it is important to have a strategy for the empowerment of women so that the two strategies, working in tandem, can focus on reconfiguring hegemonic masculinities. The evidence shows that positive action in this direction is ineffective unless men are also engaged in the effort to eliminate discriminatory institutional norms, redistribute resources and power, and eliminate privileges, which also have implications for the health of many men.

Finally, while robust gender analysis is crucial for GM, it is also essential to incorporate all the remaining minimum requirements explored in Chapters 1 and 2 above, as well as impact activities, networks, and knowledge management. Ensuring that these varied elements produce coherent results requires a clearly developed strategic plan (Murison, 2004:131).

3.3. Prioritize health-focused GM policies that seek to eliminate the structural roadblocks against progress toward gender equality

The evidence shows that it was easier to include the gender perspective in targeted programs that concentrate
on the classical topics on the gender and health agenda, particularly sexual and reproductive health. However, it is necessary to expand that perspective to other emerging issues on the agenda and, where necessary, revise and clarify the gender perspective adopted for analysis, since it affects programming.

Targeted GM policies would benefit from a systematic review in response to suggestions regarding their approach and content. Also, programs that will structurally transform gender relations—“the structural challenges to the achievement of gender equality,”13 according to the Montevideo Strategy (ECLAC, 2017e:14)—and that coincide with key SDG targets and the priorities of the PAHO Gender Equality Policy (2005) should be prioritized. The following are examples of structural aims that are aligned with the central normative frameworks for GM:

- Create policies that are more equitable by recognizing and assessing the impact of the “care economy” on the health sector.

- Prevent and reduce pregnancy in childhood and adolescence. There are some good intersectoral initiatives in the Region with specifically allocated budgets (e.g., the ENIA Plan in Argentina14) that could be adapted and monitored at the national and regional level.

- Promote inclusive diversity education starting in childhood, particularly gender sensitivity training as part of comprehensive sex education initiatives in the Region in keeping with new evidence-based guidelines introduced by UNESCO (2018).

- Promote the health of men, considering the ways in which they are directly affected by the construction of masculinities.

- Promote health and reduce access barriers to health services for those at greatest disadvantage: rural populations, indigenous groups, Afrodescendants, migrants, LGBT populations, sex workers, etc.

3.4. Optimize opportunities in the Region of the Americas to develop regional or subregional strategies for gender equality in health

The interviewed experts pointed to a number of opportunities at the regional level for drafting a new road map toward gender equity in health while taking structural challenges into account.

It is important to redouble support for the international, regional, and national commitments assumed by states to drive the discussions and measures needed to ensure gender equality. The literature showed that efforts of this

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13 The Montevideo Strategy (ECLAC, 2017e) lists four such challenges: [a] socioeconomic inequality and the persistence of poverty; [b] discriminatory, violent, and patriarchal cultural patterns and the predominance of a culture of privilege; [c] sexual division of labor and unfair social organization of care; and [d] concentration of power and hierarchical relations in the public sphere.

14 See: https://www.argentina.gob.ar/planenia.
kind were useful in reducing maternal mortality under the Millennium Development Goals. Other important avenues for advancing the gender and health agenda in the Americas include supporting the universal health strategy, stepping up efforts to place the social determinants of health on the global agenda, and working to fulfill the recommendations soon to be issued by the PAHO Committee on Social Determinants of Health.

It was also noted that this Region enjoys not only economic strength but also rule of law with independent institutions that, although young, are becoming consolidated. Strengthening national agencies for women is another strategy suggested for stepping up the implementation of GM in health, together with forging partnerships with new generations of men and women. This younger cohort, born in democracy and more attuned to the human rights discourse, is in a position to facilitate the transformation of gender-based inequalities. An example of their powerful role in claims for social justice has already been seen in their support of voluntary interruption of pregnancy in Argentina in 2018.

The systematic review of literature also indicated that it would be desirable to make strategic use of mechanisms for the integration of regional policies, such as the Commission on Gender and Health of the Central American Integration System (SICA).

Lastly, the structural challenges outlined in the previous chapter need to be addressed, including the political impact of conservative groups opposed to the GE agenda and the autonomy of women. The experts pointed out the need to agree on an active long-term strategy to neutralize these attacks. Three central approaches have been proposed: (1) develop plans for legal action at the national and international level, bringing cases before international tribunals such as the United Nations Human Rights Council; (2) convene and follow up on meetings that call for international organizations, governments, academia, and civil society groups to develop an organized response in defense of gender equality; and (3) strengthen women’s movements that have lost funding or are suffering from a degree of disorganization in fulfilling their mission.

Another situational challenge is the impact of climate change on health and well-being, especially in poorer countries of the Caribbean, where organized strategies are needed to prepare for and mitigate differential gender-related damage. The same is true of the shift toward an aging population in the Region, which will require public policies to promote active and healthy aging, including paid caregiving within a social protection system (compensation for tasks that tend to be performed informally by women in the family circle), and sexual and reproductive health in older persons.
3.5. Encourage results-based documentation of policies to ensure identification of best strategies

While the generation of “top-down” evidence (at the national level) should be encouraged, it is also important to map, systematize, and document good practices for the generation of “bottom-up” evidence. Some authors noted that implementation of the GM strategy for achieving gender equality was more viable in small-scale jurisdictions and smaller institutions (Barrig, 2015).
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Gender Mainstreaming in Health: Advances and Challenges in the Region of the Americas


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Gender Mainstreaming in Health: Advances and Challenges in the Region of the Americas

Objective
Evidence was collected on the outcomes from applying the gender mainstreaming strategy in health along two dimensions: institutional interventions and targeted interventions.

1. Results of institutional interventions designed to integrate the gender perspective into national health policies in the countries of the Region of the Americas. The actions performed towards this goal addressed one or more of the minimum requirements for achieving GM:
   a. Adoption of an institutional policy or plan for gender equality coupled with measures to address gender-based inequalities;
   b. Identification of priority issues on the GMH agenda;
   c. Allocation of specific budget funding for gender equity;
   d. Disaggregation of data by sex, age, and other social determinants of health;
   e. Gender analysis;
   f. Strengthening of institutional capacity for gender equity in health (including training of health human resources, undergraduate- or graduate-level education or training for personnel in general, policies on personnel parity, promotion of health research from a gender perspective);
   g. Monitoring and evaluation;
   h. Accountability;
   i. “Do no harm” policies.

2. Results of targeted interventions aimed at integrating gender analysis into certain policies and health programs. Results were documented for policies and programs aimed at:
   - Promotion of gender equity in universal access to SRH services in general;
   - Prevention of pregnancy in childhood and adolescence and provision of related care;
   - Prevention of maternal mortality;
   - Prevention of transmission of HIV/AIDS and other STIs and provision of care for persons living with these infections;
   - Prevention of intimate partner violence and improvement of related health responses;
   - Prevention of road deaths and injuries, and other deaths due to external causes;
   - Prevention, detection, and treatment of mental illnesses in which gender is
a key determinant (e.g., depression);
- Identification or promotion of gender equality in health policies or programs that provide health care to the LGBT population;
- Recognition of unpaid health care performed by women as part of the total health system expenditure in national accounts.

**Search Strategy**

The initial search strategy was developed in October-November 2017 and a second search strategy was prepared in May-July 2018. In addition to the literature search, interviews were conducted with key informants specialized in gender and health policies in the Region of the Americas.

**Databases**

Four databases that index quality scientific literature were consulted: in English, PubMed and Cochrane; in Spanish, SciELO and open access PLOS. In addition, the contents of one of the most rigorous scientific journals in the field of health and gender (*Lancet: Gender & Society*) were reviewed in English and the Google Scholar search engine was consulted. Finally, consolidated reports prepared by several international agencies, including PAHO/WHO, were reviewed.

**Languages**

English, Portuguese, and Spanish. Table 2 shows the search terms used for the search strategy.
Gender Mainstreaming in Health: Advances and Challenges in the Region of the Americas

Criteria for Exclusion and Inclusion

Articles and publications that failed to meet the following requirements were excluded:

1. contains results on the topics being reviewed;
2. published between 1994 (the year when a key international body first issued the call to integrate the gender perspective and human rights in the health agenda) and 2018; and
3. refers to some or all of the countries in the Region of the Americas.

Countries under Review

The systematic review of the evidence targeted the Region of the Americas as a whole or any of its countries and territories.

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>KEYWORDS</th>
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<tr>
<td>[5] LGBTI</td>
<td>“Health” AND “LGBTI” OR “lesbians” OR “intersex” OR “transgender” OR “bisexual” OR “transvestite” OR “gender identity” OR “sexual orientation” OR “gays” OR “trans” OR “transsexual” OR “gender perspective”</td>
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<td>[6] Mental health</td>
<td>“Gender” OR “gender equality” OR “gender inequality” OR “masculinity” OR “femininity” OR “women” OR “men” OR “gender norms” AND “mental health” OR “wellbeing” OR “addictions”</td>
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<td>[9] HIV and STIs</td>
<td>“Prevention” OR “transmission” AND “HIV” OR “STI” OR “gonorrhea” OR “HPV” OR “AIDS” OR “sexually transmitted infections” OR “AIDS” OR “human papillomavirus” OR “condom use” OR “syphilis”</td>
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<tr>
<td>[10] Informal caregivers</td>
<td>“Health” AND “informal caregivers” OR “informal care” OR “spousal caregivers” OR “elderly caregivers” OR “caregiving strain”</td>
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Table 3. List of countries and territories of the Region of the Americas

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<th>Country</th>
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Evaluation of the Studies and Summarization of Findings

The selected studies that met the criteria, following an evaluation of the full text, were listed in an Excel document containing the following fields: citation (author/s, year, title, journal, etc.); type of work (review of evidence or analysis of an intervention); geographic area of influence; topics of the interventions as defined in the protocol; results evaluated; facilitators; barriers; future challenges.
Universal Access to Sexual and Reproductive Health Services

In the literature reviewed, most publications on health policies in the Region that call for universal access to sexual and reproductive health (SRH) were found in Argentina, Colombia, Mexico, and, to a lesser extent, Chile and Peru.

Analysis of the publications on this subject revealed that in countries where universal access to SRH services is not guaranteed, numerous NGOs and other groups and individuals have stepped up to at least partially fill the void left by inadequate or poorly implemented public policies (Richardson & Birn, 2011; Zaldúa et al., 2010).

All the reports agreed that the main obstacle standing in the way of universal access to SRH care is socioeconomic inequality (Restrepo-Méndez et al., 2015; Agudelo, 2009). The low impact of some of the programs implemented at the national level was also noted, and attributed to three main issues: the norms that govern them are not followed (Freyermuth Enciso et al., 20015), specialized health services are not offered (Rojas Cabrera et al., 2017), or infrastructure is lacking to maintain them (Mendoza et al., 2017). Low use of available SRH services by men is another point to be considered in policy design (Pantelides & Gaudio, 2009). Finally, the fact that certain religious groups have a strong impact on political decisions is an impediment that needs to be considered, especially in Latin America (Richardson & Birn, 2011; Figueroa-Perea, 2007).

Maternal Mortality

In the literature reviewed, publications that cited health policies in the Region for combating maternal mortality were found in Brazil, Canada, Colombia, Mexico, the United States, Uruguay, and, to a lesser extent, Argentina, Ecuador, and Peru.

The reports indicated that reducing maternal mortality requires effective policies on access to SRH in even the most remote areas (Jarlencki et al., 2017; Landini et al., 2015; Martins Pollyanna et al., 2017; Martínez-Fernández et al., 2015), especially policies on strengthening the prevention of unwanted pregnancies that lead to unsafe abortions (Matía et al., 2016; Briozzo et al., 2016; Briozzo, 2016) and on the detection and control of preexisting health conditions that increase the risk of death during pregnancy, childbirth, or the puerperium (Metcalfe et al., 2017).
They also emphasized the importance of improving the collection, quality, and analysis of data in order to understand the dimensions of the problem (Joseph et al., 2017; Delgado Lara et al., 2013). Another finding extracted from the review is that circumstances that aggravated maternal mortality included belonging to a vulnerable population, certain races or ethnicities, as well as low socioeconomic level (del Carpio Ancaya et al., 2013; Metcalfe et al., 2017; Bula Romero & Galarza, 2017; Sanhueza et al., 2017; Santos et al., 2017). The reports also cited lack of data, resulting in underdiagnosis or unawareness of risk factors (e.g., gender-based violence), as an obstacle to reducing maternal mortality (Cook et al., 2017; Lisonkova et al., 2011; Salazar et al., 2015; Montoya et al., 2017), especially in countries like Canada, which has the lowest rate in the Region.

Pregnancy in Childhood (under 15 Years of Age) and Adolescence (15 to 19 Years)

In the literature reviewed, publications describing health policies in the Region on pregnancy in childhood and adolescence were found in Chile, Colombia, Mexico, the United States, and, to a lesser extent, Brazil and Venezuela. Evaluation of these reports showed that many programs were not effective or did not have a significant impact on the prevention or reduction of pregnancy in children or adolescents (Francis et al., 2016). However, there was agreement that access to sexual and reproductive health services is indispensable, especially for vulnerable populations (Morais Pereira & Taquette, 2007; Atienzo et al., 2011; Castle Riascos, 2016).

One of the biggest challenges is the lack of evidence that the programs implemented were effective (LaChausse, 2016; Flora et al., 2013), which makes it difficult to design new policies and lines of intervention. Another concern noted was that, even though it has been demonstrated that programs for the prevention of adolescent pregnancy increase knowledge about contraceptive methods, this knowledge does not have a significant impact on the behavior of young people (LaChausse, 2016); this conclusion has been questioned by other authors (Chin et al., 2012).

Transmission of HIV/AIDS and Other STIs

In the literature reviewed, publications that cited health policies in the Region on the transmission of HIV/AIDS and other STIs were found in Canada, Chile, Colombia, the Dominican Republic, Mexico, the United States, and, to a lesser extent, Argentina, Barbados, Cuba, Nicaragua, and Puerto Rico.

The reports mentioned that multifaceted approaches were more effective in achieving results from the interventions (Ruiz-Pérez et al., 2017). Consideration should be given to access to health...
care and also to circumstances that specifically affect certain populations, such as education (Souradet et al., 2016; Guerra et al., 2016; Gonzalez et al., 2015); socioeconomic level (Báez-Feliciano et al., 2005; Arrivillaga-Quintero, 2010); geographic location (Potter et al., 2016; Román-Poueriet et al., 2009); and discrimination (Arrivillaga-Quintero, 2010).

One of the main obstacles observed was that, despite widespread access to diagnosis and antiretroviral (ARV) treatment, mortality from AIDS has not declined as much as had been hoped. Examples were cited in Colombia (García et al., 2005), Mexico (Bautista-Arredondo, 2015), and Puerto Rico (Báez-Feliciano et al., 2005). Several reports noted that sex workers were one of the groups most exposed to HIV and other STIs, and that priority should be given to developing programs for them to receive the best health care (García et al., 2006, 2014; Azhar et al., 2014; Román-Poueriet et al., 2009; Pando et al., 2011; Egger et al., 2000). Issues such as feelings of shame, lack of privacy, and lack of sensitivity on the part of health workers were identified as obstacles that impeded access to information, diagnosis, and treatment (O’Byrne et al., 2014; Landis et al., 2013; Gallegos et al., 2008).

Intimate Partner Violence

In the literature reviewed, publications on health policies in the Region that addressed intimate partner violence were found in Brazil and Mexico. There were also evaluations of policies implemented in Costa Rica, Cuba, Haiti, and Mexico. The assessment revealed the need for improved intersectoral dialogue to help health systems respond more effectively to problems associated with violence against women (Gutiérrez et al., 2012; Haddad Kury, 2015). Few programs have been successful in adequately integrating a response to violence into the health care structure (Contreras et al., 2010; Deslandes et al., 2016). One of the main omissions noted by some of the authors was the lack of a rights-based framework for health care, making it difficult for health professionals to identify the role of the health system in these situations (García-Moreno et al., 2015; Andrade et al., 2016). This can result in negative consequences such as failure to intervene in cases of violence against women (Loria et al., 2014; Haddad Kury 2015) or victims being turned away (Contreras et al., 2010; López Angulo et al., 2010).

The reports analyzed emphasized the importance of training and raising awareness among health personnel so that systems can provide adequate interventions and respond effectively in situations involving violence against women (Fernández Pérez, 2010; Loria et al., 2014; Contreras et al., 2010; Guedes et al., 2014), especially when it comes to emergency care following sexual abuse (Contreras et al., 2010). Governments are urged to develop or strengthen...
multisectoral action plans to address violence against women, which should be given high priority in health policies (García-Moreno et al., 2015; Couture et al., 2010). It is also very important to apply comprehensive strategies that address violence both against women and against their children (Guedes et al., 2014). Institutions should improve their response to include access for women who are experiencing violence but do not seek help because they do not know where to go or because they do not believe they will receive compassionate, effective, and confidential assistance (Guedes et al., 2014). Women often say that health workers focus on treating their injuries without offering assistance or useful guidance on how to proceed in broader terms (Guedes et al., 2002a; 2002b). Girls and women who suffer repeated sexual violence may go to health workers in search of help, but the evidence in the Region indicated that the quality of the response is poor (Contreras et al., 2010). Other crucial elements found lacking by the review include monitoring and evaluation mechanisms, documentation of events, systematic recording of experiences, and data analysis (Bott et al., 2005). Finally, Barker et al. (2010a) underscored the importance of involving men in ending all forms of violence. Topics for further exploration include understanding the socialization of men with regard to different forms of violence; the adoption of a punitive approach, particularly in the case of intimate partner violence; and intervention through policies that seek to reconfigure patterns of hegemonic masculinity. Furthermore, Barker recommended that some of the policies in countries of the Region should take a new look at the stigmatization of men in general as assailants.
Operational GM in emerging topics of the gender and health agenda

Men’s Health and Masculinities

In the literature reviewed, publications on health policies in the Region that referred to men’s health and masculinities were found in Brazil, Canada, Mexico, and, to a lesser extent, Argentina, the Dominican Republic, and the United States.

The analysis revealed the need to recognize the sociocultural and historical dimensions of masculinities and their influence on health processes as a basis for designing policies within the framework of gender equity (Couto & Gomes, 2012; Machado & Ribeiro, 2012; Couti et al., 2010).

The main obstacle mentioned was failure to recognize that being male is a risk factor for not receiving health care and disease prevention services, as men receive less attention in health centers (Fernández Moreno, 2008; López et al., 2006; Nunes Moreira et al., 2016; Stergiou-Kita et al., 2016). Some authors warned against the negative effects of naturalizing gender roles in health care for men and cited the need to take steps to change these characterizations (Figueredo & Terenzi, 2008; Fleiz Bautista et al., 2008; Fleming et al., 2014; Griffith, 2015).

Health Care for the LGBT Population

In the literature reviewed, publications describing health policies in the Region on health care for the LGBT population were found in Argentina, Brazil, Canada, Colombia, and the United States.

The reports in question emphasized the need to move beyond the acritical reinforcement of stereotypes and imaginary conceptions of what is masculine and what is feminine in medical practice and begin to design interventions aimed at improving access to health care for the LGBT population (Lasso, 2014; Caravaca-Morera et al., 2017; Ruiz Lopez et al., 2015; Brown et al., 2014).

One of the main challenges mentioned was the nonexistent or conflicted relationship between trans people (especially trans women) and the health services (Farji Neer, 2016; Cardozo Rocon et al., 2016). This situation puts their lives at serious risk because, if the health system fails to respond, these people sometimes resort to self-administration of hormones and self-performed surgeries (Lasso, 2014). Another issue mentioned is inadequate coordination between the different services within the health agency (especially between...
LGBT-friendly services and others) and between different health agencies (Casal & Pugliese, 2009), as well as an overall lack of training for health workers on gender-related topics and LGBT rights (Caravaca-Morera et al., 2017; Gruskin et al., 2007).

**Unpaid Caregiving and Health Care in the Home**

In the literature reviewed, health policies in the Region that addressed unpaid caregiving and health care in the home were found in Argentina, Brazil, Uruguay, and, to a lesser extent, in Canada, Chile, Colombia, Cuba, Mexico, Peru, and the United States.

An analysis of these reports made it clear that the contribution of women who are informal caregivers, and therefore bridging a gap neglected by health policies, is invisible in the formal health system structure (Jofré & Mendoza, 2005; Marante Pozo, 2014). Many factors contribute to placing these women in a situation of serious vulnerability, including the traditional sex-based division of labor, the invisibility of the work, the excessive burden it imposes, and the limited social recognition of the task (Batthyány et al., 2017; Rozario, 2017).

There was also a lack of systematic research on the impact of informal caregiving on women’s health (Covarrubias & Andrade Cepeda, 2012; Fernández & Herrera, 2016; Zunino et al., 2016; Brazil et al., 2009). More information is needed in order to understand the dimensions of this problem in all its complexity. The reports noted an absence of public policies on care for older adults, persons with disabilities, and people in other situations of dependency (Oddone, 2014). However, perhaps the greatest challenge of all is the phenomenon of an aging population, a global reality that will increasingly call for solutions to meet the need for care (Meira et al., 2017; Banchero & Mihoff, 2017).

**Mental Health**

In the literature reviewed, publications on mental health in the Region’s health policies were found in Brazil, Canada, Mexico, and, to a lesser extent, Colombia, Puerto Rico, and the United States.

The analysis found that strategies are needed to improve access to mental health care, with a gender perspective that takes into account the specific needs of different groups (Mackenzie et al., 2006; Willging et al., 2006).

One of the main obstacles identified is the reluctance of men and LGBT people to recognize mental health problems and seek help, which results in their underutilization of mental health services (Mackenzie et al., 2006; Willging et al., 2006).

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15 Substance use disorders were a core issue in the reports on this topic.
Willging et al., 2006). Another obstacle is difficult access to mental health services in the case of women (Cabiya et al., 2006; Belló et al., 2008; Müller de Andrade et al., 2017) and people in rural areas (Willging et al., 2006), which increases their vulnerability. Another obstacle in several of the subregions is a lack of awareness of existing policies on psychological and social care on the part of users and health professionals alike (Barbosa et al., 2014; Da Graça Costa et al., 2015).
Experiences with integrating the gender equality perspective in health

Bolivia – Accountability for women’s advancement: Municipal Public Hearings on Health; Directorate of Environment–Mining Corporation of Bolivia (Dirección de Medio Ambiente–Corporación Minera de Bolivia [DIMA-COMIBOL])
The purpose of this project was to ensure the participation of women in the process of health accountability, through public “health hearings” in the municipality of Colquechaca. The goal was to redefine accountability and include women in the planning, accountability, and monitoring of decisions. The project resulted in development of a methodology that incorporates accountability for the advancement of women in all municipal health programs. The public hearings conducted in Colquechaca include the active participation of women and this improvement has been reflected in the infrastructure, the composition of teams, and prevention activities. Steps are being taken to implement similar projects in other communities. Available from: https://www.paho.org/hq/dmdocuments/2012/gender-ethnicity-best-practices-accountability-women-2012.pdf

Peru – The participation of women and men of Tutumbaru in monitoring maternal and child health in Ayacucho, Peru; Management Sciences for Health
In the community of Tutumbaru, women had limited participation in the management of health problems, where decisions were made by men. The project was designed to increase the participation and presence of women at the decision-making level and promote the involvement of men in health work traditionally assigned to women. As a result of the project, both men and women are now involved in health responsibilities and decision-making, with women comprising nearly half the membership of the community neighborhood board and men involved in maternal and child health surveillance, family planning, and maternal health. Available from: https://www.paho.org/hq/dmdocuments/2013/best-practices-gender-participation-tutumbaru-ingles-BP-peru-2013.pdf

Colombia – Safe Motherhood in the Cauca Pacific coast: the road toward a happy and safe childbirth; PAHO, Colombia: Cauca Department Secretariat of Health; Guapi, López de Micay, and Timbiquí Municipal Secretariats of Health; Guapi and Western State Social Enterprises (Empresas Sociales del Estado—ESE); Matamba and Gausa Women’s Network; and Cauca Pacific Coast Midwives Group

Annex 4
This project, which focused on displaced indigenous and Afrodescendant communities on the Cauca Pacific Coast of Colombia, involved training midwives and local health agents to spot risk factors, protective factors, and warning signs in pregnant women and newborns with a view to reducing barriers to health service access. Cultural and ethnic diversity were incorporated into the materials used in the training. The outcome was increased recognition of maternal and perinatal morbidity as a public health problem in these communities. The project has been replicated in other communities using the same dynamics and educational materials.

**Uruguay – Changing relationships in the health care context: the Uruguayan Model for reducing the risk and harm of unsafe abortions; Health Initiatives (Iniciativas Sanitarias) Civil Association**

The aim of this project was to implement and monitor a strategy for reducing the risk and harm of unsafe abortion through the coordinated intervention of professionals, health teams, user communities, and health service institutions. The model included the development of clinical guidelines based on expert information and ethical considerations so that every woman can make a decision regarding whether to interrupt or continue her pregnancy freely, responsibly, and safely, with assurance that she will receive comprehensive post-abortion care. This project can be adapted for use in countries with restrictive legislation regarding abortion. Available from: https://www.paho.org/hq/dmdocuments/2013/Publication-EN-BP-Uruguay-2012.pdf

**Argentina – Promotion of Sexual and Reproductive Health and Prevention of HIV in Adolescents and Young Adults Living in Marginal Areas of Buenos Aires; Fundación Huésped**

This project was designed to actively engage key groups of young people, including those in conditions of poverty, those living with HIV/AIDS, the indigenous population, and migrants, in sharing evidence, especially qualitative evidence, demonstrating that inequalities exist between men and women. By transforming practices and attitudes toward exercising the right to sexual and reproductive health, the project sought to improve quality of life for both men and women. It resulted in an increase in the number of consultations, especially by men; an improved level of knowledge; and increased use of condoms. It has also seen a clear multiplier effect in the creation of a young people’s network in response to HIV, Latinoamerican@s Unid@s (Latin American@s United), made up of approximately 100 organizations in six countries of the Region.

**Trinidad and Tobago – Prevention in HIV-serodiscordant Heterosexual Couples; Tobago Health Promotion Clinic, PAHO**

HIV-discordant heterosexual couples are a growing group at high risk for contracting HIV. The country had no strategic plans aimed at meeting the
health needs of this group, especially in terms of prevention, but also of sexual and reproductive health in general. In view of this gap, the project aimed to provide support for several types of groups, including 100 HIV-discordant heterosexual couples, with a view to reducing the number of separations and domestic violence related to their HIV status, as well as to provide training in conflict resolution. The project helped to reduce anxiety related to the spread of HIV, specifically in connection with pregnancy. It was expanded across the country to include HIV-positive mothers and the participation of private physicians and community and religious leaders.

El Salvador – Empowerment of Women, Family Members, and Communities to Reduce Maternal and Neonatal Mortality, with the Participation of Adolescents and Young Adults; Ministry of Public Health and Social Welfare, PAHO

This project was conducted in the municipality of Nahuizalco, where major inequalities existed in maternal and neonatal health care for adolescents. The project sought to promote health as a right in the context of sexual and reproductive health through participatory planning, including capacity-building for health service users, improvement of the quality of health services, and intersectoral work with civil society organizations, municipalities, and governmental and nongovernmental agencies. Outcomes included a reduction in maternal mortality and increases in prenatal visits and institutional deliveries, as well as a reduction in infant mortality.

Argentina – Comprehensive Adolescent Health Care: Risk and Harm Reduction in Reproductive Health with Gender Equality; Cosme Argerich General Hospital, Foundation for Adolescent Health 2000 (Fundación para la Salud del Adolescente del 2000 – FUSA 2000)

This project positively affected 15% of migrant and other adolescents in Buenos Aires. It began in response to high rates of adolescent pregnancy, limited prevention in the area of sexual and reproductive health, and the need for consultation following complications from induced abortions. Through workshops on sexuality, gender, and rights held in waiting rooms, it was also possible to create a space for pre- and post-abortion counseling. The workshops address everyday situations in the life of adolescents. Results are measured by the number of workshops offered, the number of adolescents who have participated (disaggregated by gender), the increase in the number of adolescents who seek counseling, and the decline in pregnancy-related complications. Available from: http://www1.paho.org/hq/dmdocuments/gdr-bp-argentina-2010-EN.pdf

Brazil – Program H and Program M: Engaging young men and empowering young women to promote Gender Equality and Health; Promundo

These programs seek to benefit low-
income young people in Rio de Janeiro and engage them in critical thinking about gender standards and their impact on their own sexual and reproductive health, gender-based violence, and other health issues. There are group learning activities for young people, supplemented with a radio drama series that addresses such topics as unplanned pregnancy, condom use, and adolescent paternity. Impact assessment studies show that young men who participate in the program show greater acceptance of domestic work, higher rates of condom use, and lower rates of violence against women. Available from: https://promundo.org.br/wp-content/uploads/2014/12/Program-H-and-Program-M-Evaluation.pdf.

**Bolivia – Primary Health Care with a Gender Approach (Star Health Services); Department of Health Services, La Paz; Ministry of Health and Sports, and the PAHO/WHO Representative Office-BOL**

This program benefits migrant women and Aymara indigenous women living in poverty in urban sections of the Municipality of La Paz. The initiative originated as a result of low coverage and participation by women in the care and prevention of illness and disease for reasons related to discrimination, treatment, and other pressing needs in their lives. Through coordination with health service providers and women-focused agencies, changes were made to improve the response of health services to specific user needs based on an intercultural approach, thereby increasing care coverage, especially for labor.

**Brazil – Empowering Families to face Domestic Violence; Federal University of São Carlos, School Health Unit, Analytical Laboratory for the Prevention of Violence (Laboratório de Análise e Prevenção da Violência – LAPREV)**

This project addressed high rates of violence through prevention and treatment. Based in the city of São Carlos, it began in police stations and eventually became a part of the health system. As a partnership between the university and the municipality, it worked with parents and followed 800 beneficiaries to transform their violent behaviors toward their children. The results included a reduction in violent relationships and improvements in the ability of providers to detect and address cases of violence. Available from: http://www1.paho.org/hq/dmdocuments/2009/BP_en_2010_BRA.pdf.

**Bolivia – Building Bridges between the Community and the Health Services with a Gender and Intercultural Approach; Program for Comprehensive Health Coordination (Programa de Coordinación en Salud Integral – PROCOSI)**

With emphasis on the empowerment of women, community participation, and a cultural and gender perspective, this best practice has helped reduce maternal and child mortality in the towns of Calamarca and Morochata. Community promoters and local women
learned about reproductive health and their human rights and, as a result, they demanded and obtained access to better health care. The project also included the participation of men, municipal authorities, and health providers in finding ways to secure greater support and attention to their rights and claims. Available from: http://www1.paho.org/hq/dmdocuments/2010/ethnicity_health_best_practices.pdf

**Mexico – Gender Mainstreaming in Priority Health Programs: The Case of the Diabetes Mellitus Prevention and Control Program in Mexico; Mexico, Ministry of Health, National Center for Gender Equity and Reproductive Health (Centro Nacional de Equidad de Género y Salud Reproductiva)**

This best practice, which has been implemented throughout the country, focuses on disseminating information on the best ways to manage differences in adopted behaviors and the effects experienced by men and women with diabetes. The initiative is part of the national campaign “Taking Steps as Men and Women” (“Los hombres y las mujeres estamos tomando medidas”), which has also included disseminating specific information for men and women and for health workers with a view to improving health coverage of this disease. Available from: http://www.paho.org/hq/dmdocuments/2008/BEST%20PRACTICES%20MEX%20EN.pdf.
Gender mainstreaming, a strategy to institutionalize actions oriented towards the achievement of gender equality, has been implemented in the countries of the Region of the Americas since the 1990s. Despite advances in gender equality, both in the field of health and its social determinants, the mainstreaming process presents challenges that need to be identified, analyzed, and addressed.

This document presents an analysis of various components of the gender mainstreaming strategy applied to health. It provides lessons learned based on countries’ experiences, achievements, and challenges, and identifies transformative and forward-looking actions to implement. Some of the components of the strategy that deserve to be highlighted in their approach include multisectoral work, the identification gender intersections with diverse exclusion and discrimination factors, the strengthening of civil society participation, the updating of policy frameworks with resource allocations, and the consideration of the diversity of populations, among others.

Accelerating the implementation of the components of the health-related gender mainstreaming strategy, in a comprehensive and homogeneous manner in countries, requires institutional frameworks in conjunction with specific programs based on results. For the health sector, it warrants new commitments aimed at women’s empowerment and accountability processes supported by the 2030 Agenda for Sustainable Development. The Pan American Health Organization hopes the information contained in this document will encourage new responses that will enable the achievement of gender equality in the field of health.