PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

20th SESSION OF THE SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 25-26 March 2003

Provisional Agenda Item 5

MSD20/5 (Eng.)
11 February 2003
ORIGINAL: SPANISH

COUNTRY EXPERIENCES WITH MONITORING HEALTH POLICIES WITH A GENDER PERSPECTIVE

Experience in Mexico

CONTENTS

Page

Program of Action for Women and Health 2001-2006
An Initiative to Promote Gender Equity in Health in Mexico

How has the Government dealt with gender inequities in health policy and the health budget?

Background

1. In Mexico, civil society, and the women's movement in particular, has been working for more than 20 years in an organized effort to secure legal, social, and domestic equality for women. The Federal Government's effort to address this issue in its program budget took place in 1980 with the creation of the National Program for Integrating Women in Development, aimed at promoting initiatives to raise the social status of women. Fifteen years later in 1995, the government established the National Program for Women 1995-2000: Partnership for Equality. In 1998 the Coordinating Office of the National Commission on Women was created. This entity was the immediate predecessor of the current National Women's Institute (INMUJERES), set up by the National Congress in January 2001.

2. Health policies targeting women have been implemented throughout Mexico, from the health system which includes the Secretariat of Health (SSA) as the steering agency of the sector, to the Mexican Social Security Institute (IMSS), to the Social Services and Social Security Institute for State Workers (ISSSTE), down to the health services of certain sectors, such as the Secretariats of National Defense and the Navy and the parastate oil company, Petróleos Mexicanos (PEMEX). These policies have passed through several stages.

3. The first began 50 years ago with Mexico's important contribution to hormonal contraception, followed in 1973 by its shift from a pro-birth population policy to birth control programs. The second was the launching of family planning and maternal and child health programs, and the third after the IV International Conference on Population and Development, held in Cairo in 1994, which proposed a shift in paradigm, putting women at the center of health policies as actors with full rights of their own and not only in terms of the health of the rest of the population. It was during this stage that Mexico's current reproductive health policies were designed.

4. Reflecting these different visions of health policy as it relates to women, the SSA initially created a Bureau of Family Planning (first known as the General Coordination Office). The Bureau's programs ultimately led to a change in its name, orientation, and scope; in the second half of the 1980s, the focus began to center on maternal and child health, and in the 1990s, on reproductive health. During this stage, moreover, a

coordinating unit for the Program on Women, Health, and Development was created under the Bureau of Health Promotion, based on the guidelines proposed by the Pan American Health Organization.

The Women and Health Program

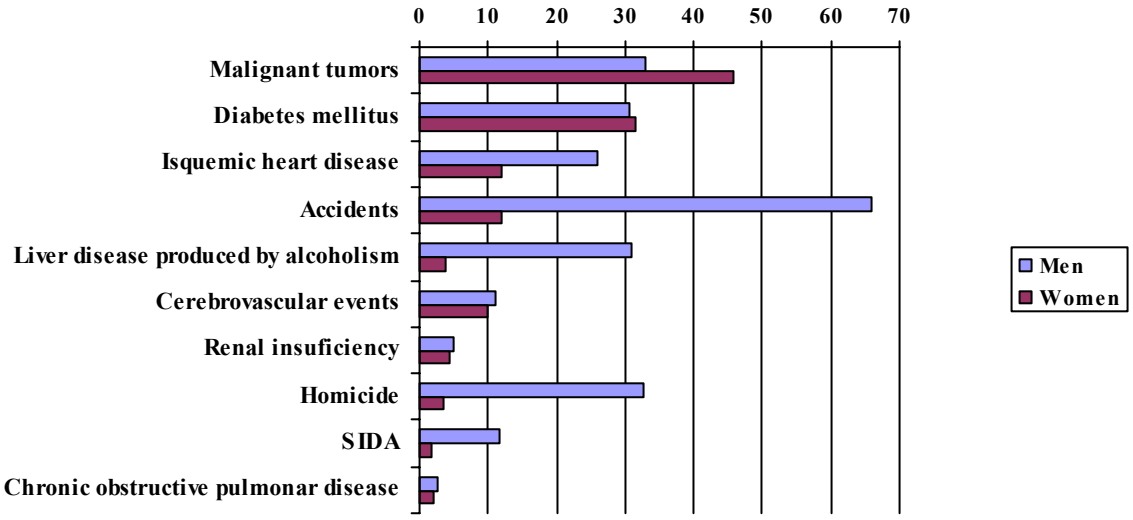
5. The Women and Health Program is largely a response to the demands of the national and international women's movement to ensure that in designing public policies that affect women, the health sector considers gender-related differences and needs, as well as the interaction of gender with other variables such as age, ethnicity, migration status, socioeconomic level, schooling, and employment, which place certain population groups at a disadvantage.

6. The Women and Health Program marks what we consider to be the fourth stage, and notwithstanding the progress made, we are seeking to coordinate with the Reproductive Health Bureau to address the issues that make "women and health" a complex concept.

7. The relationship between women and health is complex, involving at least the following areas: women's health throughout the life cycle; the role of female health professionals, and women as health care providers in both home and community.

8. Although there is little information with a breakdown by sex—one of the key problems that we would like to address—the following are some examples that illustrate the current situation of women in these areas.

Figure 1. Leading causes of mortality in Mexico, by sex, 1999
(rate per 100,000 population)

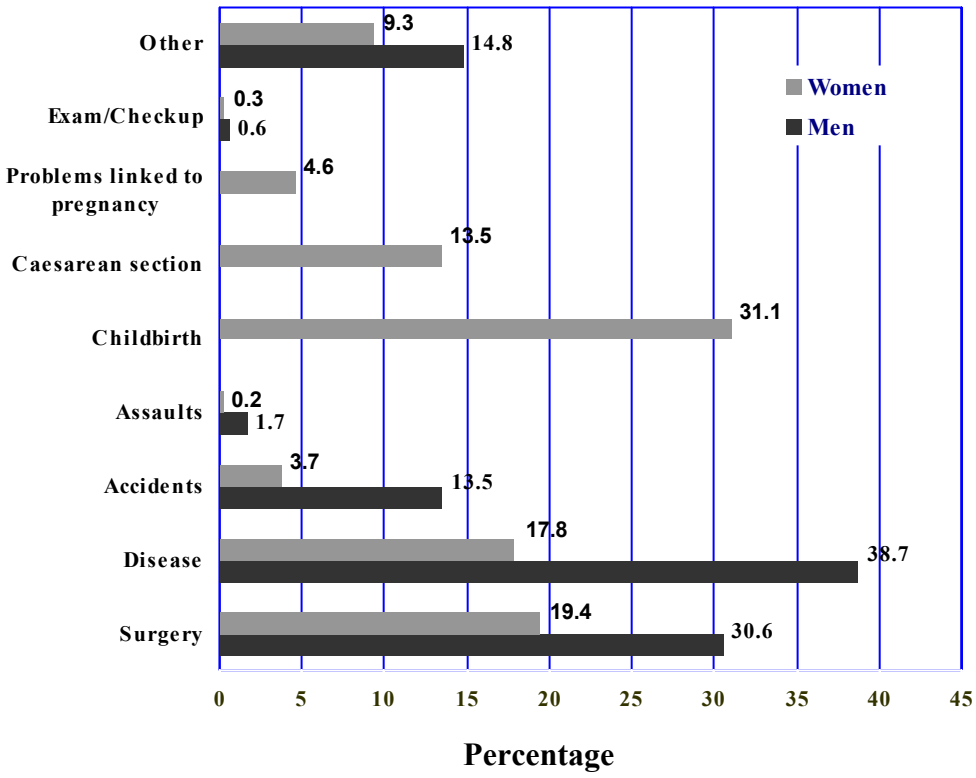


Source: *SSA. Dirección General de Información y Evaluación del Desempeño. Anuario Estadístico* 1999. Mexico, D.F.

9. Figure 1 shows the principal causes of mortality in Mexico. The bars in black represent women and the bars in gray, men. While women die more of cancer and diabetes, men exhibit higher mortality from accidents, liver disease produced by alcoholism, and homicides.

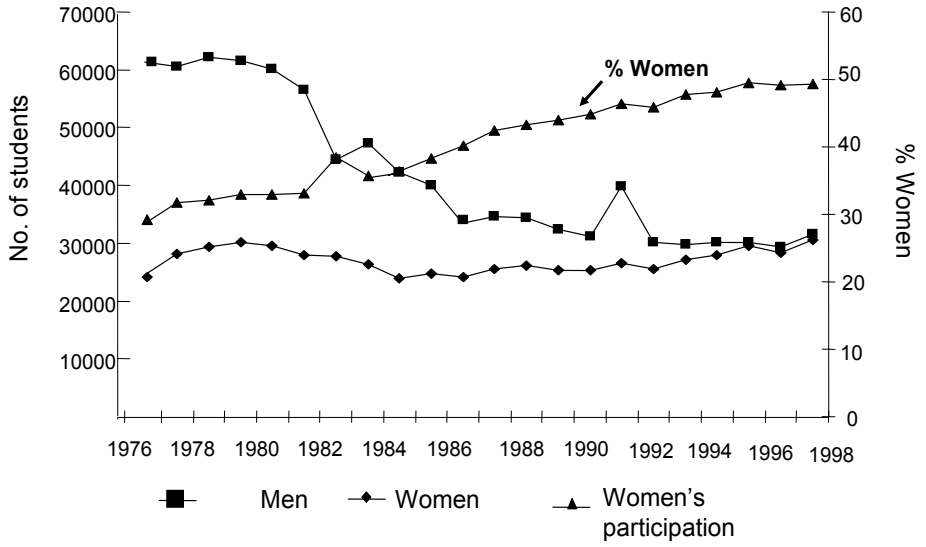
10. Figure 2 indicates the utilization of hospital services and shows that, except for matters related to pregnancy and childbirth (normal births or caesarean sections) women use these services less. However, reproduction is such a factor that whenever hospital use is discussed, women are viewed as the principal beneficiaries. In reality, however, timely, quality health services in pregnancy and childbirth should be regarded as beneficial to society as a whole, which women contribute to in a fundamental way.

**Figure 2. Utilization of hospital services by sex.
National Health Survey, Mexico, 2000**



11. In the matter of women as professional health care providers, Figure 3 shows a decrease in the number of male medical students from 1976 to 1998, while the number of female medical students held steady. The current ratio is approximately 50% (some schools now have even more women than men).

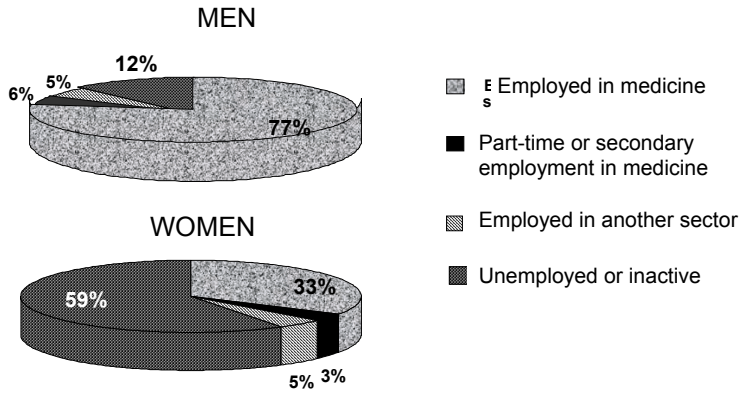
Figure 3. Medical school enrollment by sex; Mexico, 1976-1998



Source: *ANUIES. Anuarios estadísticos 1976-1998*. México, D.F.

12. However, as Figure 4 indicates, unemployment or inactivity in the profession is much higher for women: 59% of women versus 12% of men.

Figure 4. Employment patterns in medicine, by sex, 1999



Source: INEGI, National Urban Employment Survey, 2nd Quarter, 1999.

13. Even though the health services are largely staffed by women—nurses, social workers, physicians, and paramedical professionals—the number of women in positions of authority is very limited.

Adopting the Gender Perspective

14. One of the main objectives of the Program is to employ the gender perspective in all health policies. Although women exhibit lags and disadvantages that warrant compensatory affirmative action policies, it is no longer possible to formulate public policy without employing the gender perspective if the goal is really to obtain efficient results. The term "gender" is not synonymous with "women," nor is it a more elegant or politically correct way of referring to sex.

15. The different roles assigned to women and men for social and cultural reasons are largely responsible for the differences noted above: the health lags of women, and in many cases, the health problems of men.

16. Gender is what determines the special health care needs of men and women, even for diseases affecting both sexes, and this implies specific risks associated with activities or attitudes considered feminine or masculine; different perceptions about the risk of becoming ill and health needs; a different degree of access to resources and their control; different responsibilities distributed inequitably in the family and community; a different

priority in the allocation of public resources for health care and research; and a different share in the democratization of health.

The Five Components of the Women and Health Program

Institutional Adoption of the Gender Perspective

17. This component implies the amendment of laws, standards, policies, and budgets in the sector and a change in the way health problems, the organizational culture, institutional frameworks, and operating procedures are interpreted and analyzed. It involves the regular and systematic consideration of gender in all practices and activities of health institutions. This will require changes across the board.

Women's Health

18. This component promotes a vision of women's health throughout the life cycle, considering sexual and reproductive health an essential, but not the sole, element. It pays special attention to the most prevalent or serious problems or issues affecting women's health that have not been adequately addressed. Thus, part of this component will involve coordinated action to prevent and deal with domestic and sexual violence, mental health issues, addictions and the problems related to lifestyle, such as nutritional disorders and chronic diseases, whose genesis is clearly linked to behavior and, accordingly, gender.

Information and Research

19. This component promotes the collection of information with a breakdown by sex and age in the relevant health statistics, as well as the analysis of information from primary sources, which will enable us to disaggregate the data. The first issue of a semiannual bulletin, ***Salud y Género en Cifras*** **[Health and Gender in Figures],** has already been published. This bulletin will serve as the Program's information organ, documenting inequities and promoting decision-making in this regard. Efforts will also be made to move forward in the preparation of health indicators with a gender approach, which will facilitate monitoring of the activities contained in the National Health Program.

20. As to clinical and public health research, especially research to evaluate interventions or programs, the Women and Health Program is currently conducting a study on the place assigned to women, examining the issues investigated, the sex of subjects recruited, and the relevance of the conclusions for women. The Program is also promoting the exploration of relevant topics and the gender perspective in all lines of research.

Female Health Workers.

21. Women participate in the health sector on a massive scale. However, for historical reasons, they are not where they should be. For example, affirmative action policies are needed that give priority to women with equal qualifications in professional recruitment. Training and specialization programs in medicine, psychology, nursing, and social work must take the household and childrearing responsibilities of women into account; these responsibilities are often insurmountable obstacles, making it impossible for professional women to reconcile motherhood with the demand of their profession. Steps must be taken to raise the status of the work performed by nurses and social workers and to take their specific needs into account—for example, by providing child care centers for the night shift.

Family and Community Health

22. Family health care has traditionally been the responsibility of women, provided without remuneration or recognition and little valued by the family, society, and women in Mexico. The Mexican population is rapidly aging. This implies additional challenges in the near future, part of which will have to be addressed by families. Furthermore, social changes that imply the shrinking of traditional support networks will make the work of women even more onerous if the burden continues to fall exclusively on them.

23. Thus, the Women and Health Program seeks to promote policies that encourage the participation of other family members, particularly men, in protecting family health--policies that facilitate the full development of women and men as individuals and social actors.

Gender-sensitive Budgets

24. It is certainly true that "a priority not reflected in the budget is simply demagoguery," and the same holds true for public policies. Notwithstanding, to reduce gender inequities, it is not enough to have a program with a budget, however generous. Government budgets must be gender-sensitive, and this has become one of the demands of the women's movement and personnel of both sexes who are sensitive and knowledgeable about gender theory.

25. This is a very complicated process, launched by the Women and Health Program with an initial publication as part of the component on institutional adoption of the gender perspective. This publication shows how to identify gender inequities in the different fields of health and how to integrate the costs of the interventions necessary for reducing those inequities and reflect them in the budgets. Each year it will publish the progress made in this process. This will first require efforts to raise awareness and obtain technical support from the Ministry of the Treasury and Congress, since it is the representatives, male and female, who approve the Budgetary Expenditures of the Federation.

26. It should be noted that this is the first attempt to draft gender-sensitive budgets in the health sector and, indeed, the Federal Government of Mexico. As this initiative moves forward, financial support will be obtained to implement activities aimed at reducing gender inequities in health in this country.

What surveillance indicators are used to monitor the impact of these policies and how were they selected?

Indicators of the Plan of Action for Women and Health

27. The success of the Plan of Action for Women and Health is measured through the following outcome or impact indicators, which coincide with the goals of the Plan:

Component/activity	INDICATOR
INSTITUTIONAL ADOPTION OF THE GENDER PERSPECTIVE	• Proportion of mid-level and senior staff trained through seminars on gender equity, gender and public policy, and gender and health. • Proportion of priority programs that employ the gender perspective in their diagnostic studies, objectives, lines of action, goals, and evaluation indicators. • Proportion of mid-level and senior staff trained through courses in how to prepare gender-sensitive budgets. ***BUDGET*** • Publication of proposed modifications to the structure of the health program to facilitate the preparation of gender-sensitive budgets in sector agencies. *
WOMEN'S HEALTH	• Essential health services for incarcerated women and their children • Quality.* • Mental health. * • Addictions. *
INFORMATION AND RESEARCH	• Proportion of reports from the Health Information System with a breakdown by age and sex. • Publication of an annual report on health situation indicators with a gender perspective, which will make it possible to monitor the impact of gender on the health of men and women. • Number of published reports containing research findings on the impact of gender on the health of Mexican women and men. • Number of health research lines that employ the gender perspective.
HEALTH WORKERS	• Proportion of women benefiting from the hiring and promotion processes for senior positions with a high degree of responsibility. • Proportion of women benefiting from institutional fellowships for graduate education. • Proportion of women benefiting from extramural training commissions. • Terminal efficiency of women enrolled in graduate medical residencies. • Proportion of health units with night shift that have child care available during those hours.
FAMILY AND COMMUNITY HEALTH	• Average hours a week that women residing in locations with community health programs devote to the activities of those programs. • Annual number of men who participate in the activities of community health programs.
DOMESTIC VIOLENCE, SEXUAL VIOLENCE, AND VIOLENCE AGAINST WOMEN	• Proportion of health units in which the NOM-190-SSA1-1999 (Health Services Delivery. Criteria for Medical Care for Domestic Violence in Health Units) is correctly applied. • Publication of the Integrated Health Care Model for cases of domestic and sexual violence.

Who is in charge of using these indicators to monitor the application of health policies, and how do they do it?

28. The SSA has a Bureau of Performance Data and Evaluation, responsible for the semiannual monitoring of improvements in the indicators. In addition, the National Women's Institute monitors the progress of sectoral programs on gender, which obviously include the program of the health sector.

29. The indicators in the box above were selected to evaluate the performance of the Women and Health Program. Those marked with an asterisk are impact indicators for the activities of other sector programs that are particularly important for women's health.

30. Of the 58 indicators selected for assessing the impact of the Women and Health Program's strategies and lines of action, 39 are pertinent for monitoring the situation of gender equity in health (see Annex).

31. Direct responsibility for monitoring Ministry of Health activities at the federal level falls to the Coordinating Office of the Women and Health Program. Progress made at the state level and in the remaining sector institutions will be channeled through their representatives in the National Consortium on Women and Health and will be presented to the National Health Council.

32. Sector institutions will submit a report on the progress in each of the proposed goals to the annual meeting of the Management Council of the National Consortium on Women and Health.

33. Furthermore, the National Women's Institute is responsible for monitoring activities to promote gender equity in health through these and other indicators provided periodically by the Ministry of Health.

Indicate the direct stakeholders in this process and how they became involved in the preparation and monitoring of these policies

34. To meet the objectives established for this new phase in addressing the health problems of women and men with the gender approach, the work must take place on a national scale. The entire health sector must become involved, and the collaboration and commitment of other sectors, governmental and nongovernmental, as well as academia, must be secured. To this end, the National Consortium on Women and Health was created.

The National Consortium on Women and Health

35. This Consortium is an initiative supported by public health institutions specializing in women's issues, as well as nongovernmental technical organizations. These joint efforts benefit the Program, since they combine the prestige of such institutions with the mandate to define the policies, standards, and programs of public institutions with proven knowledge, experience, and commitment in the field. Furthermore, this collaboration in itself is an experience worthy of study--and replication, if successful.

36. The Consortium is national and sectoral in scope, for it works with all the agencies of the Ministry of Health and the National Health System. It is also an intersectoral initiative that collaborates with key entities in the field of women and health, whether generating and processing data or operating health care centers or programs with a clear impact on women's health--especially those targeting the most vulnerable groups. In addition, the program interacts with the technical institutions and institutions of higher education responsible for training health professionals and other health workers, and with the private sector that produces health inputs for women or has a tradition of providing financial support for programs and activities that improve women's health.

37. The Consortium is thus an inclusive initiative representing the interests and perceived needs of women. It promotes the collaboration and participation of civil society, represented by nongovernmental organizations--especially those working in the areas of data management, research, technical cooperation, information dissemination, and the linking of research with decision-making on issues that affect women's health.

38. The Consortium is made up of two councils, whose guidelines have been established by the participating institutions and organizations and which operate through cooperation agreements:

- The Management Council, comprised of the heads of the governmental and nongovernmental organizations, is responsible for developing policies and strategies for meeting Consortium objectives. Its members name representatives from their institutions to the Technical Council and provide them with the institutional support necessary for its operation and compliance with agreements.

- The Technical Council is comprised of experts from the different governmental and nongovernmental organizations and has decision-making power. The plenary of the Technical Council meets formally four times a year to implement the policies designed by the Management Council. The Technical Council has organized working groups to move forward in specific areas. These groups are

drawing up their work plans and developing mechanisms for interfacing with the other working groups.

39. The National Consortium on Women and Health is made up of 32 institutions from government, academia, and organized civil society. Among these health sector institutions, obviously; institutions involved in the generation of statistical data and population policy; agencies that provide care for especially vulnerable populations, such as indigenous groups, the elderly, and the disabled; human rights agencies; academic institutions, such as universities and institutes of higher education and scientific research; and eight civil society organizations with interests in areas related to gender and health.

40. Through the Technical Council and its working groups, the Consortium suggests initiatives to reduce gender inequity and identify the relevant indicators for its evaluation and monitoring, although it is not necessarily involved in the direct monitoring of trends in the proposed indicators.

41. In addition to promoting adoption of the gender perspective in programs of action, budgets, information systems, lines of research, and health services, the mission of the Coordinating Office of the Women and Health Program in Mexico is to monitor the progress made in that direction, using the year 2006 (the end of the current Federal Administration) as its medium-term horizon. By this date, the plan is to have 80% of staff and programs gender-sensitive, enabling them to draft budgets with a gender perspective, with information systems that facilitate evaluation of the population's health status from this perspective, and with broad civil society participation in the design of public policies and their application.

ANNEX

GENDER EQUITY PERFORMANCE EVALUATION INDICATORS

1. Life expectancy at birth, by sex
2. Life expectancy at 65 years, by sex
3. Total fertility rate
4. Infant mortality (adjusted), by sex
5. Under-5 mortality, by sex
6. Mortality from diarrheal diseases in children under 5, by sex
7. Mortality from acute respiratory infections in children under 5, by sex
8. Prevalence of moderate and severe malnutrition in children under 5, by sex
9. Maternal mortality (adjusted)
10. Mortality from cervical cancer in women aged 25 and over
11. Mortality from breast cancer in women aged 25 and over
12. Age-adjusted mortality from ischemic heart disease, by sex
13. Age-adjusted mortality from cerebrovascular disease, by sex
14. Age-adjusted mortality from diabetes mellitus, by sex
15. Mortality from cirrhosis of the liver, by sex
16. Mortality from lung cancer, by sex
17. Mortality from traffic accidents, by sex
18. Mortality from suicide, by sex
19. Mortality from homicide, by sex
20. Morbidity from pulmonary tuberculosis in the population aged 15 and over, by sex
21. Morbidity from AIDS, by year of diagnosis, by sex
22. Prevalence of STI/HIV, by sex
23. Number of active users of family planning methods per 100 women of childbearing age
24. Average prenatal check-ups per pregnant woman
25. Percentage of deliveries in medical facilities
26. Percentage of newborns tested to ensure early detection of congenital hypothyroidism *
27. Vaccination coverage with the full series: children 1 year of age *
28. Vaccination coverage with the full series: children aged 1-4 *
29. Number of consultations with medical specialists per 1,000 population *
30. Number of surgical interventions per 1,000 population *
31. Percentage of pulmonary tuberculosis cases that completed the treatment and were cured *
32. Percentage of individuals in the National Registry of AIDS Cases who are still alive*
33. Percentage of deliveries by caesarean section
34. Waiting time in outpatient facilities *
35. Waiting time in emergency rooms *
36. Percentage of patients who receive information about their illness *
37. Percentage of users who would recommend the health services *
38. Public health expenditure per inhabitant, disaggregated by type of population *
39. Percentage of deliveries in women under 19

* The disaggregation and publication of these indicators by sex have been recommended.

- - -