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WORLD HEALTH ORGANIZATION



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REPORT OF THE SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

The Director is pleased to submit to the Executive Committee the Final Report of the 18th Session of the Subcommittee on Women, Health, and Development of the Executive Committee, which took place at PAHO Headquarters on 8 and 9 February 1999. The report contains the deliberations of the Subcommittee on: the activities of the Women, Health, and Development Program during 1997-1998; presentations on gender equity and health sector reform, its monitoring and responses to women's needs; health sector reform and gender equity experiences in Chile and Ecuador; addressing violence against women in health sector reform policies in Central America; and the experiences of the six Members (Brazil, Costa Rica, Cuba, Jamaica, Paraguay, and the United States of America) on addressing gender equity in health sector reform. The Report concludes with recommendations for PAHO and Member States for incorporating gender equity in health sector reform processes and policies in the Region.

The Executive Committee is asked to review the report and to focus particularly on the recommendations for incorporating gender equity in the health sector reform processes and policies of Member States. The Executive Committee is requested to consider and endorse the recommendations of the Subcommittee.

Annex



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SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

18th Session, 8-9 February 1999

CE124/6 (Eng.)
Annex A

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FINAL REPORT

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FINAL REPORT

The 18th Session of the Subcommittee on Women, Health, and Development of the Executive Committee was held at the Headquarters of the Pan American Health Organization in Washington, D.C., on 8 and 9 February 1999.

The session was attended by representatives of the following Members of the Subcommittee, elected by the Executive Committee or named by the Director in accordance with the Subcommittee's Terms of Reference: Brazil, Costa Rica, Cuba, Jamaica, Paraguay, and United States of America. Also present were observers for Canada, Chile, Ecuador, Mexico, Nicaragua, Uruguay, and Puerto Rico.

Officers

The Subcommittee elected the following officers:

<i>President:</i>	Dr. Carmen Frutos de Almada	Paraguay
<i>Vice President:</i>	Ms. Belkis Feliú Escalona	Cuba
<i>Rapporteur:</i>	Ms. Mary Lou Valdez	United States of America

Dr. George A. O. Alleyne (Director, Pan American Sanitary Bureau) served as Secretary *ex officio*, and Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development) served as Technical Secretary.

Opening of the Session

The Director opened the session and welcomed the participants. He was delighted that so many of the countries had sent representatives to the session. Their presence was indicative of the Member States' interest in and enthusiasm for the work of the Subcommittee. Several changes had occurred in the interval since the previous session in 1997, most notably the appointment of Dr. Marijke Velzeboer-Salcedo as the new coordinator of the Program on Women, Health, and Development (HDW). In the Director's view, the Program's evolution over the preceding four years and its success in mobilizing both financial and human resources to advance the cause of gender equity in health had amply justified the decision he had taken in 1995 to make HDW a regular program of technical cooperation within the Division of Health and Human Development. The developments over the previous four years had also strengthened his conviction that

the area of gender was one of the areas in which health inequities were manifested most egregiously and that gender must therefore be one of the key variables considered in health situation analysis.

The work of the previous four years had also justified the Secretariat's insistence that HDW was not just a women's health program. In fact, women's health issues were not the primary focus of the Program; rather, it was concerned with women's health problems as manifestations of gender inequity. Because gender inequity was a broad societal issue, attempts to address it must involve a broad range of participants of both sexes. Therefore, the Program could not focus exclusively on women's health issues. Another major area of action for the Program—and for the Organization as a whole—was health sector reform and efforts to address gender inequities in the framework of reform processes. The topic of health sector reform would figure prominently in the Subcommittee's discussions.

Adoption of the Agenda and Program of Meetings (Documents MSD18/1 and MSD18/WP/1)

In accordance with Rule 2 of its Rules of Procedure, the Subcommittee adopted the provisional agenda prepared by the Director and a program of meetings.

Presentation and Discussion of the Items

Report on the Activities of PAHO's Women, Health, and Development Program at the Regional and Country Levels (Document MSD18/3)

Dr. Marijke Velzeboer-Salcedo (Coordinator, Program on Women, Health, and Development) began by presenting an overview of the situation of women and the status of issues relating to gender, health, and development in the Region of the Americas. She noted that there was good reason for optimism because efforts to improve women's health and draw attention to gender concerns in health and human development had been largely successful. There had been a marked shift away from a focus on women as vulnerable and passive recipients of programs and projects toward empowering women and increasing their control over the internal and external factors that affected their health. Nevertheless, women continued to suffer and die from preventable causes more often than men, frequently as a result of factors that had to do with gender, social class, and ethnic background. Moreover, women were increasingly and disproportionately poor—a phenomenon known as the feminization of poverty. Hence, much remained to be done in order to correct the gender inequities that led to health inequities for women.

Dr. Velzeboer-Salcedo then highlighted the Program's main activities during 1997-1998 in the following areas:

Training for a Gender Perspective: The manual for gender training had been completed during 1997 and HDW Program staff had conducted training seminars for PAHO personnel and for personnel from ministries of health, international organizations, and nongovernmental organizations (NGOs) in 20 countries. The personnel trained had subsequently replicated the training seminars throughout the Region.

Addressing Gender-based Violence: Projects to address gender-based violence were under way in 10 countries of the Region. In coordination with national counterparts in those countries, the Program had developed a model for addressing domestic violence against women, consisting of a multisectoral, community-based network for detecting and preventing domestic violence against women and providing support for women living in violent situations.

Advocating for Gender Equity in Health: Advocating for gender equity was a priority mandate of the Program. Program staff had made numerous presentations and had met with international, regional, and national policy-makers and donors to promote attention to gender issues and, especially, to call attention to domestic violence as a priority public health problem. The Program also continued to advocate the disaggregation of data by sex and the application of gender analysis as a key means of identifying gender inequities, especially in the framework of health sector reform processes.

Promoting Research on Gender Equity: In collaboration with the Inter-American Commission of Women of the Organization of American States, the Program was analyzing differences in maternal and female mortality in the border states of Mexico and the United States. Results would inform policy-makers and NGOs about the specific gender-related health concerns of women in that border region. The Program's research on quality of care, under way since 1996, continued to yield important information about how gender influenced patient-provider interactions and quality of care.

Incorporating a Gender Perspective in Reproductive Health Services: In keeping with the platforms of action of the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995), the Program continued to promote gender-sensitive reproductive health programs. Among other activities, HDW had developed a proposal and obtained funding to promote men's participation in decision-making about reproductive health through programs in seven Central American countries. Pilot programs and operations research on the subject would be launched during 1999.

Expanding Access to Information on Gender and Health: The Program had recently mounted a Web page [<http://www.paho.org/english/hdp/hdwmuje.htm>] in English,

<http://www.paho.org/spanish/hdp/hdwmuje.htm> in Spanish] that would eventually provide access to all its publications, as well as information on the Program's various projects and initiatives, access to databases and electronic discussion groups containing information on matters pertaining to gender and health, and links to related Internet sites.

Strengthening Technical Exchange in the Region: The Program had provided technical cooperation to Member States in project design, implementation, and monitoring, as well as in preparing donor and project proposals. The establishment of the first WHO Collaborating Center for Women's Health in Canada in 1997 had enhanced the Program's ability to cooperate effectively and efficiently with the countries.

Assuring Gender Equity in Health Sector Reform: The incorporation of a gender perspective and gender equity in health sector reform processes had been a major focus of the Program's work in 1997-1998 and was the overarching theme of the Subcommittee's 18th Session. The Program's main concerns were improving access to health services, resources, and information; assuring quality of care; and involving stakeholders in decision-making about health sector reform. Among other activities, the Program was working to develop gender equity indicators for inclusion among the indicators that PAHO was using to monitor health reform processes. It had also sponsored a meeting of experts and policy-makers aimed at identifying indicators and strategies for incorporating gender equity in reform processes and policies in the Region.

Additional details about the Program's activities in each of these areas were included in Document MSD18/3.

The Subcommittee welcomed the Program's efforts to call attention to violence against women as a public health issue and its development of the community-based model for addressing domestic violence. Various delegates commented on efforts under way in their countries to deal with domestic violence; in several cases, the materials developed by HDW had been utilized as a guide for implementing programs to prevent violence against women and assist victims. The Subcommittee also applauded the Program's progress in electronic dissemination of information, although it was pointed out that many communities in the Region still did not have Internet access. Several delegates offered to include links to the HDW Web page on their governments' Web sites devoted to women's health and suggested that the Program's page include links to relevant sites of both government agencies and NGOs working on women's health and gender issues.

The Subcommittee agreed that ensuring women's participation in health reform processes was crucial in order to rectify gender inequities and commended the Program for its identification of health sector reform as a priority area of action. The Delegate of Cuba noted that her country had included a gender perspective from the outset of its

health sector reform process, which had been under way since the 1960s. She provided English and Spanish versions of a document on her country's national multisectoral plan of action to follow-up on the recommendations of the Beijing conference, which analyzed gender gaps and proposed ways of addressing them. The Delegate of Canada announced that a symposium on developing and customizing tools for sex- and gender-based analysis would be held in her country in late September or early October.

The Delegates of Mexico and the United States expressed particular interest in the study of mortality among women in the border region between their two countries and requested that the Program continue to keep them apprised of the study's findings so that the information could be disseminated among policy-makers. Several questions were asked regarding the Program's infrastructure for supporting its various projects and carrying out its mandate throughout the Region. In addition, more information was requested about the indicators that the Program was developing and the availability of the report of the expert meeting mentioned by Dr. Velzeboer-Salcedo.

Dr. Velzeboer thanked the delegates who had offered to establish linkages between their government Web sites and the Program's site, noting that HDW was channeling more and more of its energies into dissemination of information via the World Wide Web because electronic communication was clearly a growing phenomenon in all countries. However, the Program would continue to publish hard-copy versions of its documents to serve those who lacked access to the Web. In addition, all the information included on its Web site would be downloadable so that it could be printed and shared with communities and populations in the countries that might not have Internet connections. In regard to the study of the female population on the Mexico-United States border, she noted that the Program was exploring the possibility of broadening the study to include morbidity as well as mortality.

Responding to the questions concerning indicators, Dr. Velzeboer-Salcedo pointed out that the process of developing suitable indicators for monitoring progress toward gender equity was just beginning. Among other activities, the Program planned to hire a consultant who would develop a guide for the countries to use in carrying out health situation analysis with a gender perspective. Because the Program was well aware that different countries had different needs and characteristics, care would be taken to ensure that the guide was adaptable to the specific conditions in individual countries. In addition, the Program was exploring ways of getting all the various stakeholders (ministries of health and other ministries, women's organizations, NGOs, donors) involved in making decisions about how to use the data and information obtained from health situation analyses. With regard to the report and documentation from the expert meeting, those materials were quite voluminous and were not yet available for distribution. The Program hoped to make them available on its Web site within three months.

As for the Program infrastructure, Dr. Velzeboer-Salcedo explained that, in addition to the Regional Office at PAHO Headquarters, the Program had a network of focal points in the countries, who extended the Program's capacity to provide technical cooperation at the national level. In addition, the Program relied on national counterparts who had received the gender and health training and had been involved in operationalizing the community and national networks for domestic violence prevention.

The Director added that, while the Program consisted of relatively few people, it had "a lot of muscle." Dr. Velzeboer-Salcedo's report reflected only a fraction of the Program's myriad activities. In addition to its own projects and program activities, HDW worked closely with other PAHO programs to ensure the presence of a gender perspective in all facets of the Organization's work. Over the course of the session, the delegates would no doubt become more aware of the breadth of the Program's work.

Towards Gender Equity in Health Sector Reform Policies (Document MSD18/4)

Presentations were given on this item by Dr. Pedro Crocco (Advisor on the Health Sector Reform Initiative, Division of Health Systems and Services Development), Dr. Cesar Vieira (Coordinator, Program on Public Policy and Health), and Dr. Elsa Gómez (Regional Advisor on Women, Health, and Development).

Dr. Crocco gave an overview of PAHO's work in the area of health sector reform, in particular through the Health Sector Reform Initiative, a joint effort of the Organization and the United States Agency for International Development (USAID). He began by reviewing the background of PAHO's involvement in health sector reform. Notable events had included the first Summit of the Americas, held in Miami in 1994, in which health sector reform had been discussed and PAHO had been charged with monitoring and evaluating plans and programs for health sector reform in the countries of the Americas, and the Special Meeting on Health Sector Reform, held at the PAHO Headquarters in September 1995 in conjunction with the 38th Directing Council, which had resulted in the adoption of Resolution CD38.R14. That resolution had requested the Director "to continue to work with the Member States and agencies in the design and development of a process for monitoring health sector reform in the Americas." In response to the mandate for interagency collaboration, and to support health sector reform initiatives in the countries, PAHO and USAID had initiated discussions aimed at identifying priority areas for regional cooperation on health reform. The outcome of those discussions had been the Health Sector Reform Initiative, launched in 1997.

The Initiative had three main areas of action: development of tools and methodologies for monitoring health reform processes, monitoring and evaluation of those processes, and exchanges of experiences between countries of the Region in the area of

health reform. The first step in monitoring and evaluating health reform had been to define the concept. Based on the definition agreed at the Special Meeting, health sector reform was understood to be a process aimed at introducing substantive changes in the structure and functions of the sector with a view to increasing the equity of its benefits, the efficiency of its management, and the effectiveness of its actions in order to thus meet the health needs of the population. The criteria by which PAHO proposed to assess health sector reform processes were equity, quality, efficiency, sustainability, and social participation. The ideal reform would be one in which all five aspects had been improved by the end of the process.

The first year of the Health Sector Reform Initiative had been devoted largely to developing methodologies and generating information on health sector reform to assist decision-makers. The Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean had been developed in collaboration with several divisions and programs within PAHO, including the Program on Women, Health, and Development. Future efforts would focus on improving the methodology, especially through the incorporation of a gender perspective. More information on the Initiative and on PAHO's activities in the area of health sector reform could be obtained through the Organization's Web site (<http://www.paho.org>).

Dr. Vieira summarized the activities of the Program on Public Policy and Health in regard to health sector reform. The Program's main focus had been on increasing equity through activities in its areas of expertise, namely, health policy, legislation, and economics. In the area of policy development and advocacy, its principal activity was the project "Managing Health Sector Reform for Poverty Alleviation," which was aimed at determining how health sector reforms in the Caribbean—especially those related to decentralization and changes in health sector financing—were affecting the situation of the poor in that region. Another objective was to identify benchmarks, parameters, and good practices for orienting reform processes and ensuring that the reforms being introduced did not end up exacerbating the situations they were intended to correct.

The Program was also promoting discussion of health reform in national and subregional legislative bodies (including the Latin American Parliament, the Central American Parliament, and the Andean Parliament), and it was providing technical cooperation for the drafting of framework laws and other legislation relative to health sector reform and health care financing. In the area of research and situation analysis, the Program had compiled several databases to provide decision-makers with information about health policy, legislation, and financing issues. It had undertaken various studies, including a pioneering study on national health accounts, aimed at generating accurate, reliable, and comparable data on health spending in the countries. That project was expected to yield important information on the allocation of health resources in the

countries. Another study was examining inequities in health status, access to and use of health services, and health care financing. An interprogrammatic group on health inequities had recently developed a proposal for a new study on the relationship among inequities, poverty, ethnicity, and gender.

The Program was collaborating with HDW to incorporate a gender perspective into its activities in the area of health care reform. It had participated in a recent workshop on health policies and reform organized by HDW, and the two programs had recently initiated a joint study, together with the Program on Family Health and Population, the IDB, and the World Bank. That study was similar to the aforementioned study on inequities in health status, use and access to services, and health spending, but focused specifically on the gender dimension. The Program was organizing a special session of the commissions on health and women's affairs of the Latin American Parliament, scheduled for May 1999, to discuss various topics relating to women's health, domestic violence, and health care reform. That event would mark the first time the two commissions worked together on common gender-related concerns.

The experience thus far had shown that there was tremendous potential for interprogrammatic work on issues relating to gender equity and health sector reform. The Program on Public Policy and Health was committed to ongoing collaboration with HDW to improve the situation of those social groups in the Region who suffered the greatest inequities in health status and access to health resources and services.

Dr. Gómez's presentation focused specifically on the incorporation of a gender perspective in health sector reform processes. She began with a review of PAHO's institutional mandate for work in this area and outlined the conceptual framework for the analysis of gender equity in health sector reform. She then summarized the implications of health reform for gender equity and the main challenges for incorporating a gender perspective in health reform processes. Finally, she outlined the strategies for doing so proposed in Document MSD18/4.

The conceptual elements on which the proposal in the document were built were gender, equity, and social participation. Approaching health reform from a gender perspective meant recognizing that socially constructed differences between men and women were key determinants in women's unequal access to and power over health services and resources, both at the macro level and at the micro level of the family and the individual. Gender distinctions also led to differences in the way men and women contributed to and benefited from health development. Moreover, because women's health work was frequently unpaid, their contributions were not reflected in national health accounts. Gender equity in health meant reducing unnecessary or unfair differences between men and women in terms of their risk of becoming ill or suffering death or disability from preventable causes, as well as in their access to health services.

It also meant correcting the gender-based inequities that resulted in women's paying proportionately more for health care and contributing more to health development, while receiving fewer rewards and benefits than men. Social participation played a pivotal role in the achievement of equity. Women must be involved as active participants in setting priorities and making decisions about health reform processes.

The emphasis on women in discussions of equity and health reform derived from the fact that women had a greater need for health services due to their reproductive role and their greater longevity, they were disproportionately represented among the poor, and they were generally more affected than men by increases or reductions in public services. In addition, women were at a disadvantage within the health system, since they were among the lowest paid health workers in the formal health system; they were the principal providers of health care in the family, but received no remuneration for their work; and they were underrepresented in the power structures that set priorities and allocated resources for health.

In applying a gender perspective to the analysis of health sector reform processes, the basic question that should be asked was whether proposed changes would help to reduce or would exacerbate existing gender inequities in health status, in the satisfaction of needs and access to appropriate services and resources, in payment and financing of services, in the balance between contributions to health development and the rewards or benefits received, and in participation in decision-making. Certain reform measures, such as decentralization and policies aimed at improving efficiency, might actually worsen the situation of women by increasing the amount of unpaid labor they were expected to provide. Similarly, reforms in health care financing and the definition of basic packages of health services might result in a greater financial burden for women, since many insurance schemes and basic packages either did not cover or charged more for health services women required during their childbearing years or in old age.

In order to overcome the challenges to incorporating a gender perspective in health sector reform processes, the Program on Women, Health, and Development proposed a series of strategies and activities aimed at generating and disseminating information on gender inequities and the potential impact of health reforms on those inequities, strengthening the technical capacity of governments to apply gender analysis in the formulation of health policies, advocating health reforms that would lead to greater gender equity, and involving women in making decisions about health reform and health policies. The document provided a more detailed account of the proposed activities and also contained a list of suggested recommendations, which the Subcommittee was asked to consider including among its recommendations to the Executive Committee.

The Subcommittee endorsed the strategies and recommendations contained in the document, especially those relating to disaggregation of data by sex, development of indicators of gender equity, recognition of the value of women's work in the health sector, and increased participation by women in identification of priorities, decision-making, and policy formulation. It was pointed out that, in addition to disaggregating data by sex, it was important to disaggregate by race and ethnicity, in order to better understand the different health risks and barriers to access faced by different groups of women. In regard to the participation of women, it was pointed out that it was very difficult to transform words into concrete action. The need to increase women's involvement and leadership in the health sector had been under discussion for years, yet in many countries women continued to be excluded from power structures at all levels. The countries were encouraged to exchange information on successful experiences and strategies for achieving meaningful participation by women. Guaranteeing women's rights to equal treatment and opportunities in all spheres—through the enactment and enforcement of specific legal provisions—was seen as an important means of progressing toward greater gender equity, as was promoting their participation as elected representatives at all levels of government.

Several delegates noted that health sector reform was taking place in the broader context of economic adjustment and state reform. Many of the measures being introduced, such as downsizing of government and reduction of public services in order to cut costs, would make it even harder to achieve gender equity in health reform processes. It would therefore be essential to continue to draw attention to the detrimental impact that certain health reform proposals might have on women. For example, in many countries, various modalities of home health care were being promoted to ensure care for those who had lost their health coverage as a result of reductions in public services. However, this would clearly increase the burden on women, as they would most often be the providers of such care, often without remuneration.

In relation to the development of indicators and the valuation of women's work in national health accounts, it was considered important to find indicators that related the productive and reproductive spheres, in order to reflect the amount of unpaid labor and the time that women devoted to their families and tasks related to their reproductive role. Finally, the importance of coordinating activities with other agencies within the inter-American system, especially the Inter-American Commission of Women, was underscored. It was pointed out that the Commission was concerned with many of the same issues raised by the Subcommittee, including gender equity, equality of opportunities, and participation of women in power structures and decision-making.

Dr. Gómez responded that the Program on Women, Health, and Development was working closely with the Inter-American Commission of Women in several areas,

including the research project on the Mexico-United States border. In addition, several meetings had recently been held with a view to integrating the efforts of all the inter-American agencies working on women's issues.

Dr. Vieira agreed that, in the breakdown of national health accounts, it was important to try to measure the value of the unpaid work done by women, in both the productive and reproductive spheres, in order to obtain a more accurate estimate of the "gross domestic health product" in the countries of the Region. He also indicated that he would make available to the Subcommittee the findings of another joint study undertaken by HDW and the Program on Public Policy and Health, which he had neglected to mention during his presentation. That study concerned legislation on health, gender, and reform in Central America. Dr. Crocco emphasized that the Organization was always open to proposals from Member States as to possible indicators to be used in monitoring health reform processes, and encouraged the delegates to communicate any suggestions they might have.

Women's Needs and the Response of Health Sector Reform: Experiences in Chile and Ecuador (Documents MSD18/5 and MSD18/6)

Two presentations were given on this item. First, Dr. Verónica Báez Pollier (Director, Health Section, National Women's Service, Chile), following up on a presentation made to the Subcommittee in 1996, described the impact of health care reform in Chile on women and on gender equity, focusing in particular on the discriminatory practices of ISAPREs, private entities that provided health care coverage for their subscribers. Subsequently, Dr. Lola Villaquirán (Executive Director, National Council of Women, Ecuador) outlined the process that had led to the adoption of a law on free maternity care in the context of health reform in her country.

Dr. Báez began with an overview of the Chilean health care system, in which the ISAPREs functioned alongside FONASA, the public-sector health insurer. Although the armed forces had their own health care services, and a small proportion of the population paid for health services directly, on an out-of-pocket basis, most Chileans were covered either by FONASA or by an ISAPRE. In both the private and public subsectors, health care was financed through mandatory payroll deductions of 7%. In theory, Chileans were free to choose their health care providers, since the country's Constitution guaranteed them that freedom. Nevertheless, in practice, the freedom of choice was limited by certain discriminatory practices of the ISAPREs. Women, in particular, were adversely affected by those practices.

Because low-income workers could not generate the same level of revenues for the ISAPREs, they were not welcome in the ISAPRE system. Because women earned less

than men (on average, 65% of the amount earned by men with similar training and job responsibilities), the ISAPREs sought to exclude them from coverage. In addition, they charged higher premiums (over and above the 7% salary deduction) and copayments for women of childbearing age because they were expected to require more care for pregnancy, childbirth, and other reproductive health needs. The monthly charges for women between the ages of 18 and 34 were often double the amount paid by men in the same age group, although the women earned less. Moreover, ISAPREs provided no coverage for preventive care and health promotion programs, such as immunization and supplementary feeding programs. ISAPRE members received such services free of charge from the public system, but the ISAPRE was not required to reimburse the government for the cost of those services and it continued to collect the 7% payroll deduction for the members who received them. The ISAPREs also refused to cover the cost of the prenatal and postnatal paid leave periods to which all Chilean women were entitled by law. The State was obliged to assume those costs, even for women who were ISAPRE subscribers. Hence, the ISAPREs, which covered the highest-income segments of the population, were being subsidized by the public health care system, which was funded by the payroll deductions of the lowest-income segments of the Chilean population and therefore had fewer resources.

One of the most egregious abuses of the ISAPREs was their exclusion of persons who had preexisting conditions, which encompassed even congenital conditions such as Down's syndrome. As new research revealed genetic links to diseases such as breast cancer, they might also be considered preexisting conditions—a particularly worrisome prospect for women.

Since the early 1990s, SERNAM had been working to draw attention to and bring about changes in the discriminatory practices of ISAPREs. The study and recommendations outlined in Document MSD18/5 had been part of that effort. However, attempts to introduce reforms in the ISAPRE system or curtail their discriminatory practices had met with stiff opposition from lawmakers, who were influenced by powerful economic interests. As a state agency devoted to advocating public policies that would benefit women, SERNAM felt it had a responsibility to other countries in the Region to highlight the clear disadvantages of ISAPREs for women. Proponents of the ISAPRE system pointed to the impressive reductions in maternal and infant mortality achieved in Chile since the system had come into existence, and the ISAPRE model had been held up as something to be emulated by other countries. Nevertheless, before adopting a similar system as part of their health reform efforts, SERNAM urged countries to look carefully at the gender inequities inherent in the ISAPREs.

Dr. Villaquirán described the interinstitutional process through which the 1998 Ecuadorian Reform Law on Free Maternity Care had been formulated and adopted, as

well as the prospects for ensuring its full implementation in the future. The law represented a proposal for a new model of health care aimed at improving access for women and children; reducing maternal mortality; guaranteeing comprehensive reproductive health care; diversifying service providers; involving health services, municipal governments, and community organizations in the management of resources; and strengthening the participation of civil society in decision-making and social control over the quality of services.

The law built upon an existing law on free maternity care, which had been adopted four years earlier but was not being applied. It provided that every Ecuadorian woman would have the right to free, high-quality care during pregnancy, childbirth, and the postpartum period, as well as access to sexual and reproductive health programs. It also provided for health care without cost for newborns and children under the age of 5. The funding for this care would come from a special tax on alcoholic beverages, soft drinks, and cigarettes and monies from various other national funds, as well as investment of international cooperation resources.

The law was developed through a cooperative process involving various institutions, including the National Council of Women (CONAMU), the Ministry of Public Health, the National Health Council, a World Bank project for modernization of the health sector (MODERSA), PAHO, and the Center for Responsible Parenthood (CEPAR), a nongovernmental organization. The Health Commission of the National Congress also took part in the process. From the outset, CONAMU had worked to ensure that the law provided for a basic but comprehensive reproductive health care package for women, and care for newborns and children under 5, in accordance with the strategy for Integrated Management of Childhood Illness (IMCI). In addition, it had promoted the creation of women's users' committees in order to institutionalize women's participation and social control over services and foster better quality of care. Ideally, those groups would have had the power to issue certificates of user satisfaction, which would have carried the same weight as accreditation by official agencies and would have been a requirement for the transfer of funds to service providers. Unfortunately, the latter provision had not been included explicitly in the law, but there was still the possibility that it could be incorporated in the formulation of the regulations for application of the law.

CONAMU had also been instrumental in lobbying lawmakers and securing passage of the law by the National Congress. The law was adopted by Congress and signed by the President of Ecuador in August 1998. Nevertheless, certain difficulties remained to be overcome before it could be fully implemented. In particular, it was necessary to determine what segment of the population would be entitled to receive care entirely free of charge. The country's new Constitution, also adopted in August 1998, provided that all public health programs and services would be provided free of charge and that public

medical care services would be provided free to persons who needed them. However, the exact services that fell under the heading of “public health” had not been defined, nor had an income threshold been set for determining who would receive free medical services. The government had recently established a special solidarity benefit to be paid to low-income women who met certain criteria (children under 18 years of age, income below a certain level). Possibly, the same criteria might be used to determine who would receive free care under the new law.

The application of the law on free maternity service, like the implementation of other public policies intended to benefit women, had entailed a difficult process of negotiation and change in norms, laws, procedures, and attitudes. CONAMU was committed to persevering in that process because it saw the adoption and application of the law as a springboard for improving women’s health conditions and facilitating the full exercise of their rights.

In the Subcommittee’s discussion of this item, concern was expressed regarding the issue of preexisting conditions and the possibility that a genetic predisposition for diseases such as breast cancer might be used as a justification for excluding women from health care coverage. It was pointed out that, even if individuals were not excluded due to preexisting conditions, insurers could still discriminate against them by charging higher rates or premiums. Questions were asked regarding what future steps were envisaged to correct the gender inequities in Chile’s ISAPRE system. It was also pointed out that all the presentations heard by the Subcommittee during the session had illustrated the need to develop indicators other than the traditional mortality and morbidity indicators in order to better reflect the gender-based inequities and discrimination that women experienced in the health care system.

Dr. Báez noted that the main problem with the ISAPREs was the almost total absence of controls over their actions. Although a number of excellent proposals had been formulated to correct the problems cited in her report, obtaining the necessary legislative support for them had proved very difficult, partly because women were so sparsely represented in the National Congress. In addition, economic and political interests stood in the way of reforms. She emphasized that SERNAM was not opposed to the existence of a private health care system. However, it insisted that such a system should be transparent and regulated. Over the next two years, SERNAM would be working to raise awareness among health authorities and policy-makers regarding the need to regulate the discriminatory practices of the ISAPREs. It would also work to inform users about what services they could expect to receive if they subscribed to an ISAPRE, since the services actually provided often did not correspond to what had been promised.

In regard to the development of indicators, she said that SERNAM had conducted several studies that had clearly shown the need for indicators that would better reveal the overall condition of women. However, as had been pointed out earlier, it was essential to have data disaggregated by sex, without which gender analysis was not possible. To that end, SERNAM had proposed that the gender variable be incorporated into the entire national statistical system in Chile.

Addressing Violence Against Women in Health Sector Reform Policies in Central America (Document MSD18/7)

Dr. Lea Guido (Subregional Coordinator for Central America, Program on Women, Health, and Development) summarized the document on this item, which expanded on the information presented earlier by Dr. Velzeboer on HDW's activities in regard to gender-based violence. Addressing gender-based violence in the framework of health sector reform processes and programs had been one of the primary focuses of the Program's technical cooperation in Central America in the past several years. Its work was based on the definition of violence against women approved in Beijing at the Fourth World Conference on Women in 1995, which encompassed many kinds of gender-based violence. Among all those forms of violence, HDW had given priority to domestic or marital/spousal violence because it occurred throughout the life cycle, but it most affected women of childbearing age (15-49 years).

The Program had employed three main strategies in its technical cooperation: health situation analysis with a gender perspective, aimed at increasing the visibility of violence against women as a public health problem; application of gender analysis in the formulation of public policies and generation of specific policies to address gender-based violence; and development of a model for a comprehensive approach to domestic violence in the framework of health sector reform. The third strategy formed the core of the Program's work in this area. The approach was comprehensive in that it provided for action at three levels: the macro level, or the level of public policies and the legal system; the meso, or sectoral, level, at which guidelines were developed for the various sectors; and the micro, or municipal, level, at which networks were formed and the community participated in addressing gender-based violence. Under each level, there were four lines of action: detection of gender-based violence, prevention of violence, treatment of victims, and promotion of nonviolent behaviors.

The document contained a table setting out the objectives, strategies, target population, and participating actors for each line of action at the various levels. HDW's technical cooperation had concentrated especially on the role of the health sector at the meso level, since the health sector had an essential role to play in formulating specific

policies of action on violence, developing basic packages or baskets of services, and addressing violence as a public health problem that had an impact on women throughout their life cycle.

Currently the model was being applied in all seven Central American countries. The document outlined the principal achievements at the subregional and country levels. It also recommended that the Subcommittee affirm the need to incorporate the model for addressing domestic violence into health sector reform processes and thereby encourage screening and early detection of persons affected by domestic violence; identify factors that led to the development of violent behaviors in young people, as well as protective factors that made men and women resilient in the face of domestic violence; promote nonviolence and nondiscriminatory attitudes; institutionalize guidelines and standardized procedures for monitoring and addressing domestic violence; develop activities for controlling repeated incidents of aggressive behavior, in coordination with other state and educational systems, law enforcement officials, and NGOs; and develop indicators that would make it possible to evaluate interventions.

The Subcommittee stressed the need to promote nonviolent behaviors and to examine the social factors that led to domestic violence, which was the most extreme expression of discrimination against women. From a strategic perspective, a health promotion approach was seen as the most effective means of addressing the roots of the problem. It was also pointed out that domestic violence was not limited to violence by men against women, but also included violence by women against other women, since abused women often perpetuated the cycle of violence by abusing their female children. The establishment of linkages between the health sector and the social services sector was deemed crucial, since health care providers might be reluctant to actively screen for and detect domestic violence unless they were in a position to refer the victims to the appropriate social services for assistance.

Several delegates noted that the presentation on this item, like the earlier presentations, had underscored the need for specific indicators that would reveal gender-related inequities, as well as the need to make gender a cross-cutting theme in all public policies and health reform processes. In order to effect any real change, the gender perspective must be integrated into all projects, programs, and activities in the health sector, rather than being added on as an annex or appendix. It was felt that PAHO could help the countries in this regard by ensuring that the gender perspective permeated all its activities and by carrying out policy research and developing methodologies that would assist the governments in introducing gender as a pervasive theme in their policies, especially those relating to health reform. The Inter-American Convention for the Prevention, Punishment, and Elimination of Violence against Women (commonly known as the Belém do Pará Convention)—adopted in 1995 and since ratified by some 30

countries in the Region—was cited as evidence of the political will of the governments to confront gender-based violence. It provided a legal and conceptual framework for addressing the problem.

Dr. Guido agreed that the Belém do Pará Convention represented a landmark in the gender equity movement. As a result of the convention, violence against women had been recognized as a criminal offense, which previously had not been the case in many countries. However, it was not sufficient to have laws that penalized perpetrators of domestic violence; as the Subcommittee had pointed out, it was necessary to employ a broader approach that also sought to dismantle the mechanisms and social constructs that led to such violence. For that reason, HDW was emphasizing promotion of health and nonviolence in family relationships as an important component of the model. The Program also recognized that domestic violence, like other public health problems such as alcoholism and HIV/AIDS, could not be addressed solely by the health sector. The model therefore stressed the concept of networks and interdisciplinary and intersectoral coordination. In her view, the three strategies that HDW was promoting in its technical cooperation (health situation analysis with a gender perspective, gender-sensitive public policies, and the comprehensive model) offered an excellent means for incorporating gender equity as a cross-cutting theme in the health reform process.

Presentations by Subcommittee Members on Gender Equity and Health Sector Reform Policies in their Countries

Presentations were given by the Delegates of Brazil, Costa Rica, Cuba, Jamaica, Paraguay, and the United States of America. In each case, the presenters began with general information about their respective countries and on the social, political, and economic context surrounding health sector reform efforts, as well as data on the health and social situation of women. All this information is available in the written materials distributed by the speakers, which may be requested from the PAHO Secretariat. The summaries below focus specifically on the major features of health sector reform in each country and their impact on women's health and gender equity.

Brazil

Dr. Tania di Giacomo (Special Advisor, Ministry of Health, Brazil) noted that the health sector reform process in Brazil had been shaped by efforts to curb inflation and stabilize the country's economy. Although those efforts had been largely successful, they had resulted in higher unemployment, which had created greater demand for public services. At the same time, however, the State had been obliged to reduce expenditures and so had been less able to provide many social services. The health sector had not suffered such drastic budget cuts as other sectors, but its budget had been reduced.

Consequently, cost containment and increased efficiency were among the major objectives of health reform.

In the face of financial constraints, the health sector had been obliged to reorder and reduce its priorities. Some programs were eliminated, but women's health remained a priority and investment in the provision of services to women had increased, despite the budget cuts. New programs had been created or existing ones enhanced in areas such as cervical cancer screening and prevention and health services for women who had suffered sexual violence. One area in which no improvement had been made—mainly for economic reasons—was family planning. Previously, funding for the acquisition of contraceptives had come mainly from international agencies, but that funding had been reduced. In addition, the country had enacted a law that made the State responsible for providing contraceptives. Ironically, that law had resulted in lesser availability of contraceptives, since no new funding had been made available to enable health officials in the states and municipalities to purchase them.

Health reform had yielded some obvious benefits for women, since women's health had been defined as a priority and spending in that area had increased. Nevertheless, the very fact that women's health had been identified as a priority had also produced negative impacts for women. In order to increase funding for women's health, it had been necessary to eliminate other programs and services, including institutional care for the disabled and those with mental health problems, and there had been a notable shift toward home care. As a result, women were devoting considerably more time and energy to the care of elderly and ill family members in the home. It was not yet clear whether, on balance, health reform efforts thus far had improved the lives of women or exacerbated the gender inequities they faced.

Costa Rica

Dr. Xinia Carvajal Salazar (Vice Minister of Public Health, Costa Rica) said that the health reform process had been under way in Costa Rica for some 10 years, although actual implementation of activities had begun about 6 years earlier. The revised health care model was founded on the principles of universal coverage, comprehensive care, equity of access, solidarity in financing, and broad participation by all social forces. Health was viewed as a social product. The country had developed a comprehensive package of basic services, into which an attempt had been made to incorporate components that responded to the specific needs of women. Those attempts had not been completely successful, but the package did at least include services for victims of domestic violence and occupational health services geared toward women.

Within the Ministry of Public Health, it had been decided that the best way of incorporating a gender perspective into health reform processes was through a cross-cutting approach. Accordingly, rather than creating a special office devoted to gender and women's health, the Ministry had formed an advisory group consisting of persons who were actively engaged in applying the gender perspective in a broad range of disciplines and sectors.

An analysis of the components of health reform and the revised health care model from the perspectives of social class, ethnicity, and, in particular, gender had revealed the following:

- the package of services did not really take account of the specificities of gender, and it emphasized mainly biological aspects;
- a gender perspective was not being applied in health situation analysis or in the provision of services, owing in part to the lack of gender socialization of health care workers;
- the model was not oriented toward providing comprehensive, gender-sensitive care;
- women's participation in the health sector was concentrated mainly in the execution of programs, especially programs relating to their reproductive function; they had little involvement in decision-making or leadership;
- although women made up a larger proportion of health care workers, managerial positions continued to be held mainly by male physicians;
- male health care professionals continued to earn more than their female counterparts;
- the system for training of human resources and the labor market for health care workers favored men's access to managerial positions and limited women's possibilities for professional advancement; in some cases, that discrimination was directly linked to women's reproductive function.

Hence, much remained to be done in order to achieve gender equity for women. As had been pointed out repeatedly during the Subcommittee's discussions, it was essential to develop specific indicators that would make gender inequities visible and to integrate the gender perspective into all aspects of health reform.

Cuba

Ms. Belkis Feliú Escalona (National Director of Nursing, Ministry of Health, Cuba) noted that the Cuban Constitution stated that all citizens had the right to care and protection of their health and established that the State would guarantee that right. In keeping with those precepts, the State had created the National Health System, which provided universal coverage free of charge. All Cubans, male and female, regardless of age and socioeconomic or employment status, had equal access to health services.

As mentioned earlier, health reform had been an ongoing process since the 1960s and was aimed at further enhancing coverage, accessibility, equity, and quality, satisfying the demands and needs of the population, while also seeking efficiency within the sector. The gender perspective was being incorporated into reform processes through a multisectoral approach in which women had played a leading role. The Cuban Federation of Women had been instrumental in developing policies designed to enable women to fully exercise their rights in all spheres, which had fostered their direct participation in the formulation of laws relating to women and the specific needs of women who were heads of household, women who had physical disabilities, single mothers, and other groups of women. The Cuban government had manifested its support for the elimination of all forms of gender-based discrimination through the implementation of the national plan of action to follow-up on the Beijing conference.

The country had developed a comprehensive health care plan for women that included health promotion activities, as well as preventive, curative, and rehabilitative services for women throughout their lifetimes. That plan was complemented by a comprehensive maternal and child health program. There was also an educational program aimed at preventing and treating sexually transmitted diseases, promoting shared responsibility in sexual and family life, and reducing unwanted pregnancies and abortions. Nevertheless, there were still gaps in meeting women's gender-related needs and in ensuring their participation in decision-making at the highest levels of the health sector. It was therefore necessary to critically examine existing health policies with an eye to assuring the incorporation of a gender perspective in health programs, promoting health research that would lead to better care for women, and encouraging the development of new policies that would facilitate women's access to managerial positions.

In regard to the impact of specific aspects of health sector reform on gender equity, with the trend toward decentralization, there had been a shift from provision of services in institutions to care in the home. However, community support services and resources were available to reduce the burden that such care imposed on women and enable them to keep their jobs outside the home. Although certain measures had been adopted to increase the efficiency of the National Health System, they had in no way affected access to services by women or any other group.

Jamaica

Ms. Margaret Lewis (Director of the Planning and Evaluation Unit, Ministry of Health, Jamaica) said that mainstreaming gender in social and economic development was an important policy goal of the Jamaican government. That mainstreaming had commenced in several sectors, including health. A gender management system for the health sector was being piloted with a view to incorporating gender planning and gender management in the health sector. The gender management system recognized the different health needs of women and men and sought to put in place mechanisms in the health system that would equitably address those differences.

Historically, the health sector had focused on biological aspects of prevention, diagnosis, and treatment, and it had emphasized the reproductive role of women. Consequently, the reproductive health needs of males had been somewhat neglected. The recently introduced Family Health Program provided for a more holistic approach to care for men and women, in which men were seen as potential partners in the implementation of reproductive health programs, especially in relation to decreasing sexually transmitted diseases, including HIV/AIDS; participating in family planning and preventing unwanted pregnancies; promoting safe motherhood, child care and development; and reducing abuse and violence against women.

Specific aspects of the health reform process, including decentralization, reorganization of services, and health care financing, had not had any significant impact on women's access to care or the quality of the care provided. However, as the quest to contain costs continued, there must be careful planning to ensure that some aspects of care were not devolved to family or community members (mainly female). In regard to women's participation in the health sector, they continued to be underrepresented in the top decision-making structures, although they were involved at the middle-management level. Female workers dominated in the health sector, and women were at the center of formal and informal health services, fostering the promotion of health, prevention of illness, treatment of disease, and rehabilitation of those who had been ill.

Future efforts would focus on increasing the collection and availability of gender-sensitive data in public, private, and nongovernmental organization settings, improving the accuracy of recording and reporting of health data, monitoring indicators specific to gender mainstreaming and gender equality on a national basis, and sensitizing all sectors of the population about gender roles and issues in order to foster gender mainstreaming and equality in all spheres of life.

Paraguay

Dr. Carmen Frutos de Almada (Minister of Health, Paraguay) observed that factors that contributed to social exclusion and inequity in her country included not just gender, but also age, educational level, geographic location, and ethnicity and language. In rural areas, especially, a large proportion of the population was indigenous and spoke only Guaraní.

The legal framework for efforts to achieve gender equity in health sector reform processes was provided by the Constitution, the health code, the law establishing the National Health System, and various antidiscriminatory laws. The National Plan of Opportunities for 1997-2001 established policies on equality of opportunities that would help make it possible to address the mechanisms that led to discrimination against women in various spheres, including health. The country's comprehensive women's health policy, formulated in 1998, called for improvement of women's access to health services and quality of care, strengthening of preventive programs, reductions in mortality, sexual and reproductive rights, gender-sensitive occupational health, promotion of a gender perspective in the training of human resources, and dissemination of information about women's health. The policy also provided for user participation by women in reproductive health programs at the community level, which marked a small but significant step toward greater gender equity.

Although the health sector reform process was incipient in Paraguay, several important lines of action aimed at increasing gender equity and improving the quality of life for women were being pursued under the health plan for 1998-2003. They included improvement of the technical quality and humaneness of care; implementation of the safe motherhood initiative and free maternal and child health care; attention to prevalent diseases and priority health problems of women; implementation of a plan for prevention and treatment of domestic violence in health services; extension of the coverage of services and reduction of barriers to access, including adjustment of the hours of operation of health services; and increased coverage of basic sanitation and drinking water services.

As for effects of specific health sector reform measures on women and gender equity, the decentralization process, initiated in 1998, had exacerbated equity gaps due to power struggles and competition for resources. Equity criteria were not being applied in the distribution of budgetary funds, and consequently marginalized populations had even less access to services. The law on decentralization was being revised in order to avoid exacerbating the problems. The rising cost of health services had led to a transfer of health care to the home setting, which increased women's workload. As in other countries, women were involved mainly in the provision of services and the execution of activities, but they had little decision-making power at the community level. This was

especially true in the case of indigenous women, partly owing to the dominance of men and the complete subordination of women in the Guaraní culture. However, women were well represented in positions of authority within the Ministry of Health.

United States of America

Dr. Susan Wood (Deputy Director, Office of Women's Health, Department of Health and Human Services, United States of America) began by explaining that the health care system in the United States was mainly a private system, although public programs existed to provide health care to the poor, those with long-term disabilities, and persons over the age of 65. A significant proportion of the population, especially the female population, was uninsured and therefore had limited access to care. Poor women were 3.5 times more likely to lack health insurance than non-poor women, and poverty was more common among women than men. Hispanic and Black women were twice as likely as white or Asian women to be poor. Women were also less likely than men to have health insurance through their employers, and it was difficult for them to afford private insurance on their own. They were therefore more likely than men to rely on publicly funded coverage, which did not provide the same choices or range of services as were available through many private health insurance plans.

Expansion of insurance coverage was seen as critical in order to improve women's access to services and protection in the health care system. Recent legislation had ensured that individuals could retain their insurance coverage even if they changed jobs or became unemployed, and it had prohibited insurance companies from denying coverage due to preexisting conditions. However, it had not prevented them from raising premiums to the extent that coverage became unaffordable.

In response to the problems of access, as well as rapidly rising health care costs, a large-scale, global health reform proposal had been put forward in the early 1990s, but it had not been approved by the United States Congress. Instead, health reform was being approached incrementally through the enactment of separate pieces of legislation that addressed specific issues. An example was a recent law mandating minimum hospital stays for women who had undergone mastectomy. There was a growing trend toward "managed care," a system under which health care providers were organized into groups or networks with the aim of controlling costs and quality and managing access to health care. Managed care had the potential to improve health care for women, especially through its emphasis on screening and other preventive services; however, it also had the potential to restrict their access to appropriate care. The country had several quality initiatives aimed at assuring the quality of health care and increasing user satisfaction. A patient's bill of rights had recently been proposed which included several provisions that were particularly germane to women. Efforts were also under way to increase teaching

and research on women's health. In addition, the Secretary of Health had made improving women's health a special priority within the Department of Health and Human Services.

In the Subcommittee's discussion of the presentations, the need for data disaggregated by sex, gender-sensitive indicators, health situation analysis with a gender perspective, and the incorporation of gender as a crosscutting theme was reiterated. It was emphasized that these matters should be included among the recommendations that the Subcommittee would be submitting to the Executive Committee. It was also

emphasized that efforts to raise awareness of issues relating to gender equity should continue throughout the Region. The workshops on gender and health developed by HDW were seen as a good vehicle for that purpose.

The Subcommittee noted that another recurring topic of discussion during the session had been the heavy burden imposed on women by the multiple roles they were called on to play as homemakers, mothers, employees, and increasingly, providers of health care in the home. One delegate mentioned a study that had found that women named stress as their number-one health concern. In this connection, the need to ensure that mental health services were included in basic health care packages was underscored.

Several delegates observed that achieving gender equity also meant considering the specific needs of men and addressing the problems that caused men to die at an earlier age than women. Violence, in particular, was cited as a serious cause of morbidity and premature mortality among males in many countries.

It was pointed out that, as women's social roles changed and they had become more active in traditionally male-dominated spheres, they might have a tendency to acquire habits such as tobacco use, which had previously been more common among men. Several delegates expressed concern about the rising prevalence of smoking among women and girls. Moreover, women were increasingly being targeted by tobacco industry marketing campaigns, especially in developing countries. In light of these concerns, it was suggested that the Subcommittee should recommend the incorporation of a gender perspective in the proposed regional convention on tobacco control.

Finally, it was pointed out that the Subcommittee session had brought together an extraordinarily talented group of health professionals, which accounted for the richness of the discussion. Moreover, the delegates were persons in positions of authority who could have a real influence in promoting a women's health agenda and bringing about greater gender equity in their countries. In order to continue fostering exchange between leaders in the area of women's health and gender equity, it was proposed that networks for the exchange of ideas and information be established or strengthened.

Other Matters

It was pointed out that the United Nations Commission on the Status of Women would be meeting in New York in early March 1999 and would be discussing many issues relating to health. It was suggested that the Member States might wish to take advantage of that highly visible event to put forth some recommendations that reflected the common concerns expressed during the Subcommittee session in relation to health reform, violence, integration of a gender perspective in health policies, and other issues.

A number of suggestions were made with regard to possible topics to be discussed at the Subcommittee's 19th Session. They included: indicators of gender equity and instruments and methodologies for gender-sensitive health situation analysis, violence against women and progress in the incorporation of violence prevention into health sector reform efforts, tobacco use among women and incorporation of a gender perspective in tobacco control initiatives, adolescent pregnancy, and follow-up on the recommendations and platforms for action of the Beijing conference, the Cairo conference, and other international gatherings at which women's issues have been addressed.

Presentation of Recommendations of the Subcommittee to the Director of the Pan American Sanitary Bureau

The Subcommittee presented the following recommendations to the Director for submission to the Executive Committee.

The 18th Session of the Subcommittee on Women, Health, and Development,

Aware that

Various forms of discrimination are created or exacerbated by health sector reform (HSR) processes, and that PAHO has a critical role to play in working with the Member States to address the challenges of seeking gender equity and the enhancement of reform policies and processes;

These challenges include: availability of information of better quality and disaggregated by sex; implementation of surveillance systems to monitor and evaluate the impact of HSR; strengthening of alliances, including alliances with other agencies of the United Nations and the inter-American system, development banks and financing institutions, national ministries, and civil society; identification and elimination of barriers that impede progress toward the achievement of equity objectives; establishment and/or strengthening of effective networks and channels of information and communication;

Recommends,

In its capacity as an advisory body of the Executive Committee, that the Executive Committee, after reviewing the report of the Subcommittee, endorse the following recommendations:

That the Member States

- collect and make available health statistics disaggregated by sex in the areas of mortality, morbidity, coverage and utilization of health services, and situation of human resources in the health sector;
- establish—with the participation of representatives of the public sector, national offices of women’s issues, and civil society groups that advocate for gender equity—a set of basic indicators for carrying out situation analysis and monitoring the effects of HSR on gender inequities;
- carry out situation analysis (national and local) and conduct monitoring of HSR, also with the participation of representatives of the public sector, national offices of women’s issues, and civil society groups that advocate for gender equity;
- promote research with a gender focus on the impact of HSR on different socioeconomic, geographic, ethnic, and age groups;
- expand the scope of health reforms to include a health promotion dimension aimed at creating a non-discriminatory culture;
- address explicitly, within the regulatory frameworks for the provision of services by the private sector, the reproductive health needs of women and gender inequities in access;
- ensure that the content of basic packages of service responds to the priority needs of women and emphasizes, as a basic right, the inclusion of family planning and obstetric emergency services, as well as the incorporation of services related to domestic violence;
- incorporate in the various levels of care, in coordination with other social services, activities for prevention, detection, and care for victims of domestic violence and sexual abuse against women;

- provide free access to preventive services, such as immunization, growth monitoring of children, contraception, prenatal care, cervical cancer screening, and prevention of sexually transmitted diseases and HIV infection;
- consider measures that would redistribute the cost of reproductive health services (family planning, prenatal care, care during childbirth, maternal leave, breastfeeding), so that this cost is not borne exclusively by women;
- extend health care coverage for male and female workers in the informal sector and in temporary or part-time occupations in which women predominate;
- consider the establishment or strengthening of support mechanisms for home care, which is provided mainly by women and which has increased in volume as a result of processes of decentralization and cost reduction in health services;
- establish support mechanisms to promote and strengthen women's social participation in community structures for decision-making about health, without this increasing their workload;
- form national commissions on gender and health—including representatives of various agencies of the ministry of health, other ministries, national offices of women's issues, and nongovernmental organizations—to serve as advisory bodies for processes of policy formulation, implementation, and evaluation.

That PAHO

- compile, develop, and disseminate indicators of women's health and gender inequities in health and human development;
- develop indicators of the economic worth of women's unpaid work in the health sector to be incorporated into national health accounts systems;
- prepare methodological guidelines for carrying out health situation analysis with a gender perspective;
- prepare and disseminate a document that will alert governments and civil society to reform measures that may have an adverse impact on women and gender equity
- carry out advocacy activities to promote gender equity among bilateral and multilateral institutions that provide financing for HSR;

- provide technical support to the countries, with the participation of the technical programs most directly involved—Women, Health, and Development, Health Policies, Health Situation Analysis, and Health Systems and Services Development—to enable them to develop basic indicators, analyze the health situation, and evaluate the effects of HSR, all from a gender perspective;
- support the process of gender sensitization among health policy managers and planners;
- develop contents and methodologies on gender and health for incorporation into the curricula for the training of health professionals;
- incorporate a gender perspective into the development of the proposed regional convention on tobacco control and other regional instruments that support or complement the framework convention;
- strengthen the system of national focal points of the Program on Women, Health, and Development.

The Director commended the Subcommittee for its decision to focus the recommendations on a few major themes and congratulated the delegates on having synthesized so aptly the principal issues that needed to be dealt with in the immediate future. The recommendations were practical and feasible. The Secretariat could commit itself without any reservation to implement those that pertained to the work of the Organization at the Regional and country levels, and it would be accountable to the Subcommittee for carrying out the activities requested of it. The recommendations to the Member States reflected the delegates' knowledge of conditions in the countries and of the possibilities for their successful implementation. He hoped that the delegates would promote the recommendations when they returned to their countries, since only through consistent and persistent advocacy at the national level would they come to constitute points of discussion and be translated into action in the countries. The Organization had clear ideas about how gender inequities were expressed and how they might be resolved, but its technical cooperation could only assist member States to the extent that they wished to take action to address the issue.

He invited the delegates to submit any written comments that they or their colleagues at home had in regard to the recommendations or the documents presented during the session. It would be a source of great satisfaction to the staff of the Secretariat to know that the documents had been useful in prompting discussion in the countries.

He concluded by noting that he had sometimes been accused of being a romantic at heart because of his optimism that the world could be made a better place through what

people did during their lifetimes. However, he considered that optimism to be fully justified in the area of gender equity, since the tools and capabilities were available to bring about a real improvement.

Closing of the Session

The President thanked all the participants for their excellent presentations and comments. She assured the Director that his romanticism was not misguided and observed that the natural romanticism of women had already begun to be translated into action in the countries. She urged the delegates to view the recommendations as a commitment to action that would validate the work that they had done together during the session. She then declared the 18th Session of the Subcommittee on Women, Health, and Development closed.

AGENDA

1. Opening of the Session
2. Election of the President, Vice President, and Rapporteur
3. Adoption of the Agenda and Program of Meetings
4. Report on the Activities of PAHO's Women, Health, and Development Program at the Regional and Country Levels
5. Towards Gender Equity in Health Sector Reform Policies
6. Women's Needs and the Response of Health Sector Reform: Experiences in Chile and Ecuador
7. Presentations by Subcommittee Members on Gender Equity and Health Sector Reform Policies in their Countries
8. Addressing Violence against Women in Health Sector Reform Policies in Central America
9. Other Matters

LIST OF DOCUMENTS

<i>Document No.</i>	<i>Title</i>
MSD18/1	Agenda
MSD18/2	List of Participants
MSD18/3	Report on the Activities of PAHO's Women, Health, and Development Program at the Regional and Country Levels
MSD18/4	Towards Gender Equity in Health Sector Reform Policies
MSD18/5	Women's Needs and the Response of Health Sector Reform: Experience in Chile. Health Insurance and Women's Coverage
MSD18/6	Women's Needs and the Response of Health Sector Reform: Experience in Ecuador. Implementation of the Reform Law on Free Maternity Care in Support of Health Sector Reform
MSD18/7	Addressing Violence against Women in Health Sector Reform Policies in Central America

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